ASSESSMENT OF THE SUBSTANCE USE DISORDER TREATMENT AND RECOVERY SERVICE SYSTEMS FOR NATIVE AMERICANS IN MICHIGAN

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Acknowledgements

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Background & Need

BACKGROUND

The place that is now known as Michigan resides on Anishinaabeg homelands-- the land of the Three Fires Confederacy, an alliance of Tribes closely related through culture and language – the Ojibwe/Chippewa, Odawa/Ottawa, and the Bode'wadmi/Potawatomi. Prior to early 1800s, Native people inhabited most of the 57,000 square miles that comprise Michigan. By 1864, Tribal lands had been reduced to less than 32 square miles, the rest ceded in treaties with the US government. As a result of the 1836 Treaty alone over 13 million acres were ceded, making it possible for Michigan territories to become a state the following year.

According to 2020 U.S. Census data, the American Indian and Alaskan Native population (AI/AN) totaled 246,458 persons, or 2.4% of the Michigan population, with 0.6% (61,261) identifying as solely one race and 1.8% (185,197) identifying as AI/AN and at least one other race. According to the U.S. Census Bureau, Michigan is one of 10 states with the largest population of Native people. Within the boundaries of Michigan, there are currently 12 federally recognized and dependent sovereign Native nations. Of these, five Tribes are located in the upper peninsula, three Tribes in the northern lower peninsula, and four Tribes in the central and southern lower peninsula. The Michigan state government also recognizes four additional Tribal bands located throughout the lower peninsula. There is also a sizeable urban Indian population in Michigan in the southeast and southwest regions of the lower peninsula.

Each federally recognized Tribe has their own Constitution, policies, and legal procedures that were acknowledged by the federal government and through which they exercise Tribal sovereignty. Each are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States. As sovereign Nations, Tribes self-govern within the US through legal agreements, or treaties, with the federal government. Tribal self-governance happens with respect to education, law enforcement, housing, economic development, health and social services, and government. Most Tribes also have their own judicial system for tribal citizens to protect personal rights guaranteed by Tribal law, federal law, and the Tribal constitution. Notably, State recognition status forges relationships between Tribal and state governments but does not grant federal benefits unless federal-recognition status is determined. Two of the four state-recognized Tribes have petitioned for federal acknowledgement.

Generally, the State of Michigan does not have legal authority over Tribal governments and Tribal members inside the Tribes' territories-- lands designated as Tribal reservation or trust lands. The State interacts with Tribes on a government-to-government basis. Formal government-to-government agreements are executed between Tribes and the State government regarding issues such as treaty fishing rights, taxation, water quality, economic development, casino gaming, transportation, and other issues of importance to the education, health, and welfare of Tribal members. A government-to-government accord

was executed between the State of Michigan and the federally recognized Tribes in Michigan in 2002. Tribal-State affairs were reaffirmed and further clarified in Executive Directive 2019 – 17 signed by Governor Whitmer in February 2020.

NEED

Colonization, violence, and social injustices have been inflicted upon Native Americans and perpetuated over multiple generations, which has had lasting consequences for Native individuals, families, and communities in Michigan. Native Americans survived massacres, genocidal policies, pandemics, forced relocations, legal prohibition of spiritual and cultural practices, and forced removal of children through boarding school policies. The injustices enacted upon Native people is not ancient history. In fact, Native American Boarding Schools were established nationwide by the Bureau of Indian Affairs in the 19th century to assimilate Native American children. Three Native American Boarding Schools located in Michigan near Baraga, Harbor Springs, and Mount Pleasant operated throughout most of the 1900s. The boarding school in Harbor Springs, Michigan operated until 1983. Historical trauma is well documented in research and widely recognized as the root cause of behavioral health disparities, as well as other persistent issues like substance use disorders, that negatively impact the health and wellbeing of Native people.

Through treaty agreements with Tribes, the federal government committed to provide for the health of Native Americans in perpetuity in exchange for millions of acres of ceded land. To fulfill this trust responsibility, a unique health care system evolved that allows Native Americans to receive health services through multiple sources, including the Indian Health Service, the U.S. Veterans Administration, private health care systems, and Federally Qualified Health Centers. The Indian Health Service (IHS), within the Department of Health and Human Services (DHHS), is one of the primary Federal agencies responsible for fulfilling the health care obligation to Tribes. IHS is charged with providing primary care and behavioral health services to American Indians and Alaska Natives living on or near reservations. IHS provides health services to approximately 1.6 million American Indian and Alaska Native (AI/AN) people through federally and tribally operated facilities. Following implementation of the Indian Self-Determination Education Assistance Act (ISDEAA) in 1975, IHS established a model for fully transitioning administrative decision-making and operational management of health care services to federally recognized Tribes. Since then, Native nations determine and deliver health care through direct services, contracts, or compacts with the IHS.

Advocates for Native health have longstanding concerns that IHS has insufficient funding to provide eligible individuals with all needed services. Specifically, there is a consistent trend of IHS having lower funding levels relative to other federal health programs. Analysis conducted by the U.S. Government Accountability Office (GAO) found that average per capita spending levels (2013-2017) for IHS were approximately $4,078 compared to $10,692 (Veterans Affairs), $13,185 (Medicare) and $8,109 (Medicaid) for other federal health programs.

In addition to IHS being consistently underfunded for the size and health care needs of the patient population, there are also several key differences in terms of design and structure, funding, and populations served between Indian Health Service (IHS) and the other federal health programs--particularly Medicaid, and Medicare. Whereas Medicare and Medicaid are entitlement programs

and have no annual spending caps, IHS has funding that is largely determined through the annual appropriations process and has spending limits. IHS must deliver services within the available annual appropriations and any increases in the number of people served could result in reductions in per capita spending, without any additional increases in funding. The IHS is designated as a "payer of last resort," meaning that Medicare, Medicaid, and private insurance companies are billed before IHS is required to pay for medical costs. Medicare, Medicaid, and private insurance payments help to cover IHS and Tribal health care expenses without a reduction in IHS appropriated funding.

While each of the programs may be able to pay for a wide variety of services (including behavioral health), there are differences in the availability of certain services. Medicare and Medicaid pay for primary and specialty services in a variety of hospitals and other settings throughout the country. In contrast, most IHS-funded facilities are smaller, in rural areas, and mainly offer primary and ambulatory care services. While IHS funds can pay external providers to provide care not available at Tribal facilities through the Purchased and Referred Care process, the agency has reported that the funding available has not been sufficient to pay for all necessary care for other types of health services, such as inpatient treatment and hospital care.

The Michigan Department of Health and Human Services (MDHHS) was awarded a planning grant from the U.S. Centers for Medicare and Medicaid Services under Section 1003 of the SUPPORT Act of 2018. The grant funded the "Michigan State Medicaid Demonstration Project," which included a statewide assessment of the state's Substance Use Disorder (SUD) Treatment and Recovery system. The assessment had a special focus on selected priority groups, including American Indians and Alaska Natives (AI/AN). Through this assessment, MDHHS hoped to quantify and qualify both provider and patient experiences with SUD services, and the relationship and processes by which Native people access care at both Tribal and non-Tribal service locations.

Purpose of the Assessment

Beginning in 2020, MDHHS contracted with Michigan Public Health Institute (MPHI) to work with thirteen Tribal behavioral health programs and the Inter-Tribal Council of Michigan (ITCM) to assess substance use disorder (SUD) treatment and recovery services and provider capacity. MDHHS hoped to quantify and qualify both provider and patient experiences with SUD services, and the relationship and processes by which Tribal members access care at both Tribal and non-Tribal service locations. MPHI, ITCM, and Tribal behavioral health programs in Michigan had over 15 years of experience carrying out similar projects, and ongoing collaborative efforts focused on ensuring quality, culturally-responsive behavioral health services are provided to Native people throughout the state.

This report begins by describing the purpose, design, and methodology for conducting this assessment. The 'Results' section (page 14) details key findings that emerged from qualitative and quantitative data analyzed and interpreted by MPHI and Tribal partners. In 'Emerging Insights' (page 40), the findings are synthesized across data sources to present a cohesive picture of the service system from multiple perspectives as well as the implications of these systems on Native people navigating them. Finally, 'Future Directions' (page 46) presents a set of recommendations for improving the systems, developed with the input of individuals impacted by them, and aligns the recommendations with other relevant frameworks and guidance documents.

Assessment Design

The assessment used a community-based participatory approach. Community members were involved in the fundamental aspects of assessment design, implementation, and knowledge creation. This approach centered on the wisdom of communities and professionals in the Tribal behavioral health systems through all stages of the assessment. The MPHI evaluation team coordinated planning and implementation of assessment activities. Inter-Tribal Council of Michigan (ITCM) served as a liaison to Tribal partners and advisors regarding assessment activities and played a key role in analysis and interpretation. The Tribal Behavioral Health Communication Network, a network comprised of Tribal behavioral health managers and staff from twelve Tribes, the Urban Indian Health Center in Detroit, and ITCM, was also actively involved with interpreting results and generating recommendations based on assessment findings.

In the spring of 2021, a Tribal Advisory Group was formed including behavioral health experts and service providers working with Tribes and Tribal organizations in Michigan. A total of seven Tribal behavioral health program managers and Inter-Tribal Council of Michigan staff were invited and agreed to serve as advisors. Advisory group members participated in regularly scheduled meetings and were instrumental in deciding the approach, methodology, and participant recruitment procedures; informed and ensured that the protocols were culturally appropriate; and provided thoughtful interpretation of the findings. The Tribal Advisory Group gave feedback that helped improve materials and processes throughout implementation, ensuring the assessment would be responsive to the needs of program managers, service providers, and clients.

With guidance from the Tribal Advisory Group, several objectives were identified to guide the focus of the assessment including, understanding the current context of the SUD service system; the accessibility, capacity, and provision of SUD-related services; and client experiences and perspectives. A series of qualitative interviews were conducted to obtain a holistic understanding of SUD treatment and recovery systems and services for Native Americans throughout the state.

The Tribal Advisory Group also identified the value of adding a secondary data analysis component to the assessment in order to help understand what types of service utilization and outcomes would be observed for Native Americans when barriers to accessing services, such as cost, transportation, and coordination, are reduced or removed. With guidance and mentorship from a Tribal Advisory Group member who served as an ITCM staff member that worked closely with clinics receiving Access to Recovery (ATR) funding throughout Michigan, multiple quantitative datasets from the ATR grant period were included for analysis in this assessment. This retrospective data was included in the assessment opportunistically, as it aligned with the goals and insights that tribal behavioral health professionals wished to communicate with the state. This advisory group member served as a co-principial investigator alongside the MPHI project team to inform and develop the quantitative data analysis approach.

Qualitative data was shared with the Tribal Advisory Group for reflection and interpretation upon completion of each stage of interviews and preliminary analysis by the MPHI team. All preliminary findings were shared at a meeting of the Tribal Behavioral Health Communication Network in July 2022 for interpretation and prioritization of the major system barriers, facilitators, and recommendations to bring forth from the assessment. This report summarizes the culmination of a methodical community participatory approach that carefully incorporated tribal knowledge, wisdom, and insight into understanding the current context of the substance use disorder treatment and recovery service systems for Native Americans in Michigan.

Methodology & Analysis

QUALITATIVE DATA COLLECTION

The assessment included key informant interviews with three groups: 1) **program managers** from Tribal behavioral health centers; 2) **service providers** working with the Tribal SUD treatment and recovery service system; and 3) Native American **clients** who received SUD treatment and recovery services within the past two years.

Between May 2021 and May 2022, **a total of 32 semi-structured interviews were completed with 10 Tribal behavioral health program managers, 17 other service providers, and 5 Native American clients**. See *Figure 1* and *Figure 2* for a breakdown of regions represented within each interviewee type.

Figure 1. Regions represented in interviews

Program managers included individuals employed by a Tribe or Urban Indian Health Center and who managed the administrative and operational responsibilities of the behavioral health and substance use treatment and recovery services. **Service providers** interviewed represented the diversity of people involved in providing or coordinating SUD treatment and recovery services for Native Americans, including: 2 case managers, 1 counselor, 3 therapists, 3 peer recovery coaches, 1 psychiatrist, 1 behavioral health clinician, 1 referral liaison, 2 cultural advisors, 1 court administrator, 1 probation officer, and 1 Tribal police chief. **Clients** were individuals who identified as Native Americans with lived experience with substance use treatment and recovery services in Michigan within the past two years. A snowball sampling approach was used to recruit participants: Program managers that were interviewed assisted with identifying and recruiting service providers and clients from their communities for interviews.

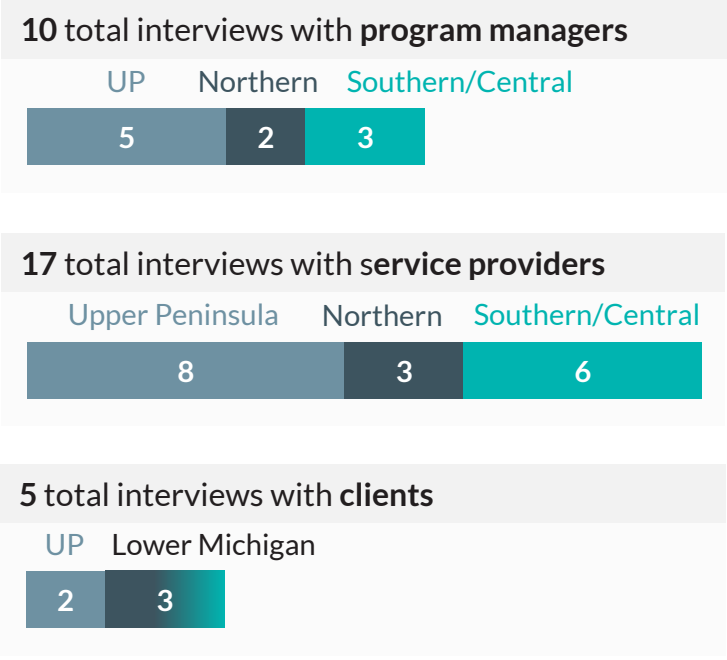


Figure 2. Regions represented among each interview type

Program managers and service providers were asked a comprehensive set of 8-10 questions covering topics including their professional role(s) and responsibilities, services provided, successes and challenges with service delivery, and ways in which substance use treatment and recovery services could be improved. The client interview protocol included 6 open-ended questions asking them to describe where their journey with substance use began; their experiences with tribal and non-tribal services; facilitators and barriers in their recovery journey; and their reflections on what could be improved to better serve people with SUD in their communities.

Each interview lasted approximately one hour and was conducted by an MPHI project team member using Zoom. Interviews were audio recorded with permission and professionally transcribed by project staff from the University of Michigan. Upon finalizing materials with the Tribal Advisory Group, all interview protocols, consent processes, and data management procedures for this assessment were reviewed and approved by MPHI's Office of Research Integrity and Compliance (ORIC). All approved interview protocols are included in the appendix at the end of this report.

QUALITATIVE DATA ANALYSIS

All interview transcripts were reviewed for accuracy prior to analysis. The MPHI evaluation team developed an initial thematic codebook for each type of key informant interview. The team worked collaboratively to refine the codebooks to include predetermined and emergent themes as they reflected the assessment objectives. All transcripts were uploaded into the qualitative data analysis software NVivo, carefully reviewed, and coded line by line.

Upon completion of coding, program manager and service provider interview data were analyzed using a grounded theory approach[2]. This systematic inductive approach generated general themes, topics, and trends used to address overarching assessment objectives. Team members were each assigned several codes and sub-codes to analyze and generate multiple thematic lists that delineated the dominant themes, ideas, and processes emergent in participants' responses. Due to the diversity of managers and providers interviewed, each representing different levels of knowledge and engagement with the treatment and recovery service system, codes were analyzed with the role of the speaker and the region (Upper Peninsula, Northern Michigan, Southern/Central Michigan) in mind to abstract any findings relevant to these attributes. The team reviewed the thematic lists collaboratively, discussing and revising the analysis using consensus methods.

Client interview data was analyzed using a life history theory approach. A life history approach takes an individual's retrospective account of their life, in whole or in part, and emphasizes the importance of understanding the meaning of behavior and experiences from the perspective of the individual.[3, 4] Team members were each assigned a coded transcript from which they

[2] Glaser, B.G. & Strauss, A.L. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. Aldine Publishing Co.

[3] Rosenthal, G. (1993). "Reconstruction of Life Stories: Principles of Selection in Generating Stories for Narrative Biographical Interviews." *The Narrative Study of Lives* 1(1): 59-91.

[4] Shacklock, G. and L. Thorp. (2005). "Life History and Narrative Approaches." Chapter 18 in *Research Methods in the Social Sciences*, B. Somekh and C. Lewin, eds. Pp. 156-163.

created a detailed timeline of the events, experiences, barriers, and facilitators that occurred during each client's recovery journey. A common timeline structure emerged for all clients which included a discussion of their past, the start and extent of substance use in their lifetime, their experiences with recovery services, their life currently, and reflections and aspirations for the future. The team plotted major events on a visual timeline for each client. These figures are included in Appendix E. The team carefully reviewed and compared the clients' timelines to create a thematic table identifying common themes and experiences that were described across all clients.

The final phase of qualitative analysis involved identifying dominant themes that emerged across the program manager, service provider, and client interviews. The evaluation team generated a thematic table that cross-referenced common themes and interrelated processes across all interviews, related to specific SUD recovery services, barriers and facilitators to recovery, and recommendations for change. These themes were further cross-referenced by regions to denote any unique regional experiences.

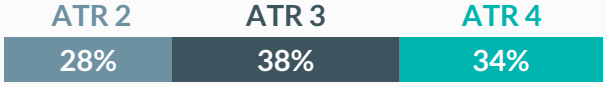
QUANTITATIVE DATA COLLECTION & ANALYSIS

To complement the interview data, voucher transaction and outcome data collected 2007-2018 for the ATR initiative were also examined. Quantitative datasets were provided to the MPHI project team by the ITCM Behavioral Health Department. MPHI staff worked with an ITCM project advisor (who also served as member of the Tribal Advisory Group) very closely through all phases of the quantitative data component of this assessment. These datasets contained de-identified client data pertaining to behavioral health screening summaries, assessment summaries, service provider utilization, ATR voucher transactions, and treatment codes.

Datasets Used. The ATR voucher system dataset used for analysis included a total sample size of 7,845 clients who used ATR vouchers and had Government Performance and Results Act (GPRA) intake and outcome data collected during the grant program. The sample consisted of 2,168 clients from the ATR 2 dataset, 3,030 from the ATR 3 dataset, and 2,647 from the ATR 4 dataset.

7,845 clients included in analysis

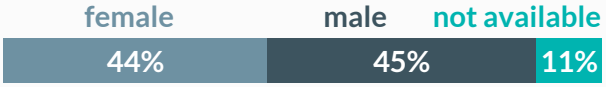
% of clients represented from each ATR dataset



Gender. Within the sample, 3,413 were female, 3,532 were male, 2 identified as "Other," and the remainder did not have gender-related data[5].

Gender of clients included in analysis

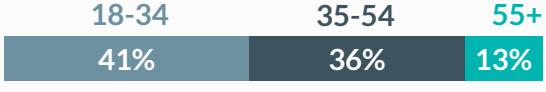
% of clients in the analysis with each identity



Age. Most clients were 18 years or older; 3,186 were between ages 18 and 34 years, 2,832 between ages 35 and 54, and 1,010 were 55 years or older[6].

Age of clients included in analysis

% of clients in the analysis in each age group



[5] Five clients (0.1%) chose not to provide their gender and 893 (11.4%) had missing data for gender.

[6] The ages of 3 clients (0.0%) were unknown.

Tribal affiliation of ATR clients was also collected and is displayed in Figure 3 below.

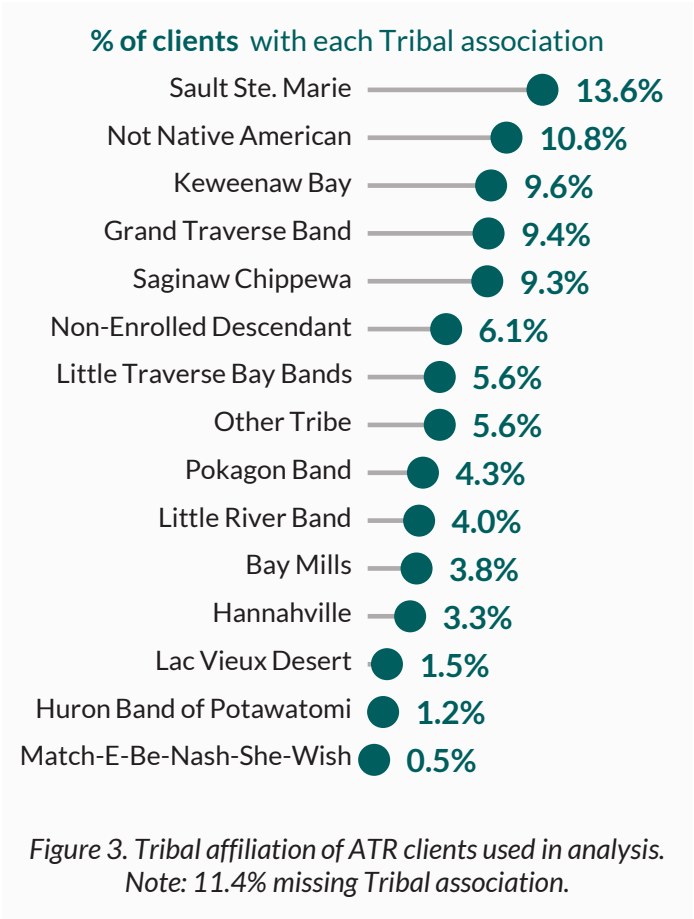


Figure 3. Tribal affiliation of ATR clients used in analysis. Note: 11.4% missing Tribal association.

Quantitative analysis was an iterative process between the MPHI team and the ITCM project advisor that included developing questions, establishing data inclusion criteria, defining variables, developing analysis plans, running analysis, and reviewing output collaboratively. Quantitative data were extracted from datafiles and imported into various software including Microsoft Excel, Tableau, SPSS, and Power BI, for cleaning, merging, and analysis. GPRA datasets were merged with the ATR voucher datasets to assess what services ATR vouchers were used to pay for services for Native American clients, as well as the status of their health and wellbeing at the time they entered and exited ATR-covered services. The types of services coded in the ATR voucher system were established by Substance Abuse and Mental Health Services Administration (SAMHSA) and the Indian Health Service (IHS)[7], and modified as needed by ATR staff. There were a total of 138 types of services that ATR vouchers covered, which were grouped into 15 broader "parent" categories in collaboration with the ITCM project advisor. Appendix X lists the 138 services and the parent categories they were grouped under. Analysis used these broader parent categories for ease of making meaningful interference of service use.

The data analysis included a combination of descriptive statistics and chi-square testing with outcome data. Two major questions drove the quantitative analysis, including: (1) What type of services were received by clients in the ATR program, and (2) How are the types of services received associated with client outcomes? To answer these, the team examined the variability in services accessed by ATR clients and examined patterns and clusters of services received by ATR clients and how those patterns varied by socio-demographic characteristics and outcomes. The exploratory approach to analysis was also informed by insights that emerged from the qualitative data. Limited quantitative results are presented in this report relative to findings that emerged from the qualitative data. In the 'Results' section of this report, the qualitative data findings from interviews pertain to the SUD treatment and recovery service system within the past two years, while the quantitative findings (from ATR datasets) pertain to the service system that was available during the ATR program from 2007 to 2018.

[7] IHS. (2022). "Treatment Types: Overview of Substance Abuse Treatment Programs." www.ihs.gov/asap/treatment/treatmenttypes/

Results

TRIBAL SUD TREATMENT AND RECOVERY SERVICE SYSTEMS: PROGRAM MANAGER AND SERVICE PROVIDER PERSPECTIVES

Interviews with Tribal behavioral health program managers described the scope of services currently available to clients in their Tribal SUD treatment and recovery service systems. In this assessment, "services" were understood to not only include direct or clinical treatments provided directly by their Tribal programs, but also any engagement with or support provided to clients as part of their SUD treatment and recovery journey. This broad view of services included: screening, psychotherapy, counseling, inpatient treatment, detoxification, Medication Assisted Treatment (MAT), traditional medicine, cultural healing, complementary and alternative medicine, peer support, case management, court assistance, transportation, and housing assistance, among others. Most Tribal behavioral health programs were based within the Tribal health system. However, some Tribe's behavioral health programs were located within their Tribal family services or social services departments. All Tribal behavioral health programs provided services to enrolled members of their Tribe and members of other federally recognized Tribes. Some Tribal programs also provided services to Native descendants, Tribal employees, non-Native persons living with Tribal members, and non-Native persons.

Tribal behavioral health programs commonly offered individual and group therapy, counseling, peer support, and traditional and cultural healing services directly within their program, although these services varied somewhat among Tribes. Traditional and cultural services described often included traditional healers, traditional ceremonies, sweat lodges, smudging, pow wows, cultural teachings, and Wellbriety Recovery Circles.[8] White Bison's Wellbriety is a holistic recovery support group model that is nationally recognized and culturally-based. The model uses the Red Road to Wellbriety sobriety, recovery and wellness workbook that follows the teachings of the Native American Medicine Wheel and 12 Step Tradition.

Medication Assisted Treatment (MAT) was also offered by some Tribal behavioral health programs. However, the delivery of MAT services was sometimes performed by other local (non-Tribal) providers through patient referrals and care coordination. Tribal programs in the Northern and Central/Southern Michigan regions, in particular, were more likely to refer clients to providers outside of the Tribe for MAT services. Most Tribal programs in the Upper Peninsula offered the medication Vivitrol through Tribal health services, but the program referred clients to providers outside of the Tribe for other medications. Medications that were specifically named by Tribal behavioral health program managers for MAT services that were offered included Suboxone, Subutex, Vivitrol, and methadone.

[8] White Bison (2022). Culturally-based Healing to Indigenous People. Online: https://whitebison.org

Program managers and service providers described ways their programs worked with SUD treatment and recovery agencies located throughout the state, as well as services that were regionally located. Several types of services were described as only being offered regionally. For example, case management and Acudetox (a type of acupuncture) were often discussed as being offered to clients by Tribal behavioral health programs in the Upper Peninsula and Southern/Central regions. Teletherapy was discussed as being offered by Tribal programs in Northern and Southern/Central regions. Services that were described by programs located in the Upper Peninsula were psychiatric services, intensive outpatient therapy, court assistance, and aftercare services such as transitional sober living. A service that was uniquely described by service providers serving Tribes in Northern Michigan was the use of electronic monitoring devices (electronic devices that monitor individuals' movements) required of clients involved in court ordered services. Services that were uniquely described by service providers of agencies serving Tribes in Southern/Central Michigan included Eye Movement Desensitization and Reprocessing (EMDR), and integrated care.

Program managers and service providers discussed services being paid for in various ways, dependent on the type of service being offered and the individual client. Most commonly, health care and behavioral health services were billed through Medicaid or private insurance first. When asked, most service providers stated that they or someone at their agency assisted clients in enrolling in Medicaid if they were not already enrolled. Services not covered through health insurance were paid for by Indian Health Service, other third-party payers, Tribal funds, and grants.

GAPS AND BARRIERS WITHIN THE SUD TREATMENT AND RECOVERY SERVICE SYSTEM

Program managers and service providers were asked to describe gaps and barriers to service provision they've experienced in their work. The most prominent gap discussed by all program managers and providers was access to inpatient services: detox and residential treatment. Detox referred to medical centers where clients are carefully monitored for an extended period of time to safely withdraw from substances under the supervision of a physician. Residential treatment referred to longer term and intensive inpatient care. Notably, among Tribal programs in the Southern/Central region, treatment facilities were frequently described as being full. The limited number of facilities throughout the state made referring and transferring clients to local centers incredibly difficult for program managers and service providers. It was common practice to resort to sending clients to facilities outside of their regions, often many hours away or even out of state, if a "bed" became available. As one interviewee described:

> *The lack of detox in our area here. We're had clients where we sometimes have to transport them for three hours and sometimes they have to use before they go to make sure they don't have any seizures or anything, any DTs. That's always been a huge barrier here, the lack of detox in the area."*
>
> **-Program Manager, Upper Peninsula**

Most detox and residential services were described as not being culturally appropriate or trauma informed for Native people:

> *It seems like every time I have to deal with a state facility, they have more of a Caucasian-type mentality, and they don't understand the timing and the family dynamics of Native American families on the reservations. So, some of their expectations are just not attainable for somebody born and raised and living on the reservation."*
>
> **-Probation Officer, Upper Peninsula**

Detox and residential facilities described as being culturally informed were located in other states such as South Dakota, Illinois, and Wisconsin. One facility most frequently used by program managers and providers was the Keystone Treatment Center in South Dakota. However, care coordination with this center has diminished recently due to lack of consistent funding sources to pay for services, as explained by one program manager:

> *The Keystone Treatment Center. That's in South Dakota. We had the funding to be able to get someone [in the Upper Peninsula], put them on a plane, and they got off in South Dakota and they would go through the medical detox there … and they have sweat lodges and they have a specific Native American track that people could do. We got really good feedback about Keystone. … If someone had any opiate problem, that was always our recommendation and off they would go. Well, then we lost ATR. … right now, we have none."*
>
> **-Program Manager, Upper Peninsula**

Interviewees also discussed the reality for some clients who were not able to access detox and residential services engaging in a potentially dangerous practice called social detox. Social detox was described as when a client goes through detoxification without medical support or supervision, which can lead to dangerous withdrawal and health effects.

In addition to being unable to send clients to detox and residential treatment facilities due to lack of available funding, interviewees commonly described with great frustration the limitations and complicated restrictions of insurance and Medicaid coverage for these services. Particularly for Medicaid clients, the limitations in coverage resulted in them not being able to receive services long enough to meet their needs, if at all. One interviewee explained:

> *"We struggle quite a bit with clients that only have Medicaid. Their options for inpatient care are very, very limited. We have just a couple Medicaid treatment centers that are available to our Medicaid only clients. They are typically a 14-day turnaround, and they are not as inclusive, especially when it comes to Native American care. They are not as friendly, they are not as thorough, they are not as clean, they are not as nice, they are pretty invasive."*
>
> **-Program Manager, Central/Southern Michigan**

Another prominent gap in services that program managers and service providers commonly reported was transportation. Transportation access was described as a larger systemic issue affecting entire communities and regions. As a case manager from Northern Michigan explained, "*at this point, we don't have a public transportation service in our community and the taxis that we do have are super expensive.*" Addressing transportation barriers was often an urgent area of focus for program managers and providers, whose clients are consistently in need of transportation to attend meetings or appointments, outpatient services, inpatient care, and detox or residential centers. Most interviewees shared that their agencies have limited funding or personnel to provide transportation services for their clients. A program manager from the Upper Peninsula expressed that their agency has to "eat the cost" of providing transportation since the ATR program ended, since ATR funding had typically covered transportation costs for clients:

> *[ATR funding] allowed us money for transporting people. It allowed us to give out gas cards for people that had to secure rides. It allowed us to get vouchers with taxi companies … it allowed us to get vouchers where they could use them to come to services. A lot of time, people in this area, especially in the wintertime, don't have access to a vehicle that's going to bring them in a snowstorm, to their appointment…. There's so many things that it allowed us to do."*
>
> **-Program Manager, Upper Peninsula**

Program managers and service providers often identified access to other aftercare services as a major gap in services for their clients. Aftercare services include services such as transitional housing, peer support groups, and ongoing case management upon a clients' exit from treatment

services. Interviewees most often expressed that transitional housing and ongoing case management were aftercare services their clients needed to maintain their sobriety yet were typically not available or well-coordinated. Notably, interviewees from Northern agencies were most likely to discuss a major need for safe housing support in their communities. Lack of available aftercare supports and services, stringent eligibility rules, and lack of funding to cover the cost of transitional housing, were identified as major barriers to ensuring that clients were able to fully integrate back into their communities in safe environments and with social supports. One program manager from the Upper Peninsula:

> *I think the biggest thing that the clients face in this area is going back into that environment that they left, say their home or whatever. Some of them are homeless when we get them. We try to get them set up in transitional housing, but our transitional housing here is very, very limited and a lot of times they don't qualify. If they had a prior drug charge, then they won't qualify for that transitional housing. You run into a multitude of problems sometimes that you're trying to navigate to get this person into a safe environment where hopefully they can stay and recover."*
>
> **-Program Manager, Upper Peninsula**

Another prominent barrier was limited funding or lack of coverage for services that may be considered "non-medical." Program managers and providers predominantly described these services as cultural and traditional healing services (such as Sweat Lodges or Traditional teachings), alternative medicine (such as acupuncture), and case management. As a result, many reported that their agencies covered these services with limited grant funds or other tribal program funds, which limited their ability to consistently and reliably offer these services when needed. One program manager from an agency in Central/Southern Michigan explained:

> *We do get some support for traditional healing services through a grant from the county. … It's pretty much all grant based. Nothing is covered by insurance for the services the cultural coordinator provides like sweat lodges and things."*
>
> **-Program Manager, Central/Southern Michigan**

While some program managers said they find ways to piece together funding for such services, some interviewees lamented the additional layers of bureaucracy required to use such funding. As one program manager explained, accepting grant funding required additional program evaluation activities that were burdensome for their agency and clients: *(next page)*

> *If we want to do cultural services, it's all grant funded, so you're giving people surveys all the time. And just to get services, people have to constantly do these surveys. Really, it's kind of rough having to survey the same people over and over again when they're just trying to get healing services. … so they can get ceremonies and treatment services that they need in order to heal … Medicaid doesn't pay for traditional services.*
>
> **-Program Manager, Central/Southern Michigan**

Several interviewees noted that many funding sources are substance-specific, meaning that they are only available to cover services for individuals with particular substance use diagnoses. Most often this funding was for opiate use and specific types of treatment, and did not cover "non-medical" services like cultural or traditional healing.

The last prominent barrier that program managers and service providers discussed was challenges with staffing. Many program managers said their programs operate with small provider teams burdened with large caseloads. Staffing shortages had ripple effects, such as long waitlists for clients to access various services, high staff turnover, staff members taking on roles and responsibilities outside of their primary role (such as care coordination), and referring case management services to other agencies or organizations. One program manager explained:

> *My staff, I don't have a case manager per se, so my counselors are responsible for pretty much everything with the patients they serve. The peer recovery coach will step up and do a lot of the case management or coordination I should say, coordination with care into a residential facility."*
>
> **-Program Manager, Central Southern Michigan**

Many program managers and providers noted that lack of funding to pay adequate salaries for staff, to hire new positions, or retain existing staff was a major barrier to providing consistent services to their clients. One program manager shared their struggle finding a new counselor for their agency because they simply could not compete with other agencies:

> *The lack of staff and the lack of funding for staff. We almost had another mental health counselor come in, but because everyone is looking for these guys and they were not willing to up the wages, she got a better offer with a lot more money. So, she went there."*
>
> **-Program Manager, Northern Michigan**

FACILITATING FACTORS WITHIN THE SUD TREATMENT AND RECOVERY SERVICE SYSTEM

Program managers and service providers were asked to describe successes they've experienced coordinating care and providing services for treatment and recovery. They described specific types of supports and services as facilitators for their clients' SUD recovery journeys that often mirrored the service gaps and barriers they observed. In other words, when systemic barriers were removed, these services were the most facilitative and impactful for their clients' recovery journeys.

Across program managers and providers, being able to address the immediate, concrete needs of their clients, were identified as facilitators for successful recovery. Many described that when their agencies had flexible funding to cover the cost of transportation, and assistance for housing, food, and childcare, this helped clients focus on their recovery. One service provider explained all the services they typically helped coordinate for their clients:

> *Whether it's addressing car payment, rent, food, we work to address some of those stressors for them…coordinating, referring them to local food banks, they might be able to get some sort of financial assistance, and then just ensuring that we have the appropriate releases so we can communicate with people.*
>
> **-Cultural Services Coordinator, Central/Southern Michigan**

While interviewees highlighted lack of transportation as a prominent barrier, when provided it was also described as a major facilitator for their clients. Transportation services and supports (including transportation vouchers) were discussed as key to clients being able to attend court and medical appointments, peer recovery meetings, and engage in treatment services. One program manager expressed that transportation was covered through a grant their agency received:

> *We also offer the Road to Wellness program. Which is a grant fund from ITC, which helps with transportation barriers. It helps clients be able to get to their appointments. So, they just have to be one of our behavioral health clients and then we can help get them to their appointment in Petoskey or down state, or if they need to go to treatment for residential. So that's been great because up here transportation is a huge thing.*
>
> **-Program Manager, Upper Peninsula**

Another dominant facilitator for client recovery described by program managers and providers were cultural and traditional healing services. Interviewees overwhelmingly described how these services were valuable for helping clients explore and reconnect to their culture and community. As one case manager explained:

> *Just the cultural events, getting people to pow-wows, connecting with the community, doing beading, …traditional arts and crafts. Helping clients get back to their roots and get back to the traditions of the Tribe.*
>
> **-Behavioral Health Case Manager, Northern Michigan**

Program managers and providers discussed that in the past, ATR funding was crucial for being able to provide cultural and traditional healing services and other "non-medical" services. Interviewees noted that the flexibility of this funding was the key aspect that allowed their agencies to truly provide person-centered services. One program manager expressed:

> *"There was like four to six pages of all the different services that you had access to for these clients. [ATR] was an amazing, amazing program. We could order moccasin kits for the clients, we could order a drum kit, and these could be things in outpatient that they were utilizing that would help this person recover. It allowed us to actually see, just for a moment in time, what actually works the best.*
>
> **-Program Manager, Upper Peninsula**

Notably, all of these major facilitators that program managers and service providers emphasized as critical for clients in recovery, were contingent on having other ample and flexible funding sources to supplement the gaps where insurance coverage restrictions and limited availability or accessibility of insurance-eligible services existed.

NAVIGATING TREATMENT AND RECOVERY IN SUD SERVICE SYSTEMS: NATIVE CLIENTS' PERSPECTIVES

At the start of interviews, clients were prompted with the question, "*Tell me about your journey with addiction treatment and recovery. Where does your story begin?*" This story-based approach encouraged participants to reflect and self-identify experiences over the course of their lives that were important to their journey with substance use, treatment, and recovery. A common pattern emerged in how participants recounted their story, where their journey to recovery was structured around distinct stages including: their past, the onset and extent of substance use, their experiences with treatment, sobriety and recovery, and their aspirations for the future. Several common themes emerged across client interviews in several areas including experiences leading up to substance use, experiences of loss and disconnection during the extent of their substance use, experiences engaging in multiple SUD treatment services, and the experience of system-related and personal barriers and facilitators to recovery.

CLIENT RECOVERY STORIES

The clients interviewed for this assessment were asked by MPHI interviewers to 'share their story,' to help others understand their journeys and improve the system. We honored these requests by presenting summaries of the clients' recovery stories in this report with names and identifying details withheld to protect their identities.

When asked where their story began, all clients chose to begin by sharing their experiences leading up to substance use, often including adverse childhood experiences. Most clients mentioned the impacts of intergenerational trauma, a history of addiction and substance use in their family, and the normalization of substance use among their family, friends, and/or community. As one participant explained:

A lot of Natives don't know what's wrong with them. They don't understand intergenerational trauma... Growing up in a broken house, or growing up in an alcoholic home, everybody thinks that's the way life is and that's not the truth. … Being able to teach people the truth is the beginning of healing and the beginning of recovery, and that's what I've learned so far, being in all these treatment centers.

-Client 2

Many clients also recounted multiple, enduring types of child maltreatment from family, foster care guardians, and romantic partners. Many described having problems in school, leading some to drop out of high school or college. All clients reported a history of using multiple substances which started before or during early adolescence. Substances they disclosed using included alcohol, opioids, marijuana, hallucinogens, and methamphetamine.

Experiences of loss and disconnection was a prominent theme across clients' journeys. Clients centered the impact of loss and disconnection in their lives in a variety of ways. Many described being physically and emotionally disconnected from their loved ones and family members during periods when they were using substances. Some expressed a deep sense of loss and grief caused by losing custody of their children. Multiple clients experienced deaths of loved ones, impacting their mental health and leading to challenges in coping with grief and loss. Some clients were also isolated from loved ones and did not have consistent support systems during their recovery journey. As one client described:

> *I had faced a big family death. I was really helping there with my grandfather when he had got diagnosed with stage 4 [cancer]. When he had passed away, it had taken a toll on me because I was with him the last 24 hours of his death, consistently. I told my family, 'I'm just going back to the drinking and drugs, like I'm over this.' I had no means, I guess, to live because that was the one guy who kept me clean, my grandfather.*
>
> **-Client 5**

In addition, some described living transient lifestyles, often traveling to other states in pursuit of work or SUD recovery services. The culmination of loss and grief were often interrelated with a profound sense of disconnection to their Tribe, culture, and spirituality during their substance use.

For all the clients interviewed, their journeys to recovery were not a linear path, instead most described spending numerous years in and out of treatment and recovery services, experiencing several periods of sobriety and relapse in their lifetime. Clients described accessing and using many different types of recovery services and supports including mandated services through interactions with the legal system; inpatient and outpatient treatment; and cultural or traditional healing. Mandated services included court ordered detoxification, rehabilitation, and probation. Inpatient and outpatient services included inpatient rehabilitation, Alcoholics Anonymous and Narcotics Anonymous, and outpatient therapy. Additional outpatient services included support and mental health care from peer specialists, case managers, counselors, and psychiatrists. Cultural and traditional healing included Wellbriety, Sweat Lodges, Traditional Healers, and cultural teachings, gatherings, and activities. There were numerous barriers and facilitators to accessing and staying engaged in services as described in the stories told by clients.

CLIENT RECOVERY STORIES

CLIENT 2 , 46 – 55 YEARS OF AGE, TRIBE IN SOUTHERN/CENTRAL MICHIGAN

RECOVERY FROM ALCOHOL AND METHAMPHETAMINE

Client 2 was a proud union worker, college athlete, and Marine Corps member. They had a deep spiritual connection to Creator and the understanding that culture is healing. They began their story by sharing several adverse childhood experiences, including being abandoned by their mother, separated from their siblings, profound abuse in foster care, and forced assimilation and physical abuse by their adoptive parents. They described how their childhood experiences culminated into a deep sense of feeling unwanted. Despite the trauma they endured, they did well in school, attended the Marine Academy, and went on to college where their exposure to alcohol began. After college, they moved to another state to be near their siblings. The stress of helping their siblings through school exacerbated their drinking and drug use, which led to them staying in jail multiple times. After a near fatal overdose, a social worker got them into a rehabilitation program at a Christian organization where he stayed for a year. After rehab, they later worked supporting other people with SUD. Upon their return to Michigan, they struggled to cope with the death of a family member and a distressing reunion with their birthmother. During this period, they began drinking alcohol again. However, over the next 10-12 years, they focused on following cultural practices, including ceremonies, language, teachings from Elders, and spiritual experiences which solidified their connection to their culture and the Creator. They explained how support from their Tribe was pivotal in their recovery, especially throughout their struggle with sobriety after losing a beloved job and a close friend being murdered. In their words, "culture is prevention… It was the first time I felt I belonged somewhere in my life." Over time, staying connected, understanding their needs, and practicing their culture supported their sobriety. They were receiving treatment for Post Traumatic Stress Disorder and had plans to bring Wellbriety to their Tribe and complete their education in a Native-centered organization.

BARRIERS IN THE RECOVERY JOURNEY

Lack of accessibility and availability to local detox and residential treatment centers were the most prevalent system-related barriers clients experienced on their recovery journeys. Multiple clients reported that over the course of their substance use they had participated in treatment services throughout Michigan, within their own Tribes, within other Tribal communities, and in other states like South Dakota, Wisconsin and Arizona. Multiple clients experienced long waitlists to access treatment services when they needed them, regardless of location. As one client described:

> *When I went to treatment last year in [state]—matter of fact, the only reason I went to [state], is because there was nothing in the state of Michigan at the time. That's why I went to [state] so I could get that Sweat Lodge. This year was the same thing. The only place available was up in Petoskey or something like that, and they were booked out for two months, and I knew I couldn't last that long. I'd probably be in jail or hurt somebody. I didn't want that. So that's why I [went] to [city].*
>
> **-Client 2**

When clients were able to access detox and residential treatment centers for care, many described a lack of culturally based services and practices. Multiple clients discussed not being allowed to engage in traditional practices during treatment, being prevented from using traditional medicines, smudging, and praying. Clients had to travel long distances to see a Traditional Healer or visit a Sweat Lodge.

Clients also described staffing issues as barriers they experienced to treatment and recovery services. Clients expressed that treatment staff and providers often seemed not engaged in their roles, were distracted by other tasks, or did not have their 'hearts in the work' of caring for people in substance use recovery. Some said that the lack of consistency due to staff and provider turnover negatively impacted their ability to heal and recover, as expressed by one client:

> *I was repeating myself in the office. I also told [my counselor], 'I'm not going to even open up to you until I know how long you are going to stay here.' … I'm tired of repeating my story, I'm tired of reliving it. I never get to the part where I can heal. I start to heal, but then [] the people just quit or get fired.*
>
> **-Client 1**

In addition to system-related barriers to recovery, clients also shared many personal barriers that impeded recovery. A common personal barrier included being continuously exposed to drugs through interactions with friends or family members who also struggled with substance use. As one client shared, "*I was alone. Friends, people who I thought were friends, they were just using buddies.*" Some explained that drugs and alcohol were often present in their living arrangements and home environments, and for those who spent time in jail, they were continuously exposed to drugs via other substance users while incarcerated. Relatedly, the instability caused by periodic incarceration and unstable housing were also barriers to treatment and recovery.

CLIENT RECOVERY STORIES

CLIENT 4 , 36 – 45 YEARS OF AGE, TRIBE IN SOUTHERN/CENTRAL MICHIGAN

RECOVERY FROM ALCOHOL AND METHAMPHETAMINE USE

Client 4 told their story of navigating numerous treatment and recovery systems, both Native and non-Native, while keeping a focus on personal growth and connection to others. They began their story recounting their early twenties living in the Midwest, trying to manage life while in an abusive relationship. Recognizing their need for help, they first tried numerous treatment options, including outpatient rehabilitation and AA. Their substance use led to other high-risk behaviors, and eventually they tested positive for HIV. Over the years, as they went through periods of sobriety and relapse, they began to understand their triggers and heal as part of their recovery journey. They linked their experiences to their understanding of intergenerational trauma they experienced as a Native person and how alcohol wasn't introduced into Native culture until the 1800s. Anger management, individual therapy, intensive outpatient therapy, sex addiction therapy, acupuncture, Wellbriety, residential treatment, and traditional Native ceremonies, were part of the services and supports they used on their recovery journey. They described additional supports that helped them through recovery including other people who had achieved sobriety within and outside their Native community; supportive family members and friends; learning how to identify and acknowledge triggers for their relapses; the ability to "connect" and "communicate" with people; and their connection to their Native community.

FACILITATORS IN THE RECOVERY JOURNEY

While clients experienced numerous hardships and barriers that impeded their recovery, they also shared many positive factors that facilitated their sobriety and healing. Some of these facilitators represented aspects of treatment services that worked well for them. Overwhelmingly, clients said that access to cultural and traditional services and practices were the most influential form of care they received across their recovery journeys. Clients specifically identified Sweat Lodges and ceremonies, Traditional Healers, receiving cultural teachings from Elders and cultural teachers, Wellbriety, prayer, smudging, and traditional medicines. However, as previously mentioned, cultural and traditional services were not always easily accessible, affordable or available to them. For most, engagement in cultural services occurred sporadically at various points in their recovery journey, yet they were described as having the most profound impact on clients' personal commitments to long term sobriety. As one client described:

Most described their engagement in cultural services as having a cumulative impact by instilling within them a lasting commitment to engaging in cultural and spiritual activities both on a personal basis and together with members of their Native communities. As one client told us emphatically, "*My spirituality is the best thing ever that happened to me and still is to this day*."

Clients also emphasized that achieving and maintaining sobriety was often linked to long term, consistent relationships to peers and professionals within the recovery system. Peer support through programs like Narcotics Anonymous, Alcoholics Anonymous, and Wellbriety were especially valued as spaces for learning from others' shared experiences. Clients said long term care coordination and support from trusted service providers, including counselors and case managers, were especially valuable for their recovery, both during and after receiving treatment services.

> *I love that they brought me back and showed me that culture is prevention, culture is connection, language is connection, and all that stuff that I was doing. Next thing you know I wasn't drinking; next thing I was seeking them [out], going to the sweat lodges and get[ting] the healings that I needed. … That interconnectedness between us and the Creator, us and our language, us and the culture, and us belonging somewhere—that's where healing is. I never put that together until now, and now it's exploding inside of me, the revelation, the clarity."*
>
> **-Client 2**

CLIENT RECOVERY STORIES

CLIENT 3 , 26 – 35 YEARS OF AGE, TRIBE IN SOUTHERN/CENTRAL MICHIGAN

RECOVERY FROM ALCOHOL, METHAMPHETAMINE, AND OTHER DRUGS

Client 3 was a parent who was earning their college degree and working as a peer support person for other people experiencing SUD. They began their story by recounting a difficult childhood that included negative peer influences and dropping out of school. They were exposed to numerous hard drugs through their friends who were using them. In young adulthood, they spent time in jail, had periods of homelessness, and lived a transient life in multiple states. While struggling through substance use, they were disconnected from their children. They had various legal issues which led to court mandated services, including multiple residential treatment programs in other states. They described struggling in these programs because they felt they were designed for privileged clientele. During this period, they had the support of a long-term case manager. While avoiding a warrant for their arrest, they entered another rehabilitation program outside of Michigan where they believe the combination of solitude and less obligations and pressure led to their "lightbulb" realization and commitment to sobriety. They also began working with their peers, cultivating a passion for supporting individuals with SUD. Upon exiting this program, they moved closer to family, re-established a relationship with their former partner and children. They said they became more aware of their triggers and how by maintaining various hobbies, distancing themselves from negative influences, focusing on education, avoiding boredom, setting up a daily routine, and learning to have self-love, they could maintain sobriety. They viewed their purpose in life as helping individuals struggling with substance use and were working on a degree to work in the substance use treatment field professionally.

One client, who has had a strong relationship with her counselor for many years said:

> *I wasn't very good at keeping appointments, nothing, when I was drinking. Nothing. Thank God my counselor stuck with me. This year will be her 14th year being here. … [She] has been a big help from day one. She has always been a big help even when I was in treatment. There were times where I would have to call her and I just would haven't it any other way, like, 'I'm not getting what I need here so I need to call my counselor' … She would go get food for me from the food bank and there were times she would stop by.*
>
> **-Client 1**

CLIENT RECOVERY STORIES

CLIENT 1 , 56 – 65 YEARS OF AGE, TRIBE IN UPPER PENINSULA MICHIGAN

RECOVERY FROM ALCOHOL AND NARCOTICS

Client 1 was a parent, grandparent, and former law enforcement officer. Their spiritual convictions were their greatest motivator. They grew up with alcoholism in the home. Their mother was absent throughout their childhood, and they were sexually abused by their father. They became pregnant at a young age and guardianship of their child was given to a family member. They began to drink heavily upon leaving home. Over the years, they became disconnected from their family, endured multiple partners who used substances and were abusive toward them. They had two other children who were also put in the custody of other adults. They had multiple interactions with the legal system. They experienced multiple traumatic deaths of loved ones including the death of a sibling due to alcoholism. Beginning at age 17, they were in and out of several treatment facilities around the country. They had periods of sobriety over the years, including maintaining sobriety while pregnant, while being a caretaker for their mother, and while working in law enforcement. They said they struggled to maintain sobriety after the death of their spouse and decided to attend a treatment center outside of Michigan where they valued being able to participate in Sweat Lodges. When they turned 50, they were court mandated to services in Michigan. Throughout their treatment experiences, a long-time counselor was one of their most helpful supports. They learned that their spirituality and connection to cultural healing practices were especially influential to their healing. Most recently, they enrolled in treatment services in another community since there were no inpatient services in their area. They described that experience as challenging, saying they would "never advise anybody to go there," due to the lack of support for smudging, using traditional medicines on the premises, and having to travel too far to see their traditional healer. Despite these limitations, a year ago, they told us they finally "quit" alcohol, motivated by their spirituality and desire to reconnect with their grandchildren and son. They stressed their strong belief that the Creator has other plans for them.

In addition to receiving long term care coordination from service providers and support from peers, most clients also found motivation from services that got them involved in helping others recover from substance use. Treatment programs that involved them, or even hired them, to help others supported their own sobriety. Clients specifically mentioned their service in Narcotics Anonymous, leading Wellbriety, and working in youth substance use prevention. As one client who previously worked in a rehab center said:

> *I worked in the rehab, I got to be not only the client, but I got to be the employee, the authority figure. I mean, I'm the felon guy, the meth head felon guy, that's giving these guys drug tests now, you know? ... I grew a compassion for people. ... it makes me super understanding to people's actions ... I mean, just helping others, you get a lot out of it even if you don't get anything instantly. You just get a lot out of it at the end of the day.*
>
> **-Client 3**

Another client who regularly serves others described how the cultural and spiritual significance of the Wellbriety program encouraged her to continue helping others. She explained:

> *Wellbriety is the traditional talking circle and program here that is based on White Bison. ... I love, love, love when I see other people in this, decades ahead of me, cause I'm like "yes, I can learn from you – anything, something." I was confused about it at first. When I first started Wellbriety, I was like 'Why are we all touching the feather? We shouldn't be sharing energy? Why are we doing this?' ... I knew that I didn't want to disrespect the medicines or the eagle feather that came around and the traditions that we use in our talking circles. I learned in the time of Wellbriety that everything is happening for the cleansing of us. … We can walk this red road without even the temptation ... I had actually went on and received my Wellbriety facilitator training certificate.*
>
> **-Client 5**

There were several personal facilitators that helped clients achieve and maintain their recovery. While loss and disconnection were prominent barriers for clients on the road to recovery, connection (and re-connection) to family and community was framed as a prominent facilitator for recovery. Some mentioned (re)connection in relation to being more involved in their communities, including their cultural communities, spiritual communities, and sobriety communities. Overwhelmingly, these (re)connections most often centered on rekindling relationships with their family members. Clients

spoke of focusing on moving past previous mistakes, rebuilding trust, and forging stronger relationships for the future as priorities for them now. For some, the recentering of familial relationships brought purpose to their sobriety, as shared by one participant who said:

> *My grandkids are everything to me. So, it was just about a year or so [ago], trying to find the right path and realizing how much I've lost over the years, that I think I finally quit because … at the time I was like, 'I can't die now, my kids are going to be devastated, my grandkids don't know me.' It's still in my mind all the time. ... I'm not going to go back to that way of life.*
>
> **-Client 1**

All clients expressed a deep sense of self-awareness of their successes on the road to recovery. Self-awareness took multiple forms including having a strong personal will for sobriety; commitment to programs, support systems, and cultural or spiritual practices they knew worked for them; and recognition of their own personal triggers. For most, this involved being introspective about themselves, recognizing negative influences in their lives, and making changes accordingly. This process involved withdrawing from negative or enabling family members and friends, moving to more secure housing, or creating a spiritual foundation in their lives to better support their continued sobriety. One client, who shared the deep impact her renewed spirituality has had on her life, said:

> *If I feel like I need to light any kind of medicines, I can do it… I learned what my coping skills are, and practice it, and [am] seeing that it works. I'm using it all the time and now it's easier… It took a lot to get me to this point… it takes a lot from the person's inside, the willingness, to do it… I had a lot of learning to do to be able to block off things around me so that I can stay focused on what I'm doing.*
>
> **-Client 1**

Another prominent facilitator for clients was setting personal goals for the future, especially for finding employment and continuing their education. Multiple clients linked their experiences and commitment to sobriety with wanting to help others dealing with substance use disorder. Most reported returning to school to obtain their college degrees and focusing on educational programs that would allow them to work in the substance use and recovery system supporting others on the road to recovery. Multiple clients discussed wanting to continue and expand their engagement in their Native communities, including being involved in community leadership positions and advocating for substance use prevention programming. One client described the personal significance of pursuing such work: "***It's important that more of us, like myself for example, work [] more with our own Native community… because there are a lot of us who are [recovered]– there is not many of us, Natives and descendants of Natives, who work in recovery or over at disability services." (Client 4)***

CLIENT RECOVERY STORIES

CLIENT 5 , 26 – 35 YEARS OF AGE, TRIBE IN UPPER PENINSULA MICHIGAN

RECOVERY FROM ALCOHOL, OPIOIDS, ACID, AND METHAMPHETAMINE USE

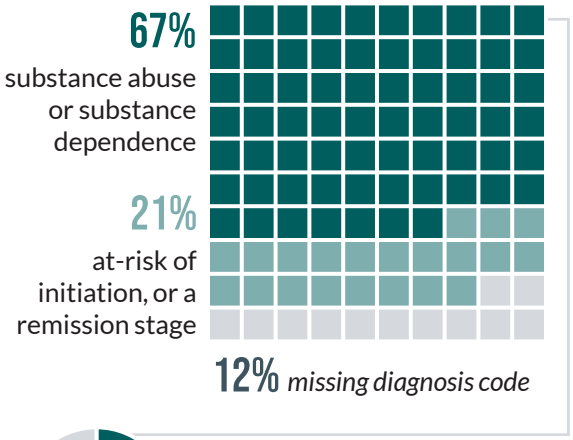
Client 5 was a parent, an active member of Narcotics Anonymous, and recent GED recipient. They began their story by recounting their childhood during which substance use was normalized among family members and friends. They began taking prescription opioid pills at age 13, and shortly after, dropped out of high school. They described having strained relationships with their parents and siblings as a result of dealing drugs, being incarcerated, and negative peer influences. After the death of a grandparent, whom they had a close relationship, they began drinking alcohol heavily. In 2020, they had a child, but custody of their child was removed from them by CPS. They described experiencing postpartum depression, struggling to maintain a sense of reality, and feeling alone and unsupported. After ordering a large supply of drugs and having it seized by law enforcement, they had a spiritual awakening and made the decision to detox from methamphetamine use without medical management. Motivated to reconnect with their child, they joined Narcotics Anonymous and Wellbriety, where they met supportive friends, valued learning from other's experiences, and strengthened their connection to their culture, community, and spirituality. They expressed that although they wanted to attend a detox center, they couldn't bear putting their family through more trauma. They also wanted to enroll in a counseling program, but the waitlist was too long. They said they detoxed on their own and believed they "needed to get through it alone and really do it for myself." They stressed how Wellbriety's focus on tradition and culture, through talking circles and spirituality, had been one of their strongest motivators on their recovery journey. During sobriety, they had been able to spend more time with their child, obtain a driver's license, seek employment, and set goals for the future that include going to college and having more children.

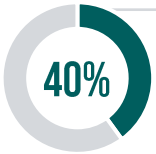
FINDINGS FROM THE ATR AND GPRA DATA

Among the 7,845 clients in the final data set, a total of 5,256 (67%) clients had a primary diagnosis that was either substance abuse or substance dependence; 1,669 (21%) clients had a primary diagnosis of either at-risk of initiation, early full remission, early partial remission, sustained full remission, or sustained partial remission; and 920 (12%) clients were missing a diagnosis code. Of those clients with a primary substance abuse or dependence diagnosis, the most common diagnosis was related to alcohol use, with 3,518 (67%) clients being diagnosed with alcohol abuse or dependence. A total of 683 (13%) clients were diagnosed with opiate abuse or dependence. Of all clients with a primary substance use or dependence diagnosis, 40% were also diagnosed with a secondary substance use or dependence diagnosis, meaning that these clients used multiple substances. A summary of the services clients received using ATR vouchers is provided below in Figure 4.

PRIMARY DIAGNOSIS OF CLIENTS

% within each category



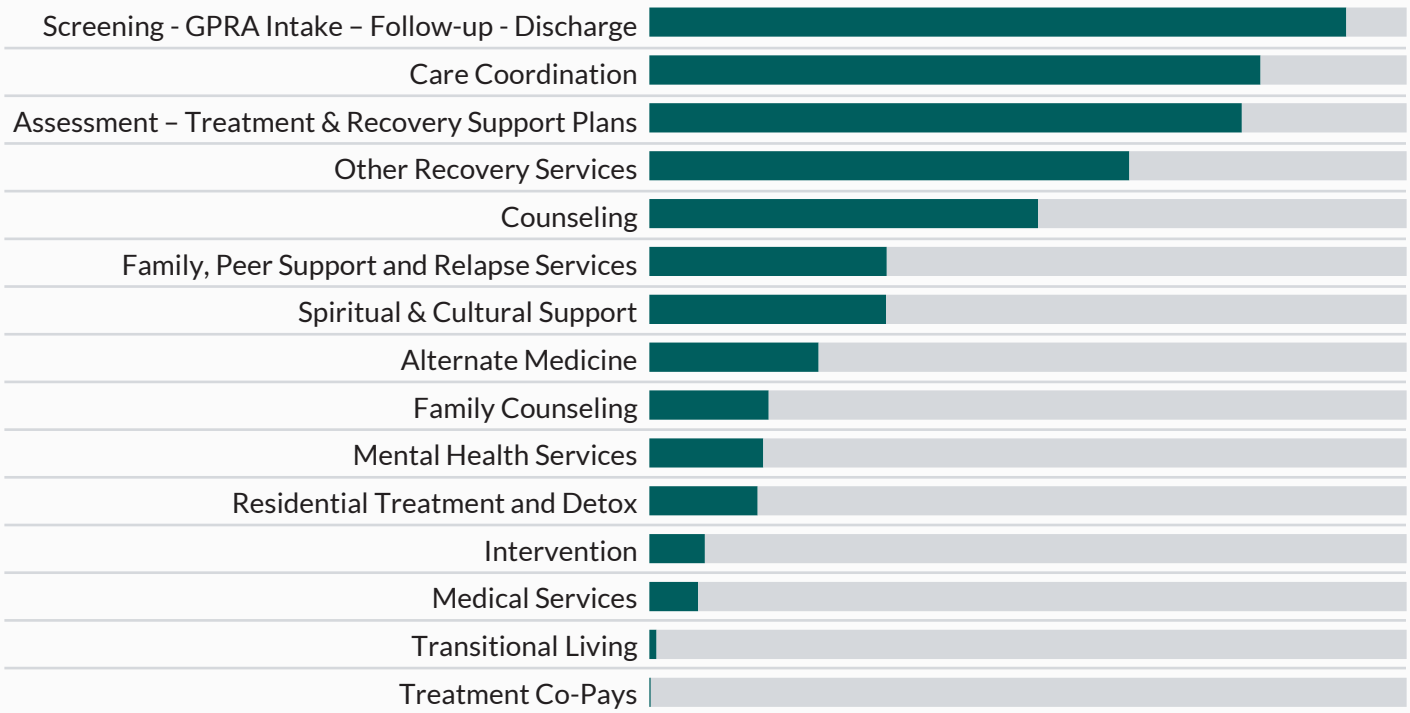


diagnosed with a **secondary substance use or dependence diagnosis**

SERVICES CLIENTS RECEIVED USING ATR VOUCHERS

Figure 4.

% of clients who used services in these categories in ATR



Services were combined into larger categories depending on the services clients received and how they were billed. The service categories that clients most often used ATR vouchers were: Screening – GRPA Intake, Follow-up or Discharge; Care Coordination; and Assessment - Treatment and Recovery Support Plans. An important note for interpretation of the ATR voucher data is that the number of clients utilizing vouchers to pay for services within each category are not mutually exclusive because clients were able to use ATR vouchers to cover multiple services. It should also be noted that ATR clients used vouchers to cover services that were described in this report as having restrictions or limitations in coverage by health insurance or Medicaid. These services included:

• Care Coordination	**81%** of clients
• Other Recovery Services (including transportation)	**63%** of clients
• Counseling	**51%** of clients
• Family, Peer Support & Relapse Services	**31%** of clients
• Spiritual & Cultural Services	**31%** of clients
• Residential Treatment & Detox	**14%** of clients

The outcome data analysis was conducted for the subset of ATR clients who reported using alcohol or drugs at baseline (i.e. when they entered ATR program). Among this subset of clients, the outcomes at the time of six-month follow-up (i.e. six months after entering ATR program) were examined in relation to the specific services they received within broader categories of inpatient detox and residential treatment services, cultural services, counseling, care coordination, other support services, and social support. These broader categories were created by collapsing the 15 parent categories mentioned previously into fewer groups.

After the initial analysis, there were many findings not statistically significant. To keep the focus on answering some critical questions for this assessment and learnings from the qualitative findings, the analysis team narrowed the inquiry to comparisons in outcomes for the subset of clients that received any inpatient detox and residential treatment services with other services and clients that did not receive any inpatient services with other services.

The findings for these analyses are presented in the following section. The limitations of these analyses and ongoing analyses of these datasets are also described in later sections of this report.

GPRA OUTCOME MEASURES ANALYSIS

CULTURAL SERVICES

Among ATR clients who received inpatient detox and residential treatment services, at the time of 6-month outcome measurement:

- The percentage of clients who attended a ***voluntary self-help group for recovery*** in the past 30 days was 49% for clients who engaged in cultural services and 39% for clients that did not, and it was statistically significant (p=.013).
- The percentage of clients who attended a ***religious or faith-based self-help group for recovery*** in the past 30 days was 24% for clients who engaged in cultural services and 12% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who attended an ***organization meeting to support recovery*** (other than previously described) in the past 30 days was 18% for clients who engaged in cultural services and 11% for clients who did not, and it was statistically significant (p=.011).

Among ATR clients who did not receive inpatient detox and residential services, but did receive other treatment and recovery services, at the time of 6-month outcome measurement:

- The percentage of clients who **used illegal drugs** in the past 30 days was 13% for clients who engaged in cultural services and 18% for clients who did not, and it was statistically significant (p=.003).
- The percentage of clients who attended a ***voluntary self-help group for recovery*** in the past 30 days was 17% for clients who engaged in cultural services and 12% for clients who did not, and it was statistically significant (p=.001).
- The percentage of clients who attended a ***religious or faith-based self-help group for recovery*** in the past 30 days at was 19% for clients who engaged in cultural services and 8% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who attended an ***organization meeting to support recovery*** (other than organizations described) in the past 30 days was 10% for clients who engaged in cultural services and 5% for clients who did not, and it was statistically significant (p<.001).

	ATR clients who **received inpatient detox and residential treatment services**			ATR clients who **did not receive inpatient detox and residential services**		
Support groups attended	**Received** cultural service	**Did not receive** cultural service	**Difference significant?**	**Received** cultural service	**Did not receive** cultural service	**Difference significant?**
Voluntary self-help	**49%** attended	**39%** attended	**Yes**, p=.013	**17%** attended	**12%** attended	**Yes**, p=.001
Religious or faith-based self-help	**24%** attended	**12%** attended	**Yes**, p<.001	**19%** attended	**8%** attended	**Yes**, p<.001
Organization meeting	**18%** attended	**11%** attended	**Yes**, p=.011	**10%** attended	**5%** attended	**Yes**, p<.001
	n=282	*n=371*		*n=756*	*n=1871*	

COUNSELING SERVICES

Among ATR clients who received inpatient detox and residential treatment services, at the time of 6-month outcome measurement:

- The percentage of clients who ***used alcohol*** in the past 30 days was 35% for clients who also received counseling services and 26% for clients who did not, and it was statistically significant (p=.043).
- The percentage of clients who ***experienced serious depression*** for 1 or more days in the past 30 days was 47% for clients who also received counseling services and 31% for clients who did not, and it was statistically significant (p=.001).
- The percentage of clients who ***experienced serious anxiety*** for 1 or more days in the past 30 days was 54% for clients who also received counseling services and 36% for clients who did not, and it was statistically significant (p=.000).

Among ATR clients who did not receive inpatient detox and residential treatment services, but did receive other treatment and recovery services, at the time of 6-month outcome measurement:

- The percentage of clients who ***used illegal drugs*** in the past 30 days was 21% for clients who received counseling services and 11% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who ***used alcohol*** in the past 30 days was 33% for clients who received counseling services and 42% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who ***experienced serious depression*** for 1 or more days in the past 30 days was 41% for clients who received counseling services and 18% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who ***experienced serious anxiety*** for 1 or more days in the past 30 days was 50% for clients who received counseling services and 23% for clients who did not, and it was statistically significant (p<.001).

	ATR clients who **received inpatient detox and residential treatment services**			ATR clients who **did not receive inpatient detox and residential services**		
Client conditions	**Received** counseling	**Did not receive** counseling	**Difference significant?**	**Received** counseling	**Did not receive** counseling	**Difference significant?**
Used alcohol	**35%** used	**26%** used	**Yes**, p=.043	**33%** used	**42%** used	**Yes**, p<.001
Serious depression	**47%** depressed	**31%** depressed	**Yes**, p=.001	**41%** depressed	**18%** depressed	**Yes**, p<.001
Serious anxiety	**54%** anxious	**36%** anxious	**Yes**, p<.001	**50%** anxious	**23%** anxious	**Yes**, p<.001
	n=512	*n=146*		*n=1,517*	*n=1,115*	

CARE COORDINATION SERVICES

For this analysis, the category 'Care Coordination Services' included services such as case management, medical services, and information and referral.

Among ATR clients who did not receive inpatient detox and residential treatment services, but did receive other services, at the time of 6-month outcome measurement:

- The percentage of clients who ***experienced serious depression*** for 1 or more days in the past 30 days was 30% for clients who received care coordination services and 36% for clients who did not, and it was statistically significant (p=.007).

ATR clients who **did not receive inpatient detox and residential services**		
Received care coordination services *(n=2,101)*	**Did not receive** care coordination services *(n=506)*	**Difference significant?**
30% depressed	**36%** depressed	Yes, p=.007

SOCIAL SUPPORT SERVICES

For this analysis, the category 'Social Support Services' included services that help clients access and receive social support, such as family services, peer recovery coaching, education groups, and support groups, among others. **Among ATR clients who received inpatient detox and residential treatment services**, at the time of 6-month outcome measurement:

- The percentage of clients who had ***stable housing*** in the past 30 days was 83% for clients who received social support services and 90% for clients who did not, and it was statistically significant (p=.009).
- The percentage of clients who ***attended religious or faith-based self-help group*** for recovery in the past 30 days was 22% for clients who received social support services and 13% for clients who did not, and it was statistically significant (p=.003).
- The percentage of clients who ***attended an organization meeting to support recovery*** (other than organizations described) in the past 30 days was 17% for clients who received social support services and 11% for clients who did not, and it was statistically significant (p=.024).

	ATR clients who **received inpatient detox and residential treatment services**		
	Received social support services	**Did not receive** social support services	**Difference significant?**
Had stable housing	**83%** housed	**90%** housed	**Yes**, p=.009
Attended religious self-help group	**22%** attended	**13%** attended	**Yes**, p=.003
Attended organization meeting	**17%** attended	**11%** attended	**Yes**, p=.024
	n=271	*n=382*	

SOCIAL SUPPORT SERVICES (continued)

Among ATR clients who did not receive inpatient detox and residential treatment services, but did receive other services, at the time of 6-month outcome measurement:

- The percentage of clients who ***used illegal drugs*** in the past 30 days was 13% for clients who received social support services and 18% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who ***experienced serious depression*** for 1 or more days in the past 30 days was 25% for clients who received social support services and 34% for clients who did not, and it was statistically significant (p<.001).
- The percentage of clients who ***experienced serious anxiety*** for 1 or more days in the past 30 days was 32% for clients who received social support services and 42% for clients who did not, and it was statistically significant (p<.001).

	ATR clients who **did not receive inpatient detox and residential treatment services**		
	Received social support services	**Did not receive** social support services	**Difference significant?**
Used illegal drugs	**13%** used	**18%** used	**Yes**, p<.001
Experienced serious depression	**25%** depressed	**34%** depressed	**Yes**, p<.001
Experienced serious anxiety	**32%** anxious	**42%** anxious	**Yes**, p<.001
Reported positive social connectedness	**93%** reported	**87%** reported	**Yes**, p<.001
	n=750	*n=1,888*	

- The percentage of clients who ***reported positive social connectedness***[9] in the past 30 days was 93% for clients who received social support services and 87% for clients who did not, and it was statistically significant (p<.001).

[9] Positive social connectedness is a variable that combines the following: clients that attended a voluntary (non-religious or faith-based) self-help group, clients that attended a religious or faith-based self-help group, clients that attended an organization meeting to support recovery, and clients that interacted with family and friends.

OTHER SUPPORT SERVICES

For this analysis, the category 'Other Support Services" included services that supported clients with accessing and attending treatment and recovery services, including employment assistance, transportation, childcare, legal support, and housing support.

Among ATR clients who received inpatient detox and residential treatment services, at the time of 6-month outcome measurement:

- The percentage of clients who ***attended a voluntary (non-religious or faith-based) self-help group*** for recovery in the past 30 days was 46% for clients who received other support services and 36% for clients who did not, and it was statistically significant (p=.021).
- The percentage of clients who ***attended religious or faith-based self-help group*** for recovery in the past 30 days was 19% for clients that received other support services and 12% for clients who did not, and it was statistically significant (p=.049).
- The percentage of clients who ***attended an organization meeting to support recovery*** (other than organizations described) in the past 30 days was 16% for clients who received other support services and 8% for clients who did not, and it was statistically significant (p=.014).

	ATR clients who **received inpatient detox and residential treatment services**		
Support groups attended	**Received** other support services	**Did not receive** other support services	**Difference significant?**
Voluntary self-help	**46%** attended	**36%** attended	**Yes**, p=.021
Religious or faith-based self-help	**19%** attended	**12%** attended	**Yes**, p=.049
Organization meeting	**16%** attended	**8%** attended	**Yes**, p=.014
	n=474	*n=179*	

Among ATR clients who did not receive inpatient detox and residential treatment services, but did receive other services, at the time of 6-month outcome measure:

- The percentage of clients who ***used illegal drugs*** in the past 30 days was 15% for clients who received other support services and 19% for clients who did not, and it was statistically significant (p=.031).
- The percentage of clients who ***reported positive social connectedness*** in the past 30 days was 90% for clients that received other support services and 86% for clients who did not, and it was statistically significant (p=.001).

	ATR clients who **did not receive inpatient detox and residential treatment services**		
	Received other support services	**Did not receive** other support services	**Difference significant?**
Used illegal drugs	**15%** used drugs	**19%** used drugs	**Yes**, p=.031
Reported positive social connectedness	**90%** reported	**86%** reported	**Yes**, p=.001
	n=1,589	*n=1,049*	

Emerging Insights

Tribal behavioral health program managers, service providers, and clients emphasized that numerous aspects of Tribal substance use treatment and recovery systems were especially important and valuable for Native people on the journey to recovery. These included access to detox and residential treatment services; engagement in spiritual and cultural services and traditional healing; care coordination; ensuring clients' immediate needs were met; and access to aftercare support services. However, several interrelated factors within the current system created barriers to making these aspects a consistent reality for Native people in recovery.

DETOX AND RESIDENTIAL TREATMENT SERVICES

In general, there were limited detox and residential treatment facilities available throughout Michigan. It was clear that inpatient detox and residential treatment services were the hardest for Native people to access from within Tribal behavioral health systems due to compounding barriers. Tribal program managers and service providers found it difficult, and sometimes impossible, to overcome the myriad of barriers they faced in order to assist clients most at-risk for negative outcomes with getting the services they needed when they were ready to enter treatment. Limited funding and restrictions in how funding can be used prevented Native people from being able to access these services. The treatment facilities that Tribal programs may be able to access for their clients are often long distances from Tribal communities, and Tribal agencies did not have adequate, flexible funding sources to reliably meet transportation needs, as were available when the ATR program existed. When ATR funding was available, agencies were able to use ATR vouchers to fulfill whatever transportation needs clients had in order to get them to the detox and residential treatment that was available, even services located in other states that were preferred for being more culturally responsive.

During the ATR program, about 1 in 6 clients used vouchers for inpatient detox and residential treatment. The map in Figure 5 indicates where ATR vouchers were used for detox and residential treatment services.[10] This map was created using provider data from the ATR voucher payment system.

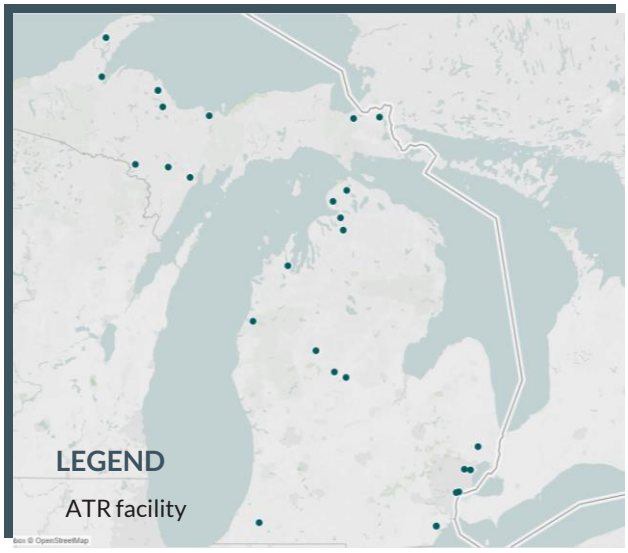


Figure 5. ATR facilities where vouchers were used for detox and residential treatment services

[10] While the map presented is limited to Michigan, other detox and residential treatment centers located in South Dakota and Wisconsin were also present in the ATR data.

Figure 6. ATR facilities where vouchers were used for detox and residential treatment services

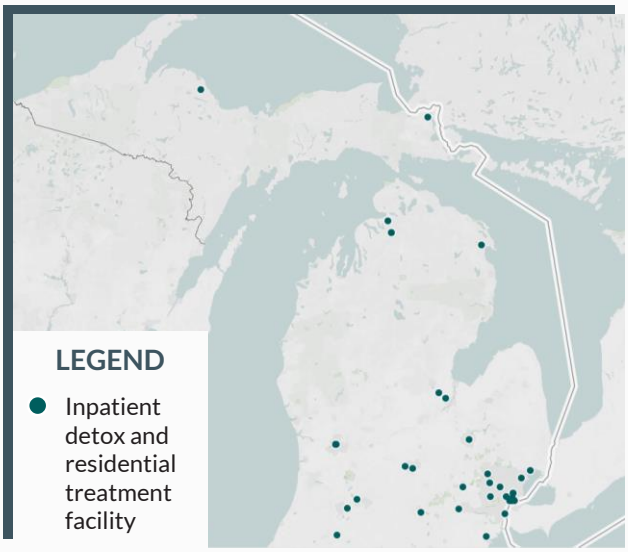


Figure 7. SAMHSA treatment facilities

By comparison, the map in Figure 7 displays the location of inpatient detox and residential treatment facilities according to data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Facilities Locator.[11] A visual comparison of the maps (Figure 6 and Figure 7) reveals that more inpatient detox and residential treatment facilities were available to Native clients in the Upper Peninsula and Northern Michigan regions through the ATR program than are currently available. According to the SAMHSA Treatment Facilities map there appears to be more inpatient detox and residential treatment facilities that currently exist within the state, however many of them are in the greater Detroit Metro Area and far fewer options exist in the Upper Peninsula and Northern Michigan.

Qualitative findings illustrated how limited access to inpatient detox and residential treatment services impacted clients negatively. Foremost, clients were exposed to serious risks when attempting to detox without medical management and supervision by a physician, which can lead to serious health problems and death. While private insurance and Medicaid may provide coverage for detox and residential services, providers described how the limits and restrictions of this coverage resulted in clients not being able to receive services that met their needs. Many clients were not receiving adequate duration of treatment or culturally responsive support during treatment they believed necessary to achieve long-term sobriety. This was evident from clients' recovery stories, that recounted multiple periods of inpatient treatment over the course of many years; and stays at different types of treatment centers before finding a program that met their needs and reaching sustained sobriety. Clients who were able to access inpatient detox and residential services often received services from providers with no knowledge or understanding of Native culture or traditional beliefs and practices. In the worst cases, providers actively prevented clients from

[11] Substance Abuse and Mental Health Services Administration, "Locator Map." SAMHSA, Accessed August 2022, https://findtreatment.samhsa.gov/locator

using traditional medicines and practicing traditional lifeways while in treatment.

In contrast to the current system, when the ATR program existed, program managers and providers indicated that their agencies were able to use ATR funding more flexibly to get clients into facilities when needed, and where they provided more culturally responsive detox and residential treatment services, if that was what their clients desired. For example, nearly 5% of all ATR client vouchers used for inpatient detox and residential treatment were used for one facility, Keystone Treatment Center in South Dakota, which offered culturally responsive programs.

Analysis of ATR program outcome data compared groups of clients that received inpatient detox and residential treatment services with clients that did not receive these services. The results suggested that certain types of services (spiritual and cultural services, other support services, care coordination, and aftercare services) in combination with inpatient services may have significantly different impacts on clients' short-term outcomes. The direction, magnitude, and duration of these relationships need further examination. However, in combination with the qualitative findings from this assessment it was clear that sustaining sobriety and staying on the path of long-term recovery required flexible funding to access services when needed and coordination of a comprehensive and individualized set of services over a long period of time.

SPIRITUAL AND CULTURAL SERVICES AND TRADITIONAL HEALING

Across all interviews, it was evident that spiritual and cultural services and traditional healing were highly valued and impactful aspects of the recovery process, helping clients reconnect to their spirituality and gain (or regain) positive social connections. While many Tribal behavioral health programs offered culturally informed programming, such as Traditional Medicine and Healers, Sweat Lodges, smudging, and other cultural activities like crafts and beadwork, these were services that were no longer billable or covered by insurance plans since the ATR program ended. Tribal behavioral health programs had to continuously seek and work to sustain other funding sources to cover these costs; find creative ways to absorb the costs within program budgets; and limit the cultural services and Traditional healing they can provide. Clients identified cultural healing as the single most impactful aspect of their recovery. For clients that depend upon cultural services for their recovery, this manifested in them traveling to other Tribes, regions, or states to meet their needs. Further, exposure to systems and care that lacked understanding of Native history, culture, and traditional practices were a detriment to clients' recovery, as evidenced in their stories.

Figure 8. Spiritual and cultural services and traditional healing services provided by ATR

ATR data indicated that spiritual and cultural services were accessed regularly by clients. Nearly a third of clients (31.2%) used ATR vouchers to cover the cost of these services. Spiritual and cultural services included cultural education, talking circles, storytelling, Native art and craftwork, Traditional Healing, and Sweat Lodges. These services were described by program managers, providers, and clients as highly facilitative for recovery. In the absence of ATR funding which helped mitigate some of the barriers to accessing spiritual and cultural services, clients may be receiving less optimal care and less opportunity to maximize positive outcomes.

The outcome data showed that clients who received spiritual and cultural services, regardless of whether they received inpatient detox or residential services, were more likely to attend voluntary recovery groups, including non-religious self-help groups, religious self-help groups, and organizational recovery support meetings than those who did not. Receiving spiritual and cultural services was also associated with lower rates of illegal drug use than for clients who didn't receive spiritual and cultural services.

ADDRESSING CLIENTS' IMMEDIATE NEEDS

Tribal behavioral health programs that had the ability to address the immediate needs of clients were notably valuable contributors to their recovery. Interviews indicated that stable housing, food security, childcare, employment, and transportation were areas of significant need among clients seeking recovery. Recently, Tribal systems have not consistently been able to address these needs. Providing such services was impacted by several factors, most notably the lack of flexibility or availability of grants and Tribal funding, limited staff and personnel, and lack of insurance coverage because they are not billable medical services. Transportation was the most frequently mentioned client need among all interviewees that was identified as a barrier to clients accessing and engaging in SUD treatment and recovery services.

In the past, program managers and service providers used the flexible funding available through ATR to cover the cost of addressing clients' immediate needs like transportation and housing. ATR data indicated that nearly two-thirds (63.4%) of clients used vouchers for Other Recovery Services, which included services to meet immediate needs. More specifically, 58.6% of clients used ATR vouchers for transportation, 6.4% for housing support, and less than 1% for childcare.

The outcome data showed that in the past, clients who used Other Support Services, regardless of whether they received inpatient detox or residential treatment services, were more likely to attend voluntary recovery groups, including non-religious self-help groups, religious self-help groups, and organizational recovery support meetings and more likely to report positive social connectedness than those who did not use Other Support Services. Clients who utilized this category of services were also less likely to report illegal drug use at 6-month follow-up than clients who did not receive inpatient detox and residential services. The data showed that clients who received Other Support Services to address their immediate needs were more likely to report increased social connectedness, whether or not they received inpatient services. Among clients who did not receive inpatient detox and residential services, those who received Other Support Services reported lower rates of illegal drug use at follow-up.

CARE COORDINATION

Care coordination involved organizing the logistics of various patient treatment, aftercare, and recovery support services. Care coordination was highly valued by Tribal program managers, service providers and clients for the positive impact they perceived them having on clients' treatment and recovery journeys. Care coordination proved beneficial for helping meet clients' immediate needs, navigating complicated administrative processes and overcoming barriers to accessing SUD services, and helping clients to manage the complexity involved in actively participating in multiple SUD treatment and recovery services. In Tribal behavioral health programs, care coordination services were not processed as billable services, and therefore could not be paid by private insurance or Medicaid. Tribal programs that were able to provide care coordination were often paying for it through other grants or Tribal funding sources, and their ability or capacity to provide these services was limited in comparison to how frequently and consistently it was needed.

In the past, care coordination services were highly utilized and frequently paid for with ATR vouchers. This is evident in the ATR data, where 80.7% of clients used vouchers to cover the cost of care coordination services. The outcome data showed that receiving care coordination services was associated with less clients reporting serious depression symptoms among clients who did not receive inpatient detox and residential services.

AFTERCARE SERVICES FOR INPATIENT TREATMENT

Program managers and providers emphasized that Aftercare Services were especially important for helping Native clients sustain sobriety upon transitioning out of inpatient services. Aftercare Services that were deemed particularly valuable from the perspective of program managers and service providers included transitional housing, recovery homes, or other sober living options; counseling; care coordination; and sober activities and events. For clients, Aftercare Services that were most helpful were long term counseling, peer support, case managers, and support groups. Aftercare Services, as a category of services, was described as least likely to have costs covered by insurance. Most program managers and service providers said they were often unable to provide clients with help arranging these services to ensure they were in place for clients immediately upon transitioning out of inpatient care. Communication and coordination with inpatient treatment facilities regarding clients' treatment and discharge plans were a common barrier to arranging Aftercare Services upon their return to the community.

ATR data indicates clients used vouchers for various services that would constitute aftercare. Through ATR, 1% of clients used vouchers for transitional living; 31.4% used vouchers for peer support and relapse prevention services (such as peer support groups, peer-to-peer coaching and mentoring, and alcohol-free and drug-free social activities); 51.3% used vouchers for individual counseling; and 15.8% for family counseling. The ATR outcome data showed that clients who received inpatient detox or residential services and received counseling services, were more likely to attend voluntary recovery groups, including religious self-help groups, and organizational recovery support meetings and report positive social connectedness than those who did not.

KEY FINDINGS RELATED TO ACCESS AND UTILIZATION OF SERVICES

One key finding of this assessment was that a combination of services which included inpatient detox and residential treatment with aftercare services (including spiritual and cultural services and traditional healing) may help produce more positive outcomes for Native clients than inpatient services without aftercare and spiritual and cultural services. A combination of spiritual and cultural services, social support services, and other support services may be associated with more positive outcomes for Native clients regardless of whether they received inpatient treatment or comprehensive outpatient treatment; however, they seem particularly important for Native clients that did not receive inpatient detox and residential treatment services. Inpatient services were the most prominent gap in substance use treatment and recovery systems that Native clients faced.

Another key finding was related to the most common barriers that program managers, service providers, and clients faced when trying to help Native clients on their journeys through treatment and recovery. The lack funding or insurance coverage for 'non-medical' services (i.e., services that were not billable) and/or complicated restrictions and limitations of coverage resulted in Native clients not getting the type or duration of services that would meet their needs. The gaps and limitations in coverage created a ripple effect of other systemic barriers. Tribal behavioral health programs had to pursue additional sources of funding that could be flexibly used to pay for services and other supports their Native clients needed. Inconsistency in these other sources of funding limited the capacity of Tribal programs to consistently employ and sustain staff and continuously offer these services within their own agencies; services offered within Tribal agencies are usually more culturally responsive to Native clients spiritual and cultural beliefs and practices than services provided by non-Tribal agencies. Further, Tribal program managers and providers had to take on more responsibilities to manage and fulfill requirements for their additional funding sources which impacted their service capacity. Tribal providers had to spend significant time navigating a complex maze of eligibility, coverage, and availability to help clients get the array of services necessary to fulfill their needs. The added burden providers faced trying to overcome these obstacles and meet their clients' needs contributes to turnover and depletes workforce capacity.

Finally, throughout this assessment it was clear that Tribal behavioral health systems strived to provide person-centered, integrated behavioral health care that met each client's unique needs by helping every individual access the appropriate combination of treatment, support, and resources necessary to achieve sobriety and foster long term recovery. While in the past this endeavor was more feasible for Tribal agencies through participating in the ATR voucher program, in the current system Tribal behavioral health systems must overcome many obstacles to meet the needs of Native clients that are seeking help.

Future Directions

Through all phases of this assessment, we gathered input and recommendations from Native clients, service providers, program managers and advisors about how to improve the treatment and recovery service system to promote better outcomes for Native people in Michigan. Recommendations were captured during interviews, thematically analyzed by the MPHI project team, then interpreted, vetted, and discussed during collaborative meetings. Finally, the MPHI team summarized the comprehensive list of recommendations that emerged through this process into the recommendations presented in this report.

This section describes four overarching recommendations, or future directions, that the MDHHS could explore to significantly impact the substance use disorder treatment and recovery service system for Native people. Notably, our recommendations are not entirely new or unique to Tribes in Michigan. Our recommendations are discussed as they relate to recommendations included within other nationally recognized frameworks for addressing inequities. This assessment provides evidence of how and why the MDHHS might prioritize specific recommendations within these frameworks to improve Michigan's systems to better serve Native people.

RECOMMENDATIONS FOR MDHHS

1 Strengthen and expand formal mechanisms for Tribal Consultation and Tribal Self-Determination to inform how decisions are made to provide better access to culturally responsive SUD services for Native people.

To provide person-centered, integrated care that better meets the unique needs of each Native client, Tribal program managers, service providers, and advisors recommended that Tribes have increased decision-making authority over what and how costs for programs and services are covered for SUD treatment and recovery. This recommendation, if acted upon, would create a stronger foundation for successfully exploring, planning, implementing, and monitoring the recommendations that follow.

According to U.S. Indian Affairs, Tribal Consultation is a "formal, two-way, government-to-government dialogue between official representatives of Tribes and [government] agencies" to discuss proposals before decisions are made.[12] Advisors from the Tribal Behavioral Health Communication Network stressed the importance of the MDHHS fully engaging in culturally responsive and formal Tribal Consultation processes on a regular basis to ensure that elected Tribal leaders have input on programs and policies administered by MDHHS. Further, more culturally responsive engagement with Tribal

[12] U.S. Department of the Interior. Bureau of Indian Affairs. What is Tribal Consultation? Accessed online: https://www.bia.gov/service/tribal-consultations/what-tribal-consultation | Indian Affairs (bia.gov)

agencies could be facilitated by MDHHS if there were Native representation in MDHHS leadership and appointed positions responsible for Tribal Consultation. Examples of how formal Tribal Consultation processes effectively function on a government-to-government basis are modeled by health agencies such as the IHS Tribal Advisory Committee and CDC Tribal Advisory Committee. There are also established models of supporting Tribal Self-Determination among federal agencies that contract and compact with Native nations to ensure the delivery of health, education, and other services for Native people. For example, IHS implements Title I Contracting and Title V Compacting Under the Indian Self-Determination Education Assistance Act (ISDEAA) or Public Law (P.L.) 93-638. ISDEAA allows federally recognized Tribes to plan, conduct, and administer one or more individual programs, functions, services, or activities that would otherwise be provided by IHS. Federally recognized Tribes can request to participate by Tribal resolution or other official action by the governing body of each Tribe to be served, and by demonstrating fiscal and financial management capability.[13]

While the IHS contract/compact models have many positive attributes that support Self-Determination, the amount of IHS funding that is authorized and appropriated through the U.S. Congress and made available for Tribal service agreements is not adequate to meet the level of need of Tribal patients with SUD in Michigan.

2

Expand the array of services and benefits covered by Medicaid Plans to allow Tribes to transform their systems to provide and sustain a more comprehensive suite of recovery supports (including cultural and traditional healing services) to better meet the unique needs of Native people.

Services currently considered "non-medical" (i.e., not billable to insurance) are difficult or impossible for Tribal programs to pay (such as spiritual and cultural services, traditional healing, care coordination, peer support, and transportation) and need better coverage by insurance and Medicaid plans for individuals to get their SUD treatment and recovery needs fully met. Expanding Medicaid coverage to include these services will allow Tribal Behavioral Health Agencies to provide and sustain essential home and community-based recovery services and supports within their Tribal communities, where culturally responsive inpatient care is likely unavailable and where the cultural lifeways of Native people can be supported.

Innovative system transformations using Medicaid is an approach being explored by other states and Tribes. During the National Indian Health Board's Tribal Health Summit (August 16, 2022), participants discussed issues related to Medicaid coverage for culturally responsive services, and Tribal leaders advocated for states to work with Tribes to establish Tribally-managed Medicaid state

[13] Indian Health Service. Differences Between Title I Contracting and Title V Compacting Under the Indian Self-Determination Education Assistance Act (ISDEAA). Accessed online: Differences between Title 1 Contracting and Title 5 Compacting under the Indian Self-Determination Education Assistance Act (ISDEAA) (ihs.gov)

plans or design a waiver process to cover services for Tribal members that are not currently covered. There are several federal authorities that offer states pathways to flexibly transform their systems and improve coverage for individuals with substance use disorder conditions.[14] Through these authorities states can start new initiatives or enhance existing efforts under a Medicaid state plan amendment, or use demonstration or waiver authority to explore integrated care models, or pilot new Managed Care Organizations (MCOs) who offer care coordination to individuals from targeted groups or geographic areas. Many of the Tribal health systems in Michigan are already operating health systems that align with coordinated care models, Health Homes for patients with chronic conditions, and Integrated Care Models.

There are important workforce considerations for any expansion of coverage for these types of services in Tribal behavioral health systems, particularly related to the types of providers and other professionals that are authorized to oversee, provide, and bill for these services. For example, the relatively small workforce of Tribal health systems and limited availability of clinicians, requires careful attention for determining how to cover services that are recommended, not only provided, by a physician or other licensed practitioner of the healing arts within the scope of their practice. Further, to expand coverage to include cultural services and traditional healing, there must be learning and attention surrounding the sensitive nature of establishing certification and/or licensing criteria for cultural and traditional healers in order for them to be qualified or eligible to provide billable services. Clearly, a formal and culturally responsive Tribal Consultation process would be essential for any effort to explore or establish criteria for delivery of services that is based in traditional cultural knowledge and belief systems.

3 Create new and more flexible system innovation grants to allow Tribes to determine what workforce issues are most pressing and implement strategies that are most appropriate for increasing local capacity with minimal administrative reporting requirements.

Tribes clearly understand the ongoing, unique workforce capacity challenges impacting their provider systems, recognizing the similarities and distinct differences of each Tribe which will require tailored strategies to address them. By providing Tribes with direct funding without preconceived solutions to workforce challenges would allow them to determine how to expand their own capacities to provide SUD services. Tribes would have resources needed to ameliorate the major barriers this assessment revealed related to retention, stagnant and uncompetitive salaries, lack of availability of services in the local community or region, and recruitment and hiring of Native people or other culturally-responsive professionals. Increasing Tribal workforce capacity would have important implications for improving the availability of services that this assessment found to be particularly impactful, including peer recovery coaching, aftercare services, trauma informed care, and spiritual and cultural services and traditional healing.

[14] Centers for Medicare and Medicaid Services. Behavioral Health Services. *Pathways for Covering Mental Health and Substance Use Disorders.* Accessed online: pathways-2-9-15.pdf (medicaid.gov)

4 Incentivize behavioral health systems to provide more inpatient detox and residential treatment programs that include culturally responsive providers and services.

This assessment revealed a strong and growing need for increased investments to expand the availability of inpatient detox and residential treatment services. For Native people, it is particularly important that these services include culturally responsive care. The lack of inpatient treatment options alone can be a formidable barrier, but for Native people their options are especially limited if they need services in or near their family and community or desire services that support their spiritual and cultural practices. Tribal behavioral health programs could help better meet this need with funding to construct new detox and residential treatment centers or provide programming in partnership with existing facilities, particularly in the Upper Peninsula and Northern Michigan. Physical infrastructure is necessary to increase availability of inpatient beds, expand access to timely services, reduce or remove waitlists for time sensitive clients, and ensure there are locally available services that don't require Native clients to travel long distances away from their home and community. Moreover, expanding insurance and Medicaid coverage for longer lengths of stay at culturally informed detox and residential treatment centers may better serve Native clients holistic needs and increase the likelihood of achieving and sustaining sobriety.

ALIGNMENT WITH NATIONAL FRAMEWORKS FOR EQUITY

The recommendations that emerged from this assessment align with several of the goals and strategies put forth by the U.S. Centers for Medicare & Medicaid Services' (CMS, 2022-2023) *Framework for Health Equity*[15] and the National Indian Health Board's (NIHB) *Recommendations for Medicare and Medicaid to Advance American Indian and Alaska Native Health Equity* (2022-2023),[16] and *The National Tribal Behavioral Health Agenda* (2016).[17]

The CMS Framework prioritizes the assessment of the root causes of disparities within CMS programs and the development of approaches to address inequities in policies and operations to close gaps. As described in CMS's Health Equity Priority 2, the agency is focused on, "assessing programs and policies for unintended consequences and making concrete, actional decisions about our policies, investments, and resource allocations… to develop sustainable solutions that close gaps in health and health care access, quality, and

[15] Centers for Medicare & Medicaid Services (April 2022). *CMS Framework for Health Equity 2022-2032*. Accessed online: https://www.cms.gov/files/document/cms-framework-health-equity.pdf

[16] National Indian Health Board (2022). *Recommendations for Medicare and Medicaid to Advance AI/AN Health Equity*. Accessed online: https://www.nihb.org/health-equity/health-equity-resources.php

[17] Substance Abuse and Mental Health Services Administration, Indian Health Service, & National Indian Health Board Tribal (2016). *The National Tribal Behavioral Health Agenda*. Accessed online: https://www.nihb.org/docs/12052016/FINAL%20TBHA%2012-4-16.pdf

outcomes, and to invest in solutions that address health disparities" (p. 10). This assessment and its recommendations create a foundation from which MDHHS could specifically address issues within its policies and operations and establish solutions to barriers experienced by Native clients seeking SUD treatment services in Michigan.

Since CMS has declared health equity and reducing disparities a focus area, the agency is compelled to understanding how these programs impact unique communities and "engineering tailored solutions across communities and settings of care" (p.17), which serves as justification for Future Directions 2 and 3 recommended in this report. Expanding Medicaid coverage in Michigan for Native clients in need of 'non-medical' services to better support their recovery is a system transformation that would allow many tailored solutions to emerge for Tribal communities, in turn allowing them to address the unique needs of Native people seeking treatment and recovery.

According to the Framework, CMS prioritizes building capacity of health care organizations and workforce to reduce health disparities (Health Equity Priority 3). Our Future Directions 3 and 4 are in alignment with this priority by proposing that Tribes receive direct funding to increase local workforce capacity, and that coverage and funding should include special consideration for culturally-responsive programming, especially for services that are in high demand with very limited capacity (inpatient SUD treatment).

The CMS Framework also prioritizes advancing language access, health literacy, and the provision of culturally tailored services (Heath Equity Priority 4). CMS states that the agency must "ensure that every individual served by the Agency can get the care they need at a provider to whom they can travel, who will serve them, and who they are comfortable with," (p. 18) which further lends support to Future Directions 2 and 4.

The NIHB's *Steps Forward for CMS* identified five broad recommendations to advance health equity and proposed "steps that CMS can take in partnership and consultation with Tribes to build on the CMS Framework for Health Equity."[18] Our Future Direction 1, 2, and 3 aligns directly with NIHB's Recommendations 1, 3, and 4 which include steps related to Tribal sovereignty, strong Tribal institutions, and Tribal representation in state and federal governance. Our Future Direction 2 to expand Medicaid coverage to include cultural services and traditional healing, among other support services, would enable Tribal agencies to develop and manage culturally-responsive treatment and recovery services for Tribal members that are fully billable. Future Direction 2 is fully aligned with NIHB's Recommendation 2, Resilience through Culture, which includes supporting Indigenous knowledge, traditional healing, and culturally relevant services.

Finally, our proposed Future Directions are well aligned with many aspects of the National Tribal Behavioral Health Agenda (THBA, 2016),[19] which was developed by NIHB in collaboration with Tribal leaders, Tribal

[18] National Indian Health Board. Tribal Health Equity Summit Resources. Webpage accessed online: National Indian Health Board | Tribal Health Equity (nihb.org)

[19] Substance Abuse and Mental Health Services Administration, Indian Health Service, & National Indian Health Board Tribal (2016). *The National Tribal Behavioral Health Agenda*. Accessed online: https://www.nihb.org/docs/12052016/FINAL%20TBHA%2012-4-16.pdf

organizations, and federal agencies. The Agenda is grounded in the "Declaration of Cultural Wisdom" (p. 4-7) and formed around five foundational elements (p. 14) that "should be considered and integrated into both existing and potential programmatic and policy efforts" (p. 18). The contents of the Agenda overlap significantly with the findings from this assessment (e.g. intergenerational trauma, community connectedness, programming that meets community needs, etc.) as well as the Future Directions we've offered to the MDHHS for exploration with the Tribes.

In general, the underlying philosophy of all our Future Directions is consistent with the TBHA which emphasizes meaningful Tribal consultation with Tribes on programs for which they are eligible; improving federal, state, and Tribal coordination to align program resources; and supporting capacity-building to raise the collective capacity of Tribes to speak about the effectiveness of culture in prevention and care and their own best practices. Our Future Directions speak to each of these strategies and echo the TBHA which proposes:

> ***"Allowing tribes, within existing programs and new funding streams, the flexibility to develop, tailor, and/or implement support mechanisms that best address their local and specific manifestations of trauma [and] increasing flexibility in funding requirements to tribes to support culturally based programming that meets the programmatic needs of tribal communities."*** **-p. 49**

More specifically, our Future Direction 2 and 4 aligns with the TBHA's strategy of "integrating authentic cultural interventions and culturally tailored evidence-based practices into existing tribal programs as a means for reestablishing tribal spiritual conditions of physical, mental, and spiritual health" (p. 50). The TBHA proposes incorporating traditional practitioners within service delivery systems, providing cultural competency training, and assessing funding opportunities for inclusion of traditional services and staff. Regarding treatment, the TBHA suggests "identifying new models of care delivery that ensure more accessible intensive inpatient and long-term care," (p. 63) and "treating mental and substance use disorders as chronic conditions requiring not only a broad spectrum of support and services, but tribally driven assessments and best practices" (p.58).

Limitations of this Assessment

There are limitations respective to the qualitative and quantitative data used for this assessment that should be noted for interpreting results.

Foremost, the qualitative results are not generalizable, and on their own should be understood to represent the real lived experiences, perspectives and opinions of the individuals interviewed within the Tribal treatment and recovery service system currently and in the recent past. The qualitative data reflects the interviewees' realities but may or may not accurately reflect the full scope of services available in the system now. Instead, interview data reflects how the system worked for them when they were navigating it. Qualitative research is open-ended and allows for participants to share their perspectives and have control over what they chose to share and not share. Due to this, the data is subjective and should be interpreted to only represent the system and context as experienced and understood by those who were interviewed. Qualitative analysis for this assessment was a labor-intensive process, requiring several months of coding, review, cross-referencing and sensemaking. As such, to streamline this process the evaluation teams' approach largely focused on identifying commonalities and dominant interconnected themes across all qualitative interviews, while unique or less common concepts, experiences, and inductive themes were not pursued for further in-depth analysis at the time of this report.

The quantitative data presented in this report represent only initial findings that informed the qualitative data. A full analysis and interpretation of the ATR datasets is ongoing. Deeper inferential statistics are needed to understand how the combination of certain treatment services manifested in outcomes. While the chi-square analyses used in this report indicate where there are relationships between variables, they do not control for other variables. As such, further regression analysis is needed to predict relationships among multiple variables. Further sensemaking with the Tribal Behavioral Health Communication Network will inform additional community participatory analysis, interpretation, and sensemaking. The quantitative analysis was a time-consuming process that required the evaluation team to be selective with the inclusion criteria for client data. Because the assessment only included ATR data for clients who also had GPRA outcome and health data, the quantitative data presented in this report does not fully represent all ATR voucher services. Additionally, during the analysis, it was discovered that some services that were not covered by ATR vouchers in earlier years were covered in later years. The change in coverage and voucher utilization over time needs further exploration.

The Path Forward

This assessment is one step on the pathway toward equity for Native people experiencing substance use disorders, as well as the families and communities impacted by these conditions. This is not the starting point. Efforts to help Native communities overcome substance use and addictions have been going on for many, many years. There is significant wisdom within Native communities in Michigan to foster healing and support recovery. This assessment was a process of gathering and organizing the wisdom, experiences, and stories that exist among Tribal communities, and translating it into learnings that can be applied by MDHHS and other institutions to prioritize their next steps for removing systemic barriers and transforming the broader SUD service system. What is ultimately needed for the path forward to achieve equity in substance use disorder treatment and recovery was well summarized in the National Tribal Behavioral Health Agenda:

"One of the messages that framed development of the TBHA remains one of the most important messages on which to frame the path forward: ***There is no single entity, program, or activity alone that will improve behavioral health outcomes for American Indians and Alaska Natives.*** *Tribal leaders asked for tribes and Federal agencies to "work together differently" to improve the wellness of their communities. Through extensive conversations, Tribal leaders, Tribal administrators, and Tribal members from communities across Indian Country provided input on what they believed was best for healing their people from traumatic events compounded over time. And, despite the differences across tribes, geography, cultures, and language, they found areas of common benefit on which to frame priorities that allow for collaborative work across sectors and governments to target the factors contributing to behavioral health problems."*

-National Tribal Behavioral Health Agenda (2016, p. 71)

APPENDICES

Appendix A

CATEGORIES OF SERVICES COVERED BY ATR VOUCHERS

Assessment- Treatment and Recovery Support Plans
- Clinical Assessment
- Recovery Support Assessment
- Clinical Treatment Plan
- Recovery Management Plan

Screening-GPRA Intake-Follow-up-Discharge
- GPRA Intake
- GRPA Discharge
- GPRA Follow-up
- ATR Intake Interview
- GPRA Discharge (no client interview)
- GPRA Follow-up
- GPRA Follow-up with Incentive
- GPRA Follow-up Data Management
- GPRA Follow-up Interview Tier 2 Tracker
- GPRA Follow-up Interview Completed Out of the Window
- Incentive 30-day GPRA Follow-up
- Discharge Planning from Clinical Treatment

Intervention
- Brief Intervention
- Crisis Intervention

Counseling
- Individual Counseling
- Group Counseling/Per Person

Family Counseling
- Family /Marriage Counseling
- Family Therapy w/o Client
- Family Counseling w/ Client

Mental Health Services
- Co-Occurring Treatment/Recovery Services
- Other Co-Occurring Treatment
- Pharmacological Interventions
- Psychological Testing
- Psychiatric Evaluation and Follow-up

Treatment Co-Pays
- Residential Treatment Co-pay
- Outpatient Treatment Co-pay

Residential Treatment and Detox
- Adult Residential Treatment - Great Lakes Recovery
- Adolescent Residential Treatment - Great Lakes
- Residential Treatment - Keystone (Adult and Adolescent)
- Women & Children Residential Treatment - Great Lakes
- Residential Treatment - Ain Dah Ing
- Sub Acute Detox - Harbor Hall
- Individual & Family Residential - KiiKeeWanNiiKaan
- Adult Residential Treatment - New Day Treatment
- Sub-Acute Detox Great Lakes
- Residential Treatment Saginaw Chippewa Tribe
- Residential Treatment - Phoenix House Inc
- Residential Treatment - Addiction Treatment Services
- Sub Acute Detox - Addiction Treatment Services
- Residential Treatment - Harbor Hall
- Residential Treatment - Muskegon River Youth Home
- Secure Detention Treatment - MRYH
- Sexual Offender Treatment - MRYH
- Charlevoix County Probate/Family Court
- Sub Acute Detox - Keystone
- Sub Acute Detox - Salvation Army Harbor Light
- Residential Treatment - Salvation Army Harbor Light
- Residential Treatment - Bear River Health
- Sub Acute Detox - Bear River Health
- Transitional Living Program - Harbor Hall
- Residential Treatment - Sacred Heart Rehabilitation
- Sacred Heart Rehabilitation - Clearview Women's Specialty Residential
- Sacred Heart Rehabilitation - Clearview Sub Acute Detox
- Sub Acute Detox - Sacred Heart Rehabilitation

Transitional Living
- Supportive Living Program - Saginaw Chippewa Tribe
- Great Lakes Recovery Center Transitional Housing/3.1 Level of Care
- Addiction Treatment Services - Transitional Living / Housing
- Transitional Living - Salvation Army Harbor Light

Medical Services
- HIV/AIDS Counseling
- Nutritional Management Per Session
- Medical Care
- Vivitrol Injections
- Suboxone Prescription
- Alcohol/Drug Testing
- HIV/AIDS Medical Services

CATEGORIES OF SERVICES COVERED BY ATR VOUCHERS (continued)

Family, Peer Support and Relapse Services
- Other Clinical Services
- Family Services
- Employment Services
- Employment Coaching
- Relapse Prevention Individual Service
- Relapse Prevention Group
- Recovery Coaching Individual Service
- Self-Help and Support Groups
- Domestic Violence Group
- Substance Abuse Education Group
- HIV/AIDS Education Group
- Peer Coaching or Mentoring - Individual Service
- RCI Sober Activities (per person)
- RCI Peer Recovery Coaching (per person)
- RCI Self-Help and Support Groups (per person)
- Alcohol and Drug-Free Social Activities
- RCI Recovery Education, Workshop (per person)
- Other Peer-To-Peer Recovery Support Services

Other Recovery Services
- Child Care
- Pre-Employment
- Transportation to Treatment / Detox / Transitional Living
- HIV/AIDS services
- Supportive Transitional Drug-Free Housing Services
- Special Need Fund
- Legal Support
- Housing Support
- Transportation

Care Coordination
- Individual Services Coordination (Case Management)1
- Individual Services Coordination (Case Management)2
- Report and Record Keeping
- Continuing Care
- Other After Care Services
- Information and Referral
- Record Retrieval
- Other Case Management

Alternate Medicine
- Other Medical Services
- Acupuncture
- Auricular Acupuncture
- Alternative Therapies
- Physical Fitness and Well-Being Activities
- Stress Management
- Massage Therapy
- Circuit Healing
- Circuit Healing II
- Circuit Healing III
- Healing Energy Therapy

Spiritual and Cultural Support
- Spiritual Support - Individual
- Other Education Services Group
- Indigenous Language Recovery/Expression Group
- Storytelling/Cultural Teaching Group
- Tribal Song and Dance Group
- Tribal Arts and Crafts Group
- Daily Living Skills Group
- Motivational Development Activities
- Digital Storytelling
- Digital Story-Viewing - Facilitated Group
- Digital Story-Viewing - Individual
- Traditional Healing Services1
- Traditional Healing Services2
- Sweat Lodge1
- Sweat Lodge2
- Talking Circle1
- Talking Circle2
- Spiritual/Cultural Feast Supplies
- Spiritual/Cultural Retreat Support
- Sweat Lodge Materials
- Tribal Arts and Crafts Supplies
- Daily Living Skills & Cultural Subsistence Materials Support
- Digital Story-Viewing – nDigiFest

Other or Administrative
- Other Clinical

Appendix B

TRIBAL SUD ASSESSMENT CLIENT INTERVIEW PROTOCOL

1. Please tell me about your journey with addictions treatment and recovery. Where does your story begin?
    a. Can you please tell me more about _____?
        i. …the types of treatment programs/services you've been through?
        ii. … **Medicaid or other state-assisted programs** you've been on during your journey? (What was that like for you?)
        iii. … programs or services that used to be available but aren't any more (did you ever do a program called Access to Recovery or ATR?) Prompt for more information about why they aren't available any more
    b. What are your thoughts or experiences with Medication Assisted Treatment (M.A.T.) programs?
        i. If client says they were offered MAT services, but chose not to participate then ask why they weren't interested
        ii. If client says they received MAT services, ask how this type of treatment affected them.

2. Tell me what your experience has been like getting support from treatment and recovery programs.
    a. Say more about _____...
    b. Clarify if programs/services were provided by a tribal or non-tribal agency
    c. Prompt for specific services, providers, counseling, treatment, coordination with outside providers/services

3. What challenges or roadblocks have you faced on your journey?
    a. Can you please tell me more about _____? (timeliness of receiving services; loss of funding available to cover personal expenses; access)
    b. What may have helped you overcome the challenges you faced?

4. What has gone really well for you on your journey?
    a. Can you please tell me more about _____?
    b. What (program/service/support/person) do you think has helped you the most?

5. If you had a magic wand or 3 wishes to make anything about treatment and recovery services better for people in your community, what would you wish to change?
    a. Prompt if needed: What changes would've had the biggest positive impact on your journey?

6. Do you have any other experiences or ideas that you feel would be helpful for Michigan Department of Health and Human Services to know or understand about addictions, treatment, and recovery opportunities for Native American people in Michigan?

Appendix C

TRIBAL SUD ASSESSMENT PROGRAM DIRECTOR/MANAGER INTERVIEW PROTOCOL

PROGRAM STRUCTURE AND OPERATIONS

1. Please tell me about your tribal behavioral health program structure and operations.
    a. How is it organized within the Tribe's organizational structure *(prompts: Is it part of the health division? In another department? On its own?)*
    b. How many and what types of providers are employed by the program?
        i. What qualifications (licenses or certifications) must providers have in order to provide substance use treatment and recovery services within your program?
        ii. Who determines these requirements?
        iii. Are you currently, or have you previously, provided direct services to clients at this agency?
    c. Who does the program serve *(prompts: Who is eligible? About how many clients per year?)*
    d. How are behavioral health services paid/covered *(prompts: IHS funds? Tribal funds? 3rd party billing? Medicaid billing? Grant funding)*?
        i. Does the Tribe participate in Medicaid for any services? For behavioral health specifically?
        ii. [If the Tribe DOES NOT cooperate/bill Medicaid] To your knowledge, what are some of the reasons that your program doesn't participate in Medicaid for behavioral health services?

SPECTRUM OF SERVICES

2. Could you please describe (in detail) the array of services your Tribe is able to offer clients who need substance use treatment and recovery support?
    a. What services does the Tribe provide directly to clients and what services must be referred or coordinated with other programs or agencies?
        i. For SUD services provided directly by your program, how are these services paid for?
        ii. To what agencies do you most commonly refer clients for services?
        iii. Why are clients referred for these services (i.e. Tribe doesn't offer these services, Tribe doesn't cooperate with Medicaid; unique client situation, etc.)?
        iv. How do service options differ for clients that have Medicaid?
        v. In what ways does referral/coordinating care work well? Where do you face barriers or see gaps?

    b. To what extent does your program offer or support Medication Assisted Treatment (M.A.T.)? [***If Tribe provides NO MAT services, SKIP ALL FOLLOW-UP QUESTIONS IN THIS SECTION; If any MAT services are provided, CONTINUE***]
        i. What agencies/providers offer M.A.T. services to people in your community?
        ii. How are these services paid or covered for patients?
            a. What sources of funding are available to them?
            b. Does Medicaid cover them?
            c. Does your Tribe participate in any of the Opioid- related grants that are coordinated by ITCM (such as M.A.T. or S.O.R.2.)? ***[If YES, CONTINUE; IF NO, SKIP TO NEXT SECTION]***

iii. How would you describe the level of acceptance that community members have for your program offering MAT as an essential option for treating addiction?
iv. How would you describe the level of acceptance and commitment that Tribal leaders' have for your program offering MAT as an essential option for treating addiction?
v. Does your program follow the standards of care outlined by ASAM for *Use of Medications in the Treatment of Addiction Involving Opioids*? Why or why not?
vi. What successes has your program had with implementing MAT services?
vii. What barriers or challenges has your program had with implementing MAT services?
    a. Think specifically about situations in which clients are discharged from residential treatment services, and you are collaborating with the tribal referral agency to help clients transition to MAT in the community: What successes have you experienced in these situations? What challenges have you experienced?
viii. What could be done to help reduce the barriers or challenges you experience with integrating MAT into Tribal Health Services?

c. What alternative or complimentary therapies are available for clients with a Substance Use Disorder diagnosis?
    i. Who provides them?
    ii. How are these services paid for? Does Medicaid cover them? What sources of funding are available now or have been available in the past?
d. What cultural practices or culturally-based programming is your Tribe providing to tribal members to support treatment and recovery (*prompts: traditional healing, ceremonies, medicines*)?
    i. How are these services paid for? Does Medicaid cover them? What sources of funding are available now or have been available in the past?

SUCCESSES & CHALLENGES

3. What are the biggest challenges you face while trying to provide clients with any of the substance use treatment and recovery services they want or need?
    a. What services are hardest to access (due to distance, availability, cost, or other reasons)?
        i. Is this different for clients with Medicaid? How so?
    b. What factors most often lead to clients having difficulty getting the services they want or need?
        i. Getting services: Think about factors like client demographics, eligibility status, diagnosis or health status, income levels, location, etc.
    c. What factors most often lead to clients having difficulty continuing the services they want or need?
        i. Continuing services: employment, housing, lack of childcare, lack of transportation, lack of social supports, clients not thinking they need services, relationship(s) with service provider(s), etc.
4. What processes work best for your Tribe when coordinating care and providing services for treatment and recovery with external agencies?
    a. What partnerships are running/working smoothly?
    b. What services and supports are most often meeting client needs?

TRIBAL SUD ASSESSMENT PROGRAM DIRECTOR/MANAGER INTERVIEW PROTOCOL
(continued)

CHANGES LEADING TO IMPROVEMENT

5. A few years ago, the Access to Recovery (ATR) grant ended. Some tribal programs went through changes as a result of that grant ending. What impact (if any) has the end of that grant had on your program's substance use treatment and recovery services? (e.g. how are services different now?)
    a. What aspects of Access to Recovery (ATR) services do you wish you could get back?

6. If you had a magic wand, or 3 wishes you could be granted, to magically improve treatment and recovery services for people in your community, what would you wish to change?

OTHER

7. Is there anything else that you would like MDHHS to know or understand about treatment and recovery services for Native Americans in Michigan?

7. Would you be interested in working with MPHI to recruit and consent participants for the assessment?

Appendix D

TRIBAL SUD ASSESSMENT SERVICE PROVIDER INTERVIEW PROTOCOL

To get us started, I have a couple of basic questions about your professional role.

- *What organization or group do you work for?*
- *Tell me about your position [at organization]. What is your title?*

SERVICES

1. In your professional role, what is the process for identifying or assessing a person's need for treatment and recovery services (how do you know that someone needs help)?
    a. What prompts you to help an individual seek treatment and recovery services?
    b. Is there a standard assessment tool or process? Who does the assessment?
    c. Are individuals also assessed for other factors that may impact their substance use treatment and recovery journey (such as mental illness, chronic health issues, employment, transportation, housing)?

2. Could you please describe (in detail) the assistance or services you (or your organization) is able to offer or provide individuals who need substance use treatment and recovery support?
    a. What assistance or services do you (or your organization) provide directly?
        i. What is the process for determining eligibility?
            a. What factors make someone eligible or ineligible?
            b. Who decides eligibility? At what point?
            c. Are any services 'mandated' or required for individuals?
    b. What assistance or services must be referred or coordinated with other programs or agencies?
        i. What factors affect the type(s) of assistance that can be provided (from you or your organization)?
        ii. How do service options differ for people with Medicaid?
            a. Does your agency assist with Medicaid enrollment?
        iii. To what agencies do you most commonly refer or coordinate services?
            a. Does your agency/program contract with specific provider organizations?
        iv. What does service coordination look like from your perspective? (*For example, coordination with hospitals, treatment centers, mental health professionals, etc.*)
        v. Why are clients referred for these services *(i.e. Tribe doesn't offer these services, Tribe doesn't cooperate with Medicaid; unique client situation, etc.)?*
        vi. In what ways do referral processes or coordinating care work well? Where do you see barriers or gaps?

3. To what extent do you work with Medication Assisted Treatment (M.A.T.) services (or agencies that provide this type of treatment)?
    - **a.** [***If YES to any involvement with MAT services***]:
        - i. What agencies/providers offer M.A.T. services to individuals you serve?
        - ii. How accepting do you think other service providers are of individuals receiving MAT as an essential option for treating addiction?
        - iii. How accepting do you think community leaders' are of programs offering MAT as an essential option for treating addiction?
        - iv. What successes have you seen with MAT services?
        - v. What barriers or challenges have you seen with MAT services?
        - vi. What could be done to help reduce the barriers or challenges people encounter with MAT services?
    - **b. [If NO to any involvement with MAT]:**
        - i. Has program/agency leadership made a decision or policy not to participate with MAT services? (If yes- When was this decided and why have they taken this position?

4. To your knowledge, what alternative or complimentary therapies are available for individuals with a Substance Use Disorder?
    - a. What cultural practices or culturally-based programming is available for tribal members to support treatment and recovery (*prompts: traditional healing, ceremonies, medicines*)?
    - b. Who provides these services?
    - c. What factors impact individuals' decisions to seek these types of services?

SUCCESSES & CHALLENGES

5. How is individual progress through treatment and recovery monitored, if at all, by your agency?
    - a. How are you involved if or when someone relapses?
    - b. How is it documented when someone completes or discontinues their treatment program?
    - c. Are there consequences (with your agency) or implications for individuals who relapse or discontinue their treatment or recovery services?

6. What are the biggest challenges you face while trying to help individuals get the substance use treatment and recovery services they want or need?
    - a. What services are hardest to access (due to distance, availability, cost, or other reasons)?
        - i. Is this different for people with Medicaid? How so?
    - b. What limitations, if any, do you see with regards to service capacity or rules and restrictions?
        - *i. Waitlists; payment/reimbursement methods and rates; administration requirements, regulatory structures, workforce, etc.*
    - c. What factors most often prevent people from getting the services they want or need?
        - *i. Getting services: Think about factors like client demographics, eligibility, diagnosis or health status, income levels, location, etc.*
    - d. What factors most often cause people to have difficulty continuing services as long as they want or need?
        - *i. Continuing services: employment, housing, lack of childcare, lack of transportation, lack of social supports, clients not thinking they need services, relationship(s) with service provider(s), etc.*

CHANGES LEADING TO IMPROVEMENT

7. What do you see as the most important ways to improve substance use treatment and recovery services? (*Payment/reimbursement methods and rates, administration requirements, regulatory structures, workforce, Medicaid policies etc.)*

8. If you had a magic wand, or 3 wishes you could be granted, to magically improve treatment and recovery services for people in your community, what would you wish to change?

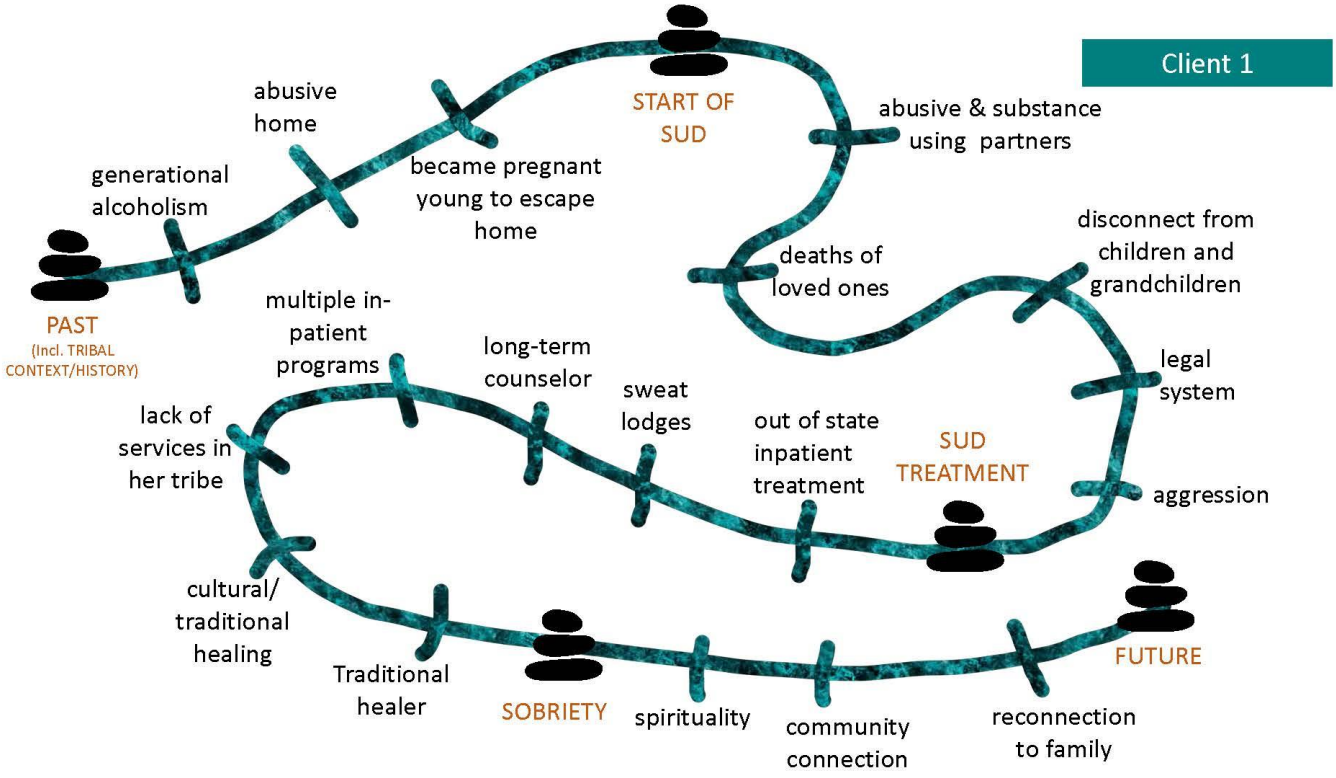
OTHER

9. Is there anything else that you would like MDHHS to know or understand about treatment and recovery services for Native Americans in Michigan?

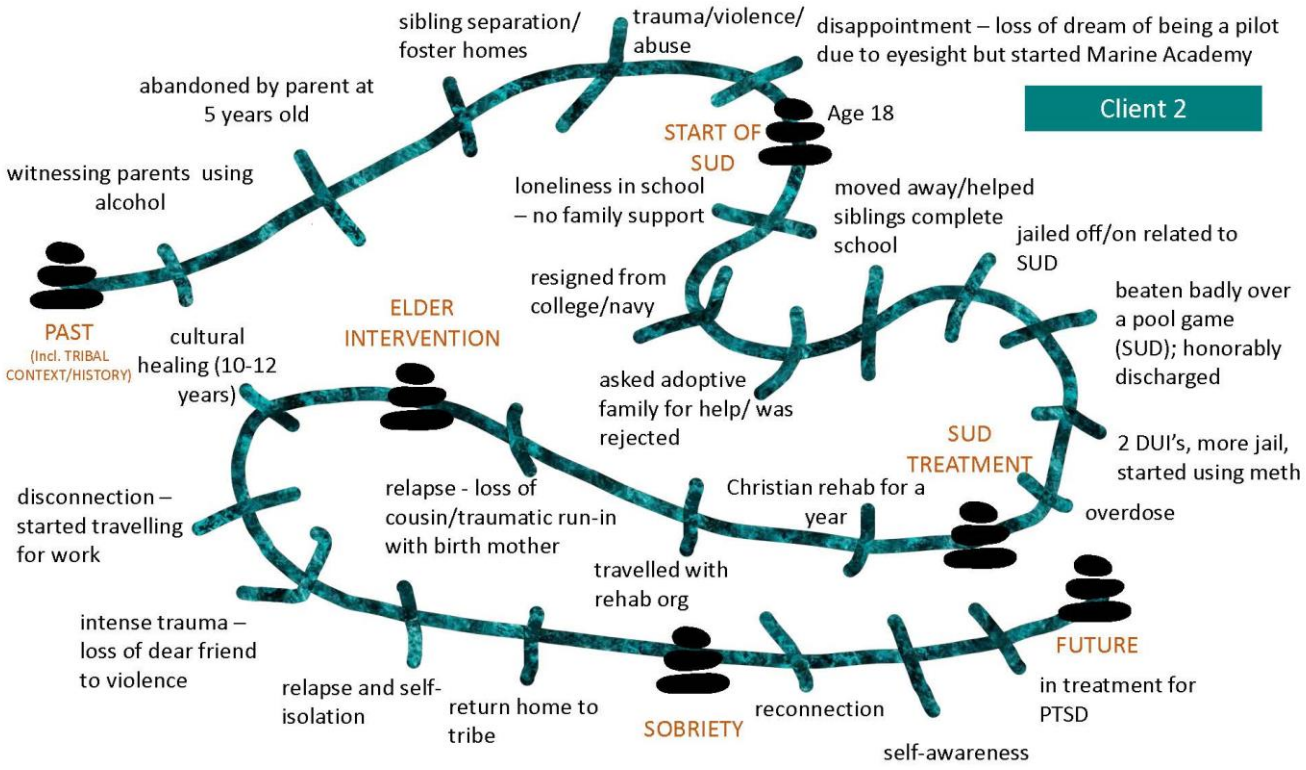
10. Would you be interested in working with MPHI to help recruit and consent participants (people who receive treatment and recovery services) for interviews?

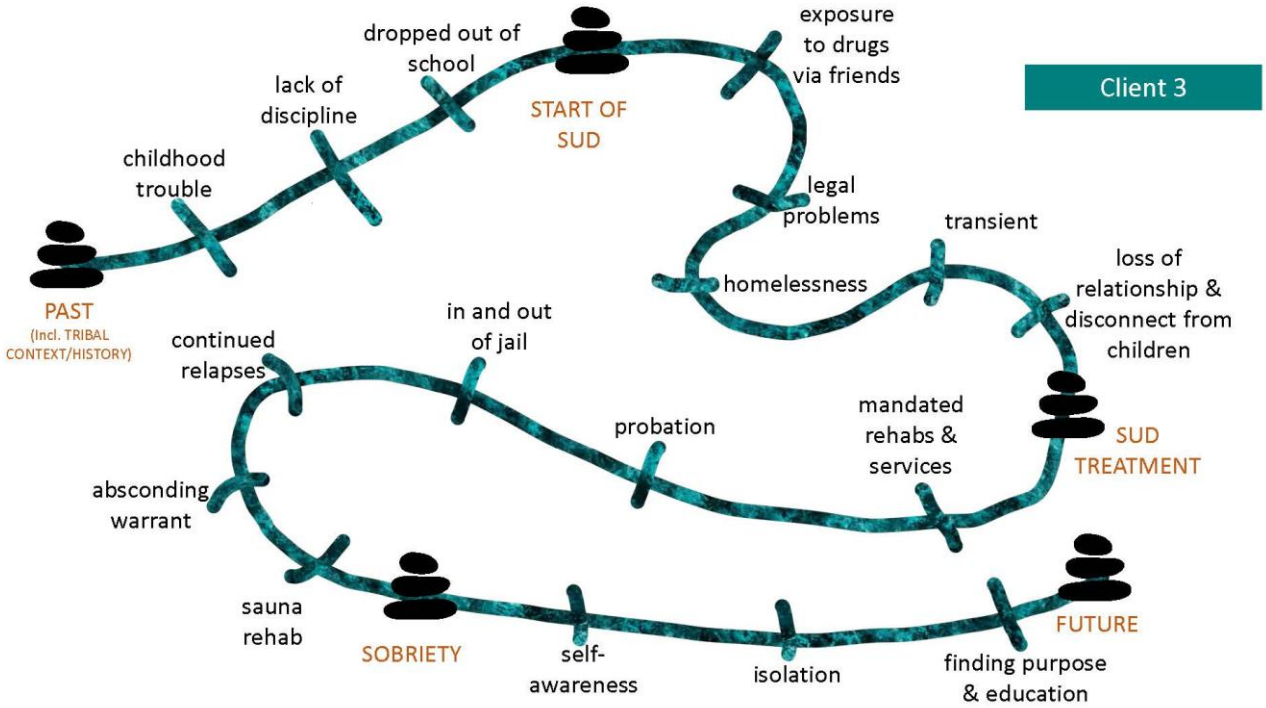
Appendix E

TRIBAL SUD CLIENT LIFE HISTORY RIVERS



TRIBAL SUD CLIENT LIFE HISTORY RIVERS





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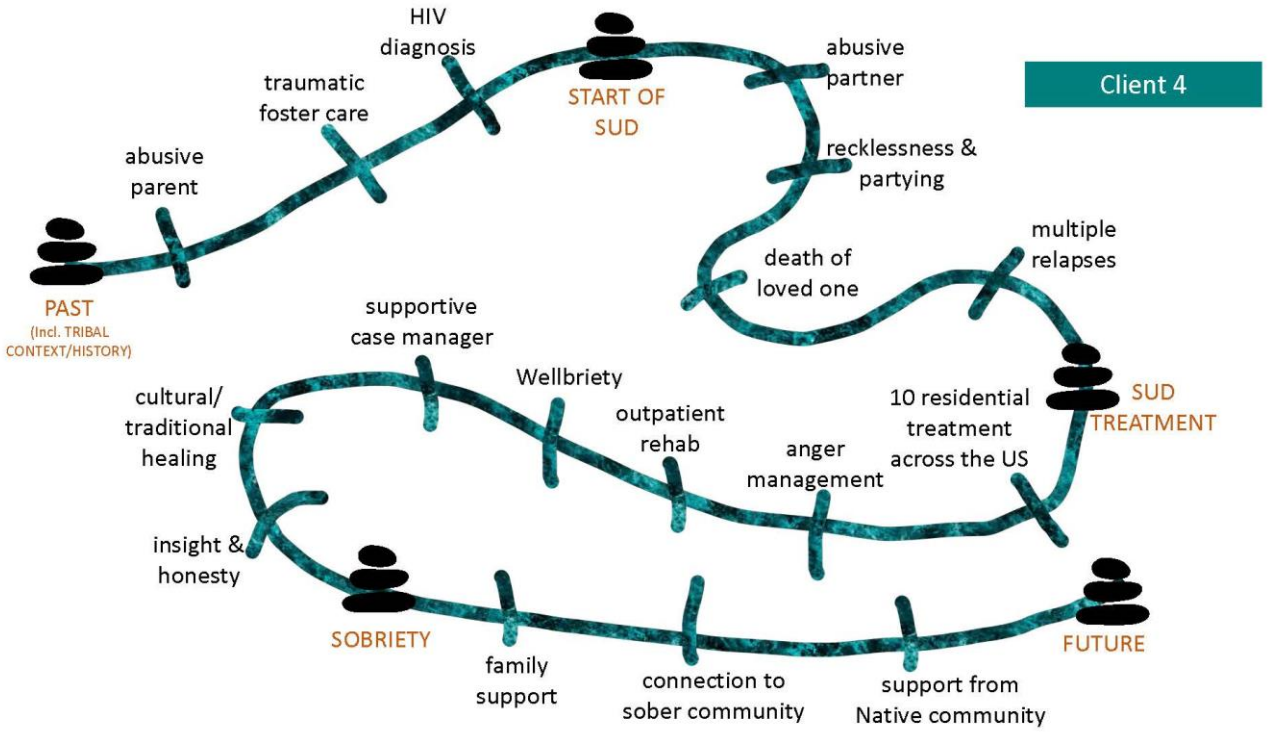

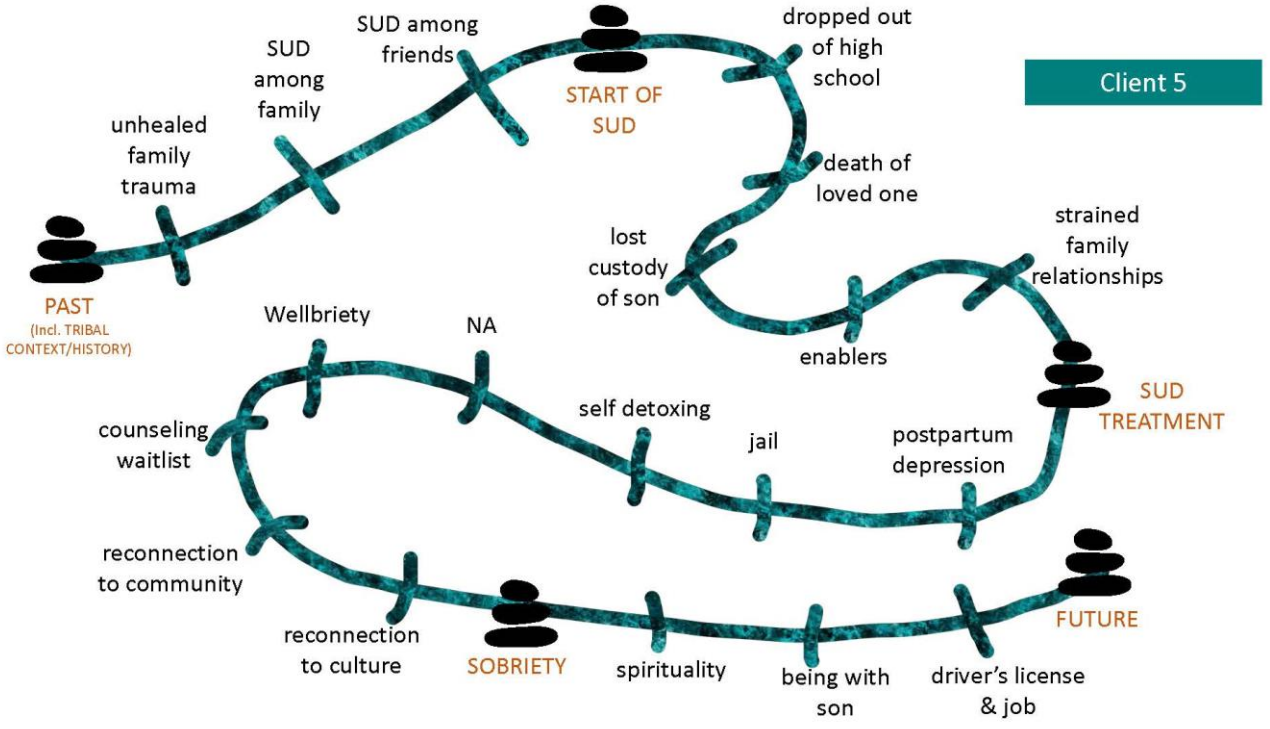

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Appendix G: Glossary of Terms

ATR: Access to Recovery; a previous program that provided vouchers to cover treatment services and recovery support services, including cultural and immediate need services.

Acudetox: an alternative treatment service that is a type of acupuncture used to treat addiction and trauma.

Aftercare Services: services that continue in a supportive capacity for clients that have achieved sobriety. Services include peer support, transitional housing, sober living events, care coordination, and counseling.

Alternative Services: therapies often used alongside conventional medical treatment and focus on helping individuals feel better. Services include Acudetox, massage, and yoga.

ATR Voucher: a funding voucher that was used during the ATR program that covered variety of services for clients.

Case Management: an often long-term service that helps clients individually navigate, coordinate, and monitor progress in SUD treatment and recovery services.

Client: individual currently or previously involved in tribal SUD treatment and recovery services.

CMS: Centers for Medicare & Medicaid Services.

Cultural Healing: services focused on reconnecting clients with their cultures, with the focus of enhancing health and wellness.

Detox: services, often discussed as inpatient in this assessment, that focus on helping clients get safely through acute withdrawal.

EMDR: Eye Movement Desensitization and Reprocessing, a type of psychotherapy that focuses on addressing trauma.

GPRA: Government Performance and Results Act, data collected as part of a 1993 United States law that measures performance on a number of indicators, including health indicators.

Grounded Theory: qualitative data analysis approach that involves a systematic and inductive approach to identify general themes, topics, and trends used to address overarching assessment objectives from interview data.

IHS: Indian Health Service.

Immediate Needs: the needs of individuals to live and engage in their everyday lives, including housing, food, transportation, and childcare.

Inpatient Treatment: services where clients stay for an extended period of time with round the clock supervision for SUD treatment. Services can include detox and residential treatment.

Intensive Outpatient Therapy: a combination of SUD treatment services that do not require detox or round the clock supervision. Services often include individual therapy, group therapy, medication management, psychiatric care, and complementary therapies.

Intergenerational Trauma: trauma that has been transmitted through generations that continues to have negative health impacts on individuals.

ITCM: Inter Tribal Council of Michigan.

Life History: a qualitative data analysis approach that takes an individual's retrospective account of their life, in whole or in part, and emphasizes the importance of understanding the meaning of behavior and experiences from the perspective of the individual.

Mandated Services: SUD services that are required for clients that are involved in the legal system.

MDHHS: Michigan Department of Health and Human Services.

MPHI: Michigan Public Health Institute.

MAT: Medication Assisted Treatment, service used to treat SUD that use medications that are supportive in blocking substance effects, relieving cravings, and normalizing body functions.

NIHB: National Indian Health Board.

Northern Michigan: for this assessment, defined as tribes located south of the Mackinaw Bridge and north of a Mason County to Arenac County line.

NVivo: a data analysis software used to theme qualitative data.

ORIC: Office of Research Integrity and Compliance

Pow Wow: a sacred indigenous cultural social gathering.

Primary Early Full Remission Diagnosis: ATR client diagnosis (from ATR dataset) based on DSM-IV criteria. An ATR client who is within 12 months of a dependence diagnosis and is at high risk for relapse, whom has not met any criteria for dependence or abuse during the period of remission.

Primary Early Partial Remission Diagnosis: ATR client diagnosis (from ATR dataset) based on DSM-IV criteria. An ATR client who is within 12 months of a dependence diagnosis and is at high risk for relapse, whom has met at least one criteria for dependence or abuse during the period of remission.

Primary Substance Abuse or Dependence Diagnosis: ATR client diagnosis (from ATR dataset) based on DSM-IV criteria. An ATR client who has a maladaptive pattern of substance use leading to clinically significant impairment or distress, occurring within a 12-month period.

Primary Sustained Full Remission Diagnosis: ATR client diagnosis (from ATR dataset) based on DSM-IV criteria. An ATR client who is past 12 months of a dependence diagnosis and has not relapsed, whom has not met any criteria for dependence or abuse during the period of remission.

Primary Sustained Partial Remission Diagnosis: ATR client diagnosis (from ATR dataset) based on DSM-IV criteria. An ATR client who is past 12 months of a dependence diagnosis and has not relapsed, whom has met at least one criteria for dependence or abuse during the period of remission.

Program Manager: individual that manages a tribal behavioral health agency.

REDCap: secure web database used for collection and management of client quantitative data, including contact information and demographics.

Residential Treatment: service where clients were inpatient and received intensive SUD services for an extended period of time. Clients often entered these services right after detox.

Service Provider: individual that provides direct services to clients as part of their SUD treatment at a tribal behavioral health agency. Service providers include therapists, case managers, counselors, cultural advisors, and probation officers.

Smudging: traditional indigenous practice of purifying or cleansing the soul of negativity using sacred herbs.

Snowball Sampling: recruitment technique where participants are asked to help identify other potential participants.

Social Detox: described as being a practice where clients attempt detox without medical supports.

Southern/Central Michigan: for this assessment, defined as tribes located south of the Mason County to Arenac County line.

Spirituality: traditional indigenous spiritual beliefs and practices.

SAMSHA: Substance Abuse and Mental Health Services Administration.

SUD: Substance Use Disorder.

Sweat Lodges: traditional indigenous practice of entering heated dome-shaped structures to promote healthy living.

Telepsychology: mental health services provided over the phone or via video conferencing.

Thematic Codebook: list of code names and definitions used in qualitative analysis.

Traditional and Cultural Services: services grounded in indigenous traditional and cultural beliefs o and practices. Services include language classes, traditional healers, pow wows, cultural education, and sweat lodges.

Traditional Ceremonies: traditional indigenous practices conducted by traditional healers that are an essential part of indigenous healing and focus on healing the body and spirit.

Traditional Healers: indigenous individual that uses traditional practices, including ceremonies, to heal the body and spirit of tribal members using substances.

Transitional Services: services that focus on helping clients readjust to living and maintaining sobriety in their environment. Services include transitional housing, sober living activities, and case management.

Upper Peninsula: for this assessment, defined as tribes located above the Mackinaw Bridge in Michigan.

Wellbriety: indigenous peer support movement focused on culturally based healing and support from substance use and intergenerational trauma

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