May 2021

Mapping the Network of Care:

Substance Use Treatment and Recovery Services for American Indians and Alaska Natives in California

Addendum to the 2020 Tribal MAT Evaluation Report

Prepared by the University of Southern California for the California Department of Health Care Services

About this Report

This report was prepared by the University of Southern California (USC) Tribal MAT Project team for the California Department of Health Care Services (DHCS) in May 2021. It is an addendum to the Tribal MAT Project Evaluation Report that was submitted to DHCS in September 2020. This report details the team's efforts to survey California Tribal and Urban Indian community-based treatment programs.

Authors

University of Southern California

Claradina Soto (Navajo/Jemez Pueblo), PhD, MPH
Julia D'Isabella, MPH
Cynthia Begay (Hopi/Navajo), MPH
Hector Sanchez Perez, MPH
Ellen Rippberger, MPH
VyVy Nguyen, MPH
Regina Pearce
Simon Kim
Guadalupe Ramos, PhD
Angelica Al Janabi, MPH

Consultants

Valentine Antony (Mohawk) MPA, MCRP – California Consortium for Urban Indian Health

Acknowledgements

This report was made possible with funding provided by DHCS [contract #17-94722], funded by California's State Targeted Response to the Opioid Crisis Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The authors wish to thank all the facilities involved for taking the time to participate and for their provision of treatment, prevention, and education activities in California's American Indian and Alaska Native communities. A special thanks to Darren Urada and our partners at UCLA Integrated Substance Abuse Programs for their continued support and guidance provided across all project efforts to address SUD and the needs of Native communities in California. We would also like to thank all Tribal and Urban Indian populations in California for their continued support of our efforts.

AIAN Population Identity Statement

This document refers to terminology including “AIAN,” “Native American,” “American Indian,” “Native,” and “Indigenous” depending on the data source, community authorship, or originating referenced sources. AIAN peoples have diverse identities and complex political histories that make it impossible to classify these communities uniformly. “AIAN” is the current U.S. federal designation; however, for the purpose of this document, we will be using some of these terms interchangeably and based on community preference where possible. These terms seek to identify Native people originating from the land now known as the U.S. and their decedents.

Community Advisory Board

List of Acronyms

2SLGBTQ	Two-sprit, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning
AIAN	American Indian and Alaska Native
ASAM	American Society of Addiction Medicine
CAB	Community Advisory Board
CCUIH	California Consortium for Urban Indian Health
CDEP	Community-Defined Evidence-Based Practices
CRIHB	California Rural Indian Health Board
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
EBP	Evidence-Based Practice
EMDR	Eye Movement Desensitization and Reprocessing
GONA	Gathering of Native Americans
IHP	Indian Health Program
IHS	Indian Health Service
IOP	Intensive Outpatient Programs
LIHEAP	Low Income Home Energy Assistance Program
MAT	Medication-Assisted Treatment
ODS	Organized Delivery System
OUD	Opioid Use Disorder
RTF	Residential Treatment Facility
SAMHSA	Substance Abuse and Mental Health Services Administration
SLF	Sober Living Facility
SOC	System of Care
SNAP	Supplemental Nutrition Assistance Program
SUD	Substance Use Disorder
TANF	Temporary Assistance for Needy Families
THP	Tribal Health Program
UIHP	Urban Indian Health Program
USC	University of Southern California

Table of Contents

Introduction

This report is an addendum to the Tribal MAT Project Evaluation Report that was submitted to the California Department of Health Care Services (DHCS) in September 2020. This report details the efforts and results of data gathered from California Tribal and Urban Indian Health Programs and community-based treatment programs to understand the recovery services available and gaps in services that need to be addressed to reduce substance use disorder (SUD).

Opioid Crisis in AIAN Communities

American Indian and Alaska Native (AIAN) communities have been and continue to be disproportionately affected by health disparities related to substance use and the opioid epidemic. In 2017 and 2018, AIAN communities experienced a rapid increase in opioid and synthetic opioid overdose mortality rates; AIAN communities currently have the second highest rate of opioid overdose when compared to other racial and ethnic groups (Wilson et al., 2020). These disparities are important to address as California is home to over 720,000 of the 5.2 million AIAN individuals in the United States (Norris et al., 2012).

California AIAN Population

California has the largest AIAN population in the US with over 720,000 AIAN individuals (approximately 2% of the California population). There are 109 federally recognized Tribes in California, as well as numerous state recognized Tribes and non-federally recognized Tribes (Bureau of Indian Affairs, 2014; Norris et al., 2012). There are an estimated 78 state Tribes petitioning for federal recognition (Judicial Council of California, 2020). AIANs in California, including California Indians and AIANs who relocated from other states, are dispersed throughout rural and urban areas around the state (Intertribal Friendship House, 2002). This is primarily due to the US government policies that relocated AIANs from reservations to urban areas (Intertribal Friendship House, 2002).

AIAN Health Care

AIAN access to health care is often limited and, historically, has been complicated by various federal policies. Congress initially funded Indian health care and defined the federal government's responsibility in the Snyder Act of 1921 (Warne & Frizzell, 2014). Termination and relocation policies of the 1950s and 1960s impeded the ability of many individuals to access care by stripping many Tribes of their federal recognition and moving many AIANs away from Tribal reservations and into urban areas (California Rural Indian Health Board, n.d.). Many Tribes had their federal recognition restored; however, some have yet to regain their federally recognized status (Clarke, 2016). The broadening of the Snyder Act under the Indian Health

Care Improvement Act of 1976 ensured the provision of health care specifically for urban AIAN individuals (Kidwell et al., 1988). The Indian Health Service (IHS), an agency within the US Department of Health and Human Services, provides direct medical and public health services to federally recognized Tribes (Indian Health Service California Area Office, 2015). Access to health care services can be complicated for AIAN populations because IHS facilities in California are limited (Indian Health Service California Area Office, 2015).

Drug Medi-Cal Indian Health Program Organized Delivery System

The Drug Medi-Cal (DMC) Waiver amendment, as part of the larger California 1115 Waiver, introduces reforms to California's SUD system and enhances SUD services. This is a state pilot program to test a new paradigm for the organized delivery of health care services for Medicaid-eligible individuals with SUD. The DMC program demonstrates how organized SUD care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC pilot include provision of a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and the efficient use of resources, evidence-based practices (EBPs) in substance abuse treatment, and increased coordination with other systems of care.

Carved into the DMC Waiver is the authority to form an Indian Health Program Organized Delivery System (IHP-ODS). By design, the IHP-ODS will allow Indian Health Programs and AIAN Medi-Cal beneficiaries to bypass the county-based ODS system and create a statewide "county equivalent" or "59th County" IHP-ODS. It is also designed to reflect culturally appropriate treatment services and community defined practices, as well as enhance fee/reimbursement schedules aligned with the current work at Indian Health Programs.

The IHP-ODS has not been implemented and is still in the concept stage. Tribal and Urban Indian health leaders are actively working on system design and implementation planning with partners at the Centers for Medicare and Medicaid Services, DHCS, and IHS.

MAT Expansion

The 21st Century CURES Act was passed in December 2016, allowing the Substance Abuse and Mental Health Services Administration (SAMHSA) to award grants under the State Targeted Response to the Opioid Crisis initiative to provide prevention, treatment, and recovery services with the primary aim of reducing opioid overdose-related deaths. DHCS received State Targeted Response (STR) funding to implement the Hub and Spoke system, increase the statewide availability of buprenorphine, and increase the use of medication-assisted treatment (MAT) in Tribal and Urban Indian communities. DHCS also launched the MAT Expansion Project with a

sub-project called the Tribal MAT Project. Please see the Tribal MAT Project Evaluation Report for additional information on these efforts.

Report Aims

Through the Tribal MAT Project, the USC team developed and released *Addressing the Opioid Crisis in American Indian & Alaska Native Communities in California: A Statewide Needs Assessment* in 2019 (Soto et al., 2019). This needs assessment report identified gaps in SUD and opioid use disorder (OUD) prevention, treatment, and recovery services accessible to AIAN community members in California. **A primary recommendation from this work was to increase the availability of detox, residential, and sober living facilities.** In response, DHCS funded the USC team to survey existing community-based programs that included Tribal Health Programs (THP), Urban Indian Health Programs (UIHP), Native-specific residential treatment facilities (RTF), and sober living facilities (SLF) to understand what services are available to AIAN individuals with SUD, with an emphasis on identifying traditional healing and culturally adapted services. These facilities serve different roles in the addiction medicine continuum of care, with THPs and UIHPs providing outpatient services, RTFs providing 24-hour inpatient SUD treatment, and SLFs providing group home environments after completion of inpatient treatment.

The USC team gathered and compiled information on these facilities and prepared this report to provide a better understanding of the available SUD recovery services and recommendations to sustain and meet the needs of services to reduce SUD among AIAN populations in California. This report includes a summary of the services available, service eligibility criteria, current funding sources, program partnerships and networks, existing barriers to care, and service gaps identified by the community. The report culminates in recommendations for policy stakeholders and Tribal and Urban Indian communities.

Methods

Community Advisory Board

A nine-member community advisory board (CAB) was developed to include experts in the areas of traditional healing, residential treatment, and SUD treatment. All CAB members have extensive experience working with AIAN communities, and seven CAB members identify as AIAN. Members provided cultural guidance and assistance with project activities including the identification of all eligible facilities for participation and the development of survey and key informant interview guide questions. The survey and interview questions were developed by the USC team based on a list of key variables discussed with the CAB and informed by their

expertise and community insight. In addition, CAB members assisted with facility recruitment, data analysis, and the development of this report.

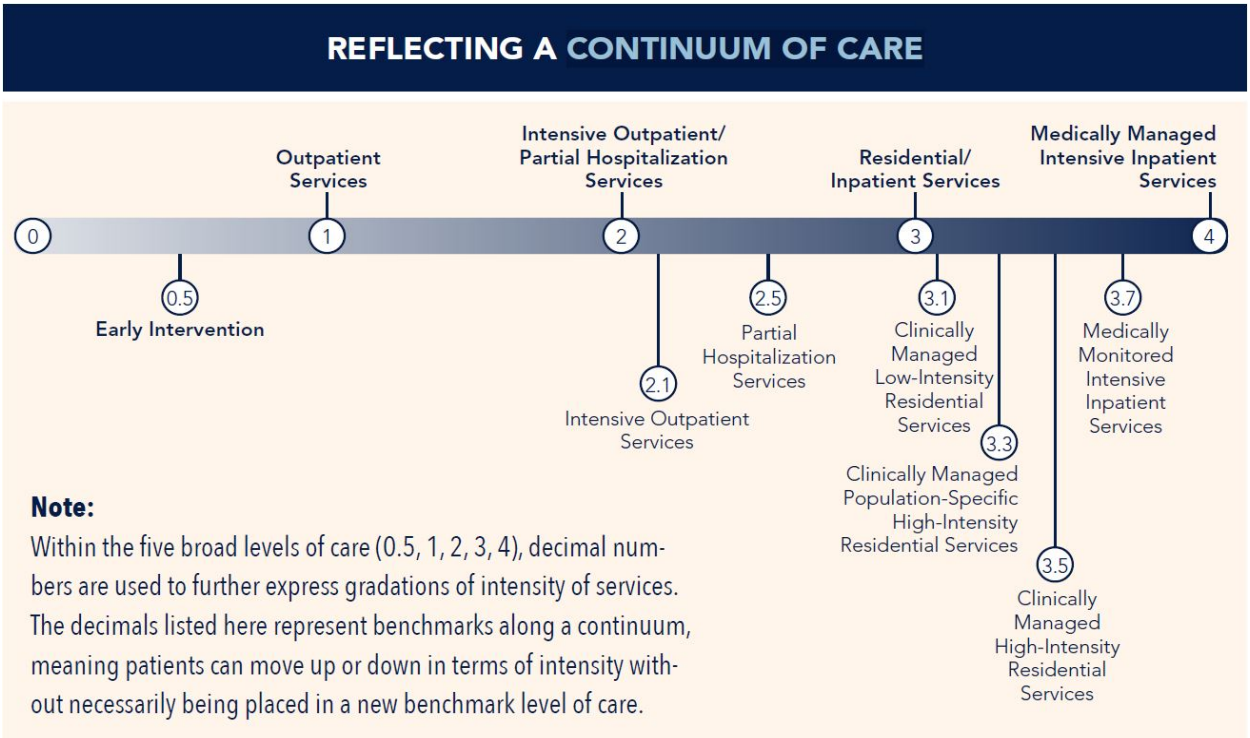
Surveys

Eligible facilities (N=50) in California included 34 THPs, eight UIHPs, five adult-specific RTFs, one youth-specific RTF, one mental health center, and one SLF. The survey was administered using Qualtrics. Facilities were invited to participate with direct emails from the Indian Health Services (IHS) California Area representative, CAB members, and the USC team. The locations of the participating facilities can be found in Figure 2.

The survey asked a broad range of questions to ensure a complete picture of the services available to AIAN individuals with SUD were captured. To characterize each facility type, the survey asked about populations served, eligibility requirements, funding sources, and ASAM levels of care. ASAM provides facilities with a level of care from 0.5 (early intervention) to 4 (medically managed intensive inpatient services); each level indicates the breadth and availability of services at each facility. Figure 1 provides a brief description of what the ASAM levels mean (American Society of Addiction Medicine, 2015). The survey also asked about relapse prevention and maintenance services, traditional healing and culturally adapted services, and assistance with enrollment in safety net resources. Relapse prevention and maintenance services were an area of interest because they are necessary for continued sobriety, personal growth, health, and wellness when individuals return home to their families and communities. Available traditional healing and culturally adapted services were another area of interest as these services are an essential piece of holistic care for AIAN individuals and incorporating them into recovery treatment models can improve mental, physical, emotional, and spiritual well-being. The survey also asked about each facility's capacity to provide assistance with client enrollment in safety net resources as these services are especially important in supporting individuals' unique needs external to treatment. Enrollment in safety net resources can be a very important part of harm reduction as well as recovery support while individuals complete treatment and prepare for their return to the community.

Figure 1

ASAM levels of care



Note: From "What are the ASAM Levels of Care? – ASAM Continuum | ASAM Criteria Decision Engine." By American Society of Addiction Medicine. (2015).

Please note that since the survey did not define an age for "youth," participants may have interpreted the term differently. Some health facilities may designate youth as minors below 18 years of age and, depending on source of funding, some consider youth as individuals up to 26 years of age. Consequently, this report references the broadest definition of youth: individuals up to 26 years old.

Of the 50 eligible facilities invited to participate, 40 facilities completed the Qualtrics survey, including 27 THPs, six UIHPs, five adult-specific RTFs, one youth-specific RTF, and one mental health center. All facilities that participated in the survey are presented below in Table 1. However, it should be noted that both American Indian Changing Spirits (adult RTF) and American Indian Counseling Center (mental health center) do not receive IHS funding.

The USC team used IBM SPSS Statistics (version 27) to perform data analysis. Frequencies and cross tabulations were used to describe facilities grouped by type (i.e., THP, UIHP, adult RTF, YRTF, mental health center). To clearly identify the organizational structure, funding, and direct/referral services available within these facilities, all quantitative survey data were analyzed by facility type and will be presented in separate results sections to allow distinction.

Table 1

Tribal Health Programs (THP)	
Anav Tribal Health Clinic (Quartz Valley Program)	Riverside/San Bernardino County Indian Health, Inc.
Central Valley Indian Health, Inc.	
Chapa-De Indian Health Program, Inc.	Round Valley Indian Health Center, Inc.
Consolidated Tribal Health Project, Inc.	Santa Ynez Tribal Health Clinic
Feather River Tribal Health, Inc.	Shingle Springs Tribal Health Program
Fort Yuma Indian Health Center	Sonoma County Indian Health Project
Greenville Rancheria Tribal Health Program	Southern Indian Health Council, Inc.
Indian Health Council, Inc.	Strong Family Health Center
Karuk Tribe (Happy Camp)	Susanville Indian Rancheria
K'ima:w Medical Center	Toiyabe Indian Health Project, Inc.
Lake County Tribal Health Consortium, Inc.	Tule River Indian Health Center, Inc.
Northern Valley Indian Health, Inc.	Tuolumne Me-Wuk Indian Health Center
Pit River Health Service, Inc.	United Indian Health Services, Inc.
Redding Rancheria Tribal Health Center	Warner Mountain Indian Health Program
Urban Indian Health Programs (UIHP)	
Bakersfield American Indian Health Project	San Diego American Indian Health Center
Fresno American Indian Health Project	United American Indian Involvement
Native American Health Center	
Sacramento Native American Health Center	
Adult Residential Treatment Facilities (RTF)	
Friendship House Association of American Indians*	Tule River Alcoholism Program
Native Directions, Inc.*	American Indian Changing Spirits**
Sierra Tribal Consortium, Inc. (Turtle Lodge)	
Youth Residential Treatment Facilities (YRTF)	
Desert Sage Youth Wellness Center	
Mental Health Center	
American Indian Counseling Center**	

* The RTF is also considered an UIHP.

**The program does not currently receive IHS funding.

Key Informant Interviews

Beginning August to October 2020, 13 interviews were completed with representatives from selected THPs, UIHPs, RTFs, and SLF (see Table 2 for complete list). Facilities were strategically selected for participation in interviews with guidance from CAB members with the goal of having representation from each facility type (THP, UIHP, RTF, SLF) serving AIAN communities across northern, central, and southern California. The interviews provided an opportunity for more in-depth conversations with program staff and administration to learn about the accessibility of Native-specific treatment services, traditional healing and culturally adapted services, funding support, program partnerships/referral networks, and barriers to care. Participants included directors of behavioral health services, chief program officers, program directors, senior counselors, assistant directors, health system administrators, cultural and recreation specialists, chief executive officers, clinical supervisors, and executive directors. All interviews were recorded with permission for transcription and a notetaker was present for all interviews.

The USC team used ATLAS.ti (version 8) to code and analyze interview data. The coding approach for analyzing interview data was developed using thematic analysis (Braun & Clarke, 2006). A codebook was developed collaboratively by the USC team and CAB, and all transcripts were coded by at least two team members. Weekly meetings focused on identifying themes and achieving consensus on how to code specific interview pieces. Key themes included the importance of partnerships and networks, the impact of cultural services, barriers, funding, stigma, and impacts of COVID-19. Unlike the analysis of survey results, emerging themes identified across interviews will not be divided by facility type. Instead, interview results will be presented collectively in one section to maintain confidentiality because of the small sample size (n=13).

Table 2

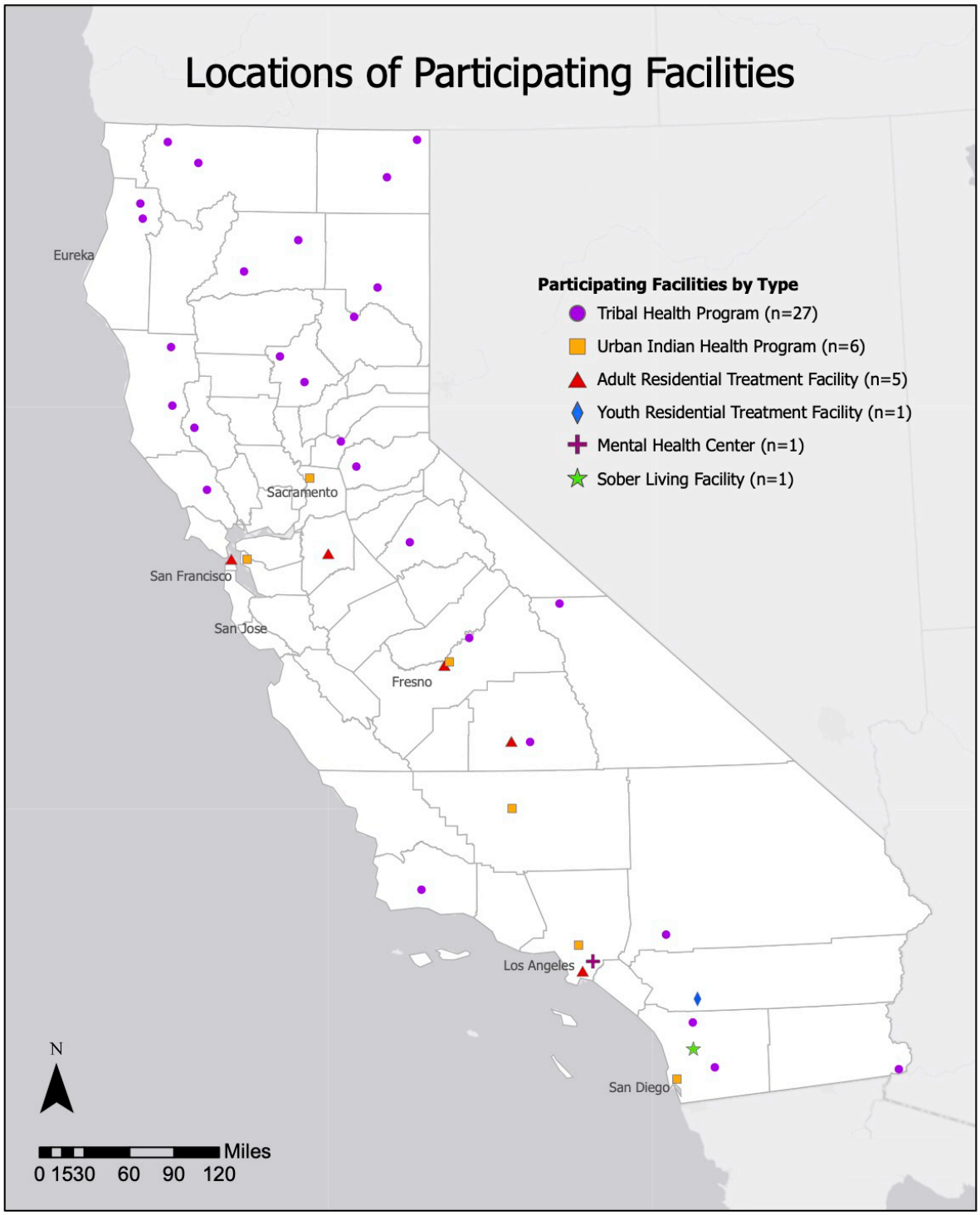
Facilities that participated in key informant interviews

Tribal Health Programs (THP)	
Riverside/San Bernardino County Indian Health, Inc.	Sonoma County Indian Health Project
Urban Indian Health Programs (UIHP)	
Fresno American Indian Health Project	San Diego American Indian Health Center
Sacramento Native American Health Center	United American Indian Involvement
Adult Residential Treatment Facilities (RTF)	
American Indian Changing Spirits*	Native Directions, Inc.
The Friendship House Association of American Indians	Sierra Tribal Consortium, Inc./Turtle Lodge
	Tule River Alcoholism Program
Youth Residential Treatment Facilities (YRTF)	
Desert Sage Youth Wellness Center	
Sober Living Facility (SLF)	
Natives in Recovery, Inc.*	

*The program does not currently receive IHS funding.

Figure 2

Map of all facilities that participated in the survey and/or interview



Quantitative Results

Tribal Health Programs

There are currently 34 THPs in California and 27 participated in the survey. Tribal Health Programs (THPs) are health clinics based on or near reservations and rancherias and managed by specific AIAN Tribes; they maintain core contracts or are compacted with the IHS to provide a range of healthcare services for AIAN community members. Federally recognized Tribes have the authority to decide if they want to receive health care directly from the IHS, contract with the IHS to administer programs and services, or compact with the IHS "to assume control over health care programs" (Indian Health Service, 2018). As there are no facilities directly operated by the IHS in California, emergency and inpatient care cannot be provided specifically for AIANs. THPs provide services such as outpatient medical, dental, behavioral health, substance use, and cultural health services. Some THPs serve only one federally recognized Tribe, while others are consortia of Tribes providing services to their members. These facilities also provide education, prevention, and other wellness services to their communities.

ASAM Level

The highest ASAM level reported was 2.1. Eleven of the THPs have an ASAM level of 1.0, which means their programs have the capacity to provide a maximum of nine hours a week of outpatient recovery services for adults and six hours for adolescent patients (American Society of Addiction Medicine, 2015). Three facilities reported ASAM levels of 2.0 to 2.1, which means that in addition to the services offered at the 1.0 level, these facilities have the capacity to treat the complex needs of individuals with addiction and co-occurring conditions in an outpatient setting (American Society of Addiction Medicine, 2015). Thirteen facilities did not report their ASAM level.

Service Eligibility Requirements

All 27 THPs serve men, women, and youth. Only one facility provides inpatient services, with five inpatient beds available for men and six beds available for women. None of the THP respondents reported inpatient beds available for youth. Eleven of the THPs require documentation to confirm an individual's IHS eligibility, such as a Certificate of Degree of Indian Blood, a Bureau of Indian Affairs letter, or a Tribal ID card. Some facilities may also require address verification to confirm residency within their IHS service area. As seen in Table 3, only one facility requires detox or abstinence from substances to begin services. This is consistent with the role of THPs within the ASAM continuum of care, as clients may access initial substance use screening, outpatient treatment, and recovery support from local THPs in addition to their general medical, psychiatric, and behavioral health services. Therefore, THPs are a primary resource for individuals just starting their road to recovery.

Twelve of the 27 THPs require mental health evaluations to be completed, in some cases during a patient's initial visit or assessment (Table 3). These evaluations are conducted by behavioral health specialists and qualified staff and may consist of mental health service questionnaires, biopsychosocial assessments, and other mental health intake screenings (e.g., PHQ-9). Including these mental health evaluations as part of the initial patient assessment and intake process allows the THPs to gain an understanding of each patient's comprehensive healthcare needs.

Table 3

Service eligibility requirements at the THPs (n=27)

Service eligibility criteria	Number of facilities responding "Yes"
Clients need to identify as AIAN to receive services	11
If yes, is self-identification sufficient to receive services?	3
Clients need to be California residents to receive SUD, OUD, or mental health services	13
Clients need to register with IHS to receive SUD, OUD, or mental health services	5
Clients are required to be abstinent from substances in order to receive services	1
Clients are required to enter pretreatment or detox before accessing services	1
Clients need to have a primary SUD diagnosis in order to receive services	4
If yes, which primary diagnoses allow a patient/client to be eligible for services?	
SUD	6
OUD	5
Other	2
Clients are required to have a mental health evaluation to receive services	
All patients/clients are required to have one	7
In some cases, but not all	5
No patients/clients are required to have one	13
Facility conducts the mental health evaluation	12

Funding Sources

Major sources of funding for SUD and mental health services within the participating THPs include IHS, Medi-Cal/Medicare, federal and state grants (e.g., SAMHSA Tribal Opioid Response

grants, CalWORKs), and private insurance (Table 4). As IHS funding is finite, the additional sources (e.g., Medi-Cal/Medicare) provide third party revenue, which can be used to support and expand the services available to the community. It is important to highlight that the vast majority of THPs do not receive DMC funding for their SUD services (Table 4). This gap in funding should be acknowledged as it limits valuable revenue which could provide a substantial range of services for AIAN individuals in California.

In addition to IHS core contract or compact funding, THPs also receive funding through IHS competitive grant programs such as the Methamphetamine and Suicide Prevention Initiative and the Special Diabetes Program for Indians. Other sources of funding reported for SUD and mental health services include the Health Resources and Services Administration, Veterans Administration (e.g., VA Choice Program), DHCS Hub and Spoke, and the California Rural Indian Health Board, Inc. (CRIHB). More than half of the participating THPs also provide a sliding scale fee option to support individuals who may be uninsured or underinsured (Table 4).

Table 4

Funding and/or payment sources for SUD services and/or mental health services at THPs (n=27)

Funding and/or payment source	Number of THP facilities
Medi-Cal and/or Medicare	26
Drug Medi-Cal (DMC)	2
Private insurance (HMO and/or PPO)	23
DHCS	4
Partnerships with local organizations/agencies	8
IHS	25
Federal or state grants	22
Private foundation	1
Other	10
Cash/check/private pay	15
Sliding fee	15

Available Services

Table 5 presents both the general services offered both within the 27 THP facilities surveyed and the services offered by referral. Almost all THPs provide community outreach, primary care services, and SUD patient education to adults and youth within their facility. Laboratory drug testing, family reunification services, and transgender-inclusive resources and services are also available within THP facilities. Additional general services reported by the THP respondents

include dental, pharmaceutical, and nutritional services (e.g., Special Supplemental Nutrition Program for Women, Infants, and Children).

Table 6 shows the in-depth treatment services offered within THP facilities. These services include SUD screening, brief or crisis intervention, individual and group therapy, and discharge/aftercare services for adults and youth. Twenty-five of the THP respondents stated their facilities' SUD and mental health services are trauma informed. One THP respondent stated that equine therapy is offered through their facility as well. Another THP respondent stated transitional housing is available for men (within their facility) and women (by referral), and batterer's intervention courses are provided for men and women. Additionally, some THPs provide client transportation to outside recovery support meetings and events (e.g., Alcoholics Anonymous/Narcotics Anonymous meetings, recovery conventions, and annual Sobriety Camp).

Twenty-two THP respondents reported that substance use treatment services are also available for youth within their facilities. Services include alcohol and other drug (AOD) education and prevention activities, crisis intervention, 12-step programs (e.g., White Bison's Red Road to Wellbriety and/or other Red Road approaches), individual and group counseling, psychiatric services, and case management. One THP respondent stated their facility used the five-year SAMHSA Youth and Family TREE grant to provide mental health and SUD services specifically for youth and young adults. Other general and prevention programs that are available to youth at the participating THP facilities include afterschool programs, suicide education and training, tutoring, and summer outreach programs.

Table 5

Number of THP facilities that reported general services (n=27)

General service	Within facility				By referral			
	Adults only	Youth only	Adults & youth	NA /unknown	Adults only	Youth only	Adults & youth	NA /unknown
Primary care	-	-	26	1	-	-	11	16
DUI program	2	-	1	24	5	-	6	16
Laboratory drug testing	4	-	18	5	2	-	7	18
Family reunification services	-	1	6	20	1	-	9	17
Transgender-inclusive resources and services	1	-	16	10	-	1	9	17
OUD/SUD patient education[a]	2	-	21	4	-	-	9	18
School-based services	1	3	8	15	-	5	4	18
Community outreach	-	-	25	2	-	-	6	21
Other	-	-	3	24	-	-	1	26

[a] e.g., criminal justice mandated programs

Table 6

*Number of THP facilities that reported treatment services **in facility*** (n=27)*

Treatment service	Adults only	Youth only	Adults & youth	NA /unknown
Screening for OUD and SUD	1	-	23	3
Brief intervention for OUD and SUD	1	-	23	3
Crisis intervention	-	-	22	5
Discharge/aftercare planning	1	-	19	7
Inpatient detox	-	-	-	27
Outpatient detox	1	-	4	22
Medication management for co-occurring disorders	1	-	21	5
Residential treatment	-	-	-	27
Sober living/transitional housing	1	-	-	26
In-house physician consultation	-	-	18	9
Access to emergency/inpatient services	-	-	3	24
Intensive outpatient programs (IOP)	2	-	7	18
Individual therapy[a]	1	-	24	2
Peer-led group therapy/support	5	-	7	15
Provider-led group therapy/support	3	-	19	5
Gender-specific group therapy	3	1	9	14
Cultural activities as recreational therapy for anxiety and stress management[b]	-	1	16	10
Recreation therapy for anxiety and stress management[c]	-	1	15	11
Family therapy	-	-	23	4
Couples therapy	4	-	17	6
Wellbriety/Red Road	5	-	16	6
Other	-	1	1	25

* Treatment services offered by referral can be found in Appendix A (Table A2).

[a] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[b] e.g., basket making, regalia making, other traditional arts

[c] e.g., outdoor activities, fitness groups, music

As seen in Table 7, most THP respondents reported their facilities offer prescription MAT medications, including buprenorphine/suboxone, naloxone, and naltrexone. A few THP respondents reported that methadone, disulfiram, and acamprosate may be prescribed as part of MAT services within their facilities. Dual diagnosis treatment is provided by qualified staff (e.g., psychiatrist, certified SUD counselor, licensed clinical social worker) at 24 THPs. Services reported include, but are not limited to, psychiatric care, individual and group SUD or behavioral health counseling and therapy, eye movement desensitization and reprocessing (EMDR), medication management, MAT, case management, and cultural activities such as talking circles and drumming. Additionally, almost all THPs provide prescription medication for patients with a dual diagnosis, including antidepressants, antipsychotic, anti-anxiety, and mood stabilizers.

Table 7

Number of THP facilities that reported prescribing MAT medications (n=27)

MAT medication	**Within facility**[a]			**By referral**			
	Adults only	Adults & youth	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Methadone	2	-	25	4	-	10	13
Buprenorphine/Suboxone	8	11	8	3	1	3	20
Naltrexone	8	9	10	3	-	3	21
Naloxone	8	10	9	2	-	2	23
Disulfiram	3	4	20	1	-	3	23
Acamprosate	3	3	21	1	-	3	23
Other	-	-	27	-	-	-	27

[a] The "Youth Only" column has been omitted from this section of the table as no facility selected this response.

Twenty-six of the participating THPs reported the use of telehealth services. Some of the telehealth services available include a range of primary care, outpatient psychiatry, psychotherapy, SUD and behavioral health individual/group counseling sessions, recovery support (e.g., White Bison's Red Road to Wellbriety and/or other Red Road approaches), MAT, medication management, and case management. One THP respondent stated their facility used telehealth to reach AIAN individuals in county jail and other hard-to-reach populations. The use of telehealth services by THPs may also expand the facilities' base of providers and services available for patient access. See Appendix A (Tables A1-A3) for full survey information on the availability of services and dual diagnosis medications offered within facility or by referral.

Although participating THPs are not designed to offer inpatient detox within their facilities, referrals are provided to outside agencies whenever necessary. It should be noted, however, that these referrals are often to detox centers outside the Indian health care network and even outside the referring clinic's county. One THP respondent also noted that there are very few detox centers that accept standard Medi-Cal, which may present an additional challenge for Tribes with limited IHS resources and for clients with limited funding resources. THPs will also refer patients to RTFs for higher levels of inpatient care and recovery support when treatment needs exceed the capacity of their outpatient facilities. The THP respondents shared some of the RTFs used for patient referral, which included Friendship House, Tule River, Sierra Tribal Consortium (Turtle Lodge), American Indian Changing Spirits, Native Directions (Three Rivers Indian Lodge), and, for youth, Desert Sage Youth Wellness Center. However, it was noted that patient access to residential treatment depends on the availability of beds, particularly within the Indian health care network where the number of RTFs are limited. One THP respondent stated that there are currently no residential or detox facilities located within their county and that a DMC contract and, more specifically, an IHP-ODS within DMC, would allow their clinic to access detox centers and RTFs outside the county and within the Indian health care network.

Relapse Prevention and Maintenance Services

Relapse prevention and maintenance services available within the participating THP facilities, or by referral, are listed below in Table 8. Some of the relapse prevention and maintenance services available within the majority of participating THPs include case management, family services, life skills training, anger management, and commercial tobacco cessation services. THP respondents also stated their facilities may continue to offer outpatient recovery support groups, such as White Bison's Red Road to Wellbriety groups, for clients that have completed recovery treatment or services. Another THP respondent shared that although their facility does not offer ongoing case management, community health representatives do provide home visits for clients with medical issues.

Table 8

Number of THPs that reported relapse prevention/maintenance services (n=27)

Relapse prevention/ maintenance service	Within facility				By referral			
	Adults only	Youth only	Adults & youth	NA /unknown	Adults only	Youth only	Adults & youth	NA /unknown
Case management	3	-	19	5	-	1	5	21
Self-help and support groups[a]	2	-	13	12	-	1	15	11
Recovery coaching	2	-	13	12	-	-	6	21
Employment coaching	2	1	7	17	1	-	10	16
Refusal training	1	1	6	19	-	-	6	21
Family services[b]	3	-	20	4	1	-	6	20
Life skills training	2	1	15	9	1	1	7	18
Family groups	-	-	11	16	1	-	8	18
Anger management	3	-	15	9	2	-	10	15
Commercial tobacco cessation services	1	-	16	10	-	-	7	20
Other	-	-	2	25	-	-	-	27

[a] e.g., Alcoholics Anonymous, 12-step groups
[b] e.g., marriage counseling, parenting training

Traditional Healing and Culturally Adapted Services

Integrating traditional healing and cultural practices within SUD treatment requires the support of culturally competent staff. All 27 THP facilities offer cultural sensitivity and awareness training, but only 17 locations require this training for all staff members. Eleven of the facilities provide cultural sensitivity and awareness trainings to outside providers and community partners including county health and human services departments, local health facilities, medical providers, SUD counselors, probation officers, court workers, Temporary Assistance for Needy Families (TANF) employees, Tribal agencies, and Tribal police. Cultural sensitivity and awareness training topics include the history of the AIAN community, AIAN cultural practices, cultural humility, historical trauma, and providing trauma informed care. Some specific training programs mentioned include the White Bison's Red Road to Wellbriety, Mending Broken Hearts, and other Red Road approaches. Training opportunities may also be provided through CRIHB, local universities, or health facilities.

Each THP facility reported traditional healing and culturally adapted services available either within their facility or by referral (Table 9). Multiple THP respondents stated their facilities

utilize the insight of community, Elder, and youth advisory committees to guide their facilities' cultural approach to treatment and service delivery. Opening and closing prayers and smudging are often included before and after meetings, events, talking circles, and/or gatherings, such as Gatherings of Native Americans (GONAs). One THP respondent also stated that prayer and sage burning may be used to assist in mental health and SUD treatment. Fifteen facilities reported offering group prayer and ceremonies for both adults and youth within their facility. Several THP respondents stated their facility provides access to specific infrastructure (e.g., sweat lodges, arbors, roundhouses) to support client participation in ceremonial activities. Commonly used ceremonial and traditional medicines available within THP facilities include sage, ceremonial tobacco, sweet grass, cedar, and angelica root. Other cultural activities available within these facilities include, basket weaving, plant gathering, jewelry making, singing, drumming, and beading. THP respondents also reported their facilities' use of culturally adapted program curriculums, guest cultural practitioners, and encouraged client attendance at community events focused on AIAN culture. THPs may also provide client referrals for cultural activities and ceremonies (e.g., Bear Dance) offered outside their facilities as well.

The cultural importance of food is shared within THPs during activities such as weekly cooking sessions, educational cultural food classes for individuals with diabetes, and holiday events with a potluck style dinner. One THP respondent stated their facility also hosts events to share how certain foods are prepared within AIAN cultures and how to process livestock. Food is also blessed and provided for group meetings and for gatherings with Elders. Furthermore, one THP respondent mentioned that both a community garden and food sovereignty program are also made available to their clients.

Cultural and traditional healers are consulted for treatment of patients and clients within some facilities. Elders may be available in-house or by referral. One THP facility explicitly mentioned periodically contracting with cultural practitioners to provide clients with the opportunity to learn more about AIAN traditional and cultural practices throughout their treatment as part of the healing process.

Table 9

Number of THPs that reported traditional healing/culturally adapted services (n=27)

Traditional healing/culturally adapted service	Within facility				By referral[a]	
	Adults only	Youth only	Adults & youth	NA /unknown	Adults & youth	NA /unknown
Use of ceremonial and traditional medicines in group settings	2	-	15	10	7	20
Use of ceremonial and traditional medicines for individual use[b]	2	-	14	11	6	21
Cultural uses of food	1	-	11	15	6	21
Group prayers and ceremonies	-	1	14	12	8	19
Individual prayers and ceremonies	-	-	9	18	7	20
Consultations with traditional persons, Elders, and leaders	-	-	9	18	13	14
Infrastructure to support ceremonial activities[c]	1	-	10	16	9	18
Other	-	-	-	27	-	27

[a] The "Adults only" and "Youth only" columns have been omitted from this section of the table as no facility selected these responses.
[b] e.g., sage, sweet grass, tobacco
[c] e.g., sweat lodge, arbor, roundhouse

Assistance with Safety Net Resource Enrollment

Facilities reported the ability to support client enrollment in many safety net resources. Enrollment in medical care resources, such as Medi-Cal and Medicare resources, is supported at 23 of the participating facilities. Enrollment support is also available for transportation resources, such as bus vouchers and van services. This is especially important for individuals who are not able to travel to work and treatment/therapy services at the THP facilities. Food and nutrition service enrollment is also offered at over 50% of these facilities. Assistance with enrollment in domestic and intimate partner violence resources is also offered at the THP locations. Clients are provided referrals for support with enrollment in safety net resources such as utility bill assistance, housing resources, and other services not available within THP facilities. One facility mentioned that many of these services are provided through an individual's Tribe. For full survey data regarding assistance with enrollment in safety net resources (direct or by referral), see Appendix A (Table A4).

Urban Indian Health Programs

This section will review the survey responses from six UIHP facilities. Urban Indian Health Programs (UIHPs) are health clinics that have a core contract with IHS. UIHPs were created to address issues in health care service delivery to AIAN individuals that were a result of cultural barriers, healthcare provider prejudice, and lack of understanding of AIAN health issues (Kidwell et al., 1988). UIHPs provide a broad range of outpatient health care services to AIAN individuals residing off Tribal lands. Similarly to THPs, UIHPs provide services such as outpatient medical, dental, behavioral health, substance use, and cultural health services. These facilities also provide education, prevention, and other wellness services to their communities. There are ten UIHPs in California, including two RTFs. Survey data from two UIHP RTFs are presented in the RTF section. Six of the remaining eight UIHPs participated in the survey.

ASAM Level

The six participating UIHPs have ASAM levels ranging between 0.5 and 1.0. One UIHP reported an ASAM level of 0.5, suggesting that facility has the capacity to provide early intervention services for individuals who are at risk but may not yet be diagnosed with OUD or SUD (American Society of Addiction Medicine, 2015). The remaining five UIHP respondents reported an ASAM level of 1.0, indicating that their facilities can provide a range of outpatient addiction recovery and therapy services for up to 9 hours a week for adults or up to 6 hours a week for adolescent patients (American Society of Addiction Medicine, 2015).

Service Eligibility Requirements

All six UIHPs reported that outpatient services are available to men, women, and youth. As seen in Table 10, three UIHPs require individuals to identify as AIAN and provide documentation such as a Certificate of Degree of Indian Blood or Tribal ID cards to confirm IHS eligibility. None of the facilities require patients to have a primary SUD diagnosis, nor do they require individuals to be abstinent from substances to receive treatment within their facility. These data are consistent with the status of UIHPs within the ASAM continuum of care as a primary source of prevention, initial screening, and outpatient recovery services for Urban Indian community members. Patients may be required to obtain a mental health evaluation as part of the intake process and initial patient assessment. These evaluations are typically facilitated by qualified staff within the UIHP prior to initiating therapy or services. The mental health evaluations are used to assess the patients' biopsychosocial history, various risk factors (e.g., food insecurity, relationship safety), mental health disorders, and/or substance use.

Table 10

Service eligibility requirements at the UIHPs (n=6)

Service eligibility criteria	Number of facilities responding "Yes"
Clients need to identify as AIAN to receive services	3
If yes, is self-identification sufficient to receive services?	1
Clients need to be California residents to receive SUD, OUD, or mental health services	5
Clients need to register with IHS to receive SUD, OUD, or mental health services	1
Clients are required to be abstinent from substances in order to receive services	-
Clients are required to enter pretreatment or detox before accessing services	1
Clients need to have a primary SUD diagnosis in order to receive services	-
If yes, which primary diagnoses allow a patient/client to be eligible for services?	
SUD	-
OUD	-
Clients are required to have a mental health evaluation to receive services	-
All patients/clients are required to have one	-
In some cases, but not all	5
No patients/clients are required to have one	1
Facility conducts the mental health evaluation	5

Funding Sources

Historically, funding for UIHPs has accounted for an extremely small proportion of the total IHS budget. This limited funding requires UIHPs to seek funding from other federal agencies to expand their capacity and diversify their services to meet the needs of Urban AIANs. As seen in Table 11, major sources of funding for SUD and mental health services at UIHPs include IHS, federal and state grants (e.g., SAMHSA Native Connections and CalWORKs), Medi-Cal/Medicare, and some private insurance. One respondent stated that SUD funding is also provided through the California Consortium for Urban Indian Health (CCUIH), a statewide organization serving Urban Indian communities through advocacy, shared resources, program support, and promotion of health and wellness. UIHP respondents stated that in addition to core contracts, IHS funding may also be attained through competitive IHS grants including the "4-in-1" grant program, Methamphetamine and Suicide Prevention Initiative, Domestic Violence Prevention Initiative, and Special Diabetes Program for Indians grant program. Three of the six UIHP

respondents stated their facilities also provide a sliding scale fee option for patients who are uninsured or underinsured (Table 11). The capacity to offer this option to patients is likely based on their status as federally qualified health centers.

It should be noted that IHS funding is finite and, consequently, often the payer of last resort for UIHP patient services. Therefore, UIHPs must rely on funding from various sources, including Medi-Cal and Medicare, to sustain their facilities and expand the services available to the AIAN community. Interestingly, all UIHPs reported zero funding from DMC (Table 11). This is consistent with the same funding gap identified by THPs and, consequently, across California IHPs providing SUD services for AIAN individuals.

Table 11

Funding and/or payment sources for SUD services and/or mental health services at UIHPs (n=6)

Funding and/or payment source	Number of UIHP facilities
Medi-Cal and/or Medicare	5
Drug Medi-Cal (DMC)	-
Private insurance (HMO and/or PPO)	4
DHCS	1
Partnerships with local organizations/agencies	3
IHS	6
Federal or state grants	4
Private foundation	2
Other	1
Cash/check/private pay	2
Sliding fee	3

Available Services

Tables 12-13 present the continued range of services provided by the UIHPs. Most UIHPs provide primary care, community outreach, SUD education, screening, and brief intervention within their facilities. These UIHPs also provide crisis intervention, individual/group therapy, cultural activities, and White Bison's Red Road to Wellbriety and/or other Red Road approaches for adults and/or youth. Most UIHPs provide MAT services and as seen in Table 14, naloxone was the most frequently reported MAT medication prescribed within facility.

UIHP respondents also reported the availability of general/prevention services and SUD treatment specifically for youth within their facilities. These youth services include educational programs, cultural activities, outpatient mental health and SUD counseling, individual therapy,

and behavioral health groups and services. Some of the cultural services provided by these facilities include GONA and cultural strengthening events. UIHPs also offer youth outreach and wellness programs, after school programs, and clubhouse prevention programs. Youth, teen, and transitional group activities that focus on a broad range of educational topics (e.g., mental health, sexuality, substance use) are also available at some UIHPs. These various programs and activities mentioned by UIHP respondents help create a welcoming environment for youth to receive prevention and treatment services.

As seen in Table 13, UIHPs do not provide inpatient detox, residential treatment, or sober living within their facilities. This is expected as UIHPs are not designed to offer inpatient treatment and support services. The UIHP respondents shared some of the detox centers they often refer clients to, which consist of mostly privately owned or county-funded facilities outside the Indian health care network. Respondents also listed some of the RTFs their UIHPs typically refer patients to, including Friendship House, Tule River Alcoholism Program, Native Directions (Three Rivers Indian Lodge), American Indian Changing Spirits, and Sierra Tribal Consortium Inc. (Turtle Lodge), all of which are AIAN culturally centered residential treatment programs. While the wide variety of services provided to AIAN individuals at these facilities demonstrates the strength of these programs and the Indian health care network, the number of AIAN specific treatment centers within California is limited. Therefore, patients may also be referred to treatment centers outside the Indian health care network, when necessary.

Table 12

Number of UIHPs that reported general services (n=6)

General service	**Within facility**				**By referrals**			
	Adults only	Youth only	Adults & youth	NA /unknown	Adults only	Youth only	Adults & youth	NA /unknown
Primary care	-	-	5	1	-	-	3	3
DUI program	-	-	-	6	1	-	4	1
Laboratory drug testing	-	-	5	1	-	-	3	3
Family reunification services	-	-	1	5	-	-	4	2
Transgender-inclusive resources and services	1	-	3	2	-	1	4	1
OUD/SUD patient education[a]	-	-	5	1	-	-	4	2
School based services	-	2	2	2	-	2	2	2
Community outreach	-	-	6	-	-	-	2	4
Other	-	-	-	6	-	-	-	6

[a] e.g., criminal justice mandated programs

Table 13

*Number of UIHPs that reported treatment services **in facility*** (n=6)*

Treatment service [a]	Adults only	Adults & youth	NA /unknown
Screening for OUD and SUD	-	6	-
Brief intervention for OUD and SUD	1	5	-
Crisis intervention	-	6	-
Discharge/aftercare planning	-	6	-
Inpatient detox	-	-	6
Outpatient detox	1	-	5
Medication management for co-occurring disorders	-	4	2
Residential treatment	-	-	6
Sober living/transitional housing	-	-	6
In-house physician consultation	-	5	1
Access to emergency/inpatient services	-	-	6
Intensive outpatient programs (IOP)	-	-	6
Individual therapy [b]	-	6	-
Peer-led group therapy/support	2	2	2
Provider-led group therapy/support	-	6	-
Gender-specific group therapy	-	2	4
Cultural activities as recreational therapy for anxiety and stress management[c]	-	6	-
Recreation therapy for anxiety and stress management [d]	-	6	-
Family therapy	2	4	-
Couples therapy	2	4	-
Wellbriety/Red Road	1	4	1
Other	-	-	6

* Treatment services offered by referral can be found in Appendix B (Table B2).

[a] The "Youth only" column has been omitted from this section of the table as no facility selected these responses.

[b] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[c] e.g., basket making, regalia making, other traditional arts

Table 14

Number of UIHP facilities that reported using MAT medication (n=6)

MAT medication	**Within facility**[a]			**By referral**[b]	
	Adults only	Adults & youth	NA/ Unknown	Adults & youth	NA/ Unknown
Methadone	-	2	4	3	3
Buprenorphine/Suboxone	2	2	2	3	3
Naltrexone	2	2	2	3	3
Naloxone	2	4	-	1	5
Disulfiram	1	-	5	4	2
Acamprosate	1	-	5	4	2
Other	-	-	6	-	6

[a] The "Youth only" column has been omitted from this section of the table as no facility selected this response.

[b] The "Adults only" and "Youth only" columns have been omitted from this section of the table as no facility selected these responses.

All UIHPs are equipped to provide services for individuals with dual diagnoses. Dual diagnosis services are facilitated by qualified staff (e.g., Certified Alcohol Drug Counselor, Licensed Clinical Social Workers, psychiatrists), and medications (e.g., antidepressants, antipsychotics, mood stabilizers) may also be prescribed for individuals with dual diagnoses within the participating UIHPs. Some facilities offer additional services for clients, including psychiatric care, anger management, and case management. One UIHP respondent also reported their facility offers empirically supported clinical interventions such as Seeking Safety, cognitive behavioral therapy, and eye movement desensitization and reprocessing (EMDR). Furthermore, UIHP respondents stated that traditional medicines are also available for clients with dual diagnoses. The availability of such services within UIHPs provides patient access to comprehensive treatment and holistic care.

UIHP respondents described some of the mental health and SUD telehealth services available through their programs as well. These services included individual, couple, or family outpatient sessions with counselors or therapists, trauma-informed care, youth treatment, group treatment, education, and recovery support/groups. Telehealth services are typically provided via Zoom, Doximity, or OTTO. Telehealth services allow UIHPs to expand their provider base and increase patient access to treatment and specialty care services. See Appendix B (Tables B1-B3) for full survey information on the availability of services and dual diagnosis medications offered within facility or by referral.

Relapse Prevention and Maintenance Services

As seen in Table 15, most UIHPs offer case management, life skills training, anger management, and family support groups to their clients as part of relapse prevention and maintenance services within their facilities.

Table 15

Number of UIHPs that reported relapse prevention/maintenance services (n=6)

Relapse prevention/maintenance services	**Within facility**				**By referral**			
	Adults only	Youth only	Adults & youth	NA /unknown	Adults only	Youth only	Adults & youth	NA /unknown
Case management	1	-	5	-	-	1	1	4
Self-help and support groups[a]	2	-	1	3	-	-	4	2
Recovery coaching	2	-	2	2	-	1	3	2
Employment coaching	-	1	2	3	-	-	4	2
Refusal training	-	-	1	5	-	-	4	2
Family services[b]	3	-	2	1	1	1	2	2
Life skills training	-	2	4	-	-	-	2	4
Family groups	-	-	5	1	-	-	1	5
Anger management	2	-	3	1	-	-	2	4
Commercial tobacco cessation services	2	-	3	1	-	-	4	2
Other	-	-	-	6	-	-	-	6

[a] e.g., Alcoholics Anonymous, 12-step groups
[b] e.g., marriage counseling, parenting training

Traditional Healing and Culturally Adapted Services

Integrating traditional healing and cultural practices within SUD treatment requires the support of culturally competent staff. All six UIHPs provide their employees with access to cultural sensitivity and awareness training. One facility reported that this training is mandatory for only some of the staff, while other facilities require all staff to complete this training. The training may address cultural competency, historical trauma, and the cultural components of providing treatment services for Urban AIAN individuals. Programs that host GONAs may also provide training for new staff members on how to facilitate GONAs. The six UIHPs also make trainings

available to outside organizations and individuals including, but not limited to, local RTF and SLF staff, departments of mental health or child and family services, and juvenile justice employees.

Survey respondents were given the opportunity to share some of the culturally adapted services offered by their facilities. Table 16 presents the cultural services available to adults and/or youth through UIHPs. Most UIHP respondents reported that their facilities begin each activity, group, or meeting with an opening prayer. Group prayer is also included before the start of events such as suicide vigils, GONAs, and talking circles. As seen in Table 16, infrastructure support for activities such as sweat lodge ceremonies may not be available at all UIHPs; however, access may be provided by referral to outside locations when necessary. One respondent stated that providing access to such ceremonial infrastructure (e.g., sweat lodges) can be difficult at times and therefore limits opportunities for client participation in desired ceremonial activities. Four of the six UIHP respondents also mentioned that their facilities receive guidance from community advisory committees, and all six respondents stated that their facilities consult with traditional healers and Elders when providing culturally adapted services and traditional healing practices. Some traditional healers also visit these facilities to bless buildings, guide and facilitate traditional ceremonies and cultural activities, and/or meet with clients individually throughout their treatment to provide guidance. Smudging and the use of traditional medicines (e.g., sage, tobacco) is also available to clients and staff. UIHP staff can also participate in talking circles with traditional healers to support wellness and provide individualized guidance. One respondent also stated their facility provides education about each traditional medicine and its use, and one facility even offers a sage-picking workshop.

All six urban facilities incorporate the cultural importance of food within events and workshops for staff and patients. One UIHP respondent stated their facility provides traditional cooking classes for their community members. Another UIHP offers a group called “Culture is Prevention,” where AIAN cultural practices and food are shared to promote health and healing. Each of the cultural practices and ceremonies utilized by these UIHPs has become a central part of the treatment and services provided to their patients and continues to promote the health and wellness of AIAN community members.

Table 16

Number of UIHPs that reported traditional healing/culturally adapted services (n=6)

Traditional healing/culturally adapted services	**Within facility**[a]			**By referral**[b]	
	Adults only	Adults & youth	NA /unknown	Adults & youth	NA /unknown
Use of ceremonial and traditional medicines in group settings	-	5	1	2	4
Use of ceremonial and traditional medicines for individual use[c]	-	5	1	2	4
Cultural uses of food	-	6	-	2	4
Group prayers and ceremonies	-	6	-	1	5
Individual prayers and ceremonies	-	5	1	1	5
Consultations with traditional persons, Elders, and leaders	-	6	-	2	4
Infrastructure to support ceremonial activities[d]	1	2	3	4	2
Other	-	-	6	-	6

[a] The "Youth only" column has been omitted from this section of the table as no facility selected these responses.
[b] The "Adults only" and "Youth only" columns have been omitted from this section of the table as no facility selected these responses.
[c] e.g., sage, sweet grass, tobacco
[d] e.g., sweat lodge, arbor, roundhouse

Assistance with Safety Net Resource Enrollment

The survey asked respondents to share opportunities for enrollment in safety net resources available within their facilities or by referral. Most UIHPs assist with enrollment in medical care, transportation, and domestic violence safety net resources. Assistance also includes enrollment in gas or bus vouchers and transportation services, and enrollment in intimate partner violence resources for individuals who may be returning home to an environment where support is limited. Client enrollment in safety net housing, food/nutrition, vocational, and educational attainment resources may also be supported by staff within these facilities. If such client enrollment assistance is not available, the UIHPs will refer individuals to other local agencies that can ensure this support is provided. Full survey data regarding safety net resources can be found in Appendix B (Table B4).

Adult Residential Treatment Facilities

A residential treatment facility (RTF) is an inpatient health care program that provides 24-hour living support in a culturally sensitive environment for a range of 30 to 180 days where individuals receive SUD treatment. RTFs also provide therapy for behavioral health, mental health, and SUD that goes beyond the capacity of outpatient programs. RTFs may also provide traditional healing and culturally adapted services, SUD education, relapse prevention, and support with enrollment in safety net resources for individuals throughout the duration of their treatment.

There are six AIAN specific RTFs in California, all of which participated in our survey. One of these six serves only AIAN youth. To better distinguish between services for adults and youth, this section will focus solely on the five RTFs that primarily serve AIAN adults. A detailed review of information provided by the one youth-specific RTF will be included in the next section of this report.

ASAM Level

RTFs are assessed using the ASAM criteria levels. Three of the five adult RTFs surveyed reported a facility ASAM level of 3.1 and the fourth reported an ASAM level of 3.5. One facility did not report their ASAM level. Facilities with an ASAM level of 3.1 have the capacity to provide 24-hour living support coupled with a broad range of low-intensity clinical services facilitated by qualified medical personnel for a minimum of five hours each week (American Society of Addiction Medicine, 2015). In addition to these services, facilities with an ASAM level of 3.5 have a trained counselor to support clients with high-intensity residential service needs (American Society of Addiction Medicine, 2015). See Figure 1 for ASAM level descriptions and continuum of care.

Service Eligibility Requirements

All five of the adult RTFs reported having beds available for men while only three had beds for women. For men, the facility with the fewest number of beds had eight and the facility with the most beds had 40. For women, the facility with the fewest number of beds had five and the facility with the most beds had 47. None of the facilities reported serving youth.

Four of the five adult RTFs require individuals to provide documentation such as a Certificate of Degree of Indian Blood, Tribal enrollment forms, or lineal descendant paperwork to confirm IHS eligibility. Additionally, four of the RTFs surveyed require individuals to abstain from substance use to receive treatment (Table 17). Facilities generally require clients to be abstinent for 72 hours prior to entering treatment services. However, one facility mentioned that the duration of required abstinence depends on the substance used and the treatment protocol. Three of the five facilities require that patients enter pretreatment or detox prior to receiving inpatient residential treatment services (Table 17). However, only one RTF reported the capacity to provide such detox services for clients within their facility. This is important to acknowledge as

access to detox services is limited and only available through privately owned or county-funded centers outside the Indian health care network.

Three of the adult RTFs also require some patients (on a case-by-case basis) to complete mental health evaluations prior to receiving services (Table 17). One facility requires all clients to complete a mental health evaluation, and two facilities require this evaluation only if the client has a recent history of, or active, mental illness that would put themselves or others at risk during treatment participation. Though required, none of the RTF respondents reported their facilities' capacity to conduct the mental health evaluations onsite. However, individuals may complete these evaluations prior to arrival within their local clinic, at an IHP, or by referral.

Table 17

Service eligibility requirements at the adult RTFs (n=5)

Service eligibility criteria	Number of facilities responding "Yes"
Clients need to identify as AIAN to receive services	4
If yes, is self-identification sufficient to receive services?	-
Clients need to be California residents to receive SUD, OUD, or mental health services	-
Clients need to register with IHS to receive SUD, OUD, or mental health services	1
Clients are required to be abstinent from substances in order to receive services	4
Clients are required to enter pretreatment or detox before accessing services	3
Clients need to have a primary SUD diagnosis in order to receive services	3
If yes, which primary diagnoses allow a patient/client to be eligible for services?	
SUD	3
OUD	3
Clients are required to have a mental health evaluation to receive services	3
All patients/clients are required to have one	1
In some cases, but not all	2
No patients/clients are required to have one	-
Facility conducts the mental health evaluation	-

Funding Sources

The adult RTFs reported funding SUD and mental health services through multiple sources such as IHS, federal and state grants, private foundation funds, Medi-Cal/Medicare, and private insurance (Table 18). Respondents reported that services may be funded through other sources as well (e.g., Tribal dollars or the CA Department of Social Services). Some respondents specified that, in addition to their core IHS funding, they may also receive additional annual competitive grants from IHS. Four RTF respondents also stated their facilities offer a sliding scale fee option to support individuals who may be uninsured or underinsured, and when other payer sources are not available (e.g., IHS funding).

Of note, only two adult RTFs reported DMC as a funding source. However, one of these facilities, American Indian Changing Spirits, does not receive IHS funding and must rely on county funding, agreements with Tribal organizations, and sources of third-party revenue (e.g., Medi-Cal, DMC, private insurance, and private foundation funding) to sustain their facility and culturally centered services.

Table 18

Funding and/or payment sources for SUD services and/or mental health services at adult RTFs (n=5)

Funding and/or payment source	Number of adult RTFs
Medi-Cal and/or Medicare	2
Drug Medi-Cal (DMC)	2
Private insurance (HMO and/or PPO)	3
DHCS	-
Partnerships with local organizations/agencies	2
IHS	4
Federal or state grants	2
Private foundation	3
Other	5
Cash/check/private pay	4
Sliding fee	4

Available Services

As seen in Tables 19-20, the five adult RTFs offer a vast number of services to their clients, including SUD education, screening, brief/crisis intervention, individual/gender-specific group therapy, and cultural activities.

Culturally centered care, including White Bison's Red Road to Wellbriety and/or other Red Road approaches, is available at all RTFs. Four RTFs offer trauma-informed treatment and use cultural activities as recreational therapy for stress and anxiety management. In addition to the holistic care provided during treatment, discharge/aftercare planning services are offered at all RTFs to provide the support needed for continued recovery. Additionally, three of the RTFs provide sober living or transitional housing for adult clients in continuation with their treatment program. This may serve as a great advantage for clients looking to reside in a culturally sensitive environment after completing residential treatment, especially when access to Native-specific SLFs is extremely limited in California. Clients may otherwise be referred to sober living/transitional housing outside of the Indian health care network (e.g., privately owned SLFs).

Table 19

Number of adult RTFs that reported general services (n=5)

General service	**Within facility**[a]			**By referral**			
	Adults only	Adults & youth	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Primary care	1	-	4	3	-	1	1
DUI program	-	-	5	2	-	-	3
Laboratory drug testing	3	-	2	2	1	-	2
Family reunification services	-	-	5	3	-	1	1
Transgender-inclusive resources/services	1	1	3	2	-	2	1
OUD/SUD patient education[b]	4	1	-	1	-	1	3
School-based services	-	-	5	2	1	-	2
Community outreach	3	1	1	2	-	1	2
Other	-	-	5	-	-	-	5

[a] The "Youth only" column has been omitted from this section of the table as no facility selected these responses.

[b] e.g., criminal justice mandated programs

Table 20

*Number of adult RTFs that reported treatment services **in facility** (n=5)*

Treatment service	Adults only	Youth only	Adults & youth	NA/ unknown
Screening for OUD and SUD	4	-	1	-
Brief intervention for OUD and SUD	3	1	-	1
Crisis intervention	3	-	1	1
Discharge/aftercare planning	5	-	-	-
Inpatient detox	1	-	-	4
Outpatient detox	-	-	-	5
Medication management for co-occurring disorders	2	-	-	3
Residential treatment	5	-	-	-
Sober living/transitional housing	3	-	-	2
In-house physician consultation	2	-	-	3
Access to emergency/inpatient services	2	-	-	3
Intensive outpatient programs (IOP)	2	-	-	3
Individual therapy[a]	3	-	1	1
Peer-led group therapy/support	3	-	-	2
Provider-led group therapy/support	3	-	1	1
Gender-specific group therapy	2	-	1	2
Cultural activities as recreational therapy for anxiety and stress management[b]	4	-	1	-
Recreation therapy for anxiety and stress management[c]	4	-	1	-
Family therapy	3	-	-	2
Couples therapy	1	-	-	4
Wellbriety/Red Road	5	-	-	-
Other	1	-	-	4

* Treatment services offered by referral can be found in Appendix C (Table C2).

[a] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[b] e.g., basket making, regalia making, other traditional arts

[c] e.g., outdoor activities, fitness groups, music

Medication services including MAT (e.g., suboxone, naloxone) and prescription medication for patients with a dual diagnosis (e.g., antidepressants, antipsychotics, mood stabilizers) are only available to clients by referral to outside programs (Appendix C Tables C3-C4). Although these RTFs may not be able to prescribe these medications within their facilities, some survey respondents stated that their staff are still able to monitor the use of prescription medications and ensure patients have access to qualified providers in the local area for any refill or additional medication needs. Three of the five facilities provide services for patients/clients who have a dual diagnosis. Services for clients with a dual diagnosis include individual and group counseling, therapy, cultural groups, patient education, and additional services available by referral. These facilities may also connect clients to psychiatric and medication management services provided by qualified personnel within the community. Other treatment or healing services for individuals with a dual diagnosis may be provided by trained telehealth staff or Tribal spiritual leaders. The facilities' capacity to provide such trauma-informed care and dual diagnosis services is important, as the complexity of patient recovery needs varies and access to resources may be limited.

Three RTFs reported currently using telehealth services for SUD and mental health treatment. One RTF respondent stated that their facility utilizes the TeleWell Indian Health Program MAT Project telehealth services, while another respondent stated their facility provides outpatient services for clients via weekly Zoom meetings. Services also accessible through telehealth include anger management, Positive Indian Parenting, healthy relationships, SUD services, and the 52-week batterer's intervention. These telehealth services offered within the adult RTFs allow facilities to expand patient access to specialty providers and services that may not be available in-person or otherwise within their facilities. See Appendix C (Tables C1-C4) for full survey information on the availability of services, MAT medications, and dual diagnosis medications offered within facility or by referral.

Relapse Prevention and Maintenance Services

Respondents also reported that relapse prevention and maintenance services are offered within their facilities or on a referral basis. Such services include case management, self-help, support groups, life skills training, and others, as seen in Table 21.

Table 21

Number of adult RTFs that reported relapse prevention/maintenance services (n=5)

Relapse prevention/maintenance service	**Within facility**[a]			**By referrals**[b]		
	Adults only	Adults & youth	NA /unknown	Adults only	Youth only	NA /unknown
Case management	4	1	-	1	-	4
Self-help and support groups[c]	5	-	-	2	1	2
Recovery coaching	3	-	2	-	1	4
Employment coaching	3	-	2	2	-	3
Refusal training	2	1	2	-	-	5
Family services[d]	2	1	2	2	-	3
Life skills training	4	1	-	-	-	5
Family groups	4	-	1	1	1	3
Anger management	4	-	1	1	1	3
Commercial tobacco cessation services	1	1	3	3	-	2
Other	-	-	5	-	-	5

[a] The "Youth only" column has been omitted from this section of the table as no facility selected these responses.
[b] The "Adults & youth" column has been omitted from this section of the table as no facility selected these responses.
[c] e.g., Alcoholics Anonymous, 12-step groups
[d] e.g., marriage counseling, parenting training

Traditional Healing and Culturally Adapted Services

All respondents stated that their facilities provide opportunities and support for staff to attend cultural sensitivity and awareness trainings. Four of these facilities require all staff to complete such training. These requirements may include cultural competency and humility trainings as well as educational/awareness trainings regarding AIAN spiritual practices. Some of these cultural sensitivity and awareness trainings may also be provided to outside stakeholders such as police, fire, medical emergency service professionals, school staff, social service providers, local departments of the Public Health Human Services Agency, and other local organizations.

Table 22 presents the specific traditional healing and culturally adapted services offered within the participating adult RTFs or by referral. All adult RTFs offer group and individual prayer and ceremonies. Clients are invited to participate in monthly ceremonies with traditional healers, as

well as talking circles, smudging, drumming, powwows, and other gatherings. Four facilities have a sweat lodge onsite and hold ceremonies led by spiritual leaders. Some of these facilities also provide a roundhouse, hogan, and an outdoor-built talking circle to support ceremonial activities. As a means of educating others and honoring diverse cultures and traditions, clients are often asked to lead prayers and ceremonies in line with their Tribal traditions. All facilities consult with traditional healers and Elders, and many Elders also serve as active board members for the facilities. In these facilities, clients are encouraged to hold individual sessions with spiritual leaders as well. One facility specifically mentioned that they support the use of all Tribal practices to assist clients in their spiritual growth and personal relationships with their cultures.

All five facilities reported the use of ceremonial and traditional medicines in individual and group settings. Some of the specific traditional medicines used by these facilities include sage, sweet grass, tobacco copal, pepperwood, cedar, and wormwood. One facility reported growing some of their own traditional medicines onsite for use during talking circles, prayer and smudging, sweat lodge ceremonies, and other traditional activities. Facility staff also teach their clients the use of traditional medicines, as some individuals may have lost such knowledge or never had the opportunity to learn their Tribal traditions.

Furthermore, within these RTFs, offering traditional foods during group meetings, social activities, and other practices is an integral component of the facilities' cultural service delivery. These events and activities also provide an opportunity for clients to learn about ceremonial food, such as corn and water, and cultural practices, such as offering spirit plates. Additionally, one respondent stated that some of these foods are grown in a garden onsite and used within the facility's daily menu or to teach traditional cooking and share traditional recipes with clients.

Table 22

Number of adult RTFs that reported traditional healing/culturally adapted services (n=5)

Traditional healing/culturally adapted service	**Within facility**[a]			**By referral**[a]		
	Adults only	Adults & youth	NA /unknown	Adults only	Adults & youth	NA /unknown
Use of ceremonial and traditional medicines in group settings	4	1	-	1	1	3
Use of ceremonial and traditional medicines for individual use[b]	4	1	-	1	1	3
Cultural uses of food	3	1	1	2	-	3
Group prayers and ceremonies	4	1	-	1	1	3
Individual prayers and ceremonies	4	1	-	1	1	3
Consultations with traditional persons, Elders, and leaders	4	1	-	2	-	3
Infrastructure to support ceremonial activities[c]	3	1	1	2	-	3
Other	1	-	4	1	-	4

[a] The "Youth only" column has been omitted from this section of the table as there were no facilities that offered these services to youth only.
[b] e.g., sage, sweet grass, tobacco
[c] e.g., sweat lodge, arbor, roundhouse

Assistance with Safety Net Resource Enrollment

Staff within three of these facilities provide support for client enrollment in services that offer educational attainment resources and domestic/intimate partner violence resources, while only a few have the capacity within their facility to provide enrollment assistance for resources such as medical care, housing and transportation, food and nutrition services, TANF, cell phone/landline assistance, and vocational resources. In recognition of the significance of client access to such safety net resources, all five adult RTFs offer referrals for enrollment in each of these services so that clients may be supported throughout their recovery process. Full information on safety net resource enrollment can be found in Appendix C (Table C5).

Youth Residential Treatment Facility

An amendment to the Indian Health Care Improvement Act in 1992 authorized the development of two youth residential treatment facilities (YRTF) in California to address the specific need for culturally centered residential treatment and care for AIAN youth (Indian Health Service, 2000). This section highlights the organizational structure and services provided by the participating AIAN-specific YRTF (n=1). The YRTF provides 24-hour inpatient living support, culturally centered SUD treatment, and recovery services. Information on the YRTF is presented separately from the adult RTFs to show specifically what services are available for California youth.

ASAM Level

This facility reported an ASAM level of 3.1, indicating their capacity to provide low-intensity clinical residential services. According to the ASAM criteria, facilities with a level of 3.1 provide 24-hour living support and clinical services facilitated by addiction treatment staff, mental health staff, or other medical staff/professionals for a minimum of five hours per week to each client (American Society of Addiction Medicine, 2015).

Service Eligibility Requirements

This facility currently has 32 inpatient beds available to serve AIAN males and females ages 12 to 18 years old. The facility requires youth to identify as AIAN and provide documentation to confirm IHS eligibility (e.g., Tribal descendancy or census number). In some cases, mental health evaluations are required from external practitioners if a patient was recently hospitalized (e.g., 5150) or is currently experiencing active psychosis that may risk the safety of themself or others. Additionally, assessment may be required if a patient's cognitive function appears impaired or limited.

Pretreatment or detox is not required for all youth clients but can be recommended for those with a pattern of substance use that may risk serious withdrawal symptoms that will interfere with the individual's treatment or wellbeing. Consequently, a patient may be required to obtain detox or medical clearance prior to initiating residential treatment. However, the youth facility is not currently equipped to manage medical detox services onsite. Therefore, youth need to access detox services outside the Indian health care network and/or local area as pretreatment services for youth are limited in California. For full survey data on service eligibility requirements at the YRTF, see Appendix D (Table D1).

Funding Sources

Funding sources for SUD and mental health services at this facility include IHS, Medi-Cal, and private insurance. Due to the YRTF's status as a federal IHS facility, it has also negotiated contracts for Arizona and Nevada Medicaid reimbursement. Full survey data on funding sources at the YRTF can be found in Appendix D (Table D2).

Available Services

Table 23 displays the specific services offered for youth at the YRTF. At the start of treatment, the YRTF assigns each patient a substance use counselor and a mental health counselor as part of their efforts to provide well-rounded care. A family nurse practitioner, licensed clinical social worker, clinical psychologist, and psychiatrist are also available to provide services for youth with dual diagnoses.

The YRTF provides comprehensive services that include trauma-informed SUD and mental health care, primary care, crisis intervention, MAT, provider-led group therapy/support, medication management for co-occurring disorders, cultural activities, recreational therapy, and family reunification services (Table 23-24). This facility also offers Mending Broken Hearts (a White Bison Wellbriety program) group activities/training for youth and a weekly 12-step Red Road to Wellbriety program. Youth are also connected with weekly Native Challenges workshops, available through Riverside-San Bernardino Indian Health, that may cover various topics of recovery support (e.g., healthy relationships) over a 16-week period. The availability of these services (i.e., direct or by referral) provides AIAN youth access to holistic care as they work toward their recovery.

Although this is an inpatient facility, telehealth services are used for individual or group sessions when health care providers cannot be physically present. The availability of telehealth services increases patient access to specialty providers and services that otherwise may not be available on-site. The frequency of telehealth services increased during the COVID-19 pandemic to ensure the health and safety of both clients and staff. See Appendix D (Tables D3-D4) for full survey information on the availability of services and dual diagnosis medications offered within facility.

Table 23

General services offered at the YRTF or by referral (n=1)

General service	**Within facility**[a]		**By referral**[a]	
	Youth only	NA /unknown	Youth only	NA /unknown
Primary care	1	-	1	-
DUI program	-	1	-	1
Laboratory drug testing	1	-	1	-
Family reunification services	1	-	1	-
Transgender-inclusive resources and services	1	-	1	-
OUD/SUD patient education[b]	1	-	1	-
School-based services	1	-	-	1
Community outreach	-	1	-	1
Other	-	1	-	1

[a] The "Adults only" and "Adults & youth" columns have been omitted from this section of the table as they are not applicable.

[b] e.g., criminal justice mandated programs

Table 24

Treatment services offered by the YRTF (n=1)

Treatment service	**Within facility**[a]	
	Youth only	NA/unknown
Screening for OUD and SUD	-	1
Brief intervention for OUD and SUD	-	1
Crisis intervention	1	-
Discharge/aftercare planning	1	-
Inpatient detox	-	1
Outpatient detox	-	1
Medication management for co-occurring disorders	1	-
Residential treatment	1	-
Sober living/transitional housing	-	1
In-house physician consultation	1	-
Access to emergency/inpatient services	-	1
Intensive outpatient programs (IOP)	-	1
Individual therapy[b]	1	-
Peer-led group therapy/support	-	1
Provider-led group therapy/support	1	-
Gender-specific group therapy	1	-
Cultural activities as recreational therapy for anxiety and stress management[c]	1	-
Recreation therapy for anxiety and stress management[d]	1	-
Family therapy	1	-
Couples therapy	-	1
Wellbriety/Red Road	1	-
Other	-	1

[a] The "Adults only" and "Adults & youth" columns have been omitted from this section of the table as they are not applicable. The "By referral" columns have also been omitted as the facility did not select any of these response options.

[b] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[c] e.g., basket making, regalia making, other traditional arts

[d] e.g., outdoor activities, fitness groups, music

Traditional Healing and Culturally Adapted Services

To maintain a culturally centered program, staff at the participating YRTF are required to complete specific trainings focused on cultural competency and awareness, historical and intergenerational trauma, and general understanding of AIAN cultural practices. The YRTF also provides their direct-care staff, such as substance use and behavioral health providers, with training through Mending Broken Hearts (a White Bison Wellbriety program). Additionally, the YRTF seeks guidance from their Tribal advisory board and uses a variety of approaches to include cultural practices and experiences in their program, including the opportunity to connect with Elders. These cultural experiences help promote physical, mental, emotional, and spiritual health and healing.

Traditional medicines, such as sage and sweet grass, are available daily for both individual and group use for prayer and smudging. Additional cultural services offered include storytelling, beading, and crafting dream makers. Elders facilitate talking circles and a sweat lodge (available onsite) at least twice per month. These services provide cultural connection and can serve as recreational therapy for anxiety and stress management.

Furthermore, the facility works with several Tribes to host ceremonies and additional cultural services to support the youth in their healing process. The facility supports attendance at community events such as youth conferences and local powwows. Upon completion of treatment, a blanket ceremony is performed as a traditional blessing for the youth to usher them into the next phase in their lives. All staff are invited and encouraged to participate in these ceremonies to show their support for the youth and their recovery. For full survey data on traditional healing/culturally adapted services offered at the YRTF, see Appendix D (Table D5).

Relapse Prevention, Maintenance, and Support Services

The YRTF offers relapse prevention and maintenance services such as case management, recovery coaching, family services, and life skills training. Following discharge, clients may be connected with outside agencies, traditional healers, and community members who will support continued participation in Wellbriety programs or cultural practices and ceremonies. The YRTF also supports their older youth by connecting them with local colleges and universities if clients are interested in continued education opportunities and contact with Native student programs. Client enrollment in medical care, education attainment, and domestic violence/intimate partner violence safety net resources is supported by the YRTF staff. It should be noted that enrollment in some safety net services is not available as these services are not applicable to youth. See Appendix D (Table D6) for full survey data on relapse prevention/maintenance programs at the YRTF and Appendix D (Table D7) for safety net resources.

Mental Health Center

American Indian Counseling Center (AICC) is a mental health center and one of 80 directly operated programs within the Los Angeles County Department of Mental Health system. Though it is a county-operated program with no IHS funding, AICC is unique in its aim to provide AIAN individuals in Los Angeles county with mental health services and AIAN culturally centered recovery support.

ASAM Level

AICC has been assessed using the ASAM criteria levels and has an ASAM level of 1.0. This means the facility is able to provide a maximum of nine hours of outpatient services to adults per week and six hours for youth (American Society of Addiction Medicine, 2015). The outpatient services provided by AICC include, but are not limited to, individual and group counseling, medication support, case management, and substance use prevention and recovery services.

Service Eligibility Requirements

AICC serves men, women, and youth ages 12 and older. As AICC is a mental health center that provides outpatient services, there are no inpatient beds available within the facility.

Since AICC operates within the Los Angeles County Department of Mental Health system, their service provision is not limited to AIAN individuals. Clients do not need to identify as AIAN, nor do they need to be IHS eligible to access services. There are no requirements regarding abstinence, sobriety, or having a primary SUD diagnosis. All clients are required to complete a mental health evaluation to be eligible to receive services, and this evaluation can be conducted in-house at AICC. See Appendix E (Table E1) for full survey data on service eligibility requirements at AICC.

Funding Sources

Funding and payment sources for SUD and/or mental health services at AICC are shown in Table 25. As previously mentioned, AICC does not receive IHS funding despite AIAN individuals being the population of focus for this facility. Some of AICC's sources of funding include the Los Angeles County Department of Mental Health and the California Mental Health Services Act. AICC services are also funded through federal and state grants, partnerships with local organizations, DMC, Medi-Cal/Medicare, and private insurance. AICC also provides a sliding scale fee option available to clients who may not have adequate care coverage.

Table 25

Funding and/or payment sources for SUD and/or mental health services at AICC (n=1)

Funding and/or payment source	"Yes" response
Medi-Cal and/or Medicare	1
Drug Medi-Cal (DMC)	1
Private insurance (HMO and/or PPO)	1
DHCS	-
Partnerships with local organizations/agencies	1
IHS	-
Federal or state grants	1
Private foundation	-
Other	-
Cash/check/private pay	1
Sliding fee	1

Available Services

Table 26-27 show the diverse services available at AICC. As expected with an ASAM level 1.0 facility, services are outpatient. These services include trauma-informed OUD, SUD, and mental health treatment. AICC also provides psychiatry services, individual/group therapy (e.g., Seeking Safety groups), case management, and cultural engagement activities to address the needs of clients with a dual diagnosis. These services are facilitated by qualified staff and are available to both adults and youth. There is a comprehensive availability of medications prescribed to clients with a dual diagnosis (e.g., antidepressants, mood stabilizers). Additionally, MAT medications (e.g., naloxone and naltrexone) are available and prescribed to patients within AICC, when necessary (see Appendix E, Table E4).

To supplement the services available within the facility, AICC uses telehealth services for SUD/mental health treatment as well. Telehealth services are used for individual sessions with clients and can have a focus on substance use, psychiatric care, and therapeutic counseling. AICC has also used telehealth to facilitate White Bison recovery groups for clients. The services that are not available at AICC (i.e., inpatient detox, outpatient detox, residential treatment, sober living/transitional housing, intensive outpatient programs) are available to clients via referral to external facilities. Gender-specific group therapy and cultural activities/recreation therapy for anxiety and stress management are available both within AICC and by referral to

external facilities. See Appendix E (Tables E2-E5) for full survey information on the availability of services, MAT medications, and dual diagnosis medications offered within facility or by referral.

Table 26

General services offered at AICC or by referral (n=1)

General service	**Within facility**[a]		**By referral**[a]	
	Adults & youth	NA /unknown	Adults & youth	NA /unknown
Primary care	-	1	1	-
DUI program	-	1	1	-
Laboratory drug testing	-	1	1	-
Family reunification services	1	-	-	1
Transgender-inclusive resources and services	1	-	-	1
OUD/SUD patient education[b]	1	-	1	-
School-based services	1	-	-	1
Community outreach	1	-	-	1
Other	-	1	-	1

[a] The "Youth only" and "Adults only" columns have been omitted from this table as the facility did not select these responses.
[b] e.g., criminal justice mandated programs

Table 27

*Treatment services offered by AICC **within facility** (n=1)*

Treatment service[a]	Adults & youth	NA /unknown
Screening for OUD and SUD	1	-
Brief intervention for OUD and SUD	1	-
Crisis intervention	1	-
Discharge/aftercare planning	1	-
Inpatient detox	-	1
Outpatient detox	-	1
Medication management for co-occurring disorders	1	-
Residential treatment	-	1
Sober living/transitional housing	-	1
In-house physician consultation	1	-
Access to emergency/inpatient services	1	-
Intensive outpatient programs (IOP)	-	1
Individual therapy[b]	1	-
Peer-led group therapy/support	1	-
Provider-led group therapy/support	1	-
Gender-specific group therapy	1	-
Cultural activities as recreational therapy for anxiety and stress management[c]	1	-
Recreation therapy for anxiety and stress management[d]	1	-
Family therapy	1	-
Couples therapy	1	-
Wellbriety/Red Road	1	-
Other	-	1

* Treatment services offered by referral can be found in Appendix E (Table E3).

[a] The "Youth only" and "Adults only" columns have been omitted from this table as the facility did not select these responses.

[b] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[c] e.g., basket making, regalia making, other traditional arts

[d] e.g., outdoor activities, fitness groups, music

Relapse Prevention and Maintenance Services

AICC provided data regarding the relapse prevention and maintenance services offered at their facility or via referral (see Table 28). These services include case management, family counseling, anger management, and support services like recovery and employment coaching and life skills training. Most are available to both youth and adults.

Table 28

Relapse prevention/maintenance services offered at AICC or by referral (n=1)

Relapse prevention/maintenance service	**Within facility**[a]			**By referral**[b]		
	Adults only	Adults & youth	NA /unknown	Youth only	Adults & youth	NA /unknown
Case management	-	1	-	-	-	1
Self-help and support groups[c]	1	-	-	1	-	-
Recovery coaching	-	1	-	-	-	1
Employment coaching	-	1	-	-	-	1
Refusal training	-	-	1	-	1	-
Family services[d]	-	1	-	-	-	1
Life skills training	-	1	-	-	-	1
Family groups	-	1	-	-	-	1
Anger management	-	1	-	-	-	1
Commercial tobacco cessation services	-	-	1	-	1	-
Other	-	-	1	-	-	1

[a] The "Youth only" column has been omitted from this section of the table as the facility did not select these responses.

[b] The "Adults only" column has been omitted from this section of the table as the facility did not select these responses.

[c] e.g., Alcoholics Anonymous, 12-step groups

[d] e.g., marriage counseling, parenting training

Traditional Healing and Culturally Adapted Services

As part of AICC's mission to support each clients' holistic health, culturally centered services are an integral part of the facility's treatment and recovery program. AICC staff includes individuals with AIAN heritage and/or experience working with AIAN communities, and all staff are provided and required to complete cultural sensitivity and awareness training. A cultural approach is used to guide the development of client treatment plans, therapy sessions,

culturally centered support groups, and opportunities for client engagement in cultural/community events. Table 29 shows that the culturally adapted services available within AICC include group prayer, ceremonies, and traditional medicines used in group settings. Group prayer is included during staff or client events and prior to community meetings. Ceremonial/traditional medicines used in group settings include sage and tobacco. The cultural importance of food is also shared within AICC during client and staff events. Cultural services that the facility cannot provide are offered by referral to external facilities and organizations. Referrals to AIAN community events and resources are provided for any additional traditional healing or culturally adapted services not readily available within AICC.

Table 29

Traditional healing/culturally adapted services offered at AICC or by referral (n=1)

Traditional healing/culturally adapted service	**Within facility[a]**		**By referral[a]**	
	Adults & youth	NA /unknown	Adults & youth	NA /unknown
Use of ceremonial and traditional medicines in group settings	1	-	-	1
Use of ceremonial and traditional medicines for individual use[b]	-	1	1	-
Cultural uses of food	1	-	-	1
Group prayers and ceremonies	1	-	-	1
Individual prayers and ceremonies	-	1	1	-
Consultations with traditional persons, Elders, and leaders	-	1	1	-
Infrastructure to support ceremonial activities[c]	-	1	1	-
Other	-	1	-	1

[a] The "Adults only" and "Youth only" columns have been omitted from this table as the facility did not select these responses.
[b] e.g., sage, sweet grass, tobacco
[c] e.g., sweat lodge, arbor, roundhouse

Assistance with Safety Net Resource Enrollment

AICC staff assist clients with enrollment in safety net resources for medical care, utility bill assistance, housing, transportation, food, vocational, educational attainment, and domestic and intimate partner violence resources. When staff cannot help clients enroll in resources, clients are referred out to organizations that can assist with enrollment. For full survey data on safety net resources, see Appendix E (Table E6).

Sober Living Facility

Sober living facilities (SLFs) provide an environment where individuals can reside with their peers after completing inpatient SUD treatment programs to continue therapy or support services and maintain sobriety. There is no state or local oversight for SLFs in California. There are few that provide services specifically for AIAN individuals. One participated in the study.

The participating SLF is a non-profit organization that provides culturally centered SUD recovery support, prison re-entry program services, and Tribal vocational rehabilitation in a culturally sensitive environment specifically for AIAN community members. It should be noted that, at the time of the interview in October 2020, the facility had just recently opened and was still awaiting completion of certification and state licensing due to delays in inspection caused by COVID-19. This section will share some of the information regarding the facility's eligibility requirements, funding, and available services.

The format of this section differs from previous sections because the facility only participated in an interview and not the survey. However, the interview information corresponds closely to that of the survey results from the other facility types. This information is presented here.

Service Eligibility Requirements

The SLF currently serves AIAN men ages 18 years and older. Although the SLF does not currently serve women or youth, there are plans to expand services to AIAN women in the future. Clients must remain abstinent from substances for at least three days prior to admission to be eligible for facility services. Although the facility is not funded by IHS, individuals must be IHS eligible as some of the foundational SUD recovery support services are provided to clients through partnerships and referral access to IHS-funded Indian health clinics and providers in the local community.

Funding Sources

Some sources of funding for services within the facility include contributions from local Tribes and other private sources. As previously mentioned, the SLF is not funded by IHS. However, clients are provided access to local IHS-funded clinics and providers for various services (e.g., medical, psychiatric) when needed. If necessary, clients may also fund an extended stay by working for the facility to pay for their continued rent and services.

Available Services

The SLF provides a culturally sensitive environment for individuals to continue the healing process and maintain sobriety with the support of substance use recovery services (e.g., drug and alcohol counseling by certified staff) and access to traditional healing/medicines and cultural services. The average length of stay was reported to be between three and six months with plans to extend client stays up to one year.

Available services are facilitated by qualified staff. The SLF maintains close relationships with various local Indian health clinics and providers to support the SUD counseling, therapy, psychiatric, and medical services needed by clients throughout their stay. The interview participant stated their facility frequently provides referrals to neighboring clinics to ensure clients have access to services to support each client's holistic health. The facility also receives AIAN client referrals from various agencies including privately owned detox centers, local RTFs, and other privately owned SLFs.

Traditional Healing and Culturally Adapted Services

The SLF staff and leadership all identify as AIAN and complete cultural sensitivity training offered through organizations such as White Bison. Training topics include AIAN cultural practices, historical trauma, and unresolved grief. The facility also respects each client's religious beliefs by accommodating preferred cultural practices or ceremonies and supporting client access and transportation to religious events and preferred churches.

In addition to general recovery services, the SLF offers clients a sweat lodge ceremony three times a week, drum making, gourd making, bird singing, drumming, storytelling, and beading. Additionally, the facility provides client transportation to and encourages attendance at AIAN ceremonies (e.g., Sun Dance), cultural events, and gatherings. Due to the COVID-19 pandemic, events and travel have recently been limited. The traditional healing and cultural services offered by the SLF provide an opportunity for clients to connect with their heritage and culture as part of the healing process.

Discharge Support Services

Following completion of the three- to six-month stay at the SLF, or completion of court-mandates or requirements from Child Protective Services and parole departments, the facility ensures each client is connected with their local recovery community and support system for continued sobriety and wellness. One example of the facility's continued client support services offered after discharge is the transportation they provide for clients to and from recovery support meetings, groups, and events. This support service was noted to be particularly important for Tribal members that must travel far distances and for those with limited transportation resources. Additionally, the facility strives to maintain connections with alumni and create a welcoming environment for individuals to come back and visit or share their examples of recovery with other AIAN clients.

Qualitative Results

In addition to the quantitative data provided by the surveys, the USC team conducted semi-structured key informant interviews with participants from 13 facilities. Facilities were selected to ensure adequate representation of each facility type and geographical representation across California.

The interviews primarily focused on understanding facility partnerships, structures, services, and practices, as well as patient/client trajectories. Several themes emerged during the analysis process: 1. The impact of traditional healing and cultural services; 2. The importance of partnerships and networks; 3. The importance of cultural sensitivity and awareness; 4. Two-sprit and lesbian, gay, bisexual, transgender, queer/questioning (2SLGBTQ+) inclusiveness in services; 5. Funding; 6. Barriers to care; 7. Stigma; and 8. The impact of COVID-19. This section reports on these key themes and includes quotes from interview participants to highlight AIAN community voices.

Traditional Healing and Culturally Adapted Services

Facilities discussed the availability and value of traditional healing and culturally adapted services, including the importance of AIAN staff, culturally informed assessment tools, culturally centered MAT programs, culture- and trauma-informed therapy, and creating an environment where community members can share and learn from the stories and cultural practices of others as a part of individual healing and growth. Participants discussed how the inclusion of traditional healing and culturally adapted services within these Native-specific recovery programs has had a positive effect on the lives of the AIAN individuals they serve.

Cultural Connectedness Assessments

Cultural connectedness assessments provide an opportunity for clinics to assess a client's connection to their traditional/cultural practices. These assessments are usually administered during an intake or at the beginning of a program. Assessment can be administered individually or as part of a focus group. An example of an individual cultural connectedness assessment is the 29-item youth cultural connectedness scale developed by (Snowshoe et al., 2015). This scale measures three dimensions: identity, traditions, and spirituality. This scale has been adapted for Urban AIAN youth and is widely used throughout California AIAN communities. Studies like this have shown that being connected to culture can serve as a protective factor. Clinics can use surveys such as these to assess how connected clients feel to their cultures, their past or current engagement in AIAN cultural and healing practices (e.g., their use of traditional medicine and healers), and their interest in learning more about their AIAN Tribal cultures or specific religious/spiritual beliefs. Most participants expressed that their facilities use a cultural

connectedness assessment; however, only a few participants mentioned a formal and consistent process of administering them. One participant mentioned their facility's approach can vary based on grant deliverable requirements and may include a community-wide paper-based assessment or a smaller sample of people interviewed, recorded, and evaluated by staff. Participants stated that the cultural connectedness of clients can also be assessed through informal methods including individual discussion with spiritual leaders or informal surveying during talking circles or cultural groups. Creating streamlined, formalized processes for the use of cultural connectedness assessments can help facilities understand the effects their programs/services are having on increasing connection to culture and how this affects program retention and other outcomes of interest.

Cultural Services

All facilities interviewed provide cultural services. The most common service mentioned was the sweat lodge ceremony, with two sites specifically offering gender-specific sweat lodges. Although traditions and practices vary between Tribes and regions, sweat lodge ceremonies are typically facilitated in an enclosed dome-shaped structure with a fire pit. These ceremonies are meant for purification and are led by a traditional healer or cultural advisor. Some facilities' representatives also mentioned that they have healing gardens and teach clients about the traditional uses of plants such as sweet grass and sage. Other cultural activities offered are drumming, drum making, gourd making, bird singing, storytelling, and basket making. Drumming and drum making sometimes include community leaders who provide guidance on different styles of powwow drumming and singing and connect community members to powwow groups. Some facilities' representatives stated that services from a traditional healer or spiritual leaders are accessible by referral. These services are important to preserving traditional songs and practices as well as providing an opportunity for individuals to reconnect with their cultures. One participant said the following regarding the importance of reintegration.

> We get a lot of clients who didn't grow up traditionally. So when they come here, it's their first opportunities to engage in these types of activities. [...] And then we have clients who did grow up traditionally and are looking to re-engage because they've lost that connection while in their addiction. And so, it's important to them to be able to reconnect when they come here.

All interview participants mentioned receiving overwhelming positive feedback from clients regarding the culturally centered services; clients frequently request more of these services, and some request traditional ceremonies specific to their Tribe. One participant discussed how clients have expressed that receiving these culturally centered services has helped them realize the importance of their traditions. In addition, these services provide a space that "feels like home," which helps their clients feel connected to the facility and others who are enrolled in the program. Participants shared their thoughts on the value of cultural services for patients in the following quotes.

> [One of my clients] said, “When I first came here, I hated myself so much that I couldn't even look at myself in the mirror. […I] think that's a lot of why I did the drugs and drank...Since I've been here, these brothers”—and he pointed to the other residents—and he said, “these people here who run the program [...] they love me, and I've never been loved before.”
>
> It’s very important to have [a cultural piece to programs] and to have people that come in and share their stories and their cultural practices with our population because most of [...] the people that are following that cultural lifestyle are clean and sober [...]. If programs have those connections, then they have an advantage over programs that do not.

Despite the profoundly positive impact of these culturally centered services, there are significant barriers. Logistically, some culturally centered services may pose an insurance liability or violate the terms of the lease of the land/building for the clinic. Sweat lodge ceremonies, one of the most common types of cultural services mentioned, can be seen as hazardous given that they require fires in enclosed spaces. Funding is also a common barrier to providing and sustaining cultural and traditional services. Many of these services are not typically reimbursable through local government or state funding, and funding is often tied to specific criteria, such as offering evidence-based treatments. This challenge has limited the ability of facilities to receive reimbursements for services. There are few funding mechanisms that will provide grant funding and/or reimbursement for programs and practices that are not evidence-based. This can be particularly problematic as currently there are few available EBPs specifically for AIAN communities, and EBPs can take a long time to establish. One participant expressed this concern by saying:

> The opportunity for funding [should be expanded] to include non-Western, non-evidence-based processes because they [Westernized treatments] don’t always work and/or they're really just not always appropriate for those communities. […] When those requirements are tied to funding, for me, it brings out the continued attempts to maybe downplay or belittle Native cultural healing practices.

Some evidence-based services have been adapted for use with the AIAN community, and many facilities’ representatives talked about offering these services, such as White Bison’s Red Road to Wellbriety and/or other Red Road approaches (e.g., Generation Red Road), Drum-Assisted Recovery Therapy for Native Americans (DARTNA), Strengthening of the Spirit, and GONAs. However, services that are not adapted from EBPs often have limited funding. In addition, funding restrictions such as treatment time limits have negatively impacted the cultural services that are offered.

Culturally centered services are unique in that they have been developed outside of Western models of medicine to best fit AIAN culture, and individuals who facilitate these services may not necessarily be substance use counselors or providers. This can pose some challenges when

programs try to incorporate them into treatment service, as expressed by one participant who said, “I think the only challenge is getting enough time to build [traditional healing and culturally adapted services] out, and to honor them, and make sure you have fidelity. [...] So giving time to programming can be a barrier.”

Partnerships and Networks

Throughout the interviews, participants were asked to discuss their relationships with local IHS-affiliated or non-affiliated treatment facilities and support agencies. These partnerships include both formal (e.g., defined by contracts) and informal relationships. Partnerships supported both primary SUD treatment service provision and supplementary services like workforce development and literacy programs.

Participants discussed how their facilities’ relationships with AIAN-specific RTFs, youth programs, SLFs, and local IHPs help support the medical, dental, SUD, and specialty treatment services needed by their AIAN clients in recovery. They described MOUs and strategic partnerships with agencies such as adult and/or youth judicial and correctional systems, county departments, drug court systems, family service courts, criminal courts, county probation, Child Protective Services, hospitals, police departments, and the California Department of Social Services. Additionally, participants discussed service agreements and collaboration with the California Bridge MAT Program, privately funded detox centers or SLFs, local LGBTQ+ centers, and West Care, as well as the advantages of subcontracting with organizations that can provide access to their network agencies. These partnerships support direct service and SUD treatment provision by improving patient care coordination and increasing service availability and accessibility. “They’re like our brothers and sisters,” one participant said, describing the relationship with partner RTFs. Another participant said that when they cannot schedule a client immediately, sometimes because of paperwork issues, they “try to coordinate with local shelters or, again, other programs to try to get them into those services [that] don’t require things like Tribal documents” while they work to help the individual get the appropriate documentation.

Participants discussed collaborations and partnerships that offer supplementary services that may not directly relate to SUD treatment. For example, participants discussed how collaboration with local colleges and universities (e.g., various University of California campuses, community colleges) also help provide support services and programs including literacy programs and Native student support programs. Some facilities also work with institutions such as local school districts, American Indian Education Programs, and the Sherman Indian School (Bureau of Indian Education and Department of Interior).

Additionally, support agencies provide clients with clothes, bus tickets, parking, resume-writing workshops, mock interviews, and vocational training, among other treatment and safety net services. Facilities have established relationships with Tribal TANF, Tribal Indian Child Welfare Act departments, and the Department of Child and Family Services for youth and families

needing support. The existing partnerships and networks provide valuable resources for the holistic care and comprehensive support needed for AIAN clients throughout recovery.

Participants were asked to share any challenges encountered with partnership development. Barriers included the amount of time, effort, and coordination it can take to complete the lengthy process of establishing formal agreements (e.g., MOUs). One facility with IHS funding also mentioned they experience challenges maintaining their budget due to lengthy delays in accounts receivable when they work with other facilities. Moreover, expanding the facilities' network to include new programs, treatment centers, or SLFs can be difficult, as it takes times to learn the location of each, what services are available, and whether the program offers culturally centered services. Long-distance collaboration and variations in eligibility requirements or intake processes can also create barriers to client referrals and initiating or maintaining formal program partnerships. One participant discussed challenges with being aware of other partnering agencies, saying, "I think that's always an issue of, well, knowing where [partner organizations] are, and knowing what they ask, what they're requiring. […] It seems like every place is different. And space. A lot of them are not accepting new people."

Cultural Sensitivity and Awareness Training

During interviews, participants were asked to expand upon some of the cultural sensitivity and awareness trainings provided for staff within their facilities. Most facilities provide cultural competency training for new employees as well as other formal or informal trainings. For example, formal training may include structured curriculums and materials provided by IHS, the Health Resources and Services Administration, and SAMHSA (e.g., SAMHSA *CultureCard: A Guide to Build Cultural Awareness: American Indian and Alaska Native).* Participants also mentioned valuable cultural competency trainings are frequently offered to staff through White Bison, CCUIH, and CRIHB. Informal training opportunities include talking circles and individual staff discussions with Tribal Elders and traditional healers. Staff at some facilities are invited by spiritual leaders to participate in cultural activities as an opportunity to learn and better understand the significance of cultural practices and ceremonies for recovery and general wellness. Local Tribal partners provide informal discussion and training for staff members based on their knowledge and familiarity with the community and history of the local Tribes and land.

These formal and informal training opportunities ensure staff have the knowledge and awareness necessary to provide culturally centered care. Training topics include awareness of AIAN Tribal history in the U.S. and in California, Tribal sovereignty, general AIAN cultural practices, individual Tribal traditions and culture, common misconceptions or stigmas, implicit bias, and cultural humility. Other education and training topics include historical trauma and intergenerational trauma, which impact substance use and family systems. Specific training for motivational interviewing and for those providing trauma-informed care or working with youth is also available. Other training topics not related to Native culture were mentioned, such as awareness of gang culture and addressing sensitive issues such as grief, suicide, the culture of

substance use/drug addiction, and sensitivity toward HIV treatment and patient care needs. These trainings provide staff with the opportunity to learn about providing culturally centered and well-rounded care to different populations.

2SLGBTQ+ Inclusiveness

Interview participants shared some of the specific trainings and accommodations their facilities have implemented to bring about an inclusive environment. All participants stated their facilities value inclusiveness and welcome two-spirit (2S) and LGBTQ+ individuals. Traditionally, "two-spirit people were male, female, and sometimes intersexed individuals who combined activities of both men and women with traits unique to their status as two-spirit people," though it's important to note that there is significant variation across Native communities (Indian Health Service, n.d.). Competency training opportunities are offered by White Bison, CCUIH, and CRIHB. Training topics include gender identity/sexual orientation, transgender services, and how to respectfully support 2SLGBTQ+ individuals and those with specific pre-operative or post-operative transgender service needs. Elders and traditional healers may also provide informal training to promote inclusive values and share the cultural perspective of gender identity and the history of reverence toward two-spirit individuals within AIAN culture. Participants shared that their facilities respect individual identities by using clients' preferred gender pronouns and respecting client decisions of which gender they would like to be housed with and where they would feel most comfortable receiving care. One participant captured this sentiment by saying, "They're [2SLGBTQ+ individuals] our brothers and sisters. And we should treat them like that. And if we're going to give care to other alcohol and drug addicts, why not give care to all of them, no matter who or what their personal preference is."

Some facilities also provide two-spirit talking circles and/or support groups in addition to coordinating with local LGBTQ+ community centers and agencies that provide health and support services or groups. Education, resources, and referrals are also provided for transgender individuals interested in specific services (e.g., hormone replacement) to ensure that they have access to comprehensive care during or following treatment. Furthermore, multiple participants stated that their facilities reflect their inclusiveness by ensuring that staff include individuals who identify not only as AIAN community members but also as members of other cultures, ethnicities, generations, genders, and 2SLGBTQ+ communities. These staff members serve a critical role within the facility, and the inclusive environment provides patients with an opportunity for healing, recovery, and improved wellness. One participant discussed that though every Tribe has different values, "one of the things that is kind of pan-Indian is the inclusiveness."

Funding

During interviews, participants were asked to describe how extended stays for patients/clients and traditional healing/culturally adapted services are currently funded at their facility, as well as any funding barriers or needs they have encountered.

Traditional Healing and Culturally Adapted Services

As discussed briefly in the previous section, funding is a significant barrier to providing traditional healing and culturally adapted services. There are some traditional healers and spiritual leaders who do not take monetary compensation; however, many do, and adequate funding needs to be available. In addition, there is a need for funding to support logistical aspects of traditional and culturally adapted service provision. These logistical aspects include integration into facility workflows, development of physical infrastructure, supplies for activities and ceremonies (e.g., wood and blankets for sweat lodge, art materials), and transportation to community cultural events and gatherings. Participants expressed that their facilities have limited funding to support the integration of traditional healing and culturally adapted services within their treatment programs, as facilities are unable to bill for many of the cultural services sought by clients. State or county funding is often restrictive or may not be provided; as one participant mentioned, "I think the challenge is getting people to recognize, our funders, that those are important for healing and for wellness. A lot of places don't pay for that kind of stuff. [...] having more data, I think, to support [cultural services] would be helpful."

Some facilities did, however, state that they have been able to use their scarce IHS funds and general operating budget to provide treatment as they see fit, which includes the integration of culturally centered services. Although limited, other sources of funding mentioned by participants for cultural services included some federal grants (e.g., SAMHSA Native Connections, Zero Suicide, Garrett Lee Smith, Circles of Care), state grants (e.g., CalWORKs), and other grants available through CCUIH. Participants also mentioned using third party revenue from insurance billing, private donations, Tribal contributions, and Tribal pay to fund culturally centered services as well. These sources have the advantage of often being less restrictive and allowing more freedom with the traditional healing and cultural services that may not be considered "billable" by other major funding sources. When speaking about the limitations of funding, one participant said, "some of the traditional activities, traditional, cultural healing activities are not a recognized [...] 'evidence-based' model. So that can limit our impact, our ability to get reimbursement for some of those services."

Funding Sources for Extended Stay

Interview participants also shared some of the methods used to fund extended stays for clients with medical necessity. Extended stays are primarily funded by private insurance, private pay, and third-party reimbursement (e.g., Medicaid). If these methods of funding are unavailable, the facility will serve as the payer of last resort through their scarce IHS funding, risk pool

funding, and remaining grant, Tribal contribution, or private donation funding set aside. If clients must be referred to external facilities for continued treatment, the extended treatment/stay may be funded by Tribal contribution, individual insurance, or IHS purchased/referred care (for care outside of IHS or Tribal health facilities).

Multiple participants expressed that their facilities do the best they can to support extended stays when there is therapeutic need. Furthermore, for those clients in need of an extended stay in a sober living environment, some of the cost may be paid out of packet. More options include third party funding through food stamps and general relief to supplement their extended stay and continue participation in services as long as needed.

Funding Needs

Throughout the interviews, participants described funding challenges and needs encountered by their facilities. These include funding to support programs that absorb the cost of extended treatment and underinsured or uninsured clients as well as the reimbursement challenges that may come with those requests. Regarding the issues with receiving reimbursement for extended treatment, one participant said:

> We used to have somebody over there [funding agency] who really appreciated Native culture and used to help us. But now it's things like, “No, you only can fund for 30 days.” And I'm like, “That just gets them dry; it doesn't heal them.” That's just barely enough to detox, a month. [...] And we keep having more and more restrictions. […] It’s just, ugh, shutting us down right out of the gate. And I thought, you've got people that are ODing on the street. You've got to use some good judgment here and weigh the different options.

Additional funding is needed to hire necessary medical staff, support client transportation, and endure unexpected funding cuts or increased operating costs. This additional funding support is especially needed for Native-specific programs that are not funded by IHS. Participants discussed feeling like funders have not truly heard and supported their needs. They discussed that not being heard and supported may not stem from a place of malice but from misunderstanding the intricacies and needs of AIAN communities and of AIAN-serving facilities. This is expressed in the following quote.

> We do not have appropriate funding. Our legislators and our government funders do not listen to our needs. They end up hurting us quite often as much as they help us. [...] It's like a child going "I love you. I hate you." We feel on one hand—we hear that people want to support us, but on the other, then it's like people go out of their way to interfere with the culture, and they're not even aware. I do not believe they're trying to do this intentionally, I really don't. I believe it's because they don't take the time to see what the needs of the people are.

Another participant discussed that a significantly smaller proportion of IHS funding is allocated to Urban Indian facilities when compared to Tribal facilities despite the large proportion of AIAN individuals that they serve. One participant expressed that the imbalance contributes to a sense of competition between Tribal and Urban Indian facilities for funding. There is a need to address the funding inequities as well as a need to encourage collaboration between Tribal and urban programs as AIAN communities are the most affected.

Barriers

Participants were asked to discuss barriers they encountered in the provision of services to AIAN individuals seeking treatment. Prominent barriers were experienced at the facility level, system level, and patient level.

Facility and System-level Barriers

Current facility-level barriers to treatment access include limited bed availability, limited administrative and medical staff capacity, outdated EMRs, and challenges in meeting the needs of homeless individuals and clients seeking assistance after hours. Staff capacity affects their ability to meet the needs of clients. Barriers include timely paperwork assistance, challenges meeting client transportation needs, as well as limited ability to offer MAT services and/or manage co-occurring health conditions. As more AIAN individuals seek out Native-specific treatment programs, facilities are facing the challenge of limited bed availability. Delayed treatment due to limited capacity can adversely impact clients' level of readiness and/or ability to start treatment if they were to relapse. When space is limited, programs try to connect clients with other culturally centered treatment programs nearby, but this remains a challenge due to a lack of AIAN-specific detox centers, residential treatment programs, and SLFs. Two facilities shared that changes in county policy and funding resulted in the closure of the local detox center, forcing clients to attain detox services through primary care or resort to the nearest emergency room. Usually, a community only has one local detox center, meaning closures have severe consequences. This can create a major challenge for those who are required to complete detox as part of their eligibility to enter residential treatment. The quote below illustrates a systemic barrier in funding for AIAN-specific RTFs, SLFs, and detox services, which leads to a lack of available bed space to accommodate individuals in need.

> In California, we need more Native American programs with more funding to help people with opioid problems, or any other problem. Lack of funding, lack of bed space. We're willing to take more clients. We just don't got space. So, people don't want to go to, how they say, "a white man's program." They want it Native American specific. And if we had more programs and more beds available at the programs, it's going to help a lot more people.

Even if facilities can refer patients to a detox center nearby, many facilities do not currently have the funding to support detox services. This means patients must still arrange payment for

the service, which is a major barrier to recovery. This places a disproportionate burden on low-income community members who do not have the resources to afford private pay or insurance-paid detox services.

There is also a need for more Native-specific SLFs, as clients have shared their experience with culturally insensitive, non-Native programs, where lack of oversight leads to continued substance use in and around the facilities. One participant noted, “Those [sober living] facilities are right in the middle of people selling, right outside the door, drugs. And there's people using in the house. [...] There's a problem with monitoring. And they are non-Native facilities.” This participant also mentioned the lack of SLFs on Tribal reservations as a barrier when people need to return home.

Long waitlists, limited options, high costs, and poor funding not only increase the risk of client relapse, but also limit the reliable support AIAN individuals need to work toward recovery. In recognition of these challenges, programs have started considering and implementing plans to provide detox services and Native-specific transitional housing or sober living environments on their property in continuation with their existing treatment program to give AIAN clients as much support as possible in an environment where they can heal and maintain sobriety. As explained in the quote below, creating Native-specific detox centers, transitional housing, and SLFs will also allow for the provision of cultural aspects of healing that are needed in the recovery care for clients.

> [F]rom my interaction with [AIAN community members] in focus groups, it was the need for their own Native SLE, their sober living environment, housing. They requested that because they want to be together, and they want to want to have more of a Native approach to their meetings. Maybe they have sage and smudging and traditional song or drum group, whatever it might be.

Patient Barriers

Aside from the existing system- and facility-level challenges to obtaining treatment, participants also detailed the individual level barriers clients may encounter. Seeking care might be delayed in these communities due to historical distrust of government-sanctioned healthcare systems. Some community members do not trust the IHS because it is a part of the federal government, which has committed atrocities against AIAN communities. One participant said their grandmother used to refer to the hospital as “a place where you go that you never return from.” Other barriers include unstable housing, unreliable transportation, inadequate funding, conservatorship needs, and limited access to technology such as phones, computers, or reliable internet bandwidth. Clients may also encounter difficulty with gathering necessary identification and registration documents such as ID cards, Social Security cards, birth certificates, and Tribal enrollment documentation. Limited literacy skills can make the completion of legal documents and eligibility paperwork a challenge for some individuals. One facility mentioned they do everything they can to help with this aspect saying, “We have them

come in and sign a consent to release, so that we can contact Tribes or Indian health centers, so that we can help them get their Tribal documents and get all of that stuff taken care of for them."

Of these barriers, lack of transportation was one of the issues most frequently mentioned by the staff who were interviewed. Clients must have access to transportation to travel to and from the facility, detox centers, regular group meetings, and community events. Challenges with transportation include clients living in remote areas, lack of available transportation, and unreliable transportation. Some clients travel from very far distances, which requires air travel and poses further barriers including unreliable transportation to the airport, limited flights available in some areas, the costs associated with airfare, and in the case of minors, the need for that client to be accompanied on their journey. Challenges with transportation can lead to increased stress and agitation in clients who urgently need treatment. Some facilities provide transportation services for their clients; however, many are limited by time, funding, distance, and/or staff capacity.

In acknowledgement of these barriers, interview participants stated that their programs and staff do everything they can to assist their clients and provide well-needed support as individuals struggling with these limited personal resources are often the ones who need treatment the most. One participant noted that these barriers become a significant issue as individuals with SUD often seek treatment urgently, with an immediate want and need for help.

Intake Barriers

Some of the barriers that specifically affect the timeliness of patient intake or admission for treatment services include long waitlists, varying levels of patient readiness, and delays in the completion or submission of required eligibility paperwork and health assessments. As discussed previously, limited bed availability and facility staff shortages can affect the timeliness of client access to care negatively. Extended wait times and waitlists can present a major barrier to recovery as clients can lose momentum in their desire to seek treatment. Extended wait times can make it difficult to maintain communication with clients over time when many are struggling with unstable housing, limited resources, or are living in an unsupportive environment risking further substance use. When speaking about the lack of detox centers and the extended time it can take to get clients in, one participant shared a story that illustrates why this is an issue.

> They took the individual to the brother, because the brother would keep him clean and sober until the 72 hours before they got here. Well, it took the referring agency a couple of weeks before we got the paperwork. By that time, the guy was gone. [...] And we're losing these people. And it's all because of detox, and because they need to do that before they come in.

There is a delicate relationship between delays in intake assessments and paperwork and patient readiness. Lower levels of patient readiness and commitment to completion of

treatment can lead to the client not completing eligibility requirements (e.g., paperwork, physical exams, tuberculosis tests) in a timely manner. In addition, delays in the completion of eligibility requirements can lead to decreased levels of patient readiness and commitment to complete treatment. Overall, this causes a delay in timely access to care. Barriers of this nature take place at the facility level as well, including delays in communication between referral and treatment facility staff, submission of paperwork, and scheduling required assessments or accessing detox services. When speaking about delays with physical clearance for substance use assessments from referring facilities, one participant said, “Different Tribes and Tribal clinics have various degrees of resources. And so, if they only happen to have one counselor for the entire clinic, it can sometimes pose a little bit of a delay or a challenge, that way.” In acknowledgement of these challenges, programs are working to address these barriers and support their clients as much as possible with available resources and referrals.

Youth Treatment Barriers

Participants stated that access to detox services, culturally centered mental health services, and residential treatment programs in California is particularly challenging for Native youth. While some preventive and treatment services are available, many participants noted the lack of Native-specific YRTFs within California. For the Native-specific youth programs that do exist, there are a limited number of beds available, long waitlists, or a limited capacity to address acute or severe needs. To meet these challenges, youth may be referred to either treatment programs that are AIAN specific but out-of-state or in-state programs that are not AIAN specific.

As the treatment needs of Native youth increase, facilities are providing support and referrals to as many resources and services as they can while acknowledging the need for more education, prevention, and Native-specific youth treatment programs in California. Youth referred to non-Native treatment programs within California may be forced to reside with members of the general population who are not peers of the same age, community, or culture. Participants discussed that there are few local treatment facilities that will take direct referrals and, regarding the facilities that do exist, one participant said, “those [residential treatment facilities] have had contracts with California Department of Children Family Services and more aligned with the CPS or foster care system for those needs of higher-level behavioral health management.”

Payment can be a compounding issue for youth needing referral to out-of-state facilities due to challenges with IHS funding, Medi-Cal, and Tribal insurance coverage for services and providers outside of California. One participant talked about the lack of funding for youth, noting that there are not enough treatment options for AIAN youth with SUD and there are even fewer options for youth who need mental health treatment but are not using drugs. The quote below demonstrates the extra considerations that must be made for AIAN youth in need as a result of the lack of available treatment services.

> I mentioned we had a youth regional treatment center. But they can only service a small group of patients that we have. If they're not using drugs, there's no place to put any kids. [...]There's no funding source for mental health for kids. The only kid that can get some mental health services is when they're 5150'd. So, we can put them out of state, which is what we do. But that's very costly to our Indian Health. And we have to do that very carefully, because we don't want to give a youth a boarding school experience that their previous generations have experienced. So, we need more awareness and more money to help youth. That's a funding barrier.

Stigma

Participants discussed how stigma is associated with SUD services and can create barriers for community members trying to access services. Self-stigmatization can occur when an individual internalizes the stigma associated with SUD and treatment services. Self-stigmatization, stigma in the community, and even stigma among employees at the facilities are considerable challenges.

Participants discussed the stigma their clients face when seeking services. One participant stated clients may feel that seeking SUD or mental health treatment is associated with the perception or stigma that "something's wrong with you." Providers also stated that clients often do not report the types of substances and/or frequency of use because they may worry about their provider's perceptions of them. This prevents providers from addressing the patient's needs and providing appropriate treatment.

Clients may also be apprehensive about how they receive services due to concerns regarding privacy and community visibility. Due to the small size of many clinics and close encounters with other community members at such clinics, clients are worried about who will see them receiving services. For example, one participant mentioned that some clients do not feel comfortable receiving naloxone even if it is readily available as they do not want other community members to find out. One participant noted that individuals seeking treatment may "kind of put a label on themselves, and it'd prevent them from wanting to come in, because they don't want their family shamed, because that's a tradition. You don't do anything to bring shame down on your family." Receiving services discreetly, such as putting naloxone in a basket (or box) by the pharmacy window, may alleviate client anxiety.

Tribal communities are very connected through kinship and fellow community members. Though these relationships can serve as a protective factor, family and/or community perceptions and expectations can also inhibit uptake of treatment services. One participant mentioned that community members' initial reaction may be skepticism when new SUD services are introduced. Services like these may be unsustainable if they are not accepted by the community. Community members become more comfortable with new services when they know a friend or family member who has attended or received the services. This is key to destigmatizing SUD and treatment services.

When speaking about MAT services, one participant mentioned the perception that MAT is "trading one drug for another." Another participant said, "We still do encounter people in the community or even professionals that sort of struggle to view substance use from a disease model perspective." Understanding and accepting substance use from a disease model perspective is often the first step in shifting perception from blame to support for someone who is seeking recovery services. Community perception and self-perception of SUD can be misguided by individual perceptions of what addiction is. One participant mentioned the distinction of how behaviors and physical addiction can vary between substances.

> Physical addiction is one thing. Addiction is another. So, if I'm addicted to heroin, and you take me off heroin and put me on Suboxone, I'm going to have a physical addiction to Suboxone for sure. But my behavior is radically changed being on Suboxone. My behavior on heroin, now I'm a bad dude. There's a real distinction that needs to be clarified in the community between physical addiction that changes your life, versus addiction to a drug that destroys your life.

Impacts of COVID-19

All facilities that participated in the interviews were affected by COVID-19 and the stay-at-home orders. The most common concern was the delay in patient care. Inpatient facilities reported a two- to three-week delay in new admissions that resulted from the necessity of COVID-19 testing and the 14-day isolation period. One facility modified their admission queue based on the 14-day isolation period for new intakes. A common approach to expediting the intake process was having COVID-19 testing available onsite. Some facilities discussed challenges associated with securing enough COVID-19 tests for their clients. One clinic mentioned implementing a mobile COVID-19 testing service where a public health nurse performed wellness checks on patients in the area and identified clients to get tested.

Most clinics have incorporated telehealth services, which has brought some successes and some challenges. One positive effect of the increase in telehealth appointments has been a decrease in the number of missed appointments. In addition, one facility mentioned that telehealth has provided them with the means to increase the availability of their therapy services. Despite this increase, however, many clients face other barriers, including the barriers to reliable internet and adequate devices to access telehealth. For clients who face such barriers, services can be provided through phone calls, and some facilities have been able to provide phones for clients who do not have them.

For in-person visits, transportation is a common problem that has been exacerbated by COVID-19. Due to the stay-at-home restrictions, clinics were not able to provide transportation for clients to attend their appointments. One clinic mentioned providing bus tokens, though they stated their community's public transportation system is limited. Another challenge posed by COVID-19 was decreased staff coverage at each facility. For example, some staff commute from

far distances and/or out-of-state to the clinic and were considered an increased risk for COVID-19 at the facility.

Discussion

California is home to 109 federally recognized Tribes as well as many non-federally recognized Tribes and AIAN populations from out-of-state. As demonstrated throughout this report, there are approximately 50 facilities in California that, collectively, provide a unique and responsive network of care for AIAN individuals in recovery. These facilities have a history of providing accessible and culturally centered care to AIAN families throughout the state.

Strengths of the Indian Health Care Network

The THPs, UIHPs, adult specific RTFs, youth-specific RTF, mental health center, and SLF captured in this assessment each provide a diverse range of behavioral health and SUD treatment and rehabilitation services to AIAN communities in both rural and urban areas. The range of services provided by these facilities includes general services (e.g., primary care, community outreach), mental health and treatment services (e.g., MAT, residential treatment), relapse prevention and maintenance services (e.g., case management, support groups), traditional healing and culturally adapted services (e.g., prayer, ceremonies, Red Road approaches), and assistance with client enrollment in safety net resource services. Additionally, many of these facilities offer trauma-informed care and dual diagnosis care, as well as some youth education, prevention, and recovery support programs. California is also home to one of only 10 Indian Health Service funded AIAN-specific YRTFs nationwide, which is significant, as culturally centered youth treatment services have historically been limited or nonexistent. Furthermore, the use of telehealth services for SUD and mental health treatment has expanded patient access to a broad base of providers and specialty care services that otherwise would not be readily available within facilities and/or the community. The diversity of services provided by these facilities with limited resources demonstrates the strength and resilience of existing models of care serving AIAN individuals statewide.

The Indian health care network is unique in its provision of culturally centered treatment and recovery services that incorporate both Western and traditional healing modalities specifically tailored for AIAN communities. Through grassroot efforts and the dedication of these community-based programs that provide culturally centered care, treatment and recovery services within these facilities often include the use of traditional medicines, White Bison's Red Road to Wellbriety and other Red Road approaches, sweat lodge ceremonies, prayer and smudging, talking circles, and other traditional practices and cultural activities that support the physical, mental, emotional, and spiritual well-being of AIAN individuals in recovery. One facility representative stated that, "[Cultural services are] an integral, critical part, not just of the program, but of their healing […] It's critical. And there's so little left for people today." These facilities also strive to maintain an inclusive environment and ensure staff are trained in cultural sensitivity and awareness. The inclusion of culturally informed assessment tools, traditional healing, and culturally adapted services as an integral part of treatment is perceived to have a positive impact on the recovery and holistic health of AIAN individuals. One program leader

stated, “[W]e need to invest more into the Native people in recovery from alcohol and drugs and utilize cultural practices to do so. I strongly and highly recommend we continue to utilize Native practices for treatment. It’s the number one component with our cultural programs.”

These existing models of care exemplify the benefits and importance of supporting culturally centered programs that serve an essential role within care provided for AIAN individuals in recovery.

Gaps in the Indian Health Care Network

As identified throughout the quantitative and qualitative results, the participating AIAN-specific facilities are continually working to provide comprehensive care for their community members with extremely limited funding available through a finite number of sources and competitive grants. Facilities that provide AIAN culturally centered recovery support must combine various sources of funding in a patchwork-like method to sustain their current treatment programs and recovery services. This is particularly evident in discussions of funding for traditional healing and culturally adapted services, as many of these services are not yet considered evidence-based treatment; therefore, they are ineligible for reimbursement through major health care funding sources. Thus, despite the invaluable role these services play within the holistic care provided to AIAN individuals in recovery, facilities must sustain these services with limited patchwork funds. Inadequate funding to sustain, let alone expand, services was well acknowledged throughout the results. One example of a significant funding gap is the lack of DMC funding provided for SUD and mental health services within AIAN-specific facilities. This lack of funding limits valuable revenue which could be used to support the extensive range of treatment and recovery services needed. Establishing DMC contracts and/or an IHP-ODS within DMC could increase the accessibility of needed services within the Indian health care network. An increase in opportunities and sources of funding is needed to not only sustain but also expand the comprehensive treatment and recovery services available to AIAN individuals in California.

As indicated throughout the results, several critical infrastructures are also needed to strengthen and complete the statewide system of care for AIAN individuals in recovery. The success of the existing models of care and the high demand for culturally centered recovery programs call for the expansion of such services and an increase in the number of facilities based on existing models. The findings of this report highlight a particular need for the expansion of AIAN-specific and culturally centered adult RTFs, YRTFs, and SLFs within California. Moreover, increasing the number of facilities with ASAM levels of 3.1 to 4.0 and, consequently, the capacity to provide services for patients with high acuity recovery and treatment needs is crucial to improving the existing network of care.

Furthermore, the availability of detox services within existing AIAN-specific facilities is limited, and there are currently no AIAN-specific detox centers located in California. Individuals are only able to access detox centers by referral to facilities outside the Indian health care network,

which complicates the continuum of care for both patients and facilities. Additionally, while some prevention and general services are available to youth through IHPs, a very limited number of residential treatment and recovery programs exist for AIAN youth in California, especially for those with high acuity treatment needs. The development of AIAN-specific detox centers and increased availability of treatment/recovery programs for youth are also fundamental to strengthening the statewide system of care available to AIANs.

AIAN-specific facilities offering treatment and recovery services are often located in clusters throughout the state. This causes fragmentation of the continuum of care within the Indian health care network that can separate patients from their communities and from where their care began or will continue. It is important that expansion based on the existing models of care is geographically spread throughout the state to ensure AIANs across rural and urban areas in California have access to adequate and comprehensive care.

The findings of this report also highlighted that the current continuum of care is disjointed due to many services only being available by referral between facilities or to those outside the Indian health care network. The disconnected system requires facilities to piece together services for their patients when recovery needs exceed the facilities' treatment capacity. Although services offered by referral provide access to needed care, the disjointed continuum can lead to delays in access to treatment due to many of the intake, facility-level, and individual-level barriers discussed in the qualitative results. Examples of these barriers include patient challenges navigating the referral system, delays in the multiple intake processes required, transportation barriers, funding barriers, and poor coordination between programs. All of these can contribute to an increased risk of patient relapse or recidivism. Additionally, when specific services are limited within the Indian health care network, referrals to non-AIAN-specific facilities (e.g., youth residential treatment, detox services) are often the only available option. These non-AIAN-specific facilities lack the culturally centered approaches to healing that are crucial to the holistic care and support needed by AIANs in recovery. The services often pieced together through separate referrals need to be streamlined so that patients encounter fewer barriers and delays to access treatment, regardless of where their care begins. Staff at multiple facilities discussed the need to streamline services and patient access to care by advocating for the integration of detox, residential treatment, and sober living services within one location to improve access to a centralized continuum of care for AIAN clients.

The perspectives shared by the AIAN-specific facilities providing substance use and recovery treatment for AIAN youth and adults in California clearly suggest treatment disparities within the SUD network of care. With the rapid increase in stimulant, opioid, and synthetic opioid overdose mortality rates, there is a critical need to increase the availability of detox centers, RTFs, and SLFs. Recommendations are provided on ways to sustain and expand the access and availability of culturally centered programs and treatment services to reduce SUD in AIAN populations in California. One major infrastructure system change recommended by many of the facility participants included the creation of an IHP-ODS to improve the coordination of

system of care components to prevent AIANs from receiving limited and fragmented services. Recommendations described below propose specific methods through which an IHP-ODS could be created and coordinated to better serve these populations. Efforts to implement these recommendations will require close partnership with AIAN community stakeholders in order to achieve optimal results and improve the health and well-being of AIAN populations in California.

Recommendations

Acceptability and efficacy of these recommendations vary by communities, and selection of strategies and/or recommendations to implement should be decided by each community.

California has the largest population of AIANs in the United States, and there is a significant need to increase access and availability to SUD treatment services and to address treatment barriers. Below are recommendations to achieve positive treatment outcomes for AIANs with mental health and SUD needs.

The following recommendations are based on the voices of leadership within AIAN-serving agencies and service providers in rural and urban settings where key informant interviews and surveys were conducted. Based on these perspectives, in partnership with the CAB for this project and the analysis of the project evaluation team, these recommendations were developed to assist AIAN communities, policy makers, and other stakeholders in strategizing achievable goals to improve critical health care and recovery services for AIANs living in California.

1. **Create Access to the Drug Medi-Cal Program for AIANs and IHPs through an Indian Health Program Organized Delivery System (DMC IHP-ODS).** The report data shows DMC, the Medicaid payer source responsible for SUD treatment and services in California, is not widely accessed by IHPs (i.e., THPs and UIHPs). DMC's current county based ODS model is historically problematic for the delivery of culturally appropriate services to AIANs. Additionally, THPs, UIHPs, and RTFs face multiple DMC contracting barriers. The solution proposed by Tribal leaders and IHPs is the creation of an IHP-ODS to bypass the county-based ODS model and create a statewide "county equivalent" or "59th County" IHP-ODS. The report data shows that the IHP delivery system already contains a full continuum of care through a distinct and unique network of THPs, UIHPs, RTFs, and established contracts/MOUs with local entities. The authors of this report recommend state and DHCS leadership re-engage with Tribal leaders and IHPs in a renewed discussion about the importance of an IHP-ODS to meet the SUD treatment needs of AIANs in California. DMC IHP-ODS opportunities include:
    - An IHP-ODS allows for flexibility in fee schedules, sustainability of traditional healing, and community-defined practices.
    - An IHP-ODS keeps AIAN beneficiaries within the established Indian health care network.
    - An IHP-ODS avoids the need for RTFs to contract with multiple counties when honoring AIAN referrals from around the state.
    - An IHP-ODS gives administrative oversight and network functions to an AIAN controlled entity.

- An IHP-ODS more closely resembles the government-to-government relationship in that it bypasses the county system.
- Revenue from DMC will lead to enhanced services at THP, UIHP, RTF, including detox and transitional care services.

2. **Develop a More Integrated and Collaborative Systems of Care.** Fragmented services contribute to gaps in communication among providers from different disciplines and along different phases of the recovery continuum (e.g., detox, inpatient, outpatient, transitional care), creating lapses in services or insufficient follow-up that place the patient at risk for relapse. One such model to improve patient care services is the system of care (SOC) model. The SOC philosophy proposes a coordinated network of community-based services and supports that are organized to promote recovery and healing from mental health and substance use problems. To develop an SOC approach to SUD and mental health services in the California AIAN population, the authors of this report recommend funding a "pilot program" involving one inpatient rehabilitation facility, a detox center, an SLF, and an Indian health clinic (with behavioral and medical support) all in one local area to support individuals entering the system. For example, this can be accomplished in northern California where focus groups and/or executive meetings could help engage facility staff and community members to create a system of care. Discussions would include how to assign individuals a case manager who oversees that patient's entire comprehensive treatment plan, including emergency detox, inpatient rehabilitation, outpatient SUD treatment, outpatient psychotherapy for any co-occurring mental health issue(s), placement in sober living, traditional AIAN healing services, and connection to a recovery support group.

    a. **Implement an AIAN System of Care (SOC) Navigators (Case Managers) Program.** The case manager would be responsible for facilitating progression through the different treatment settings as well as communication between various providers and agencies involved in the patient's continuum of care, taking the pressure off the patient to be responsible for navigating and coordinating a complex set of interventions and services. Below are strategies to integrate services, as outlined by key informants:

        - Chronic pain management/pain management contracts
        - Active case management
        - Management of relapse
        - Referrals
        - Treatment of mental health comorbidities alongside SUD
        - Inclusion of traditional healers and cultural practices
        - Multiple-entry points into SUD services

b. **Develop an AIAN Warm Line for Statewide Referral and Resource Navigation.** Develop and fund an AIAN-specific warm line to assist AIANs in accessing county and statewide treatment and recovery services and resources. Warm lines provide non-emergency call, chat, and messaging functions for individuals seeking mental health treatment, support, and resources. Warm lines provide peer-run and tailored services to individuals in crisis who might otherwise call emergency lines (e.g., 911). This resource has demonstrated success in California, saving emergency call operators time and funding resources by connecting individuals directly to mental health resources in their counties.

c. **Fund Integration of Patient Centered Care for all IHPs.** Integrated behavioral health care is a team of health care professionals working together with patients and families to provide patient centered care. It is often referred to as a "health home" providing expanded types of care for the whole person, mind and body. Health care professionals involved with integrated care include physicians, nurses, medical assistants, pharmacists, traditional healers, and behavioral health providers. The behavioral health provider can be embedded within the medical clinic to provide direct care as needed to a medical patient. The integration of traditional healers can also benefit the whole person by providing cultural wisdom, guidance, and non-Western healing. Warm handoffs (e.g., referrals) can be made from the integrated care team to SUD counselors and therapists to address mental health and SUD treatment plans.

d. **Increase Program Collaboration Between AIAN-Specific Treatment Programs.** Increase program collaboration, IHS support, and funding opportunities to improve services for AIAN clients. Participants acknowledged there are variations in medical staff, resources, and treatment services available within IHS-affiliated and non-affiliated programs that serve Tribal and Urban Indian populations. This report outlines the invaluable outpatient services available through IHPs despite funding deficiencies, the need for expansion of inpatient programs, and the importance of coordination between all facilities within the Indian health care network. Participants recommended improved collaboration and coordination between existing AIAN-specific treatment programs, medical facilities, and available MAT services (e.g., California Bridge Program, TeleWell) to ensure clients are supported with a coordinated continuum of care, regardless of where their treatment began. As previously mentioned, access to a DMC IHP-ODS would support the development of a more integrated system of care, targeted SUD funding, and better coordination between the critical AIAN-specific outpatient recovery programs and inpatient treatment centers serving AIANs in California.

e. **Increase Funding for Culturally Based Services.** An AIAN coordinated service system, such as an SOC approach, would also help ensure that services remain in harmony with cultural approaches to recovery from a strengths-based and integrative/holistic perspective. Such a system would employ cultural

consultants to help connect the patient to culturally based services and/or advocate for the need for the incorporation of cultural understanding and sensitivity throughout all the services the patient is receiving.

f. **Increase the Availability of Culturally Centered Recovery Programs**. Program leaders strongly recommended that cultural healing practices remain a central role within treatment services and should be expanded and made available to all AIAN individuals seeking recovery. Resources to support the existing AIAN-specific programs in California should continue and improve as there is an increasing demand for culturally centered programs and services to meet the holistic needs of California's AIAN community members. Programs most commonly contract with traditional practitioners to provide individual or group services to clients. Programs are encouraged to include AIAN staff, culturally informed assessment tools, culturally sensitive MAT programs, culture- and trauma-informed therapy, and to create an environment where community members can share and learn from the stories and cultural practices of others as a part of individual healing and growth. A few examples are listed and can be culturally adapted to meet the needs of AIAN communities.

    White Bison: Funding for recovery programs that are culturally specific for AIAN communities are essential in order to achieve sobriety and abstinence from substance use. White Bison, Inc., offers sobriety, recovery, and wellness programs based on Wellbriety, which help AIAN individuals attain sobriety while concentrating on the spiritual, mental, emotional, and physical aspects of one's well-being through cultural healing. Culturally appropriate recovery programs typically include the Medicine Wheel and the 12-step program for men, women, and youth with a series of modules focused on character and values: 1. honesty, 2. hope, 3. faith, 4. courage, 5. integrity, 6. willingness, 7. humility, 8. forgiveness, 9. justice, 10. perseverance, 11. spiritual awakening, and 12. service. These programs are valued healing approaches and resources for AIAN individuals in recovery and should be considered for funding and as a billable service. For more information on White Bison programs, visit http://www.whitebison.org.

    Sweat Lodge Ceremonies: Sweat lodge ceremonies are one way that AIAN recovery centers and organizations treat and support individuals working towards recovery, sobriety, and wellness. Including sweat lodge ceremonies in integrative recovery programs is essential to support AIAN individuals who use this tradition or are interested in including it as a treatment option. A sweat lodge is a place of purification where ceremony is practiced by many AIAN individuals who seek to heal, gain wisdom, give gratitude, and pray for others. This tradition is used by recovery centers serving AIANs to help with an individual's recovery process for mental and physical healing. Sweat lodge ceremonies have

been shown to increase an individual's spiritual and emotional well-being, particularly those in recovery with SUD.

Healing Ceremonies: While too extensive and diverse to list here in full, the use of ceremonies in the recovery process is central to AIAN communities in California. Ceremonial spaces offer AIANs safe, sober, and supportive gathering spaces to express traditional forms of healing practices. These approaches to healing are as diverse as the AIAN individuals practicing them; they can include sweat lodge ceremonies, traditional medicine circles, talking circles, prayer gatherings, smudging, and meetings with traditional/spiritual healers. These ceremonial practices for AIAN individuals in recovery are central to respecting and supporting healing from the effects of SUD. All efforts should be made to acknowledge, respect, and support the revitalization of these ceremonial practices with the utmost reverence and flexibility for how communities implement these practices. Particular efforts should be made to educate funders and agencies on the importance of ceremonial practices and emphasize community-based evaluation approaches to traditional forms of healing.

3. **Increase the Availability of AIAN Residential Treatment Facilities.** There is a fundamental need to increase the accessibility and availability of culturally centered residential treatment programs in California to support the reduction of SUD among AIAN individuals. There are only five AIAN-specific adult RTFs and one YRTF in California. As identified throughout this report and in existing state and county data, this limited number of AIAN-specific RTFs is insufficient to meet the needs of AIAN communities. Currently, there are facility- and system-level barriers to treatment access that include a limited number of AIAN-specific RTFs, limited bed availability, limited administrative and medical staff capacity, and challenges in meeting the needs of clients seeking assistance after hours. According to California Department of Public Health Multiple Cause of Death and California Comprehensive Death Files data retrieved from the California Opioid Overdose Surveillance Dashboard (age adjusted rates for years 2017-2019), there are at least seven counties in California with 42 or more AIAN deaths per 100,000 residents caused by opioid overdose. Examples of these counties with high opioid overdose AIAN death include Calaveras (208 deaths per 100,000 residents), San Francisco (76 deaths per 100,000 residents), Santa Barbara (58 deaths per 100,000 residents), Inyo (52 deaths per 100,000 residents), Marin (51 deaths per 100,000 residents), Mendocino (44 deaths per 100,000 residents), and Humboldt (42 deaths per 100,000 residents) (California Department of Public Health, 2021). Of these counties, San Francisco is the only one that has an RTF that primarily serves AIAN individuals, thus highlighting the need for more AIAN-specific RTFs. It is critical to address the major gap in availability and accessibility of RTFs in counties with high opioid overdose deaths among AIANs. Discussions with AIAN community leaders and stakeholders must immediately happen to expand services, especially among regions where no RTFs exist.

a. **Provide Expansion Grants and Funding for Women and Men with Children in Residential Programs and Facilities.** Residential treatment programs should provide access to recovery services for AIAN mothers and fathers with children impacted by SUD. The ability to keep children with their parent(s) remains a significant challenge that must be addressed in a statewide approach to combating the opioid epidemic. Providing the availability for women and men to have their children with them while in a residential treatment program can increase successful recovery outcomes. A parent may delay or forego treatment because of this barrier, which places the individual and family at greater risk of the harmful effects of SUD. Tribal and urban residential programs need support in developing resources that provide access to supportive services and housing for mothers/fathers and their children. Removing this barrier to treatment could increase the utilization of SUD recovery and provide essential prevention and support services to children affected by addiction in the family.

b. **Coordinate Western Provider Program Referrals to IHPs**. Increasing access for AIANs to culturally centered services within the Indian health care network in California is critical for ongoing SUD recovery and support services. Developing statewide strategies for Western provider referrals to AIAN-specific resources may produce higher levels of utilization of SUD resources. Following the model of the Indian Child Welfare Act—which provides the concepts, guidance, and actions steps necessary for developing a structured compilation of resources designed to assist county administrators and staff to implement culturally appropriate practices for AIAN children participating in a child welfare—can guide improvements to SUD recovery referral services. Additionally, linkages and plan development with appropriate resources may be a billable service in some counties. Educating providers across California on the resources available to their AIAN community members and the resources and materials that they can use with their AIAN patients will be a critical next step in addressing the opioid crisis for AIAN communities in California.

c. **Fund Extended Stay.** Funding is limited or unavailable to provide extended stays for AIAN patients in recovery. This service is essential for AIAN individuals, as an extended stay can prevent relapse and support the maintenance stage while also providing them more time to plan the next phase after treatment.

d. **Fund Services.** Transportation is a major barrier for AIAN individuals living in remote areas. It may require air travel, and some facilities do not have the time, funding, or staff capacity to support transporting individuals. Providing transportation services would support individuals in obtaining services; traveling to and from support group meetings or community events; or returning home to their communities of residence.

4. **Increase the Availability of AIAN Specific Detox Treatment Programs.** One of the critical components missing from the Indian health care network in California is detox facilities that coordinate, on a system level, with THPs and UIHPs. As highlighted in this report, there are currently no detox centers available within the Indian health care network. We recommend new regional detox centers for AIAN individuals be centrally located to and/or connected to existing AIAN-specific RTFs in California. This would reduce distance challenges and support a continuum of care readily available for AIAN individuals seeking recovery. Having discussions with Tribal leaders and RTF administrators is a critical next step to identify the regions where detox centers are most needed. Furthermore, access to a DMC IHP-ODS would provide funding for detox centers and services for AIAN communities. It is challenging for AIAN individuals to access appropriate services during the detox process. Some facilities require clients to be abstinent for 72 hours prior to entering treatment services. AIAN individuals potentially seeking recovery may be lost to treatment due to limited access to culturally centered detox centers.

    a. **Establish Statewide Funding for Culturally Centered Detox Centers for Tribal and Urban AIANs in California.** While culturally based residential programs exist, detox centers operating on the county level often lack coordination with these residential programs or lack the resources to refer AIAN individuals to culturally based services and recovery supports. Developing Tribal and urban-based detox centers for AIANs would ensure a more integrated and coordinated continuum of recovery for the treatment of SUD. Access to traditional AIAN practices and healing for patient wellness at one of the most critical junctures in the recovery cycle of change is paramount. With the integration of AIAN detox centers in California, AIAN individuals would be able to enter the AIAN recovery system and transition more seamlessly to residential and transitional/sober living programs to sustain their recovery.

    b. **Improve Residential and Detox Patient Coordination.** To improve the systems of care for AIAN individuals who seek recovery, non-AIAN residential and detox center facilities should be made aware of all AIAN-specific treatment programs nearby so that they can automatically offer AIAN clients a referral to AIAN-specific and culturally centered facilities for continued treatment and recovery support, if needed. Support is also needed for AIAN-specific RTFs to implement plans for detox units/services to be available onsite for clients in need of detox as part of service eligibility for residential treatment programs. Including detox in continuation with residential treatment programs on the same property will reduce some of the major barriers (e.g., local access to detox, transportation) within the present continuum of care for both patients and facilities. Currently, many facilities do not have the funding to support referral detox services. This means patients must still arrange payment for the service, which, consequently, places a disproportionate burden on low-income community members who do not have the resources to afford private pay or insurance-paid detox services.

5. **Increase Sober Living and Transitional Housing for AIANs.** The need for sober living and transitional housing for Tribal and Urban AIANs was a consistent theme throughout the assessment. Many community members expressed the challenge of graduating from a residential or other outpatient treatment program only to be confronted with those same challenges and patterns when rejoining their home communities. It is recommended to support the opening of at least three regional AIAN-specific sober living and transitional housing placements and to expand availability of funding for Tribal SLFs. Transitional housing in Tribal and urban areas provide a safe, culturally centered recovery experience for individuals to integrate recovery tools into their home and community settings.

    a. **Increase Workforce Development and Job Placement Opportunities.** Transitional housing programs based in Tribal areas can offer individuals ongoing recovery support while also building skills through workforce development and job placement. They can provide long term, sustained recovery while bringing more individuals into the recovery treatment workforce. Many community members expressed a commitment to helping other AIAN individuals recover from SUD. However, the availability of job training and SUD recovery workforce programs is limited. Connecting newly recovered individuals with these resources can fulfill a need for more substance use recovery professionals while simultaneously helping to sustain recovery and prevent relapse.

    b. **Develop a Network of Transitional Housing Program Experts and Consultants.** Due to the unique nature of AIAN health care delivery, the need to develop a network of transitional housing program experts and consultants is critical. Professionals, in partnership with community members, should develop a task force to better understand the barriers, needs, and facilitators of developing a statewide strategy for implementing transitional housing programs in Tribal and urban areas. Funding, in conjunction with ongoing technical assistance, will be necessary to assist Tribes with implementing transitional housing programs and maintaining continuous evaluation and quality improvement measures for program success. Developing transitional housing is an essential step in creating a continuum of recovery services that is currently lacking in the Indian health care delivery system.

    c. **Engage Adults in Recovery and Outreach.** A central outcome of the recovery process is a commitment by the individual in recovery to serve and support other individuals in recovery. Community members expressed a strong commitment to this principle and the need to develop programs that leverage this commitment to outreach to other AIANs currently in or seeking recovery across California. Engaging the knowledge and expertise of AIAN adults in recovery should be included in community, school, and provider forums. AIAN community members in recovery should be included in the planning, development, and implementation of statewide strategies addressing SUD recovery and outreach efforts.

d. **Increase Substance Use Recovery Training and Workforce Development Opportunities.** To bolster the strategies aimed at increasing the engagement of AIAN adults in recovery, the following recommendations address the need to develop next steps for those graduating from residential or sober living programs:

- Create training and workforce development programs to more seamlessly transition recovering adults who desire to gain the skills and certifications to enter the recovery workforce.
- Evaluate existing workforce programs and make best practices available to emerging programs.
- Develop statewide funding resources to support communities in developing programs and connecting to California resources for ongoing implementation technical assistance to sustain these efforts.

6. **Increase Youth Treatment and Recovery Programs.** There is a specific need to develop and support more treatment options specifically for AIAN youth with SUD. There are currently two AIAN-specific YRTFs funded in California; however, only one has been constructed and open for community access. The existing YRTF is located in southern California, which indicates a gap in accessible treatment options for AIAN youth in central and northern California communities. Increasing the access and availability of recovery programs must include trauma-informed SUD and mental health care, crisis intervention, MAT, group therapy support, cultural activities, and family reunification services. Efforts to connect AIAN youth to positive cultural support systems will engage them in positive treatment services, provide safe spaces for youth development, and provide opportunities for them to understand their recovery. Specifically, to address immediate needs and provide accessible youth treatment and recovery programs, recommendations include:

a. **Develop More Youth Residential Treatment Facilities.** There is a need to increase the access and availability of YRTFs with detox services and culturally centered mental health services. Often, youth may be referred to an out-of-state AIAN-specific facility due to lack of availability here in California or referred to an in-state program that is not AIAN-specific. Additionally, new YRTFs should be developed with the capacity to provide services for youth with co-occurring conditions and treatment needs.

b. **Increase Mental Health Treatment Services for AIAN Youth**. Attention is needed to increase mental health care for AIAN youth. There are few options for AIAN youth who need mental health treatment, especially for youth who are not using drugs/substances. Also, culturally specific evaluation tools are needed to capture the key signs and symptoms of mental illness. AIAN youth experience high rates of mental health disorders and high rates of dual diagnosis with SUD. Providing these services in AIAN-specific YRTFs is imperative to support a comprehensive system of care encouraged by AIAN traditional healers and counselors.

c. **Increase Funding to Provide Support Services.** Support services are valuable and essential to meet the needs of AIAN youth to obtain recovery and treatment services. Transportation is a major barrier for youth living in remote areas, who may require air travel. Furthermore, facilities may not have time, funding, or staff capacity to support transportation. Continued support is needed for more culturally centered programs available for AIAN youth to keep youth connected and engaged with positive activities. We recommend providing funding to increase youth prevention programs on substance use, particularly opioid use with school-based programs and culture-based activities to engage youth in wellness. Additionally, we recommend the development of and support of youth-specific mental health and trauma-informed support programs.

7. **Develop Permanent Sources of Funding for Community Defined Evidence Based Practices (CDEPs).** Many IHPs use substance use and mental health prevention and treatment services for AIANs, such as CDEPS, which may be endorsed by communities, but which are not "empirically accepted" across funding interventions and curriculums. Most funding sources for treatment, such as Medi-Cal, require the use of EBPs and do not fund cultural and traditional practices that do not hold that designation. Efforts such as DMC IHP-ODS (listed above) would include CDEPS as billable services. However, there needs to be statewide recognition and funding dedicated to cultural and traditional practices that are endorsed by communities with demonstrated outcomes that reduce health disparities associated with SUD. Practices such as GONAs and Drum-Assisted Recovery Therapy for Native Americans (DARTNA) have significant research and evaluation efforts that demonstrate efficacy with AIAN people, yet they are currently not accepted EBPs.

   For example, large-scale efforts have been underway in California to elevate the importance of CDEPs (through evaluation and research) such as the California Reducing Disparities Project (CRDP). Founded in 2009 with the goal of achieving mental health equity for five priority populations in California (i.e., African American, Latinx, AIAN, Asian and Pacific Islander, and LGBTQ+), CRDP is a multiethnic coalition that champions community-driven solutions to reducing mental health disparities through advocacy, policy change program development and community-based evaluation. The CRDP is funded through the Mental Health Services Act (Proposition 63) and administered by the Office of Health Equity at the California Department of Public Health. Findings from the CRDP can be used to support SUD programs to achieve competent approaches for AIAN populations.

8. **Increase Awareness of AIAN Specific Community and Service Needs**.
Recommendations to address service system needs include incorporating harm reduction approaches in treatment programs, developing holistic therapy, and providing education on how unresolved grief may contribute to addiction in the AIAN community. Providing clients with more available and accessible culturally based services to support long term sobriety is essential to the system of care for AIAN individuals.

    a. **Provide Education.** Education should include the prevalence of SUD among AIANs and the different types of treatment and support services available to these communities. In addition to the need for more education about AIAN SUD prevalence, education on how exposure to trauma, adverse childhood experiences, stigma, and unresolved grief may be influencing or contributing to addiction within the community is also necessary.

    b. **Include Harm Reduction Approaches in Treatment Programs.** To address the specific needs of AIAN communities, include compassionate and pragmatic approaches to reduce substance-related harm and improve the quality of life without requiring abstinence or use reduction. Incorporating harm reduction approaches within treatment programs is also recommended.

    c. **Utilize Holistic Therapy Approaches.** Participants recommended improving and expanding options for a diverse range of therapies that address the holistic needs of AIAN individuals, families, and youth affected by SUD and proactively addressing the health risks, comorbidities, and various determinants of health that may be impacting wellness across generations.

    d. **Increase Funding.** Increase opportunities and the accessibility of funding available to programs specifically serving AIAN communities so that these facilities can address existing service gaps, improve their available treatments, and support the sustainability and growth of culturally sensitive recovery programs.

References

American Society of Addiction Medicine. (2015). *What are the ASAM Levels of Care? – ASAM Continuum | ASAM Criteria Decision Engine*. https://www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bureau of Indian Affairs. (2014). Indian Entitles Recognized and Eligible To Receive Services from the United States Bureau of Indian Affairs. *Federal Register*, *79*(19), 1–6. https://www.federalregister.gov/documents/2014/01/29/2014-01683/indian-entities-recognized-and-eligible-to-receive-services-from-the-united-states-bureau-of-indian

California Department of Public Health. (2021). *California Opioid Overdose Surveillance Dashboard*. California Department of Public Health. https://skylab.cdph.ca.gov/ODdash/

California Rural Indian Health Board. (n.d.). *History*. Retrieved April 8, 2021, from https://crihb.org/about/history/

Clarke, C. (2016). *Untold History: The Survival of California's Indians*. KCET. https://www.kcet.org/shows/tending-the-wild/untold-history-the-survival-of-californias-indians

Indian Health Service. (n.d.). *Two-Spirit*. Retrieved April 8, 2021, from https://www.ihs.gov/lgbt/health/twospirit/

Indian Health Service. (2000). *2000 Annotated Codification of IHCIA Indian Health Care Improvement Act, Public Law 95-437*. https://www.ihs.gov/sites/ihcia/themes/responsive2017/display_objects/documents/home/2000_IHCIA_Codification.pdf

Indian Health Service. (2018). Office of Tribal Self-Governance; Planning Cooperative Agreement. *Federal Register*, *83*(74), 1–8. https://www.federalregister.gov/documents/2018/04/17/2018-07942/office-of-tribal-self-governance-planning-cooperative-agreement

Indian Health Service California Area Office. (2015). *Fiscal Year 2015 Annual Report*. https://www.ihs.gov/california/tasks/sites/default/assets/assets/File/FY2015IHSCAOAnnualReport.pdf

Intertribal Friendship House. (2002). *Urban Voices: The Bay Area American Indian Community* (S. Lobo (ed.); 1st ed.). University of Arizona Press.

Judicial Council of California. (2020). *California Tribal Communities*. https://www.courts.ca.gov/3066.htm

Kidwell, K. D., Purvis, T., Levine, A., Tsen, C., & Carlson, R. E. (1988). *The Urban Indian Health Program: A Bridge to Mainstream Health Care Delivery*. https://oig.hhs.gov/oei/reports/oai-09-87-00027.pdf

Norris, T., Vines, P. L., & Hoeffel, E. M. (2012). *The American Indian and Alaska Native Population*. http://2010.census.gov/news

Snowshoe, A., Crooks, C. V., Tremblay, P. F., Craig, W. M., & Hinson, R. E. (2015). Development of a cultural connectedness scale for first nations youth. *Psychological Assessment*, *27*(1), 249–259. https://doi.org/10.1037/a0037867

Soto, C., West, A. E., Unger, J. B., Miller, K., Zeledon, I., Telles, V. M., Henderson, B., Nguyen, V., Begay, C., Franklin, R., Johnson, C. L., Dickerson, D. L., Antony, V., Domaguin, D., Schweigman, K., & Moerner, L. (2019). *Addressing the Opioid Crisis in American Indian & Alaska Native Communities in California: A Statewide Needs Assessment*.

Warne, D., & Frizzell, L. B. (2014). American Indian Health Policy: Historical trends and contemporary issues. In *American Journal of Public Health* (Vol. 104, Issue SUPPL. 3, pp. S263–S267). American Public Health Association Inc. https://doi.org/10.2105/AJPH.2013.301682

Wilson, N., Kariisa, M., Seth, P., Smith, H., & Davis, N. L. (2020). Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018. *MMWR. Morbidity and Mortality Weekly Report*, *69*(11), 290–297. https://doi.org/10.15585/mmwr.mm6911a4

Appendix

Appendix A: Tribal Health Program Tables

Table A1

Services offered at THP facilities (n=27)

Service	Yes	No	Not Answered
Use telehealth services for OUD/SUD/mental health treatment	26	1	-
Provide trauma-informed SUD, OUD, and mental health services	25	2	-
Provide services for patients/clients that have a dual diagnosis	24	3	-
Provide SUD treatment for youth	22	5	-
Provide any general or prevention programs for youth	2	3	22

Table A2

*Number of THP facilities that reported treatment services **by referral*** (n=27)*

Treatment service	Adults only	Youth only	Adults & Youth	NA /Unknown
Screening for OUD and SUD	-	-	6	21
Brief intervention for OUD and SUD	-	-	3	24
Crisis intervention	-	-	7	20
Discharge/aftercare planning	-	-	3	24
Inpatient detox	1	-	18	8
Outpatient detox	2	-	13	12
Medication management for co-occurring disorders	-	-	9	18
Residential treatment	-	-	20	7
Sober living/transitional housing	4	-	14	9
In-house physician consultation	-	-	4	23
Access to emergency/inpatient services	-	-	17	10
Intensive outpatient programs (IOP)	2	-	12	13
Individual therapy[a]	1	-	5	21
Peer-led group therapy/support	-	1	10	16
Provider-led group therapy/support	-	-	5	22
Gender-specific group therapy	2	1	6	18
Cultural activities as recreational therapy for anxiety and stress management[b]	-	-	10	17
Recreation therapy for anxiety and stress management[c]	-	-	10	17
Family therapy	-	-	5	22
Couples therapy	1	-	3	23
Wellbriety/Red Road	-	-	9	18
Other	-	-	-	27

* Treatment services offered in facility can be found in text

[a] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[b] e.g., basket making, regalia making, other traditional arts

[c] e.g., outdoor activities, fitness groups, music

Table A3

Number of THP facilities that reported using medications prescribed for patients with dual diagnosis (n=27)

Dual diagnosis medication	**Within facility**[a]			**By referral**			
	Adults only	Adults & youth	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Antidepressants	3	21	3	1	-	5	21
Antipsychotic medications	4	20	3	2	1	5	19
Anti-anxiety drugs	4	19	4	2	1	5	19
Mood stabilizers	3	21	3	2	-	5	20
Other	-	-	27	-	-	-	27

[a] The "Youth only" column has been omitted from this section of the table as no facility selected this response.

Table A4

Number of THP facilities that reported enrollment in safety net resources (n=27)

Safety net resource	**Within facility**				**By referral**			
	Adults only	Youth only	Adults & youth	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Medical care resources[a]	2	-	21	4	-	-	4	23
Utility bill assistance[b]	3	-	4	20	-	-	12	15
Housing resources[c]	4	-	4	19	1	-	12	14
Transportation resources[d]	4	-	16	7	-	1	6	20
Food & nutrition resources[e]	3	-	10	14	-	-	10	17
Cash assistance	3	-	2	22	-	-	11	16
Tribal TANF enrollment	2	-	9	16	1	-	13	13
Cell phone/landline assistance	3	-	3	21	-	-	10	17
Vocational resources[f]	4	-	5	18	2	-	10	15
Educational attainment resources[g]	3	1	2	21	1	-	11	15
Domestic violence and intimate partner violence resources	3	1	13	10	-	-	14	13
Other	-	-	-	27	-	-	-	27

[a] e.g., Medi-Cal, Medicare

[b] e.g., Low Income Home Energy Assistance Program (LIHEAP)

[c] e.g., Rental assistance, emergency housing, transitional housing, temporary address usage

[d] e.g., Gas vouchers, bus vouchers, van/bus services

[e] e.g., Supplemental Nutrition Assistance Program (SNAP)/CalFresh, food pantries, food bank, community garden, commodities

[f] e.g., Job readiness/placement assistance, work experience, on-the-job training

[g] e.g., GED assistance, classroom readiness training

Appendix B: Urban Indian Health Program Tables

Table B1

Services offered at UIHP facilities (n=6)

Service	Yes	No	Not answered
Use telehealth services for OUD/SUD/mental health treatment	6	-	-
Provide trauma-informed SUD, OUD, and mental health services	6	-	-
Provide services for patients/clients that have a dual diagnosis	6	-	-
Provide SUD treatment for youth	5	1	-
Provide any general or prevention programs for youth	3	-	3

Table B2

*Number of UIHPs that reported treatment services **by referral*** (n=6)*

Treatment service	Adults only	Youth only	Adults & youth	NA /unknown
Screening for OUD and SUD	-	1	2	3
Brief intervention for OUD and SUD	-	1	1	4
Crisis intervention	-	1	1	4
Discharge/aftercare planning	-	-	2	4
Inpatient detox	-	-	6	-
Outpatient detox	-	-	6	-
Medication management for co-occurring disorders	-	1	3	2
Residential treatment	-	-	6	-
Sober living/transitional housing	1	-	5	-
In-house physician consultation	-	-	2	4
Access to emergency/inpatient services	-	-	6	-
Intensive outpatient programs (IOP)	-	-	6	-
Individual therapy[b]	-	-	1	5
Peer-led group therapy/support	-	1	4	1
Provider-led group therapy/support	-	-	1	5
Gender-specific group therapy	-	-	4	2
Cultural activities as recreational therapy for anxiety and stress management[c]	-	-	1	5
Recreation therapy for anxiety and stress management[d]	-	-	1	5
Family therapy	1	1	1	3
Couples therapy	1	1	2	2
Wellbriety/Red Road	-	-	2	4
Other	-	-	-	6

* Treatment services offered in facility can be found in text

[a] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[b] e.g., basket making, regalia making, other traditional arts

[c] e.g., outdoor activities, fitness groups, music

Table B3

Number of UIHP facilities that reported using medications prescribed for patients with dual diagnosis (n=6)

Dual diagnosis medication	**Within facility**[a]			**By referral**[b]		
	Adults only	Adults & youth	NA/ unknown	Youth only	Adults & youth	NA/ unknown
Antidepressants	1	4	1	1	2	3
Antipsychotic medications	2	2	2	1	2	3
Anti-anxiety drugs	1	4	1	1	2	3
Mood stabilizers	3	1	2	1	2	3
Other	-	-	6	-	-	6

[a] The "Youth only" column has been omitted from this section of the table as no facility selected this response.

[b] The "Adults only" column has been omitted from this section of the table as no facility selected this response.

Table B4

Number of UIHP facilities that reported enrollment in safety net resources (n=6)

Safety net resource	**Within facility**[a]			**By referral**			
	Adults only	Adults & youth	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Medical care resources[b]	-	5	1	-	-	1	5
Utility bill assistance[c]	1	2	3	2	-	3	1
Housing resources[d]	1	1	4	1	-	4	1
Transportation resources[e]	1	1	1	1	-	1	4
Food & nutrition resources[f]	-	4	2	1	-	3	2
Cash assistance	-	1	5	1	-	5	-
Tribal TANF enrollment	-	1	5	-	-	5	1
Cell phone/landline assistance	1	1	4	-	-	4	2
Vocational resources[g]	-	2	4	-	1	4	1
Educational attainment resources[h]	-	1	5	-	-	5	1
Domestic violence and intimate partner violence resources	-	4	2	-	-	3	3
Other	-	-	6	-	-	-	6

[a] The "Youth Only" column has been omitted from this section of the table as no facility selected this response.
[b] e.g., Medi-Cal, Medicare
[c] e.g., LIHEAP
[d] e.g., Rental assistance, emergency housing, transitional housing, temporary address usage
[e] e.g., Gas vouchers, bus vouchers, van/bus services
[f] e.g., SNAP/CalFresh, food pantries, food bank, community garden, commodities
[g] e.g., Job readiness/placement assistance, work experience, on-the-job training
[h] e.g., GED assistance, classroom readiness training

Appendix C: Adult Residential Treatment Facility Tables

Table C1

Services offered at adult RTFs (n=5)

Service	Yes	No	Not answered
Use telehealth services for OUD/SUD/mental health treatment	3	-	2
Provide trauma-informed SUD, OUD, and mental health services	4	-	1
Provide services for patients/clients that have a dual diagnosis	3	2	-
Provide SUD treatment for youth	-	-	5
Provide any general or prevention programs for youth	-	-	5

Table C2

*Number of adult RTFs that reported treatment services **by referral*** (n=5)*

Treatment service	Adults only	Youth only	Adults & youth	NA/ unknown
Screening for OUD and SUD	-	-	-	5
Brief intervention for OUD and SUD	2	-	-	3
Crisis intervention	1	-	1	3
Discharge/aftercare planning	-	-	-	5
Inpatient detox	2	-	-	3
Outpatient detox	3	-	1	1
Medication management for co-occurring disorders	2	-	-	3
Residential treatment	1	1	-	3
Sober living/transitional housing	2	-	-	3
In-house physician consultation	2	-	-	3
Access to emergency/inpatient services	3	1	-	1
Intensive outpatient programs (IOP)	3	-	-	2
Individual therapy[a]	3	-	-	2
Peer-led group therapy/support	1	-	1	3
Provider-led group therapy/support	1	-	-	4
Gender-specific group therapy	1	-	-	4
Cultural activities as recreational therapy for anxiety and stress management[b]	-	-	1	4
Recreation therapy for anxiety and stress management[c]	-	-	1	4
Family therapy	1	1	-	3
Couples therapy	3	-	-	2
Wellbriety/Red Road	-	1	-	4
Other	-	-	-	5

* Treatment services offered in facility can be found in text

[a] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[b] e.g., basket making, regalia making, other traditional arts

[c] e.g., outdoor activities, fitness groups, music

Table C3

Number of adult RTFs that reported prescribing MAT medications (n=5)

MAT medication	**Within facility**[a]	**By referral**[b]	
	NA/ unknown	Adults only	NA/ unknown
Methadone	5	4	1
Buprenorphine/Suboxone	5	4	1
Naltrexone	5	4	1
Naloxone	5	4	1
Disulfiram	5	2	3
Acamprosate	5	2	3
Other	5	-	5

[a] The "Adults only," "Youth only," and "Adults & youth" columns have been omitted from this section of the table as no facility selected these responses.
[b] The "Youth only" and "Adults & youth" columns have been omitted from this section of the table as no facility selected these responses.

Table C4

Number of adult RTFs that reported using medications prescribed for patients with dual diagnosis (n=5)

Dual diagnosis medication	**Within facility**[a]	**By referral**[b]	
	NA/ unknown	Adults only	NA/ unknown
Antidepressants	5	3	2
Antipsychotic medications	5	3	2
Anti-anxiety drugs	5	3	2
Mood stabilizers	5	3	2
Other	5	-	5

[a] The "Adults Only," "Youth only," and "Adults & youth" columns have been omitted from this section of the table as no facility selected these responses.
[B] The "Youth only" and "Adults & youth" columns have been omitted from this section of the table as no facility selected these responses.

Table C5

Number of adult RTFs that reported enrollment in safety net resources (n=5)

Safety net resource	**Within facility**[a]		**By referral**			
	Adults only	NA/ unknown	Adults only	Youth only	Adults & youth	NA/ unknown
Medical care resources[b]	2	3	3	1	-	1
Utility bill assistance[c]	-	5	3	-	-	2
Housing resources[d]	2	3	3	1	-	1
Transportation resources[e]	2	3	3	-	1	1
Food & nutrition resources[f]	2	3	3	-	1	1
Cash assistance	-	5	2	-	1	2
Tribal TANF enrollment	1	4	3	-	1	1
Cell phone/landline assistance	1	4	3	-	1	1
Vocational resources[g]	2	3	3	-	1	1
Educational attainment resources[h]	3	2	3	-	1	1
Domestic violence and intimate partner violence resources	3	2	3	-	1	1
Other	-	5		-	-	5

[a] The "Youth only" and "Adults & youth" columns have been omitted from this section of the table as no facility selected these responses.
[b] e.g., Medi-Cal, Medicare
[c] e.g., LIHEAP
[d] e.g., Rental assistance, emergency housing, transitional housing, temporary address usage
[e] e.g., Gas vouchers, bus vouchers, van/bus services
[f] e.g., SNAP/CalFresh, food pantries, food bank, community garden, commodities
[g] e.g., Job readiness/placement assistance, work experience, on-the-job training
[h] e.g., GED assistance, classroom readiness training

Appendix D: Youth Residential Treatment Facility Tables

Table D1

Service eligibility requirements at the YRTF (n=1)

Service eligibility criteria	Number of facilities responding "Yes"
Clients need to identify as AIAN to receive services	1
If yes, is self-identification sufficient to receive services?	-
Clients need to be California residents to receive SUD, OUD, or mental health services	-
Clients need to register with IHS to receive SUD, OUD, or mental health services	1
Clients are required to be abstinent from substances in order to receive services	1
Clients are required to enter pretreatment or detox before accessing services	1
Clients need to have a primary SUD diagnosis in order to receive services	1
If yes, which primary diagnoses allow a patient/client to be eligible for services?	
SUD	1
OUD	1
Clients are required to have a mental health evaluation to receive services	
All patients/clients are required to have one	-
In some cases, but not all	1
No patients/clients are required to have one	-
Facility conducts the mental health evaluation	-

Table D2

Funding and/or payment sources for OUD/SUD services and/or mental health services at the YRTF (n=1)

Funding and/or payment source	
Medi-Cal and/or Medicare	1
Drug Medi-Cal	-
Private insurance (HMO and/or PPO)	1
DHCS	-
Partnerships with local organizations/agencies	-
IHS	1
Federal or state grants	-
Private foundation	-
Other	1
Cash/check/private pay	-
Sliding fee	-

Table D3

Services offered at YRTF (n=1)

Service	Yes	Not answered
Use telehealth services for OUD/SUD/mental health treatment	1	
Provide trauma-informed SUD, OUD, and mental health services	1	
Provide services for patients/clients that have a dual diagnosis	1	
Provide SUD treatment for youth	1	
Provide any general or prevention programs for youth	-	1

Table D4

The YRTF reported using the following prescription medications (n=1)

Dual diagnosis medication	**Within facility[a]**	
	Youth only	NA/ unknown
Antidepressants	1	-
Antipsychotic medications	1	-
Anti-anxiety drugs	1	-
Mood stabilizers	1	-
Other	-	1

[a] The "Adults only" and "Adults & youth" columns have been omitted from this section of the table as they are not applicable. The "By referral" columns have also been omitted as the facility did not select any of these response options.

Table D5

Traditional healing/culturally adapted services offered at the YRTF (n=1)

Traditional healing/culturally adapted service	**Within facility[a]**
	Youth only
Use of ceremonial and traditional medicines in group settings	1
Use of ceremonial and traditional medicines for individual use[b]	1
Cultural uses of food	1
Group prayers and ceremonies	1
Individual prayers and ceremonies	1
Consultations with traditional persons, Elders, and leaders	1
Infrastructure to support ceremonial activities[c]	1

[a] The "Adults only," "Adults & youth," and "NA/unknown" columns have been omitted from this section of the table as they are not applicable. The "By referral" columns have also been omitted as the facility did not select any of these response options.

[b] e.g., sage, sweet grass, tobacco

[c] e.g., sweat lodge, arbor, roundhouse

Table D6

Relapse prevention/maintenance services offered at the YRTF (n=1)

Relapse prevention/maintenance service	**Within facility**[a]	
	Youth only	NA/ unknown
Case management	1	-
Self-help and support groups[b]	-	1
Recovery coaching	1	-
Employment coaching	-	1
Refusal training	-	1
Family services[c]	1	-
Life skills training	1	-
Family groups	-	1
Anger management	-	1
Commercial tobacco cessation services	-	1
Other	-	1

[a] The "Adults only" and "Adults & youth" columns have been omitted from this section of the table as they are not applicable. The "By Referral" columns have also been omitted as the facility did not select any of these response options.
[b] e.g., Alcoholics anonymous, 12-step groups
[c] e.g., marriage counseling, parenting training

Table D7

The YRTF reported enrollment in safety net resources (n=1)

Safety net resource	**Within facility**[a]	
	Youth only	NA/ unknown
Medical care resources[b]	1	-
Utility bill assistance[c]	-	1
Housing resources[d]	-	1
Transportation resources[e]	-	1
Food & nutrition resources[f]	-	1
Cash assistance	-	1
Tribal TANF enrollment	-	1
Cell phone/landline assistance	-	1
Vocational resources[g]	-	1
Educational attainment resources[h]	1	-
Domestic violence/intimate partner violence resources	1	-
Other	-	1

[a] The "Adults only" and "Adults & youth" columns have been omitted from this section of the table as they are not applicable. The "By referral" columns have also been omitted as the facility did not select any of these response options.
[b] e.g., Medi-Cal, Medicare
[c] e.g., LIHEAP
[d] e.g., Rental assistance, emergency housing, transitional housing, temporary address usage
[e] e.g., Gas vouchers, bus vouchers, van/bus services
[f] e.g., SNAP/CalFresh, food pantries, food bank, community garden, commodities
[g] e.g., Job readiness/placement assistance, work experience, on-the-job training
[h] e.g., GED assistance, classroom readiness training

Appendix E: Mental Health Center (AICC) Tables

Table E1

Service eligibility requirements at AICC (n=1)

Service eligibility criteria	"Yes" response
Clients need to identify as AIAN to receive services	-
If yes, is self-identification sufficient to receive services?	-
Clients need to be California residents to receive SUD, OUD, or mental health services	-
Clients need to register with IHS to receive SUD, OUD, or mental health services	-
Clients are required to be abstinent from substances in order to receive services	-
Clients are required to enter pretreatment or detox before accessing services	-
Clients need to have a primary SUD diagnosis in order to receive services	-
If yes, which primary diagnoses allow a patient/client to be eligible for services?	
SUD	-
OUD	-
Clients are required to have a mental health evaluation to receive services	
All patients/clients are required to have one	1
In some cases, but not all	-
No patients/clients are required to have one	-
Facility conducts the mental health evaluation	1

Table E2

Services offered at AICC (n=1)

Service	Yes	Not answered
Use telehealth services for OUD/SUD/mental health treatment	1	-
Provide trauma-informed SUD, OUD, and mental health services	1	-
Provide services for patients/clients that have a dual diagnosis	1	-
Provide SUD treatment for youth	1	-
Provide any general or prevention programs for youth	-	1

Table E3

*Treatment services AICC offers **by referral*** (n=1)*

Treatment service[a]	Adults & youth	NA /unknown
Screening for OUD and SUD	-	1
Brief intervention for OUD and SUD	-	1
Crisis intervention	-	1
Discharge/aftercare planning	-	1
Inpatient detox	1	-
Outpatient detox	1	-
Medication management for co-occurring disorders	-	1
Residential treatment	1	-
Sober living/transitional housing	1	-
In-house physician consultation	-	1
Access to emergency/inpatient services	-	1
Intensive outpatient programs (IOP)	1	-
Individual therapy[b]	-	1
Peer-led group therapy/support	-	1
Provider-led group therapy/support	-	1
Gender specific group therapy	1	-
Cultural activities as recreational therapy for anxiety and stress management[c]	1	-
Recreation therapy for anxiety and stress management[d]	1	-
Family therapy	-	1
Couples therapy	-	1
Wellbriety/Red Road	-	1
Other	-	1

* Treatment services offered in facility can be found in text

[a] The "Youth only" and "Adults only" columns have been omitted from this table as the facility did not select these responses.

[b] e.g., cognitive behavioral therapy, motivational therapy, supportive counseling, EMDR

[c] e.g., basket making, regalia making, other traditional arts

[d] e.g., outdoor activities, fitness groups, music

Table E4

AICC reported offering the following MAT medications (n=1)

MAT medication	**Within facility**[a]		**By referral**[a]	
	Adults & youth	NA/ unknown	Adults & youth	NA/ unknown
Methadone	-	1	1	-
Buprenorphine/Suboxone	-	1	1	-
Naltrexone	1	-	-	1
Naloxone	1	-	-	1
Disulfiram	-	1	1	-
Acamprosate	-	1	1	-
Other	-	1	-	1

[a] The "Adults only" and "Youth only" columns have been omitted from this table as the facility did not select these responses.

Table E5

AICC reported offering the following prescription medications (n=1)

Dual diagnosis medication	**Within facility**[a]	
	Adults & youth	NA/ unknown
Antidepressants	1	-
Antipsychotic medications	1	-
Anti-anxiety drugs	1	-
Mood stabilizers	1	-
Other	-	1

[a] The "Adults only" and "Youth only" columns have been omitted from this table as the facility did not select these responses. The "By referral" columns have also been omitted as the facility did not select any of these response options.

Table E6

AICC reported enrollment in the following safety net resources (n=1)

Safety net resource	**Within facility**[a]		**By referral**[a]	
	Adults & youth	NA/ unknown	Adults & youth	NA/ unknown
Medical care resources[b]	1	-	-	1
Utility bill assistance[c]	1	-	-	1
Housing resources[d]	1	-	-	1
Transportation resources[e]	1	-	-	1
Food & nutrition resources[f]	-	1	1	-
Cash assistance	-	1	1	-
Tribal TANF enrollment	-	1	1	-
Cell phone/landline assistance	-	1	1	-
Vocational resources[g]	1	-	1	-
Educational attainment resources[h]	1	-	1	-
Domestic violence and intimate partner violence resources	1	-	1	-
Other	-	1	-	1

[a] The "Adults only" and "Youth only" columns have been omitted from this table as no facility selected these responses.
[b] e.g., Medi-Cal, Medicare
[c] e.g., LIHEAP
[d] e.g., Rental assistance, emergency housing, transitional housing, temporary address usage
[e] e.g., Gas vouchers, bus vouchers, van/bus services
[f] e.g., SNAP/CalFresh, food pantries, food bank, community garden, commodities
[g] e.g., Job readiness/placement assistance, work experience, on-the-job training
[h] e.g., GED assistance, classroom readiness training