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CHEROKEE NATION®

Cherokee Nation Behavioral Health Recovery Oriented System of Care

Juli R. Skinner

Ashley Lincoln

Coleman Cox

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u li s ge di de tsa da ye lv se s di

“Treat each other’s existence as being sacred or important”

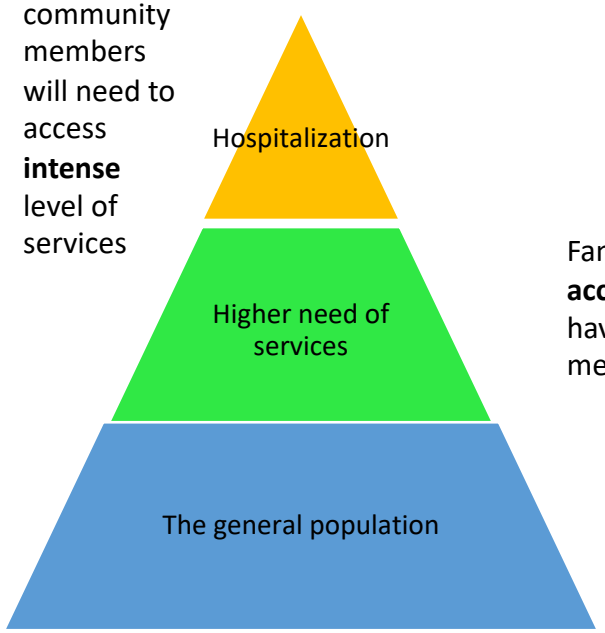
Goals of Presentation

- Understanding Cherokee Nation’s Recovery-Orientated System of Care
- Knowledge of Cherokee Nation’s integrative approach to MAT service delivery
- Cultural Considerations
- Managing treatment expectations for patients and providers
- Harm Reduction Services

Behavioral Health-Levels of Work

- Macro
  - Cabinet on Children and Families
  - Policy Development
  - Building Pipelines- Workforce Capacity (partnering with Universities, etc…)
  - Development & Testing of EB interventions in tribal communities
- Mezzo
  - Integration of Behavioral Health into Primary Care through system wide screenings and policy
  - Community Organizing/Mobilization (Youth MOVE, Action Teams, Coalitions)
  - Integration into school systems
  - EB parenting curriculums (Collaborative Problem Solving, Circles of Security, TBRI)
  - Increased Screenings/Assessments (Social, Emotional, Developmental)
  - Workforce Development with Indian Child Welfare, Early Education Settings, OT, etc..
  - Self-Care
- Micro
  - Clinical Services – MAT, Psychiatry and Therapy (TF-CBT, PCIT, etc… 0-21)
  - Infant mental health
  - Two generation interventions
  - Family Care Management & Peer Support

Only a **small** number of community members will need to access **intense** level of services



Families are more likely to **access** services when they have an understanding of mental health

By increasing community knowledge of mental health families are able to support on another and **recognize** mental health concerns


Cherokee Nation Behavioral Health Services
Psychiatry Adult & Children
Jack Brown Center
MAT
Crisis response team
Adult Therapy
Child Therapy
Prevention Programs
Research & Evaluation
Inpatient (contract services)
Syringe Exchange

Cherokee Nation Recovery-Oriented System of Care

Prevention & Early Intervention Services
Level 0

Prevention and Early intervention services including education and harm reduction services for individuals with more serious substance misuse, intervention in these settings can serve as a mechanism to engage them into treatment.

Locations: Clinics & NEW CENTER

Outpatient Services
Level 1

A professionally delivered treatment modality providing daily to weekly attendance at facility, typically requiring 9 hrs of service/week for adults and 6 hrs for adolescents, allowing patient to return home or to other living arrangements during non-clinical hours.

Locations: Clinics & NEW CENTER

Intensive Outpatient & Partial Hospitalization
Level 2

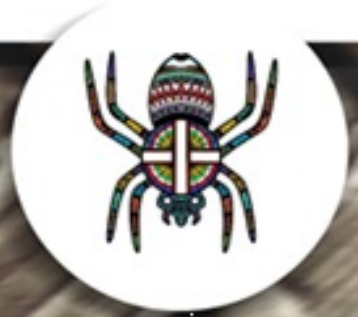
A professionally delivered treatment modality providing daily to weekly attendance at facility, typically requiring 9 to 20 hrs or more of service/week, allowing patient to return home or to other living arrangements during non-clinical hours.

Locations: Clinics & NEW CENTER

Clinically Managed Low to High Intensity Residential Services
Level 3

A professionally delivered treatment modality providing 24 hr living support and programmatic structure with available trained personnel, clinical and co-occurring disorder services, and stabilization for patients in imminent danger.

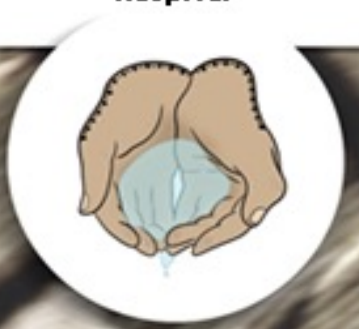
Locations: NEW CENTER



Medically Managed Intensive Inpatient Services
Level 4

A professionally delivered treatment modality providing 24 hr nursing care and medical staff with daily physician care and counseling available for patients suffering from severe instability and imminent danger.

Locations: W.W. Hastings Hospital



Background of CN MAT Services

- Received Tribal Opioid Response Grant in 2018
- Began treating patients in summer of 2019
- Created Opioid Workgroup with CN departments

Participating Departments	Milestones
Cherokee Nation Public Health Behavioral Health Health Services Grants Management Health System Administration Tribal Attorney General's Office Prevention Recovery *…along with guests from different areas of our communities and tribal services*	Provider Recruitment Partnered Media Campaigns Safe Syringe Program Research Clinical Guidelines Patient Orientation Handbook Open dialogue between departments


Psychiatry Adult & Children
Jack Brown Center
MAT
Crisis response team
Adult Therapy
Child Therapy
Prevention Programs
Research & Evaluation
Inpatient (contract services)
Syringe Service Program
Cherokee Nation Behavioral Health Services

Levels of Integrated Care

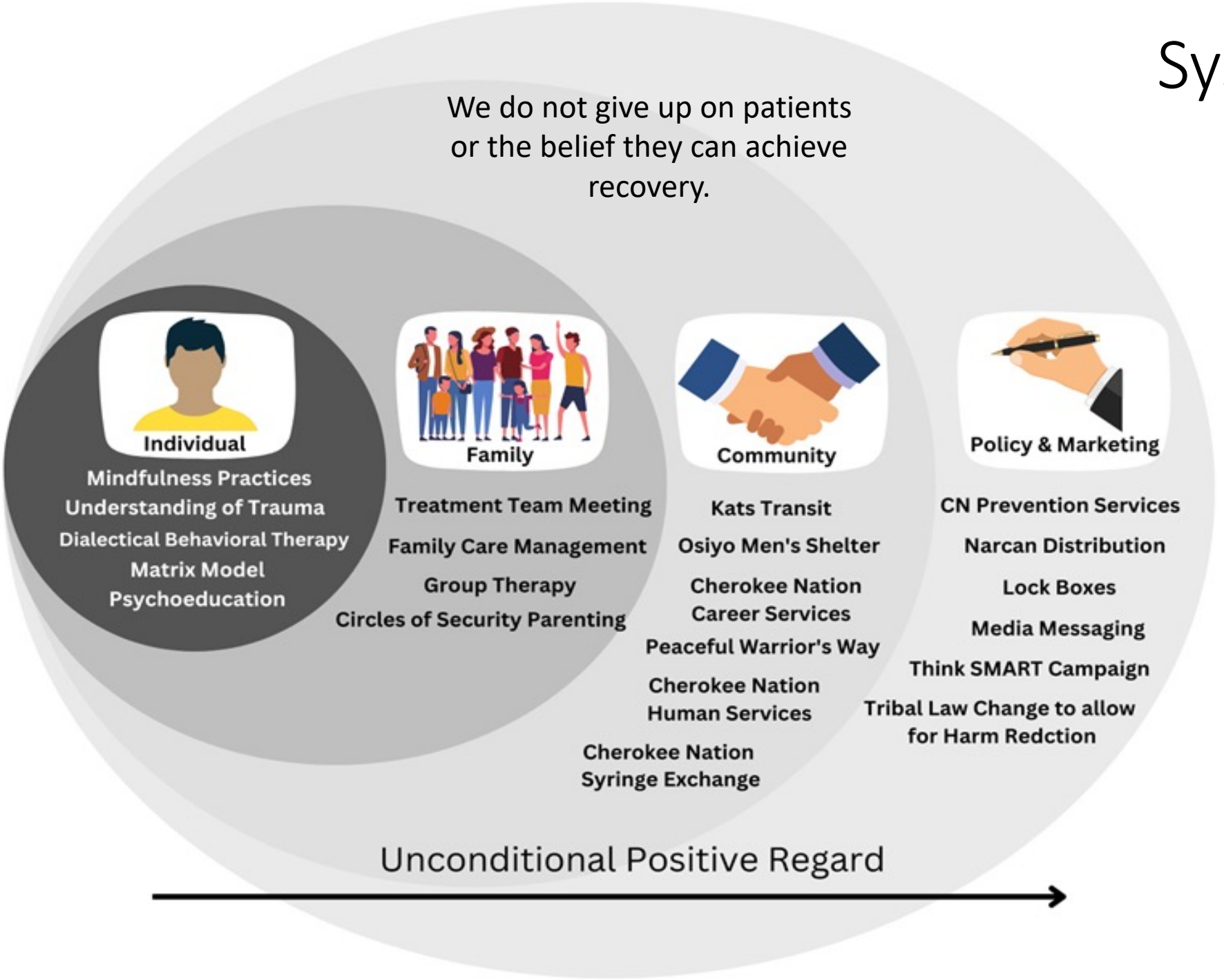
- **Level One: Minimal Collaboration**
  - Mental health and other health care professionals work in separate facilities, have separate systems, and rarely communicate about cases.
- **Level Two: Basic Collaboration At a Distance**
  - Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. All communication is driven by specific patient issues. Mental health and other health professionals view each other as resources, but they operate in their own worlds, have little sharing of responsibility and little understanding of each other's cultures, and there is little sharing of power and responsibility
- **Level Three: Basic Collaboration On-Site**
  - Mental health and other health care professionals have separate systems but share the same facility. They engage in regular communication about shared patients, mostly through phone or letters, but occasionally meet face to face because of their close proximity.
- **Level Four: Close Collaboration In a Partly Integrated System**
  - Mental health and other health care professionals share the same sites and have some systems in common, such as scheduling or charting. There are regular face-to-face interactions about patients, mutual consultation, coordinated treatment plans for difficult cases, and a basic understanding and appreciation for each other's roles and cultures.
- **Level Five: Close Collaboration In a Fully Integrated System** 
  - Mental health and other health care professionals share the same sites, the same vision, and the same systems in a seamless web of biopsychosocial services. Both the providers and the patients have the same expectation of a team offering prevention and treatment.

http://www.ibhpartners.org/background/levels-of-integrated-behavioral-health-care/

Clinical Interventions

- Buprenorphine/naloxone strips, Buprenorphine extended-release, Natrexone
- Cultural Groups
- Peer lead groups (PWW)
- Family Care Management
- Parenting Support
- Holistic Care

Systems Approach to MAT Service Delivery



MAT Treatment Teams

Dr. Miller

Clinic Administrator

APRN

LPN

Licensed Behavioral Health Provider

Family Care Manager

APRN

LPN

Licensed Behavioral Health Provider

Family Care Manager

APRN

LPN

Licensed Behavioral Health Provider

Family Care Manager

RN Case Manager

Special Projects Officer

Health Registration Specialist

Health Registration Specialist

New Patient Process

- Patients meet with Family Care Manger first visit to complete paperwork before induction.
- During their visit with their provider they are introduced to their LBHP who does a check-in and screener.
- Patient is scheduled to complete collaborative assessment with LBHP before next appointment with provider.
- Patient is required to attend group and/or individual sessions with assigned LBHP
- If patient is struggling in the program a team meeting may be called with patients assigned treatment team and their identified supports.

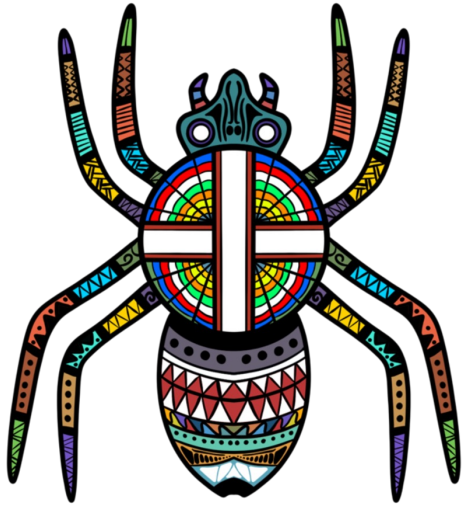
There are 5 different levels of treatment within the MAT Outpatient program. The length of time in each level is at the discretion of your Treatment team. This amount will be less if you become employed while in the program or are employed upon entry. Please note: **NO CHILDREN ARE ALLOWED AT GROUP.**

1) **First Steps (Daksi "Turtle")** group is for clients new to the program. Clients are required to have an assessment and treatment plan completed. This is one of the bravest decisions to make and will require hard work and commitment. Just like the turtle, slow and steady is the pace. We are here to help you along this journey of recovery. This is to be completed within two weeks of induction date.

   In this step you will be expected to attend an Orientation meeting, meet your Treatment Team, and do the following:

   a. No missed appointments
   b. Complete urine drug screen
   c. Actively participate in group
   d. Follow your dosing schedule set by your provider
   e. Meet with your Behavioral Health Provider
   f. Complete required paperwork with Family Care Manager

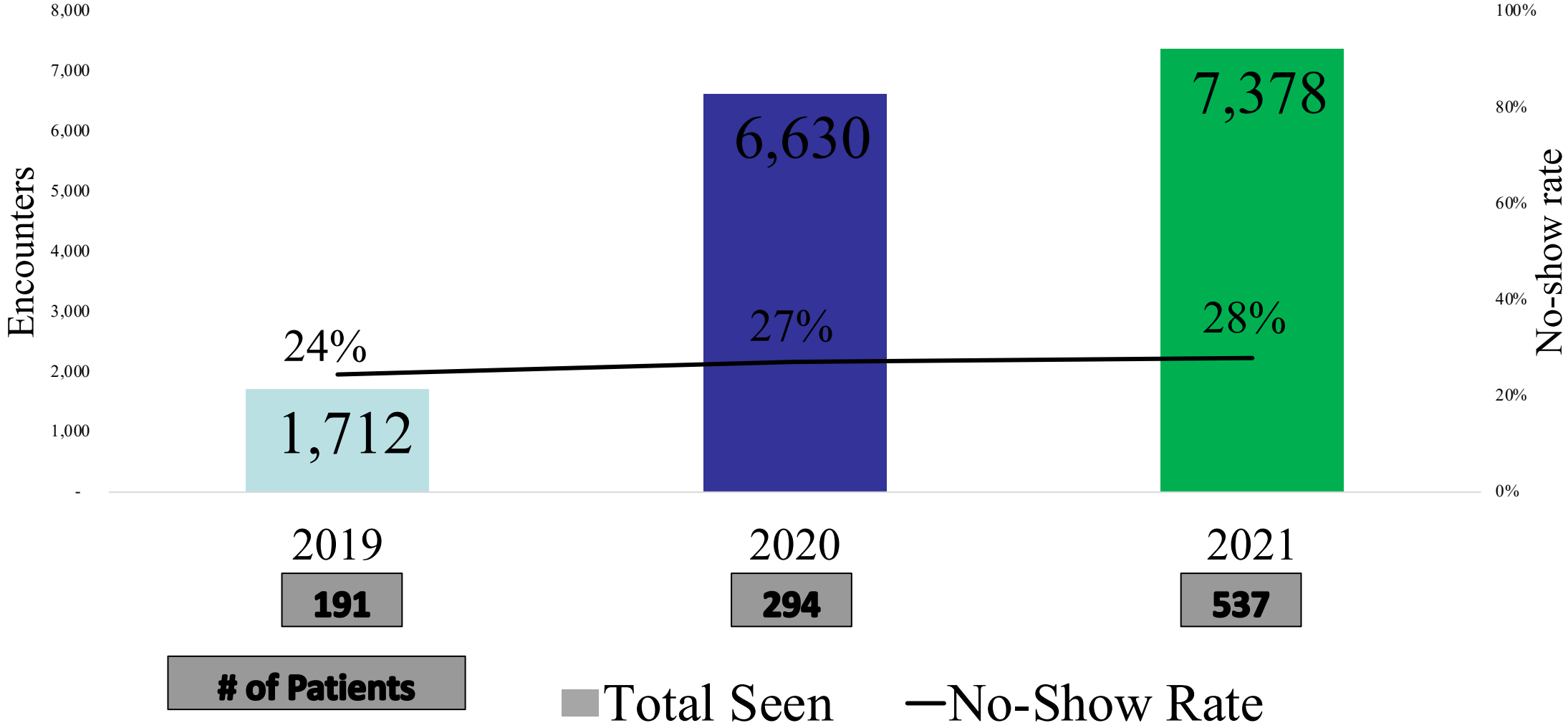
1) **Early Recovery (Kahnanesgi "Spider")** The spider represents creativity and is often believed to connect the past to the future. In the Cherokee culture, the spider is the weaver of life. You are on a journey to a new life of recovery! It is important to acknowledge and process your past to move forward. Months 1-3. To accomplish this step, you must do the following:



a. No missed appointments or call in advance if needing to reschedule
b. Complete urine drug screen upon request by provider
c. Have three BH contacts a week. This can include interactions with your Family Care Manager, meeting with PRSS, group attendance, meeting with BH provider, or attendance to an outside support group.
d. Follow your dosing schedule set by your provider
e. May be asked to do random strip count

* You will graduate this step when you complete 24 BH contacts

Total Patients Encounters and No-Show Rate by Year



*Currently we are tracking another 229 inactive patients through follow-up contacts to ensure they know how to re-engage services when or if needed.

Duration of Therapy

- There is no standard of care for duration of therapy
- Patients have an expectation that treatment will end
- Patients wanting to end treatment will be made aware of their options.
- Tapering on buprenorphine is a very slow process and requires close medical oversight.

Cherokee Nation Approach to Harm Reduction

- MAT Clinic
- Syringe Service Program
- Provide basic hygiene items
- Hep C Testing
- Narcan 4mg vs Kloxxado 8mg
- Safe Sex Resources
- Education around consumption (i.e. using the buddy system when using substances)
- Fentanyl Test Strips
- Harm reduction kits given in MAT Clinic and UC/ER.

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Case Presentation

Case Presentation- Jane Doe 57 yo

Substance Use History

	Details
Caffeine	x
Nicotine	x
Alcohol	
Cannabis/Spice	
Methamphetamine	x
MDMA	
Heroin	
Opiates	x
Hallucinogens	
Inhalants	
Benzodiazepines	x
OTHER:	

Current Medications:

- Sublocade
- Buprenorphine-naloxone Films
- Gabapentin
- Naloxone
- Aspirin
- Buspirone
- Diclofenac topical
- Lisinopril
- Atorvastatin
- Ibuprofen
- Ergocalciferol

Medical Comorbidities:

- Generalized anxiety disorder
- PTSD
- Major depressive disorder
- Vitamin D deficiency

Depression:

- ☑ Insomnia/Hypersomnia
- ☐ Diminished Interest
- ☑ Worthlessness/Guilt
- ☑ Loss of Energy
- ☐ Diminished concentration
- ☐ Significant Weight Loss
- ☐ Psychomotor Agitation/Retardation
- ☐ Suicidal Ideation/Thoughts of Death

Mania:

- ☐ Distractibility
- ☐ Indiscretion (dangerous activities)
- ☐ Grandiosity
- ☐ Flight of Ideas
- ☐ Activity Increase
- ☐ Decreased Need for Sleep
- ☐ Talkativeness

Anxiety:

- ☑ Trauma
- ☐ Hypervigilance
- ☐ Increased Startle
- ☐ Avoidance
- ☑ Negative Cognitions
- ☐ Excessive Worry
- ☐ Panic Attacks
- ☐ Obsessions
- ☐ Compulsions

Psychosis:

- ☐ Delusions
- ☐ Hallucinations
- ☐ Auditory/Visual/Tactile
- ☐ Disorganized Behavior

Jane Doe

- Pt ID a Hx. Of substance use beginning at the age of 29, and using “a line of meth“ at that time. She discussed using substance 7 days per week beginning at the age of 31, and using “Lortabs“. She ID taking substances in larger amounts and for longer periods than she meant to. She ID wanting to cut down or stop using the substance but unable to on numerous occasions since usage onset.
- Pt. ID spending a lot of time getting, using, or recovering from her substance use. In addition, she ID continued cravings and urges to use the substance as well as continuing to use even when it causes problems with her functioning including but not limited to: (home, relationships, jobs, legal, health (mental and physical). She ID needing more of the substance to get the effect she desired (increased tolerance). Furthermore, she ID the development of withdrawal symptoms, which can only be relieved by taking more of the substance/other substances. She reported that she has not been to inpatient treatment and or detox due to substance use.
- Pt reported a Hx of trauma (PTSD) including domestic violence. She ID that when her children were young her children's father kidnapped her in a house for apprx. a week, injecting her with methamphetamine while being held against her will. She was tied up during this traumatic experience.
- She presented to clinic limping and with a black eye and several wounds stating she was recently assaulted. Pt has recently started monthly sublocade injection.

Case Presentation- John Doe 25 yo

Substance Use History

	Details
Caffeine	x
Nicotine	x
Alcohol	x
Cannabis/Spice	x
Methamphetamine	x
MDMA	x
Heroin	x
Opiates	x
Hallucinogens	
Inhalants	
Benzodiazepines	x
OTHER:	

Current Medications:

- Buprenoprphine-naloxone
- Prazosin
- Trazodone
- Naloxone

Medical Comorbidities:

- PTSD
- Stimulant Use Disorder
- Opioid Use Disorder
- Depression
- Bipolar Disorder

Depression:

- ☑ Insomnia/Hypersomnia
- ☑ Diminished Interest
- ☑ Worthlessness/Guilt
- ☑ Loss of Energy
- ☐ Diminished concentration
- ☐ Significant Weight Loss
- ☐ Psychomotor Agitation/Retardation
- ☑ Suicidal Ideation/Thoughts of Death

Mania:

- ☑ Distractibility
- ☐ Indiscretion (dangerous activities)
- ☐ Grandiosity
- ☑ Flight of Ideas
- ☐ Activity Increase
- ☐ Decreased Need for Sleep
- ☑ Talkativeness

Anxiety:

- ☑ Trauma
- ☐ Hypervigilance
- ☐ Increased Startle
- ☐ Avoidance
- ☐ Negative Cognitions
- ☑ Excessive Worry
- ☐ Panic Attacks
- ☑ Obsessions
- ☑ Compulsions

Psychosis:

- ☐ Delusions
- ☐ Hallucinations
- ☐ Auditory/Visual/Tactile
- ☐ Disorganized Behavior

John Doe

- Began use at the age of 10.
- Pt ID Hx of IV heroin and meth use and as the main substance(s) of use in his life. Pt ID using this substance on a regular basis for approximately 10 years.
- Pt has been to inpatient treatment and/or counseling for his substance use approx 4 times. He is currently being seen in MAT for OUD.
- Pt ID substance use has impacted his functioning in life "Its caused so many ups and downs throughout the day with my mind, and now I deal with a lot of trauma, and its hard to have people around me anymore".
- Pt ID a family Hx on both his mother/fathers sides with Substance use and Psychiatric issues.
- He ID a Hx. Of A/V hallucinations and paranoia. Pt has episodic problems with depression and suicidal thoughts. Currently no suicidal ideations.

Case Presentation- Jason Doe 34 yo

Substance Use History

	Details
Caffeine	x
Nicotine	x
Alcohol	x
Cannabis/Spice	x
Methamphetamine	x
MDMA	x
Heroin	x
Opiates	x
Hallucinogens	
Inhalants	
Benzodiazepines	x
OTHER:	

Current Medications:

- Buprenorphine-naloxone
- Naloxone
- Paliperidone
- Risperidone
- Lisinopril
- Gabapentin
- Prazosin
- Albuterol

Medical Comorbidities:

- Hypertension
- Hep C
- Opioid Use Disorder
- PTSD
- Schizoaffective psychosis
- Stimulant Use Disorder

Depression:

- ☑ Insomnia/Hypersomnia
- ☐ Diminished Interest
- ☑ Worthlessness/Guilt
- ☑ Loss of Energy
- ☐ Diminished concentration
- ☐ Significant Weight Loss
- ☐ Psychomotor Agitation/Retardation
- ☑ Suicidal Ideation/Thoughts of Death

Mania:

- ☐ Distractibility
- ☑ Indiscretion (dangerous activities)
- ☑ Grandiosity
- ☑ Flight of Ideas
- ☐ Activity Increase
- ☑ Decreased Need for Sleep
- ☑ Talkativeness

Anxiety:

- ☑ Trauma
- ☐ Hypervigilance
- ☐ Increased Startle
- ☐ Avoidance
- ☐ Negative Cognitions
- ☐ Excessive Worry
- ☐ Panic Attacks
- ☑ Obsessions
- ☑ Compulsions

Psychosis:

- ☐ Delusions
- ☑ Hallucinations
- ☑ Auditory/Visual/Tactile
- ☐ Disorganized Behavior

Jason Doe

- Pt has a history of psychiatric problems including A/V hallucinations, paranoia, Suicidal Ideations/ attempts, Homicidal Ideations, and aggressive behaviors.
- He has a Hx. of domestic violence towards his siblings as well as a recent assault charge.
- Pt has been flagged by hospital/clinic due to his violent verbal and physical behaviors towards staff, and requires supervision from hospital security while at the clinic/hospital.
- Pt has a history of Alcohol, Meth, and Heroin use. Pt has attempted to present to treatment, but became verbally violent/threatening and/or went AWOL before intake.
- He has a Hx. of legal issues due to substance use and/or his psychiatric issues. Pt reported PTSD from being in prison in the past. In addition, Pt has been to several psychiatric hospitals for psych stabilization.
- He has a Diagnoses Hx including PTSD, Schizoaffective Psychosis, and Schizophrenia.

Case Presentation- Jacob Doe 24 yo

Substance Use History

	Details
Caffeine	x
Nicotine	x
Alcohol	x
Cannabis/Spice	x
Methamphetamine	x
MDMA	
Heroin	
Opiates	x
Hallucinogens	
Inhalants	
Benzodiazepines	x
OTHER:	

Current Medications:

- Sublocade
- fluoxetine
- Gabapentin
- Hydroxyzine
- Levothyroxine
- Buprenorphine tab
- Quetiapine
- Ergocalciferol
- Rizatriptan
- Naloxone

Medical Comorbidities:

- Hypothryoidism
- Major depression disorder
- Nicotine use disorder
- Obesity
- Generalized Anxiety Disorder
- Hypertension
- Vitamin D deficiency
- Elevated liver function

Depression:

- ☑ Insomnia/Hypersomnia
- ☑ Diminished Interest
- ☑ Worthlessness/Guilt
- ☑ Loss of Energy
- ☐ Diminished concentration
- ☐ Significant Weight Loss
- ☐ Psychomotor Agitation/Retardation
- ☐ Suicidal Ideation/Thoughts of Death

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- ☐ Increased Startle
- ☐ Avoidance
- ☐ Negative Cognitions
- ☑ Excessive Worry
- ☐ Panic Attacks
- ☑ Obsessions
- ☑ Compulsions

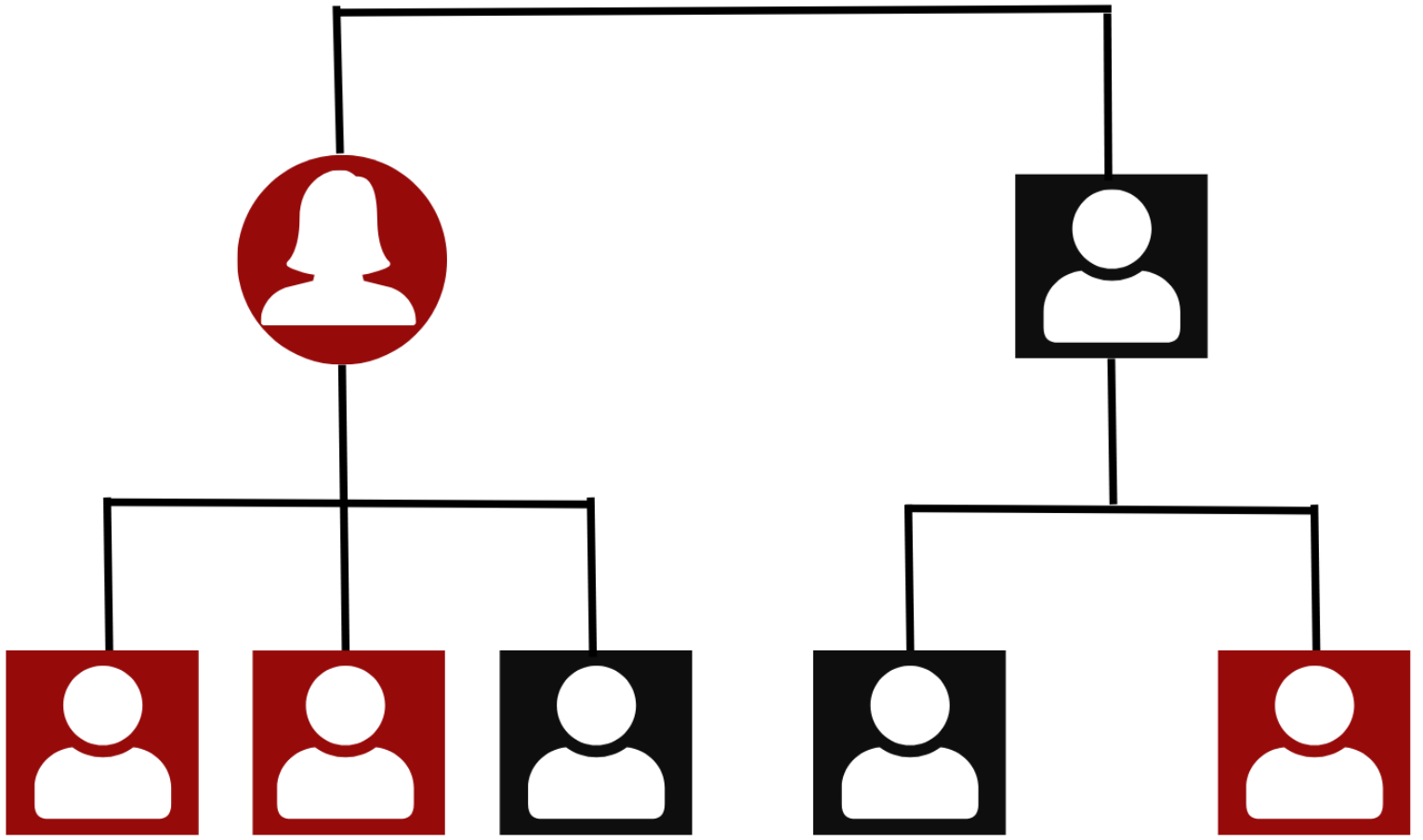
Psychosis:

- ☐ Delusions
- ☐ Hallucinations
- ☐ Auditory/Visual/Tactile
- ☑ Disorganized Behavior

Jacob Doe

- PT ID a Hx. Of substance use beginning at the age of 13. He ID using substances 7 days per week at the age of 17: He ID a Hx of Heroin/opiates, Cocaine, Meth, LSD, Cannabis, Alcohol, and Benzos use. He ID his drug of choice as "heroin".
- Pt reported that he has been to inpatient treatment 2x and Detox on 3 occasions for opiate use.
- Pt reported a HX. of anxiousness and worrying that has occurred for the last six months . He ID worrying about several things including "people out to get me or something is going to happen". Pt ID not being able to manage his worrying ID feelings of being unsettled, irritable, tension in their muscles, and becoming tired quickly. He ID having difficulty with his sleep, including waking up, being able to fall asleep and not feeling refreshed after a night of sleep.
- Pt ID a HX of Depression beginning at the age of 13 including w/mood most of the day, nearly every day. He ID of diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. He ID experiencing fatigue or loss of energy nearly every day. In addition, he reported Feelings of worthlessness or excessive or inappropriate guilt.
- Pt has faced several legal issues including possession of Heroin with intent to distribute.
- Pt started sublocade with suboxone to help manage cravings. He is currently working as a Peer Recovery Specialist and states he feels he is at a good place in his recovery.

Family System and Addiction



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de tsa da tli yv se s di

(Struggle to hold onto one another)

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CHEROKEE NATION®

Harm Reduction

State of Affairs: Poisoned Drug Market

What is Fentanyl?

Synthetic Opioid. 50-100x stronger than Morphine. Highly Addictive and short acting. 2mg = few grains= lethal dose.

- Emerging Analogues: much stronger MME.
- LE interdiction is vital but very difficult
- Counterfeit pills mimic known Rx drugs.
- Fentanyl Test Strips (FTS) are not 100% accurate, especially with meth. Positive results do not tell fentanyl strength or mg.
- Withdrawal can be life threatening.

Photo by DEA

Emerging Threat: Nitazenes

Nitazenes, aka "ISO" or Benzo Dope

- 20-100x More potent than fentanyl.
- Often contains benzodiazepine, rendering Naloxone ineffective on its own.
- Often combined with fentanyl which needs Lots of naloxone to reverse overdose.
- BUT medical evidence shows that overuse of naloxone can exacerbate complications to health without prompt medical attention.
- Naloxone induced cardiopulmonary edema, aka " Dry Drowning"
- Don't Stop giving Naloxone! Give it, call 911, state the victim is "unresponsive."
- Follow 911 instructions for Rescue Breathing.

Emerging Threat: Xylazine

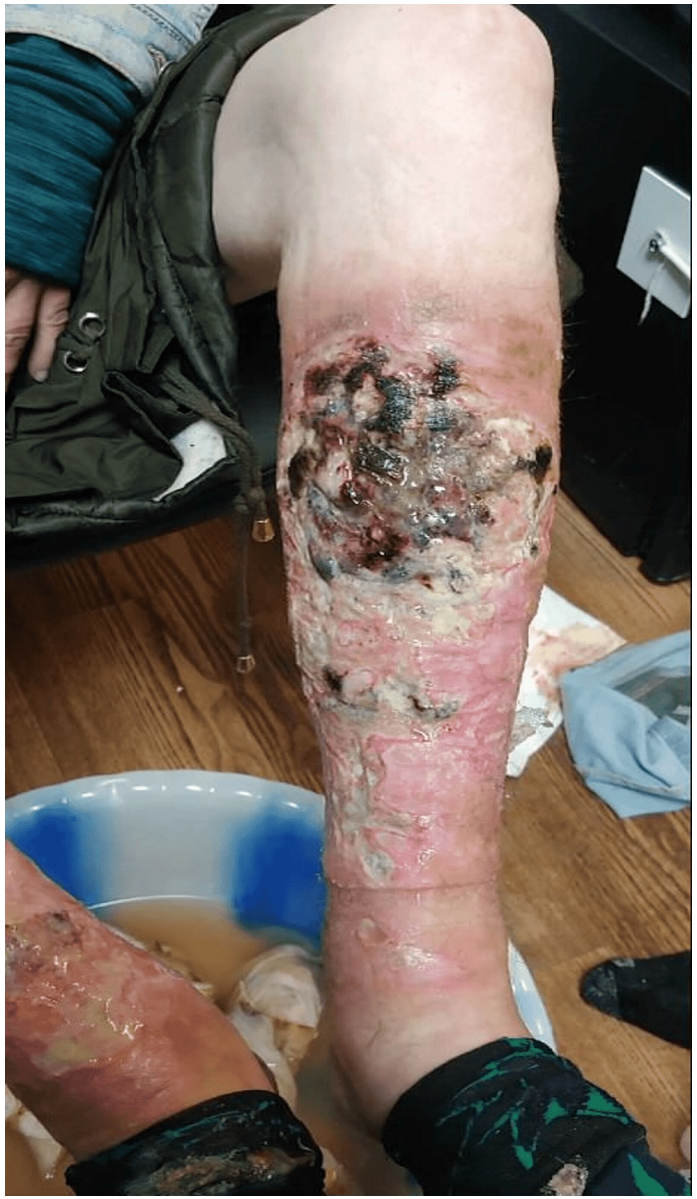
aka “TRANQ” and “Zombie Dope”

- Veterinarian tranquilizer for large animals. Trials deemed Toxic to Humans.
- **Non- narcotic, non-opioid** analgesic and sedative
- Alpha 2 Agonist activates pain blocking receptors but also a CNS depressant like Opioids
- Results in breathing difficulties, very low blood pressure.
- Naloxone ineffective on its own. Do Rescue Breathing plus oxygen PLUS naloxone.

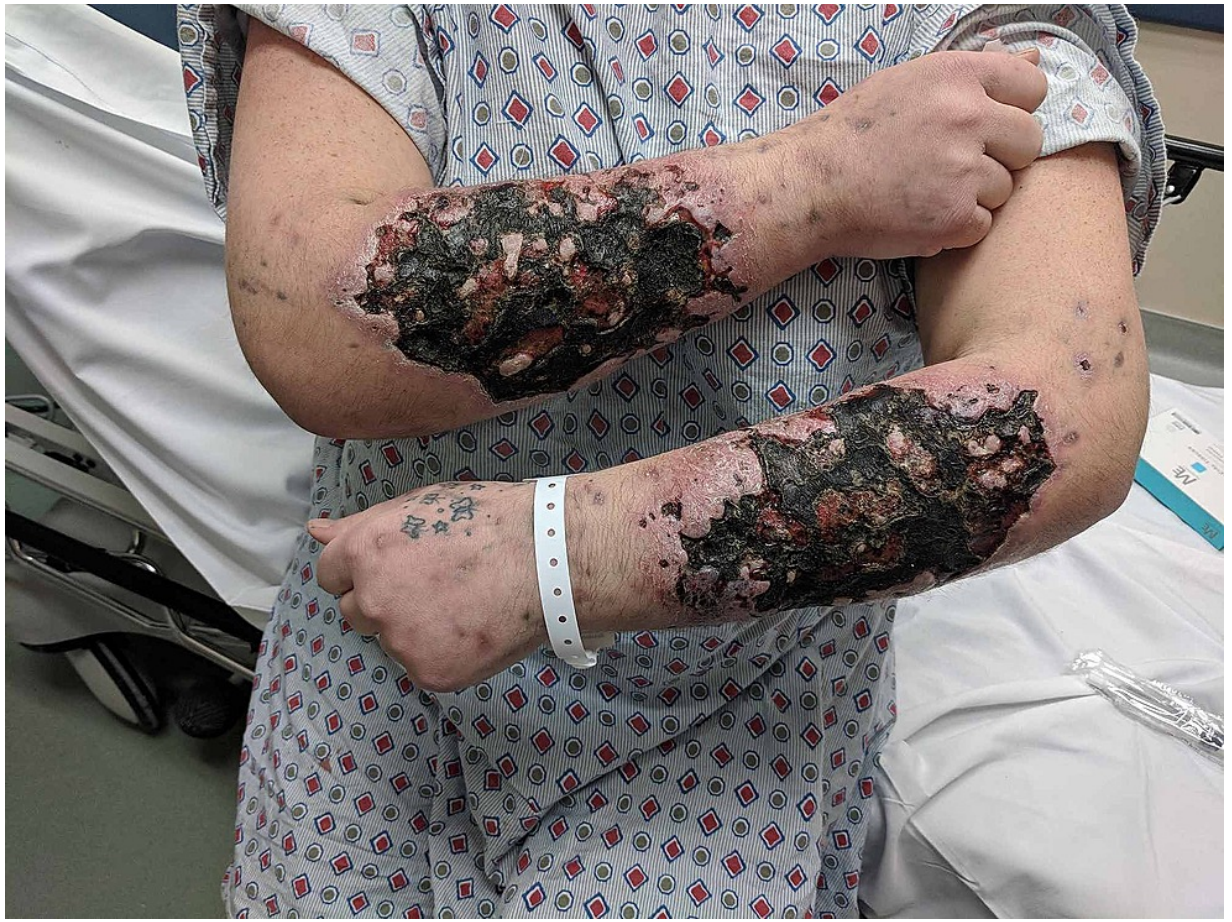
Why is Xylazine Used in the Street Market?

- Xylazine provides a nostalgic high
- Extremely concentrated product
- Potentiator
- Reduces cardio related side affects
- Less Mortality concerns than fentanyl

DIRE Warning from HIDTA Agent about Powdered Xylazine.



Xylazine-induced Necrosis



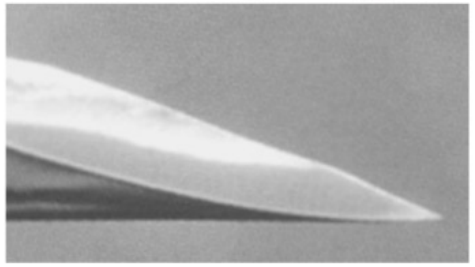
Houck J, Ganti L (May 30, 2019) A Local Epidemic of Laced Heroin Causing Skin Necrosis. Cureus 11(5): e4782. doi:10.7759/cureus.4782

HARM REDUCTION:

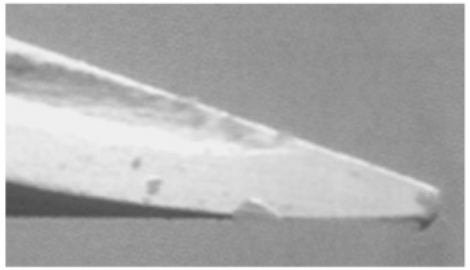
Theory to Application

Weighing the Costs

New Syringe



After 1 Use



6 Uses

5 = Average Uses Reported Per Syringe [4]

1 Endocarditis

~$50,000 per episode [6]

1 HIV+

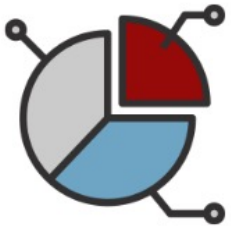
$384,000 over a lifetime [5]

OR

1 New

~$0.17 per syringe [7]

People Who Misuse  = **40x** **more likely to end up using heroin**[1]

30 years research findings  = SSP's are safe, effective, cost-saving, do not increase illegal drug use or crime, and reduce the spread of viral hepatitis and HIV.[2]

What HR Looks Like

- More than sterile syringes for active drug users.
- Its a movement to support the rights of all peoples to receive equitable healthcare.
- Prioritizes wellbeing over abstinence
- Tools to reduce risk of harm to self and/or others.

We can ALL practice Harm Reduction

Harm Reduction at Cherokee Nation

Phase 1

- Draft Policies and Procedures
- Needle Exchange and Disposal
- First Aid/ Wound Care Supplies
- Safer Use Education
- Sexual Health Resources
- Overdose Prevention Tools
- Male and Female Hygiene Kits

Phase 2

- HIV & HCV Testing
- Linkages to Other Services Lines
- First Aid/Woundcare Provided Onsite

Supplies include overdose reversal kits (including Narcan, CPR face shields, vinyl gloves, and quick reference guides), fentanyl test kits (including test strips, sterile water, instructions for testing), sharps containers, sterile syringes alcohol swabs, hand sanitizer and disinfectant wipes, sexual health supplies.

Outreach Worker, April, building hygiene kits in our Care Corner.

PRSS, Kevin (right) training new staff on safer injection national best practices.

Mobile Outreach Program

- Goal 1: Reach people who would otherwise not access Healthcare services.
- Goal 2: Provide overdose prevention tools, syringe services, and program referrals.

Considerations for Program Outreach

- **Connect to other services:** Primary Care/ MAT Clinic and UC/ER HR Kits and referrals.
- **Naloxone and Beyond:** IM naloxone vs. nasal Narcan 4mg vs nasal Kloxxado 8mg. Lanyard Pulse oximeters and Rescue Breaths/ O2 masks
- **Drug Checking/Scanning:** Gives consumer street level data on drug supply
- **Emerging threat alerts and community education:** ODMAP bad batch alerts/toxic drug contamination alerts. Proper FTS techniques with Meth or xylazine.
- **Empower People who Use Drugs** to take your knowledge and resources to the places they can go that you cannot. Payment for Secondary Exchangers, volunteers/ advisory boards, and needle brigades.

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