

Department of Health and Human Services
**OFFICE OF
INSPECTOR GENERAL**

**INDIAN HEALTH SERVICE
YOUTH ALCOHOL AND
SUBSTANCE ABUSE PROGRAMS**



Richard P. Kusserow
INSPECTOR GENERAL

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OEI-07-89-00940

EXECUTIVE SUMMARY

PURPOSE

The objective of this inspection was to determine the extent to which the Indian Health Service (IHS) has implemented youth alcohol and substance abuse programs funded under Public Law 99-570.

BACKGROUND

Over the past two decades, American Indians have recognized the importance of treating their alcohol abuse problems, and national attention has been provided to address the situation. Reasons attributing to this concern include an alcoholism related death rate of over four times the age adjusted rates for the U.S. population, and an admission rate of 34 percent to alcohol and drug abuse programs for Indians who are under 25 years of age. For Indians under 35 years of age, this statistic increases to almost 70 percent.

In the late 1960's, the Office of Economic Opportunity funded outreach and treatment programs. The National Institute on Alcohol Abuse and Alcoholism (NIAAA), established in the 1970's, provided seed monies for treatment of alcohol abuse among the Indians. In the Indian Health Care Improvement Act of 1976 (Public Law 94-437), Congress directed that NIAAA programs be transferred to IHS jurisdiction.

On October 27, 1986, Congress enacted Public Law 99-570, subtitled the "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986." In the first three years of Public Law 99-570, approximately \$50 million in recurring funds and \$19 million in nonrecurring funds were appropriated for youth alcohol and substance abuse programs.

METHODOLOGY

To secure the information needed to examine operations and activities regarding Public Law 99-570, data collection instruments were mailed to the 11 IHS area offices. An analysis of the information was conducted to determine to what extent each area office had implemented the provisions of Public Law 99-570. To verify data received, three IHS area offices were selected for on-site visits. On-site visits were also made to the two regional treatment centers which were operational at the time of our study. Administrative and program staff were interviewed to determine the level of operations that the centers had achieved.

FINDINGS

- The IHS Headquarters has not completed IHS alcoholism treatment standards.
- The IHS Headquarters has failed to meet quality assurance objectives.
- The current IHS management information system is outmoded and ineffective to monitor alcohol program activity.
- The IHS has failed to comply with requirements in Public Law 99-570 to establish regional treatment centers in all IHS service areas.
- Nearly two-thirds of alcoholism counselors in the IHS are not certified.
- The Bureau of Indian Affairs has not established emergency shelters as required by Public Law 99-570.
- Evidence of inappropriate use of funds has been referred to the OIG Office of Audit Services.

RECOMMENDATIONS

- The IHS should complete and promulgate operating standards.
- The IHS Headquarters and area offices should conduct reviews in accordance with their own quality assurance goals.
- The IHS should establish a process to review all area office program reports and provide feedback to the area offices.
- The IHS should develop an adequate management information system which provides data on alcohol and substance abuse treatment.
- The IHS should establish regional treatment centers in every IHS service area, or advise Congress of their recommendation for an alternative strategy to provide residential services.
- The IHS should ensure that all alcoholism counselors become certified.
- The IHS should work with the Bureau of Indian Affairs to secure the release of funds which have been appropriated for emergency shelters and halfway houses.

COMMENTS

We received comments to the draft of this report from the Public Health Service (PHS). The PHS concurred with all the recommendations. However, PHS comments state that successful implementation of the last two recommendations cannot be assured because those two areas are not solely within IHS's control.

We agree that programs of the Bureau of Indian Affairs are not under PHS's direct control. However, we believe the IHS should continue coordination efforts with the Bureau of Indian Affairs in order to assure the timely construction and operation of emergency shelters and halfway houses.

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INTRODUCTION

PURPOSE

This inspection was undertaken to determine the extent to which the Indian Health Service (IHS) has implemented provisions for youth alcohol and substance abuse programs funded under Public Law 99-570.

BACKGROUND

The problem of alcoholism among American Indians has existed for many years. Over the past two decades, however, Native Americans have recognized the importance of treating their alcohol abuse problems. Reasons attributing to this concern include an alcoholism related death rate of over four times the age adjusted rates for the U.S. population, and an admission rate of almost 34 percent to alcohol and drug abuse programs for Indians who are under 25 years of age. For Indians under 35 years of age, this statistic increases to almost 70 percent.

National attention began to focus on the problem of alcohol abuse among American Indians in the late 1960's when the Office of Economic Opportunity (OEO) provided funding for outreach and treatment in Indian communities. The National Institute on Alcohol Abuse and Alcoholism (NIAAA), which was established in the 1970's, provided seed monies for treatment of alcohol abuse among the Indians. The NIAAA funded the OEO-supported programs and also provided start-up or special funding for additional demonstration projects. The NIAAA monies were not meant for long-term funding, therefore, Congress created the Indian Health Care Improvement Act of 1976 (Public Law 94-437), directing that NIAAA programs be transferred to IHS jurisdiction. There was a gradual transfer of these programs between 1978 and 1981.

Most of the grants were converted to contracts, the majority of which were called "638 contracts" in line with Public Law 93-638, the Indian Self-Determination and Education Assistance Act. The Self-Determination law, which was reauthorized in October 1988 as Public Law 100-472, is currently in effect and represents a substantial component of the award process. The Self-Determination law allows the IHS to contract directly with Indian tribes for operation of their own service programs. The IHS awards and monitors these programs through its 11 area offices.

On October 27, 1986, Congress enacted Public Law 99-570, the "Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986." In addition to regular appropriations, this Act authorized substantial funds for both IHS and the Bureau of Indian Affairs (BIA) for alcohol and substance abuse services to the Indian youth population.

On November 18, 1988, Congress reauthorized and amended Public Law 99-570. Specifically, the law authorized appropriations to the Secretary of Health and Human Services for funding to implement an Indian Health Service Youth Program. Under this program, the Secretary, acting

through IHS, was to establish an alcohol and substance abuse program for Indian youth that included the following activities:

- Development and implementation of a program for detoxification and treatment for Indian youth who are alcohol and substance abusers. This was to include regional treatment centers designed to provide detoxification and rehabilitation for both sexes on a referral basis. These regional treatment centers are to be integrated with the intake and the rehabilitation programs that exist in the Indian communities.
- Renovation or construction of a youth regional treatment center in each area under the jurisdiction of an IHS area office. For the purpose of constructing or renovating these regional treatment centers, \$6,000,000 was authorized for the fiscal year 1989 and \$3,000,000 was authorized to be appropriated for fiscal years 1990 and 1991.

Also, for the purpose of staffing and operating such centers, \$3,000,000 was authorized for fiscal year 1989 and \$11,000,000 for fiscal year 1990. For future fiscal years, there will be an amount equal to fiscal year 1990 included in the base budget of the IHS.

- Cooperation with the BIA in developing and implementing community-based rehabilitation and follow-up services for Indian youth who are alcohol or substance abusers. These services are to be designed to integrate long-term treatment and to monitor and support the Indian youth after their return to their home communities.
- Inclusion of family members of the youth in the treatment programs or other services.

METHODOLOGY

The 11 IHS area offices were the primary source of information for this review. Office staff directly involved with or knowledgeable of the various inspection topics were asked to complete data collection instruments designed to secure the information needed to examine operations and activities. The questions included in the data collection instruments addressed various topics, including guidelines and procedures, programs and services, regional treatment centers, financial accountability, operational monitoring, and the IHS management information system.

An analysis of the information was conducted to determine to what extent each area office had implemented the provisions of Public Law 99-570. To verify data received, three IHS area offices were selected for on-site visits.

On-site visits were also made to the two regional treatment centers which were operational at the time of our study. Administrative and program staff were interviewed to determine the level of operation that the centers had achieved.

FINDINGS

The IHS Headquarters has not completed IHS alcoholism treatment standards.

The Public Law 99-570 was passed in October 1986, and the IHS Alcohol and Substance Abuse Programs branch issued draft standards in February 1988. These standards were revised in September 1988 and, as of July 1990, were still in draft. The three offices we visited indicated that failure to finalize the guidelines created operational problems. For example, staff at one area office said that they feel no compulsion to follow the IHS draft alcoholism standards because they are not in final and IHS Headquarters, based on past experience, will not enforce them. Employees at a second area office said that little direction and lack of approved standards caused gaps in treatment services and weakened IHS Headquarters' credibility on alcoholism. The third area office visited developed its own alcoholism standards, based in part on IHS's draft standards. This area office follows these guidelines, in addition to aftercare program guidelines, which were developed by area office staff.

According to the three area offices, the IHS Headquarters has provided very little guidance to IHS area offices in development and implementation of Public Law 99-570 programs. The IHS Headquarters has not provided enough technical assistance to the area offices nor do they have enough hands-on knowledge of the day-to-day operations at the area offices, according to the area office interviewees.

The IHS Headquarters has failed to meet quality assurance objectives.

- The IHS Headquarters did not conduct reviews of area offices every two years.

According to IHS Headquarters directives, the IHS Alcohol and Substance Abuse Programs branch is to review area offices once every two years. Although IHS reviewed six area offices in 1988, only one area office was reviewed in 1989. Four area offices have not had a formal quality assurance review from the IHS Alcohol and Substance Programs branch in the last two years.

Because of lack of guidance and approved standards, area office staff are uncertain about the appropriateness of funding decisions made for certain activities. For example, within one area office's service area, at least two activities appeared to be inappropriately funded under the youth alcoholism programs. One was a "Sober Rodeo" in which participants and the audience were banned from bringing alcohol onto the premises, and the other was an elaborate renovation of a camping site in which substance-free lifestyles were only a small part of the campout's agenda. Area office staff doubted the validity of these alcoholism treatment programs, stating that they now question whether this was an appropriate utilization of Public Law 99-570 funds.

- Area offices did not conduct reviews of tribal programs in accordance with their own goals.

The IHS draft alcoholism standards indicate that periodic quality assurance reviews should be conducted. To check the extent to which quality assurance reviews monitored the programs, a copy of each quality assurance review conducted in calendar year 1989 by area office staff was requested. An analysis of these reviews revealed that each area office performed the reviews in their own manner with their own evaluation instrument.

All IHS area offices had different quality assurance objectives. We found variance between these objectives and the number of reviews actually conducted. Eight of eleven area offices had established their own goals for annual reviews of all their treatment programs. Two area offices had a goal for every other year reviews, while another area office attempted reviews twice annually. Only one area had successfully met their goal.

- The IHS did not make effective use of information obtained in the reviews which they did conduct.

Many common weaknesses were noted among the numerous treatment programs in the area office review reports. Several tribal alcoholism programs did not have established policies or procedures, nor did they follow the IHS draft alcoholism standards. According to many of the reviews, the forms comprising the management information system (the Alcohol Treatment Guidance System) were not being filled out or were not completely filled out. Case file organization was a serious problem among several tribal alcoholism programs. Also, treatment plans were often incomplete and unclear.

The IHS area office reviews mentioned that few of the alcoholism counselors were certified. Some reviews said that sporadic counseling among treatment providers created gaps in services, and that some youth were not receiving enough periodic individual or group counseling (e.g., P.L. 99-570 youth counselors were being used at a few treatment sites to provide counseling to clients in the adult residential treatment program, resulting in less time available to spend with the youth). A positive factor noted in the reviews is that cogent recommendations were almost always given, as well as follow-up site visits being scheduled if problems were discovered.

In discussion with staff from three area offices, we found that the area office program review reports are not requested by nor submitted to IHS Headquarters. There is apparently no process in place for IHS Headquarters to utilize information from the area office program review reports to provide feedback to all the area offices on common program deficiencies.

The current IHS management information system is outmoded and ineffective to monitor alcohol program activity.

Data submitted from the 11 area offices indicated that the Alcohol Treatment Guidance System served its purpose in the past, but has not been updated to fully serve current program management needs. The area office staff interviewed said that they did not trust the data

produced by the management information system. Among the weaknesses pointed out, all area offices raised questions about the accuracy, reliability, and efficiency of the management information system. A few offices also expressed concerns about the outdated mode of entering information into the system (i.e., keypunching). They felt that there are numerous errors associated with this type of process creating a lack of trust in this system.

While the OIG is aware that the IHS has been developing a new management information system over the last five years to track data on alcohol and substance abuse treatment, the system has yet to be implemented. The review team has learned that full implementation of the system at all area offices will not occur until 1995.

The IHS has not complied with requirements in Public Law 99-570 to establish regional treatment centers in all IHS service areas.

Public Law 99-570 provides for the construction or renovation of a youth regional treatment center (RTC) in each of the 11 IHS service areas. While presently six RTC's are reported operational by IHS, only two were operational at the time of the study. The two RTC's were the New Sunrise Regional Treatment Center in Acoma, New Mexico and the Jack Brown Center in Tahlequah, Oklahoma. In those areas where an RTC is not operational, the area offices indicated that residential treatment is generally purchased from commercial programs using P.L. 99-570 funds.

Problems were cited as reasons for noncompliance with the law. These include historical animosities among tribes causing an unwillingness to come to a consensus on the location of a facility, the purchase of comparable treatment services from the private sector, and the failure to find a suitable facility which would serve as a treatment center.

Disagreement exists among some IHS components over the efficacy of RTC's. One area office prefers to use only commercially purchased treatment. Two area offices felt that one regional treatment center per area office region is insufficient. These two offices said more RTC's are necessary to deal with the diversity of tribes and because of geographical limitations.

In one area with an IHS-operated RTC, the average cost of treatment of a youth was approximately \$20,000. In contrast, the average cost of residential treatment in a commercial program was approximately \$6,300 per individual. This is primarily due to the fact that the average stay in the IHS-operated RTC is considerably longer than the commercial programs. We recognize that there may be a difference in kinds and qualities of services. Also, according to IHS officials, the RTC deals with many cultural needs and issues that are not addressed by commercial programs.

The second regional treatment center, which was a tribally-operated facility, had provided treatment for 53 youth between the ages of 13 and 18. The average cost of treatment was about \$14,150 per youth for 122 days of inpatient treatment at \$116 a day. Discussions held with area office staff indicated that the concept of the RTC could be very successful as long as provisions are made to address multiple diagnostic issues, and to include family involvement as part of residential treatment. They also indicated that this is not always part of the treatment process in

a commercial program. In addition to the RTC, however, they noted that referral agencies such as Alcoholics Anonymous should be utilized in an effort to unite community resources in the development of aftercare teams to maintain progression made by youth and their families in treatment.

Nearly two-thirds of alcoholism counselors in the IHS are not certified.

The IHS draft operating standards, which are the only operating rules currently in existence, require counselors who provide treatment services through IHS-funded programs to be certified as substance abuse counselors. Information provided by most of the area offices indicated that they rely on the State's rules to determine counselor certification requirements.

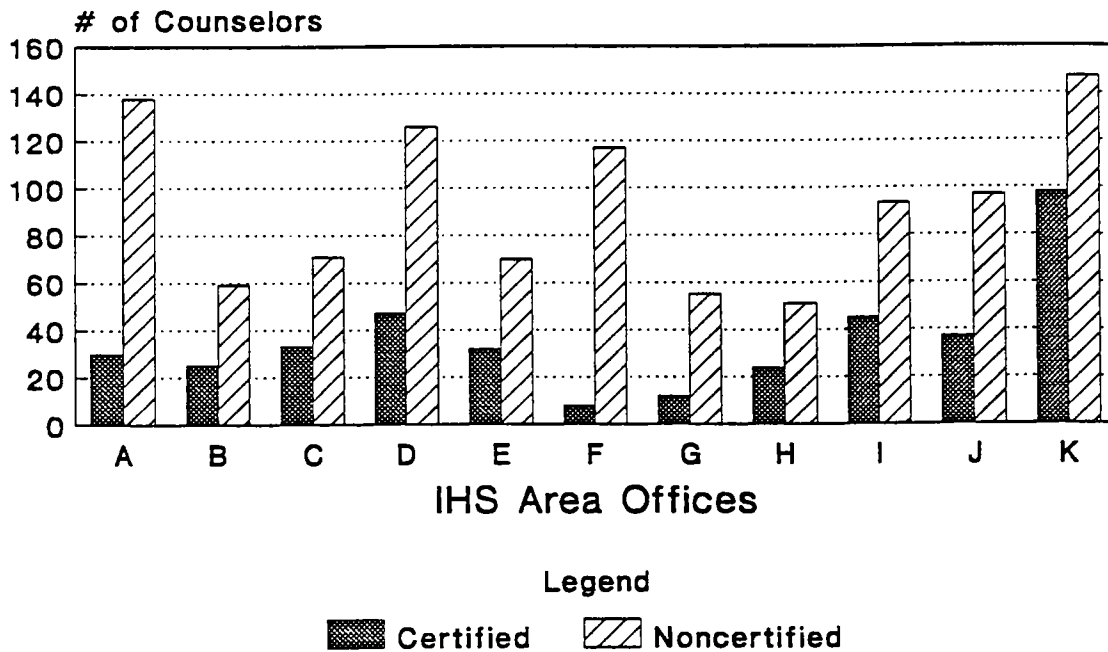
The IHS draft alcoholism standards lists three classifications of counselors and counselor interns. The intern must be in a course leading towards certification; the first level counselor shall be certified but not necessarily have any practical experience; and the second level counselor must be certified as a substance abuse counselor and have two years counseling experience in a substance abuse program or counseling agency. One year of this counseling experience must have been with youths with alcoholism/substance abuse problems and must have provided an opportunity to demonstrate knowledge of counseling theory, techniques, and practices specific to Indian youth.

The draft alcoholism standards do not provide a time frame for certification of all IHS counselors. At one area office site which we visited, the OIG review team was told that by the end of a counselor's first year, that individual had to be certified or working toward eventual certification. The IHS employee admitted that by using this criteria any counselor could fall into the latter category, which was labeled "certifiable." A recovering alcoholic would fit into this category. It was explained to us that this is how IHS retains its non-qualified and largely uncertified counseling staff.

As of spring 1990, approximately 62 percent of all counselors were uncertified. According to area office staff interviewed, the primary reason for this high figure is that the individuals simply could not pass the certification examination. In addition, those who do pass the exam frequently leave for more lucrative positions.

One area office site visited decided not to retain its uncertified staff. Alcoholism counselors were given three opportunities to pass the certification examination. Within one service unit in this Area, all alcoholism counselors "flunked" the certification exam 3 times, and were dismissed by the area director. The area office indicated that this manner of "getting tough" is resulting in higher competence among treatment staff and better-quality treatment programs. The following graph displays the number of certified and uncertified counselors by area offices.

Alcoholism Counselors By IHS Area Office



The Bureau of Indian Affairs has not established emergency shelters as required by Public Law 99-570.

Public Law 99-570 provides for the establishment of emergency shelters or halfway houses by the Bureau of Indian Affairs for Indian youth who are alcohol or substance abusers, including youth who have been arrested for offenses directly or indirectly related to alcohol or substance abuse. Regarding the latter, the law stipulates that when an Indian youth is arrested for an alcoholism related offense and parental custody is not possible, "...such youth shall be referred to such facility in lieu of incarceration..."

In addition to a referral facility for youth who are arrested for alcohol related offenses, emergency shelters and halfway houses also provide an alcohol-free environment for youth who have undergone residential treatment for alcoholism or substance abuse and cannot return to their community immediately.

At the time of the review, only one emergency shelter and no halfway houses had been established. Through September 1990, \$8 million has been appropriated for construction of emergency shelters for fiscal years 1987-90, but approximately \$5 million has been actually distributed. Also, although \$12 million was authorized for operation and staffing of emergency shelters for fiscal years 1987-90, only \$1 million was actually appropriated, with \$926,000 actually distributed in fiscal year 1990.

Regional treatment center and area office staff who were interviewed said that the lack of these transitional living centers results in a high incidence of relapse, and severely limits the impact of dollars spent on residential treatment. They indicated that the absence of these facilities also prevents youth who have received residential treatment from returning to an alcohol- and drug-free environment after discharge. Therefore, youth are forced to return to the same setting which may have initially contributed to their alcohol or substance abuse.

Evidence of inappropriate use of funds has been referred to the OIG Office of Audit Services.

Our inspection included a review of documentation and interviews with IHS employees. Based on information obtained in our review, we have made a referral of a possible misappropriation of P.L. 99-570 funds to the OIG Office of Audit Services for a financial audit.

RECOMMENDATIONS

The IHS should complete and promulgate operating standards.

The IHS should act expeditiously to finalize the existing draft operating standards for youth alcohol and substance abuse programs. Approved operating standards would enable the area offices to reference specific guidelines in implementing and monitoring requirements of Public Law 99-570.

The IHS Headquarters and area offices should conduct reviews in accordance with their own quality assurance goals.

The IHS Headquarters and IHS area offices should come to a consensus as to what is needed by way of program performance reviews and commit the appropriate resources to accomplish this. Protocols should be reviewed and modified to assure the most appropriate timing and content of reviews and make up of review teams.

The IHS should establish a process to review all area office program reports and provide feedback to the area offices.

The IHS Headquarters should establish a process to review all area office program review reports to identify common program weaknesses and systematically communicate them to the area offices. This would permit IHS Headquarters to specify areas of program priorities, needs, or deficiencies for area office follow up.

The IHS should develop an adequate management information system which provides data on alcohol and substance abuse treatment.

It is imperative that the IHS complete, as soon as possible, a comprehensive management information system which can appropriately distinguish between and follow all clients participating in the alcoholism programs, and the extent and nature of services that were received. The management information system should be fully developed to handle youth alcoholism program data and modern treatment methodologies.

We also recommend that the new system provide a capability for tribal input and access. This would provide timely information at the tribal level to follow clients and conduct composite analyses on the tribal caseload.

The IHS should establish regional treatment centers in every IHS service area, or advise Congress of their recommendation for an alternative strategy to provide residential services.

The IHS should increase efforts to see that service areas without a regional treatment center establish such a facility as mandated by Public Law 99-570. As some service areas have encountered barriers in attempting to establish regional treatment centers, the IHS should

coordinate with the area offices to address the problems that hinder timely establishment of regional treatment centers.

Since some disagreement exists among area office constituents over the efficacy of regional treatment centers, the IHS should formally assess the regional treatment center issue and advise Congress of their recommendation on any new strategies.

The IHS should ensure that all alcoholism counselors become certified.

The IHS should ensure that all alcoholism counselors are certified, as required by the IHS draft operating standards. If the alcohol and substance abuse treatment of Indian youth is to be effective, qualified counselors area of primary importance. Area offices should do everything possible to promote certification of and professionalism among alcoholism counselors.

The IHS should work with the Bureau of Indian Affairs to assure the timely construction and operation of emergency shelters and halfway houses.

Since treatment of the adolescent abuser often requires alcohol- and drug-free transitional living quarters, the effectiveness of the residential treatment programs is impaired when there are no emergency shelters or halfway houses.

Without transitional living centers, youth must return to an environment which may have precipitated the problem. Considerable time has elapsed since the appropriation of these funds, and it is imperative that IHS enhance efforts to see that establishment of these facilities takes place.

To ensure effective utilization of these facilities when established, provisions should be developed for adequate and timely monitoring of these facilities.

We recommend that the IHS reexamine the Memorandum of Agreement with the Bureau of Indian Affairs (BIA) to establish a management framework for the staffing and operation of emergency shelters and halfway houses that results in an effective coordination of resources and programs of IHS and BIA components. A modification of the March 1987 Memorandum of Agreement may be necessary in order for treatment goals to be met.

AGENCY COMMENTS

The Public Health Service (PHS) concurred with all the recommendations in the OIG draft report. However, PHS stated that successful implementation of the last two recommendations cannot be assured because those two areas are not solely within IHS's control.

We agree that programs of the Bureau of Indian Affairs are not directly under PHS's control. However, we believe the IHS should continue coordination efforts with the Bureau of Indian Affairs (BIA) in order to assure timely construction and operation of emergency shelters and halfway houses. In a recent contact with BIA staff, we were advised that the construction of emergency shelters and halfway houses would slip from the present schedule to a completion date in fiscal year 1992.

While agreeing to emphasize the importance of having all counselors certified, PHS believes that a more realistic and practical goal is to certify 80 percent of counselors by 1991, and then retain that level. We agree that such a program would be responsive to our recommendation.

APPENDIX A

PUBLIC HEALTH SERVICE COMMENTS



Memorandum

Date . JAN 24 1991

From Assistant Secretary for Health

Subject PHS Comments on Office of Inspector General Draft Report, "Indian Health Service (IHS) Youth Alcohol and Substance Abuse Programs"

To Inspector General, OS

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 OFFICE OF INSPECTOR GENERAL

Attached are the PHS comments on the findings and recommendations contained in the subject draft report. Though we concur with all of the recommendations, the following comments explain why successful implementation of the last two recommendations is not solely within IHS' control.

First, since IHS is outside the certification process, and because there is wide variance in the certification process among the States, there are legitimate reasons that restrict IHS from ensuring continuous certification of all alcoholism counselors employed in Indian alcohol programs. Second, though IHS has a positive working relationship with staff in the Bureau of Indian Affairs (BIA), Department of Interior, the eventual construction of emergency shelters and halfway houses using BIA appropriated funds is not under IHS control.

James O. Mason
 James O. Mason, M.D., Dr.P.H.

Attachment

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PUBLIC HEALTH SERVICE (PHS) COMMENTS ON OFFICE OF INSPECTOR
GENERAL (OIG) DRAFT REPORT "INDIAN HEALTH SERVICE YOUTH ALCOHOL
AND SUBSTANCE ABUSE PROGRAMS," OEI-07-89-00940

OIG Recommendation

We recommend that the Indian Health Service (IHS):

1. Complete and promulgate operating standards for youth alcohol and substance abuse programs.

PHS Comment

We concur. On August 20, 1990, the operating standards were submitted to the IHS Division of Management Policy for approval. It is expected that the standards will be approved by the end of March 1991. Upon approval of the standards, instructions will be developed and sent to the 12 IHS Area Alcoholism/Substance Abuse Coordinators for implementation in their area within one month of the approval of the standards. Monthly follow-up calls will be placed to each IHS Area Coordinator to check on the progress in implementing the operating procedures. Full implementation of the standards should be completed by the end of fiscal year (FY) 1991. Summary reports on the progress of implementation will be submitted to the Associate Director, Office of Health Programs (OHP), IHS, on a monthly basis.

OIG Recommendation

2. Headquarters and Area Offices conduct reviews in accordance with their own quality assurance goals.

PHS Comment

We concur. A renewed emphasis has been initiated to improve quality assurance site reviews in each of the 12 IHS Areas. On December 6, 1990, the IHS Area Alcoholism/Substance Abuse Coordinators, IHS Headquarters Alcoholism and Substance Abuse Program Branch (ASAPB) staff, and tribal representatives formed a workgroup to implement a plan for reviewing Area Office alcoholism programs using a newly revised protocol. The workgroup will finalize the review protocol by the end of February 1991. A schedule naming the sites to be reviewed and the dates of the review will be completed and distributed to each Area Office by the end of March 1991. In the interim, review teams consisting of IHS employees, tribal representatives, and alcoholism staff will be formed and, beginning in May 1991, these teams will be sent to each Area to review these programs. A report on the findings and recommendations of the reviews will be completed by October 1991.

Monthly follow-up reports summarizing the progress of reviews will be submitted to the IHS Area Directors; Associate Director, OHP; and Area Alcoholism/Substance Abuse Coordinators beginning in January 1992.

OIG Recommendation

3. Establish a process to review all Area Office program reports and provide feedback to the Area Offices.

PHS Comment

We concur. On December 6, 1990, an IHS/tribal workgroup to provide oversight for this activity was established. The workgroup will establish a process and format for reporting data concerning program administration by February 1991. The proposed format will be presented to the Area Alcoholism/Substance Abuse Coordinators for their review, comment and approval at their next meeting scheduled for March 1991. Area Coordinators will be trained on this process in order to have it implemented in all Areas by the end of April 1991. Follow-up training on the use of the process will be provided to all Area Coordinators to ensure uniform implementation by the end of May 1991.

OIG Recommendation

4. Develop an adequate management information system which provides data on alcohol and substance abuse treatment.

PHS Comment

We concur. In December 1990 a workgroup was formed to establish a workplan for revising the activities for the modification of the Alcoholism Treatment Guidance System. This workplan was developed and presented to Area Alcoholism/Substance Abuse Coordinators and tribal representatives. Area Coordinators were provided copies of the implementation plan and were asked to submit a corresponding Chemical Dependency Management Information System (CDMIS) for their Area by January 31, 1991. The Area CDMIS implementation plans will be consolidated into a master CDMIS plan. The Beta testing of CDMIS in selected Areas will be completed in August 1991, and full-scale implementation of CDMIS in all Areas will begin in the first quarter of FY 1992. Summary reports on the status of the progress of the CDMIS activity will be submitted to the Associate Director, OHP; Area Directors; and Area Alcoholism/Substance Abuse Coordinators on a monthly basis beginning January 1992.

OIG Recommendation

5. Establish regional treatment centers (RTCs) in every IHS service area or advise Congress of their recommendation for an alternative strategy to provide residential services.

PHS Comment

We concur. The ASAPB Medical Advisor and the Alcoholism Program Specialist are responsible for managing this activity. The Medical Advisor will direct those activities related to programming and treatment contained in the RTCs. The Alcoholism Program Specialist monitors issues related to meeting the legal requirements for construction of RTCs under Public Law (P.L.) 99-570.

In December 1990, a workgroup comprised of the Directors of existing RTCs was appointed to develop guidance programming and treatment services in newly constructed or proposed RTCs, and to identify common problems during the construction phase of RTCs. A report on the workplan will be completed at the first meeting of this workgroup scheduled for January 28, 1991. A matrix which graphically depicts the planning, construction and coordination phases for completing the construction of RTCs will be developed by this workgroup by the end of March 1991.

ASAPB has developed, in conjunction with the Office of the General Counsel, a policy that specifies the conditions in which IHS will construct RTCs. It is expected that this policy will be approved for implementation by the end of March 1991.

Beginning in January 1991, a monthly consolidated report will be prepared to address the completion of all RTCs currently in the planning and development phase and to report on problems from programs now serving clients. The reports will be submitted to the Area Directors, Area Alcoholism/Substance Abuse Coordinators, and the Associate Director, OHP.

OIG Recommendation

6. Ensure that all alcoholism counselors become certified.

PHS Comment

We concur with the intent of this recommendation. However, there are legitimate reasons that restrict IHS from ensuring continuous certification of all alcoholism counselors employed in Indian alcoholism programs. The IHS is outside the certification process and must rely upon existing certification or credentialing entities. There is wide variance in the

certification process among States who have such mechanisms, as well as among national credentialing bodies. Some States require counselors to take one year of non-paid, supervised employment in State certified agencies to become certified. IHS cannot require tribes to comply with such a requirement. To do so, would result in no service delivery in some tribal communities.

IHS can, however, ensure an emphasis be established on the 100 percent certification of certifiable counselors. An IHS/tribal workgroup was formed in December 1990 to assist in developing the mechanism for certifying alcoholism counselors. The first meeting of this workgroup is scheduled for January 1991, and it is expected that work on the project will be completed by the end of April 1991. IHS' goal is to certify 80 percent of all alcoholism counselors employed in alcohol programs under contract to IHS by the end of 1991 and to maintain the 80 percent certification rate.

A plan for certifying alcoholism counselors was developed in each IHS Area and implemented in 1988. Since 1988, P.L. 99-570 training funds have been allocated to each Area for the purposes of preparing alcoholism counselors to meet certification requirements and for providing continuing education to certified counselors. IHS' Headquarters ASAPB staff will provide technical assistance to the Area Alcoholism/Substance Abuse Programs to enhance training endeavors through consultation with treatment programs such as Hazelden, the Betty Ford Center, and the Commission on the Accreditation of Rehabilitation Facilities. Headquarters consultation to the Areas has been provided on a monthly basis.

A monthly progress report on the certification activities will be submitted to the Area Directors, the Area Alcoholism/Substance Abuse Coordinators, and the Associate Director, OHP.

OIG Recommendation

7. Work with the Bureau of Indian Affairs (BIA), Department of Interior, to secure the release of funds that have been appropriated for emergency shelters and halfway houses.

PHS Comment

We concur. In September 1990, the Assistant Secretary, BIA, appointed a director of the Alcoholism and Substance Abuse Program for that agency. Since this appointment, staff from IHS' ASAPB have held three meetings with this new director.

We have been informed that funds were released to the Division of Social Services, BIA, for distribution to tribes for construction of emergency shelters in 1989. Of the 20 grant awards, six tribal groups have completed construction and these emergency shelters are operational. Construction of the remaining 14 shelters is expected to be completed by the end of FY 1991.