Indian Health Service
Program Evaluation Services

Community Opioid Intervention Pilot Projects **Aggregate Report 2021–2024**

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Executive Summary

The Indian Health Service (IHS) Community Opioid Intervention Pilot Projects (COIPP) is an initiative aimed at addressing opioid use and opioid use disorder (OUD) within Tribal communities. This pilot program, funded with $20 million through IHS appropriations, was developed to implement comprehensive interventions to combat the opioid crisis, reduce harm, and improve the overall well-being of individuals affected by OUD.

The overarching goal of the COIPP is to design, evaluate, and refine an integrated, collaborative approach to opioid intervention and prevention that can be replicated and expanded for communities by addressing multiple areas, specifically (1) prevention, (2) treatment, (3) harm-reduction, and (4) community support. These efforts support COIPP's three main objectives:

- **Increase Community Awareness and Education:** Elevate public awareness and education about traditionally appropriate and family-centered opioid prevention, treatment, and recovery practices and programs in American Indian and Alaska Native (AI/AN) communities.
- **Build Traditionally Relevant Support Systems:** Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities.
- **Expand Access to Medication for Opioid Use Disorder (MOUD) Services:** Reduce unmet treatment needs and opioid-related overdose deaths through MOUD.

IHS conducted evaluations for the COIPP for the following program years:

- Grant Year 1 (GY1: April 1, 2021–March 31, 2022),
- Grant Year 2 (GY2: April 1, 2022–March 31, 2023), and
- Grant Year 3 (GY3: April 1, 2023–March 31, 2024).

Background

The COIPP was first established by the Consolidated Appropriations Act of 2019 (Pub. L.116–6) and the accompanying Conference Report (H. Rpt. 116–9). The program was designed to better combat the opioid epidemic in Indian Country, with 35 grantees awarded for the GY1, GY2, and GY3 program cycles. Through the grant program, grantees supported the development, documentation, and sharing of locally designed and traditionally appropriate prevention, treatment, recovery, and aftercare services for mental health and substance use disorders (SUDs) in AI/AN communities.

Methodology

IHS evaluated data submitted across the three grant program years by incorporating quantitative and qualitative data analyses from the following data sources:

- Annual progress reports (APRs), and
- Technical assistance support.

Quantitative Analysis

A descriptive analysis compared GY3 data to the baseline metrics established in GY1 and GY2. Additional statistical analyses were completed to evaluate relationships between variables by predetermined research questions.

Qualitative Analysis

Qualitative narrative analysis was conducted to complete an inventory of APRs and grantee evaluation assistance for each grant year. Data was extracted from both sources, and thematic coding was employed to unpack and understand grantees' personal and detailed accounts of their experience. This offered insights into successes and opportunities, as well as the impact of their efforts among the communities served.

Recommendations

To further advance opioid prevention, treatment, and recovery efforts, grantees should track educational outcomes to evaluate the impact of events, explore advertising effectiveness, and enhance outreach through community partnerships. Building a community of practice among grantees will foster collaboration and innovation in education and outreach strategies. Strengthening support systems includes establishing guidelines for traditional programming, creating youth advisory councils, fostering employee support workgroups, and providing guidance for optimal crisis response teams. Expanding MOUD services requires anti-stigma campaigns, patient satisfaction evaluations, increased overdose data access, and strong staff recruitment and retention plans. Finally, creating multidisciplinary professional teams and ensuring diverse care options will improve patient outcomes and broaden access to critical services.

Conclusion

Over the past three grant years, grantees have made substantial strides in addressing opioid prevention, treatment, and recovery. Grantees have put forth strong efforts to enhance community awareness, expand access to treatment, and strengthen support systems with meaningful outcomes. Notable progress has been achieved in expanding MOUD services, building multidisciplinary teams, and increasing access to essential resources. Grantee dedication and innovation in overcoming complex challenges drive the improvements measured in the COIPP data. As these efforts continue, a focus on sustainability, deepening partnerships, and leveraging lessons learned will ensure greater impact and ensure long-term success in addressing the opioid crisis.

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List of Abbreviations

Term	Abbreviation
Alaska Blanket Exercise	ABE
Alcohol Use Disorder	AUD
American Indian and Alaska Native	AI/AN
Annual Progress Report	APR
Attachment-Based Family Therapy	ABFT
Cognitive Behavioral Therapy	CBT
Community Opioid Intervention Pilot Project	COIPP
Community Reinforcement and Family Therapy	CRAFT
Community Reinforcement Approach Therapy	CRA
Contingency Management	CM
Dialectical Behavioral Therapy	DBT
Electronic Health Records	EHR
Evidence-Based Practice	EBP
Extension for Community Healthcare Outcomes	ECHO
Eye Movement Desensitization and Reprocessing	EMDR
Full-Time Equivalent	FTE
Grant Program Year	GY
Indian Health Service	IHS
Intensive Outpatient Program	IOP
Matrix Model	MM
Medication-Assisted Treatment	MAT
Medication for Opioid Use Disorder	MOUD
Memorandum of Understanding	MOU
Memorandum of Agreement	MOA
Motivational Enhancement Therapy	MET
Motivational Interviewing	MI

Term	Abbreviation
National Child Traumatic Stress Network	NCTSN
Northwest Portland Area Indian Health Board	NPAIHB
Opioid Treatment Program	OTP
Opioid Use Disorder	OUD
Parent-Child Assistance Program	PCAP
Question Persuade Refer	QPR
Substance Abuse and Mental Health Services Administration	SAMHSA
Screening, Brief Intervention, and Referral to Treatment	SBIRT
Secondary Traumatic Stress	STS
Substance Use Disorder	SUD
Syringe Service Programs	SSP
Urban Indian Organization	UIO
Virtual Reality	VR
Year-over-Year	YoY
Youth Gathering of Native Americans	GONA

Introduction

The IHS COIPP was established by the Consolidated Appropriations Act of 2019 (Pub. L. 116-6). This initiative aims to address opioid abuse and SUD within Tribal communities and was developed with the goal of implementing comprehensive interventions to combat the opioid crisis, reduce harm, and improve the overall well-being of individuals affected by OUD. This innovative project is funded with $20 million in IHS appropriations.

The intent of providing COIPP grants to AI/AN communities is to address the impact of the opioid crisis by increasing local knowledge and use of traditional practices and interventions and encouraging the use of MOUD.

This report presents findings from an evaluation of the 35 grantees who built and expanded their work to address the opioid crisis in their communities. The purpose of the COIPP evaluation is to:

- Understand how funding is targeted to address the range of programmatic objectives of the grant,
- Discern grantee capacity for evaluation, and
- Evaluate each grantee's APR.

The findings from this evaluation highlight the successes achieved by grantee sites through use of their IHS COIPP funding. The findings are also meant to inform the IHS COIPP grant program team of areas that may warrant further development and support to ensure the success of the overall COIPP grant program.

Background

With the $20 million appropriation in FY 2019, the COIPP program awarded grants that support the development, documentation, and sharing of locally designed and traditional practices for prevention, treatment, recovery, and aftercare services for mental health and SUDs in AI/AN communities. The notice of funding availability was published and awarded to 35 grantees. There is a need to develop and expand community education and awareness of prevention, intervention, treatment, and recovery from OUD. Moreover, there is a need for increased research and evaluation of programs implemented by and within AI/AN communities (Hirchak et al., 2023).

Nationwide, in 2010, overdose rates among AI/ANs were 1.03 times that of White individuals; in 2019, rates had risen to 1.15 times that of White individuals. However, the racial differences in overdose rates vary by state, with the highest rates among AI/ANs, as compared with White individuals in Minnesota, North Dakota, and South Dakota. Conversely, in Mississippi, South Carolina, and Florida, AI/AN overdose rates among AI/AN individuals, compared to White individuals, are the lowest (Friedman et al., 2022). Within the AI/AN population, a recent study identified significantly different opioid-

related overdose mortality growth rates across two distinct time segments with 0.36 per 100,000 (95% CI = 0.32, 0.41) between 1999 and 2019 to 6.5 (95% CI = 5.7, 7.31) between 2019 and 2021. This study noted that the most pronounced increase was observed among those between the ages of 24 to 44 years. The study also reported that mortality growth rates were similar between AI/AN females and males between 2019 and 2021, and that similar patterns were observed with AI/AN populations with Hispanic ethnicity (Bauer et al., 2024).

OUDs in AI/AN communities have both contemporary and historical roots. Contemporary disparity factors that contribute to opioid disorders include high poverty, malnutrition, and unemployment rates in many AI/AN communities. In addition, the educational quality in these settings is often poor, which correlates to OUD community rates. Historical and intergenerational trauma resulting from relocation and residential school experiences are also risk factors for OUD (Mauro, 2024).

Opioid treatment in AI/AN communities should leverage community strengths and traditions. These strengths include close family and clan-based bonds, connection to the land and ancestry, spiritual beliefs, traditional identity, and use of Indigenous languages. While traditions vary widely, they may include practices such as talking circles, traditional tea drinking ceremonies, sweat lodges, and celebrations and ceremonies that mark rites of passage and one's role in the community (Hirchak et al., 2023).

Such approaches are essential because substance misuse has long been an issue affecting AI/AN communities. Results from the National Survey on Drug Use and Health, conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2012), indicate that AI/AN adults experience higher rates of illicit drug use, binge alcohol use, and substance dependence or misuse compared to the national average. As such, the population demonstrates a greater need for substance abuse interventions. However, AI/AN individuals often do not receive treatment due to various barriers, including lack of health insurance (U.S. Department of Health and Human Services, n.d.), limited community awareness of treatment options, shame that discourages them from seeking substance abuse treatment, or a lack of available treatment facilities or programs (SAMHSA, 2012; Burrage et al., 2016; The Henry J Kissinger Foundation, 2013; Indian Health Service, 2013; SAMHSA Office of Applied Studies, 2009; SAMHSA, 2010).

Through the COIPP, IHS aims to establish a transformative model of care that recognizes the unique traditional, historical, and social determinants of health within Indigenous communities. This holistic approach encompasses evidence-based treatment (EBT), prevention, harm-reduction strategies, and community engagement to foster long-term recovery and well-being. Under the COIPP funding opportunity, grantees are encouraged to address the following objectives:

- **Increase Community Awareness and Education:** Increase public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.
- **Build Traditionally Relevant Support Systems:** Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities.
- **Expand Access to MOUD Services:** Reduce unmet treatment needs and opioid-overdose related deaths using MOUD treatment.

Thirty-five grantees were awarded through a competitive process in which grantees were selected from Tribal communities across the IHS service areas, from Urban Indian Organizations (UIO).

Collaboration lies at the heart of COIPP. Tribal governments, health care facilities, community organizations, and local stakeholders are encouraged to work together, share insights, and contribute their expertise to shape a comprehensive intervention framework that meets the specific needs of their communities. By harnessing the collective wisdom and strengths of diverse voices, COIPP aims to foster a sense of ownership and empowerment among community members.

Furthermore, COIPP is committed to advancing knowledge and understanding in the field of OUD treatment and prevention. Rigorous evaluation and data collection efforts are employed to assess the effectiveness of interventions, identify best practices, and inform future initiatives. This evidence-based approach ensures the COIPP remains adaptable, responsive, and equipped with the most up-to-date insights and strategies. This includes viewing OUD as a complex system of challenges, not a monolithic illness.

This is the third year of the program, and a separate APR was used for each year. The grant program year timelines are as follows:

- **GY1:** April 1, 2021–March 31, 2022,
- **GY2:** April 1, 2022–March 31, 2023, and
- **GY3:** April 1, 2023–March 31, 2024.

Multifaceted Approaches to OUD

The overarching goal of the COIPP is to develop, evaluate, and refine an integrated approach to OUD intervention and prevention that can be replicated and expanded to additional communities. By pooling the expertise and resources of various stakeholders, including health care professionals, community leaders, researchers, and individuals with lived experiences, this initiative seeks to address the multifaceted aspects of OUD comprehensively. The COIPP seeks to address the following aspects of OUD:

- **Prevention:** The primary goal is to prevent opioid misuse and OUD from occurring in the first place.

- **Treatment:** Make sure individuals struggling with OUD have access to effective treatment options.
- **Harm-reduction:** The COIPP approach recognizes the urgent need to minimize the harm associated with opioid use when unable to prevent it.
- **Community Support:** Building a strong support network is crucial for individuals in recovery and their families.

Addressing all these interrelated aspects in the appropriate traditional context is important for easing the devastating impact of opioids on AI/AN populations. The methods by which COIPP seeks to achieve these goals will be discussed herein.

Objectives of the COIPP

As previously stated, the COIPP initiative aims to address the opioid crisis across AI/AN communities by implementing a comprehensive intervention strategy. Each objective is described in terms of what guided the grantees.

Increase Community Awareness and Education

Although AI/AN people have witnessed personal and family harm, and community disruption caused by OUD, many AI/AN community members and some health program staff are not fully aware of the positive impact of prevention messaging and the value of increasing public awareness of OUD treatment and recovery. Training includes special population engagement (e.g., youth), overdose warning signs, naloxone administration, proper medication disposal, and holistic approaches to OUD treatment that address traditional beliefs, primary health care, and physical well-being. Promoting community engagement, trust, and collaboration focused on traditionally grounded strategies incorporating place-based knowledge and practices from AI/AN communities should also be included with training.

Build Traditionally Relevant Support Systems

To effectively address the opioid crisis in rural or urban AI/AN communities and provide comprehensive support to AI/AN families, it is essential to establish collaborative support teams that deliver traditionally responsive and holistic care. These teams should consist of various professionals and community supporters who work collaboratively to tackle the multifaceted challenges associated with OUD. Comprehensive support teams might include primary care providers, substance-use counselors, behavioral-health specialists, nutritionists, dental providers, and case managers.

Expand Access to MOUD Services

MOUD is an approach to SUD and OUD that combines behavioral therapy and counseling with the use of medications, such as methadone, buprenorphine, and naltrexone, which target the neurobiological aspects of OUD.

Methodology

IHS conducted an evaluation of the COIPP over three program years (GY1–GY3). This evaluation incorporated quantitative and qualitative analyses of data from the grantees' applications, APRs, and technical assistance support. The evaluation findings are highlighted next, followed by a narrative discussion.

Logic Model

The logic model was developed using content from the IHS COIPP funding opportunity and grantee sites applications. Aspects of grantees' applications that were reviewed included grantees' summary of evaluation and logic models to discern the breadth of evaluation activities and measures across each of the three priority areas, which align with the three referenced objectives of the COIPP—see Discussion and Recommendations.

Figure 1 depicts the logic model designed to represent how activities from local communities, focusing on the three objectives, with support from IHS and other allies create short-term, intermediate, and long-term community change. The roots of the tree represent the reinforcements that drive priority areas of the COIPP. The trunk of the tree represents the culmination of all resources and stakeholders who gather to make the tree strong (e.g., community, family, external organizations—local, regional, state, federal). The sunshine represents the growth direction of the project—moving toward healing and strength-informed care, through short-, intermediate- and long-term outcomes. As with the journey of each passing day, the sun rising and setting is symbolic of the process in making lives better through the thinking, planning, progress, and successes of every day toward making long healthy lives.

IHS developed a technical logic model by leveraging the frameworks of the general logic model. A detailed technical logic model, which can be found in Appendix A, outlines specific outcomes across short, intermediate, and long-term changes across priorities 1, 2, and 3. This report provides an aggregate of the COIPP programmatic achievements over 3 years.

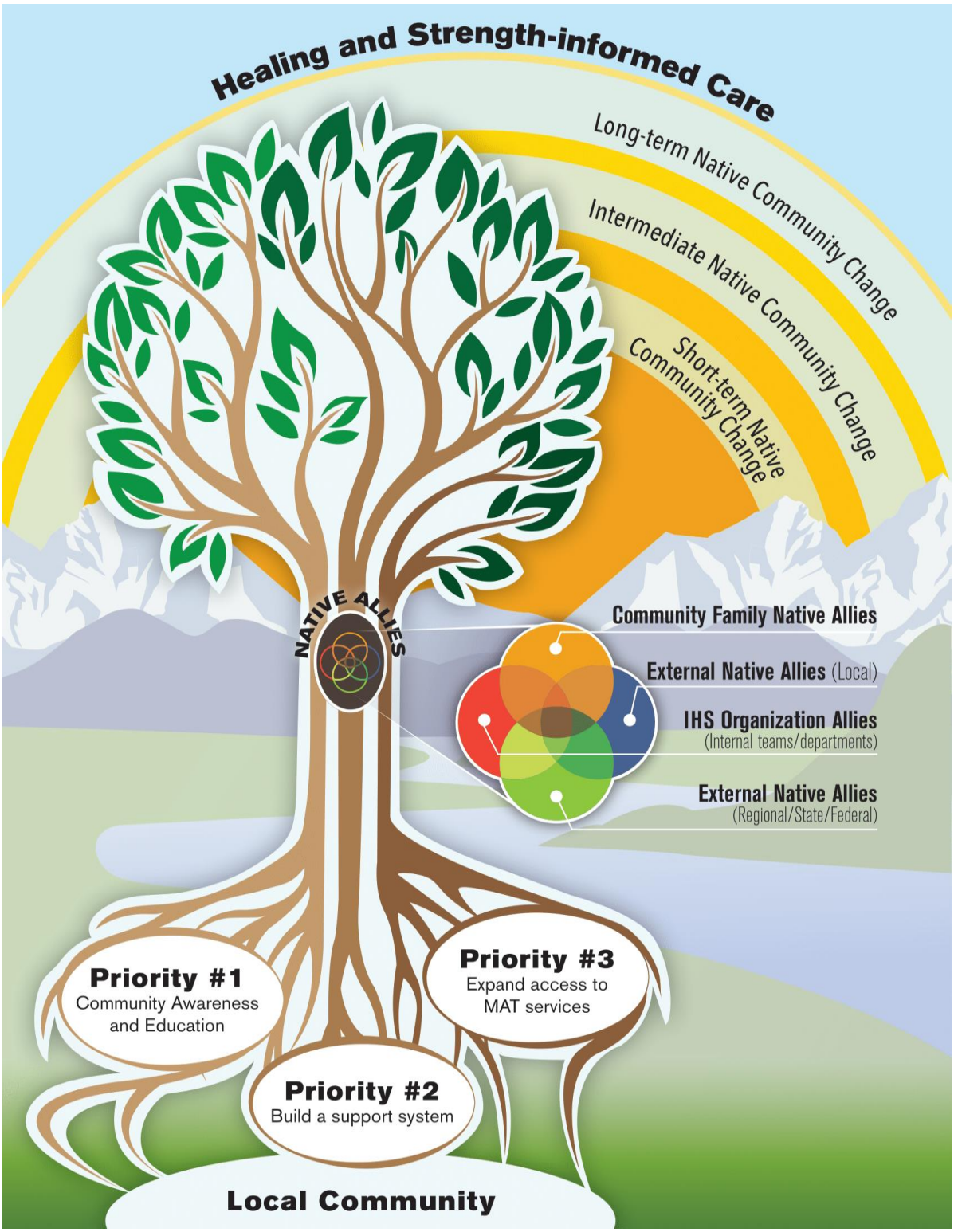

Figure 1: Holistic Logic Model

Evaluation Plan

The evaluation plan addressed the key evaluation questions below**,** tied to the priorities and sections of the APR:

- How can COIPP grantees be described and categorized?
- How are grantees increasing public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities?
- How have grantees strengthened their comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities?
- How have grantees reduced unmet treatment needs and opioid overdose-related deaths through MOUD?
- What implications do the findings of this evaluation plan have on the sources of data used?

To support answering the evaluation questions, data from the COIPP grantee applications, the IHS APR form, and technical assistance support, were analyzed and are described next.

Data Sources

The overall evaluation consisted of a review and analysis of quantitative and qualitative data from the COIPP grantee applications, the APR form, and qualitative data gathered through evaluation technical assistance. The APR collects data on both qualitative and quantitative measures pertaining to grantees' organizational capacity, service participants' characteristics, and indicators related to the fulfillment of each of the three objectives of the COIPP program. Grantees are asked to report on these measures in the APR for each corresponding reporting period. It is important to note the APR was adapted between program years—questions were removed, added, or modified to collect data that were both more accurate and more reflective of the COIPP program objectives.

All 35 grantees had access to virtual evaluation technical assistance. All assisted interactions were documented and housed in a technical assistance tracker. Examples of evaluation outreach and technical assistance provided to grantees were:

- Refining local objectives,
- Refining grantee logic models,
- Identifying outputs, data sources, and metrics related to local activities,
- Reporting to the COIPP,
- Reporting locally, and
- Understanding how to use data reporting for program improvement.

Data Analysis

This section reviews the quantitative and qualitative analyses employed and aligned with the evaluation plan and key questions of interest comparing GY1, GY2, and GY3 program years.

Quantitative Data

Descriptive analysis was completed, comparing the GY3 data to those measured in GY1 and GY2. Additional statistical analyses were completed to evaluate relationships between variables based on the predetermined research questions.

Descriptive Analysis

Descriptive data analysis for each indicator was conducted using Microsoft Excel. For indicators of count data (e.g., number of staff), measures of central tendency were calculated, including mean, range, minimum, and maximum. For indicators based on the number of responses to a question (e.g., “yes/no,” or “agree/disagree”), the number of grantees who responded by category and by question was calculated.

After calculating these metrics, year-over-year (YoY) change was determined for each indicator by dividing the difference between the initial and subsequent year’s value by the initial year’s value. Where data permitted, values were matched year-to-year, though a perfect 1:1 relationship between yearly metrics was not always achievable. YoY change was calculated based on counts per year across variables, except in some instances where variables had binary responses (e.g., "yes/no", "performed/not performed"). Here, YoY change was based on the percentage of grantees who responded in the affirmative to account for non-responses from grantees. Tables where YoY percentage change was calculated based on percentages are appropriately noted. These limitations and discrepancies are discussed as they arise throughout the narrative.

Additional Analysis

The additional analysis conducted in this evaluation centered on three primary objectives using SAS (Version 9.4).[1]

Objective 1—Research Question 2: Is the total number of radio/TV/billboard ads associated with the total number of attendees or by event type?

This analysis examined whether the total number of radio, TV, and billboard ads was associated with the total number of attendees, and to see if there was variance by event

[1] The software was developed to conduct advanced analytics and multivariate analysis, among other data analysis uses.

type. The aim was to understand the impact of media outreach on attendance across different event formats.

Objective 2—Research Question 1: Is there an association between being trauma-informed and having burnout or compassion fatigue efforts in place for program staff?

The relationship between being trauma-informed and having burnout or compassion fatigue initiatives in place for program staff was analyzed. This investigation sought to determine if trauma-informed practices were linked to supporting mechanisms addressing staff well-being.

Objective 3—Research Question 2: Is there a difference in the median number of MOUD patients satisfied with the services provided by having a MOUD policy, procedure, or protocol in place?

The analysis compared the median number of satisfied MOUD patients across facilities with and without a policy, procedure, or protocol in place for MOUD services. This comparison aimed to assess the role of formalized guidelines in enhancing patient satisfaction with MOUD services.

Exploratory analysis was conducted on each dataset, including calculating the mean, median, range, and standard deviation for each indicator. Data was visualized through histograms, boxplots, and scatterplots, depending on variable type. This analysis showed that none of the continuous variables adhered to a normal distribution; instead, they were right-skewed and contained a significant proportion of zero values. Due to the self-reported nature of the data and the absence of an established baseline range, excluding any values as outliers was not feasible.

Although user error might contribute to data variability, differences in community size resulted in certain communities reporting much higher values (e.g., number of staff, number of overdoses). Various data transformations (square root, log, cube root) were attempted, but none improved the approximation of normality. Therefore, non-parametric tests were chosen for all analyses involving continuous variables, and these tests were exclusively used when comparing means or medians of continuous variables across categorical groups. The following tests were applied:

- Mann-Whitney U (Wilcoxon Rank-Sum) for categorical variables with two categories,
- Fisher’s Exact Test (a non-parametric equivalent of Pearson’s chi-square) for variables with expected values that were too small, and
- Spearman’s Rank Correlation to assess correlations between continuous variables.

Qualitative Data

For this evaluation, qualitative data were gathered through two approaches: (1) the grantee APRs and (2) through grantee technical assistance. The qualitative data obtained from the APRs included grantee responses to narrative-based questions. A qualitative narrative analysis was conducted to complete an inventory of APRs and grantee evaluation assistance for each grant year. Data was extracted from both sources, and thematic coding was employed to analyze and understand grantees' personal and detailed accounts of their experience, offering insights into successes and opportunities, as well as the impacts of their efforts among the communities served.

Updates to the APR

Significant updates were made to the APR for GY3. The reporting form was updated to reduce observed redundancies in the original reporting form and to clarify wording to improve response quality and validity. The updated APR contains the same six sections (Sections A-F) as the previous APR, although all sections have been condensed.

Section A (Organizational Capacity) was reduced from 22 questions to five, which simplified and clarified the personnel reporting. Section B (Increasing Public Awareness) decreased from eight questions to seven, removing the question asking for observed changes in public awareness activities, which was difficult for grantees to answer. Section C (Media Tracking) was updated to "New Media Tracking" and added a question about advertising topics and an open-ended question about how they informed the community about COIPP-funded activities. The previous questions about (1) whether the community knew about the awareness campaigns and how grantees collected community awareness information, (2) marketing successes, and (3) marketing challenges were removed. Section D (Creating Comprehensive Support Teams) was updated with some wording changes for clarity and a minor reordering of questions to improve flow. Section E was renamed from "Reduce Unmet Treatment Needs and Opioid Overdose Related Deaths Through the Use of Medication-assisted Treatment (MAT)" to "Reduce Unmet Treatment Needs and Opioid Overdose Related Deaths Through the Use of Medications for Opioid Use Disorder (MOUD)" to reflect updates to language used to describe these medications. In this section, all reference to "MAT" was removed, the number of questions about medication prescribers was reduced from six to four, removing questions about what training prescribers have received, information which grantees do not collect. Finally, the question regarding risk mitigation efforts provided in the community was expanded to include a question about whether any efforts not listed were used, and the language was updated to describe the efforts listed for the purpose of clarity. There were no changes to Section F of the APR in GY3.

Evaluation Findings

This section reports evaluation findings based on analyses of the quantitative and qualitative data to highlight successes of and opportunities for the COIPP program. The evaluation findings provide an overview of program effectiveness from data gathered for GY1, GY2, and GY3. This section is organized according to the three objectives, with the six sections of the APR sorted into the appropriate objective to facilitate the analysis and later discussion.

Objective 1: Increase Community Awareness and Education

To effectively increase community awareness and education regarding the opioid epidemic within individual Tribal communities, two primary areas were assessed: public awareness and education initiatives (see APR Section B, Appendix E) and media campaign strategies (see APR Section C, Appendix E). These sections were examined to explore the strengths of the activities completed by the COIPP grantees, aiming to provide a comprehensive evaluation of their effectiveness and impact. Next, is a summary of the quantitative and qualitative key findings in alignment with this objective.

APR Section B: Public Awareness and Education

Section B focused on data collection related to public awareness and education initiatives conducted by COIPP grantees. Questions delved into the various methods used to inform Tribal community members about the opioid crisis, promote understanding of its consequences, and encourage proactive measures. Efforts captured in this section included workshops, community forums, educational seminars, and traditionally adapted training sessions designed to engage participants and ensure the information was both accessible and relevant to their unique community contexts. The data reflects how these activities enhanced knowledge, shifted attitudes toward opioid use and treatment, and mobilized community support for preventive and recovery efforts.

The COIPP aims to enhance public awareness and education on traditional practices and family-centered practices for opioid prevention, treatment, and recovery within AI/AN communities. To understand achievements and progress, grantees reported on the total number of training events, which were categorized by age groups and between health care and non-health care program staff. Additionally, grantees reported on the number of houseless individuals receiving services, reflecting a comprehensive approach to addressing the diverse needs of these communities impacted by the opioid crisis.

Training and Educational Events

The total number of community education or training events funded by the COIPP consecutively increased between all three years, with 618 in GY1, increasing to 2,173 in GY2 and 4,500 in GY3. In GY2, it was noted that one grantee reported conducting a total of 1,247 community education or training events. Furthermore, in GY3 another grantee indicated that 3,273 community education or training events were funded by the program.

Out of all 35 grantees, the percentage reporting at least one community education or training event increased from 80.0% in GY1 to 97.1% in GY2 and then decreased to 74.3% in GY3. As such, in GY3, there were more than double the number of community education or training events, but almost 23% fewer grantees hosted them. Figure 2 displays the percentage of grantees who conducted training events by event type (See Table 12 in Appendix A). Grantees most frequently provided training events on education and prevention of OUD, with 91.4% (n = 32) of grantees providing this training event type in both GY1 and GY2, and 88.6% (n = 31) in GY3. Over the years, grantees increasingly offered training events on accessing local opioid-specific services from 62.9% (n = 22) of grantees in GY1 to 71.4% (n = 29) of grantees in GY3. Similarly, grantees increased the offerings of training events on safeguarding controlled-prescription medications from 37.1% (n = 13) of grantees in GY1 to 48.6% (n = 17) of grantees in GY3. With regard to providing training events about the proper disposal of unused, controlled prescription medications, a decrease in offerings was observed from 51.4% (n = 18) in GY1 and 51.5% (n = 17) in GY2 to 40.0% (n = 14) in GY3. Finally, grantees providing training events focused on recognizing the signs of an opioid overdose and administering the overdose reversal drug naloxone increased from 71.4% (n = 25) in GY1 to 82.9% (n = 29) in GY3 (Figure 2).

Year-to-year, grantees increasingly offered training events on accessing local opioid specific services as illustrated in Figure 2. Similarly, more grantees offered training events on safeguarding controlled prescription medications in GY3 (48.6%, n = 17) compared to GY2 (47.1%, n = 16) and GY1 (37.1%, n = 13).

An increase was also observed in the number of grantees who provided training events on other topics than those listed from GY1 (54.5%, n = 18) to GY2 (63.6%, n = 21), while there was a noted decrease from GY2 to GY3 (54.3%, n = 19). The type of topics covered are listed and described next.

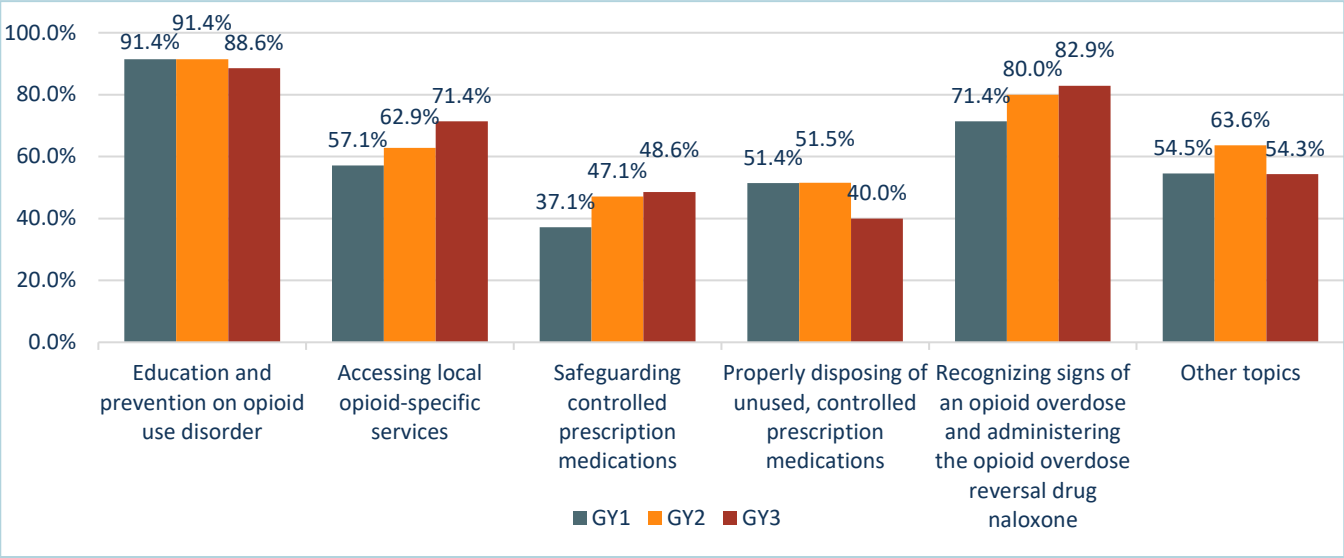

Figure 2: Percentage of Grantees that Performed Training Events by Type (GY1–GY3)

Other Training Topics

Grantees reported offering a variety of other training topics, which were highlighted across all three years. These additional training courses focused on the following topics and are subsequently described:

- Mental health and SUD awareness, prevention, and support,
- Suicide prevention (e.g., Question, Persuade, Refer (QPR): Suicide Prevention and Collaborative Assessment and Management of Suicidality),
- De-escalation, crisis stabilization, and safe restraint training,
- Traditional integration, traditional healing, and historical trauma,
- Youth-focused community education and re-engagement,
- Mental health first aid and trauma-informed care,
- Naloxone administration, and
- Risk mitigation.

In GY3, grantee sites continued to offer other training topics featured in GY1 and GY2 including youth and adult Mental Health First Aid, Community Reinforcement and Family Therapy (CRAFT), Alaska Blanket Exercise (ABE), QPR, and Wellbriety. Other training events including Sacred Fire and activities centered around traditional storytelling, drumming, and the use of Native medicines for pain management were also featured. These activities were specifically aimed at strengthening traditional identity and supporting mental and emotional healing within communities. Training on topics like fentanyl awareness and the use of fentanyl and xylazine test strips, as well as

recognizing signs of opioid use highlighted additional efforts used to reduce opioid use risks. Furthermore, Motivational Interviewing (MI) was another training topic documented.

Training topics on suicide prevention and crisis intervention were focused on peer recovery coaching and training community members on how to support individuals in crisis and intervene effectively. Grantee sites facilitated outreach, tours, and community presentations to promote public awareness about OUD and stigma reduction. Unlike GY1 and GY2, it was reported that educational sessions on Human Immunodeficiency Virus (HIV), hepatitis C, and other infections associated with substance use were offered, addressing both prevention and risk mitigation strategies.

Youth re-engagement was identified as a continued effort from GY2. In addition, training topics centered around traditional ceremonies and wellness, including horsemanship and bronco riding, were used to provide additional positive engagement opportunities. Training topics and initiatives introduced in GY3 continue to represent a traditionally aligned approach to public health within AI/AN communities, integrating traditional practices with modern risk mitigation and mental health support techniques to promote healing and resilience.

Health Care and Non-Health Care Professional Training

Training for both health care staff and non-health care staff is a crucial component of a community-level intervention project aimed at addressing the opioid epidemic within Tribal communities. Training focuses on fostering better communication among providers and community members about opioid use, emphasizing the importance of open and compassionate dialogue. By equipping staff with the skills to reduce stigma and address trauma—understanding the deep connections between trauma and opioid use—the training builds a foundation of trust and empathy that is vital for meaningful engagement. Highlighting the importance of reducing opioid use, these trainings aim to empower communities to tackle the crisis collaboratively and effectively, promoting resilience and long-term health. The results of the training over the grant years are detailed next.

Between GY1 (60.0%, n = 21) and GY2 (74.3%, n = 26), the number of grantees offering health care professional training increased. In contrast, there was a 20% decrease from GY2 to GY3 (54.3%, n = 19) (Table 1). Further depicted in Table 1 for non-heath care professional training, grantees consistently offered more of these trainings YoY with 60.0% of grantees provided these training in GY1 (n = 12) to 75.0% in GY3. Furthermore, from GY1 to GY3 (75.0%, n = 24) there was an observed increase of 25.0% for grantees reporting this training type.

The APR prompts grantees to indicate how many of each health profession types attended training held for health care professionals.

Figure 3 depicts the number of health care professional training participants by profession for GY1 through GY3. In GY1, non-licensed staff represented the most health care staff who received professional training offered by grantee sites with 1,216 participants, followed by other professions not specified (n = 145). Behavioral health and mental health professionals, nurses, and physicians comprised of the remainder of participants in GY1 at 365, 236, and 162, respectively.

Table 1: Number and Percentage of Grantees who Conducted Professional Training (GY1–GY3)

	Percentage			Total Performed			Total Responses			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1 – GY2	GY2-GY3
Health care professional training	60.0%	74.3%	54.3%	21	26	19	35	35	35	23.8%	-26.9%
Non-health care professional training	60.0%	70.6%	75.0%	12	24	24	20	34	32	17.6%	6.2%

***Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

In GY2, the number of behavioral health and mental health professionals and non-licensed staff providing services was 313 and 319 participants, respectively. There were 224 nurses, 193 physicians, and 145 other staff. For GY3, data was not collected from grantee sites for the number of other health care professionals that participated in training. However, behavioral health and mental health professionals (n = 324) and non-licensed staff (n = 320) accounted for most participants with a health care profession in GY3.

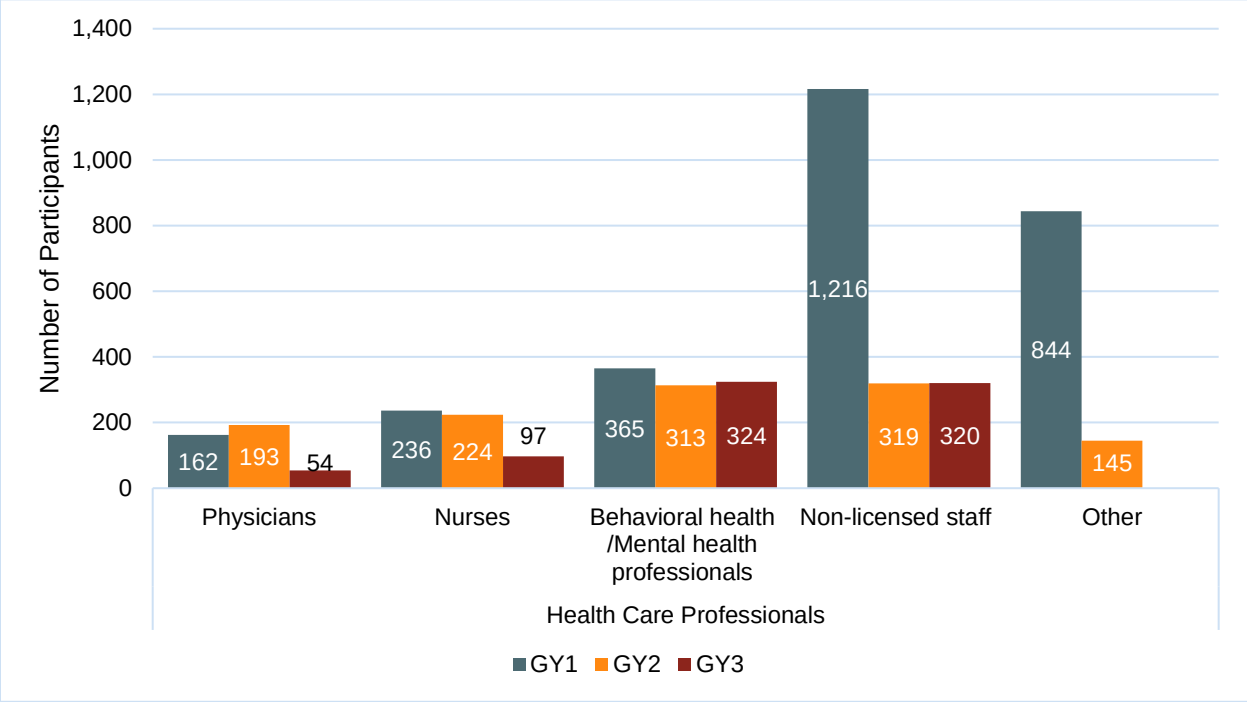

Figure 3: Number of Health Care Professional Training Participants by Profession (GY1–GY3)

Other Health Care Professional Training

Over each year, grantees offered various health care training to align with professional and community needs. In GY1, a total of nine grantee sites provided other health care professional training. Participants included family nurse practitioners, physician assistants, pharmacists, volunteers, crisis response team members, program managers, diabetic counselors, and ethnobotanists. Outreach to medical facilities was used as an approach to facilitate some training. One grantee noted that training hosted in health care settings was a challenge due to COVID-19 restrictions. Training topics highlighted by grantee sites were centered around nutrition and withdrawal, environmental changes impacting substance use, MAT, and MAT stigma. Two grantee sites reported using presentations such as Extension for Community Healthcare Outcomes (ECHO) and White Bison Traditions of Men to administer training.

For GY2, eight grantee sites reported providing other types of professional training to health care professionals. The program participants were identified as emergency medical technicians, first responders, and social services personnel, including victim advocates and case managers. Additionally, in GY2 nine of the 24 grantee sites reported offering “other trainings” for non-health care professionals. This group's participants comprised individuals from various sectors, including community members, elders, and stakeholders from local and Tribal law enforcement.

In GY3, eleven of the grantee sites described “other health care professional trainings” that were provided. Some grantees reported training through statewide conferences including Pathways to Healing and ABE workshops. These trainings were focused on the importance of heritage in crisis response and healing from historical trauma. Naloxone storage and administration, as well as service orientation including referral and intake processes were also identified as content areas of focus for other training provided. Other training was provided across clinical settings and targeted specific staff, including medical assistants, physicians, nurses, mental health professionals, medical students, and non-licensed staff. Grantees also reported providing other health care professional training to case managers, victim advocates, casino employees, school staff, community members, Tribal leaders, apartment security, housing staff, and those working in childcare.

Non-Health Care Professional Training

Grantees were also asked to report on the number of non-health care professionals trained each year. Figure 4 includes the number of non-health care professionals trained by type. Training was held with representatives from schools, traditional gatherings, partner agencies, churches, and other areas. In GY1, the most participants trained were from partner agencies (n = 21), followed by traditional gatherings (n = 15), schools (n = 11), other types not represented (n = 7), and lastly, churches (n = 1).

The number of non-health care professionals trained increased from GY1 to GY2 with participants from other areas (n = 205) experiencing the largest increase. In GY2, there were 148 participants from partner agencies, 115 from traditional gatherings, 93 from schools, and four from churches.

From GY2 to GY3, there was an observed increase across all participant types featured, except for other types not specified, in which there was a noted decrease from the previous year. Participants from traditional gatherings yielded the largest overall increase between GY2 and GY3, with the total number of participants for GY3 at 458. Partner agencies had the second largest increase in participants at 394. Representatives from schools and churches who participated in the training contributed 101 and 10 participants, respectively. Lastly, for GY3 there were 109 participants from other non-health care settings.

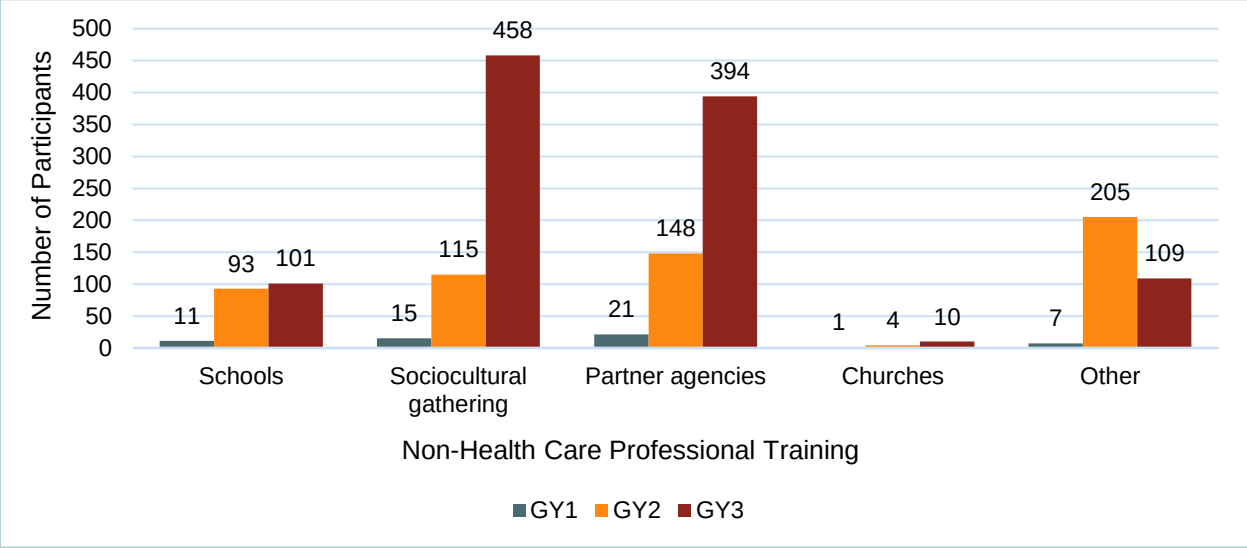

Figure 4: Number of Non-Health Care Professional Training Participants by Type (GY1–GY3)

Other Non-Health Care Professional Training

Grantees were asked to provide the number of trainings conducted with other non-health care professionals, such as teachers, law enforcement, youth workers, and child protection workers. In GY1, six grantees described other non-health care professional trainings that were provided to participants. Training was offered through community opioid taskforces or in collaboration with community health partners, coalitions, residential programs, and project teams. Community health fairs were used to host and offer training opportunities to the public, with two grantees noting that training was also provided virtually or online. Some training sessions were provided for recovery staff and Tribal workers, while others were focused on engaging the community.

In GY2, 12 grantees described their other non-health care professional trainings provided to participants. Notably, training was offered through settings such as Tribal recreation centers and powwows or hosted via Zoom. Community centered events remained an area of focus, with one grantee engaging school districts and staff from homeless shelters to provide naloxone training. Other training specified by grantees was also offered to law enforcement and Tribal security staff, as well as elders and others from the general public.

In GY3, two out of 10 grantees reported providing other non-health care professional training to law enforcement staff, with one referencing events such as Drug Take Back Day, and Pizza at the Plaza. Additional participants included first responders. Training was hosted at a variety of settings including Tribal wellness and recreation centers, casinos, and hospitals. As observed in GY1 and GY2, grantees in GY3 continued to focus on community events used to provide training and education on naloxone.

Number of Attendees by Event Type

Figure 5 displays the total number of participants who attended each training event by event type across the three grant years. (See Table 12 Appendix A for more information). The most frequently attended training event across all three years was education and prevention on OUD, with 11,114 participants in GY1, followed by 23,668 in GY2, and 28,921 in GY3. Each year, this class of events was the most well-attended per grantee reports.

In GY3 and GY2, there were 14,951 and 11,238 participants who attended training events on accessing local opioid specific services, respectively. Only 3,831 participants attended such events in GY1. For events about safeguarding controlled prescription medications, there were 3,297 attendees in GY1, which increased to 8,569 attendees in GY2 and then decreased to 5,748 in GY3. For training events on properly disposing of unused, controlled prescription medications, there was a similar trend, with 3,060 participants in GY1, which increased to 12,029 participants in GY2 and decreased to 5,465 participants in GY3.

Finally, for events centered around recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone, there were 2,310 participants in GY1, 10,310 in GY2, and 13,069 participants in GY3.

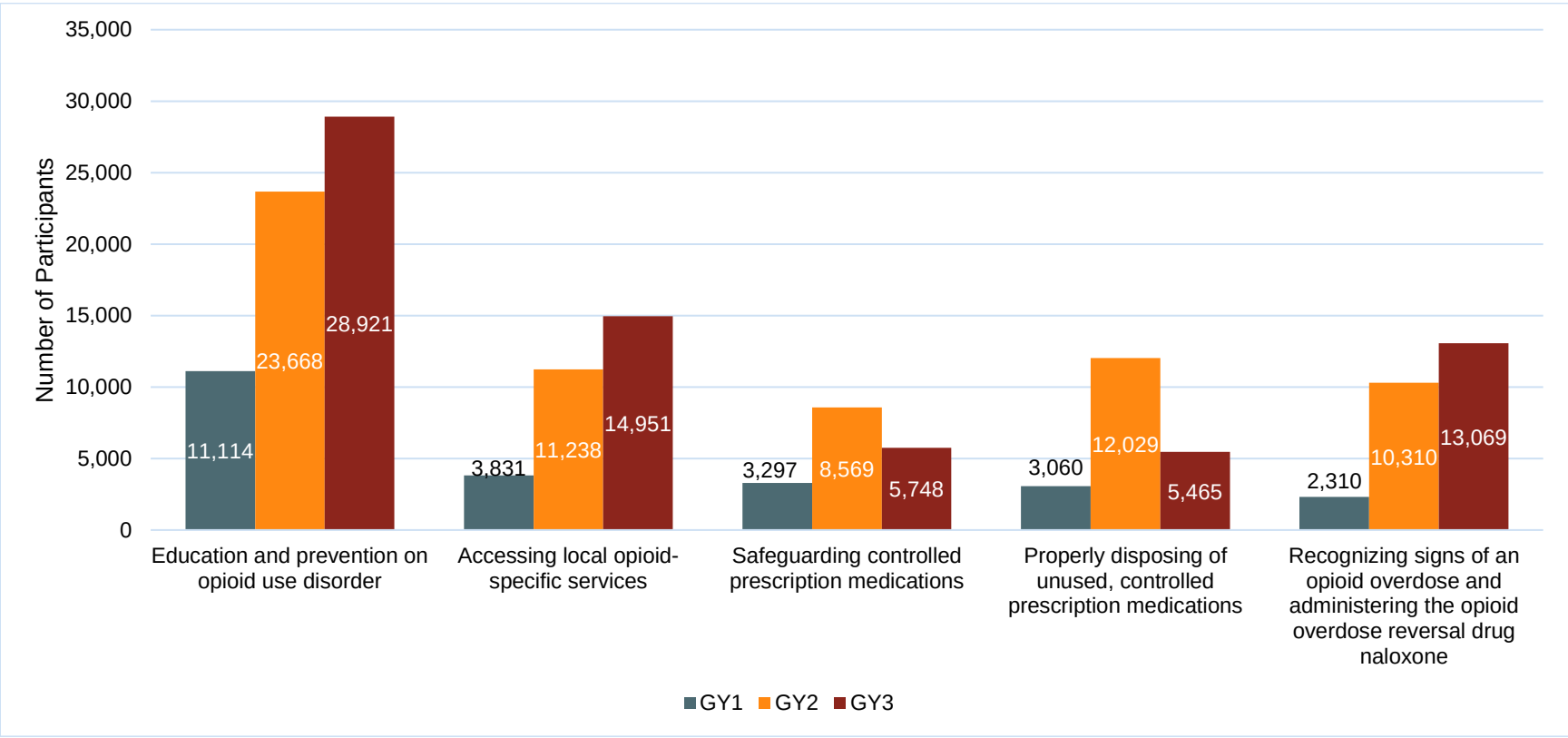

Figure 5: Number of Participants by Training Event Type (GY1–GY3)

Grantees were asked to report on the ages of their attendees. This data captures information about which demographics are receiving and participating in each type of training, which offers insight into the level of engagement and event awareness of the different age groups by training type.

Figure 6 displays the number of participants by age group and training type across each grant year. Overall, participation by age group varied across each training type. However, in GY2 and GY3, the largest number of participants across each training was consistently in the 25-to-54-year-old age group. The most significant youth representation in training was in education and prevention on OUD. The figure shows over the years, more youth were involved in training for accessing local opioid-specific services and naloxone training. In addition, elders (55+ years of age) who received training increased over the years for three of five different training types, including accessing local opioid-specific services, safeguarding controlled prescription medication, and naloxone training.

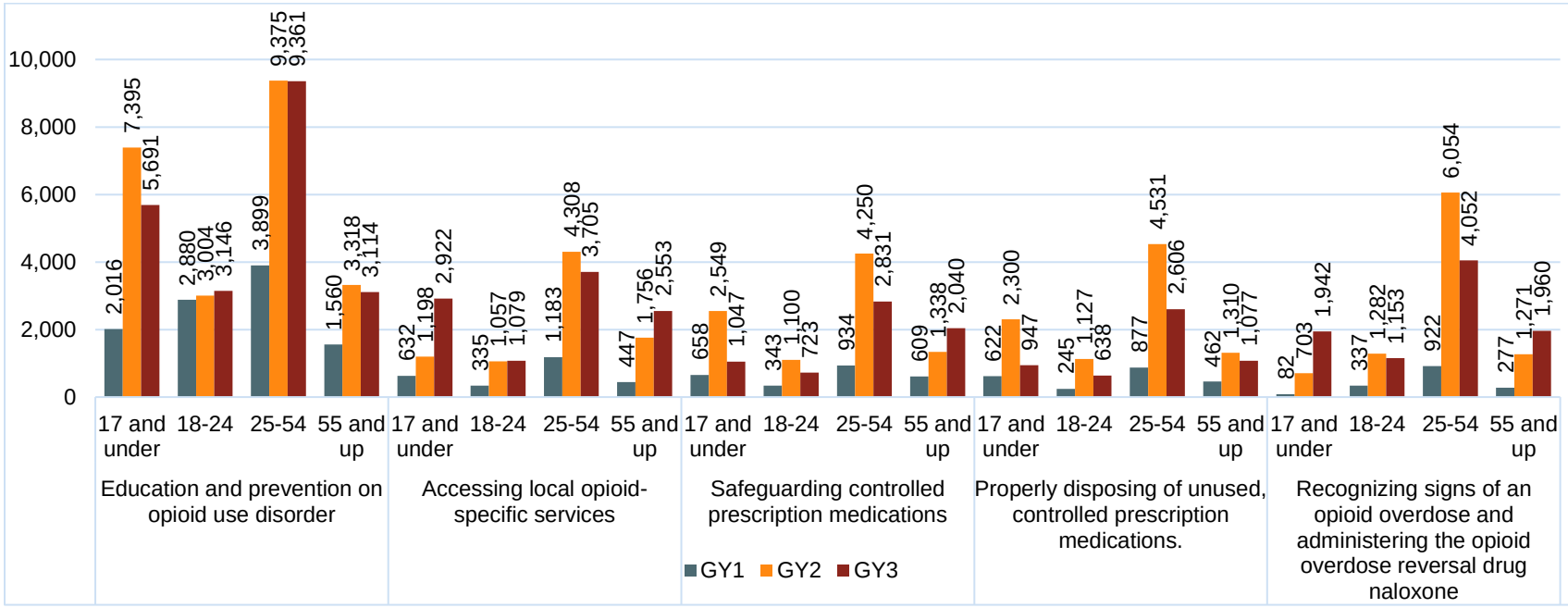

Figure 6: Number of Participants by Age Group and Training Type (GY1–GY3)

Houseless/Unsheltered Participants

Grantees were asked to report on the number of houseless/unsheltered participants they reached through their education and training events. This demographic of community members can be difficult to engage despite high needs for opioid prevention and treatment programs (Stefaniak et al., 2015). Table 2 displays the number and percentage of individuals who self-reported as houseless and receiving services or participating in program activities. Across all age group categories except the youngest (17 years of age or under), the number of participants experiencing houselessness increased between GY1 and GY2. There was an observed increase in the percentage of participants who reported being houseless between GY2 and GY3 for each age group, except the 25- to 54-year-old age group. Overall, the respective total number of participants who experienced houselessness and received education and training in GY1, GY2, and GY3 was 475, 661, and 448.

Table 2: Number and Percentage of Participants Who Self-Reported as Houseless (GY1–GY3)

	Count			Average			Percentage			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1 – GY2	GY2 – GY3
17 and under	56	9	18	2.1	0.3	0.5	11.8%	1.4%	4.0%	83.9%*	100.0%
18 to 24	63	94	98	2.0	2.9	2.8	13.3%	14.2%	21.9%	49.2%	4.3%
25 to 54	299	492	331	9.6	14.9	9.5	62.9%	74.4%	73.9%	64.5%	-32.7%
55 and up	57	66	101	1.9	2.1	2.9	12.0%	10.0%	22.5%	15.8%	53.0%
Total	475*	661	448	15.3	20.0	12.8	-	-	-	39.2%	-32.2%

*Note: This number reflects an updated count for the total houseless population in GY1. The calculated total presented provides a more detailed representation of the total population, as it is specifically based on data where age was specified by participants.

*Negative values in this context signify a downward trend or reduction in activity.

For those 17 years of age or under, participants experiencing houselessness decreased by 67.9%, with a total of 56 participants reporting houselessness in GY1 and 18 in GY3. In GY2 (n = 9) and GY3, those 17 years of age or under were the least represented age group amongst participants comprising 1.4% and 4.0% of the houseless population, respectively. Furthermore, only 11.8% of participants reported being houseless in GY1, see Figure 7.

For those 25 to 54 years of age, there was a 10.7% increase in event participants reporting houselessness from GY1 (62.9%, n = 299) to GY3 (73.9%, n = 331). In GY2, there was a total of 492 or 74.4% of participants aged 25 to 54 years who reported being houseless. The number of participants aged 25 to 54 attending training and education events who self-reported as experiencing houselessness increased between

GY1 and GY2. Overall, participants aged 25 to 54 years were the most represented age group across all three years.

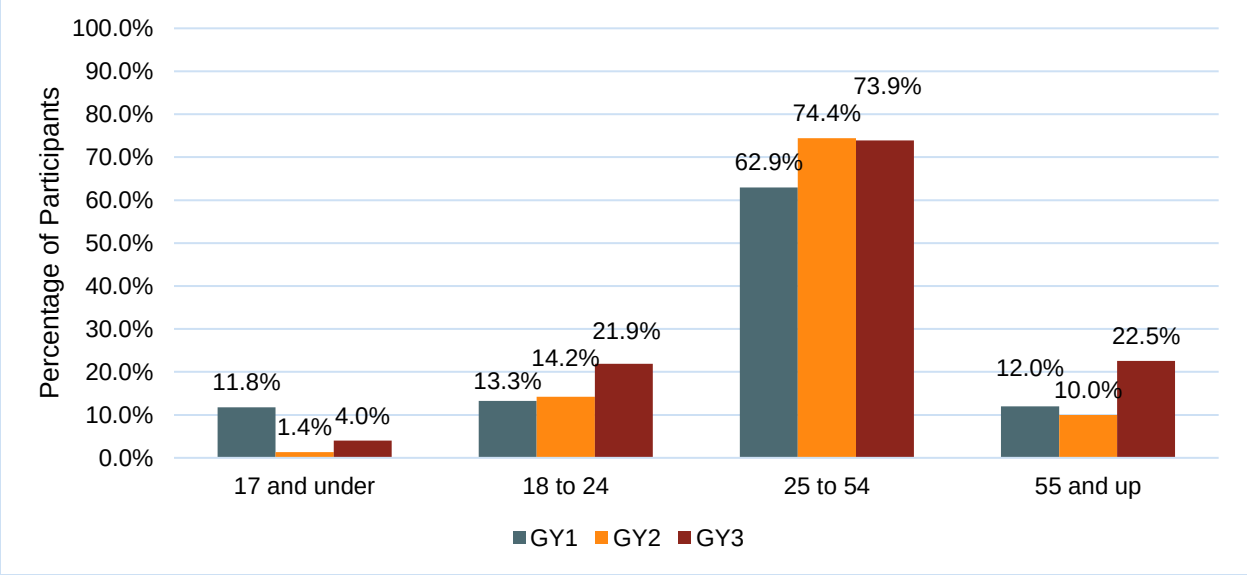

Figure 7: Percentage of Participants Who Self-Reported as Houseless by Age Group (GY1–GY3)

For those 18 to 24 years of age, the number of participants at training and educational events experiencing houselessness increased from GY1 to GY2. A 55.6% increase was also observed between GY1 and GY3. Overall, those 18 to 24 years of age consisted of 13.3% of the houseless population in GY1 (n = 63), compared to 14.2% in GY2 (n = 94). In GY3, there were 21.9% (n = 98) event participants who reported houselessness in this age group.

The number of event participants aged 55 years or older who were experiencing houselessness increased from 57 in GY1 to 66 in GY2. In addition, there was another observed increase from GY2 to GY3 (22.5%, n = 101). Overall, this age group comprised 10.0% of the total houseless population in GY2 and 12.0% in GY1.

Observed Change

In GY3 the APR did not include questions about observed changes; these questions were removed as grantees reported being unable to collect accurate data on any observed changes.

Education Awareness

Grantees shared the types of education and awareness approaches they implemented over the three grant years. Throughout GY2 and GY3, grantees focused on traditionally specific, community-based education awareness campaigns for OUD and SUD. These efforts increased each year, beginning with foundational heritage integration in GY1, followed by refinement and targeted outreach in GY2, and expanding to comprehensive

digital campaigns and digital technology use by GY3. Grantees continually broadened and enhanced their strategies to effectively reach AI/AN communities.

Heritage Integration and Community Engagement

In GY1, grantees implemented heritage-based practices, such as ABE, to address intergenerational trauma within Alaska Native communities. Grantees also held traditional events and activities, including storytelling, talking circles, and a healing-through-painting workshop, which combined art with addiction recovery education.

In GY2, grantees expanded these traditional practices. One grantee continued the ABE while adding traditional arts activities, such as storytelling, talking circles, and heritage nights with drumming, singing, beadwork, and regalia-making. By GY3, grantees maintained these traditionally based approaches while introducing structured outreach for younger audiences. Programs such as youth storytelling sessions and youth-focused drumming workshops were introduced to build resilience against OUD and SUD, while broadening reach and inclusivity.

Interactive Learning Approaches

Interactive learning methods evolved from GY1 to GY3. In GY1, grantees implemented a hybrid in-person/teletherapy model to increase service accessibility and distributed Narcan kits during training sessions. In GY2, one grantee introduced a role-playing exercise to help community members reduce stigma around naloxone use and introduced non-opioid pain management options. The "mock bedroom setup" was also introduced to teach parents and families about drug-hiding habits and social media codes related to OUD and SUD. By GY3, these approaches expanded to include additional hands-on activities and digital content, providing a more immersive learning experience for families.

Technology Integration

Technology use advanced from GY1 to GY3. In GY1, grantees developed a recovery support mobile application featuring daily reminders and positive affirmation messages. In GY2, most resources for education and awareness were print based, such as pamphlets, posters, and recovery rack cards, for distribution at local events. By GY3, these efforts evolved into more comprehensive digital campaigns with original digital content. One grantee launched a viral social media campaign with over 170,000 views, while another developed a TikTok channel focused on harm-reduction for teens and young adults. Mobile outreach vans equipped with digital content were also introduced in GY3 to provide education, services, and support to those living in remote and rural areas.

Partnerships and Outreach

Partnerships were essential across all three grant years. In GY1, local organizations helped host events, such as panel discussions following documentary screenings. By GY2, partnerships expanded to include law enforcement, behavioral health departments, public health agencies, and schools, which supported the distribution of

materials and hosting community events. In GY3, these collaborations were further strengthened using mobile outreach vans that provided school-based health education to remote areas.

From GY1 through GY3, grantees built upon their earlier successes while incorporating new technology-driven educational methods. The emphasis on heritage integration remained strong throughout all three grant years, while interactive learning approaches became increasingly refined. By GY3, grantees had effectively expanded their outreach through digital tools while maintaining traditionally grounded practices that resonated with diverse communities.

Summary of Findings

Grantees demonstrated their ability to increase public awareness and education on opioid prevention through hosting educational events for community members and health care professionals. Across the six types of educational event types, the percentage of grantees offering each increased between GY1 and GY2, excluding education and prevention on OUD, which stayed the same across both years. Three of the event types had notable increases from GY2 to GY3, including accessing local opioid-specific services, safeguarding controlled prescription medications, and lastly recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone. In addition, between GY1 and GY2 there was an increase in the number of houseless participants who attended educational events for all age groups, except those under 18. In contrast, from GY2 to GY3 there was an increase in all age groups presented, except for those 25 to 54 years old. For GY2, grantees were asked to report whether they had observed any change in education or awareness in the community, which they overwhelmingly indicated that they had observed an increase.

Grantees illustrated their traditionally grounded and comprehensive approaches to addressing opioid-related issues in AI/AN communities. Their strategies included activities such as data collection, targeted training for health care and non-health care professionals and implementing traditionally relevant education and training approaches. The project's emphasis on integrating local heritage practices, knowledge, and traditions, such as the Choctaw language and community-centered activities—enhanced their community-engagement efforts. Using digital technologies and forming collaborative partnerships extends the grantees' reach and impact. By differentiating between community and staff training development, however, grantees could more effectively address each.

APR Section C: Media and Campaign Approaches

Section C examined the range of media strategies employed by the COIPP grantees to amplify their public awareness and educational efforts. This exploration highlighted how different media channels—such as radio broadcasts, social media platforms, printed materials, and traditional methods like community bulletin boards—were leveraged to disseminate information and engage diverse audiences. The section outlined innovative practices that Tribes implemented, including multimedia storytelling, videos featuring

testimonies from individuals in recovery, and heritage-rooted messaging that integrated traditional language and symbols to resonate deeply with community members.

The IHS COIPP Section C focuses on the media approaches employed by grantees in addressing SUD within Tribal communities. This newly introduced section was added to the APR in 2023 and solicits comprehensive data on each grantee's specific awareness-raising efforts about SUD and the OUD treatment options for Tribal members. Grantees are required to provide insights into the specific media platforms they use most frequently for disseminating these messages. By emphasizing the importance of targeted media campaigns, this section underscores the role of strategic communication in promoting SUD awareness and facilitating access to treatment options among Tribal populations. The information collected in Section C is crucial for evaluating the effectiveness of media outreach strategies in the context of the COIPP.

Media Campaign Tool Use

Figure 8 displays the percentage of grantees who reported using different media campaign tools across GY1 through GY3. Overall, media campaign-tool use increased for Instagram, GoodHealthTV (a subscription-based health education network that many Tribal nations use to reach their community members), TikTok, and the "Other" category. See Table 15 in Appendix A, Section C, for more details.

Facebook was the most used media campaign tool across all years, with 91.4% (n = 32) of grantees using it in GY1, 100% (n = 35) in GY2, and 94.3% (n = 33) in GY3. Tribal websites were the next most used media campaign tool, with 55.9% (n = 19) of grantees using it in GY1, 71.9% (n = 23) of grantees using it in GY2, and 64.7% (n = 22) in GY3. The third most frequently used media campaign tool was Instagram, with its use steadily increasing to 54.5% (n = 18) of grantees in GY3 from 42.4% (n = 14) in GY1.

The use of YouTube as a media campaign tool increased from 23.5% (n = 8) of grantees in GY1 to 35.5% (n = 11) of grantees in GY2, before dropping to 33.3% (n = 10) in GY3. Podcast use also decreased from 20.7% (n = 6) of grantees in GY2 to 16.7% (n = 5) in GY3. GoodHealthTV use increased from 18.8% (n = 6) of grantees in GY2 to 27.3% (n = 9) in GY3. More grantees also reported using TikTok as a media campaign tool in GY3 (13.8%, n = 4) than in GY2 (12.9%, n = 4) or GY1 (8.8%, n = 3).

Finally, more grantees reported using another type of media not listed in GY3 (51.4%, n = 18) than in GY 2 (37.0%, n = 10). Examples of other types of media campaign tools used in GY3 included print materials, including brochures and fact sheets, phone calls, emails (including Tribal Listservs), monthly newsletters, Tribal newspapers, LinkedIn, virtual events, virtual electronic banners, and the grantee's own websites.

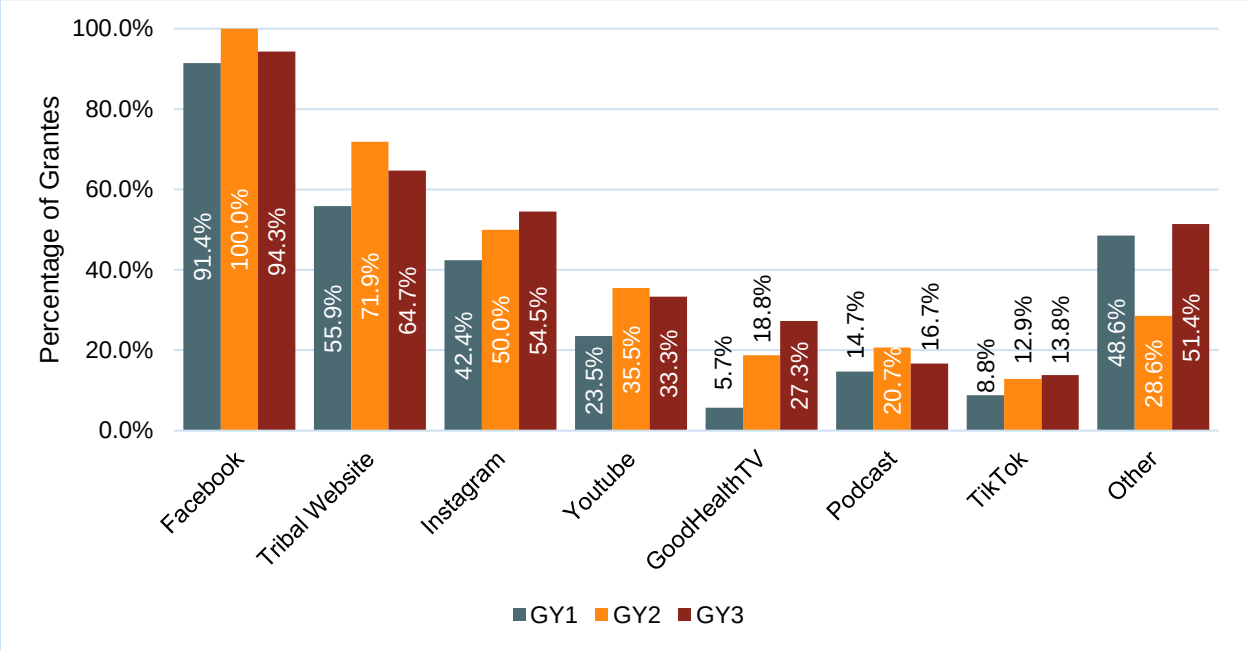

Figure 8: Percentage of Grantees Using Media Campaign Tools by Type (GY1–GY3)

Radio/TV/Billboard Ads

Grantees were also asked if they invested in billboard ads, TV ads, or radio ads. Over all years, less than half of grantees invested in such ads. The number of grantees who used their COIPP funds to create or air radio/television/billboard ads for opioid use prevention, disorder and or treatment messages doubled between GY1 (22.9%, n = 8) and GY2 (45.7%, n = 16), but decreased in GY3 to 28.6% (n = 10). See Table 15 in Appendix A, Section C, for more details.

Figure 9 displays the number of distinct ads created by media type: radio, TV, or billboard ads. Overall, more radio ads were created in GY2 (n = 20) than in GY1 (n = 6) or GY3 (n = 7). However, more billboard ads were created in GY3 (n = 33) than in GY2 (n = 22) and GY1 (n = 15). In contrast, the number of TV ads created continuously decreased over the years, from 21 in GY1 to just five in GY3. Overall, the trends show an increasing popularity in billboard ad use, with a decreasing popularity in TV and radio ads.

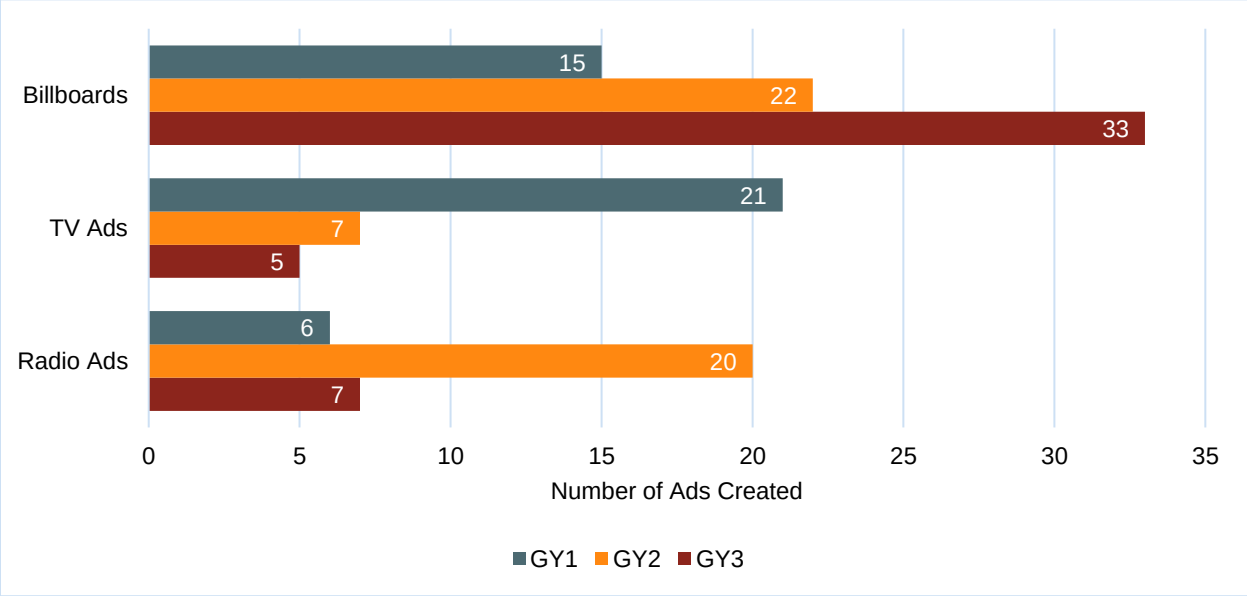

Figure 9: Number of Ads Created by Media Type (GY1–GY3)

The number of TV and radio ads aired over the reporting period is displayed in Table 3. The number of TV ads that were aired remained the same between GY1 and GY2 (n = 18) and increased to 68 in GY3. The number of radio ads increased from 77 in GY1 to 1,971 in GY2, and then decreased to just 25 in GY3, demonstrating the growing spread of TV ads, with a simultaneous decline in the use of radio ads.

Table 3: Number of Radio and TV Ads Aired (GY1–GY3)

	Count			Average			YoY Percentage Change	
Advertisement Type	**GY1**	**GY2**	**GY3**	**GY1**	**GY2**	**GY3**	**GY1 – GY2**	**GY2 – GY3**
Radio Ads	77	1971	25	12.8	131.4	131.4	2459.7%	-98.7%*
TV Ads	18	18	68	1.3	1.3	1.3	0.0%	277.8%
*Note: Negative values in this context signify a downward trend or reduction in activity.								

Campaign Targets

Grantees who had created billboards, radio, or TV ads were asked to identify the focus of their advertising campaigns. The frequency of their responses is detailed in Figure 10. A total of 25.7% of grantees (n = 9) said that treatment/services were the target of the media campaign(s). 20% of grantees (n = 7) reported that either harm-reduction or stigma were the targets of their campaigns, respectively. Further, 17.1% of grantees (n = 6) indicated that their ads targeted special populations, meaning elders, youth, people in recovery, and parents. Finally, 11.4% of grantees (n = 4) indicated that their target

was another topic not listed. Please note that this data is only available for GY3, as it was introduced into the GY3 APR.

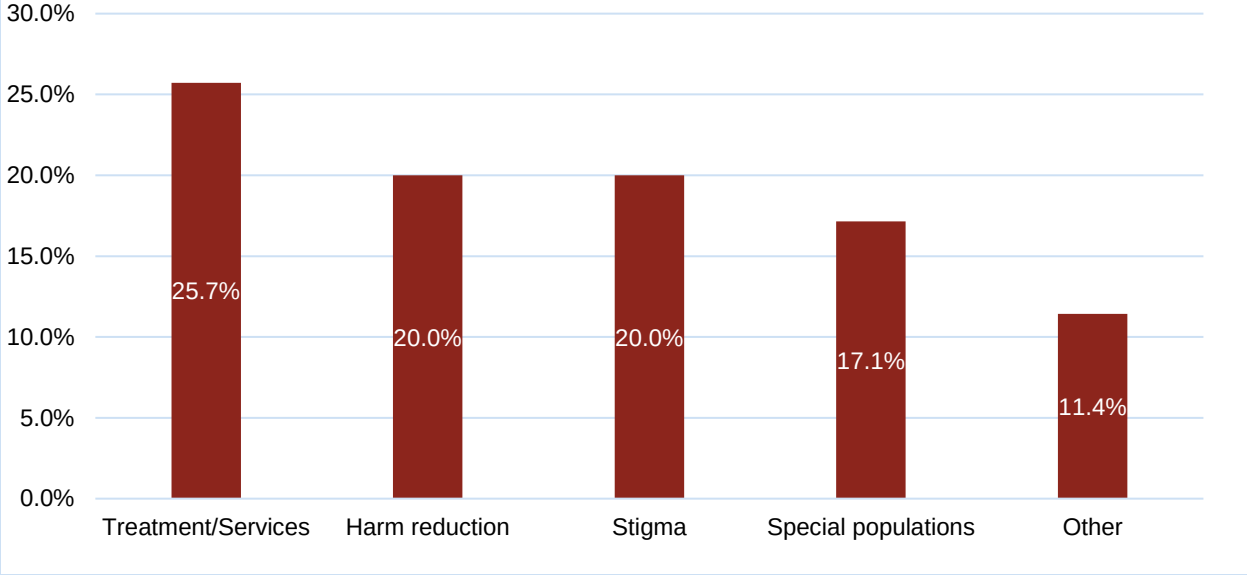

Figure 10: Topics of Media Campaigns (GY3)

In GY3, the APR did not include questions about media marketing accomplishments and challenges from GY1 and GY2. These questions were removed since many of the grantees struggled to collect data on their accomplishments and barriers; however, data on the number of media campaigns was readily available and reported.

Additional Analysis

Objective 1—Research Question 2: Is the total number of radio/TV/Billboard ads associated with the total number of attendees or by event type?

This analysis explored whether there was an association between the total number of radio, TV, and billboard ads aired and the total number of attendees across all events, as well as the total number of attendees for each specific event type. These event types included education and prevention, accessing local services, safeguarding controlled medication, proper disposal of prescription medication, and recognizing signs of an overdose. Exploratory analysis revealed non-normal distributions for each continuous variable; visual inspection of scatterplots confirmed there was no clear linear relationship between the total number of ads and the number of attendees, whether across all events or by individual event type. As a result, Spearman's Rank correlation coefficient was used to assess the strength of the relationship between these variables.

The results of the Spearman correlation analysis examined the relationship between different types of media ads—total media advertisements, radio advertisements,

television advertisements, and billboard advertisements—and attendance at various event types (Table 4). The analysis included combined attendance across all events, as well as attendance at individual events. The correlation coefficients (Spearman's Rho) indicated the strength and direction of the relationship between ad exposure and attendance, with positive values suggesting a positive association and negative values indicating an inverse relationship.

Spearman's rho revealed a medium to large positive correlation ($\rho = 0.33$), and a borderline statistically significant *p*–value of0.05, suggesting a meaningful trend toward increased attendance with total media advertisements. For other event types and ad types, the correlations were low or negative, with p-values consistently exceeding 0.05, indicating no statistically significant relationship between ad volume and attendance.

While there is a potential meaningful trend for education and prevention events, overall, the data does not support a consistent link between the number of ads aired and increased attendance at these events.

Summary of Findings

Overall, media campaign tool use increased in GY3 for Instagram, TikTok, and GoodHealthTV. There were small declines in the usage of Facebook, Tribal websites, YouTube, and podcasts for media campaigns. Consistent with GY1 and GY2, the most used types of media were Facebook, Tribal websites, and Instagram in GY3. In addition, in GY3 more grantees reported using other media channels, demonstrating a deepening sophistication in media campaign tool use.

Grantees continued to use multiple approaches for reaching their diverse audiences. Instagram and TikTok are the most popular among younger groups, and Facebook and even word of mouth and non-digital advertising are more effective for older groups. Interestingly, TV advertisements grew in GY3, while radio advertisements declined. This may be in part due to the increasing popularity of GoodHealthTV. The purposes of advertising campaigns ranged from sharing information about treatment and services, to risk management and stigma. In addition, many grantees described customizing their add campaigns to individual groups—such as youth, elders, people in recovery, or parents. Unsurprisingly, social media and other digital tools remain the most used media tools, due to their high potential reach and their cost effectiveness.

Table 4: Results from Statistical Analysis for the Total Radio/TV/Billboard Ads Aired by Number of Attendees and Event Type

Media Type	Event Type	Spearman's Rho	p-value
Total Media	All combined events	0.27	0.12
Total Media	Education and Prevention	0.33	0.052
Total Media	Accessing Local Services	-0.16	0.36
Total Media	Safeguarding Controlled Medication	-0.05	0.77
Total Media	Properly Disposing of Prescription Medication	-0.11	0.54
Total Media	Recognizing Signs of an Overdose	0.01	0.56
Radio Ads	All combined events	0.11	0.54
Radio Ads	Education and Prevention	0.109	0.53
Radio Ads	Accessing Local Services	0.006	0.97
Radio Ads	Safeguarding Controlled Medication	0.001	0.93
Radio Ads	Properly Disposing of Prescription Medication	-0.05	0.76
Radio Ads	Recognizing Signs of an Overdose	0.18	0.29
Television Ads	All combined events	-0.02	0.9
Television Ads	Education and Prevention	-0.05	0.75
Television Ads	Accessing Local Services	-0.03	0.88
Television Ads	Safeguarding Controlled Medication	-0.09	0.62
Television Ads	Properly Disposing of Prescription Medication	-0.09	0.61
Television Ads	Recognizing Signs of an Overdose	0.12	0.5
Billboard Ads	All combined events	0.19	0.26
Billboard Ads	Education and Prevention	0.26	0.13
Billboard Ads	Accessing Local Services	-0.24	0.16
Billboard Ads	Safeguarding Controlled Medication	0.16	0.34
Billboard Ads	Properly Disposing of Prescription Medication	0.05	0.76
Billboard Ads	Recognizing Signs of an Overdose	-0.15	0.38

Note: The negative values for Spearman's Rho in this table represent a negative correlation between the number of ads aired (Radio, TV, or Billboard) and the number of attendees or outcomes for a particular event type.

Objective 2: Build Traditionally Relevant Support Systems

As part of the grantees' objective to build a support system, this section sheds light on achievements in doing so through various mechanisms employed to strengthen and empower AI/AN communities (APR Section D). Next is a summary of quantitative and qualitative findings highlighting grantees' activities and accomplishments across each grant year.

APR Section D: Strengthen and Empower AI/AN Families

To understand the ways in which grantees strengthened and empowered AI/AN families, the grantees were asked to share whether they provided a number of specific interventions and how many participants enrolled in each. This information demonstrates which approaches the grantees are using and how this has shifted over time, as they learn more about their community needs.

Group Therapy Sessions

Group therapy sessions are support sessions for groups of people in recovery or who have loved ones in recovery. They are facilitated by someone trained in group therapy, who provides group members with opportunities to share their struggles, understand that they are not alone, and learn coping skills. Figure 11 displays the number of group therapy sessions hosted by grantees to support AI/AN families in their communities with addressing the opioid crisis. Figure 11: Number of Group Therapy Sessions and Attendees (GY1–GY3) also displays the number of attendees across all group therapy sessions. Appendix A provides more detailed information for Section D.

Overall, the number of group therapy sessions held decreased between GY1 (n = 2,622) and GY2 (n = 1,503), increasing again in GY3 to 2,265. In contrast, the number of attendees increased over the grant years, from 1,362 in GY1 to 7,404 in GY3.

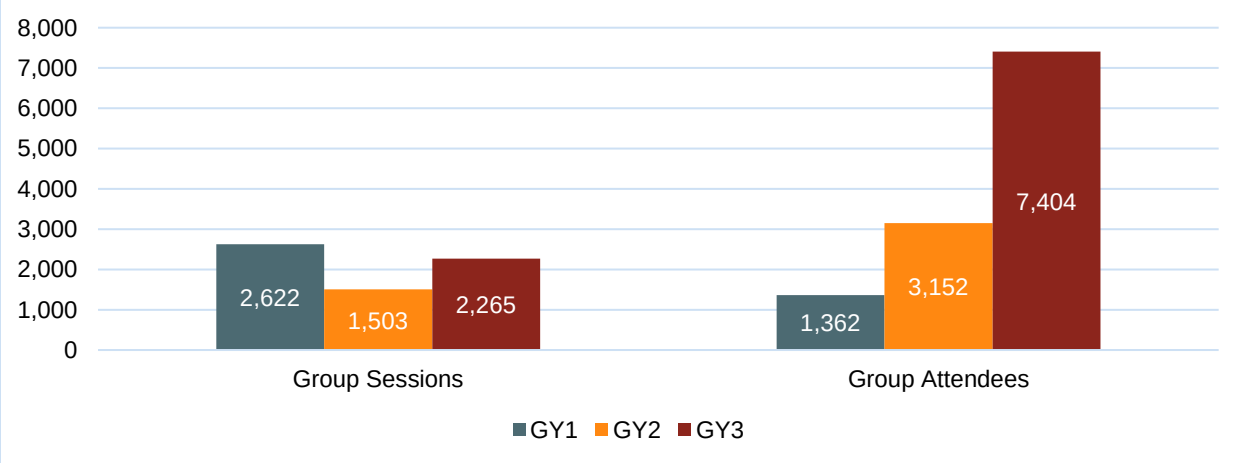

Figure 11: Number of Group Therapy Sessions and Attendees (GY1–GY3)

Traditional Activities

Figure 12 displays the percentage of grantees who used traditional activities to integrate Tribal values and heritage within treatment/sobriety efforts by type of traditional activity (See Appendix A: Tables, Section D, for more details).

Between GY1 and GY3, the percentage of grantees performing each activity increased across six of the categories and decreased among three of the nine categories. Overall, incorporating traditional crafts into treatment/sobriety efforts was most frequently reported by grantees in GY3 (87.9%, n = 29), an increase over 67.6% (n = 23). Similarly, the use of drumming increased from 57.6% in GY1 (n = 19) to 84.4% in GY3 (n = 27). In contrast, the use of storytelling increased from 81.8% in GY1 (n = 27) to 84.8% in GY2 (n = 28) but decreased in GY3 to 74.2% (n = 23). There was an increase in the percentage of grantees who incorporated singing within their efforts between GY1 (61.3%, n = 19) and GY3 (71.9%, n = 23). More grantees also reported using songs in their treatment/sobriety efforts in GY3 (71.9%, n = 23) compared to GY1 (63.6%, n = 21). A similar increase was observed for the use of dancing from GY3 (65.6%, n = 21) compared to GY1 (51.5%, n = 17). Fewer grantees reported using traditional language in their treatment/sobriety efforts in GY3 (59.4%, n = 19) compared to GY1 (69.7%, n = 23). The use of traditional games also increased between GY1 (43.8%, n = 14) and GY3 (50.0% n = 15).

Finally, the percentage of grantees who reported using equine therapy declined slightly in GY3 (23.3%, n = 7) compared to GY1 (23.5%, n = 8). This data demonstrates the popularity of traditional activities and the wide variety of traditional activities that grantees are using to support their community healing.

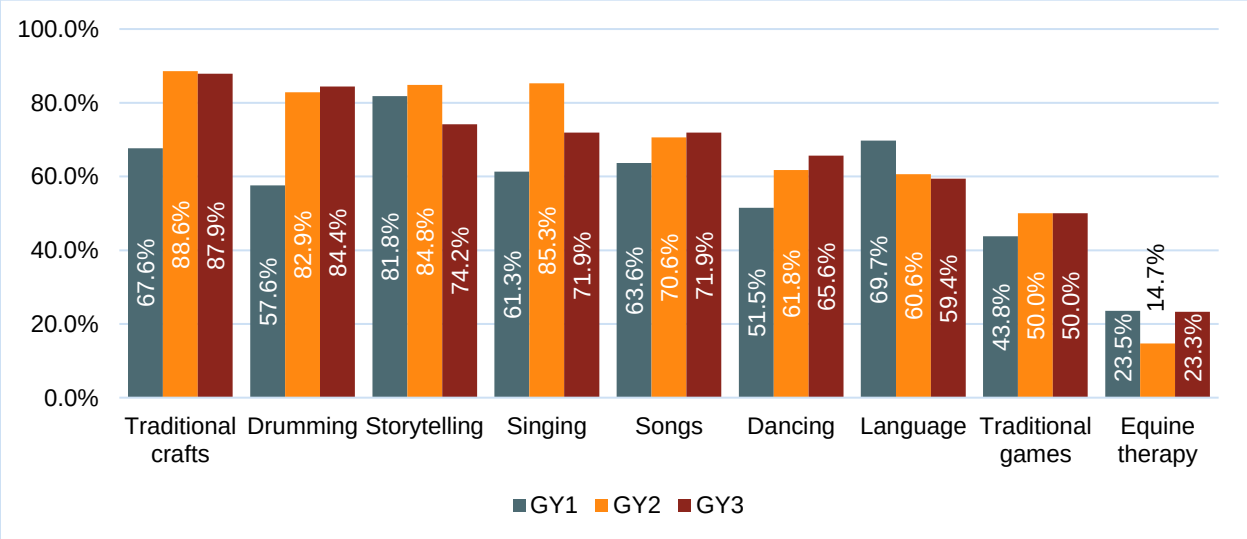

Figure 12: Percentage of Grantees Offering Traditional Activities by Type (GY1–GY3)

Traditionally tailored integrated health and wellness services across grantees provide an opportunity to improve their effectiveness and relevance to Indigenous communities. Grantees attribute clients and members feeling a more profound connection to the services and programs that reflect their AI/AN heritage, values, knowledge, and traditions. Grantees shared that this approach strengthened traditional identity and self-esteem, contributing to holistic healing. Further, essential services focus on community empowerment and continued support that addresses historical and intergenerational trauma.

Grantees were asked to share, in more detail, the practices and strategies they used to strengthen and empower AI/AN families and what outcomes and impacts they observed. Grantees described achieving this through implementing a variety of practices and strategies with their comprehensive support teams that are traditionally grounded, family-focused, holistic, evidence-based, and trauma-informed, over three program years. In doing so, support teams are better equipped to serve and meet the diverse needs of clients and families in the communities served. Over the three program years, grantees developed partnerships to ensure services are available and streamlined. To illustrate the importance of establishing and coordinating support teams, one grantee shared,

> *"COIPP team members have partnered with other support teams such as Potawatomi Alliance Toward Community Health and Recovery Action Wellness to share education and resources, provide training, and empower AI/AN families in addressing the opioid crisis in our Tribal community. Internally, there is a support team working on harm-reduction efforts such as implementing the distribution of Narcan, fentanyl test strips, and medication lock boxes. The COIPP team also works with other departments such as Tribal Court, Fire Lodge Children & Family Services, Domestic Violence, Education, Traditional Heritage Center, Workforce and Development, and the Re-entry program reaches new clients and families and offers program participants wrap-around services." (GY3)*

Family-focused strategies for supporting families in OUD treatment and prevention emphasize traditionally grounded methods tailored to both individuals and families. These approaches integrate evidence-based practices (EBPs) that address the unique needs of families within their traditional context. Key elements include multidisciplinary and comprehensive support teams, education and awareness initiatives, prevention efforts, accessible resources, peer support, trauma-informed care, family-centered therapies, and childcare services. For example, in GY2, a grantee described their MAT team which consists of behavioral health case managers, behavioral health aides, primary care providers, and nurse case managers who are both Tribal and non-Tribal members and provide a collaborative care approach to current and potential MAT clients. Some grantees emphasized the strength in having AI/AN staff and providers as a form of capacity building for the community but also ensuring a level of comfort and familiarity for clients. As shared by one grantee,

> *"(Grantee) gives hiring preference to AI/AN applicants, resulting in around 57% of its existing staff identifying as AI/AN. This ensures that the staff has extensive experience serving the project's target population and intimate familiarity with AI/AN heritages, traditional practices, and Indigenous languages." (GY3)*

Having AI/AN staff has also contributed to the development of traditional-based curriculum and training that ensures clients receive traditionally tailored and responsive care and treatment. It also serves to build upon and train staff in traditional standards for care. As highlighted by one grantee,

> *"The traditional treatment advocate has partnered with the heritage center and heritage experts to ensure that she includes heritage practices content in the development of a traditionally specific curriculum." (GY3)*

Grantees apply a holistic and comprehensive approach to address OUD with individuals and communities. Over the three program years, grantees described a broad range of available comprehensive EBPs tailored to families. As examples, grantees have explored opening a friend and family center, offering childcare and family treatment services, and offering family-centered approach services for justice-involved relatives—integrating a solid referral system and case management process. This process includes risk and needs assessments to engage entire families and provide a broad range of support, such as referrals for SUD treatment, mental health care, housing, vocational and educational development, family reunification, and parenting classes.

Grantees recognize and are addressing the impact of trauma on individuals and communities by providing trauma-informed care training to support teams and integrating trauma-informed care into services. As highlighted by one grantee,

> *"Throughout this project, we have worked diligently to reduce stigma and reinforced the importance of trauma-informed and strengths-based approaches through any training we offer, including the Narcan administration trainings and our event, the Hope in Healing Native Opioid Summit."* (GY3)

Another grantee highlighted a trauma-informed care approach that offers comprehensive services which include evidence-based therapy, MI, and contingency management (CM). Moreover, the importance of training comprehensive support teams on a trauma-informed care approach. Such trainings, "were designed with a trauma-informed and strengths-based approach, emphasizing the well-being and empowerment of individuals affected by substance use." (GY2) These approaches also integrated heritage competent care, community engagement, family-centered approaches, peer support programs, continued care, and aftercare support.

Impact of Providing Traditional Practices and Services to Clients

Over the years, grantees have documented the impact of their comprehensive support teams' efforts in providing traditional practices and services to clients and families

served. Grantees recognize that heritage is central to the community. Integrating it into practice and services builds trust with clients and the community. More specifically, “Providing traditionally tailored integrated services has assisted us in breaking down the stigma surrounding opioid use and abuse while honoring personal heritage”. (GY3) Grantees have also shared that traditionally tailored integrated services have shown to enhance effectiveness, while offering flexibility for clients and families on their journey of healing. As highlighted by a grantee,

> *“Providing traditionally tailored integrated services significantly enhances the effectiveness of support programs by ensuring that interventions resonate with participants' traditional values and traditions. This approach fosters trust, improves engagement, and increases adherence to treatment, as individuals feel respected and understood. Additionally, it promotes holistic well-being by integrating traditional practices with conventional treatments, leading to better overall outcomes and a stronger, more supportive community network.” (GY3)*

As grantees observe the benefits in offering heritage-tailored services, many have considered additional opportunities to integrate traditional practices across more programs and services, beyond the organization and broadly across the community. As an example, one grantee shared the “presence of the elder in residence has been a vital part of building resilience and maintaining sobriety, as well as two Native licensed alcohol and drug counselors.” (GY3) Reciprocal effects have been observed, whereby comprehensive support teams gain knowledge and understanding of AI/AN heritage, bringing them closer to community. As quoted by a grantee,

> *“Providing heritage-tailored services has been a benefit to both the client and provider. Having these experiences for the client demonstrates a desire of the provider to understand and be part of the community. Providers who use heritage-tailored services are able to gain client trust and better help them succeed in their programs.” (GY1)*

Some grantees observed that heritage-tailored services have reduced stigma, changed knowledge, attitudes, and beliefs toward OUD, and increased community awareness and understanding of recovery services through a traditional lens. As a result, “there is more willingness to discuss the traumas and impacts for substance abuse.” (GY2) To further illustrate the impact in their community, one grantee shared that, “more people understand what recovery and treatment services are available, and how people and heal through involvement in spiritual activities.” (GY3) Traditional practices, as noted by another grantee, have contributed to clients’ adherence to sobriety.

> *“Most of the traditional activities specifically prohibit substance use while participating so it provides clients the extra incentive needed to remain sober. Also, traditional activities bring people together and create a sense of community, which in itself holds people accountable for their choices.” (GY3)*

Finally, heritage-tailored services have contributed to empowered and more resilient program teams, clients/families, and communities that are better equipped to address OUD. Having heritage central to services, such as traditional practices and languages, contributes to increased self-esteem, pride, and sense of belonging for all involved, as is vital for service delivery as well as sustained recovery. As quoted by a grantee,

> *"Our program experiences higher engagement and retention rates as participants feel more understood and respected. This traditional relevance enhances trust and reduces feelings of alienation, making individuals more likely to commit to their treatment plans. (Grantee) Participants are also more likely to adopt and adhere to recovery strategies that resonate with their traditional beliefs and practices. They connect with others who share their heritage and traditional activities, as well as common struggles and generational trauma." (GY3)*

Heritage ties individuals, families, and the community together, and thus contributes to greater commitment and success of treatment outcomes and the overall program for the community.

Religious, Spiritual, and Faith-based Services

Religious, spiritual, and faith-based services can help people in recovery and their loved ones find meaning, coping, and courage. Grantee offerings of religious, spiritual, and faith-based services are described in Figure 13. In GY3, the most performed religious, spiritual, or faith-based service offered by grantees was traditional practices (88.2%, n = 30), followed closely by non-spiritual therapy/counseling (87.9%, n = 29). For the latter, this represents an increase from GY1, where only 64.7% of grantees (n = 22) offered this service.

Transportation remained a service offered by most grantees in GY2 (70.6%, n = 23) and GY3 (71.9%, n = 23), an increase from GY1 (57.6%, n = 19). Prayer services offered fluctuated across years with most grantees offering this service in GY1 (71.9%, n = 23). In addition, just over half of grantees (55.2%, n = 16) offered spiritually based therapy/counseling in GY3, a percentage that remained stable across GY2 (55.9%, n = 19) and GY1 (54.8%, n = 17).

More grantees offered spirituality groups in GY3 (46.7%, n = 14) than in GY1 (32.3%, n = 10), although this was a slight decline from GY2 (48.5%, n = 16). The percentage of grantees offering shelter as a service tripled between GY1 (10.0%, n = 3) and GY3 (32.3%, n = 10), due to lifted pandemic restrictions.

Pastoral care and clergy/chaplain support remained the least frequently offered services consistently across all grant years. In GY1, 12.9% of grantees (n = 4) offered pastoral care, a percentage that remained stable through GY3 (13.8%, n = 4). Likewise, the percentage of grantees who used clergy or chaplain remained stable from 12.1% in GY1 (n = 4) to 13.8% in GY3 (n = 4).

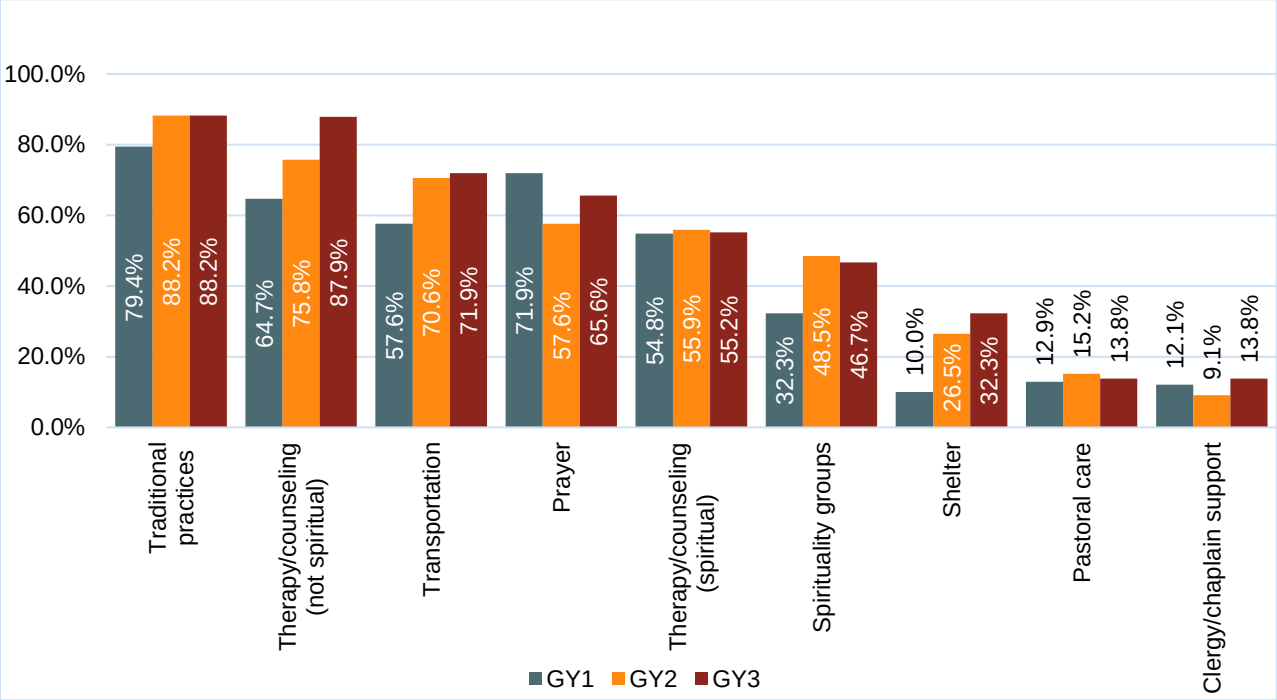

Figure 13: Percentage of Grantees Offering Religious, Spiritual or Faith-based Activities by Type (GY1–GY3)

Implementation and Impact of Providing Faith-based Services

Specific to faith-based services, grantees were asked to document the implementation and impact of their offerings. Among those grantees who do offer faith-based services, they do so in a way to meet the various needs of patients/clients and their families. Overall, the themes of the responses illustrated the complexity of a broad range of approaches, ranging from a high level of providing faith-based services to limited provision.

Some grantees perceived faith-based services as another practice to reinforce a sense of belonging, support, and healing, promote community connections, and reinforce their traditional connection with their patients/clients. As shared by a grantee,

> "*Our MAT/SUD Counseling Program providers agree that religion and faith can be a big impact in treatment and recovery for substance use disorder. When the patient expresses the desire to combine religion and faith into their recovery program, we help them focus on those spiritual needs. They may want to participate in the 12-step program or attend meetings provided in their spiritual community. If they want spiritual direction but have no connections, we provide them with a list of spiritual communities they can call. We often pray with the patient to provide peer support and comfort at the time of their visits."* (GY1)

In addition to being a great resource for healing, it offers belonging and reinforces community and traditional connections. Another grantee observed that, “COIPP participants who are involved in some form of faith-based services display more optimistic behaviors and a higher resilience to stress, which can help in the overall recovery process.” (GY2)

Grantees recognize that faith-based services help patients and their families engage with their AI/AN community and heritage, as it provides an avenue for participants to connect to their Tribal community and values, maintain sobriety, honor heritage, and provide support and spiritual connection.” (GY2) These services provide an avenue for emotional healing. As observed by another grantee,

> *“Patients begin to find emotional healing through spiritual-based principles and practices. Healing through prayer and traditional practices helps individuals in recovery by cultivating inner peace, reducing stress, and providing strength.” (GY3)*

For the grantees who did not integrate faith-based services, had limited offerings, or had no formal faith-based support programs, alternative supports were provided such as referrals to other organizations or groups offering faith-based services. Some of these grantees recognized the significance of faith-based initiatives and collaborated with faith-based service organizations to meet their community’s needs. For example, one grantee shared that they, “do not support these programs, but refer to them as some (patients/clients) have found that extra support extremely helpful in their recovery.” (GY3) Another grantee incorporated the option of including faith-based therapy options. One grantee described integrating prayer into their session and providing referrals to patients seeking faith-based community support.

Grantees shared many reasons for not offering faith-based support services. One documented the lack of a majority faith-based belief in their community. Other grantees responded that they are not currently offering any faith-based services but are exploring the option of including faith-based support in therapy due to increasing interest from the community. Some have considered or are in the process of partnering with local faith-based organizations. As one grantee shared, “We have a strong partnership with a local church focused on restorative justice, houselessness outreach, and working with other hard to reach populations.” (GY3) Another grantee indicated that they are planning to partner with local charter schools and service agencies to expand targeted, faith-based services for clients/patients. Instead of providing faith-based support services, these grantees offer traditional/spiritual activities grounded in AI/AN heritage, teachings, and traditions. Overall, faith-based services support is not universally applied and integrated in service among all grantees. Rather, it is integrated to varying degrees ranging from deeply integrated and traditionally focused approaches to more selective or exclusively AI/AN heritage, traditions, and Indigenous Knowledge and ways of knowing, based on the needs of clients/patients and communities.

Groups

Grantees were asked to indicate whether they use any formal group structures, such as advocacy groups, to help implement and organize their OUD program. Figure 14 displays the percentage of grantees who reported that they facilitated the formation of advocacy/prevention groups, youth advisory councils, elder advisory councils, and crisis response teams (See Appendix A: Tables for additional details). Focusing on elder advisory councils, the percentage of grantees who facilitated their formation increased from 17.1% in GY1 (n = 6) to 26.5% in GY3 (n = 9). Multidisciplinary coordination groups are collaborative teams that bring together health care professionals, social service providers, Tribal leaders, and community members to collectively address the complex needs of individuals with OUD in a Tribal community. These groups operate similarly to case management groups, where diverse stakeholders meet regularly to coordinate care, share insights, and develop comprehensive strategies that span multiple disciplines. The integration of perspectives from medical, behavioral health, social services, and community support systems allows for a holistic approach to treatment that not only focuses on clinical aspects but also incorporates traditional and social factors vital for effective care. Such coordination groups foster a cohesive support network, activating community-level resources and building bridges to external organizations for enhanced support. This multidisciplinary approach ensures that individuals receive personalized and community-backed care, promoting recovery and resilience. Multidisciplinary coordination groups remained the most frequently formed group type across all three grant years. Between GY1 and GY2, the percentage of grantees forming multidisciplinary groups remained the same at 54.3% (n = 19) of grantees, before decreasing slightly to 50.0% (n = 17) in GY3.

Advocacy/prevention groups were the next most frequently formed groups, with 45.7% (n = 16) of grantees in GY1 and 38.2% (n = 13) of grantees in GY3 forming this group type. In contrast, the percentage of grantees forming crisis response teams decreased by half between GY1 and GY3: from 34.3% (n = 12) in GY1 to 17.6% (n = 6) in GY3. Similarly, fewer grantees formed youth advisory councils in GY3 (14.7%, n = 5) than in GY1 (28.6%, n = 10).

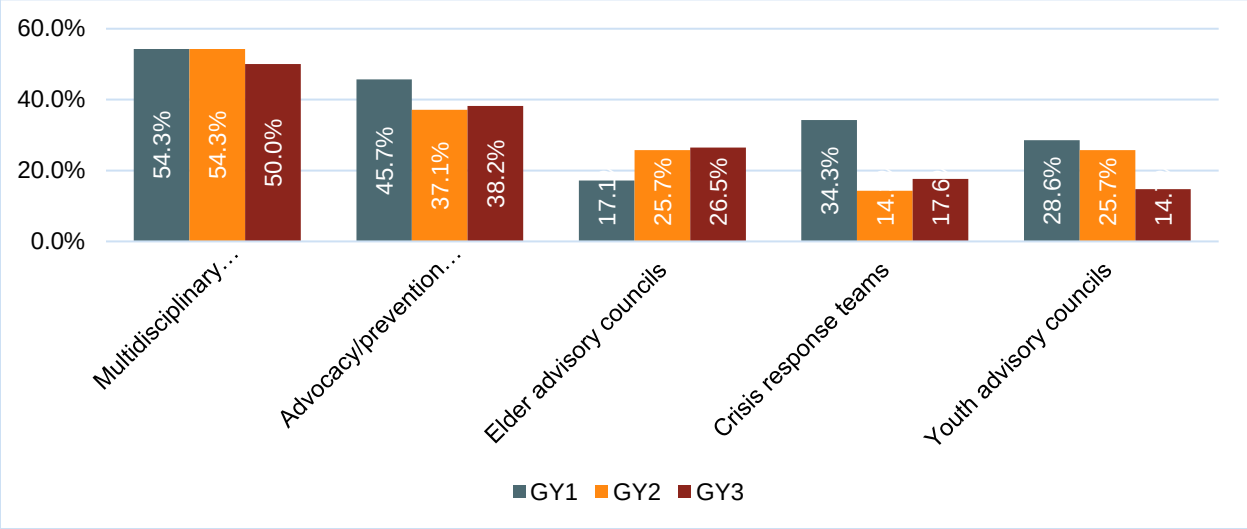

Figure 14: Percentage of Grantees Offering Groups by Type (GY1–GY3)

Number of Groups

Grantees were also asked to report on how many groups of each type they formed (see Figure 15). The number of groups of each type followed the same trend as the number of grantees using each group type. The number of multidisciplinary coordination groups formed was higher than in the other four categories, although it decreased over the years. A total of 93 groups were formed in GY1, 85 in GY2, and 62 in GY3. The number of advocacy/prevention groups formed in GY1 was not reported, however, 47 were formed in GY2, which increased to 65 in GY3.

The number of elder advisory councils formed in GY3 (n = 22) was almost half of that formed in GY1 (n = 41), although it was a slight increase from GY2 (n = 15). Similarly, the number of crisis response teams formed in GY3 (n = 7) was slightly more than that formed in GY2 (n = 6), but about half that formed in GY1 (n = 16). Finally, only six youth advisory councils were formed in GY3, while 13 were formed in GY2 and 25 in GY1. Although fewer groups were formed in GY3, there is no data on whether groups formed in earlier grant years were not continued.

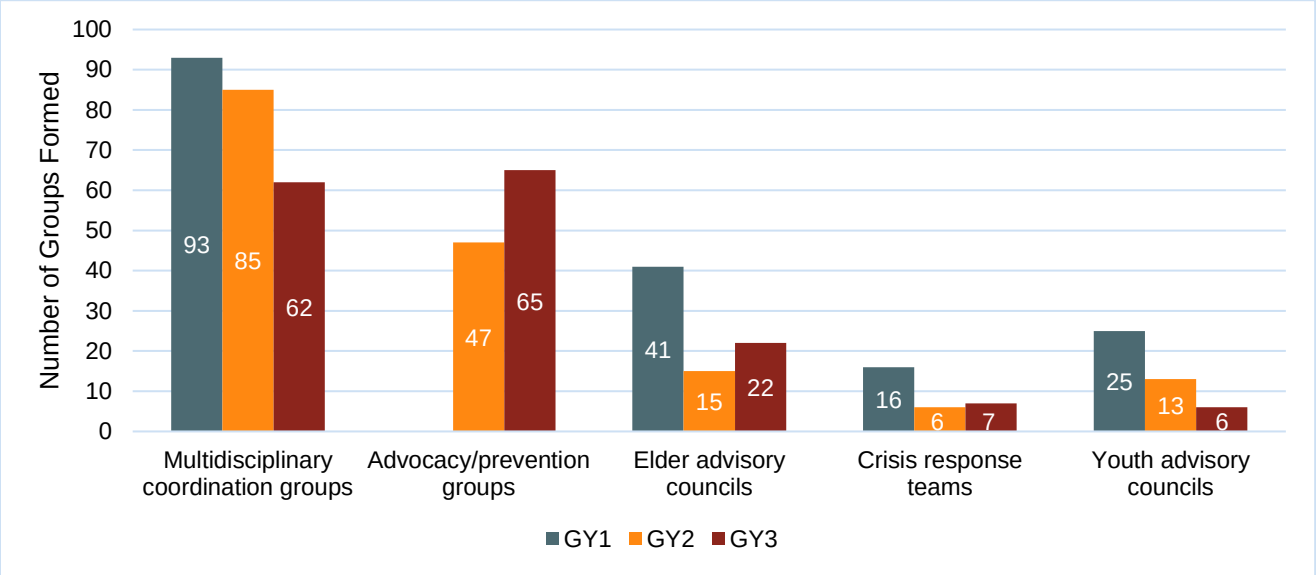

Figure 15: Number of Groups Formed by Type (GY1–GY3)

Crisis Response Teams

Grantees with crisis response teams were asked to provide additional details about these types of teams—specifically how many partner organizations they collaborated with, and how many crisis response team participants they had (Table 5). In GY3, all grantees (n = 35) reported that there were 16 partner entities that participated in their crisis response teams that were formed. This is an increase from the 13 entities identified in GY2, and a decrease from GY1 (n = 23). In addition, there were only 42 reported participants in the crisis response teams in GY3, or an average of 1.2 participants per group. This is a decrease from GY2 when 132 participants were reported (avg. = 4.1/group) and GY1 when 127 participants were reported (avg. = 12.7/group).

Table 5: Participation and Partnership in Crisis Response Teams (GY1–GY3)

	Count			Average		
	GY1	**GY2**	**GY3**	**GY1**	**GY2**	**GY3**
Total partner entities	23	13	16	2.3	0.4	0.5
Crisis response team participants	127	132	42	12.7	4.1	1.2

Trauma-informed Care

Trauma-informed care, which applies a strengths-based approach involving understanding and responding to the impact of trauma on people's lives, is an important

care approach for OUD and SUD programs and services. Grantees were asked whether they had trauma-informed policies, procedures, and practices, and whether they trained their staff on trauma-informed care. Most grantees indicated having trauma-informed policies, procedures, and practices, increased from GY1 (84.8%, n = 28) to GY3 (94.1%, n = 32).

Regarding trauma-informed care training for staff members, Figure 16 shows the number of individuals who grantees reported receiving training on trauma-informed care. Note that between the first two years and the last year, the reporting questions were changed. While in the first two years, grantees were asked simply how many of each personnel category were trained in trauma-informed care, for the last year, grantees were asked how many of each category were trained in this by their organization. Due to this discrepancy, the data for GY3 is presented separately from GY1 and GY2.

For GY3, the number of individuals who received this training was greater than that reported for the previous two years across all categories. For health care professionals, there were 1,353 individuals trained in comparison to 801 in GY1 to 746 in GY2. For program staff, there were 842 individuals trained in comparison to 760 in GY1 to 750 in GY2. Finally, the number of community members trained in GY3 was 1,117; an increase from 511 trained in GY1 to 464 trained in GY2.

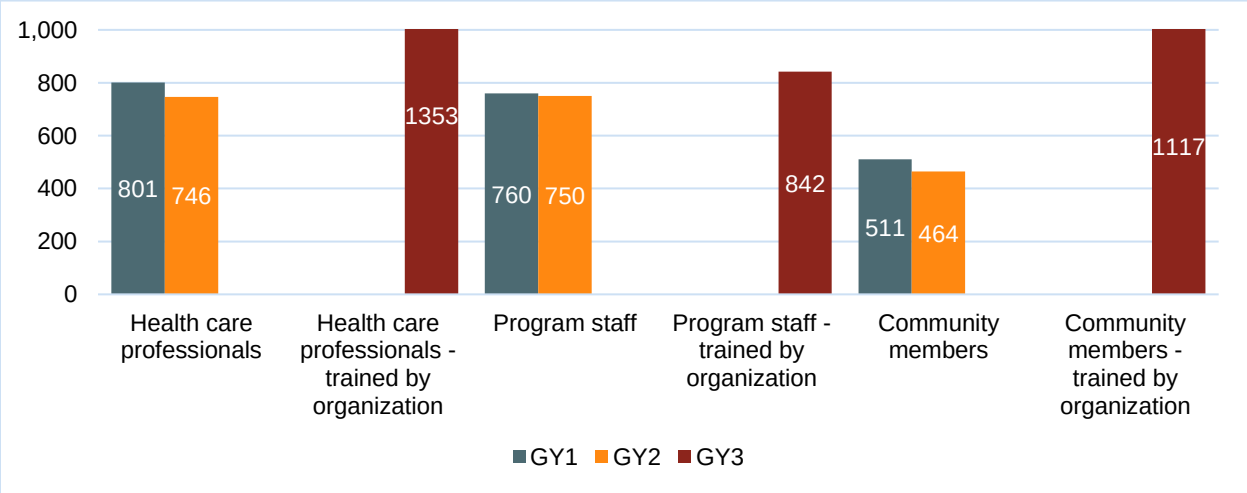

Figure 16: Number of Health Care Professionals, Program Staff, and Community Members Trained in Trauma-Informed Care (GY1–GY3)

Support Services for Staff

Grantees were asked whether they provided support services for staff. Figure 17 displays the percentage of grantees who provided support services to staff, particularly those addressing burnout and compassion fatigue. From GY1 to GY3, the percentage of grantees providing burnout and compassion fatigue support services for staff

increased year-to-year. Specifically, 62.9% (n = 22) of grantees provided these services to staff in GY1 compared to 79.4% (n = 27) in GY3. Similarly, the percentage of grantees who had efforts in place to address compassion fatigue among program staff also increased from 58.8% (n = 20) in GY1 to 76.5% (n = 26) in GY3.

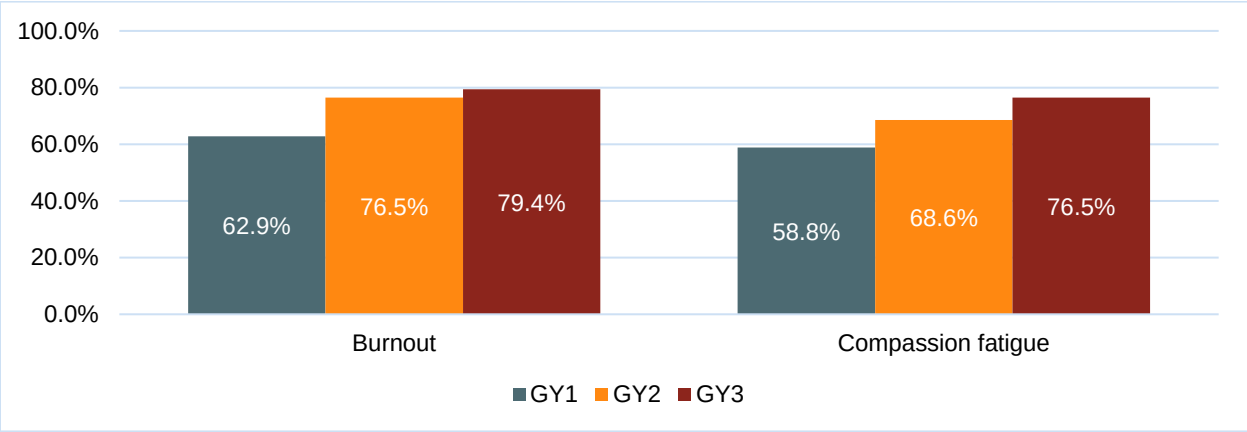

Figure 17: Percentage of Grantees Providing Support Services to Staff (GY1–GY3)

Staff Burnout

Efforts to address staff burnout—often associated with too much work and not enough resources—were consistently expressed across GY1 through GY3. To mitigate staff burnout, grantees have implemented various strategies, including both formal and informal activities, programs, and support systems to varying degrees in each program year. Unique to GY1, grantees had the added layer of managing burnout with the COVID-19 pandemic, with staff experiencing increased stress as a result of a combination of managing and balancing work with reduced staff capacity, mitigating the risk of contracting COVID-19, and managing personal care during and after contracting COVID-19. During this time, grantees put forth additional effort by providing staff support, while adhering to social distancing practices.

> *"The ongoing COVID-19 pandemic has placed a significant strain on staff. (Grantee) has amplified efforts to support through the provision of the employee warmline, connecting health care staff with a licensed mental health counselor upon their call, and providing COVID-19 virtual monthly support groups. (Grantee) also employs three licensed counselors to specifically serve employees." (GY1)*

The burnout supports and strategies described next were offered throughout all grant years, with each year, grantees continuing to build upon their offerings to staff. Notably, in GY2 and GY3 and with easing of the pandemic, grantees began implementing more in-person opportunities to connect with staff and support services, as well as more traditional approaches to mitigate burnout. These are illustrated throughout this section. Supportive leadership plays a key role in fostering a positive work environment by

encouraging open communication and active listening, ensuring staff feel valued. Examples of supportive leadership shared by grantees include regular staff-supervisor check-ins and team meetings, flexible work schedules, open-door policy for staff, staff goal setting, coaching, and recognition.

> *"We've had all staff meetings to address burnout specifically as it has been difficult due to COVID-19 and the increase in deaths due to fentanyl overdoses. We also periodically talk with staff and encourage them to take time off when they have been working extremely hard to care for others or if there have been deaths in the community." (GY3)*

Formal structures to address burnout include employee assistance programs, counseling services, paid time off for both traditional and non-traditional holidays, and mental health days. Some grantees also offered professional development, training, resources focused on techniques to prevent burnout, as well as recognizing staff as a form of appreciation and recognition. As described by a grantee, employees attend mental health training to recognize the signs of burnout both for themselves and among others.

> *"All employees attend Mental Health Resiliency Training and Mental Health First Aid classes to recognize signs of burnout and compassion fatigue in themselves and their colleagues. These initiatives promote a supportive work environment where staff can thrive both personally and professionally." (GY3)*

Flexible or reduced work schedules, wellness initiatives, and self-care activities such as staff retreats, yoga, exercise, and healthy eating education further promote work-life balance and overall well-being. Additionally, integrating and aligning traditional and spiritual practices, such as art (e.g., beading circles), traditional healing and medicine (e.g., ceremony, sweat lodge and talking circles) is crucial to meeting diverse needs and taking a holistic approach to creating a more supportive work environment. Finally, some grantees are providing mental health and wellness resources to family members of staff to strengthen and build resilient families and communities beyond the workplace.

Compassion Fatigue

Efforts to address compassion fatigue—the physical and mental exhaustion experienced when someone cares for traumatized sick individuals—were also expressed by grantees across GY1 through GY3. Similar to services that address burnout, grantees use multifaceted approaches to address compassion fatigue among their staff. Grantees provided professional development, education, and resources through company-wide learning modules focused on compassion fatigue, wellness, and self-care for staff. Grantees continue to provide ongoing training for managers and supervisors to foster a supportive work environment and how to recognize the signs of compassion fatigue. To illustrate the importance of offering multifaceted approaches and efforts to address compassion fatigue, one grantee shared,

> *"The (Grantee) fosters connections among providers by sharing experiences, emotions, and coping strategies among colleagues. This collaborative approach strengthens relationships and promotes a sense of camaraderie within the clinical team. Additionally, providers are urged to prioritize their well-being through positive self-care routines and regular check-ins with their clinical supervisors. These proactive measures ensure that providers receive the support they need to thrive in their roles and continue delivering high-quality care to the community." (GY3)*

Organizations also implement flexible work arrangements and leave policies to create a supportive environment and foster work-life balance. Compared to GY1, in GY2 and GY3, grantees shared more in the ways they integrate heritage and traditional practices to support staff with compassion fatigue, such as healing activities in the larger community, and through regular check-ins with supervisors to enhance their personal and team support systems. As an example, one grantee shared that in addition to weekly supervisor consultation and monthly trainings, "staff also have monthly treatment teams meetings to address concerns with patients and to help those feeling compassion fatigue." (GY3) From a traditional practice, one grantee shared that they offer staff the opportunity to speak with an elder for support.

Through all three program years, grantees provided compassion fatigue training as well as trauma-informed training and support for their staff and among those offering support to staff. Grantees have also offered an employee assistance program with professional assistance, including short-term counseling and referral services.

Finally, grantees emphasized the importance of social connections among staff by prioritizing potlucks, celebrations, yoga, and increased in-person activities such as office-wide retreats, particularly throughout GY2 and GY3 with the easing of COVID-19 pandemic restrictions. Staff were also encouraged to prioritize self-care practices and regularly continue with their self-care goals.

Support Services for Family Members

Figure 18 displays the percentage of grantees who provided support services to family members of individuals with OUD. See Table 23 in Appendix A for more details.

Overall, a consistent increase was observed in the percentage of grantees who offered support services to families of individuals with OUD across all grant years. In GY1, 58.8% of grantees (n = 20) offered these services, which increased to 68.6% (n = 24) of grantees in GY2. This further increased to 81.8% of grantees (n = 27) offering these services in GY3.

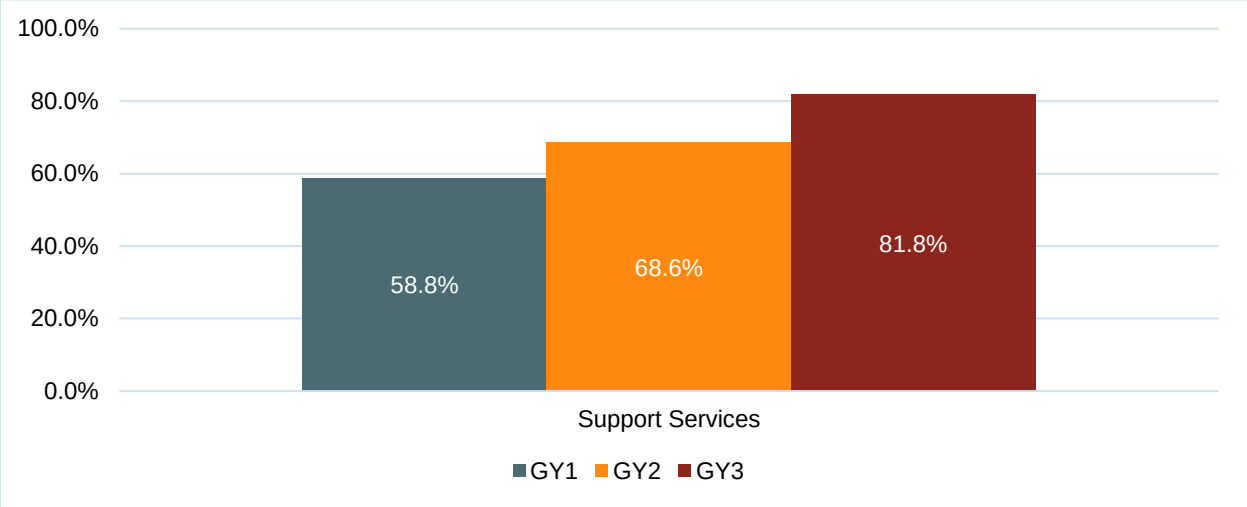

Figure 18: Percentage of Grantees Providing Support Services for Families (GY1–GY3)

Over the course of three program years, grantees have demonstrated their growth in providing support services for individuals and families. By the end of GY1, many grantees offered services through referral to resources within their organization or externally, such as to peer support specialists, recovery coaches, and counseling. Over three years, grantees have increased their capacity to provide support services that emphasize both individual and communal healing approaches. Case management now plays a vital role in coordinating comprehensive support services, particularly for families and individuals who need family therapy, counseling, peer and group support programs, and referrals to community programs. Many grantees have an expanded definition of family for inclusiveness of broader support aligned with AI/AN values, heritage, and traditions.

> *"The family education groups involve all interested members of a client's family. (Grantee) has a broader definition of 'family' that not only includes biologically related individuals, but other individuals important to the client and may include significant others, extended family members (aunts, uncles, grandparents, etc.) and other persons that may not even be directly related." (GY3)*

Grantees use a comprehensive, multi-prong approach to using an established support network addressing family needs. Case management in service coordination is vital in assisting families with navigating the complex health care environment and specific services.

> *"The (Grantee) is a full-service clinic that provides full health services to the entire community. It isn't unusual for clients to have other needs when being seen for an appointment. The (Grantee) is prepared to provide these services so clients and their families get the attention that is needed. Recovery Coaches are available for transportation and mentoring and coordinating regular sober family-*

friendly events. Outside of the (Grantee), other departments offer groups such as life skills and positive parenting which clients are encouraged to attend." (GY3)

Grantees also described the challenges relating to coordination and referrals for families. Although grantees strive to simplify coordination through in-house offerings, they will also collaborate with other departments and organizations within and outside their area to ensure service and support for patients and families. However, even with an extensive coordinated support system, sometimes family services are limited due to resource constraints between demand and availability.

Most grantees offer formal, family-focused care (focused on the individual client's treatment, while recognizing the important role of family members in healing journey), and family-based care (focused on the family as a whole throughout the healing journey), including by inviting family members to participate in therapy group sessions and educating families. Grantees applied a comprehensive system that provides mentorship, peer support, traditional integration, substance use and mental health support (therapy, counseling), and educational workshops. Some grantees cannot provide family-focused care due to staff capacity and availability to accommodate families. In such instances, robust referral systems exist to assist families in navigating the health care system. Few grantees are unable to offer family-focused care, and continue to plan, design, and implement these services in their organization. However, at least five grantees did not reference family-focused or family-based care in their program's description but instead used general descriptive language about the types of counseling and peer support.

Partnerships and Memorandums of Understanding

Programs for OUD can be strengthened through partnerships with other service providers. Partnerships can increase access to referral services and other programs and services such as transportation, healing circles, and media. Grantees were asked to report on the number of Memorandums of Understanding (MOUs) and Memorandums of Agreement (MOAs) established to support their programs (Table 6). Between GY1 and GY2, the number of MOUs/MOAs established increased from 68 to 81, and dropped to 63 in GY3.

Table 6: Count and Average of MOUs/MOAs Established (GY1–GY3)

	Count			Average		
	GY1	GY2	GY3	GY1	GY2	GY3
MOUs/MOAs	68	81	63	2.1	2.3	1.8

Developing partnerships with other organizations is a key strategy to establish coordinated and collaborative efforts in delivery of the COIPP. In GY1, grantees primarily focused on three key activities: establishing new partnerships, expanding

support services (e.g., crisis intervention, mental health, outpatient, and wraparound services), and traditional activities. Grantees continued to develop partnerships in these areas throughout GY2 and GY3, improving OUD program delivery.

Partnership efforts were strengthened through coalition building, planning, and formalizing relationships across different sectors. Grantees highlighted the importance of coalition building to improve coordination of care and increase cooperation among health care providers, law enforcement, Tribes, and many other organizations and departments. Coalition building, planning, and formalizing partnerships gives grantees the opportunity to gather, share and build traditionally grounded resources to improve overall health care service delivery and address OUD. Formalized through MOUs, partners across a range of organizations included health care providers, law enforcement agencies, Tribal organizations, community-based organizations, schools (K-12, higher education), emergency services (fire departments), county/state health departments, housing support agencies, faith-based organizations, and professional associations.

> *"Creating referral MOU with diverse partnering organizations has significantly enhanced the referral and programming processes for OUD treatment at (Grantee). By establishing partnerships with various community organizations, (Grantee) ensures that participants receive holistic care throughout their treatment journey. These partnerships facilitate seamless referrals to mental health services, MAT, and support for co-occurring needs." (GY3)*

Such partnerships facilitate broader reach of community education and awareness efforts, reaching more audience groups about OUD treatment, recovery options, and symptoms, and reducing stigma. Many of these efforts were coordinated through community-wide reaching events (e.g., health fairs, festivals, Traditional events), public talks, media campaigns, and informational education handouts. At the same time, partnerships fostered cross-organizational training and education for providers, staff, volunteers, local businesses, and community organizations as it relates to OUD. As an example, one grantee shared that,

> *"COIPP staff continue to coordinate the Substance Use Prevention Planning Committee, comprised of local agencies with similar goals and objectives, especially as it relates to substance use prevention. As a result of these partnerships, COIPP has been better able to serve the community through drug take back events, prevention efforts, such as health fairs and back-to-school bashes, and risk management means, through donation of naloxone, Deterra bags, and lockboxes." (GY2)*

Community partnerships support continuity of care and coordination across different types of providers, agencies, and organizations. These partnerships enhance grantees' ability to ensure clients/relatives with OUD receive consistent support across treatment settings, thereby reducing their risk of relapse and improving recovery outcomes.

Through partnerships, grantees can coordinate referrals from medical providers, behavioral health/mental health providers, drug courts, jails, and community organizations to offer seamless transitions. One grantee shared that they were able to embed a peer recovery specialist to help improve the quality of care:

> *"... peer recovery specialist services at [Hospital] meeting with patients admitted due to OUD per care team referral and consultation. We've strengthened referrals from [Hospital] to clinic/Tribal health OUD services and supports within the community, as well as continue to develop relationships with our local drug court and jail to improve continuity of care between systems and reduce the risk of overdose." (GY3)*

Grantees documented through partnerships, they were able to deliver a comprehensive approach to addressing the challenges of OUD through collaborative educational initiatives coupled with specialized treatment programs and recovery services. Through partnerships, they provide opioid prevention training and prevention tools to community members and professionals. For some grantees, partnerships provided opportunities for Narcan training and distribution, syringe exchange programs, and hosted drug-takeback events and health fairs to reduce opioid-related deaths and promote safer practices. Collaboration and partnerships are instrumental for sharing resources, such as for crisis lines and combined efforts of community education to address OUD.

Additional Research Questions

Objective 2—Research Question 1: Is there an association between being trauma-informed and having burnout or compassion fatigue efforts in place for program staff?

This question explored whether there was a relationship between grantees who reported they felt they were trauma-informed and grantees who had staff retention efforts in place, such as burnout or compassion fatigue efforts. Most programs reported having trauma-informed care practices in place, with 91.4% (n = 32) indicating such efforts, while only 8.6% (n = 3) did not (Table 7). Similarly, 77.1% (n = 27) of programs had burnout efforts in place, and 74.2% (n = 26) had compassion fatigue efforts.

Table 7: Distribution of Support and Care Type Among Programs

Support and Care Type	Efforts in Place (n, %)	No Efforts in Place (n, %)
Trauma-Informed Care	32 (91.4%)	3 (8.6%)
Burnout Efforts	27 (77.1%)	8 (22.7%)
Compassion Fatigue Efforts	26 (74.2%)	9 (25.7%)

Due to low expected cell counts, Fisher's Exact Test was used to assess the association between being trauma-informed and having burnout efforts, as well as

between being trauma-informed and having compassion fatigue efforts. As depicted in Table 8 Fisher's Exact Test indicated a statistically significant association between being trauma-informed and having burnout efforts in place ($p = 0.0086$). This suggests that there are more programs than expected that are either both trauma-informed and have burnout efforts or are neither. Similarly, there is a significant association between being trauma-informed and having compassion fatigue efforts in place ($p = 0.0128$), indicating that programs are more likely than expected to either have both trauma-informed practices and compassion fatigue efforts in place or neither.

Table 8: Association Between Trauma-Informed and Staff Retention Efforts

Support and Care Type	p-value
Burnout Efforts	0.0086**
Compassion Fatigue Efforts	0.0128*
Note: Significance is denoted as follows — $p < 0.05$ (*), $p < 0.01$ (**). Both p-values are from Fisher's Exact Test due to low expected cell counts.	

Summary of Findings

Through examination of reported findings across three grant years, grantees shared what practices and strategies they use to strengthen and empower AI/AN families and what outcomes and impacts they have observed. Overall, grantees described expanding their offerings of support activities while making their programs more traditionally tailored. The number of group sessions increased in GY3, after a steep decline from GY1 and GY2, and the number of group session attendees increased across GY1, GY2, and GY3. Over all the years, grantees incorporated traditional activities into their programs, focusing on crafts, drumming, and storytelling. More grantees offered religious, spiritual, or faith-based services like traditional practices and non-spiritually informed counseling, while fewer grantees offered more Western religious activities like prayer and clergy or chaplain support. In GY3, the number of grantees who formed support groups decreased for all types except for prevention groups and elder advisory councils. In particular, the number of crisis response groups and youth advisory council groups dropped again in GY3, potentially a symptom of a maturing program. However, ongoing youth advisory councils have the potential to help programs reach more youth as traditional norms and communication preferences in that age group shift.

In GY3, more grantees continued to report they believed their programs were trauma-informed in terms of their policies, procedures, rules, and practices. In GY3, an increased number of health care professionals, program staff, and community members were trained in trauma-informed care by the grantees themselves, demonstrating a commitment to this model. In addition, in GY3, the percentage of grantees who reported having efforts in place to combat staff burnout and compassion fatigue, and support services for families continued to grow.

Objective 3: Expand Access to MOUD Services

As part of the grantee's objective to expand access to MOUD services in the communities they serve, this section highlights the achievements in providing medication for SUD treatment (APR Section E). Next is a summary of the quantitative and qualitative key findings highlighting programmatic efforts to achieve this objective.

APR Section E: Medication for Substance Use Disorder Treatment

This objective is focused on mitigating unmet treatment needs and reducing opioid overdose-related deaths by implementing MOUD. This initiative involves the systematic collection of data pertaining to various aspects of MOUD services within the project's scope. The grantee reporting includes information on the total number and types of MOUD services offered, evidence-based treatment options provided, the number and type of MOUD prescribers, availability of telehealth services, frequency and types of behavioral health screenings, overdose incidents in the catchment area, referral data for treatment, and an assessment of policy development and challenges in implementing the MOUD program. The comprehensive collection and analysis of data presents a valuable opportunity to address multiple facets of the opioid crisis. By leveraging this information, ways to improve the effectiveness of MOUD interventions can be identified and gaps in treatment accessibility pinpointed. This approach has the potential to significantly contribute to reducing opioid-related fatalities. Moreover, it allows for the consideration of the broader context of policy development and implementation challenges, providing a more holistic understanding of the issues at hand. Through this data-driven approach, the complex interplay of factors influencing OUDs and their treatment—leading to more informed and effective strategies to combat this public health crisis—can be identified and addressed.

MOUD and TeleMOUD Services

MOUD services refer to the use of Food and Drug Administration (FDA) approved medications, in combination with counseling and behavioral therapies, to treat individuals with OUD. MOUD service is a proven, evidence-based approach that helps reduce opioid use, supports long-term recovery, and significantly decreases the risk of overdose and related deaths, thus lowering the morbidity and mortality associated with SUDs. TeleMOUD services extend the reach of MOUD by providing remote access to these treatments via telehealth platforms. This approach is particularly beneficial for rural communities where there are often significant barriers to accessing health care, including a shortage of clinical providers and long distances to treatment facilities. By leveraging telehealth technology, teleMOUD helps bridge these gaps, enabling patients in underserved areas to receive consistent, high-quality treatment and support. This not only enhances patient engagement and adherence to treatment plans but also ensures that those in areas with limited health care infrastructure can access life-saving services.

Figure 19 displays the percentage of grantees who reported providing MOUD or teleMOUD services or having expanded access to teleMOUD. Overall, the percentage of grantees who provided MOUD services remained the same between GY1 and GY2

(62.9%, n = 22), before decreasing slightly in GY3 (61.8%, n = 21). In GY1, grantees were asked if they had expanded access to teleMOUD; 47.1% of grantees (n = 16) had done so. In contrast, in GY2 and GY3, grantees were asked if they had provided access to teleMOUD at all. In GY3, 48.5% of grantees (n = 16) had provided access to teleMOUD, which was a slight increase from GY2 (47.1%, n = 16).

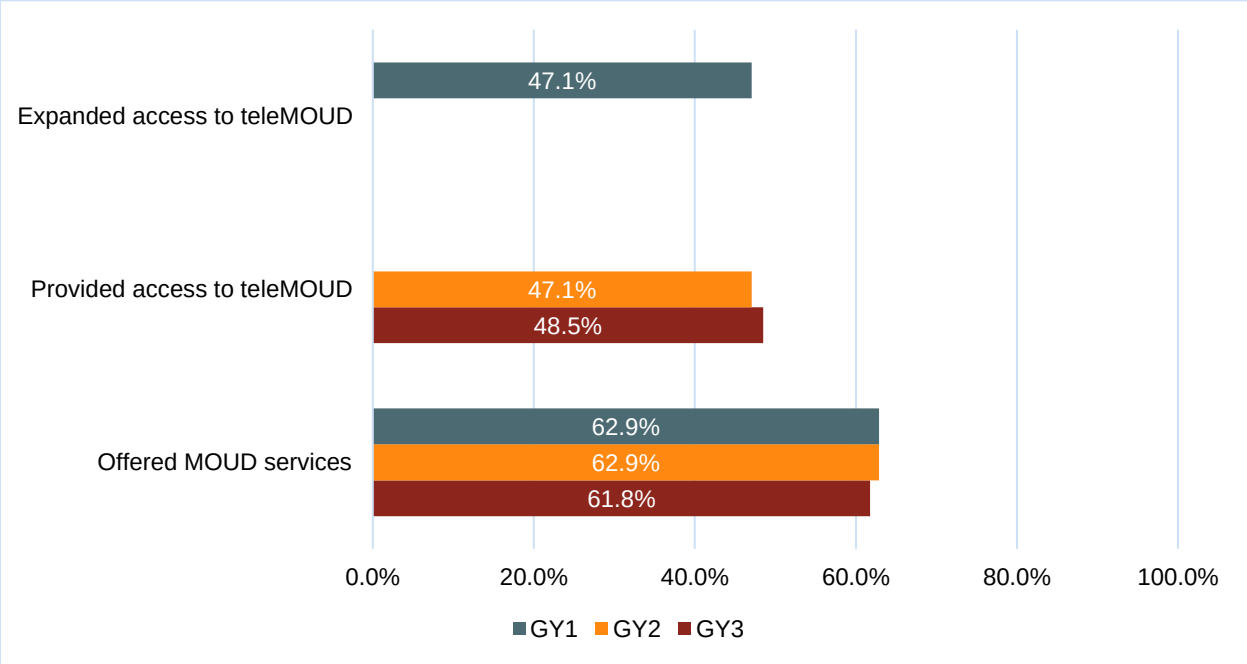

Figure 19: Percentage of Grantees Providing MOUD and TeleMOUD Services (GY1–GY3)

MOUD Prescribers

Figure 20 shows the number of prescribers for GY1 and GY2 and the number of MOUD prescribers for GY3. MOUD prescribers are defined as staff, volunteers and law enforcement who have been trained to and who may have administered naloxone in the community. From GY1 to GY2, the total number of prescribers increased by 224, rising from 181 to 405. In GY3, grantees were asked to report on the number of MOUD prescribers in their catchment area, only. Grantees reported that there were 2,587 MOUD prescribers, although it is possible that this is an overestimate given that one grantee reported 2,000 prescribers in their area alone.

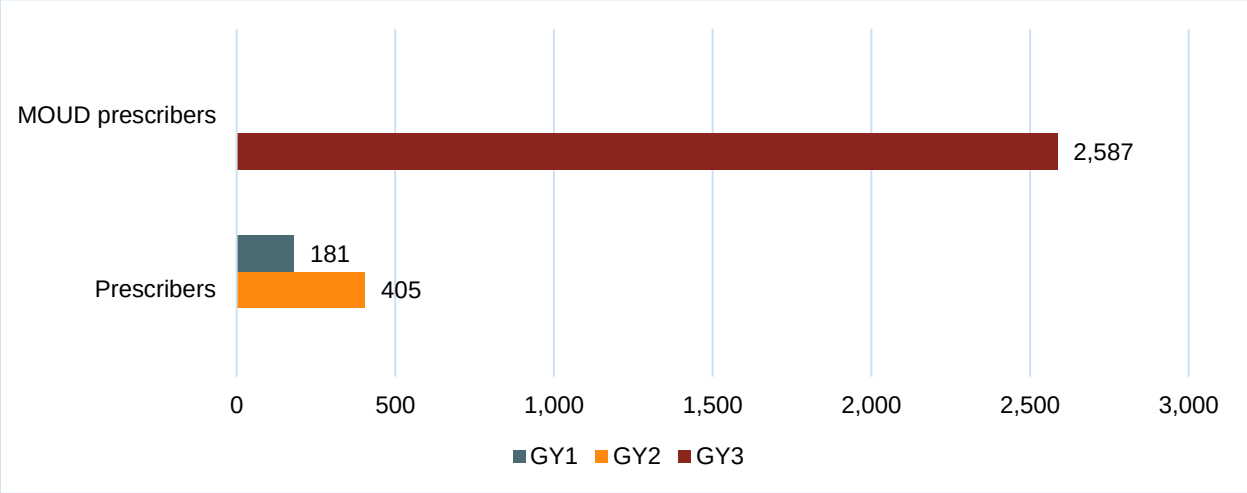

Figure 20: Number of Prescribers Total and MOUD Prescribers (GY1-GY3)

Figure 21 displays the number of non-prescribers who were trained to administer MOUD across all grant years. Overall, more individuals in law enforcement were trained to administer MOUD in GY3 (n = 610) than in GY2 (n = 36) or GY1 (n = 55). Similarly, more volunteers were trained to administer MOUD in GY3 (n = 21) than in GY2 (n = 5). However, the number of program staff trained to administer MOUD decreased over the years from 162 in GY1 to 115 in GY3.

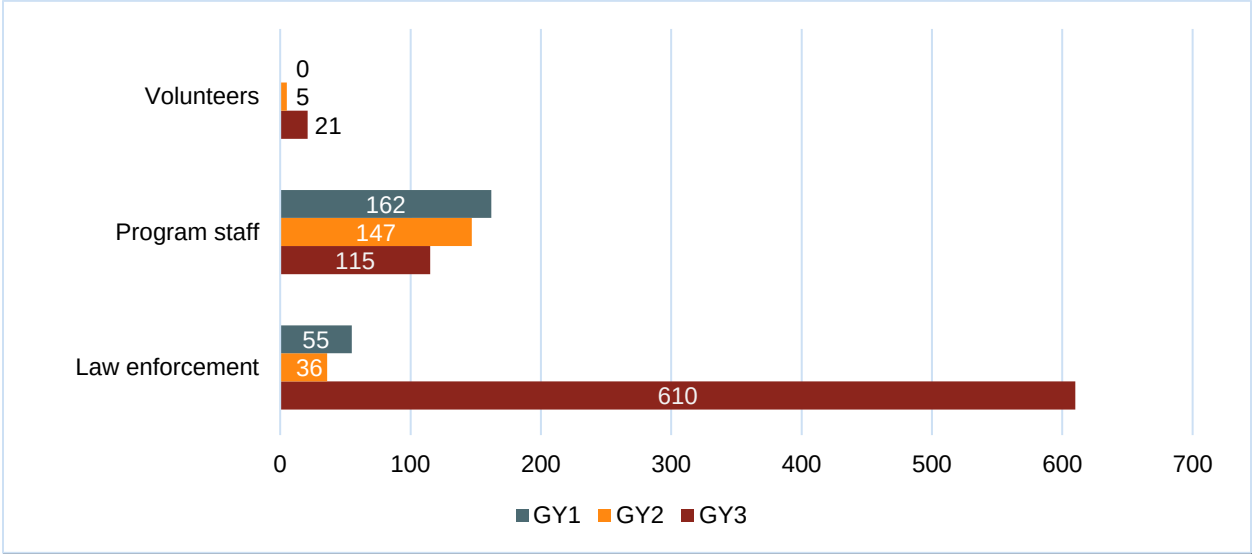

Figure 21: Number of Law Enforcement, Program Staff, and Volunteers Trained to Administer MOUD (GY1–GY3)

Use of EBPs to Reduce Unmet Treatment Needs

Grantees were asked to describe the EBPs that they used to reduce unmet treatment needs. Data reflects how grantees built upon the previous year in innovative ways, approaches, and strategies to reduce opioid-related deaths and reduce unmet needs. During all three grant years grantees used EBPs such as MAT, Cognitive Behavioral Therapy (CBT), and MI, but they were different in how they applied and integrated traditionally based interventions due to changing trends and challenges in the implementation of EBPs in reducing unmet needs and opioid-related deaths. Furthermore, in GY3, video conferencing and a new approach using virtual reality (VR) as a supportive treatment tool increased.

In GY3, the findings highlight the continued use of EBPs such as medication management that include MAT, MOUD, Intensive Outpatient Program (IOP), CBT, and MI as priority interventions. Such practices continue to be central to managing OUD, with an emphasis on combining medication management with psychotherapy to provide comprehensive support for individuals with OUD. As illustrated by one grantee,

> *“Our provider provides medication-assisted treatment, psychiatry, and therapy that is informed by evidence-based approaches, especially for our patients who have complex needs. We draw from MI, CBT, Eye Movement and Desensitization and Reprocessing, and Contingency Management as modalities to support change and seeking treatment." (GY3)*

Integrating EBPs with harm-reduction strategies, including naloxone education and distribution, was also prominent. For example, public and community awareness campaigns used harm-reduction strategies and stigma-reduction efforts to reach individuals who may not seek formal treatment. Additionally, many grantees demonstrated the integrated use of traditional-based approaches such as the medicine wheel, traditional arts, and storytelling. As described by another grantee,

> *“Our program continues to use a model that incorporates evidence-based therapy approaches with traditional approaches. We call it the Circle of Care, based on the medicine wheel, and the evidence-based materials fit in specific quadrants.” (GY3)*

The holistic approach is grounded in Indigenous values, traditional identity, family, community, and connections, and Indigenous Knowledge, with EBPs to address medical and traditional recovery needs. Grantees also used the White Bison 12-Step Wellbriety program that integrated traditional Indigenous Knowledge teachings with the core principles of Alcoholics Anonymous's 12-Step framework.

The application of EBPs varied across different settings, with outpatient residential and inpatient treatment programs offering higher levels of support. The integrated care model combines behavioral health services and primary care services to address both substance use and mental health disorders in a single care setting. Behavioral and mental health therapies such as Dialectical Behavioral Therapy (DBT) and Eye

Movement Desensitization and Reprocessing (EMDR) were also applied to support recovery. Some grantees also shared the use of screening and assessment tools for SUD, illustrating the important need for comprehensive client evaluation methods.

Peer recovery support services also play an important role. Including peer support specialists who provide ongoing support and motivation for individuals in recovery, help maintain their sobriety and assist with navigating treatment pathways. To illustrate this, a grantee shared that their "Tribe has a MAT program incorporating individual counseling, group counseling, and medication management. There are also recovery coaches who work with clients from the beginning and guide them through the various options available to them." (GY2)

Lastly, grantees discussed their use of virtual treatment methods, particularly for MI and CBT, which is a continuing trend in rural and remote areas with video conferencing. However, some programs mentioned using VR tools as part of their treatment approaches. VR is being explored to provide immersive experience for individuals with OUD and SUD. Some grantees use VR tools to support therapeutic intervention, offering a controlled immersive environment where individuals can practice coping skills, undergo exposure therapy, or participate in relaxation and meditative exercises. VR provides a client with privacy and a controlled environment to confront triggers or practice stress management without real-world risks.

In GY1, 28 grantees described their use of EBPs to reduce unmet needs and opioid overdose-related deaths across five areas. The emerging themes include MAT, screening and assessment tools, program models/services, behavioral and mental health therapies, and trained and certified staff.

In GY2, 34 grantees reported applying EBPs to reduce unmet treatment needs and reduce opioid-related deaths. Grantees integrated MOUD with EBPs such as CBT, EMDR, family therapy and moral recognition therapy. They also used heritage and community-focused approaches by incorporating traditional beliefs, traditional healing, and Indigenous place-based knowledge to deliver holistic care.

By GY3, 34 grantees reported using EBPs to reduce unmet treatment needs and reduce opioid-related deaths. They described using traditionally relevant approaches such as Wellbriety and White Bison, traditional practices such as sweat lodges, and holistic alternative therapies like equine therapy and horticulture therapy. They also described using family and community-based approaches like community reinforcement and family training therapy. These EBPs all integrate Indigenous values and practices into OUD treatment, delivering traditionally relevant and meaningful treatment to patients and families.

Figure 22 presents the EBPs used by grantees across all three program years. A consistently increasing trend was observed among the use of CBT, which was the most frequently offered EBP increasing from 78.8% (n = 26) of grantees in GY1 to 88.6% (n =

31) of grantees by GY3. Similarly, the use of MI was also increasingly reported by grantees, from 78.8% (n = 26) in GY1 to 88.2% (n = 29) in GY3.

All other types of EBPs were much less frequently offered than CBT and MI, with increasing trends only observed for DBT, CM, and Community Reinforcement Approach Therapy (CRA). The number of grantees offering DBT remained steady between GY1 (51.5%, n = 17) and GY2 (51.4%, n = 18), but increased to 57.6% (n = 19) in GY3. The use of CM decreased between GY1 (53.1%, n = 17) and GY2 (47.1%, n = 16), but increased to 51.4% (n = 18) in GY3. For CRA, more grantees offered this therapy in GY3 (36.4%, n = 12) than in GY2 (33.3%, n = 11) or GY1 (28.1%, n = 9).

The use of EMDR therapy was first measured in GY3. For GY3, 39.4% of grantees (n = 13) reported that they offered EMDR. 34.3% of grantees (n = 12) also reported that they used the Matrix Model (MM) approach, a slight decrease from the 37.5% (n = 12) who offered it in GY2 but an increase from the 28.1% (n = 9) who offered it in GY1.

The use of Motivational Enhancement Therapy (MET) also increased over the years from 24.2% in GY1 (n = 8) to 28.6% (n = 10) in GY3. However, this is a slight decrease from GY2 where 32.4% of grantees (n = 11) offered MET. The only EBP decreasingly used over the years was Attachment-based Family Therapy (ABFT), which decreased from 21.2% in GY1 (n = 7) to 11.4% (n = 4) in GY3.

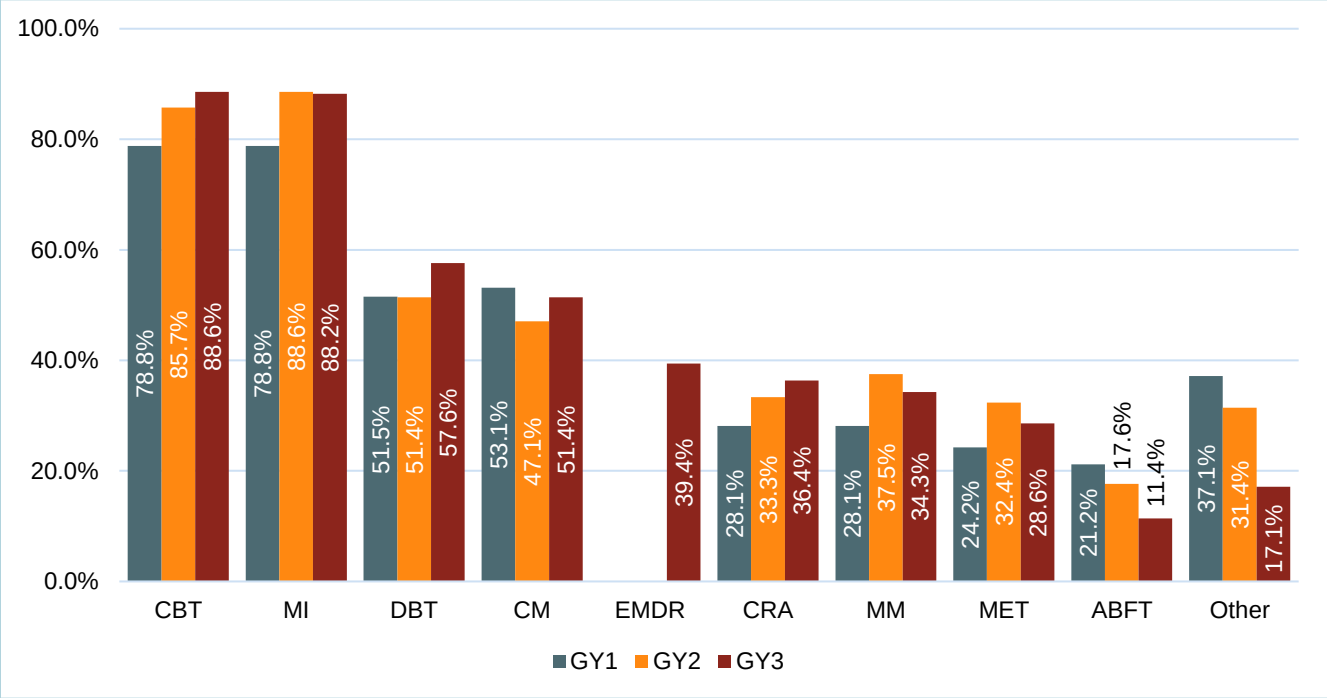

Figure 22: Percentage of Grantees Offering EBPs by Type (GY1-GY3)

Finally, the percentage of grantees who reported using another EBP not specified decreased from 37.1% (n = 13) in GY1 to 31.4% (n = 11) in GY2 and to 17.1% of grantees (n = 6) in GY3. Examples of other EBPs grantees offered in GY3 specifically included:

- Traditionally relevant approaches such as Wellbriety, White Bison, and a list of Oregon's tribes' best practices,
- Traditional practices such as sweat lodges,
- Holistic alternative therapies, including equine therapy, horticulture therapy, mind-body-medicine techniques, experiential therapy, yoga, and art therapy,
- Other therapeutic modalities, including CRAFT,
- 12-step programs for both men and women,
- Recovery coaching, and
- Harm-reduction strategies, including naloxone distribution.

Innovative Approaches to Expand Access to TeleMOUD

Across each program year, grantees shared their innovative approaches to expanding access to teleMAT (GY1 and GY2), and teleMOUD. In GY1, 28 grantees provided information on applying evidence-based approaches to meet unmet needs and halt overdose deaths in five areas. These approaches to new services were applied to MAT, screening and evaluation resources and services, behavioral and mental health

treatments, and trained certified practitioners. Screening methods included interviews, patient needs assessments, and specialized tests like the Adverse Childhood Experiences assessment. Interventions used systematic models such as the Opioid Health Home, and Canoe programs. The treatment ranged widely: DBT, CBT, family therapy, trauma-focused therapy, EMDR, and recovery support groups. These were offered by certified and vetted providers (social workers, SUD counselors, opioid health educators, and peer recovery support specialists) who provided clients with the full spectrum of evidence-based care.

In GY2, grantees demonstrated innovative approaches to improve accessibility and efficiency. They focused on transportation solutions, telehealth/telemedicine/ teleMOUD, and coordinated drug screenings. Approximately 70% of the grantees implemented various transportation options, including bus and train passes, ride-share programs for medical transport, and van shuttle services. They partnered strategically with transportation companies and other organizations to optimize resources. In addition to transportation solutions, there was a significant emphasis on telehealth and telemedicine for remote health care delivery. This shift offers convenience and ensures ongoing access to health care. Initiatives in this area included teleMOUD services, virtual peer support groups, and secure platforms for patient communication. Several grantees integrated behavioral health care with MOUD providers to offer in-person and telehealth services. Some grantees provided teleMOUD for specific situations, such as when patients could not participate in person. Another grantee offered on-site pharmacists to dispense medications and provide teleMOUD for clients who are traveling, facing emergencies, or need convenient pharmacy access.

One grantee in GY2 incentivized clients to adhere to the teleMOUD option by rewarding them, but only if they were in good standing with the treatment program. This approach aimed to address medication supply disruptions caused by transportation issues. The grantees also emphasized the importance of both in-person and virtual peer support. However, expanding access to teleMOUD presented challenges, including program applicability and resistance from MOUD providers. Moreover, the implementation of teleMOUD also faced obstacles, such as billing restrictions in certain regions.

In GY3, there was a shift in the focus toward teleMOUD compared to GY1 and GY2 that focused on the use of teleMAT. In GY3, 19 out of 35 grantees highlighted their use of telehealth platforms to provide MOUD services, particularly with clients/relatives who live in rural and remote areas—some grantees invested in infrastructure, including telehealth facilities with sound systems, tablets, and internet hotspots. As demonstrated by one grantee,

> *“Telehealth services are offered in order to increase accessibility, as are tablets and internet hotspots. In addition, Southern Indian Health Council offers ROAM, (Roaming Outpatient Access Mobile), providing outpatient medical and behavioral health services to the seven Consortium Tribal Reservations. Services are available by walk-in or by appointment.” (GY3)*

Also, teleMOUD was offered as an incentive for clients in good standing and to reduce the travel burden for clients continuing with care. For community engagement, one grantee also raised awareness about teleMAT at powwows, and community education gatherings. In contrast, another grantee used a social media platform accompanied by virtual events to increase awareness.

Like GY2, approximately 72% of grantees reported they provide transportation (direct shuttle, bus passes/vouchers, rideshare). A third of the grantees have a direct shuttle service. Some grantees were given additional funding to further their transport options. For example, one grantee provides transportation vouchers and may also cover treatment costs, depending on whether the client meets the grantee's financial eligibility requirements. This support helps patients not worry about financial burdens when seeking MAT services. Another grantee said that they transported anyone who needed it to the clinic, and another scaled up to dedicate vehicles or shuttles so that patients were consistently transported to and from clinics for life-saving treatment. Most grantees are individual client service-oriented, but one grantee can support family members. Importantly, grantees aimed to provide transportation support to those in need.

> *"Transportation is provided to those who may need it to make necessary appointments through our own clinic and outside resources. Warm handoffs to support services are also a priority whether it be therapy, counseling, or groups." (GY3)*

In addition to transportation, grantees assist in increasing access to MAT services, including care coordination and counseling services in MAT programs, which can streamline patient care, coordinate schedules, and allow for regular provider communication across providers across settings. Moreover, peer recovery help and community resources create recovery social support groups. For instance, some programs include peer support groups or put clients in touch with community mentors who have been down the same road to recovery and can offer relevant support and guidance.

This approach, together with external partners, adds to MAT access. Most organizations collaborate with doctors and transit agencies to pool resources and coordinate medical, mental health, and social services. For instance, one grantee connected with a local hospital to provide specialized MAT services that offered the patients complete support. Also, there are agreements with transit agencies and some companies for low fares or discounted bus passes. The education of health care professionals about MAT protocols is still necessary.

Furthermore, two grantees focused on collaborating with MAT providers through meetings and site visits to explore opportunities for expanding services. One grantee reported using Tribal Opioid Response Program funding to support expanding teleMOUD services. However, some challenges were noted, with two grantees reporting no new strategies for expanding MOUD and indicating that their providers were not

currently using teleMAT services. The findings reflect a strong reliance on telehealth and infrastructure improvements to increase access to MOUD, though some limitations remain in expanding teleMAT services.

Organizational Policies

Programs developed policies, procedures, and protocols to ensure quality care was provided in screening practices, MOUD services, and harm-reduction efforts. Grantees reported on their policies and procedures in specific focus areas.

Current Policies, Procedures and Protocols

Figure 23 displays the percentage of grantees who reported they or a partner organization had a policy, procedure, or protocol in place for each of the listed focus areas. Overall, the percentage of grantees who had a policy, procedure, or protocol in place increased over time or remained the same across all categories except OUD screening and syringe service programs (SSPs).

Most grantees (97.1%, n = 33) reported they had a policy, procedure, or protocol in place for the OUD referral process in GY3, a rate that remained the same as GY2, and increased since GY1 (88.6%, n = 31). Similarly, the percentage of grantees with a policy, procedure, or protocol in place for OUD screening was similar in GY2 (97.1%, n = 33) and GY3 (91.4%, n = 32), both an increase since GY1 (74.3%, n = 26). A slight increase in the number of grantees who reported they had a policy, procedure, or protocol in place for naloxone distribution was observed from GY1 (82.9%, n = 29) to GY2 and GY3 (91.2, n = 31; same for both years).

The percentage of grantees with a policy, procedure, or protocol in place for MOUD increased slightly from GY1 (85.7%, n = 30), GY2 (87.9%, n = 29), and GY3 (88.2%, n = 30). Similarly, a greater percentage of grantees had one in place for OUD wraparound services in GY3 (73.5%, n = 25) than in GY2 (70.6%, n = 24) or GY1 (71.4%, n = 25). In addition, the percentage of grantees with a policy, procedure, or protocol in place for fentanyl test strips increased from GY1 (31.4%, n = 11) to GY3 (67.6%, n = 23).

Grantees with policies, procedures, or protocols for “Other” areas decreased from 47.1% (n = 16) in GY1 to 27.3% (n = 9) in GY2, before increasing to 60.6% (n = 20) in GY3. In contrast, there was a decrease observed in the percentage of grantees with one in place for SSPs. There was an increase between GY1 (25.7%, n = 9) and GY2 (32.4%, n = 11), before it decreased to 29.4% (n = 10) in GY3.

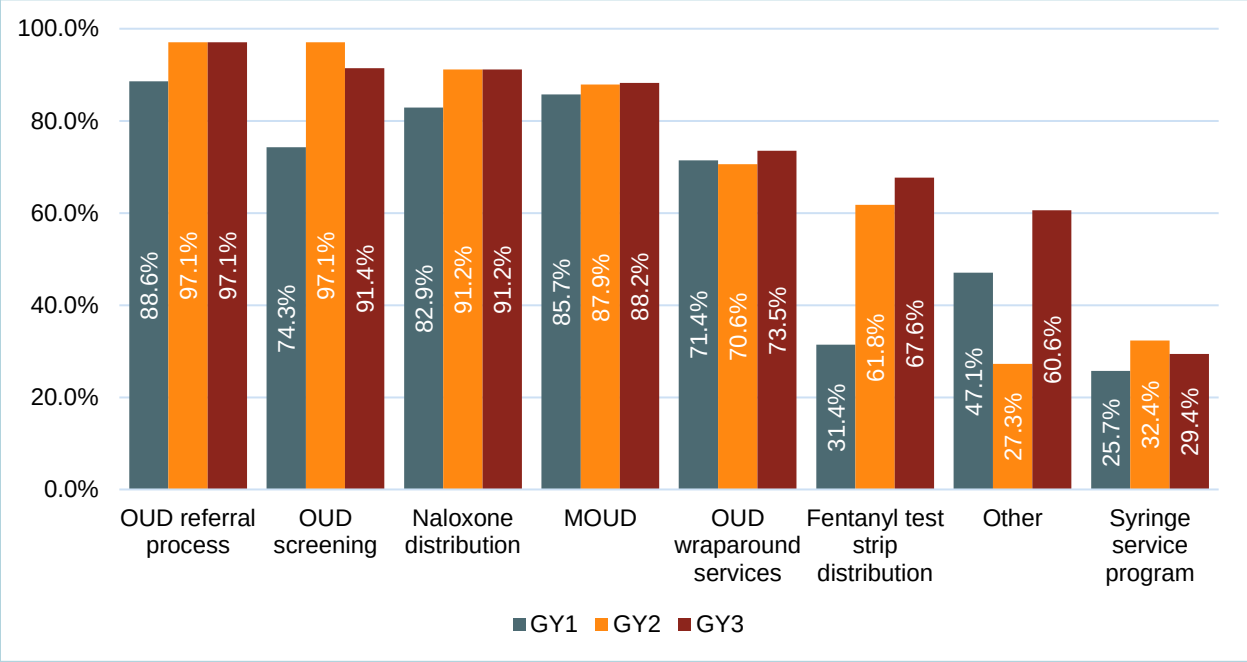

Figure 23: Percentage of Grantees who Reported Policies, Procedures, and Protocols by Type (GY1–GY3)

Grantees also reported on whether their organization or a local partner health care facility has written policy and procedures for opiate prescribing, such as surveillance and monitoring or chronic non-cancer pain management, as described in Figure 24. In GY3, (77.1%, n = 27) grantees reported that they had; a slight decrease from GY2 (80.0%, n = 28) and GY1 (79.4%, n = 27).

In addition, grantees reported on whether their organization or their local partner health care facility had access to clinical tools/resources to support provider self-monitoring of opioid prescriptions including chronic non-cancer pain management. The percentage of grantees who reported access remained stable across grant years at (70.6%, n = 24).

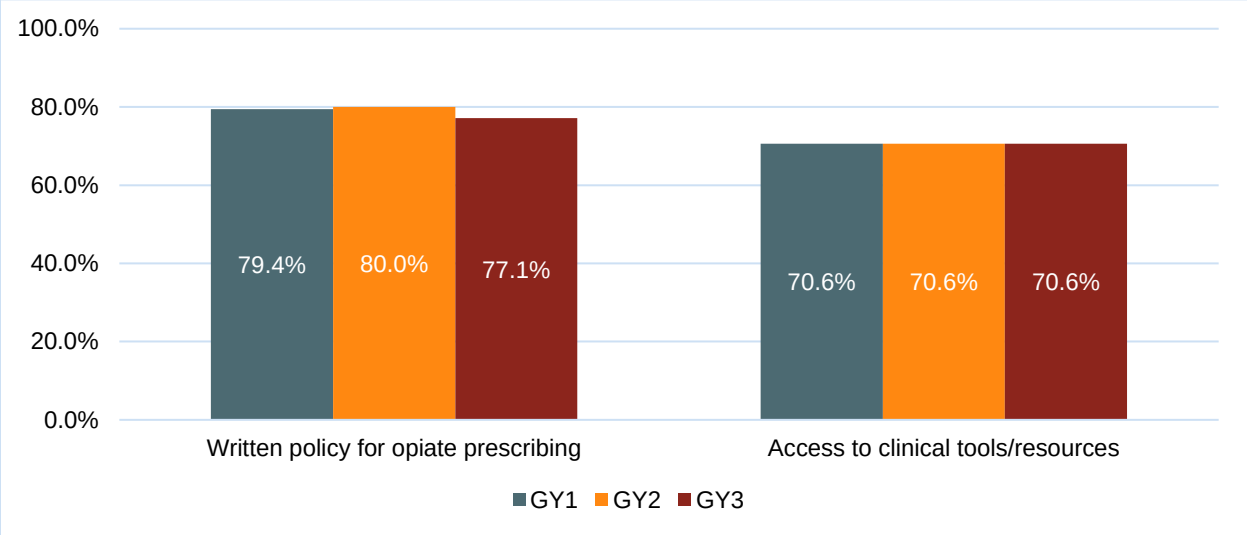

Figure 24: Percentage of Grantees with Written Policies for Opiate Prescribing and Access to Clinical Resources (GY1–GY3)

Program Efforts

Programs offered many different efforts to reduce unmet treatment needs and overdose-related deaths in their service population. These included screening for different SUDs, referrals for treatment, and the implementation of harm-reduction efforts.

Screenings

Overall, screenings increased across all years in all screening categories, as shown in Figure 25. For Universal Alcohol screenings, grantees reported completing 20,645 screenings in GY1, increasing to 47,644 screenings in GY3. For suicide screenings, there were 8,180 screenings completed in GY1, which almost doubled to 14,744 screenings completed in GY2 before increasing further still to 33,849 in GY3. Finally, 11,463 Screening, Brief Intervention, and Referral to Treatment (SBIRT) screenings were reported in GY1, which increased to 16,501 SBIRT screenings by GY3.

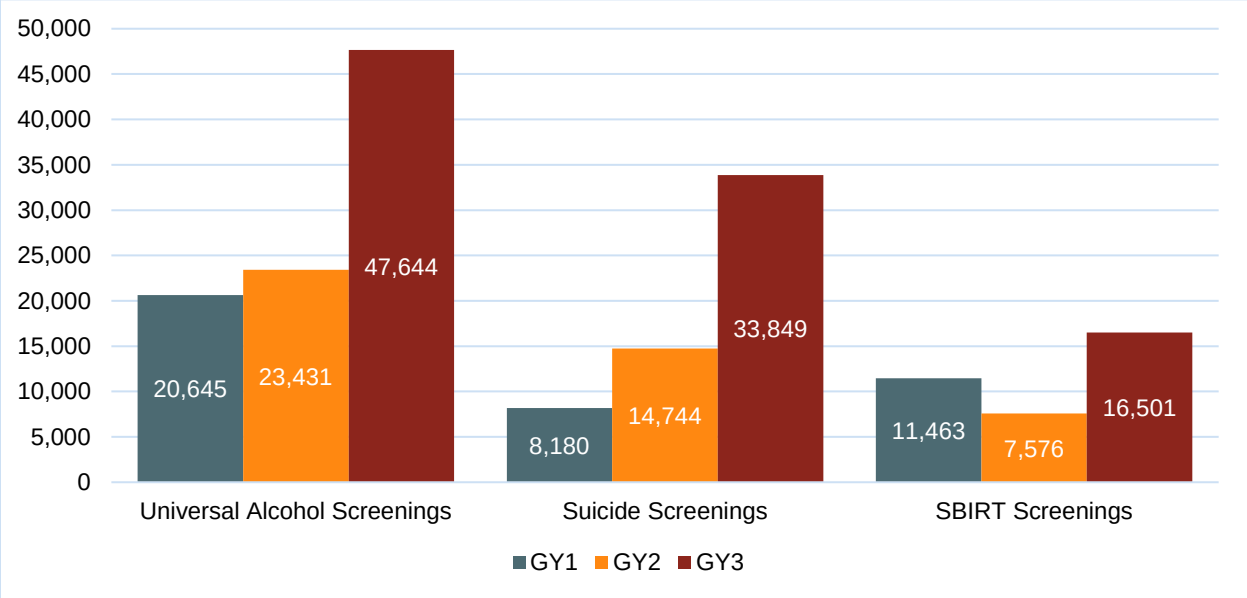

Figure 25: Number of Universal Alcohol, Suicide, and SBIRT Screenings Completed (GY1-GY3)

Figure 26 displays the number of screenings for Alcohol Use Disorder (AUD), SUD, and OUD that grantees completed. Note that the estimates for GY1 are considered unreliable and thus are not included in the graph.[2] All screenings performed increased from GY2 to GY3. In GY2, there were 1,175 reported AUD screenings performed, which increased to 1,599 in GY3. For SUD screenings, 1,214 were performed in GY2, which increased to 1,615 in GY3. There were 5,464 OUD screenings performed in GY3, which was a decrease from 8,012 performed in GY2.

[2] One grantee alone reported performing 90% of all AUD screenings (n=153,902) in GY1 but performed no screenings for AUD in GY2.

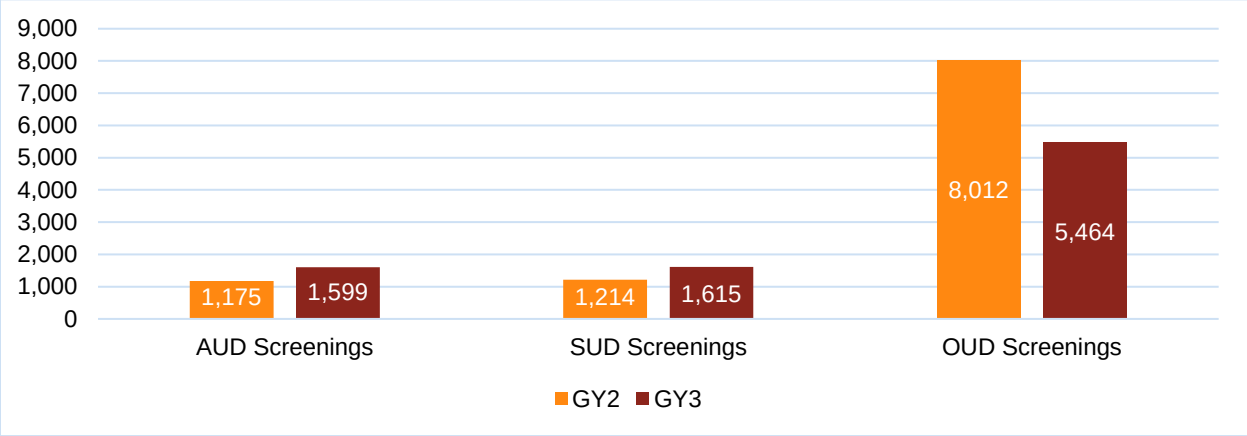

Figure 26: Number of AUD, SUD, and OUD Screenings (GY2–GY3)

OUD Treatment and Referrals

Capturing data on OUD treatment and referrals over the course of three years is crucial for assessing the effectiveness of existing treatment programs and identifying areas that require improvement. This longitudinal data provides valuable insights into patterns of opioid use, treatment adherence, relapse rates, and the effectiveness of various interventions. By tracking these metrics, programs can better understand which treatment methods yield the best outcomes and refine their approaches accordingly.

Figure 27 displays the number of patients who were referred to treatment for OUD after a screening, entered treatment after a referral, and accessed other services after completing treatment.

A substantial increase in patients referred to treatment for OUD was observed from GY1 (n = 1,368) to GY3 (n = 2,848). Similarly, the number of patients who entered treatment after a referral also increased between GY1 (n = 870) and GY2 (n = 833) to 979 in GY3. In addition, the number of patients who accessed other services after completing treatment remained stable between GY1 (n = 721) and GY2 (n = 722) but increased to 1,131 in GY3.

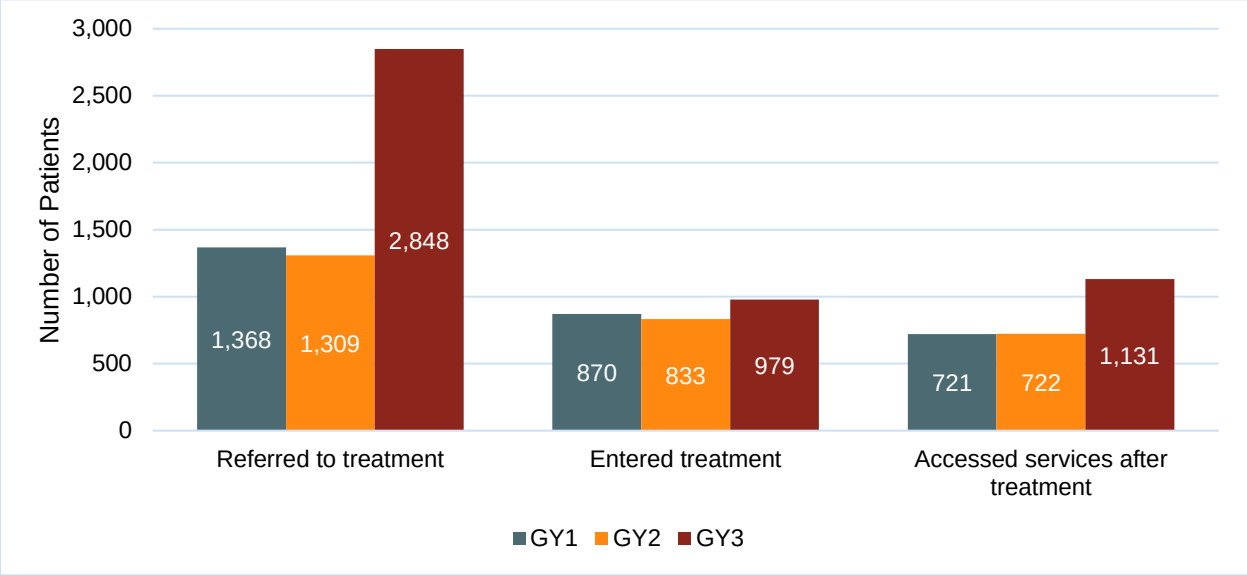

Figure 27: Number of OUD Treatment Referrals, Treatment Encounters, and Service Encounters (GY1–GY3)

Support Services

Grantees were asked to report on the number of patients referred to support services after screening for SUD or OUD to monitor and improve the continuum of care for affected individuals. This metric is crucial as it helps assess the effectiveness of screening processes and the ability of programs to connect individuals to essential treatment and recovery resources. Reporting these numbers ensures accountability, highlights gaps in service delivery, and informs future strategies to enhance the quality of care. Tracking referrals also promotes a proactive approach in addressing SUD and OUD, supporting better health outcomes and fostering a holistic, community-based response to substance use challenges within Tribal populations.

As shown in Figure 28, Overall, more patients were referred to support services after SUD screening in GY1 (n = 6,111) than in GY2 (n = 1,452) or GY3 (n = 3,531). Similarly, more patients were referred to support services after OUD screening in GY1 (n = 3,994) than in GY2 (n = 977) or GY3 (n = 2,740).

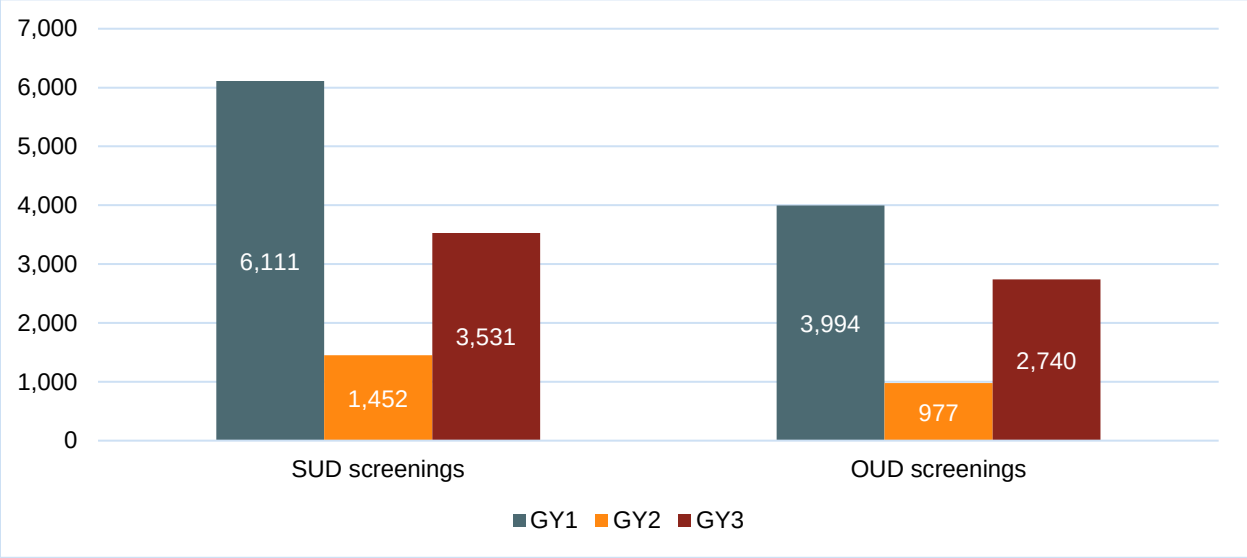

Figure 28: Number of Patients Referred to Support Services after Screenings (GY1–GY3)

Harm-reduction Efforts

Figure 29 displays the percentage of grantees who reported they had certain substance use harm-reduction efforts in place, including naloxone distribution and fentanyl test strip distribution. The metric detailing the presence of substance use harm- reduction efforts, such as naloxone distribution, fentanyl test strip distribution, and SSPs, within Tribal programs is crucial for several reasons. These initiatives are essential tools in addressing the ongoing substance abuse crisis, particularly within communities disproportionately affected by it. Naloxone distribution helps prevent fatal overdoses by reversing the effects of opioid toxicity, thus saving lives, and providing opportunities for individuals to seek further treatment and support. Fentanyl test strip distribution is vital as it empowers individuals to detect the presence of fentanyl in substances, thereby reducing the risk of accidental overdoses from this potent synthetic opioid. SSPs play a significant role in minimizing the spread of infectious diseases, such as HIV and hepatitis C, by providing clean needles and other resources, fostering safer practices among individuals who inject drugs. Collectively, these harm-reduction strategies reflect a proactive approach to substance use management, promoting health and safety, reducing the burden on health care systems, and enhancing the potential for community recovery and resilience.

Most grantees (91.4%, n = 32) implemented naloxone distribution efforts, with the percentage of grantees performing this effort remaining stable across all grant years, demonstrating its consistent and widespread use. There was a consistent increase in the percentage of grantees offering fentanyl test strips across GY1 (40.0%, n = 14), GY2 (70.6%, n = 24), and GY3 (74.3%, n = 26). Between GY2 and GY3, the percentage of grantees offering SSPs experienced a notable decline, dropping from (45.7%, n = 16) to (28.6%, n = 10).

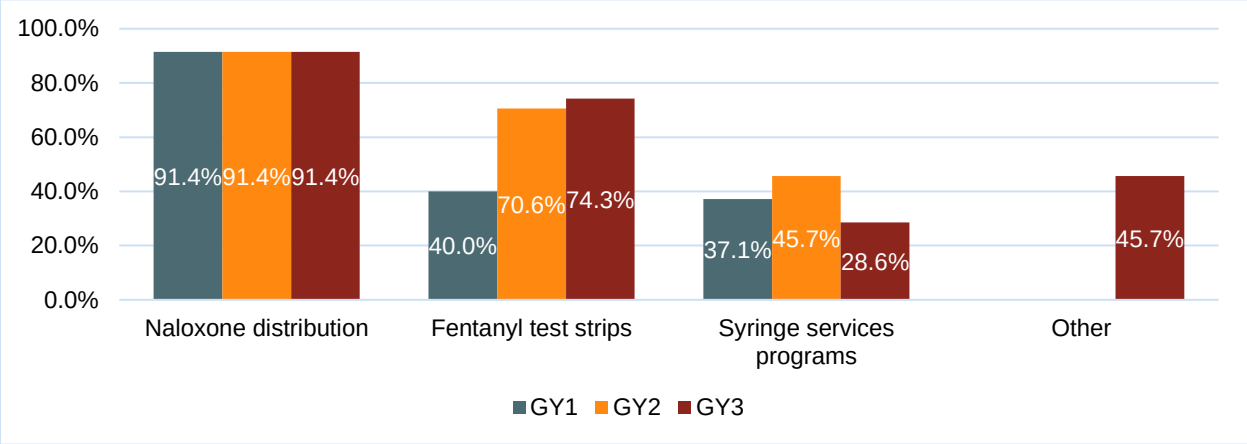

Figure 29: Percentage of Grantees with Harm-reduction Efforts by Type (GY1–GY3)

Other Risk Mitigation Strategies

In GY3, 45.7% of grantees (n = 16) also reported they had other harm-reduction efforts in place, a steep change from GY1 and GY2, when no grantees reported having such efforts. The other harm-reduction efforts offered in GY3 were primarily focused on the secondary or tertiary levels of opioid misuse prevention. For secondary prevention, these efforts included offering overdose prevention activities, including Narcan education, training, and distribution to prevent fatal overdoses. One grantee also reported offering Kloxxado distribution—an opioid antagonist that contains twice the dose (8mg) of naloxone than Narcan (4 mg; requiring two doses to reverse an overdose). Grantees also reported offering medication harm-reduction services, including medication lockboxes and the Dispose RX and Deterra medication disposal systems. Grantees also distributed test strips to test for xylazine.

Tertiary prevention consisted of providing testing for Human Immunodeficiency Virus and hepatitis C; both viruses are commonly associated with drug injections, particularly when using unsterile or shared needles. Relatedly, grantees also reported distributing condoms to reduce the possible spread of HIV and other sexually transmitted infections. Grantees also offered sharps containers for the safe disposal of used needles and basic care kits, including first aid and wound care.

Finally, grantees shared that they offered many additional support services in the community, including traditional healing and spiritual services to local incarcerated individuals, peer support specialists, and harm-reduction teams.

Program Outcomes

The COIPP project has made strides in addressing the opioid crisis, though challenges remain with obtaining accurate data on overdoses. While there has been an overall increase in reported overdoses (which are described next), it is important to note that these numbers may not fully reflect the situation due to inconsistencies in data collection and reporting. Despite the rise in overdose cases, the grantees continue to

focus on providing important services and interventions aimed at reducing opioid misuse and supporting affected individuals. Improved data collection methods are essential for accurately assessing the program's long-term impact and refining future strategies.

Incidents of Overdose

Figure 30 presents the reported number of fatal and nonfatal overdose incidents within grantees' catchment areas across all grant years. Overall, the number of reported nonfatal overdose incidents increased by 165%, while the number of fatal overdose incidents increased by 240% during the same period.

It is important to note that the data presented has limitations due to differences in how each site defines its catchment areas and collects overdose data. Participants used a variety of data sources to count overdose incidents. For instance, one grantee reported a catchment area of fewer than 20,000 people but also reported a non-fatal overdose count of 9,530 (GY1). This example depicts the presence of an outlier that accounted for 77.3% of all nonfatal overdose incidents reported in that year. On the other hand, grantees with larger catchment areas (>20,000 persons) reported very low (<20) overdose counts, which could suggest underreporting or differences in data collection methodologies.

These discrepancies highlight the need for cautious interpretation of the data, as varying sources and definitions may impact the accuracy and comparability of the reported incident numbers.

Overall, the number of nonfatal overdoses reported for GY1 (n = 12,325) decreased slightly in GY2 to 10,541 but increased in GY3 to 32,730. The number of fatal overdoses reported by grantees for their catchment areas increased across the years, from 1,567 in GY1 to 5,341 in GY3.

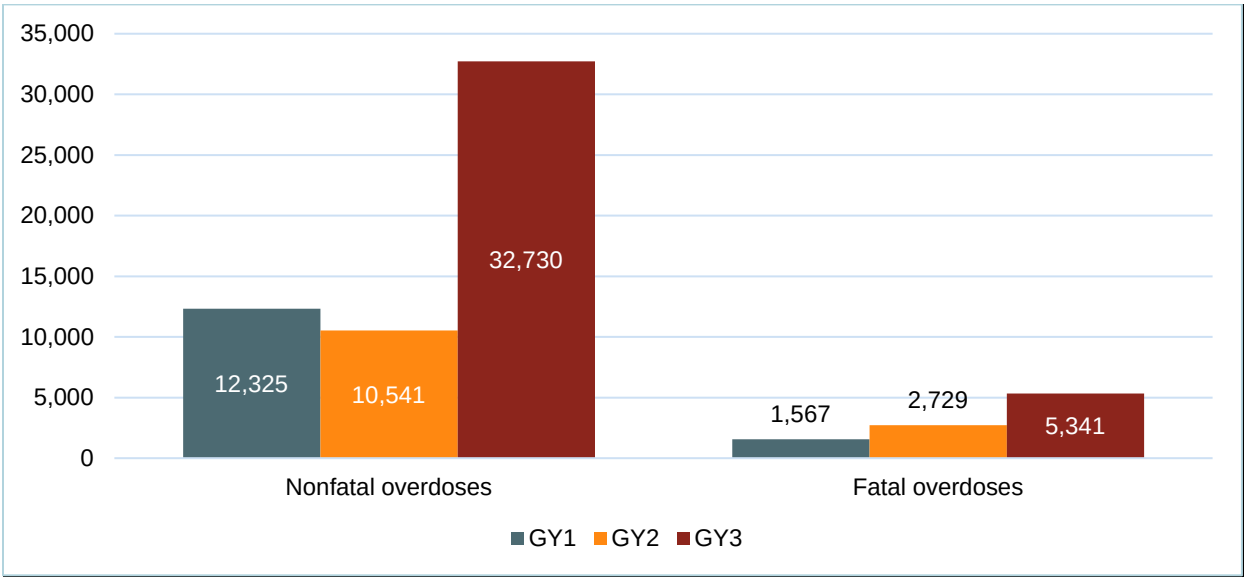

Figure 30: Number of Fatal and Nonfatal Overdose Incidents (GY1–GY3)

Grantees tasked with reporting overdose counts drew from a broad spectrum of data sources pertaining to OUD and SUD. A grantee included the Main Drug Hub, the Minnesota Drug Overdose dashboard, and the Wisconsin Department of Health, which offer data about specific counts and can provide state-level data aggregations. Moreover, the California Opioid Overdose dashboard provides insight at a state level. Other data sources are health records and medical data, including patient reports and grantees using an Electronic Health Record (EHR) as an important data source. However, for one grantee, retrieving patient data from EHRs was limited.

Program Accomplishments: Raising Awareness about OUD

Grantees were asked to list and describe their program accomplishments during the previous reporting period. Across GY1 through GY3, grantees developed their infrastructure, enhanced risk mitigating initiatives, engaged community members and integrated traditional models and practices, expanded their training and networks, and began to establish Continency Models (CM). The grantee's overall program accomplishments are described in each of the next sections.

Facility Development and Infrastructure Expansion

Facility development and infrastructure improvement were vital to expanding access to treatment services, especially in remote and underserved areas. For GY1, there were no findings regarding facility development or infrastructure expansion. By GY2, grantees began expanding treatment facilities to meet the growing needs of their communities. A couple of grantees created or expanded treatment centers—one opened a traditionally based 10-bed detox center, while another deployed a mobile medical unit to reach remote communities. Some grantees developed traditional health care protocols and toxicology labs, improving access to life-saving drugs and tests. In GY3, facility

development continued with further dedication of available resources for telehealth services and mobile units. Telehealth infrastructure was also improved with investments in sound systems, tablets, and internet connections, enabling clients in rural or distant areas to access care remotely. Telehealth advancements allowed more clients, including those living abroad or in rural areas, to access care remotely.

Risk Mitigation Initiatives

Risk mitigation efforts also became a central focus in GY2 and expanded further in GY3. Grantees distributed thousands of doses of naloxone (Narcan), with some reporting zero overdose cases due to its availability. Training on overdose prevention was provided widely to staff, residents, and community members, with a special focus on Native youth from middle school age and up in GY3. Community engagement evolved over the grant years as well. In GY1, partnerships with Tribal organizations led to traditionally grounded programs like the Healing of the Canoe Project and Youth Gathering of Native Americans (GONA) training.

> *"We have also seen a rise in demand for Narcan training and products from community Tribal members, with an emphasis on trainings provided to the Native youth middle school age and up." (GY3)*

Community Engagement and Traditional Integration

Community engagement evolved significantly over the three years. In GY1, grantees focused on building partnerships with Tribal organizations and public health departments to launch traditionally grounded programs. These initiatives fostered community support networks while addressing specific heritage needs through traditional practices. By GY3, community engagement deepened through traditionally resonant events such as powwows, the Recovery Arts series, and Skate Jam. These events raised awareness about OUD/SUD while providing healing spaces for individuals affected by SUDs. Grantees also used innovative outreach methods like social media platforms and hosted events like Skate Jam, specifically targeting middle and high school students.

> *"Using innovative ways to connect to the community through social media platforms and community awareness and outreach events, such as our first Skate Jam and middle/high school awareness event." (GY3)*

Educational and Training Programs

Educational initiatives grew more robust each year. In GY1, efforts focused on youth-centered activities such as safety camps and educational booths at school events to raise awareness about substance use among young people. Through GY2, educational efforts expanded significantly, with harm-reduction training for staff members and community groups. Narcan training became a core component of these efforts as grantees worked diligently to equip their communities with overdose prevention tools. In GY3, trauma-informed care training for staff became a priority, along with peer recovery coach training programs that provided vital support for individuals navigating recovery journeys. Additionally, heritage-specific programs such as the White Bison Medicine

Wheel were introduced, fostering a deeper understanding of traditions while promoting holistic healing practices.

> *"We continue to provide education and training to staff on trauma -informed care and recovery support services for OUD/SUD." (GY3)*

> *"We have been able to have our monthly Heritage Day, which consists of a Native Speaker in recovery, Lunch, and graduation. We have the drum out again. All Staff completed a 3-day White Bison Medicine Wheel and the 12-step training. This was a time of all staff coming together, bonding, learning, smudging, and having a talking circle." (GY3)*

Collaboration and Networking

Collaboration remained a key driver of success throughout all three years. In GY1, grantees established foundational partnerships with Tribes, schools, public health departments, and health care providers. These collaborations helped expand outreach efforts while developing traditionally grounded programs tailored to each community's needs. By GY2, collaboration grew stronger as grantees partnered with external organizations such as MAT providers to enhance service delivery options for individuals struggling with OUD/SUD. In GY3, partnerships broadened even further to include municipal courts and companies such as FACE IT TOGETHER and Call to Freedom. These collaborations extended the reach of recovery services while ensuring they remained traditionally responsive and accessible.

CM Models

In GY3, some grantees introduced CM models as part of their treatment programs. The CM models were designed to encourage clients to remain committed to their treatment plans by offering rewards for positive behaviors. For example, clients who follow their treatment protocols or regularly attend therapy sessions receive rewards such as vouchers or other incentives for maintaining treatment adherence or attending scheduled sessions. Descriptions of GY1 and GY2 CM models were limited. Grantees demonstrated a traditionally grounded, multi-pronged approach to addressing OUD/SUD by integrating facility expansion, harm-reduction strategies, community engagement, education programs, collaborations, and CM (introduced in GY3). These efforts reflect a strong commitment to continuous improvement and innovation, ensuring grantees meet their communities' needs through traditionally integrated, community-centered approaches.

Program Challenges and Barriers

Across all grant years, grantees shared contextual insights on their programs and the various persistent and ongoing challenges and barriers faced in addressing OUD and SUD in their communities. Staffing shortages (in rural communities) became a major problem in GY3, and high turnover and the lack of skilled workers disrupted service. This was a significant increase from GY1 and GY2 when staffing shortages were already very high and further intensified by the COVID-19 pandemic.

As highlighted by a grantee in GY1, “COVID-19 adversely impacts the ability to engage the community and host events. Inability to hire providers, provider reluctance to participate in MAT, and administrative turnover impacted service implementation.” The pandemic is also compounded with additional challenges, such as the fast adoption of virtual services and the need to take some in-person courses online. This reduced some roadblocks, for example, in transportation, for a while, as services could be delivered remotely, but created additional barriers to technological access, data security, and digital tool skills for both staff and clients. Access to MAT providers was still limited in rural settings in all years, and GY3 identified and added that “transportation, lack of technology, and minimum after-hours emergency services in the region can cause significant challenges.”

Stigma in the community about MAT and harm-reduction approaches was a common barrier to client involvement across the grant years. However, in GY3, grantees still dealt with stigma in their communities. Some grantees also provided staff training to address stigma and educate communities on the benefits of MAT. In GY1 and GY2, there was resistance to offering harm-reduction tools, with some health care professionals reticent to embrace harm-reduction strategies for liability reasons.

One grantee shared that, “Many individuals still look at MAT as ‘replacing one addiction for another.’ Even with the education provided, the stigma still exists.” Space was another limitation. Organizations in all grant years reported having a hard time scaling up facilities for group therapy and storage of medication and demand for in-person services increased in GY3. While the pandemic had initially forced grantees to cut down on physical interactions and put health above all, GY3 saw more in-person services, which returned the challenges of sufficient facility and programming space.

Staffing shortages—particularly in rural areas—were the most common concerns. Grantees could not hire and keep enough qualified staff, such as master’s and doctoral-level workers, to provide services and capacity for programs. Higher turnover further compounded these problems. One, for instance, had high staff turnover across their MAT clinics, which disrupted service provision to the community. According to another grantee, it was difficult to find skilled clinicians who could meet the medical and behavioral health requirements of people living with OUD.

Transportation

Transportation was a big hurdle for clients, especially those living in rural or remote areas and needing MAT services. The geographical separation and absence of after-hours emergency services limited how often clients could meet with clinicians during the initial stages of treatment. One organization that provides services and support for six villages noted that the large distances between each village made transportation issues more difficult. Another grantee shared how transportation was an issue for clients during morning MAT sessions.

> *"The biggest challenge for clients is transportation, especially during the initial induction and first phase, as the clients must attend daily for a specific early morning time frame." (GY3)*

Limited Availability of MAT Providers

In some communities, MAT providers were scarce, and client access to treatment was limited. For instance, on one reservation, they provided only Suboxone as a MOUD, which drew the client into a single scenario and increased transport costs. One other program was holding up MOUD treatment because of medical liability and policy issues.

Community Stigma around MAT and Harm-reduction

Community stigma around MAT and harm-reduction interventions is still a source of unmet client demand and access to service. Stigma among other community members also makes patients feel guilty for taking medications to stay sober. For instance, one group noted that there is still stigmatization of MOUD within the community. Another organization worked on stigma reduction by offering health care training courses that focused on MAT as a treatment for OUD.

Physical Space and Facility Restrictions

Physical space constraints limit an organization's ability to scale services or offer a full treatment suite. Some grantees struggled to fit group therapy participants in existing spaces and needed to remodel their facility. Another grantee had storage capacity problems and was unable to store enough controlled substances, such as Suboxone.

> *"Clinics lack the space for storing controlled substances, so it can be a huge barrier to offering MOUD. There is also a shortage of behavioral health and mental health professionals to meet the growing need for complementary therapy services." (GY3)*

Staff Turnover

The program challenges at the organizational level included challenges with consistent leadership, staff, participation of patients/family, and external factors.

> *"During the last year there has continued to be turnover in leadership of the behavioral health department. The inconsistency of different leaders has resulted in a program that is fragmented. Over the last 6 months, though, efforts have been made to create a stable program with clear expectations for both staff and clients." (GY2)*

Resource Limitations

At an organizational level, grantees dealt with resource limitations such as a shortage of detox facilities and housing for individuals in recovery. As described by a grantee, "Limited access to resources created additional strains on our team and sub-grantees, making it more challenging to deliver the full range of services and support as originally planned." (GY2) In addition, the COVID-19 pandemic heightened operational challenges, and grantees pivoted from in-person programs and support services to

virtual delivery, which also introduced additional technology, virtual platforms, and data security challenges. Moreover, the COVID-19 pandemic impacted staff retention, programming operations, service delivery, staff training, and patient/client engagement. Grantees' leadership addressed their unique challenges, such as frequent leadership changes, navigating through the state regulations and bureaucratic processes about the harm-reduction approach, and effectively managing contracts. Some grantees highlighted the challenges in addressing stigma while some encountered resistance when implementing harm-reduction strategies in their communities. At the supervisory level, the high staff turnover disrupted the continuity and delivery of services and programs and staff recruitment.

Increased Workload

Staff experienced an increased workload due to reduced staff and the response to the pandemic. As part of onboarding, new staff and ensuring current staff remain informed, staff professional development and training about MOUD and harm-reduction approaches, such as stigma reduction, continued to be provided throughout program years. However, patients/clients and their families faced barriers such as accessing services due to societal stigma, legal constraints, transportation access, often related to rural and remote locations, because of staff workload and capacity to serve.

Additional Analysis

Under Objective 3, four additional questions of interest were examined and included, and they are presented next.

Objective 3—Research Question 1: Is there a difference in the number of patients achieving sobriety by EBP type?

This question explored whether there is a difference in the mean number of patients who achieved sobriety by the presence or absence of each EBP type (e.g., therapeutic modality). A Mann-Whitney U test, the non-parametric test equivalent of a two-sample t-test of independent proportions, was performed to compare the distributions of two independent groups: the presence or absence of each EBP type.

According to the results of each Mann-Whitney U test, there were no statistically significant differences between the median number of patients achieving sobriety and any of the EBP types used by grantees. However, ABFT approached significance, with patients in programs using ABFT showing a higher mean rank score for sobriety (19.16) compared to those in programs without it (9.0), yielding a p-value of 0.05. The effect size for ABFT was moderate (r = 0.33), suggesting a potentially meaningful impact, though this result was only marginally non-significant (Table 9).

The confidence interval interpretation, as initially intended, is not provided due to the absence of confidence interval data in the Mann-Whitney U test output and the lack of statistically significant findings. For the other EBPs, such as °CBT, °DBT, °MM, °MET, °MI, °CRA, and °CM, no significant differences were found (p-values ranged from 0.07

to 0.94). Effect sizes for these therapies were small, ranging from r = 0.01 to r = 0.3, indicating minimal to moderate effects, none of which reached statistical significance.

Table 9: Comparison of the Number of Patients Achieving Sobriety by Type of Treatment Program EBP Type Using the Mann-Whitney U Test

EBP Type	Group 1 Mean Score (EBP Present)	Group 2 Mean Score (EBP Not Present)	Z-score	p-value	Effect Size (r)
ABFT	19.16	9	-1.9559	0.05	0.33
CBT	18.62	13.25	-1.0193	0.31	0.17
DBT	19.03	16.78	-0.6686	0.50	0.11
MM	14.12	20.3	-1.8139	0.07	0.3
MET	16.46	18.8	-0.6647	0.51	0.11
MI	18.25	17.9	0.0776	0.94	0.01
CRA	18.5	17.74	0.2031	0.84	0.03
CM	18.31	17.68	-0.1754	0.86	0.03
Other					

Note: Significance is denoted as follows — $p < 0.05$ (*)
The negative values under the Z-score column represent the direction of the difference between Group 1 (EBP Present) and Group 2 (EBP Not Present) in terms of their mean scores for patients achieving sobriety.

Objective 3—Research Question 2: Is there a difference in the median number of MOUD patients satisfied with the services provided by having a MOUD policy, procedure, or protocol in place?

This question explored the relationship between patient satisfaction with MOUD services and the presence of a long-term coordinator, director, or leader overseeing the program. The Mann-Whitney U test showed there was no statistically significant difference in the mean level of patient satisfaction with MOUD services based on whether a long-term coordinator was present ($p = 0.44$; Table 10). Programs with a long-term coordinator had a mean rank score of 18.22, compared to 10.5 for programs without one. Although the presence of a long-term coordinator was associated with a slightly higher mean rank score in patient satisfaction, the difference was not statistically significant. The effect size (r = 0.13) suggested a small effect, indicating that the presence of a long-term coordinator, director, or leader may have had a minimal impact on patient satisfaction levels with MOUD services in this sample.

Table 10: Relationship Between the Presence of a Long-Term Coordinator/Director/Leader and Patient Satisfaction with MOUD Services Using the Mann-Whitney U Test

Variable	Group 1 Mean Score (Long-Term Coordinator Present)	Group 2 Mean Score (Long-Term Coordinator Absent)	Z-score	p-value	Effect Size (r)
Patient Satisfaction with MOUD Services	18.22	10.5	-0.7684	0.4400	0.13
Note: Significance is denoted as follows — $p < 0.05$ (*) The negative Z-score in this table indicates the direction of the mean difference between the two groups.					

Summary of Findings

In GY3, more grantees offered teleMOUD services than in previous years, although fewer offered MOUD services. This may represent a shift in the mode of delivery of services. In GY3, again, there was a substantial increase in the number of prescribers in grantees' catchment areas, and more of these prescribers received MOUD training or opioid prescription guidelines training than in previous years. The use of EBP increased or remained stable across every modality except MM, MET and ABFT. Grantees increasingly had policies, programs, or procedures in place for harm-reduction efforts like fentanyl test strips.

Screenings for universal alcohol, suicide, and SBIRT increased in GY3, demonstrating an increased emphasis on proactive detection and intervention. The number of patients referred to OUD treatment, accessing OUD treatment, or accessing support services after treatment increased in GY3, suggesting improved access to services. Non-fatal and fatal incidents of overdose appeared to increase, however, there are limitations related to the accuracy of overdose reporting data.

Overview of Grantees

This section of the report provides an overview of grantees, focusing on their organizational capacity (APR Section A), the service population they cater to, and the data sources and mechanisms used (APR Section F) to track service use. A summary of the quantitative and qualitative findings is provided next.

APR Section A: Organizational Capacity

IHS COIPP APR Section A focuses on organizational capacity. Grantees were asked to gather essential data to gauge the project's operational strength. This includes details on the number of full-time staff, providing insights into the workforce that drives the project's initiatives. Program leadership information was also systematically documented, offering a clear understanding of the key decision-makers steering the organization. Furthermore, grantees tracked staff turnover throughout the reporting period, which offers an overview of staff stability and human resource information.

Grantees also reported on the number of volunteers they had, a demonstration of the project's collaborative efforts and community engagement. Additionally, the section provides data on the services provided through contracted providers and the extent of external partnerships and their contributions to the project's overall service delivery. Tribal organizations frequently rely on partnerships with external clinical providers to bolster their capacity to deliver comprehensive care as part of their opioid prevention and treatment programs. The data collection within Section A ensures a holistic assessment of organizational capacity, enabling strategic planning and informed decision-making for the IHS COIPP.

Staff Capacity

Staff capacity fluctuated across program years to meet the service needs of each grantee's service area. In terms of hiring, in GY1, grantees hired 147 staff, while in GY2 they hired 205. In GY3, there was a total number of 181 full-time staff hired. On average, 4.2 staff members were hired per grantee in GY1, and six staff members were hired to date per grantee in GY2, and just over five staff were hired per grantee in GY3. See Table 11 in Appendix A.

As the programs have matured, more have found long-term coordinators or directors to support long-standing leadership and program stability. In GY3, 97.1% (n = 34) of grantees reported having a long-term coordinator or director, in comparison to 88.6% (n = 31) in GY1. In addition, in GY3, 50% (n = 17) of the grantees reported having the same coordinators, directors, or leaders during GY1 and GY2 (Figure 31).

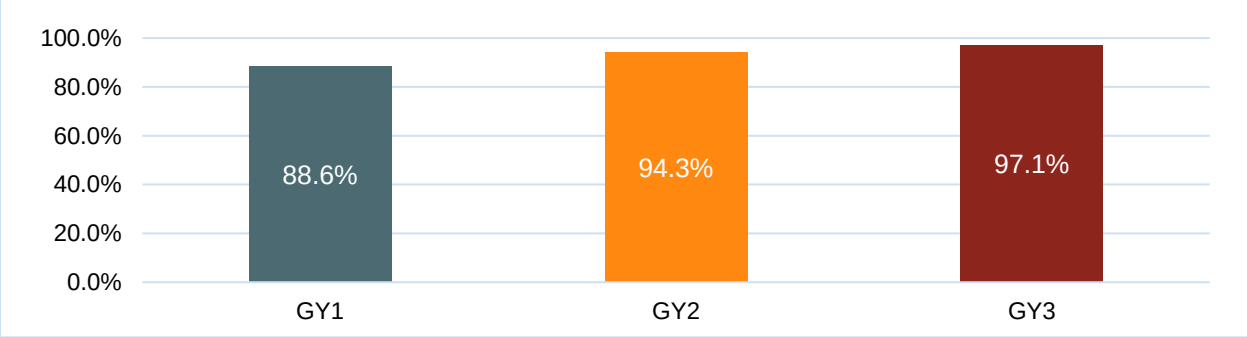

Figure 31: Percentage of Grantees Who Reported Having a Long-term Coordinator or Director (GY1-GY3)

In GY3, grantees were asked to report on the type of staff positions they have in place to successfully deliver these programs. Figure 32 depicts the number and percentage of grantees that reported having staff by type in GY3. Most grantees had behavioral health/mental health professionals (77.1%, n = 27) on staff. In addition, administrative staff (62.9%, n = 22), and paraprofessionals (60.0%, n = 21) were also represented. Only 34.3% (n = 12) grantees had nurses, and 22.9% (n = 8) grantees had physicians on staff. Tribal elders and traditional practitioners were also reported as staff among 31.4% (n = 11) of grantees. In addition, 25.7% (n = 9) of grantees had data

coordinators, and 20.0% (n = 7) of grantees had health education staff. Only one grantee reported having law enforcement officers on staff. No grantees specified having church-based staff.

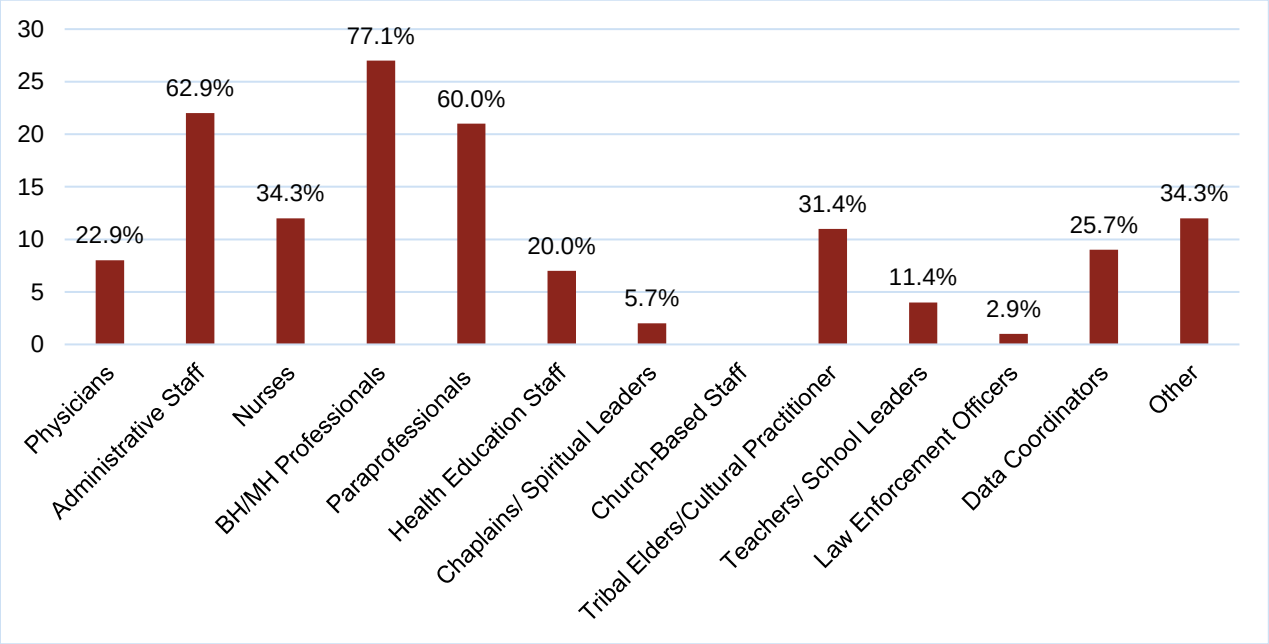

Figure 32: Number of Grantees Who Reported Staff by Type (GY3)

Volunteers are essential elements of many OUD programs. Grantees shared insights on the number of different types of volunteers in GY2 and GY3 only, which are displayed in Figure 33. In addition, data for only some volunteer types were collected under GY2: physicians, nurses, behavioral health/mental health professionals, chaplains or spiritual leaders, church-based staff, Tribal elders, teachers or school leaders, and law enforcement officers. In GY3 grantees were asked to report on the full set of volunteer types (See Table 11 in Appendix A for more details).

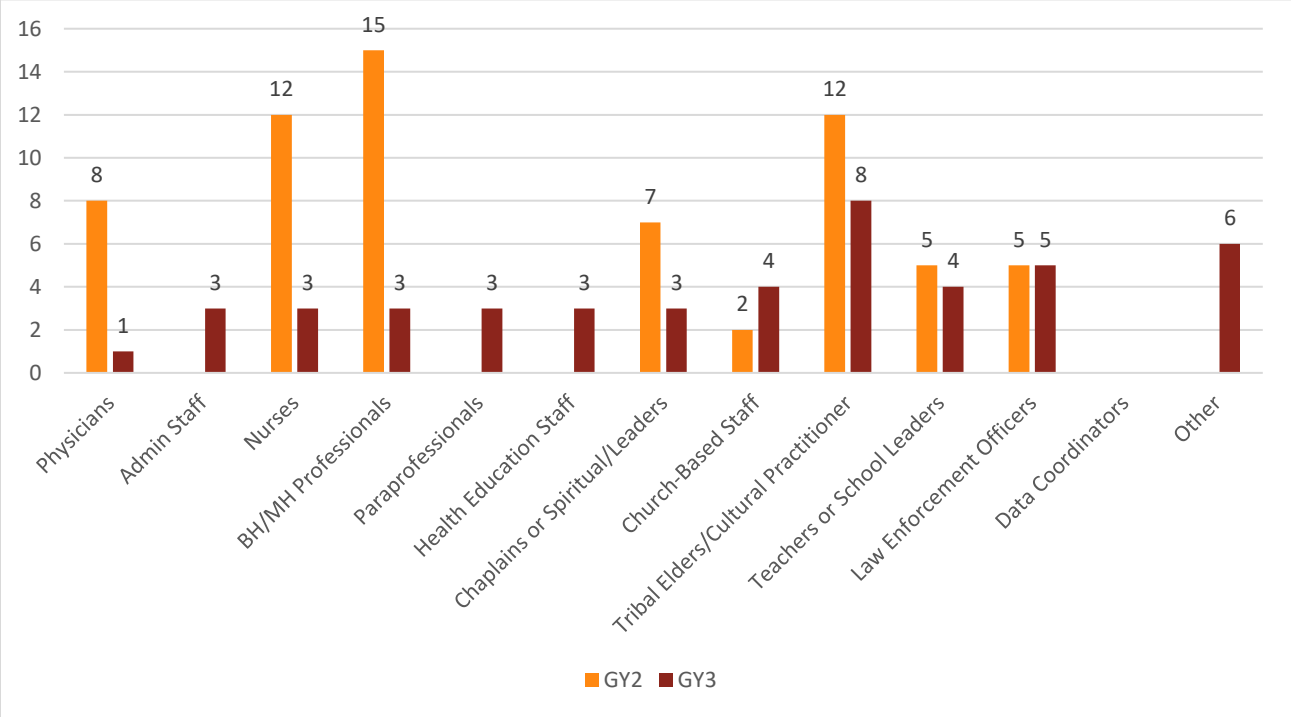

Figure 33: Number of Grantees Who Reported Having Volunteers by Type (GY2–GY3)

Most grantees reported using behavioral health/mental health volunteers, nurses, and Tribal elders and traditional practitioners in GY2. In addition, some grantees also used volunteer physicians, chaplains or spiritual leaders, teachers, or school leaders, as well as law enforcement officers. The least reported number of volunteers was among church-based staff. Of note, the number of grantees with volunteers decreased across each type from GY2 to GY3, except for law enforcement officers, which remained consistent.

Direct Services and Contracted Providers

Direct services and contracted providers are vital to the success of OUD programs due to their unique contributions to comprehensive patient care and effective program operations. Direct service clinicians, whether part of the in-house clinical staff or contracted specialists, bring specialized skills, flexibility, and expanded service capabilities that are crucial in treating OUD patients. These providers ensure patients receive consistent, high-quality, evidence-based care tailored to their unique needs, fostering an environment of trust and recovery. Direct service clinicians contribute to maintaining consistency in patient care, which is essential for OUD treatment where trust and reliability play key roles in long-term patient engagement. This consistency helps build therapeutic relationships, offering patients a stable support system throughout their recovery journey.

Contracted providers supplement the in-house clinical team by offering specialized services that may not be available within the existing staff pool, such as psychiatrists, addiction medicine specialists, and therapists specializing in trauma. Their contributions enrich the treatment program, ensuring patients receive a comprehensive approach that addresses not just addiction but also underlying co-occurring disorders and holistic well-being. The incorporation of contracted providers adds a level of flexibility that supports the scalability of OUD programs, which is particularly important when patient loads increase or when specific needs arise that require rapid response, such as crisis intervention, medication management, or specialized therapy. Contracted clinicians help bridge gaps during staffing shortages, ensuring continuity of care without interruption.

As such, starting in GY2, grantees were asked to report on how they provide each of these types of services (see Figure 34). In GY2, 77.1% (n = 27) of grantees reported they provided direct behavioral health services, while 22.9% (n = 8) did not provide such services. The percentage of grantees that offered direct behavioral health services increased to 80.0% (n = 28) in GY3. Approximately 20.0% (n = 7) of the grantees did not provide direct behavioral health services in GY3.

Only 42.9% (n = 15) of grantees reported offering services through contracted providers, while 57.1% (n = 20) did not offer services through contracted providers for GY2. There was a decrease in the number of grantees who offered contracted providers from GY2 (42.9%, n = 15) to GY3 (40.0%, n = 14). In addition, 60.0% of grantees did not provide services through contracted providers in GY3.

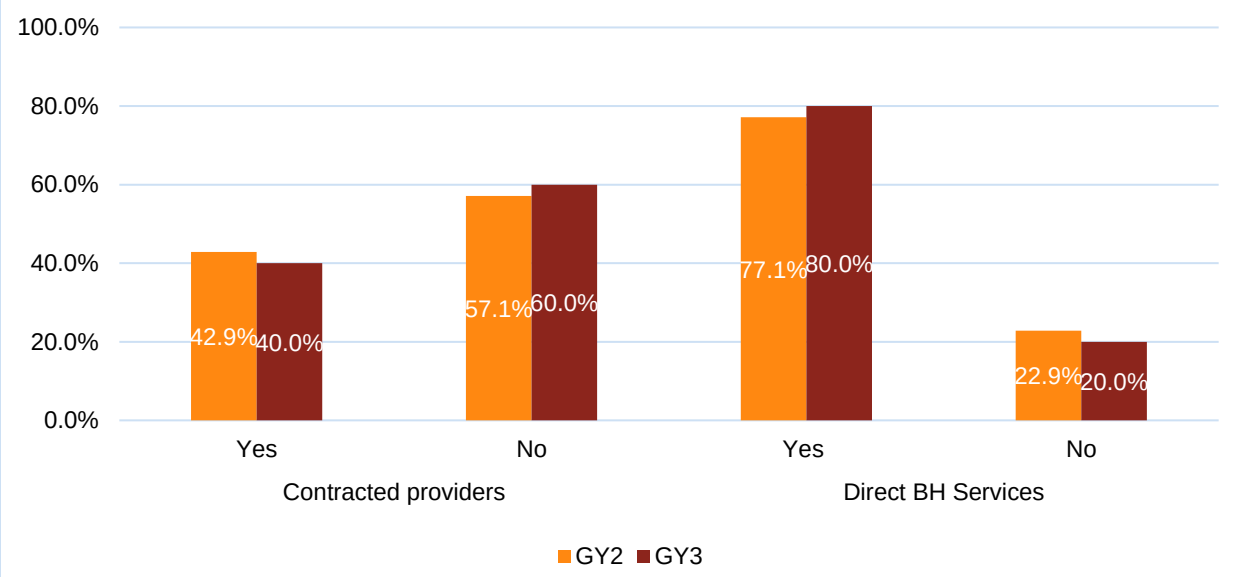

Figure 34: Percentage of Direct Behavioral Care and Contracted Services (GY2–GY3)

Grantees providing direct behavioral health services were asked to elaborate on the types of services they offered to opioid and SUD patients. In GY2, MOUD emerged as

the most frequently provided service, with 66.7% (n = 27) of grantees offering it. However, by GY3, there was a shift in the service landscape whereby, the percentage of grantees offering MOUD decreased to 46.4%, and 35.7% of grantees began providing MAT, which includes treatment for both OUD and SUD. Notably, in GY3, three grantees reported offering both MAT and MOUD services.

MOUD and MAT are terms often used interchangeably in the context of treating OUD, but they have nuanced differences. MOUD is more precise, focusing solely on the use of FDA-approved medications to treat OUD as part of a comprehensive treatment plan. It emphasizes that these medications are the primary mode of treatment and are intended to highlight the treatment of OUD specifically. MAT, on the other hand, is a broader term that refers to the use of medication in conjunction with counseling and behavioral therapies to address SUDs, not just opioid-related ones. While MAT includes the same medications used in MOUD, it stresses the combined approach of pharmacological and psychosocial components. In summary, MOUD is used to underscore the medical treatment aspect for opioid use, while MAT highlights a comprehensive treatment model integrating medication with therapy for various SUDs.

Mental health counseling, for both individuals and groups, continued to be the most offered service in both GY2 and GY3, whereby 59.3% of grantees reported providing mental health support in GY2 and 57.1% in GY3. Peer support services were widely offered in GY2 and GY3. In GY2, 55.6% of grantees provided these services, slightly decreasing to 50.0%in GY3. SUD counseling provided, for both individual and group counseling, decreased from GY2 (40.7%) to GY3 (28.6%). Traditionally specific treatments, such as combining direct behavioral services with family-inclusive therapy and traditional healing practices (e.g., sweat lodges, talking circles, spiritual rituals, and herbal medicines), were offered by approximately one-third of grantees in GY2 (33.3%) and GY3 (32.1%). Group therapy and integrated health models were offered by 46.4% of grantees in GY3, with a couple of grantees combining this approach with behavioral health therapies such as CBT. In contrast, SUD individual or group counseling decreased to 28.6% of grantees in GY3 from 40.7% of grantees in GY2. In GY3, 35.7% of grantees began offering integrated health models that address mental health, substance use, and opioid use concerns together with these core services. Additionally, in GY3, 17.9% of grantees offer an IOP, which provides immersive care without hospitalization.

Contracted Behavioral Health Service Pathway for Grantees

The grantee's use of contract service providers illustrates resourcefulness in ensuring that their clients and families have access to direct behavioral health services, particularly when specialized care or telehealth offerings are necessary. In GY2, contract services were provided by 55.6% of grantees and decreased slightly to 42.9% in GY3. The contract services included:

- MOUD,
- Behavioral health counseling,

- Heritage counseling,
- Case management, and
- Psychiatric treatment.

Through contract services, grantees were able to maintain and offer comprehensive care offerings while leveraging outside expertise, especially to address the need for traditionally specific treatments or telehealth services in rural and remote areas. Both GY2 and GY3 reflect a continued commitment and enhancement of different approaches to expand their direct behavioral health service offerings, with a growing emphasis on comprehensive patient-centered care. Core services such as mental health counseling, peer support, traditionally tailored treatments (including traditional healing practices), and telepsychiatry remain consistent across both years. In GY3, grantees expanded group therapy or combined it with CBT. Additionally, IOPs were introduced in GY3 to provide the necessary support without hospitalization.

Subgrantees

Of all 35 grantees, two grantees reported providing the COIPP program to subgrantees in GY2. Of these grantees, their program was provided to a combined nine subgrantees. These two grantees specified they collected attendance logs, event flyers, reports, and project narratives summarizing services provided from their subgrantees. In GY3, only one grantee reported providing the COIPP program to three subgrantees.

Additional Analysis

Additional analyses were conducted to obtain more detailed information regarding organizational capacity across grantees. The next two questions guided the exploration.

Organizational Capacity—Research Question 1: Is there a relationship between having a long-term coordinator or director and each of the following: (1) opioid prevention improvement, (2) training and treatment improvement, and (3) provider burnout?

This research aimed to examine the relationship between having a long-term coordinator or director on staff and whether there was improvement in opioid prevention or training and treatment efforts. In addition, it sought to examine whether there was a relationship between having a long-term coordinator/director and having efforts in place to address provider burnout. The analysis specifically aimed to gather knowledge on whether having staff in a director or coordinator role influenced programmatic outcomes in GY2. Additionally, the supplemental analysis also encompassed provider burnout, to assess whether having staff in leadership roles was associated with reporting of provider burnout. The Pearson's chi-square test was performed to address the research question and provide further insight into the infrastructure and capacity of grantees used to manage their COIPP program and provide services to the populations they serve.

A Pearson's chi-square test was conducted to determine whether there was a relationship between having a long-term coordinator or director and opioid prevention

improvement for GY2 (n = 35). Opioid prevention improvement was categorized as "improved," "no change," and "no improvement." The assigned categories for having a long-term coordinator or director were "yes" and "no." Results from the test revealed no significant relationship between the two variables (Pearson's chi-square, $p = 0.368$).

To examine whether an association was present between having a long-term coordinator or director and training and treatment improvement, a Pearson's chi-square test was conducted with data from GY2 (n = 35). Training and treatment improvement was categorized as "improved," "no change," and "no improvement." The assigned categories for having a long-term coordinator or director were "yes" and "no." The Pearson's chi-square test showed no significant relationship between the two variables, (Pearson's chi-square, $p = 0.097$).

The relationship between two dichotomous variables, including having a long-term coordinator or director and having efforts in place to address provider burnout was evaluated using a Pearson's chi-square test (n = 35). Both variables were categorized as "yes" and "no." Results from the Pearson's chi-square test indicated no significant relationship between the two variables for GY2, (Pearson's chi-square, $p = 0.634$).

Organizational Capacity—Research Question 2: Is there a relationship between having a long-term coordinator or director and patient satisfaction with MOUD services?

Patient satisfaction with MOUD services and having a long-term coordinator or director were analyzed to test for the presence of a relationship between the two variables. The distribution of the data for patient satisfaction was described as non-normal and right skewed. Based on the distribution of types of variables included in the analysis, and testing assumptions, the Mann-Whitney U test was conducted to assess whether an association was present accordingly.

The Mann-Whitney U test was used to explore the relationship between having a long-term coordinator or director and the count of patients treated with MOUD who reported being satisfied with services. Having a long-term coordinator or director was categorized as "yes" and "no." The average count of patients treated with MOUD who reported being satisfied with services was 29. For GY2, the Mann-Whitney U test was not statistically significant (Mann-Whitney U, $p = 0.156$).

Summary of Findings

Organizational capacity was examined across GY1 through GY3 to better understand grantees' ability to offer and provide optimal patient care, and opioid prevention and treatment services—such as MOUD—in their designated catchment area. Aggregate data yielded from the APR Section A were primarily reflective of staffing infrastructure and capacity, and the impact of having specific staffing roles in place. Overall, the total number of staff hired increased year-to-year, showing growth and potential demand for services required more staff to support grantee programs. Furthermore, the total Full-time Equivalent of staff also showed an increase over the years.

The presence or absence of a long-term director or coordinator was reported by grantees for all three years, revealing such roles having a greater presence by GY3. This could reflect more people being equipped to take on these roles compared to GY2. When exploring whether the presence or absence of a long-term director or coordinator in place had an impact on either opioid prevention improvement, training and treatment improvement, provider burnout, and patient satisfaction with MOUD services, no significant relationships were observed. Grantees reported using fewer volunteers in GY3, especially volunteer clinicians. Since human resource capacity is a struggle across many health care settings, a decline in clinician volunteers is a symptom of this sector-wide challenge.

In GY3, grantees provided more direct services, such as mental health counseling, peer support services, SUD counseling, and traditionally specific treatments (e.g., sweat lodges and talking circles). Additionally, grantees expanded their reach by offering services through contract providers, resulting in a comprehensive approach to supporting individuals in their recovery journeys. These contracted services ranged from MOUD therapy, behavioral health counseling, heritage counseling, case management and psychiatric treatment.

APR Section F: Service Population and Data Sources

The IHS COIPP Section F asks grantees about their service population and the array of data systems and sources used. Data collected in this section describe the total number of individuals in the service population, patient demographics, characteristics of patients using MOUD services, and the specific MOUD medications prescribed. Additionally, the report provides a count of patients who have achieved sobriety because of the program's interventions. Furthermore, Section F. captures essential metrics such as the number of patients entering inpatient treatment, total incidences of overdose recorded, and the extent of community-based events organized by the program.

Data Collection Systems Used by Grantees

The data collection systems grantees use provide some insight into how modernized each grantee is in terms of data collection, reporting, and sharing. Figure 35 displays the frequency of grantees who reported using each data collection type. EHR use consistently increased across years, with 77.1% (n = 27) of grantees in GY1 increasing to 85.3% (n = 29) of grantees by GY3. Simultaneously, the use of manual data collection methods declined between GY1 (76.5%, n = 26) to GY3 (65.7%, n = 23).

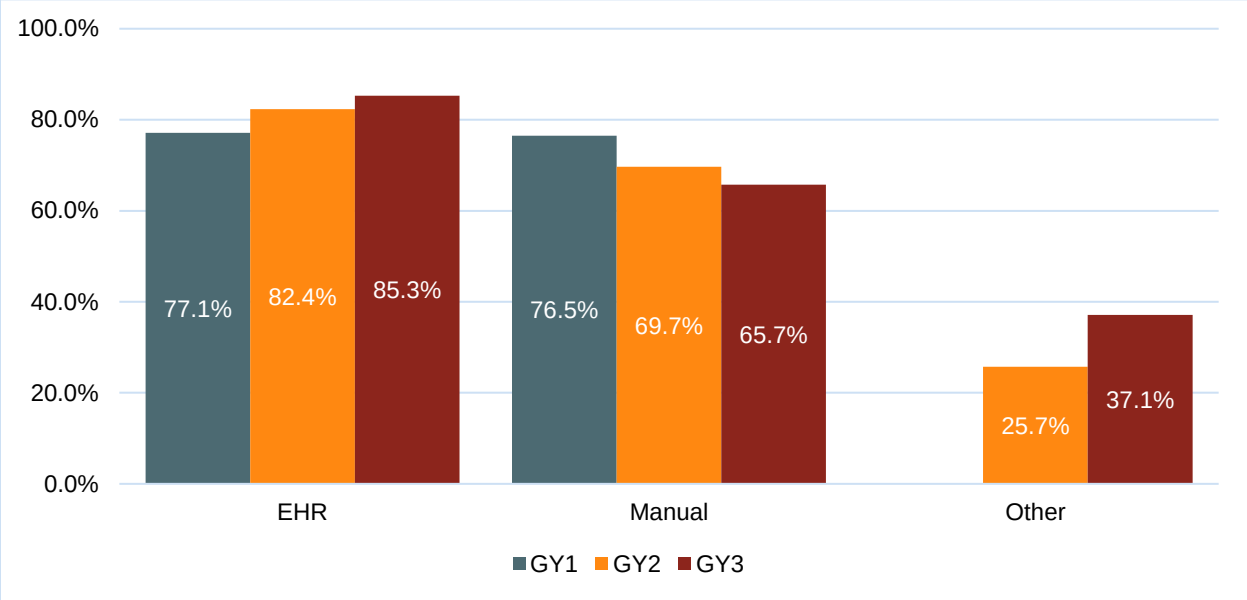

Figure 35: Percentage of Grantees Using Data Collection Systems by Type (GY1–GY3)

Grantees were asked about their use of other data collection systems for the first time in GY2, and again in GY3. In GY3, 37.1% (n = 13) of grantees reported using another form of data collection in contrast to 25.7% (n = 9) in GY2. For GY3, some of these different data collection methods included:

- Spreadsheet applications such as Excel and Smartsheet,
- Intake forms or software such as Formstack,
- Communication software such as Constant Contact,
- Data systems including Handel Information Technologies RiteTrack system, Lighthouse Database, Carelogic, and SPARS,
- Board reports, and
- Population data sources such as county health department data, Census data, and Tribal enrollment data.

Patients Treated with or without MOUD

Over the three grant years, grantees were tasked with documenting the number of clients treated with MOUD versus those treated without, providing a comprehensive view of the use of MOUD. The data revealed that while the number of patients treated without MOUD remained significantly higher, there was a consistent increase in the use of MOUD each year. Specifically, in GY1, 1,326 patients were treated with MOUD, which rose to 2,172 in GY2 and further to 2,345 in GY3. Conversely, the number of patients treated without MOUD showed substantial growth, with 3,096 patients in GY1, increasing to 2,717 in GY2, and reaching 7,490 in GY3 (see Figure 36).

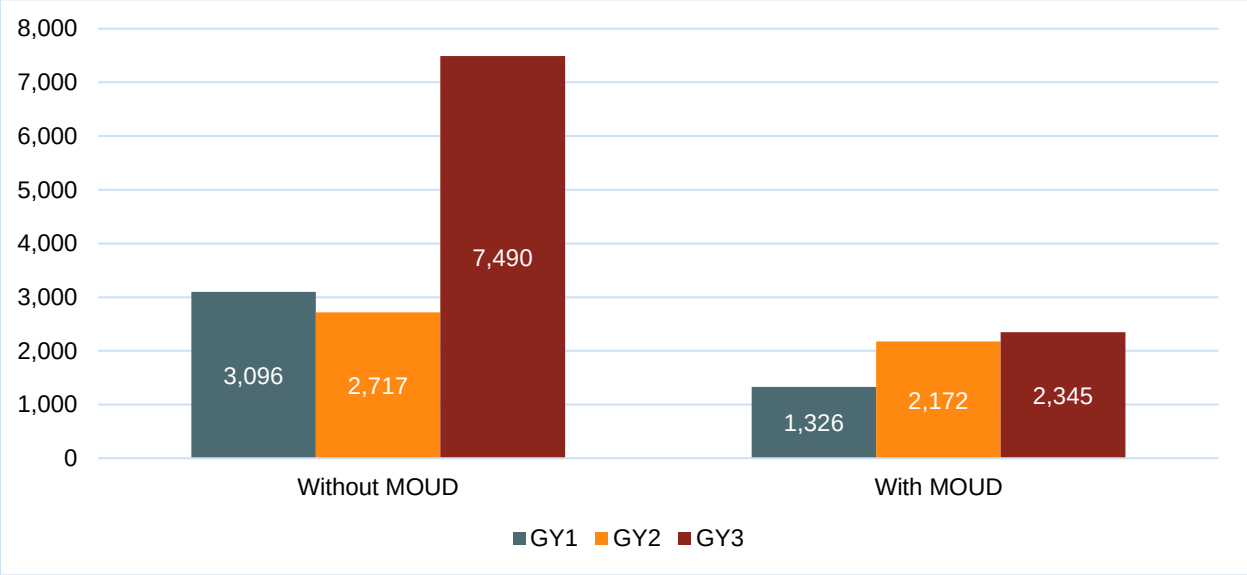

Figure 36: Number of Patients Treated with and without MOUD (GY1–GY3)

Patient Satisfaction with Services

Patient satisfaction is an important element of OUD program quality. Grantees were asked to report on patient satisfaction, stratified by whether they received services with or without MOUD (see Figure 37).

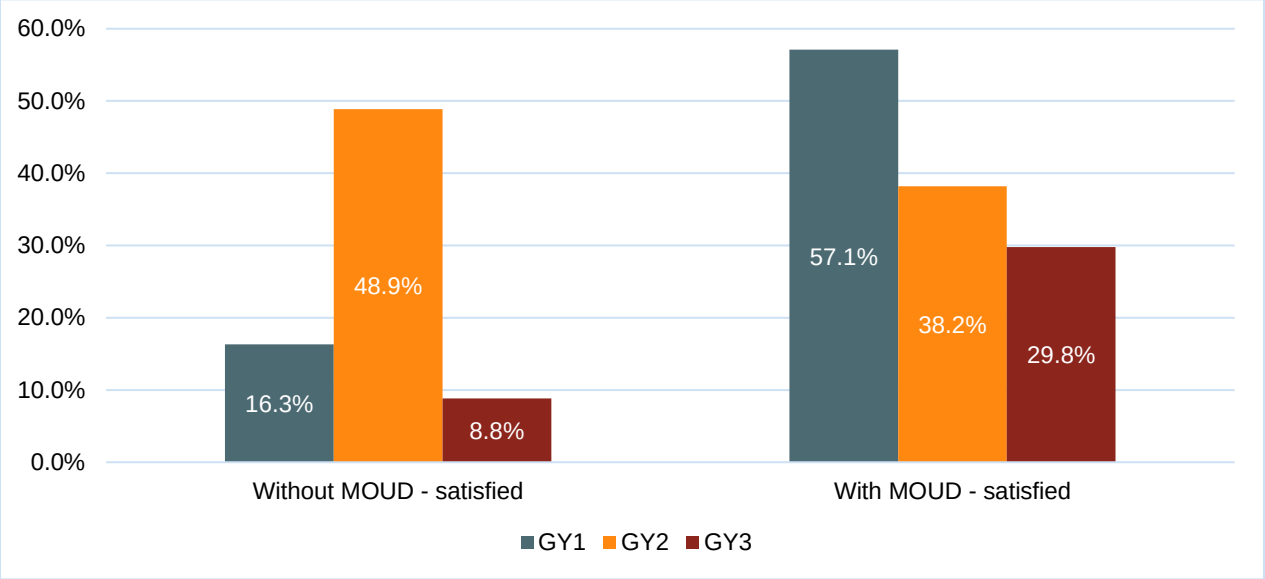

Figure 37: Patient Satisfaction with Services Based on the Type of Services

Of the patients who were treated without MOUD, a greater proportion reported they were satisfied with the services they received in GY2 (48.9%, n = 1,328) than in GY1 (16.3%, n = 505). However, in GY3, this percentage dropped to just 8.8% of patients (n = 660). The proportion of patients treated with MOUD who reported they were satisfied consistently decreased over the years: 57.1% (n = 757) reported satisfaction in GY1, which decreased to 38.2% (n = 830) in GY2, and further still to 29.8% in GY3 (n = 698).

MOUD Patient Demographics

Grantees were asked to share age and sex data for their patients. Figure 38 displays the percentage of MOUD patients by sex across each of the four reported age groups: under 18 years old, 19 to 24 years old, 18 to 24 years old, and 25 years and older (see Table 11 in Appendix A for additional details). Note, in GY3, the APR form age category for 19 to 24-year-olds was changed to 18 to 24-year-olds to be inclusive of those patients who were 18 years old. Therefore, the data for this age group in GY3 is displayed separately from the data for the 19 to 24-year-old age group (GY1 and GY2).

Overall, there were more male MOUD patients (52.9%, n = 1170) than female (47.1%, n = 1,043) in GY3. The older age group, 25 years of age or older, was consistently the largest age group by proportion of total patients across all grant years. In GY1, male MOUD patients 25 years and older were 89.0% (n = 218) of all male patients. This increased to 92.9% (n = 995) in GY2 before decreasing slightly to 91.1% (n = 1,066) in GY3. Similarly, for female patients aged 25 and older, this group comprised 86.5% (n = 192) of the female patient population in GY1, 93.1% of patients (n = 1,213) in GY2, and 88.2% (n = 920) in GY3.

In GY3 8.4% of male patients (n = 94) were between the ages of 18 and 24 years. This age group was not inclusive of 18-year-olds in GY1 and GY2, where 11.0% (n = 27) and 6.8% (n = 73) of male patients were in the 19- to 24-year-old age group, respectively.

Similarly, 10.1% (n = 105) of female patients were between 18 to 24 years of age in GY3. This is a decrease from GY1 (12.6%, n = 28), and an increase from GY2 (5.1%, n = 67) for this age group.

The youngest age group (<18 years of age) remained the smallest throughout the program years. Male MOUD patients under 18 years of age comprised 0.5% (n = 6) of male MOUD patients in GY3 and 0.3% (n = 3) in GY2. There were no male MOUD patients under 18 years of age in GY1. For female patients, 1.7% (n = 18) of patients were under 18 years of age in GY3 compared to 1.8% (n = 23) in GY2, and 0.9% (n = 2) in GY1.

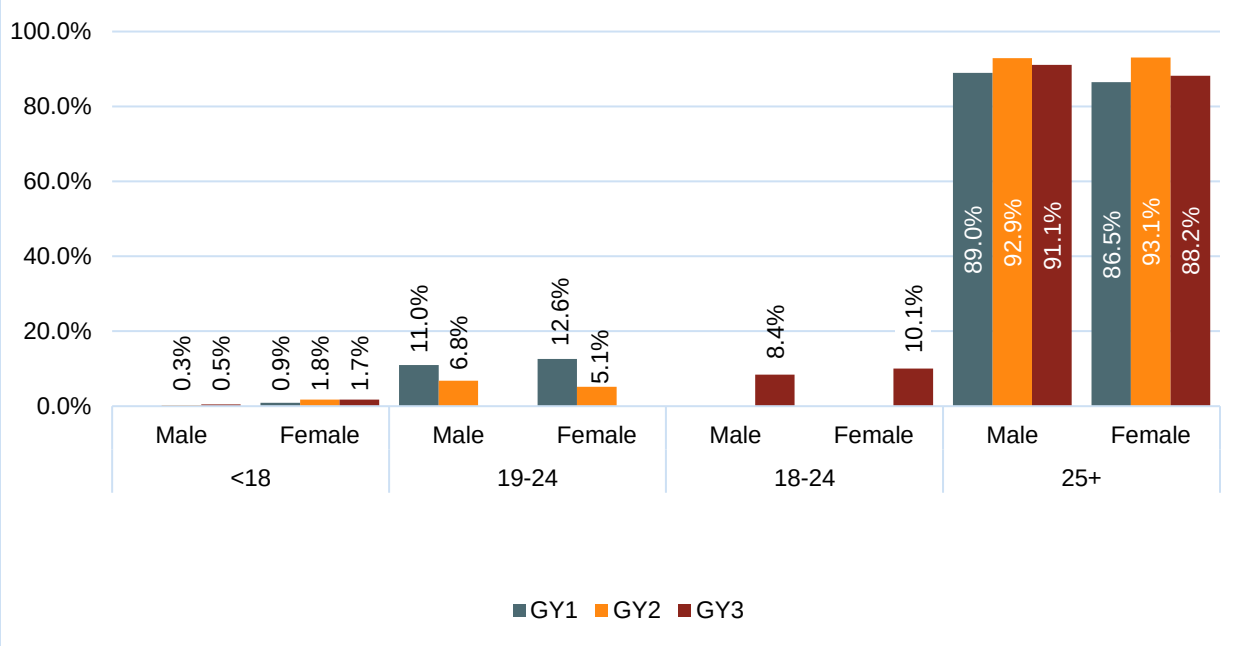

Figure 38: Percentage of MOUD Patient Demographics by Age Group and Sex (GY1–GY3): Note: GY3 age group was recategorized to 18-24 years old.

Grantees were asked to report on the living situations of their patients—often an indication of what family support patients may have in their recovery. Understanding the need for a Tribal program to collect data on the living situations of opioid patients is crucial, as it forms the foundation for a more tailored, effective response to the ongoing opioid crisis. Tribal communities often face unique socioeconomic challenges and historical trauma that influence the patterns of substance abuse and recovery. Collecting data on patients' living conditions helps identify risk factors that may exacerbate addiction, such as housing instability, overcrowding, or unsafe living

environments, which are often linked to higher stress levels and reduced access to supportive resources. Such insights allow health care providers and program administrators to design more targeted interventions, allocate resources effectively, and implement comprehensive prevention and treatment plans that address the root causes of SUDs. Moreover, this data enables the continuous evaluation and adjustment of treatment programs, ensuring they remain relevant to the patients' needs and the broader community context. Understanding living conditions can lead to better post-treatment plans that reduce the risk of relapses, support long-term recovery, and contribute to sustainable health outcomes in the community. Figure 39 displays the living situation of MOUD patients by the percentage of patients in each group (see Appendix A: Tables for more details). Note that percentages and counts are only displayed for patients where grantees reported their living situation and are not representative of all MOUD patients served.

In GY3, 34.1% (n = 177) of MOUD patients reported they lived with other adults and children, a decrease from GY2 (39.0%, n = 473) and GY1 (54.5%, n = 256). Over the same period, the proportion of MOUD patients who reported they lived with other adults increased from 16.6% (n = 78) in GY1 to 35.9% (n = 436) in GY2, before decreasing to 25.6% (n = 133) in GY3. Over the grant years, the proportion of MOUD patients who reported living alone increased to 26.0% (n = 135) in GY3 from 20.1% (n = 244) in GY2 and 22.3% (n = 105) in GY1.

Notably, there was an increase in the proportion of individuals living with pregnant or new mothers and children in GY3 (12.1%, n = 63) compared to GY2 (3.9%, n = 47), and GY1 (4.3%, n = 20). At the same time, the proportion of individuals living with pregnant or new mothers and no children remained consistent across GY1 through GY3 (Figure 40).

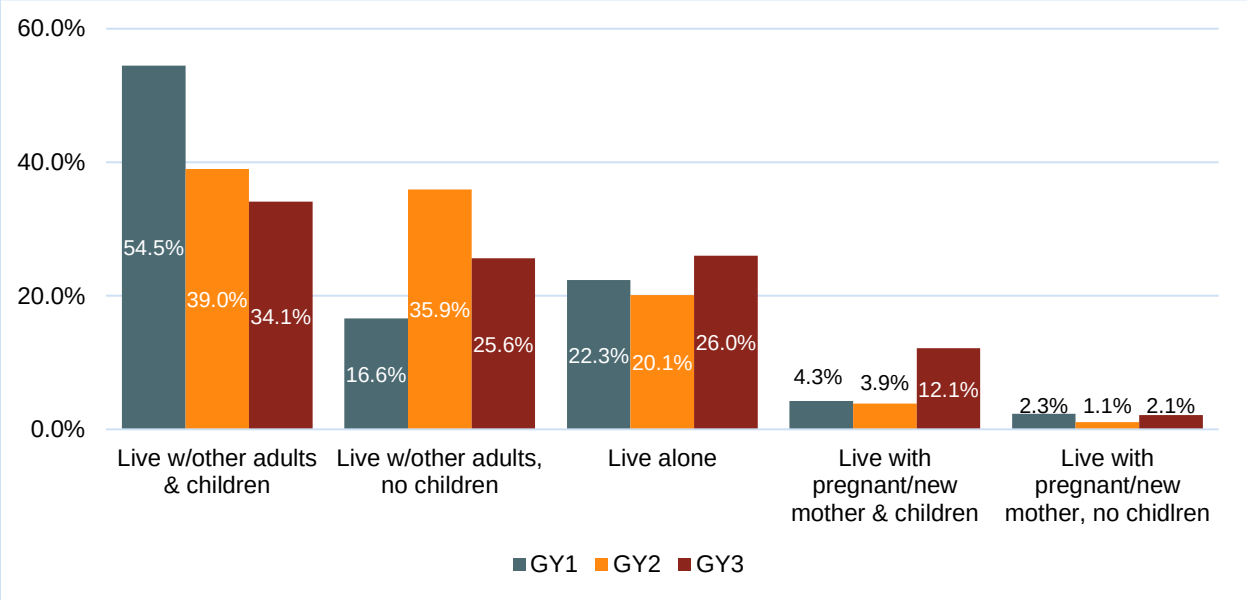

Figure 39: Percentage of MOUD Patients by Living Situation (GY1–GY3)

MOUD Patient Outcomes

Grantees were asked to report on the outcomes of all their MOUD patients by age and sex. Reportable patient outcomes included:

- Achieving sobriety,
- Entering inpatient treatment,
- Attending community-based events and, and
- Experiencing an overdose (fatal or non-fatal).

Achieving sobriety is a complex and individualized process that involves abstaining from substance use and developing healthier coping mechanisms. In the context of an opioid prevention and treatment program spanning multiple grantees, the concept of achieving sobriety takes on additional nuances. As such, a standardized definition of achieving sobriety has not been established as the path can vary greatly. Therefore, grantees had the opportunity to determine their own performance measures. This approach allows for flexibility in addressing the unique needs and circumstances of different communities and treatment of populations. For example, some grantees might focus on complete abstinence from opioids, while others might consider MAT as a form of sobriety. Others still might emphasize improvements in quality of life, reduction in drug use, or engagement in treatment as indicators of progress toward sobriety. This diversity in defining and measuring sobriety enables grantees to tailor their programs to best serve their specific populations and to capture a more comprehensive picture of recovery success across different contexts.

It is important to note that grantees may have selected more than one event per patient, as the outcomes are not mutually exclusive. For example, one patient may have experienced an overdose, but later entered inpatient treatment during the same reporting period. In addition, some patients may never have experienced any of the outcomes listed. Therefore, the numerators in each sex and age category across each outcome type may not exactly sum up to the total number of MOUD patients reported in each category.

Achieved Sobriety

Figure 40 highlights the trends in sobriety rates among MOUD patients, segmented by age and sex over three grant years. In GY1, 36.8% of MOUD patients (n = 494) achieved sobriety, which decreased to 23.0% (n = 554) in GY2 before rebounding slightly to 32.3% (n = 756) in GY3.

Breaking down the data by age and sex reveals significant variability. Notably, male patients under 18 showed no instances of sobriety in any grant year. Female patients under 18 had more positive results: in GY1, 50.0% (n = 1) attained sobriety, followed by a reduction to 43.5% (n = 10) in GY2 and a significant decline to 11.1% (n = 2) in GY3.

In the 19-24 age category, male patients demonstrated a marked decrease in sobriety rates, with 55.6% (n = 15) achieving sobriety in GY1, dropping to 19.2% (n = 14) in GY2, and further declining to 15.3% (n = 15) in GY3 (for ages 18-24). Female patients in this age group started at a higher rate of sobriety in GY1, with 78.6% (n = 22) reaching sobriety, but this sharply dropped to 13.4% (n = 9) in GY2 and then to 9.5% (n = 10) in GY3 (for ages 18-24).

For patients aged 25 and older, male sobriety rates began at 72.0% (n = 157) in GY1, falling to 23.9% (n = 238) in GY2, and continuing to decrease to 17.7% (n = 189) in GY3. Female patients in this age group followed a similar pattern: 68.2% (n = 131).

achieved sobriety in GY1, but this figure dropped to 16.9% (n = 205) in GY2 and slightly increased to 17.5% (n = 161) in GY3.

Overall, these trends indicate an initial high rate of sobriety among certain groups, particularly those aged 25 and above and females aged 19-24 in GY1, followed by a notable decline in subsequent years across most categories.

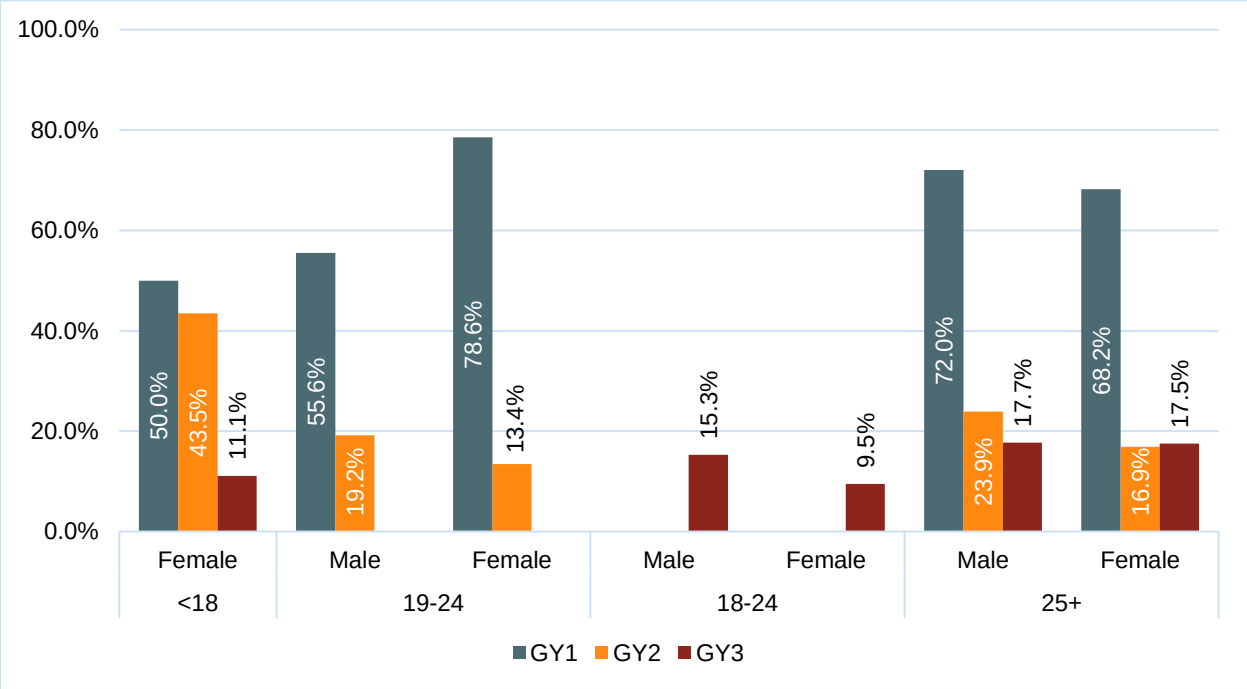

Figure 40: Percentage of MOUD Patients who Achieved Sobriety by Sex and Age Groups (GY1–GY3): Note: GY3 age group was recategorized to 18-24 years old.

Entered Inpatient Treatment

Figure 41 highlights the distribution of MOUD patients entering inpatient treatment segmented by sex and age groups over three years. The overall percentage of MOUD patients who entered inpatient treatment shows a consistent increase from 20.6% (n = 276) in GY1 to 23.5% (n = 565) in GY2, reaching 27.7% (n = 648) in GY3.

In the age group under 18, no male or female patients entered inpatient treatment during GY1. In GY2, 33.3% (n = 1) of male and 8.7% (n = 2) of female patients in this age category entered treatment. By GY3, 16.7% (n = 1) of both male and female patients under 18 entered inpatient treatment.

For the 19-24 age group, 25.9% (n = 7) of male patients entered treatment in GY1, increasing to 31.5% (n = 23) in GY2. Female patients in this group saw 50.0% (n = 14) entering treatment in GY1, but this number dropped to 23.9% (n=16) in GY2. In GY3,

the age range shifted to 18-24, where 33.7% (n = 33) of male patients and 30.5% (n = 32) of female patients entered treatment.

Among those aged 25 and older, 27.1% (n = 59) of male patients entered inpatient treatment in GY1. This figure decreased to 16.3% (n = 162) in GY2 and further to 15.1% (n = 161) in GY3. Female patients in this age group showed a decline from 25.5% (n = 49) in GY1 to 9.3% (n = 113) in GY2, with a slight increase to 11.7% (n = 108) in GY3.

These trends indicate a fluctuating yet overall upward movement in inpatient treatment admissions across different sexes and age groups over the observed years.

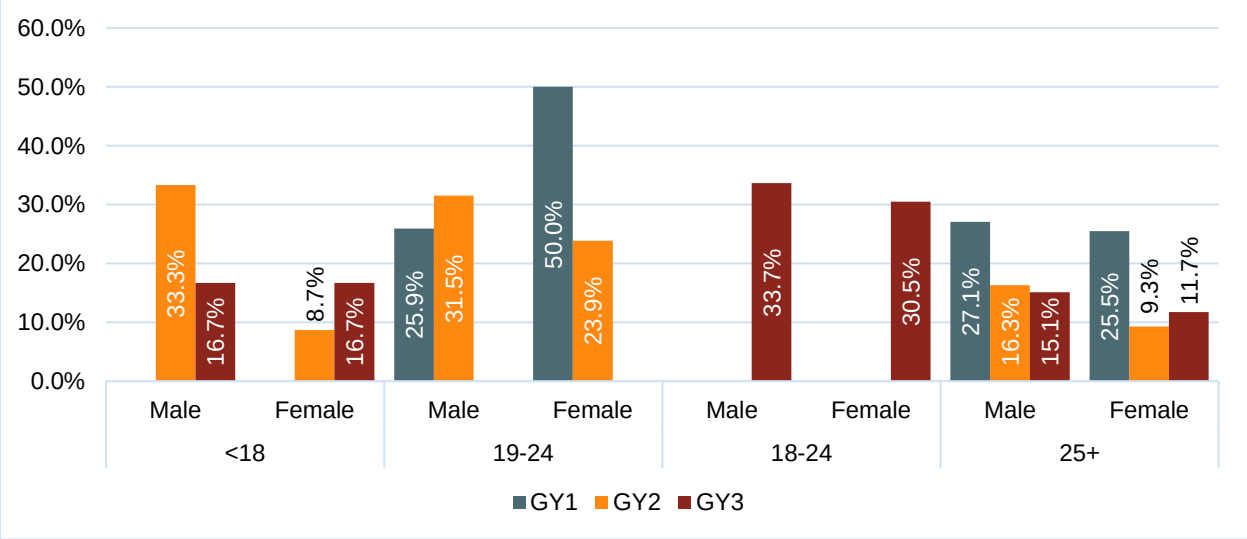

Figure 41: Percentage of MOUD Patients Who Entered Inpatient Treatment by Sex and Age Group (GY1–GY3): Note: GY3 age group was recategorized to 18-24 years old.

Attended Community-Based Events

Grantees were asked to report the number of patients receiving MOUD who participated in community-based events. These events served as platforms to educate attendees and raise awareness about the opioid epidemic, fostering greater community understanding and engagement. Tracking patient participation contributes to understanding the effectiveness of integrating treatment with community outreach to enhance public awareness and support for those affected by OUD. Figure 42 displays the number of MOUD patients who joined community-based events by sex and age group. Note that due to inconsistencies in reporting, counts have been displayed for this category, rather than percentages. Many more MOUD patients were recorded as attending community events than were recorded for each age group. Given that this occurred across multiple grantees and grant years, it is possible that this is due to misunderstanding the reporting requirements, rather than a reporting error itself. Rather than exclude data for GY2 and GY3 entirely, counts have been presented considering these limitations.

In GY1, no male MOUD patients under the age of 18 years joined any community-based events. In GY2, 42 male MOUD patients in this group joined events, which increased to 444 patients in GY3. For female MOUD patients under the age of 18 years, one patient was reported as attending community-based events in GY1. In subsequent years, attendance increased to 34 in GY2 and 67 in GY3.

For MOUD patients between 19 and 24 years of age, the number of male patients who joined community-based events increased from 11 in GY1 to 31 in GY2. Similarly, the number of female patients in this age group who joined these events increased from 15 in GY1 to 42 in GY2. For 18- to 24-year-old MOUD patients, there were 90 male patients who attended community-based events and 115 female patients who attended these events in GY3.

In GY3, 910 male MOUD patients aged 25 years and over attended community-based events in comparison to 187 in GY2 and 26 in GY1. There were 1,896 female MOUD patient attendees in this age group in GY3, in comparison to 243 in GY2 and 37 in GY1.

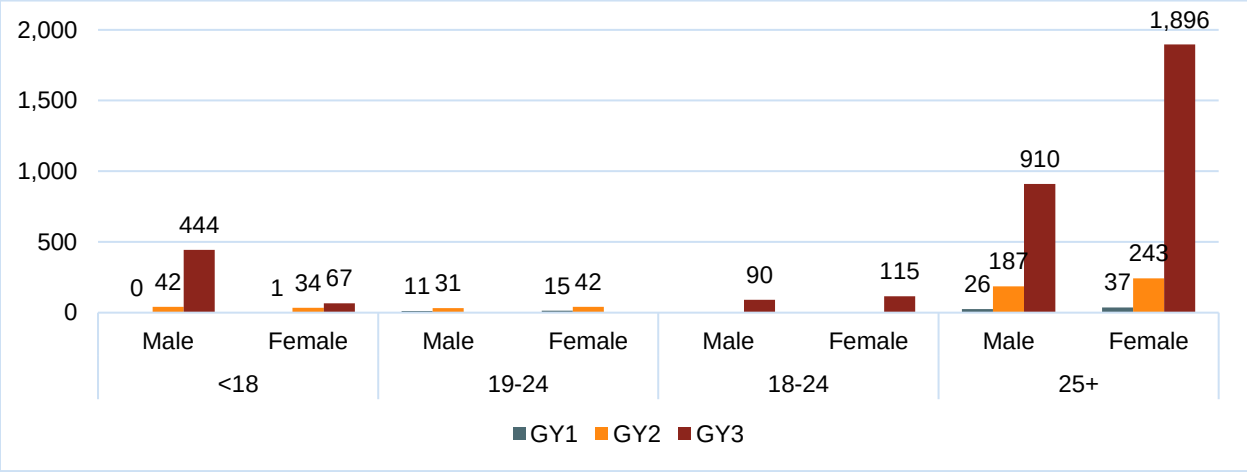

Figure 42: Number of MOUD Patients Who Joined Community-based Events by Sex and Age Group (GY1–GY3): Note: GY3 age group was recategorized to 18-24 years old.

MOUD Patients Who Experienced an Overdose (Fatal or Non-fatal)

The data depicted in Figure 43 illustrates the percentage of MOUD patients who experienced either a fatal or non-fatal overdose, categorized by sex and age group across three grant years. For patients under 18 years, there were no recorded overdoses among MOUD patients in GY1 or GY2, and no female patients in this age group experienced an overdose in any year. However, in GY3, 33.3% (n = 2) of male MOUD patients under 18 reported an overdose.

Among male MOUD patients aged 19-24, the percentage of those who experienced an overdose dropped significantly from 29.6% (n = 8) in GY1 to 5.5% (n = 4) in GY2. Similarly, female patients in the 19-24 age group saw a decline from 35.7% (n = 10) in

GY1 to 14.9% (n = 10) in GY2. The age group for GY3 was redefined to 18-24, where 25.5% (n = 25) of male patients and 10.5% (n = 11) of female patients reported an overdose.

For male MOUD patients aged 25 and older, there was a continuous decline in overdose incidents across the grant years, with 11.5% (n = 25) in GY1, 7.5% (n = 75) in GY2, and 5.8% (n = 62) in GY3. Among female patients aged 25 and older, the percentage of overdoses decreased from 14.6% (n = 28) in GY1 to 6.1% (n = 74) in GY2, followed by a slight increase to 7.6% (n = 70) in GY3.

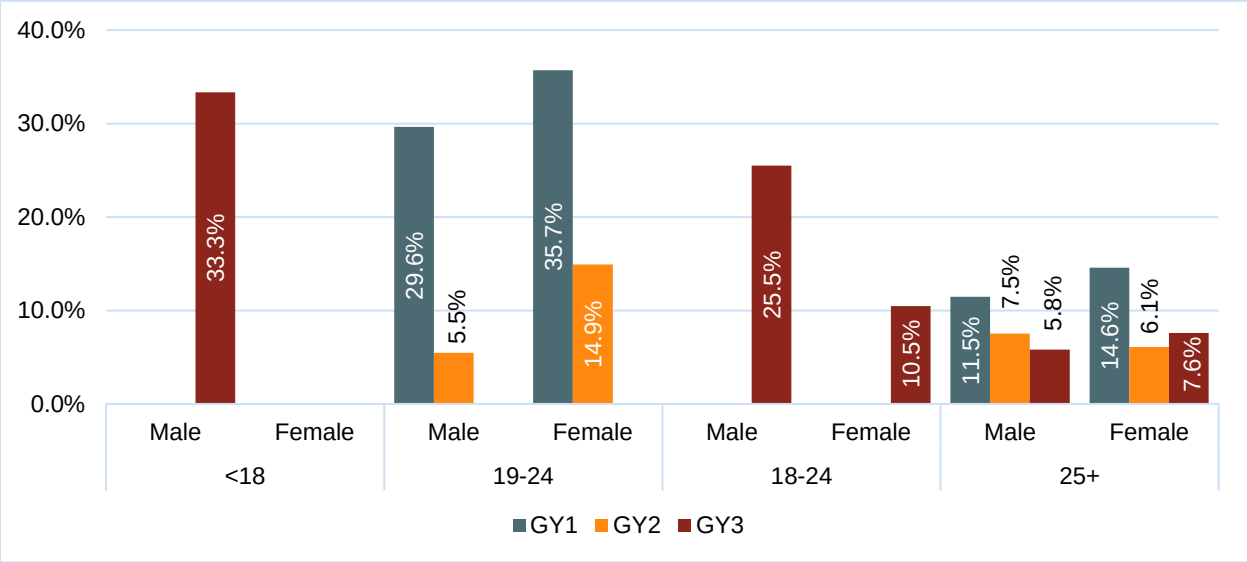

Figure 43: Percentage of MOUD Patients Who Experienced an Overdose by Sex and Age Group (GY1–GY3: Note: GY3 age group was recategorized to 18-24 years old.

Medications Prescribed

This section describes the number and type of MOUD medications and overdose prevention medications that were distributed, procured, or prescribed over the reporting period. This information demonstrates which medications grantees are using and how this shift over the program years. The use of specific MOUD medications, such as buprenorphine, naltrexone, and methadone, play a vital role in effective opioid treatment programs (OTPs). These medications support individuals in achieving and maintaining recovery by addressing the physiological dependence on opioids, reducing withdrawal symptoms, and minimizing cravings.

Buprenorphine is a partial opioid agonist that relieves withdrawal and decreases cravings. It is highly effective and can be used during pregnancy (IHS, n.d.).

Naltrexone is an opioid antagonist that prevents relapses and may reduce cravings. It is recommended for those who are highly motivated or have less severe opioid use

disorders. The overdose risk is high in those who relapse. It is not recommended for use during pregnancy (IHS, n.d.).

Methadone is a full opioid agonist that relieves withdrawal and prevents cravings. It can be used during pregnancy and is considered highly effective. It has a low overdose and abuse potential (IHS, n.d.).

The inclusion of these MOUDs in an OTP is essential as they have been proven to improve patient retention in treatment, decrease the incidence of overdose deaths, and enhance overall recovery outcomes (National Academies of Sciences, Engineering, and Medicine et al., 2019). MOUDs enable comprehensive treatment by complementing behavioral therapies and other supportive interventions, addressing both the physical and psychological aspects of addiction. Their use aligns with EBP, highlighting the need for an integrated approach in combating OUD and fostering long-term recovery.

Figure 44 displays the combined number of prescriptions made for methadone, naltrexone, buprenorphine, and buprenorphine and naltrexone. Buprenorphine prescriptions were only gathered in GY3, methadone and naltrexone prescriptions were only reported in GY2, and combined buprenorphine and naltrexone prescriptions were only gathered in GY1.

Between GY1 and GY2, the number of reported prescriptions for buprenorphine and naltrexone increased from 2,862 to 4,837. For buprenorphine prescriptions alone, there were 6,007 reported in GY3. For methadone, there were 503 total prescriptions reported in GY2, which decreased to 315 in GY3. For naltrexone prescriptions only, there were 432 prescriptions reported in GY2, which nearly doubled to 804 in GY3.

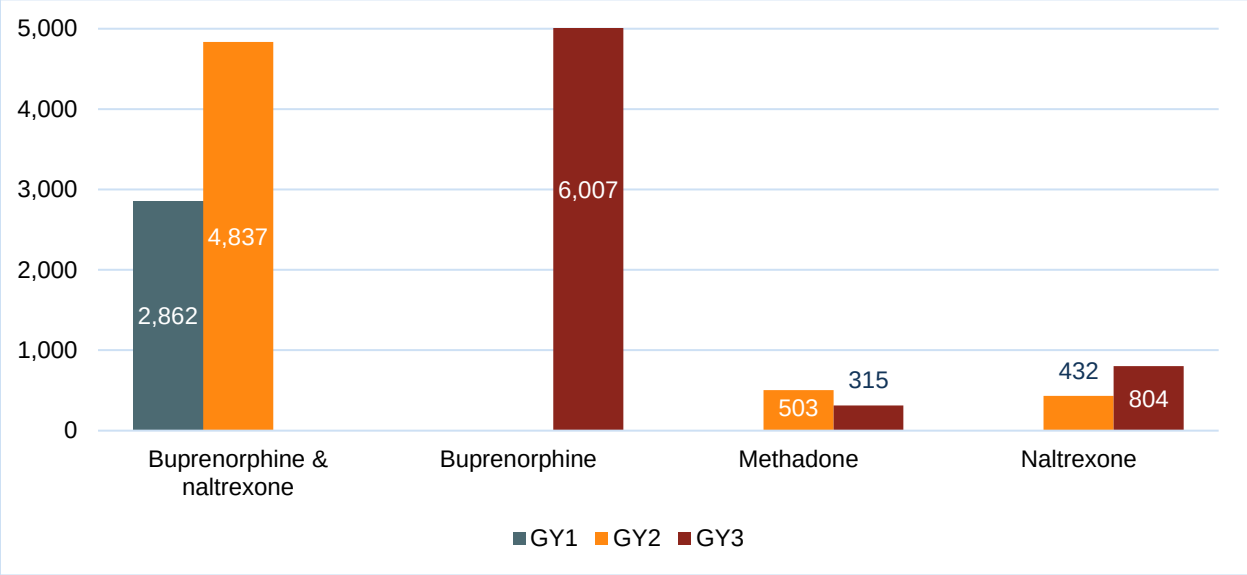

Figure 44: Number of Prescriptions for MOUD Medications (GY1–GY3)

Grantees were asked to report on the number of naloxone units procured and dispensed across the GYs. The number of naloxone units bought by a Tribal program and the number of naloxone units dispensed serve as important indicators for understanding the reach and effectiveness of overdose prevention efforts within a community. Naloxone is an essential tool in combating the ongoing opioid crisis, which disproportionately affects many Indigenous communities. Tracking the units purchased helps gauge the level of resource allocation dedicated to preventing overdoses and preparing for potential surges in opioid misuse. Meanwhile, the number of naloxone units dispensed reveals how actively these resources are being used and accessed by community members, indicating the program's engagement, reach, and the perceived or real need within the community. Together, these metrics provide insight into the community's responsiveness to the opioid crisis, the effectiveness of distribution and awareness programs, and highlight areas where intervention strategies may need adjustment to ensure naloxone is reaching those most at risk. These indicators guide public health strategies to better address opioid-related challenges and support recovery and prevention efforts in Tribal communities.

Figure 45 displays the number of units of naloxone that were procured and dispensed across grant years. In GY1, 856 units of naloxone were procured, which increased to 3,794 in GY2, and to 15,584 units in GY3. A similar trend was observed in the number of naloxone units dispensed with 1,268 dispensed in GY1, 5,183 in GY2, and 19,523 in GY3.

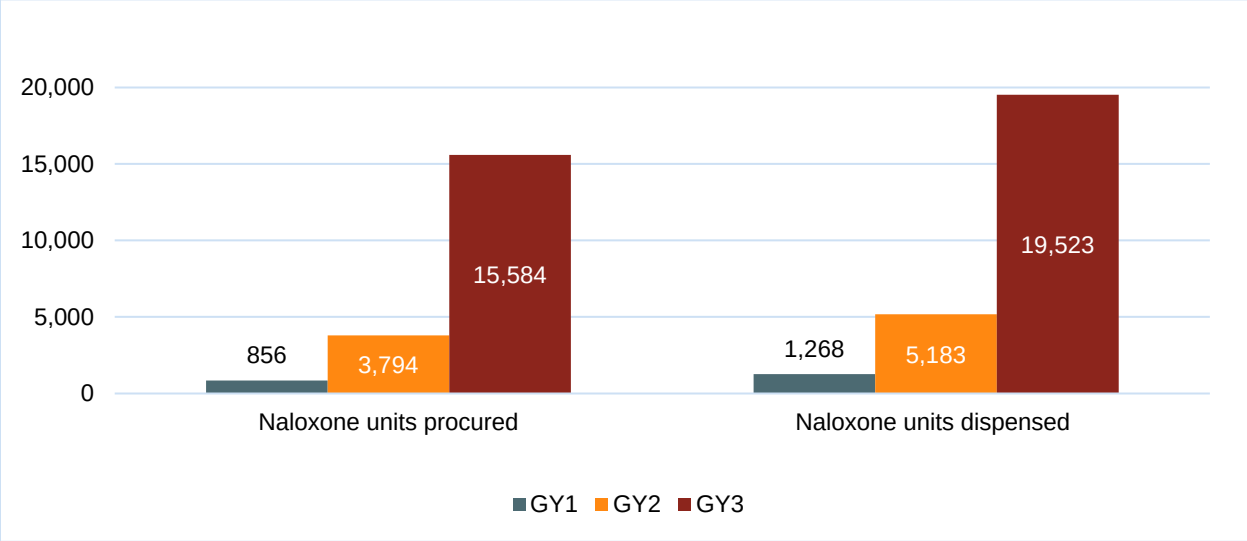

Figure 45: Number of Units of Naloxone Procured and Dispensed (GY1–GY3)

Summary of Findings

In GY3, grantees continued to transition from manual to EHR data collection systems and increased their use of other data collection systems. This is promising and may improve data collection accuracy and reliability in future reporting years. Grantees are using more electronic tools such as Constant Contact and Formstack to collect data, further reducing their reliance on manual data collection. In addition, such platforms are popular because they are typically more flexible and user-friendly than EHR systems.

In terms of patient volume and service type, an increase in the number of patients treated—most without MOUD services—was observed in GY3. These trends suggest that while the adoption of MOUD is steadily increasing, a significant gap remains in ensuring its broader implementation in Tribal opioid prevention and treatment programs. For continued progress, it is essential to expand access to and acceptance of MOUD within Tribal communities. This expansion could address underlying barriers, promote training and education about MOUD's efficacy, and integrate traditionally informed approaches to treatment. This comprehensive strategy would support more balanced and effective treatment outcomes, reduce relapse rates, and contribute to sustainable recovery pathways for individuals struggling with OUD.

Patient satisfaction for those receiving services with and without MOUD has declined sharply from GY2. Overall, less than 20% of patients are satisfied with the services they receive although those receiving services with MOUD have a higher satisfaction rate. This decline in patient satisfaction and the overall low scores need further exploration. Dissatisfaction with treatment is a major barrier to recovery.

In terms of patient demographics, although many patients continue to be in the oldest age group (25 years and older), there was a slight shift in the proportion of patients in this older age bracket to younger ages. This could be an artifact of either a shift in demographic of those with OUD, or an indication that programs are reaching more youth successfully.

The proportion of MOUD patients who achieved sobriety in GY3 continued to decline across all demographics. It is unclear whether this is related to an upswing in clients being served, however it is worth exploring further with grantees. A greater proportion of MOUD patients in GY3 entered inpatient treatment. Inpatient treatment is intensive treatment that provides patients with opportunities to work on their recovery without the distractions of home, and under the guidance of trained professionals. However, it can be difficult for patients to be removed from their families for long periods of time. The increase in inpatient services may be an indicator that access to needed care is increasing among grantees.

In GY3 overdose rates among men in MOUD treatment 18 years and under and 18 to 24 years of age increased. However, grantees noted that they were not confident in their overdose counts, due to tracking/reporting variances across systems, and that these data may not reflect actual changes. Grantees need to be supported to collect accurate outcome data because these data impact the interpretation of the programs, their activities, and their successes. Medication counts also increased in GY3 compared to previous grant years, which may be due to a variety of reasons, such as increased service volumes or improved tracking and monitoring systems. There is also a noticeable shift away from methadone to buprenorphine. Similarly, grantees reported an increase in the procurement and dispensing of naloxone in GY3 compared to previous grant years. This may indicate an increased need for naloxone treatment or more effective and accessible harm-reduction programs, or access to supply. Regardless, further inquiry is needed to better understand the various reasons grantees reported this increase.

Discussion and Recommendations

This discussion covers activities among 35 grantees over the course of three grant years and is organized according to the three objectives of the COIPP and evaluation questions associated with the APR (see Evaluation Plan, page 21). This discussion focuses on the desired short-term outcomes associated with each objective. Although designed to highlight the achievements of grantees, this section will also identify areas in which opportunities exist to further support grantees and enhance COIPP.

Objective 1: Increase Community Awareness and Education

These findings demonstrate how grantees leverage traditionally tailored and family-centered strategies to elevate public awareness within AI/AN communities. Increasing

community awareness and education is aligned with Priority 1 of the technical logic model and the four anticipated short-term outcomes of which include increased awareness of: (1) MOUD/OUD in general, (2) how stigma operates across AI/AN communities and population groups, (3) MOUD use during pregnancy, and (4) how community organizations can collaborate in supporting MOUD services.

Traditionally Relevant Events and Media

One of the most prominent findings was the emphasis on traditionally tailored educational materials that resonated with the values, traditions, and communication styles of the respective AI/AN communities served. This approach helped bridge potential gaps between generic public health messaging and heritage-specific practices, fostering greater trust and receptivity of the information. Furthermore, partnerships with local Tribal leaders and health care providers were shown to amplify the reach and credibility of these educational efforts, reinforcing a shared commitment to combating the opioid crisis at a grassroots level. The quantitative findings demonstrate that more educational events are being held, but by fewer grantees, suggesting that some grantees have found successful approaches and are amplifying their work in this area, while others may have found little traction in the events they held, have scaled efforts back, and or have limited resources to host events at the same level completed in previous years.

As in previous years, the most common educational event topics in GY3 were education and prevention on OUD and accessing local opioid-specific services. By GY3, there were fewer events about safe medication handling and more events focused on naloxone administration. As in previous years, most event participants were 25 to 54 years of age, although there was representation across all age groups, indicating that focused outreach to all age groups was achieved.

Grantees illustrated their traditionally grounded and comprehensive approaches to addressing opioid-related issues in AI/AN communities. These strategies encompassed various activities, from data collection and targeted training for health care and non-health care professionals to implementing traditionally relevant education and training approaches. Grantees' emphasis on integrating local traditional practices, knowledge, and traditions—such as the Choctaw language and community-centered activities—greatly enhanced their community-engagement efforts. Using digital technologies and forming collaborative partnerships has also extended grantees' reach and impact, especially in rural and remote service areas.

In GY3, grantees prioritized additional training on strengthening traditional identity and supporting mental and emotional community health. Further, grantees expanded their harm-reduction training to include HIV and hepatitis C prevention education. To engage youth, grantees continued targeted outreach and developing curricula and teaching approaches designed for this population group in mind. The combination of these activities demonstrates strengthened efforts to integrate heritage and traditional practices with modern risk mitigation and mental-health support techniques. However,

GY3 grantees provided training to fewer houseless individuals, who are among the most vulnerable community members, highlighting an opportunity to develop customized outreach and engagement plans for the most vulnerable community members, including those who are houseless.

Regarding media efforts, grantees increased their use of Instagram, TikTok, and GoodHealthTV—a subscription-based health education network for Tribal nations. They also reported using more “other” media approaches, such as phone calls, emails, brochures, and even LinkedIn. Media efforts employed by grantees demonstrate multi-modal approaches that ensure broad reach to all age groups (e.g., social media platforms often reaching younger audiences and analogue and personal approaches reaching older populations). Grantees are also using more billboard ads, and fewer radio and television ads. Billboard ads ranged in their topics, from advertisements about treatment services, to campaigns about harm-reduction and stigma, and to campaigns focusing on specific populations.

Regarding event attendance, although not significant, there was a moderately positive association between the total number of billboards, radio and TV ads aired, and the number of attendees at education and prevention events. Although there was a slight positive trend for education and prevention events overall, the data does not support a significant consistent link between the number of ads aired and increased attendance at these events.

The results emphasize the adaptability and creativity in campaign strategies, showcasing how some Tribes integrated modern technology with traditional forms of communication. For example, using social media for focused campaigns allowed for real-time interaction and wider outreach, while radio programs provided an avenue for engaging elders who might not use digital platforms. Campaigns often centered around themes of resilience, community strength, and unity, encouraging individuals to seek help and support their peers in recovery journeys.

Recommendations

Track Educational Outcomes

Since grantees focus their efforts on organizing, hosting, and advertising for educational events, it would be helpful to help grantees determine the impact of these efforts. One approach would be for grantees to apply the Theory of Planned Behavior (Ajzen, 1985)—a prominent theory in social psychology linking knowledge, attitudes, beliefs, and perceived behavioral control to a person's intention to perform a behavior—when measuring impact of education provided. For example, pre- and post-educational event surveys can be implemented to assess whether the information shared resulted in a change in participant’s knowledge, attitudes, beliefs, and perceived behavioral control toward performing the desirable outcome. In doing so, grantees will not only be able to confirm their events are making a positive impact but will also be able to use the information to identify areas of programming success or where adjustments are needed. When adopting this approach, grantees should consider the following best practices:

- To maximize survey responses, ask attendees to complete the survey immediately before and after the education event.
- Minimize the number of survey questions asked of participants.
- Minimize the number of open-ended questions, to reduce survey fatigue.
- Pre-test the survey with one or two members of the intended audience beforehand, to ensure it is easy to read and understand.

Explore the Impact of Advertising

Grantees would benefit in learning about media and advertising methods that are most effective and generate the most event participants, especially with rapid changes in media technology. Both evidence- and practice-based information will help in streamlining event advertising processes and contribute to tailoring communication approaches on various topics while factoring in diverse audience groups. To support grantees in this way, IHS could consider developing an advertising campaign toolkit to help them plan, implement, document, and evaluate their advertising campaigns. This would ensure grantees have the resources in place to support their advertising efforts, while also contributing to enhanced data and reporting practices. Helping grantees collect and analyze their own data will help them tailor their approaches and maximize their educational impact. It will also help them determine how best to invest in advertising strategies (e.g., media buys).

Education and Outreach Through Partnerships

Grantees work closely with partners to expand their delivery of services. These partnerships (and others) can be leveraged to increase educational outreach and impact. Grantees may choose to co-host events, advertise events through partner networks, or hold an educational event as part of a larger community event—grantees are already doing this work. Additionally, expanding the APR to capture how many events were held through partnership, and what the partner's role was (e.g., co-host, advertising the event through their network, providing space or other resources) could be considered.

Continued Targeted Outreach

Targeted outreach approaches contribute to reaching the most vulnerable community members who often benefit the most from knowledge of prevention and early intervention. Grantees have demonstrated success in conducting targeted outreach to youth and elders. However, grantees are reaching fewer houseless individuals. Developing a targeted outreach plan to (a) identify the most vulnerable community demographics and (b) developing a plan to provide targeted training and outreach will help ensure the most vulnerable community members are reached.

Enhance Social Media Expertise

Since grantees use a large and growing number of social media platforms, it would be helpful to know their expertise level and whether they have been trained in social media outreach and campaigns. This would identify whether grantees would benefit from social media training and or building expertise. Along these lines, there is an opportunity

for IHS to develop an evidence- and practice-based social media toolkit to assist grantees in their planning, implementation, monitoring, and evaluating their social media practices.

Build a Community of Practice

Through three years of the COIPP, grantees have reported using creative approaches to support their community education and outreach—digital and analogue. There is an opportunity for IHS to bring grantees together to form a community best practice knowledge sharing workgroup whereby grantees can share, borrow, or even collaborate and innovate new community education and outreach practices.

Summary

Grantees continue advancing Objective 1 through exploring new media platforms, refining their media strategies, and adjusting their mix of media approaches. They continue to emphasize integrating AI/AN heritage and traditions into their educational topics and pedagogical approaches.

There is evidence that grantees may be plateauing in terms of their ability to attract community members to their training events. This is an opportunity for grantees to enhance their social media skills, learn from each other, and track the effects of their outreach efforts and partnerships to support their outreach strategies and tactics.

The analysis brought attention to the multifaceted efforts of COIPP grantees, showcasing their capacity to blend educational programming with strategic media outreach to build awareness and foster a supportive environment for addressing the opioid epidemic. These insights highlighted not only the challenges and successes experienced but also provided actionable recommendations for future initiatives aimed at expanding the reach and impact of these essential public health interventions.

Objective 2: Build Traditionally Relevant Support Systems

Opioid treatment and prevention are complex and require multifaceted, coordinated efforts to reach community members. Grantees reported on what practices and strategies they use to empower AI/AN families and what outcomes they have observed.

In GY3, grantees used the following strategies to achieve this objective: (1) strengthened partnership and alliances to provide comprehensive care, (2) family-focused strategies that combine evidence-based care with traditionally relevant delivery, (3) hiring AI/AN staff to increase client comfort, (4) establishing trauma-informed care to address and consider underlying factors contributing to OUD. These strategies have resulted in increased client trust, greater flexibility for clients and families, and enhanced integration of heritage into their programs and delivery (which is thought to reduce stigma, improved the knowledge and attitudes related to OUD and increased community awareness and understanding).

Grantees are offering more group therapy sessions reaching more clients in their service areas. This may be due to their feasibility and popularity. Grantees continue to provide a range of traditional activities such as drumming, singing, and crafts, although there are minor shifts in how common traditional activities are. For example, dancing is becoming more commonly used, but storytelling is less popular than it once was. Such changes are to be expected as grantees adjust to offer novel approaches and activities in alignment with shifting community preferences. Likewise, grantees continue to offer a wide range of religious, spiritual, or faith-based activities to support the whole person and the whole family/community. Grantees reported offering these services to reinforce a sense of belonging, support and healing, and support client/provider connection. Although some grantees do not offer these services directly, these grantees provide referrals to patients, recognizing their importance in supportive recovery. Overall, grantees integrate these services in traditionally appropriate ways that complement patient needs and other program offerings.

Grantees have established various groups to achieve specific objectives, including multidisciplinary coordination groups, advocacy and prevention groups, elder advisory councils, youth advisory councils, and crisis response teams. While these groups continue to play a vital role in supporting their efforts, crisis response teams have increased in number, but the overall participation within each group has declined significantly. Notably, there has been a concerning decrease in youth advisory councils. It remains unclear whether this decline is due to challenges in recruiting youth or other factors not identified in this study. Given the growing number of community members with OUD being served by grantees, further investigation into the reasons behind this decrease is essential.

In GY3, grantees demonstrated more health care professionals, program staff, and community members being trained in trauma-informed care. In addition, compared with previous years, more support services are being offered to staff to alleviate burnout and compassion fatigue. The combination of training and support services demonstrates an investment in program staff, providers, and the wider community. Specifically, grantees are working to provide people with the skills and resources they need to recognize signs of trauma in themselves and others and to help prevent burnout and compassion fatigue. Grantees are offering more in-person training supports, providing supportive leadership and formal services (e.g., employee assistance programs) to prevent burnout. To address compassion fatigue, grantees train staff and leadership on the signs of compassion fatigue, offer learning modules to teach self-care, provide flexible work arrangements and leave policies, and opportunities for staff to connect through wellness and social activities. Analysis revealed that organizations that offer training on trauma-informed care are more likely to have compassion fatigue programming for staff.

Grantees are doing more to care for families offering supportive services—in particular more case management to help families who need a range of services, including counselling and referrals to community programs. Most grantees also offer family-focused care, including inviting family members to group therapy sessions and family

education sessions. Those grantees who are not explicitly offering family-centered care services refer family members to these services, recognizing the impactful role family members play in a healing journey.

Grantees continue to establish MOUs with partners to expand and strengthen their programs. These partnerships also help grantees expand their outreach, connecting with more audiences to share information about OUD treatment and educational events. The total number of MOUs has decreased among grantees, although this may indicate a more focused partnering approach. The reason for the decreased number of partnerships and their impact on the program and client experience is unclear and should be explored.

Recommendations

Establish Guidelines to Ensure High-Quality Heritage Programming

Such guidelines should be based on Indigenous values and practices, and be specific yet flexible, allowing for heritage adaptation. Since traditional practices are often a cornerstone of grantee programming and COIPP itself, providing guidance on best practices will help grantees refine their programs. Sharing anticipated impacts and outcomes may also help grantees gauge the effectiveness of their programming and adjust as needed.

Establish Youth Advisory Councils

Those grantees who have retained or expanded their youth advisory councils may be able to provide guidance and advice to those grantees wishing to establish or reestablish a youth advisory council. Youth insights are important for grantees as more youth are being enrolled in OUD programs and remain a prominent audience for OUD prevention and awareness. Foster Knowledge Sharing Work Groups

There is an opportunity to bridge practice among grantees that would foster knowledge sharing/exchange of ideas, resources, in relation to employee support programs. This would establish a community of best practice while generating collaboration and innovation among grantees.

Explore Partnerships and Their Impact

There is a need to explore the role and impact partnerships have played in grantees' efforts. Moreover, there is a need to understand the change in the number of partnerships over the years and how this has impacted the delivery of the grantees' program. For example, the reduction in these relationships may be an artifact of maturing programs with fewer but stronger partnerships, although it could be a symptom of shrinking partnership opportunities or fits in the community. More information is needed to understand this trend.

Provide Guidance for Establishing Optimal Crisis Response Teams

In GY3, there were more crisis response teams, but fewer participants on each team. Crisis response teams are an important component of an OUD program, and their

effectiveness is in part determined by their capacity in terms of both volume and skill set of staff. Providing guidance on the optimal crisis response team based on community size and service needs can drive grantees decisions around staffing and skillset requirements to meet demand.

Summary

Grantees made progress with training health professionals, staff, and the community on trauma-informed care. Furthermore, they are providing more support services for staff and families. These trends are evident of grantees' commitment to training and offering services that support staff, clients, and the community. However, grantees would benefit from greater participation and engagement in youth advisory councils and more support for their crisis response teams to strengthen their program's community engagement and responsiveness. Finally, to support the ongoing efforts to offer traditional programming to provide a holistic model of care, grantees would benefit from guidance on how to design and implement effective traditional programming that fosters connection and belonging.

Objective 3: Expand Access to MOUD Services

The three years of longitudinal data regarding MOUD services helps inform decisions on resource allocation, ensuring that programs are adequately staffed and equipped to meet the needs of individuals and families managing OUD. Consistent data collection over an extended period allows for trend analysis, which can reveal shifts in the demand for services and emerging needs within the population, facilitating proactive program adjustments. This data-driven approach contributes to more targeted, efficient, and effective treatment programs, enhancing the overall quality of care and promoting sustained recovery for individuals in the community. To demonstrate activities related to Objective 3, grantees reported on how their program provides medication and other evidence-based services for OUD, the program's capacity to provide treatment, and the outcomes recorded. Grantees continue to provide MOUD and teleMOUD services, providing options for patients and improving access through increased teleMOUD services. TeleMOUD services are especially needed in rural and remote areas. To further increase access to care, grantees offer transportation services and services to ensure consistent medication supply.

This data highlights that while more clients overall are receiving treatment each year, the proportion of clients treated without MOUD remains notably higher. Trends imply that while the adoption of MOUD is steadily increasing, a significant gap remains in ensuring its broader implementation in Tribal opioid prevention and treatment programs. For continued progress, it is essential to expand access to and acceptance of MOUD within Tribal communities. This expansion could address underlying barriers, promote training and education about MOUD's efficacy, and integrate traditionally informed approaches to treatment. A comprehensive strategy would support more balanced and effective treatment outcomes, reduce relapse rates, and contribute to sustainable recovery pathways for individuals struggling with OUD.

The number of MOUD prescribers reported and the number of people trained in how to administer MOUD (e.g., naloxone), particularly among law enforcement staff, increased by GY3. In addition, grantees continue to have administrative supports in place, such as policies for OUD referral processes, OUD screening, naloxone distribution, MOUD, OUD wraparound services, and opiate prescribing, as well as harm-reduction programs such as fentanyl strip test distribution and SSPs, and access to clinical tools and resources.

Grantees have enhanced their screening programs, increasing the number of individuals screened for alcohol, suicide, SBIRT, AUD, SUD, and OUD. With the addition of screening programs and services offered, grantees have also increased their overall service capacity, referring more patients to treatment, having more patient enter treatment, and access services after treatment, demonstrating effective coordinated care.

Grantees offer a wide range of EBPs to treat OUD. Both CBT and DBT, as well as the use of Motivational Interviewing techniques, and using CMs remain commonly used approaches. At the same time, EMDR is an emerging EBT practice being implemented by grantees. Further, grantees provided a variety of approaches that were holistic and inclusive of traditional and traditional practices. Combined, these demonstrate grantees' ability to offer a mix of conventional and innovative approaches to meet diverse client needs. Harm-reduction efforts remain strong; grantees distribute naloxone and fentanyl test strips, offer medication disposal systems, and test for HIV and hepatitis C.

Opportunities to expand access to MOUD services still exist and would help to ensure grantees can continue to provide these services. Grantees continue to face limitations such as staffing shortages and access to MOUD prescribers (especially in rural and remote areas), persistent stigma of MOUD treatment within community, insufficient space to provide in-person services, and lack of transportation to services, especially during periods of high-intensity treatment.

Although significant associations were not found in the relationship between the type of EBP received and achievement of sobriety—as well as for the type of traditional programming offered and achievement of sobriety were not found—in this evaluation, such programming is important to meet individual client needs. For example, (as expressed by grantees) providing options of EBPs grounded in heritage and tradition has shown to meet individual patient and family needs through their treatment journey.

However, patient satisfaction with treatment options with and without MOUD has decreased. Patients receiving treatment with MOUD more often report being satisfied with their program, indicating that a holistic model that includes traditional support and medication may be the best for patients. Despite this, some communities continue to resist MOUD, favoring drug-free approaches.

Finally, fatal overdoses have increased over the grant years. However, overdose counts are difficult to accurately collect and record, for a multitude of reasons as previously

described. As such, accurate overdose counts are needed to ensure the correct information is reported.

Recommendations

Expand Anti-Stigma and Educational Programs for MOUD

Patients are more satisfied with treatments that include MOUD. Although MOUD may not be the best approach for all patients, those who are good candidates for this type of therapy should have the option to explore, consider, and decide for themselves. Grantees reported that some community members oppose MOUD because it transfers dependence on one drug to another. Although this is true, the health impacts of the transition are positive for most patients and MOUD offers a safer drug-supported alternative.

Explore Patients/Clients Satisfaction

Grantees could engage with clients to explore the reasons for low satisfaction. Low satisfaction is commonly a result of long wait times, poor transportation services, or other system-level issues. By exploring causes of low satisfaction, grantees can invest in the best areas to support their programs and their patient/client needs.

Understand Patient/Client Motivations

Grantees could engage with patients/clients to explore and understand their motivations for taking their first steps toward sobriety. In doing so, grantees can adapt and tailor their programming and services, that in turn could improve sobriety achievement rates.

Increase Access to Services

Grantees can continue to explore the ways in which they can ensure access and reach of their services, especially in rural and remote areas, or for those living with limited mobility. This can include investments in transportation services through partnerships (e.g., local transportation organizations, existing rideshares, etc.) that could transport patients to and from appointments. Investing in mobile health clinics is another approach to increasing access. Although not always the best option for remote areas, continuing to expand Telehealth services is another way to close the access gap.

Monitor Staff Well-being

Grantees are working hard to support staff well-being. Monitoring staff well-being through surveys, one-on-one engagement, and staff group sessions can offer insights into the current climate. These insights may be used to implement, adopt, and adapt strategies that could promote the staff's well-being, which contributes to stronger support teams.

Develop Recruitment and Retention Plans

Tied to well-being, developing recruitment and retention plans are key to ensuring continued services and helping reduce staff turnover. Examples of strategies include providing recruitment incentives, bonuses, honoring and recognizing achievements, and even offering flexible work hours that contribute to work-life balance.

Increase Reliability and Access to Overdose Data
Reliable overdose data is difficult to obtain, but essential for COIPP. The IHS COIPP program can work with grantees to connect them with existing reliable and accessible overdose data. There is also opportunity for IHS and grantees to work with their respective regions (e.g., Tribal, city, state, or federal level) to determine what data exists, what data is needed and develop data sharing agreements and strategies to ensure the most reliable data is used to inform programs.

Summary
Grantees faced obstacles in their efforts to meet treatment needs and leverage MOUD to reduce overdose-related deaths. Results such as the significant decline in SBIRT screenings and the persistence of logistical and attitudinal barriers underscore the complexities inherent to any effective strategy for addressing the opioid crisis. These findings demonstrate an urgent need for a comprehensive, heritage-sensitive approach that not only bolsters MOUD infrastructure and addresses systemic barriers but also actively dismantles barriers rooted in societal perceptions of OUD and harm-reduction. To reach the desired outcomes described, the path forward involves not only broadening MOUD offerings but also deeply embedding Tribal values, heritage, and treatments into OUD initiatives.

Overview of Grantees
This section summarizes the key findings and recommendations as they pertain to organizational capacity of grantees and service population and data sources used by grantees.

Organizational Capacity
The success of OUD prevention and treatment programs is often tied to the development of strategic relationships with government and private organizations. However, many Tribes face significant challenges with recruiting staff, especially in rural and remote locations. In addition, this evaluation revealed how external partnerships contributed to the overall success of the project, showcasing the importance of collaborative efforts in addressing staffing shortages, which can contribute to enhancing opioid prevention and treatment within across Tribal communities.

This section describes the organizational capacity of COIPP grantees over the three program years for: (1) organizational capacity and staffing infrastructure, (2) volunteers and service providers, and (3) service expansion and adaptability.

Organizational Capacity and Staffing Infrastructure
In GY3 more grantees reported having a long-term coordinator or director, an indicator of program stability. However, grantees also reported having fewer staff operating at full-time equivalency. It is unknown if this is due to resource constraints or staff turnover. For the first time, GY3 grantees reported on their staffing structure. The most common staff type employed across grantees were behavioral health and mental health professionals, administrative staff, paraprofessionals, and nurses—a reflection of the

clinical and administrative skills needed to operate OUD programs. At the same time, grantees also employed teachers, chaplains, law enforcement, and health education staff, rounding out the clinical and administrative skillsets with community-focused professionals.

Volunteers and Service Provision

Grantees continued to report that most volunteers in GY3 consisted of non-licensed staff, such as Tribal elders/traditional practitioners, teachers, and law enforcement. Yet, by GY3 there was a decrease in the number of volunteers, particularly among physicians, nurses, and behavioral health and mental health professionals. Since GY3 was the first year that grantees reported on their staffing make-up, it is unclear whether this drop in volunteer clinicians was accompanied by an increase in paid staff clinicians. Staff clinicians, although expensive, are preferable as they can provide more dedicated, consistent, and reliable patient support.

Patient Demographics

In GY3, grantees reported an increase in the proportion of clients living with pregnant persons or new mothers and children. This finding has notable implications for community and social service planning. This marked growth suggests a shift in household dynamics that may require additional support structures to address the unique needs of these family units. Services related to maternal and child health, early childhood development, and family support may need to be expanded or adapted to accommodate this change. Additionally, this demographic shift could indicate a potential increase in demand for resources such as childcare, prenatal, and postnatal care, and nutritional assistance programs. Understanding and responding to these changes is crucial for policymakers and service providers to ensure the well-being of mothers and children and to promote positive outcomes for families within the community.

Service Expansion and Adaptability

By GY3, more grantees are offering both direct behavioral health services and contracted services, building a flexible multidisciplinary team. The use of contract providers for direct behavioral health services continues to be an invaluable resource for grantees. At the same time, grantees expanded their MAT offerings to address OUD and broader SUD needs, with some offering integrated MAT and MOUD for a more opioid-specific focus. Notably, GY3 grantees reported a more opioid-specific focus in their treatment approach. This evolution in service provision demonstrates the grantees' adaptability to the changing needs of their communities and their commitment to addressing the complex challenges of OUD and SUD.

In addition, half of grantees continue to offer peer support services, reflecting commitment to community-based support through peer-led interventions. However, SUD counseling dropped in GY3, which may reflect a shift whereby grantees are focusing more on targeted approaches that combine multiple types of care, rather than separate.

The service options provided in GY3 shifted away from individual counseling to group counseling, although individual counseling is still a mainstay of grantee programs. Finally, in GY3 grantees began using IOP services—a promising model that provides intensive in-community treatment for those individuals who prefer not to leave the community for care.

MOUD Patient Outcomes

MOUD patient outcome trends highlight areas for data collection and service provision improvement. In GY3, grantees reported that fewer patients achieved sobriety across all age groups. However, more patients entered inpatient treatment, indicating that although sobriety achievement decreased, more individuals are receiving inpatient treatment. With the increase in inpatient treatment, sobriety achievement may decrease in the future. In GY3, more MOUD patients attended community-based events, demonstrating grantee commitment to supporting MOUD outpatients. Finally, overdose rates for MOUD patients decreased from GY1 to GY2, but increased again from GY2 to GY3. There appears to have been a sharp increase in GY3 in the number of male MOUD patients under 18 years of age who have had an overdose. However, grantees noted that they were not confident in their overdose counts, due to tracking/reporting variances across systems, and that these data may not reflect actual changes.

Recommendations

Create Multidisciplinary Professional Teams

By integrating both in-house and contracted professionals, OUD programs can create a well-rounded, multidisciplinary team. This collaborative approach leverages various perspectives and treatment methods, contributing to a comprehensive care plan that addresses the complex nature of OUD. This can lead to better outcomes as patients benefit from a broad spectrum of knowledge and therapeutic strategies. Contracting specialized providers can also be a more cost-effective strategy, rather than maintaining a full roster of diverse specialists on permanent staff. This would allow OUD programs to allocate resources efficiently and invest in expert care as needed without incurring the long-term expenses required for full-time employees.

Ensure Diversity in Specialized Care

The combined efforts of direct service and contracted providers result in improved patient outcomes. The availability of diverse, specialized treatment options and consistent patient engagement fosters higher retention rates in programs, which can contribute to reducing the likelihood of relapse and promote sustained recovery. When patients feel supported by a responsive, competent team that can address their unique set of needs, they are more likely to adhere to treatment plans and achieve positive results. The integration of direct service clinicians and contracted providers enriches OUD programs by providing comprehensive, continuous, and adaptable care. This combination supports the program’s ability to respond to varying patient needs, ensures treatment flexibility, leverages diverse expertise, and contributes to efficient resource management—all essential for the success of OTPs.

Understand Dynamic Shifts in Staffing and Services

Recognizing grantees are reporting shifts in the services provided and the mixed and total number of staff and volunteers in their programs, it is important to understand the context of these shifts to support programs effectively. Firstly, there is an opportunity to explore grantees increases or decreases in staff and volunteers, especially in relation to meeting community service needs. Secondly, an exploration to better understand shifts in service provision across grantees is recommended. Combined, this information would provide a more holistic understanding of the relationship between staffing/volunteers and the ability to provide services.

Summary of Service Population and Data Sources

The findings of this evaluation reveal significant challenges and inconsistencies in both the sources and the quality of data collected. One major issue is grantees often collect data across a variety of sources, each using different collection methods. This leads to variability in how the data is recorded and reported. Additionally, differences in staffing—such as variations in training, expertise, and capacity—further contribute to inconsistencies in reporting. There is an opportunity for IHS to explore ways in which grantees currently report on data and consider offering technical assistance and training. This would contribute to more uniformly collected data across grantees, which later enhances the ability to analyze, interpret, and provide recommendations for future programmatic success.

Another opportunity exists in reporting overdose counts. Through this evaluation, inconsistent reporting was evidenced by the disparity between reported overdose counts across grantees. Such inconsistencies not only compromise the reliability of the data but also challenge the validity of the conclusions. For example, one grantee reported a catchment area of less than 20,000 and a non-fatal overdose count that comprises 9,530 or 77.3% of all non-fatal overdoses reported for that grant year. In this example, there is concern about the accuracy and representativeness of the data. Similarly, the wide variation in reported overdose counts among grantees with differing catchment area sizes underscores the need for a standardized and validated data collection approach.

Furthermore, the COIPP APR has been slightly modified from year-to-year. Based on evaluation findings in this report, there is an opportunity to map existing APR questions across each grant year and further enhance the instrument to ensure it aligns with the essence of the evaluation questions, priorities, and outcomes. This is an opportunity to refine, enhance, and consider where more information is needed and where some information may no longer be needed. Additionally, exploring alternative sources of publicly available data, such as overdose counts, could provide a more consistent basis for reporting and evaluation. Finally, while the existing data offers valuable insights, there is an opportunity to continue to build upon the current evaluation contributing to a more robust and systematic approach.

Conclusion

The IHS Office of Clinical and Preventive Services, Division of Behavioral Health, awarded 35 grants to Tribes, Tribal organizations, and UIOs to combat the opioid epidemic in Indian Country, establishing the COIPP. This program is part of the Department of Health & Human Services' five-point strategy to fight the opioid overdose epidemic in America.

The COIPP grantees are implementing innovative approaches to address the opioid crisis in AI/AN communities. The program has 3 objectives:

- **Increase Community Awareness and Education:** Elevate public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.
- **Build Traditionally Relevant Support Systems:** Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities.
- **Expand Access to MOUD Services:** Reduce unmet treatment needs and opioid overdose-related deaths through MOUD.

The findings from the third year of the COIPP offered valuable insights into the evolving landscape of opioid intervention efforts among the 35 grantees. The overall findings, organized by objective follow.

Objective 1—Increase public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs.

During GY3, grantees continued to expand their education and awareness campaigns, reaching more community members through targeted outreach to youth and families. They continued to rely heavily on digital outreach and digital platforms for education and outreach. However, as their programs mature, they are slowly shifting away from platforms such as Facebook and YouTube to platforms such as TikTok and Instagram, to reach youth. Simultaneously, the report continued efforts to reach older populations through Tribal newsletters, phone calls and word-of-mouth. Grantees also work closely with partners to help spread their messages and recruit community members for education and harm-reduction training, leveraging their networks and infrastructure. To support further growth in this area and to help grantees be more strategic in their education and outreach planning, social media and education campaign training is needed. Moreover, this is a great opportunity to develop a community of practice for grantees to share their outreach and education approaches and techniques. Finally, developing post-education surveys to track effectiveness and provide grantees with the necessary information to continually improve their educational programming and outreach, would help determine the impact of education on community behavior.

Objective 2—Create comprehensive support teams to strengthen and empower AI/AN families.

Through strengthening partnerships, delivering traditionally informed EBPs, hiring AI/AN staff, providing trauma-informed care, and supporting staff well-being, grantees have strengthened their programs. Grantees use a wide range of EBPs to support clients with OUD and their families, including many traditionally relevant approaches. Moreover, they offer numerous heritage-based and traditional healing approaches in combination with these EBPs, or to supplement them, including sweat lodges, drumming, traditional crafting, equine therapy, and singing. These are often offered through partnerships with other community organizations and with volunteer support. These services help patients feel more connected to their communities and support patient-provider relationships, building trust and understanding.

In GY3, grantees focused on training staff, health care professionals, and community members on trauma-informed care. This demonstrates an increased investment in providing teams with the knowledge and skills they need to holistically and compassionately support patients and families by understanding the role of trauma and intergenerational trauma in OUD. Moreover, trauma-informed care training also helps program staff recognize how the work they do can directly affect them as staff and care providers. This training, along with interventions and programs that grantees offered staff to prevent burnout and compassion fatigue, are important investments in staff.

However, grantees continued to struggle with retaining staff and backfilling positions. This is especially true for those in rural areas. Moreover, the number of clinical volunteers declined, putting even more pressure on existing staff, which could lead to further burnout, leaving grantees in a cycle of hiring new staff as old staff leave due to burnout. Hiring bonuses, flexible work hours, and other staffing strategies are needed to ensure that grantees have enough staff. This will support patient and family experience, coordination and continuation of care, and quality of care.

Objective 3—Reduce unmet treatment needs and opioid overdose-related deaths through the use of MOUD.

Grantees continued to offer MOUD and teleMOUD to address the critical issue of unmet treatment needs and reduce opioid overdose-related deaths. This approach recognizes the effectiveness of MAT in combating opioid addiction and its associated risks. By providing access to FDA-approved medications such as methadone, buprenorphine, and naltrexone, grantees can help individuals manage their OUD more effectively.

The implementation of teleMOUD services is particularly crucial in expanding access to treatment, especially in rural or underserved areas where in-person health care may be limited. This technology-driven approach allows patients to receive counseling, medication management, and ongoing support from the comfort and safety of their homes, reducing barriers to treatment such as transportation issues or stigma associated with in-person visits to addiction treatment centers.

By combining MOUD with counseling and behavioral therapies, grantees are offering a comprehensive treatment approach that addresses both the physical and psychological aspects of opioid addiction. This holistic strategy not only helps in reducing cravings and withdrawal symptoms but also supports long-term recovery and reduces the risk of relapse and overdose.

Furthermore, grantees are working to increase awareness about MOUD among health care providers, community organizations, and the public. This educational effort aims to reduce stigma, increase acceptance of MOUD as a legitimate and effective treatment option, and encourage more individuals struggling with OUD to seek and engage in treatment. Through these concerted efforts, grantees are making significant strides in reducing unmet treatment needs and, consequently, lowering the incidence of opioid overdose-related deaths in their communities.

In GY3 the number of grantees offering MOUD declined slightly, although more grantees offered teleMOUD, demonstrating a shift from in-person to more telehealth services. However, there is an opportunity for more grantees to offer both in-person and teleMOUD services. This is important as more patients who receive services with MOUD or teleMOUD report being satisfied with their care than those receiving services without MOUD. Overall, across both types of services, patient satisfaction rates were and remain low highlighting an opportunity to learn more about patient and family satisfaction to improve quality of care and ensure that all programs are responsive to evolving patient and family needs.

In GY3, grantees saw more patients, referred more patients to inpatient care, and provided follow-up care to more patients. They did this while struggling with staffing, demonstrating better outreach and more efficient patient placement and support. However, sobriety achievement fell in GY3 while overdose rates climbed. Sobriety achievement was not dependent on what type of therapy patients received but was overall down across all types. This could indicate that there was an increase in relapses. However, this is speculative. Regardless, further investigation into sobriety achievement is needed. Likewise, the rise in overdose (fatal and not fatal) requires investigation. Overdose rates are challenging to accurately count, but grantees need support obtaining accurate overdose data to direct resources and respond appropriately.

GY3 marked a significant milestone for the 35 programs as they experienced substantial growth and enhancement in their community impact. Building upon strategies developed during the first two grant years, the grantees in GY3 notably increased their program capacity. This expansion was further facilitated by resolving pandemic situations and the lifting of restrictions, which allowed for greater flexibility in service provision.

Many programs made remarkable strides in several key areas. They intensified their community outreach efforts, successfully extending their reach to more individuals and

families in need. The scope of programming was broadened, offering a more comprehensive range of services to address diverse community needs. As a result, the programs were able to treat an increased number of patients and families, providing vital support and care to those who needed it most.

Moreover, recognizing the importance of a strong and capable workforce, the programs made significant investments in their staff. This focus on staff development and support not only enhanced the quality of services provided but also contributed to the overall sustainability and effectiveness of the programs. The combination of these factors—improved outreach, expanded programming, increased patient care, and staff investment—positioned the programs for even greater success and impact in the future.

Taken together, the three years of COIPP data paint a picture of resilience and innovation among the grantees. By combining modern, evidence-based interventions with traditionally tailored practices, the program has achieved remarkable growth, with opportunities for even greater impact in future years. Addressing the persistent challenges of stigma and data clarity will be key in ensuring the continued success of this vital initiative.

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Appendices

Appendix A: Tables

Section A

Table 11: Number of Staff Hired (GY1–GY3)

	Count			Average		
	GY1	**GY2**	**GY3**	**GY1**	**GY2**	**GY3**
Number of staff hired	147.0	-	-	4.2	-	-
Number of staff hired to date	-	205.0	-	-	6.0	-
Number of full-time staff	-	-	181.1*	-	-	5.2
*Note: In GY3, three grantee sites reported the number of full-time staff as decimal values instead of whole numbers. This may indicate a discrepancy in some grantees' interpretation of the question with some reporting full time (e.g., 0.72) and others reported whole numbers such as 3.						

Section B

Table 12: Percentage of Grantees that Performed Training Events by Type (GY1–GY3)

	Percentage			Total Performed			YoY Percentage Change	
Grant program year	**GY1**	**GY2**	**GY3**	**GY1**	**GY2**	**GY3**	**GY1—GY2**	**GY2—GY3**
Education and prevention on OUD	91.4%	91.4%	88.6%	32	32	31	0.0%	-3.1%
Accessing local opioid-specific services	57.1%	62.9%	71.4%	20	22	25	10.0%	13.6%
Safeguarding controlled prescription medications	37.1%	47.1%	48.6%	13	16	17	26.7%	3.2%
Properly disposing of unused, controlled prescription medications	51.4%	51.5%	40.0%	18	17	14	0.2%	-22.4%
Recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone	71.4%	80.0%	82.9%	25	28	29	12.0%	3.6%
Other topics	54.5%	63.6%	54.3%	18	21	19	16.7%	-14.7%
Note: Negative values in this context signify a downward trend or reduction in activity.								

Table 13: Number of Participants by Training Event Type (GY1–GY3)

	Count			Average			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1 – GY2	GY2 – GY3
Education and prevention on OUD	11,114	23,668	28,921	347.3	739.6	826.3	113.0%	22.2%
Accessing local opioid-specific services	3,831	11,238	14,951	182.4	488.6	427.2	193.3%	33.0%
Safeguarding controlled prescription medications	3,297	8,569	5,748	253.6	504.1	164.2	159.9%	-32.9%
Properly disposing of unused, controlled prescription medications	3,060	12,029	5,465	170.0	668.3	156.1	293.1%	-54.6%
Recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone	2,310	10,310	13,069	88.8	368.2	373.4	346.3%	26.8%
Note: Negative values in this context signify a downward trend or reduction in activity.								

Table 14: Number and Percentage of Grantees that Reported Having Volunteers by Type (GY2—GY3)

	Count		Percentage		Total Responses		YoY Percentage Change
	GY2	GY3	GY2	GY3	GY2	GY3	GY2—GY3
Physicians	8	1	24.2%	2.9%	33	35	-88%
Administrative Staff	-	3	-	8.6%	-	35	-
Nurses	12	3	36.4%	8.6%	33	35	-76.4%
BH/MH Professionals	15	3	44.1%	8.6%	34	35	-80.5%
Paraprofessionals	-	3	-	8.6%	-	35	-
Health Education Staff	-	3	-	8.6%	-	35	-
Chaplains or Spiritual/Leaders	7	3	21.2%	8.6%	33	35	-59.4%
Church-Based Staff	2	4	6.1%	11.4%	33	35	86.9%
Tribal Elders/Traditional Practitioner	12	8	36.4%	22.9%	33	35	-37.1%
Teachers or School Leaders	5	4	15.2%	11.4%	33	35	-25.0%
Law Enforcement Officers	5	5	14.7%	14.3%	34	35	-2.7%
Data Coordinators	-	0	-	0%	-	35	-
Other	-	6	-	17.1%	-	35	-

Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

Section C

Table 15: Frequency of Media Campaign Tools Used by Type (GY1–GY2)

	% Yes			% No			Count Yes			Count No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Facebook	91.4%	100.0%	94.3%	8.6%	0.0%	5.7%	32	35	33	3	0	2	35	35	35	9.4%	-5.7%
Tribal Website	55.9%	71.9%	64.7%	44.1%	28.1%	35.3%	19	23	22	15	9	12	34	32	34	28.6%	-10.0%
Instagram	42.4%	50.0%	54.5%	57.6%	50.0%	45.5%	14	16	18	19	16	15	33	32	33	17.9%	9.1%
YouTube	23.5%	35.5%	33.3%	76.5%	64.5%	66.7%	8	11	10	26	20	20	34	31	30	50.8%	-6.1%
GoodHealthTV	5.7%	18.8%	27.3%	94.3%	81.3%	72.7%	2	6	9	33	26	24	35	32	33	228.1%	45.5%
Podcast	14.7%	20.7%	16.7%	85.3%	79.3%	83.3%	5	6	5	29	23	25	34	29	30	40.7%	-19.4%
TikTok	8.8%	12.9%	13.8%	91.2%	87.1%	86.2%	3	4	4	31	27	25	34	31	29	46.2%	6.9%
Other	48.6%	28.6%	51.4%	51.4%	71.4%	48.6%	17	10	18	18	25	17	35	35	35	-41.2%	80.0%
Note: Negative values in this context signify a downward trend or reduction in activity.																	

Section D

Table 16: Number and Average of Group Therapy Sessions and Attendees (GY1–GY3)

	Count			Average			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Group Sessions	2622	1503	2265	81.9	44.2	64.7	-42.7%	50.7%
Group Attendees	1362	3152	7404	42.6	92.7	211.5	131.4%	134.9%
Note: Negative values in this context signify a downward trend or reduction in activity.								

Table 17: Number and Percentage of Grantees Performing Traditional Activities by Type (GY1–GY3)

	% Yes			% No			Count Yes			Count No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Traditional crafts	67.6%	88.6%	87.9%	32.4%	11.4%	12.1%	23	31	29	11	4	4	34	35	33	30.9%	-0.8%
Drumming	57.6%	82.9%	84.4%	42.4%	17.1%	15.6%	19	29	27	14	6	5	33	35	32	43.9%	1.8%
Storytelling	81.8%	84.8%	74.2%	18.2%	15.2%	25.8%	27	28	23	6	5	8	33	33	31	3.7%	-12.6%
Singing	61.3%	85.3%	71.9%	38.7%	14.7%	28.1%	19	29	23	12	5	9	31	34	32	39.2%	-15.7%
Songs	63.6%	70.6%	71.9%	36.4%	29.4%	28.1%	21	24	23	12	10	9	33	34	32	10.9%	1.8%
Dancing	51.5%	61.8%	65.6%	48.5%	38.2%	34.4%	17	21	21	16	13	11	33	34	32	19.9%	6.3%
Language	69.7%	60.6%	59.4%	30.3%	39.4%	40.6%	23	20	19	10	13	13	33	33	32	-13.0%	-2.0%
Traditional games	43.8%	50.0%	50.0%	56.3%	50.0%	50.0%	14	16	15	18	16	15	32	32	30	14.3%	0.0%
Equine therapy	23.5%	14.7%	23.3%	76.5%	85.3%	76.7%	8	5	7	26	29	23	34	34	30	-37.5%	58.7%
Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.																	

Table 18: Number and Percentage of Grantees Who Performed Spiritual/Religious/Faith-based Activities by Type (GY1–GY3)

	% Yes			% No		Count Yes			Count No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Traditional practices	79.4%	88.2%	88.2%	20.6%	11.8%	11.8%	27	30	30	7	4	4	34	34	34	11.1%	0.0%
Therapy/ counseling (not spiritual)	64.7%	75.8%	87.9%	35.3%	24.2%	12.1%	22	25	29	12	8	4	34	33	33	17.1%	16.0%
Transportation	57.6%	70.6%	71.9%	42.4%	29.4%	28.1%	19	24	23	14	10	9	33	34	32	22.6%	1.8%
Prayer	71.9%	57.6%	65.6%	28.1%	42.4%	34.4%	23	19	21	9	14	11	32	33	32	-19.9%	14.0%
Therapy/ counseling (spiritual)	54.8%	55.9%	55.2%	45.2%	44.1%	44.8%	17	19	16	14	15	13	31	34	29	1.9%	-1.3%
Spirituality groups	32.3%	48.5%	46.7%	67.7%	51.5%	53.3%	10	16	14	21	17	16	31	33	30	50.3%	-3.8%
Shelter	10.0%	26.5%	32.3%	90.0%	73.5%	67.7%	3	9	10	27	25	21	30	34	31	164.7%	21.9%
Pastoral care	12.9%	15.2%	13.8%	87.1%	84.8%	86.2%	4	5	4	27	28	25	31	33	29	17.4%	-9.0%
Clergy/chaplain support	12.1%	9.1%	13.8%	87.9%	90.9%	86.2%	4	3	4	29	30	25	33	33	29	-25.0%	51.7%

Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

Table 19: Number and Percentage of Grantees Who Facilitated the Formation of Groups by Type (GY1–GY3)

	% Yes			% No			Yes			No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1–GY2	GY2 – GY3
Youth advisory councils	28.6%	25.7%	14.7%	71.4%	74.3%	85.3%	10	9	5	25	26	29	35	35	34	-10.0%	-42.8%
Elder advisory councils	17.1%	25.7%	26.5%	82.9%	74.3%	73.5%	6	9	9	29	26	25	35	35	34	50.0%	2.9%
Multidisciplinary coordination groups	54.3%	54.3%	50.0%	45.7%	45.7%	50.0%	19	19	17	16	16	17	35	35	34	0.0%	-7.9%
Advocacy/ prevention groups	45.7%	37.1%	38.2%	54.3%	62.9%	61.8%	16	13	13	19	22	21	35	35	34	-18.8%	2.9%
Crisis response teams	34.3%	14.3%	17.6%	65.7%	85.7%	82.4%	12	5	6	23	30	28	35	35	34	-58.3%	23.5%

Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

Section E

Table 20: Percentage of Grantees Offering EBPs by Type (GY1–GY3)

	% Yes			% No			Yes			No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
CBT	78.8%	85.7%	88.6%	21.2%	14.3%	11.4%	26	30	31	7	5	4	33	35	35	8.8%	3.3%
MI	78.8%	88.6%	88.2%	21.2%	11.4%	11.8%	26	31	30	7	4	4	33	35	34	12.4%	-0.4%
DBT	51.5%	51.4%	57.6%	48.5%	48.6%	42.4%	17	18	19	16	17	14	33	35	33	-0.2%	12.0%
CM	53.1%	47.1%	51.4%	46.9%	52.9%	48.6%	17	16	18	15	18	17	32	34	35	-11.4%	9.3%
EMDR	-	-	39.4%	-	-	60.6%	-	-	13	-	-	20	-	-	33	-	-
CRA	28.1%	33.3%	36.4%	71.9%	66.7%	63.6%	9	11	12	23	22	21	32	33	33	18.5%	9.1%
MM	28.1%	37.5%	34.3%	71.9%	62.5%	65.7%	9	12	12	23	20	23	32	32	35	33.3%	-8.6%
MET	24.2%	32.4%	28.6%	75.8%	67.6%	71.4%	8	11	10	25	23	25	33	34	35	33.5%	-11.7%
ABFT	21.2%	17.6%	11.4%	78.8%	82.4%	88.6%	7	6	4	26	28	31	33	34	35	-16.8%	-35.2%
Other	37.1%	31.4%	17.1%	0.0%	0.0%	0.0%	13	11	6	-	-	-	35	35	35	-15.4%	-45.5%

Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

Table 21: Number and Percentage of Grantees with Policies, Procedures, or Protocols in Place (GY1–GY3)

	% Yes			% No			Yes			No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
OUD referral process	88.6%	97.1%	97.1%	11.4%	2.9%	2.9%	31	33	33	4	1	1	35	34	34	9.6%	0.0%
OUD screening	74.3%	97.1%	91.4%	8.6%	2.9%	8.6%	26	33	32	3	1	3	35	34	35	30.7%	-5.8%
Naloxone distribution	82.9%	91.2%	91.2%	17.1%	8.8%	8.8%	29	31	31	6	3	3	35	34	34	10.0%	0.0%
MOUD	85.7%	87.9%	88.2%	14.3%	11.4%	12.1%	30	29	30	5	4	4	35	33	34	2.5%	0.4%
OUD wraparound services	71.4%	70.6%	73.5%	28.6%	28.6%	26.5%	25	24	25	10	10	9	35	34	34	-1.2%	4.2%
Fentanyl test strip distribution	31.4%	61.8%	67.6%	68.6%	38.2%	32.4%	11	21	23	24	13	11	35	34	34	96.5%	9.5%
Other	47.1%	27.3%	60.6%	52.9%	72.7%	39.4%	16	9	20	18	24	13	34	33	33	-42.0%	122.2%
SSP	25.7%	32.4%	29.4%	74.3%	67.6%	70.6%	9	11	10	26	23	24	35	34	34	25.8%	-9.1%
Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.																	

Table 22: Number of Universal Alcohol, Suicide, and SBIRT Screenings (GY1–GY3)

	Count			Average			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Universal Alcohol Screenings	174547	23431	47644	6018.9	710.0	1443.8	-86.6%	103.3%
Suicide Screenings	132957	14744	33849	4584.7	475.6	995.6	-88.9%	129.6%
SBIRT Screenings	16349	7576	16501	563.8	236.8	500.0	-53.7%	117.8%
Note: Negative values in this context signify a downward trend or reduction in activity.								

Table 23: Number of Referrals, Screenings, and Support Services (GY1–GY3)

	Count			Average			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Referred to treatment	1368	1309	2848	42.8	42.2	81.4	-4.3%	117.6%
Entered treatment	870	833	979	27.2	26.9	28.0	-4.3%	17.5%
Access services after treatment	721	722	1131	23.3	24.1	32.3	0.1%	56.6%
AUD Screenings	170403	1175	1599	5163.7	37.9	45.7	-99.3%	36.1%
SUD Screenings	14480	1214	1615	438.8	39.2	46.1	-91.6%	33.0%
OUD Screenings	11993	8012	5464	386.9	471.3	165.6	-33.2%	-31.8%
Received support services - SUD screenings	6111	1452	3531	203.7	48.4	100.9	-76.2%	143.2%
Received support services - OUD screenings	3994	977	2740	133.1	32.6	78.3	-75.5%	180.5%
Note: Negative values in this context signify a downward trend or reduction in activity.								

Table 24: Number and Percentage of Grantees Who Performed Harm-reduction Efforts by Type (GY1–GY3)

	% Yes			% No			Yes			No			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Naloxone distribution	91.4%	91.4%	91.4%	8.6%	8.6%	8.6%	32	32	32	3	3	3	35	35	35	0.0%	0.0%
Fentanyl test strips	40.0%	70.6%	74.3%	60.0%	29.4%	25.7%	14	24	26	21	10	9	35	34	35	76.5%	5.2%
Syringe services programs	37.1%	45.7%	28.6%	62.9%	54.3%	71.4%	13	16	10	22	19	25	35	35	35	23.1%	-37.5%
Other	-	-	45.7%	-	-	-	-	-	16	-	-	-	-	-	35	-	-

Note: Negative values in this context signify a downward trend or reduction in activity. Year-over-year (YoY) percentage change for this table was calculated using the percentage of grantees who answered 'Yes' to account for non-responses.

Section F

Table 25: Patients Treated with MOUD or Without MOUD by Patient Satisfaction (GY1–GY3)

	Percentage			Count			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Without MOUD	-	-	-	3096	2717	7490	32	31	35	-12.2%	175.7%
With MOUD	-	-	-	1326	2172	2345	33	30	35	63.8%	8.0%
Without MOUD - Satisfied	16.3%	48.9%	8.8%	505	1328	660	30	28	35	163.0%	-50.3%
With MOUD - Satisfied	57.1%	38.2%	29.8%	757	830	698	30	29	35	9.6%	-15.9%
Note: Negative values in this context signify a downward trend or reduction in activity.											

Table 26: MOUD Patient Demographics by Age Group and Sex (GY1–GY3)

	Percentage			Count			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Male patients <18	0.0%	0.3%	0.5%	0	3	6	16	28	35	-	-
Male Patients 19-24	11.0%	6.8%	-	27	73	-	16	28	-	170.4%	-
Male Patients 18-24	-	-	8.4%	-	-	98	-	-	35	-	-
Male Patients 25+	89.0%	92.9%	91.1%	218	995	1066	16	28	35	356.4%	7.1%
All Male Patients	52.5%	45.1%	52.9%	245	1071	1170	-	-	-	337.1%	9.2%
Female Patients <18	0.9%	1.8%	1.7%	2	23	18	17	28	17	1050.0%	-21.7%
Female Patients 19-24	12.6%	5.1%	-	28	67	-	16	28	-	139.3%	-
Female Patients 18-24	-	-	10.1%	-	-	105	-	-	35	-	-
Female Patients 25+	86.5%	93.1%	88.2%	192	1213	920	16	28	35	531.8%	-24.2%
All Female Patients	47.5%	54.9%	47.1%	222	1303	1043	-	-	-	486.9%	-20.0%
All Patients <18	0.4%	1.1%	1.1%	2	26	24	-	-	-	1200.0%	-7.7%
All Patients 19-24	11.8%	5.9%	-	55	140	-	-	-	-	154.5%	-
All Patients 18-24	-	-	9.2%	-	-	203	-	-	-	-	-
All Patients 25+	87.8%	93.0%	89.7%	410	2208	1986	-	-	-	438.5%	-10.1%
Calculated Total	-	-	-	467	2374	2213	35	35	-	408.4%	-6.8%
Total Patients	-	-	-	1343	2406	2339	31	28	-	79.2%	-2.8%
Note: Negative values in this context signify a downward trend or reduction in activity.											

Table 27: MOUD Patient Living Situation (GY1–GY3)

	Percentage			Count			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Live alone	22.3%	20.1%	26.0%	105	244	135	16	29	35	132.4%	-44.7%
Live w/other adults & children	54.5%	39.0%	34.1%	256	473	177	16	29	35	84.8%	-62.6%
Live w/other adults, no children	16.6%	35.9%	25.6%	78	436	133	16	29	35	459.0%	-69.5%
Live with pregnant/new mother & children	4.3%	3.9%	12.1%	20	47	63	16	28	35	135.0%	34.0%
Live with pregnant/new mother, no children	2.3%	1.1%	2.1%	11	13	11	16	28	35	18.2%	-15.4%
Total	-	-	-	470	1213	519	-	-	-	-	-

Note: Negative values in this context signify a downward trend or reduction in activity.

Table 28: Number of MOUD Patients Who Achieved Sobriety by Sex and Age (GY1–GY3)

	Percentage			Count			Total Patients			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Male patients <18	0.0%	0.0%	0.0%	0	0	0	0	3	6	16	28	35	-	-
Male Patients 19-24	55.6%	19.2%	-	15	14	-	27	73	-	16	28	-	-6.7%	-
Male Patients 18-24	-	-	15.3%	-	-	15	-	-	98	-	-	35	-	-
Male Patients 25+	72.0%	23.9%	17.7%	157	238	189	218	995	1066	16	28	35	51.6%	-20.6%
All Male Patients	70.2%	23.5%	17.4%	172	252	204	245	1071	1170	-	-	-	46.5%	-19.0%
Female Patients <18	50.0%	43.5%	11.1%	1	10	2	2	23	18	16	28	35	900.0%	-80.0%
Female Patients 19-24	78.6%	13.4%	-	22	9	-	28	67	-	16	28	-	-59.1%	-
Female Patients 18-24	-	-	9.5%	-	-	10	-	-	105	-	-	35	-	-
Female Patients 25+	68.2%	16.9%	17.5%	131	205	161	192	1213	920	16	28	35	56.5%	-21.5%
All Female Patients	69.4%	17.2%	16.6%	154	224	173	222	1303	1043	-	-	-	45.5%	-22.8%
All Patients <18	50.0%	38.5%	8.3%	1	10	2	2	26	24	-	-	-	900.0%	-80.0%
All Patients 19-24	67.3%	16.4%	-	37	23	-	55	140	-	-	-	-	-37.8%	-
All Patients 18-24	-	-	12.3%	-	-	25	-	-	203	-	-	-	-	-
All Patients 25+	70.2%	20.1%	17.6%	288	443	350	410	2208	1986	-	-	-	53.8%	-21.0%
Calculated Total	69.8%	20.1%	17.0%	326	476	377	467	2374	2213	-	-	-	46.0%	-20.8%
Total Patients	36.8%	23.0%	32.3%	494	554	756	1343	2406	2339	-	-	-	12.1%	36.5%
Note: Negative values in this context signify a downward trend or reduction in activity.														

Table 29: Number of Patients Who Entered Inpatient Treatment by Sex and Age Group (GY1–GY3)

	Percentage			Count			Total Patients			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Male patients <18	0.0%	33.3%	16.7%	0	1	1	0	3	6	16	29	35	-	0.0%
Male Patients 19-24	25.9%	31.5%	-	7	23	-	27	73	-	16	28	-	228.6%	-
Male Patients 18-24	-	-	33.7%	-	-	33	-	-	98	-	-	35	-	-
Male Patients 25+	27.1%	16.3%	15.1%	59	162	161	218	995	1066	16	28	35	174.6%	-0.6%
All Male Patients	26.9%	17.4%	16.7%	66	186	195	245	1071	1170	-	-	-	181.8%	4.8%
Female Patients <18	0.0%	8.7%	16.7%	0	2	3	2	23	18	16	29	35	-	50.0%
Female Patients 19-24	50.0%	23.9%	-	14	16	-	28	67	-	16	28	-	14.3%	-
Female Patients 18-24	-	-	30.5%	-	-	32	-	-	105	-	-	35	-	-
Female Patients 25+	25.5%	9.3%	11.7%	49	113	108	192	1213	920	16	28	35	130.6%	-4.4%
All Female Patients	28.4%	10.1%	13.7%	63	131	143	222	1303	1043	-	-	-	107.9%	9.2%
All Patients <18	0.0%	11.5%	16.7%	0	3	4	2	26	24	-	-	-	-	33.3%
All Patients 19-24	38.2%	27.9%	-	21	39	-	55	140	-	-	-	-	85.7%	-
All Patients 18-24	-	-	32.0%	-	-	65	-	-	203	-	-	-	-	-
All Patients 25+	26.3%	12.5%	13.5%	108	275	269	410	2208	1986	-	-	-	154.6%	-2.2%
Calculated Total	27.6%	23.8%	15.3%	129	565	338	467	2374	2213	-	-	-	338.0%	-40.2%
Total Patients	20.6%	23.5%	27.7%	276	565	648	1343	2406	2339	-	-	-	104.7%	14.7%
Note: Negative values in this context signify a downward trend or reduction in activity.														

Table 30: Number of MOUD Patients Who Joined Community-based Events by Sex and Age Group (GY1–GY3)

	Percentage			Count			Total Patients			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Male patients <18	-	1400.0%	7400.0%	0	42	444	0	3	6	13	26	35	-	957.1%
Male Patients 19-24	40.7%	42.5%	-	11	31	-	27	73	-	14	25	-	181.8%	-
Male Patients 18-24	-	-	91.8%	-	-	90	-	-	98	-	-	35	-	-
Male Patients 25+	11.9%	18.8%	85.4%	26	187	910	218	995	1066	14	26	35	619.2%	386.6%
All Male Patients	15.1%	24.3%	123.4%	37	260	1444	245	1071	1170	-	-	-	602.7%	455.4%
Female Patients <18	50.0%	147.8%	372.2%	1	34	67	2	23	18	14	25	35	3300.0%	97.1%
Female Patients 19-24	53.6%	62.7%	-	15	42	-	28	67	-	14	26	-	180.0%	-
Female Patients 18-24	-	-	109.5%	-	-	115	-	-	105	-	-	35	-	-
Female Patients 25+	19.3%	20.0%	206.1%	37	243	1896	192	1213	920	14	40	40	556.8%	680.2%
All Female Patients	23.9%	24.5%	199.2%	53	319	2078	222	1303	1043	-	-	-	501.9%	551.4%
All Patients <18	50.0%	292.3%	2129.2%	1	76	511	2	26	24	-	-	-	7500.0%	572.4%
All Patients 19-24	47.3%	52.1%	-	26	73	-	55	140	-	-	-	-	180.8%	-
All Patients 18-24	-	-	101.0%	-	-	205	-	-	203	-	-	-	-	-
All Patients 25+	15.4%	19.5%	141.3%	63	430	2806	410	2208	1986	-	-	-	582.5%	552.6%
Calculated Total	23.1%	141.8%	159.2%	108	3367	3522	467	2374	2213	32	27	-	3017.6%	4.6%
Total Patients	8.0%	139.9%	301.9%	108	3367	7062	1343	2406	2339	-	-	-	3017.6%	109.7%
Note: Negative values in this context signify a downward trend or reduction in activity.														

Table 31: Number of MOUD Patients Who Experienced an Overdose by Age and Sex (GY1–GY3)

	Percentage			Count			Total Patients			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Male patients <18	0.0%	0.0%	33.3%	1	0	2	0	3	6	16	28	35	-100.0%	-
Male Patients 19-24	29.6%	5.5%	-	8	4	-	27	73	-	16	28	-	-50.0%	-
Male Patients 18-24	-	-	25.5%	-	-	25	-	-	98	-	-	35	-	-
Male Patients 25+	11.5%	7.5%	5.8%	25	75	62	218	995	1066	16	28	35	200.0%	-17.3%
All Male Patients	13.9%	7.4%	7.6%	34	79	89	245	1071	1170	-	-	-	132.4%	12.7%
Female Patients <18	0.0%	0.0%	0.0%	0	0	0	2	23	18	16	28	35	-	-
Female Patients 19-24	35.7%	14.9%	-	10	10	-	28	67	-	16	28	-	0.0%	-
Female Patients 18-24	-	-	10.5%	-	-	11	-	-	105	-	-	35	-	-
Female Patients 25+	14.6%	6.1%	7.6%	28	74	70	192	1213	920	16	28	35	164.3%	-5.4%
All Female Patients	17.1%	6.4%	7.8%	38	84	81	222	1303	1043	-	-	-	121.1%	-3.6%
All Patients <18	50.0%	0.0%	8.3%	1	0	2	2	26	24	-	-	-	-100.0%	-
All Patients 19-24	32.7%	10.0%	-	18	14	-	55	140	-	-	-	-	-22.2%	-
All Patients 18-24	-	-	17.7%	-	-	36	-	-	203	-	-	-	-	-
All Patients 25+	12.9%	6.7%	6.6%	53	149	132	410	2208	1986	-	-	-	181.1%	-11.4%
Calculated Total	15.4%	6.9%	7.7%	72	163	170	467	2374	2213	16	35	-	126.4%	4.3%
Total Patients	10.8%	7.8%	10.5%	145	187	245	1343	2406	2339	-	-	-	29.0%	31.0%
Note: Negative values in this context signify a downward trend or reduction in activity.														

Table 32: Number and Type of MOUD Medications Procured, Dispensed, or Prescribed (GY1–GY3)

	Count			Average			Total			YoY Percentage Change	
	GY1	GY2	GY3	GY1	GY2	GY3	GY1	GY2	GY3	GY1—GY2	GY2—GY3
Buprenorphine & naltrexone	2862	4837	-	168.4	166.8	-	17	29	-	69.0%	-
Buprenorphine	-	-	6007	-	-	171.6	-	-	35	-	-
Methadone	-	503	315	-	18.0	9	-	28	35	-	-37.4%
Naltrexone	-	432	804	-	15.4	23.0	-	28	35	-	86.1%
Naloxone units procured	856	3794	15584	57.1	135.5	445.3	15	28	35	343.2%	310.8%
Naloxone units dispensed	1268	5183	19523	84.5	185.1	557.8	15	28	35	308.8%	276.7%
MME dispensed in service area	636808	47712164	23038163.0	39800.5	1767117.2	658233.2	16	27	35	7392.4%	-51.7%
Opioid/100 total prescriptions dispensed	3309.1	3144.1	68.2	206.8	116.4	1.9	16	27	35	-5.0%	-97.8%
MME/100 total prescriptions dispensed	26797.1	881.2	230573.0	1786.5	33.9	6587.8	15	26	35	-96.7%	26065.9%
Note: Negative values in this context signify a downward trend or reduction in activity.											

Appendix B: Technical Logic Models

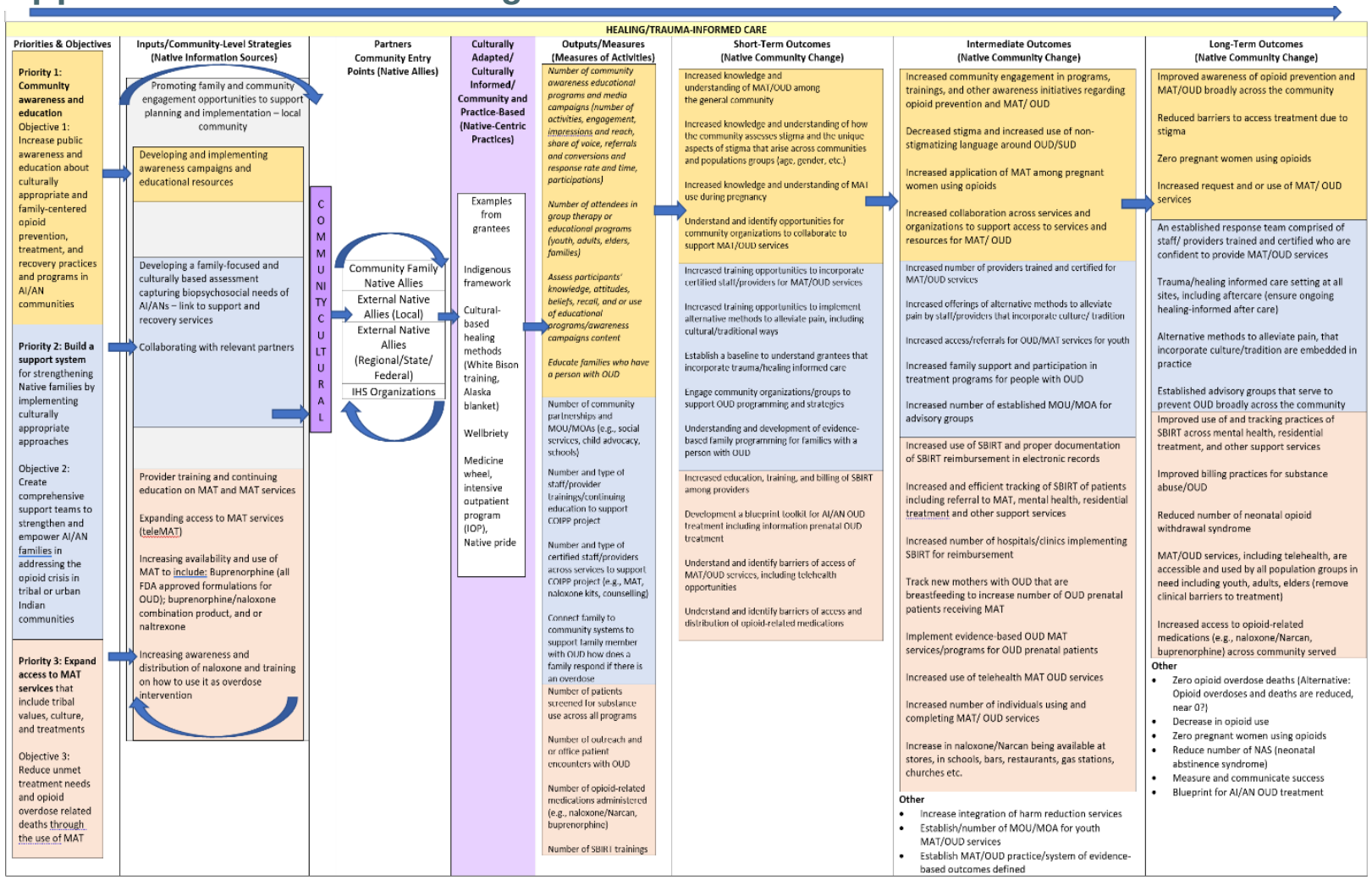

Figure 46: Healing/Trauma-informed Care Logic Model

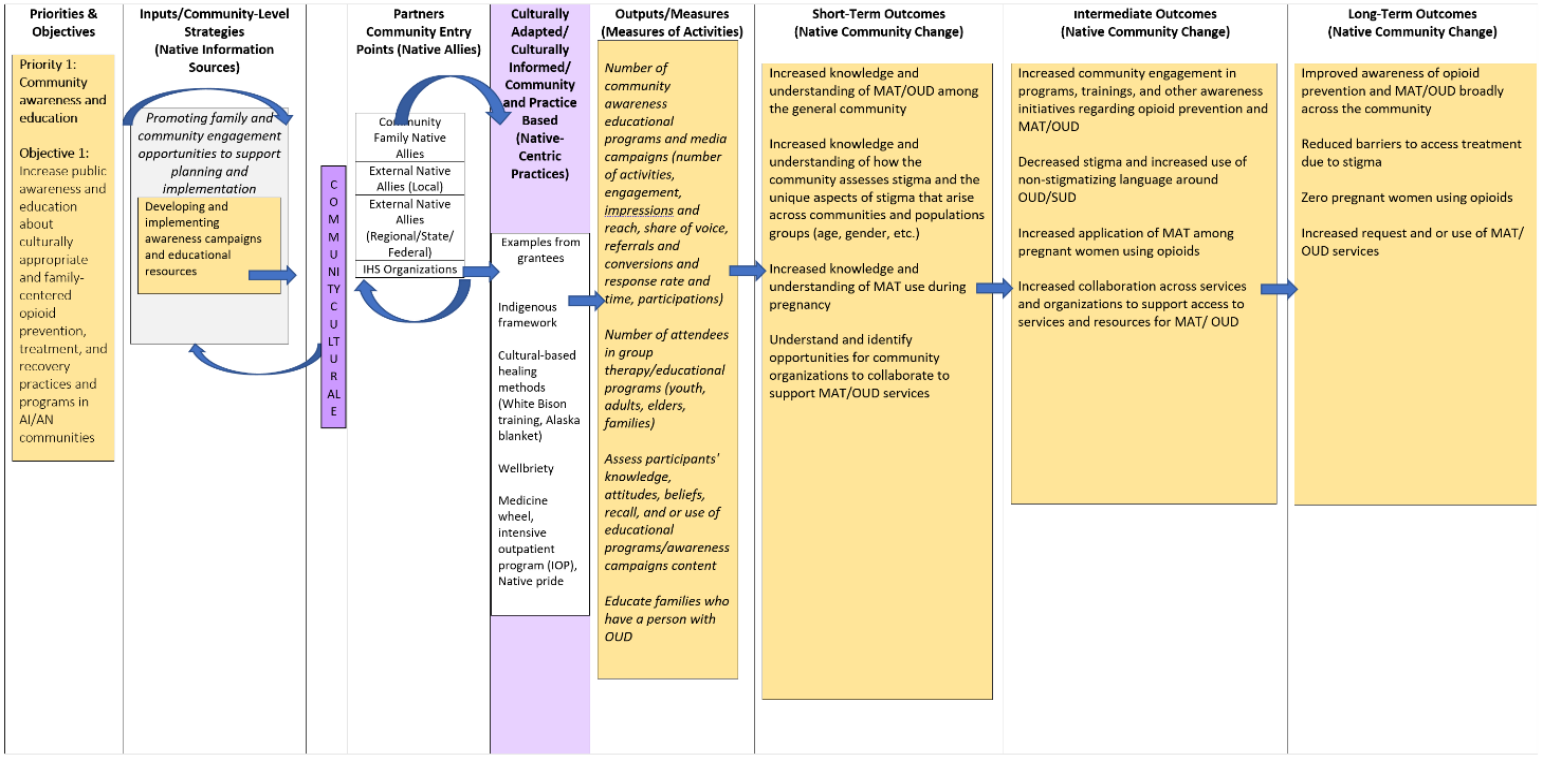

Figure 47: Logic Model for Priority 1

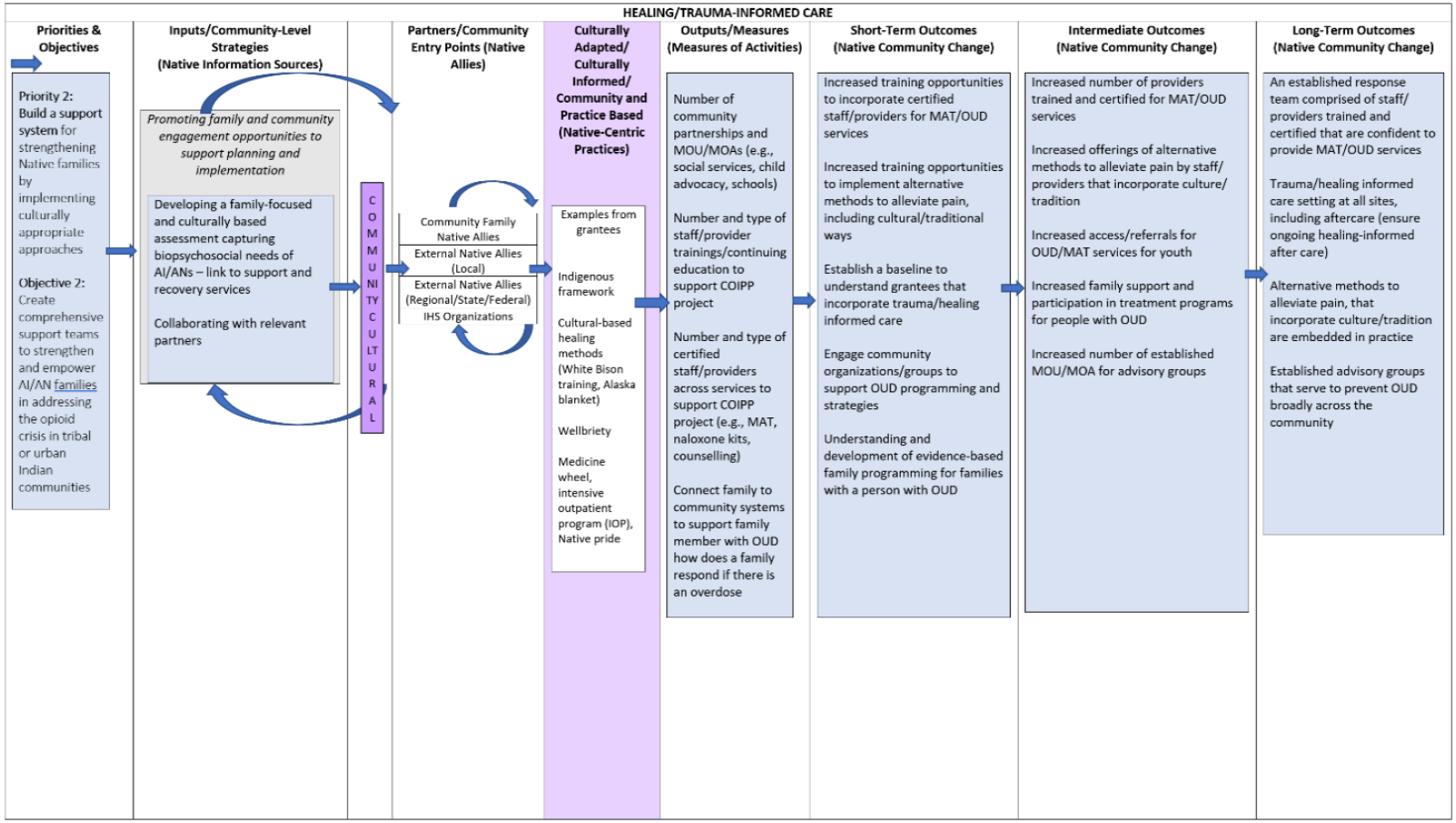

Figure 48: Logic Model for Priority 2

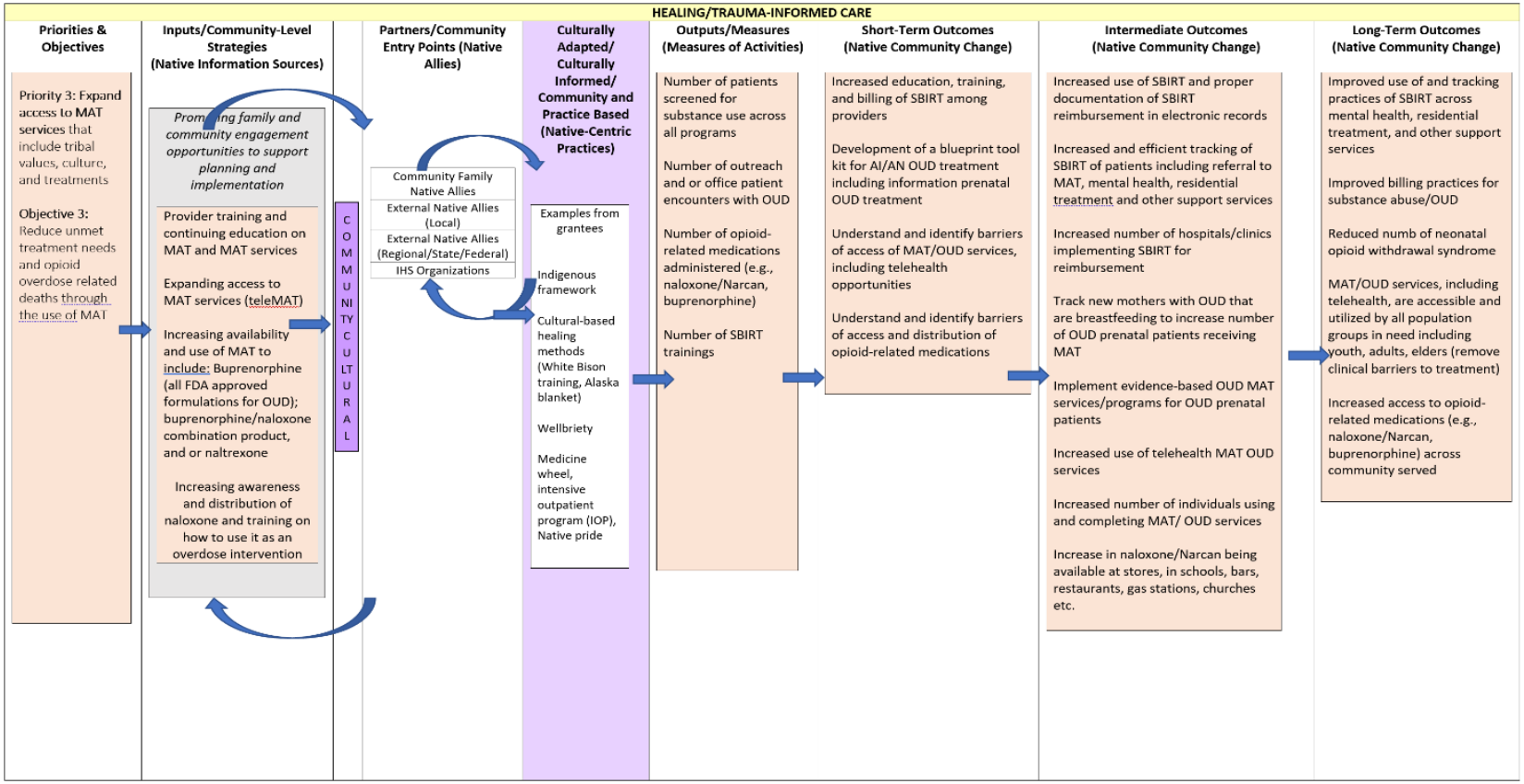

Figure 49: Logic Model for Priority 3

Appendix C: Evaluation Plan

Purpose

The purpose of the COIPP evaluation is to guide a comprehensive study of the COIPP grantees to understand how funding is being targeted to address programmatic objectives of the grant, to discern grantee capacity for evaluation, and to evaluate grantees' APR. The results of this evaluation plan will surface current gaps in grantees' data and limitations to complete the APR. The findings can also be used for formative purposes to build grantees' capacity to effectively use the new template.

Evaluation Design

The evaluation used a mixed methods designed to collect summative data to address the evaluation questions aligned with the goals and objectives. The evaluation questions, data collection instruments, timelines, and analysis methods are outlined in Table 33.

Table 33: Evaluation Questions and Analysis Methods

Evaluation Questions	Data Source/ Collection Instruments	Timeline	Methods
How can COIPP grantees be described and categorized?			
What are grantees' evaluation capacity needed to undertake their program evaluation? • High (Help grantee plan and organize program evaluation and total data collection) • Moderate (Review grantee's quality and completeness of program evaluation and data collection) • Minimal (Coordinating grantees' receipt of information from IHS)	Grant applications	April 1, 2022–March 31, 2023	Document review Frequency analysis
How are grantees increasing public awareness and education about traditional practices and family centered opioid prevention, treatment, and recovery practices and programs in the AI/AN communities?			
• What types of public awareness educational programs, events and media campaigns are being conducted by grantees within their community? • How are traditional practices incorporated into awareness	Grant applications IHS APR Form	April 1, 2022–March 31, 2023	Document reviews Frequency analysis Qualitative narrative analysis

Evaluation Questions	Data Source/ Collection Instruments	Timeline	Methods
educational programs, events, and media campaigns? • What population groups are being targeted and tracked by grantees (e.g., youth, adults, elders, families)? • What type of activities have grantees conducted to assess changes in participants' knowledge, attitudes, and beliefs? • What are the known gaps in increasing public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in the AI/AN communities?			
How have grantees strengthened their comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities?			
• How many community partnerships and MOU/MOAs are established by grantees? • What type of training events and how many trainings were conducted have grantees provided to support: • Internal staff or provider professionals • External professionals • How many certified staff or providers do grantees have in place to support COIPP-related services? • What are the known gaps in establishing comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities?	IHS APR Form	April 1, 2022–March 31, 2023	Frequency analysis Qualitative narrative analysis
How have grantees reduced unmet treatment needs and opioid overdose related deaths through MOUD?			

Evaluation Questions	Data Source/ Collection Instruments	Timeline	Methods
• Have grantees established a MOUD program? • How many outreach or office patient encounters were conducted with OUD patients? • What specific treatment options were offered (e.g., referrals, MOUD prescriptions, # of data waive providers)? • How many and what type of opioid-related medications were administered? • How many SBIRT specific training events were conducted? • How many patients were screened for intake (SBIRT) across all programs? • What are the known gaps in reducing unmet treatment needs and opioid overdose related deaths through MOUD?	IHS APR Form	April 1, 2022–March 31, 2023	Frequency analysis Qualitative narrative analysis
What implications do the findings of this evaluation have on the data sources used?			
• What are common components of reported data? • What key measures are missing from the current data available? • What additional tools and existing databases do grantees report to that can inform the COIPP evaluation and track changes in outcomes? • What evaluation assistance might be helpful to increase grantees' evaluation capacity or ability to complete the APR form? • What efficiencies can be realized in gathering reporting data?	Key data elements matrix		Comparison analysis Frequency analysis

Appendix D: Summary of Response Rates

Table 34 displays a count of the individual responses to each survey question—section A through F—as well as the reporting rate ("Rate") out of a total of 35 grantees. Questions designated as "*" represent instances where there were only sub-questions and calculated as the average response rate over the series of sub-questions. The sub-question response rate is also displayed. In some cases, more individuals responded to a prompt because skip logic was not in place, resulting in higher than 100% response rates.

Table 34: Evaluation Question Response Rates by Sections A-F

A	Rate	B	Rate	B	Rate	C	Rate	D	Rate	D	Rate	E	Rate	E	Rate	F	Rate	F	Rate
1	97.1%	1	100.0%	2e_i.3	96.4%	9i	100.0%	1	100.0%	8	100.0%	1	100.0%	21b	88.6%	1	**100.0%**	14a	85.7%
2	97.1%	2a	100.0%	2e_i.4	89.3%	9ii	91.4%	2	97.1%	9	100.0%	2	97.1%	22	85.7%	2*	76.2%	14b	82.9%
3	97.1%	2a_i	100.0%	3	94.3%	9iii	82.9%	3	97.1%	10	100.0%	3*	94.9%	23	85.7%	2a	97.1%	14c	80.0%
4	100.0%	2a_i.1	90.6%	3a	100.0%	9iv	82.9%	4*	94.3%	11	94.3%	3a	97.1%	24	100.0%	2b	94.3%	14d	80.0%
5	91.4%	2a_i.2	93.8%	4	100.0%	9v	88.6%	4a	97.1%	12	97.1%	3b	97.1%	25	97.1%	2c	144.4%	14e	82.9%
6	94.3%	2a_i.3	96.9%	4a	96.2%	9vi	91.4%	4b	100.0%	12a	74.3%	3c	100.0%	26*	96.4%	3	88.6%	14f	80.0%
7	94.3%	2a_i.4	96.9%	4b	92.3%	9vii	88.6%	4c	94.3%	13	100.0%	3e	91.4%	26a	97.1%	4	85.7%	14g	80.0%
8	94.3%	2b	100.0%	4c	100.0%	9viii	91.4%	4d	97.1%	13a	80.0%	3f	97.1%	26b	97.1%	5	80.0%	15*	75.0%
9*	95.1%	2b_i	104.5%	4d	92.3%	9ix	77.1%	4e	97.1%	14	100.0%	3g	100.0%	26c	97.1%	6	82.9%	15a	82.9%
10	97.1%	2b_i.1	86.4%	4d.i	37.1%	9x	100.0%	4f	94.3%	14a	80.0%	3h	94.3%	26d	94.3%	7	82.9%	15b	37.1%
11	94.3%	2b_i.2	95.5%	4e	54.3%	10	100.0%	4g	100.0%	15	97.1%	3i	97.1%	26e	97.1%	8	82.9%	15c	80.0%

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A	Rate	B	Rate	B	Rate	C	Rate	D	Rate	D	Rate	E	Rate	E	Rate	F	Rate	F	Rate
12	94.3%	2b_i.3	95.5%	5	97.1%	10a*	93.8%	4h	91.4%	16	100.0%	3j	80.0%	26f	97.1%	9	82.9%	15d	80.0%
13	97.1%	2b_i.4	95.5%	5a	95.8%	10a_i	93.8%	4i	97.1%	17	97.1%	4	97.1%	26g	97.1%	10	80.0%	15e	80.0%
14	94.3%	2c	97.1%	5b	87.5%	10a_ii	93.8%	4j	74.3%	18	100.0%	5	94.3%	26h	94.3%	11	80.0%	15f	80.0%
15	94.3%	2c_i	106.3%	5c	91.7%	10b*	87.5%	4j.1	100.0%	19*	100.0%	6	97.1%	26i	100.0%	12*	82.1%	15g	80.0%
16	94.3%	2c_i.1	87.5%	5d	79.2%	10b_i	87.5%	5	100.0%	19a	100.0%	7	91.4%	27*	88.6%	12a	82.9%	15h	80.0%
17	94.3%	2c_i.2	100.0%	5e	75.0%	10b_i	87.5%	6*	94.60%	19a_i	100.0%	8	94.3%	27a	88.6%	12b	82.9%	16*	73.5%
18	94.3%	2c_i.3	100.0%	5e.i	62.5%	10c	93.8%	6a	97.1%	19b	100.0%	9	94.3%	27b	88.6%	12c	82.9%	16a	77.1%
19	97.1%	2c_i.4	100.0%	6	100.0%	12	91.4%	6b	97.1%	19b_i	100.0%	10	100.0%	27c	88.6%	12d	82.9%	16b	74.3%
20	100.0%	2d	94.3%	6a	88.6%	13	97.1%	6c	94.3%	19c	100.0%	11	94.3%	27d	88.6%	12e	82.9%	16c	71.4%
20a	100.0%	2d_i	105.9%	6b	91.4%	-		6d	94.3%	19c_i	100.0%	12	97.1%	27e	88.6%	12f	82.9%	16d	74.3%
21	100.0%	2d_i.1	94.1%	6c	94.3%			6e	94.3%	19d	100.0%	13	82.9%	27f	88.6%	12g	82.9%	16e	71.4%
21a	100.0%	2d_i.2	100.0%	6d	88.6%			6f	97.1%	19d_i	100.0%	14	94.3%	27g	88.6%	12i	77.1%	16f	74.3%
22	100.0%	2d_i.3	100.0%	7a	97.1%			6g	94.3%	19e	100.0%	15	91.4%	27h	88.6%	13*	80.0%	16g	71.4%
22a	100.0%	2d_i.4	100.0%	7b	97.1%			6h	97.1%	19e_i	120.0%	16	94.3%	27i	100.0%	13a	80.0%	17	82.9%
22b	100.0%	2e	100.0%	7c	97.1%			6i	97.1%	19e_ii	91.4%	17	51.4%	28*	99.0%	13b	80.0%	18	80.0%
-		2e_i	100.0%	7d	97.1%			6j	82.9%	19e_iii	91.4%	18	82.9%	28a	100.0%	13c	80.0%	19	80.0%
		2e_i.1	85.7%	7e	94.3%			6j.1	100.0%	20	91.4%	19	82.9%	28b	97.1%	13d	80.0%	20	80.0%

A	Rate	B	Rate	B	Rate	C	Rate	D	Rate	D	Rate	E	Rate	E	Rate	F	Rate	F	Rate
		2e_i.2	89.3%	8	94.3%			7	94.3%	-		19a	100.0%	28c	100.0%	13e	80.0%	21	80.0%
		-						-				20	88.6%	29	57.1%	13f	80.0%	22	77.1%
												20a	88.6%	30	97.1%	13g	80.0%	23	77.1%
												21	85.7%	31	94.3%	14*	81.6%	24	74.3%
												21a	88.6%	-	-	-			

Appendix E: COIPP APR[3]

COIPP Objectives

1. Increase public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.
2. Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities.
3. Reduce unmet treatment needs and opioid overdose-related deaths through the use of MOUD.

Data Needed for Report

Please note that there are built-in skip patterns in the online form so depending on how it is answered you may or may not see further questions. Please fill out the online form completely so that all questions are filled in. Do not leave blanks.

Answer options are:

- Performed/Not Performed
- Yes/No
- Number/0 (or sometimes “unknown” is accepted)

Keep in mind while completing the APR, the timeframe being reported on is the previous grant year from April 1 to March 31.

Section A.

The questions below are directed at staff positions paid for by the COIPP grant and or are providing in-kind services to the COIPP and directly impact meeting COIPP objectives.

1. _____As of this reporting, what is the total number of full-time program staff?
2. _____(Y/N) Does the planned staff include a coordinator or director or leader?
3. Has the coordinator or director or leader been the same person during Year 1 and Year 2?
4. Which of these **paid** positions within your organization are critical and essential to the success of your project? Select all that apply:

[3] Minor formatting, punctuation, and spelling changes have been made to the APR to enhance readability and comprehension.

a. _____ Physicians
b. _____ Admin Staff
c. _____ Nurses
d. _____ Behavioral Health /Mental Health Professionals
e. _____ Paraprofessionals (i.e., community health workers or peer support specialists)
f. _____ Health Education Staff
g. _____ Chaplains or equivalent Spiritual/Faith Leaders
h. _____ Church-Based Staff
i. _____ Tribal Elders/Traditional Practitioner
j. _____ Teachers or School Leaders
k. _____ Law Enforcement Officers
l. _____Data Coordinators
m. _____ Other

5. Which of these **volunteer** positions are critical to the success of your project? Select all that apply
    a. _____ Physicians
    b. _____ Admin Staff
    c. _____ Nurses
    d. _____ Behavioral Health /Mental Health Professionals
    e. _____ Paraprofessionals (i.e., community health workers or peer support specialists)
    f. _____ Health Education Staff
    g. _____ Chaplains or Equivalent Spiritual/Faith Leaders
    h. _____ Church-Based Volunteers
    i. _____ Tribal Elders/Traditional Practitioners
    j. _____ Teachers or School Leaders
    k. _____ Law Enforcement Officers
    l. _____Data Coordinators
    m. _____Other
6. Does your program provide direct behavioral health care services (mental health counseling, individual or group counseling, peer support, psychiatry, MOUD)? (Y/N)
    a. If yes, please describe. (text)
7. Does your program offer services through contracted providers? (Y/N)

- If yes, please describe the contracted services, the location of the services, and if they provide in-person counseling, telehealth, or both. (text)

8. Does your program provide the COIPP program to subgrantees? (Y/N)
    a. If yes, how many? (number)
    b. How did you collect APR data from your subgrantees? (text)

Section B.

Objective I. Increase public awareness and education about traditional practices and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities:

This section includes age breakdown, however due to confidentiality, it is understood not all programs will be collecting ages. Therefore, the age group participants belong in can be estimated. Total participant count is important and highly recommended.

1. Total number of community educational/training events funded by the project. (number)

2. In the following section, please provide the following information.
    a. Education and Prevention on Opioid Use Disorder Training. (Performed/Not Performed)
        i. Total Participants _____
            1. Estimate Count of youth (17 years and under) _____
            2. Estimate Count of youth (18-24 years) _____
            3. Estimate Count of adults (25-54 years) _____
            4. Estimate Count of adults (55 years and over) _____

    b. Accessing local opioid-specific services training. (Performed/Not Performed)
        i. Total Participants _____
            1. Count of youth (17 years and under) educated on accessing local opioid-specific services ___
            2. Count of youth (18-24 years) educated on accessing local opioid-specific services _____
            3. Count of adults (25-54 years) educated on accessing local opioid-specific services _____
            4. Count of adults (55 years and over) educated on accessing local opioid-specific services _____

    c. Safeguarding controlled prescription medications training. (Performed/Not Performed)
        i. Total Participants _____
            1. Count of youth (17 years and under) educated on safeguarding controlled prescription medications ___
            2. Count of youth (18-24 years) educated on safeguarding controlled prescription medications _____
            3. Count of adults (25-54 years) educated on safeguarding controlled prescription medications _____
            4. Count of adults (55 years and over) educated on safeguarding controlled prescription medications _____

d. Properly disposing of unused, controlled prescription medications training. (Performed/Not Performed)
    i. Total Participants _____
        1. Count of youth (17 years and under) educated on properly disposing of unused, controlled prescription medications ___
        2. Count of youth (18-24 years) educated on properly disposing of unused, controlled prescription medications _____
        3. Count of adults (25-54 years) educated on properly disposing of unused, controlled prescription medications
        4. Count of adults (55 years and over) educated on properly disposing of unused, controlled prescription medications _____

e. Recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone training (i.e., NARCAN). (Performed/Not Performed)
    i. Total Participants _____
        1. Count of youth (17 years and under) educated on recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone ___
        2. Count of youth (18-24 years) educated on recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone _____
        3. Count of adults (25-54 years) educated on recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone _____
        4. Count of adults (55 years and over) educated on recognizing signs of an opioid overdose and administering the opioid overdose reversal drug naloxone _____

3. Other topics your program provided trainings on, please describe?
   _____

4. Conducted healthcare professional trainings: (Performed/Not Performed)
    a. Number of Physicians _____
    b. Number of Nurses _____
    c. Number of Behavioral Health /Mental Health Professionals _____
    d. Number of Non-licensed Staff _____
    e. Others (please describe) _____

5. Conducted trainings for non-health care professionals, such as teachers, law enforcement, youth workers, child protection workers: (Performed/Not Performed)

a. Schools _____
b. Social-Traditional gatherings _____
c. Partner agencies _____
d. Churches _____
e. Others, please describe _____

6. The estimated number of individuals who self-reported as homeless receiving services or participating in your program activities?
   _____
   a. Count of youth (17 years and under) _____
   b. Count of youth (18-24 years) _____
   c. Count of adults (25-54 years) _____
   d. Count of adults (55 years and over) ____

7. Please describe innovative educational approaches/strategies used to reach new populations?

Section C.

Use the media tracking tool to assist you in completing this section of the APR. Not all information from the media tracking tool is needed in this section.

a. Which of the following media campaign tools did your program use: (check all that apply)
b. Facebook
c. Tribal website
d. Podcast
e. X
f. YouTube
g. Instagram
h. TikTok
i. Good Health TV
j. Other (Describe) _____

1. Used radio/TV/billboard ads for opioid use prevention, opioid use disorder and or treatment messaging with COIPP funds? (Performed/Not Performed)
2. Radio
   a. Number of ads created ____
   b. Number of ads aired ____
3. TV
   a. Number of ads created_____
   b. Number of ads aired _____
4. Number of Billboards created _____
5. If you created billboards, radio, or TV, which of the following were the targets of your advertising campaign? (check all that apply)
   a. Risk Management
   b. Stigma

c. Treatment/Services
d. Events
e. Special Populations (e.g., Elders, Youth, People in Recovery, Parents)
f. Other _____

6. How did you inform your community about the COIPP funded activities?

Section D.

Objective II. Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities.

1. Describe your program's practices to create comprehensive support teams that strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities? (Practices include evidence-based, heritage-based, promising practices, practice-based, etc.).
2. How many group therapy sessions were hosted for your community to support AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities? _____
3. How many attendees were in all group therapies hosted for your community to support AI/AN families in addressing the opioid crisis in Tribal or Urban Indian communities? _____
4. Please identify any of the following types of activities your support teams used to integrate Tribal values and heritage within treatment/sobriety efforts:
   a. Dancing
   b. Drumming
   c. Language
   d. Singing
   e. Songs
   f. Storytelling
   g. Traditional crafts (e.g., beading, basket weaving, tool making, jewelry)
   h. Traditional games
   i. Equine therapy
   j. Other (please describe)
5. How would you describe the impact of providing traditionally tailored integrated services to participants/clients supported by your program?
6. Please identify any of the following types of religious, spiritual, and/or faith-based services that were linked to your program activities?
   a. Traditional Practices
   b. Therapy/Counseling, spiritually informed
   c. Therapy/Counseling, NOT spiritually informed
   d. Prayer
   e. Pastoral Care
   f. Spirituality Groups
   g. Clergy or Chaplain Support
   h. Shelter

   i. Transportation
   j. Other (please describe)
7. Describe the services providing faith-based services to participants/clients supported by your program?
8. Do you consider your organization trauma-informed? (Check box: Yes; No)
   a. If no, what resources are needed to help your agency become trauma informed (check all that apply)
      i. Policies (check box)
      ii. Procedures (check box)
      iii. Practices (check box)
      iv. Trainings (check box)
9. Count of health care professionals trained, by your organization, on trauma informed care? _____
10. Count of program staff trained, by your organization, on trauma informed care? _____
11. Count of other community members trained, by your organization, on trauma informed care? _____
12. Does your program have efforts in place to address provider burnout? (Yes/No)
   a. If Yes, describe efforts
13. Does your program have efforts in place to address compassion fatigue? (Yes/No)
   a. If Yes, describe efforts
14. What is the count of persons who received new/updated training for recovery support roles?
15. Describe any activities with your community partner(s) that improved OUD programming and strategies?
16. How many memorandum of understandings (MOU)/agreements (MOA) were established to support your program? _____
17. Did your program facilitate the formation of these groups?
   a. Youth advisory councils
      i. If yes, number _____
   b. Elder advisory councils
      i. If yes, number _____
   c. Multidisciplinary coordination groups
      i. If yes, number _____
   d. Advocacy/Prevention groups
      i. If yes, number _____
   e. Crisis response teams
      i. If yes, number _____
      ii. Count of total partner entities participating in the crisis response teams? _____
      iii. Count of persons who joined crisis response teams? _____
18. Describe your program's innovative approaches to family-based care, including roles of mentors and volunteers?

19. Does your program have support services for family members of individuals experiencing or diagnosed with opioid use disorder? (Yes/No)
    a. If Yes, describe efforts
20. Describe your program's approaches and methods for coordination and referrals for family members of individuals experiencing or diagnosed with opioid use disorder?

Section E.

Objective III. Reduce unmet treatment needs and opioid overdose-related deaths through the use of medications for opioid use disorder (MOUD).

MOUD Types of Services

1. Did your program provide MOUD services in the reporting period? (Yes/No)
2. Describe your program use of evidence-based practices to reduce unmet treatment needs and opioid overdose-related deaths.
3. What type of evidence-based practice did your program use to treat substance use disorder?
    a. Attachment-based family therapy
    b. Cognitive behavioral therapy
    c. Dialectical behavioral therapy
    d. Eye movement desensitization and reprocessing
    e. Matrix model
    f. Motivational enhancement therapy
    g. Motivational interviewing
    h. Community reinforcement approach
    i. Contingency management
    j. Other (Please describe)
4. Describe any innovative approaches to self-care (e.g., mindfulness, reminder apps):
5. Describe any innovative approaches to expand access to MOUD. Examples include: providing transportation, providing bus tickets, providing support services, etc.

MOUD Prescribers

6. What is the count of current MOUD prescribers in your catchment area of service? _____
7. Count of persons trained to administer MOUD who are law enforcement. _____
8. Count of persons trained to administer MOUD who are program staff. _____
9. Count of persons trained to administer MOUD who are volunteers. _____

TeleMOUD/TeleMOUD Services

10. Did your program provide access to teleMOUD? (Yes/No)

11. Describe any innovative approaches to expand access to teleMOUD. Examples include: added additional teleMOUD sites, contracting teleMOUD systems, provided incentives, etc.

Screenings

12. Count of completed Universal Alcohol Screenings. _____ Unknown
13. Count of completed screening, brief intervention, and referral to treatment (SBIRT). _____
14. Count of completed screening of suicidal risk. _____
15. How many individuals served by COIPP were screened for opioid use disorders? _____

Overdoses

16. Count of reported incidents of drug overdose (e.g., synthetic opioids, heroin, cocaine, methamphetamine, natural semi-synthetic opioids) in catchment area. _____
17. Count of drug overdose deaths in catchment area. _____
    a. If greater than zero, provide the data source.

Referrals

18. How many individuals did your program refer to opioid use disorder treatment? _____
    a. Of those referred, how many entered treatment? _____
    b. Of those referred for OUD treatment, are you able to share the total number of prescribers available to your catchment area (including tele) for MOUD prescribing?
19. How many individuals did your program help access recovery services after they completed a treatment programs/services? _____
    a. Of those whom your program helped access recovery services, how many individuals were screened for alcohol use disorder? _____
    b. Of those whom your program helped access recovery services, how many individuals were screened for substance use disorder? _____
20. How many individuals did your program refer to support services because of substance use disorder screenings? _____
21. How many individuals did your program refer to support services because of opioid use disorder screenings? _____

Policy

22. Does your organization or your local partner health care facility have a written policy and procedures for opiate prescribing (e.g., surveillance and monitoring, chronic non-cancer pain management)?
23. Does your organization or your local partner health care facility have access to clinical tools/resources to support provider self-monitoring of opioid prescriptions including chronic noncancer pain management?

24. Does your organization or your local partner health care facility have written policy, procedures, or protocol for the following?
    a. Opioid use disorder screening
    b. OUD referral process
    c. OUD wraparound services
    d. MOUD
    e. Naloxone distribution
    f. Distribution of fentanyl test strips
    g. Syringe services programs
    h. Other risk management efforts
    i. Please describe other: (text)
25. Does your organization or your local partner health care facility need resources to develop written policy, procedures, or protocol for the following?
    a. (OUD screening
    b. OUD referral process
    c. OUD wraparound services
    d. MOUD
    e. Naloxone distribution
    f. Distribution of fentanyl test strips
    g. Syringe services programs
    h. Other risk management efforts
    i. Please describe other: (text)
26. Does your community provide any of these risk management efforts? (check all that apply)
    a. Naloxone distribution
    b. Distribution of fentanyl test strips
    c. Syringe services programs
    d. Other risk management efforts
    e. Please describe other: (text)
27. If No to any above, please provide any barriers or complications for this effort for each effort.
28. List and describe program accomplishments and impact on community during previous reporting period. For example, efficacy of total treatment programs?
29. List and describe program challenges during the previous reporting period. For example, describe missing MOUD service capacity, including types of medications (buprenorphine, suboxone, etc.), operations (roles, hours, coordination, etc.), materials or tools that are unavailable for program.

Section F.

Describe your service population and services provided by your program for smaller catchment areas. The following data will NOT be reported publicly. It is for internal grant purposes only.

(If section regarding Objective III (MOUD) answered NO, SKIP this section)

1. Is your service population smaller than 20,000 persons? Yes/ No
2. Please indicate what data source your program uses to collect the data: (checkbox) check all that apply.
    a. Electronic health record system
    b. Manual documentation
    c. Other database, describe: _____
3. Count of patients treated without MOUD_____
4. Count of patients treated with MOUD _____
5. Count of patients treated without MOUD who reported satisfied with services _____
6. Count of patients treated with MOUD who reported satisfied with services _____
7. Count of MOUD patients who live alone_____
8. Count of MOUD patients who live with other adults and children_____
9. Count of MOUD patients who live with other adults, but no children_____
10. Count of MOUD patients who live with a pregnant or recent mother and other children_____
11. Count of MOUD patients who live with a pregnant or recent mother, but no other children_____
12. Over all Demographics of MOUD Patients
    a. Total ____
    b. Count of male patients 17 years and under
    c. Count of male patients age 18 to 24 years
    d. Count of male patients age 25 or older
    e. Count of female patients 17 years and under
    f. Count of female patients age 18 to 24 years
    g. Count of female patients age 25 or older
13. Achieved sobriety
    a. Total _____
    b. Count of male patients 17 years and under
    c. Count of male patients age 18 to 24 years
    d. Count of male patients age 25 or older
    e. Count of female patients 17 years and under
    f. Count of female patients age 18 to 24 years
    g. Count of female patients age 25 or older
14. Entered in-patient treatment
    a. Total _____
    b. Count of male patients 17 years and under
    c. Count of male patients age 18 to 24 years
    d. Count of male patients age 25 or older
    e. Count of female patients 17 years and under
    f. Count of female patients age 18 to 24 years
    g. Count of female patients age 25 or older
15. Overdosed on drugs
    a. Total _____
    b. Count of male patients 17 years and under

c. Count of male patients age 18 to 24 years
d. Count of male patients age 25 or older
e. Count of female patients 17 years and under
f. Count of female patients age 18 to 24 years
g. Count of female patients age 25 or older

16. Joined community-based events
    a. Total _____
    b. Count of male patients under the age of 17 years and under
    c. Count of male patients age 18 to 24 years
    d. Count of male patients age 25 or older
    e. Count of female patients under the age of 18 years
    f. Count of female patients age 18 to 24 years
    g. Count of female patients age 25 or older

Medications Prescribed

17. Count of prescriptions for buprenorphine ____
18. Count of prescriptions for methadone _____
19. Count of prescriptions for naltrexone _____
20. Count of naloxone units procured _____
21. Count of naloxone units dispensed _____
22. Count of morphine milligram equivalent (MME) dispensed in service area _____
23. Count of opioid/100 total prescriptions dispensed in service area _____
24. Count of MME/100 total prescriptions dispensed in service area _____

Appendix F: Further Resources

General Community Awareness

A Trickster Tale – Outsmarting Opioids Through Education and Action: This NPAIHB educational booklet provides steps Tribal communities can take to prevent opioid misuse.

Centering Culture in the Treatment of OUD with AI/AN Communities: This publicly available, peer-reviewed article discusses the development of a Collaborative Board to develop traditionally grounding of MOUD for AI/AN while defining a process for implementing Western and Indigenous practices of MOUD.

Opioid Use Disorder Treatment for People Experiencing Homelessness: A Scoping Review: This publicly available, peer-reviewed journal article reviews gaps and disparities in OUD treatment for people experiencing homelessness and identifies housing support as beneficial to mitigating these disparities.

Porky's Party: A Wake-up Call: This public service announcement by the NPAIHB shows the story of a group of Native youth navigating substance misuse and an opioid overdose. Content warning: The video contains scenes of an overdose and may be harmful or traumatizing to some audiences.

Pregnancy and Substance Use: A National Risk Management Coalition Toolkit: This toolkit reviews strategies to promote the overall health and well-being of pregnant and parenting people with SUD and offers information for their families and service providers.

Substance Use Disorders in People with Physical and Sensory Disabilities: This research brief from the SAMHSA reviews the experiences of SUD among people with disabilities and offers recommendations for promoting prevention and accessible intervention.

The Healing of the Canoe Project: This traditionally grounded curriculum for SUD and mental health prevention can be adapted by Tribes using their own traditions, practices, beliefs, values, and stories.

Tribal Opioid Response Resource Toolkit: The NIHB toolkit provides resources for Tribes working to combat the opioid epidemic within their communities.

Combating Stigma

Clinical Guidance for Treating Pregnant and Parenting Women with OUD and Their Infants: This SAMHSA guide offers recommendations for standard approaches to deliver evidence-based individualized clinical care to pregnant and parenting persons with OUD and their infants.

Closing Gaps in the Continuum of Treatment and Support Services for Pregnant and Parenting Women with OUD: This brief by the Foundation for Opioid Response Efforts describes how three of their grantees approached closing the gap in services for pregnant and parenting women with OUD in the postpartum period. One grantee collaborated with an AI/AN organization.

Evidence-Based, Whole Person Care of Pregnant People Who Have Opioid Use Disorder: This advisory from SAMHSA describes how health care providers can actively support the health of pregnant individuals who have OUD and the health of their babies.

Parent-Child Assistance Program: This evidence-based home visitation case-management model can be used by grantees to establish or improve community programs for pregnant and parenting people with SUD.

Reducing Stigma Toward MOUD Fact Sheet and Stigma and Mothers Using Opioids: These guides from the Utah State University Health Extension: Advocacy, Research, and Teaching Initiative offer guidance on how to address stigma associated with OUD.

RHI Rural Prevention and Treatment of Substance Use Disorders Toolkit: The Rural Health Information Hub's toolkit offers resources for reducing stigma associated with SUD in rural communities.

The Impact of Stigma on People with OUD, Opioid Treatment, and Policy: This publicly available, peer-reviewed journal article discusses stigma experienced by people with OUD and offers harm-reduction strategies to reduce stigma at social and structural levels MOUD Use and Pregnancy.

Trauma-Informed Organizational Assessments

Secondary Traumatic Stress Informed-Organizational Assessment: Organizations can use this assessment tool from the University of Kentucky Center on Trauma & Children to assess their approach to secondary traumatic stress (STS) prevention and intervention and use the comprehensive review of policies and practices to address STS.

The National Child Traumatic Stress Network (NCTSN) Trauma-informed Organizational Assessment: Health care organizations can use this validated assessment from the UCLA-Duke University National Center for Child Traumatic Stress and the NCTSN, to measure their practices related to trauma-informed care and apply an implementation framework.

Family Resources

Centering Culture in the Treatment of OUD with AI/AN Communities: This article from the Addiction Technology Transfer Center Network discusses ways to deliver traditionally centered MOUD in AI/AN communities.

TIP 39: SUD Treatment and Family Therapy: This SAMHSA protocol offers information and guidance on the inclusion of families in SUD treatment and services. This guide is written for SUD treatment providers and SUD treatment program administrators.