



The Substance Abuse and Mental Health Services Administration (SAMHSA)  
American Indian/Alaska Native Addiction Technology Transfer Center (AI/AN ATTC)

# ***Moving from Information Sharing to Action Plan: 2019 Update***





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## PREFACE

The United States has faced an ongoing opioid epidemic for several years, and native populations have been disproportionately affected. Native populations suffer from a higher rate of opioid-related deaths, though this is not well known outside of native communities. Opioid use disorder (OUD) has devastated native communities, causing tragic deaths, broken families and public safety emergencies. Native communities and substance use disorder (SUD) treatment providers have an additional challenge to face: effectively implementing western evidence-based treatment approaches, including medication assisted treatment (MAT) for OUD.

This report is based on a meeting the ATTC conducted in 2012 that sought to address the growing misuse of prescription drugs and develop a framework for addressing the needs of native communities in concrete ways.

Historically, the ATTC has been helping native behavioral health providers adopt evidence-based best practices in their SUD treatment programs since 1993. We seek to disseminate the best, most recent SUD information to providers while acknowledging its limits and adapt evidence-based practices to fit the needs of native communities.

It is often easier to focus on the deficits in a community struggling with opioid addiction than to focus on the positives. However, our intention with our TA initiatives is to focus on the strengths and assist in reducing the challenges in implementing MAT and evidence-based practices, disseminate information about OUD, and promote the tribal communities' efforts in developing prevention of OUD in their communities. The good news is that we are seeing a slight decrease of OUD and OUD-related deaths. We know that there are treatments that can effectively heal patients with OUD and save lives. Addiction is treatable and recovery is possible.

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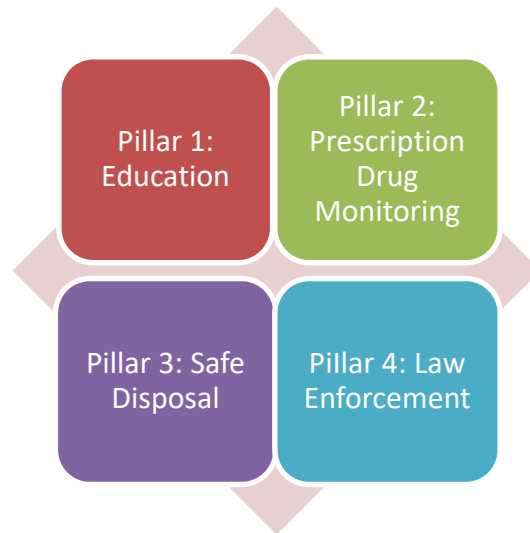




## INTRODUCTION

This report provides an update on the progress and challenges experienced by some American Indian (AI) and Alaska Native (AN) communities affected by prescription drug use since a June 29, 2012 summit identified a responsive course of action. The 2012 *Prescription Drug Meeting: Moving From Information Sharing to Action Plan Development* summit was convened by Jeffrey Coady, PsyD, the Substance Abuse and Mental Health Services Administration (SAMHSA) Region 5 Director at that time, in response to tribal leaders who expressed concerns about an increase in the misuse of prescription drugs in AI/AN communities. Participants included tribal leaders and representatives from the Health Resources and Services Administration, SAMHSA, area Indian Health Service (IHS) providers, behavioral health directors, and representatives of two Addiction Technology Transfer Centers (ATTCs).

At the 2012 summit, tribal leaders expressed concerns about opioid overdose, including accidental poisoning. They spoke about the importance of going beyond education to developing an action plan with concrete steps to tackle the problems of prescription drug abuse in tribal communities and the need to include elders in this process as partners in planning and implementing opioid misuse action plans. Participants stressed the appropriate use of medication in the holistic approach followed by tribal physicians and the hope that tribal physicians will integrate cultural values into their care of tribal members, at both tribal treatment agencies and urban Indian treatment programs. Summit participants organized the prescription drug epidemic issues into four “pillars” of a comprehensive public health action plan to combat prescription drug diversion and abuse (see graphic at right). During the summit, presentations were delivered on each of the four pillars and were accompanied by energetic and informative discussions that touched on key issues for tribes and ways to handle the prescription drug epidemic.



Seven years later, four sources were used to inform those efforts begun in 2012 to develop tribal action plans. The first source comprised input from 179 registrants representing some of the 134 AI/AN tribes funded by SAMHSA to implement a Tribal Opioid Response (TOR) to prevent and treat opioid use disorder (OUD). These grantees and other subject matter experts (SMEs) participated in a technical assistance (TA) meeting in Prior Lake, Minnesota, planned by the AI/AN ATTC to identify challenges and successes implementing evidence-based practices (EBPs), including medication-assisted treatment (MAT), prevention efforts, recovery support, and culturally appropriate practices to address the opioid crisis in AI/AN communities.

The second source informing the summit’s action plan update emerged from dialogues among AI/AN ATTC advisory board members in November 2018 about opioid-related progress and



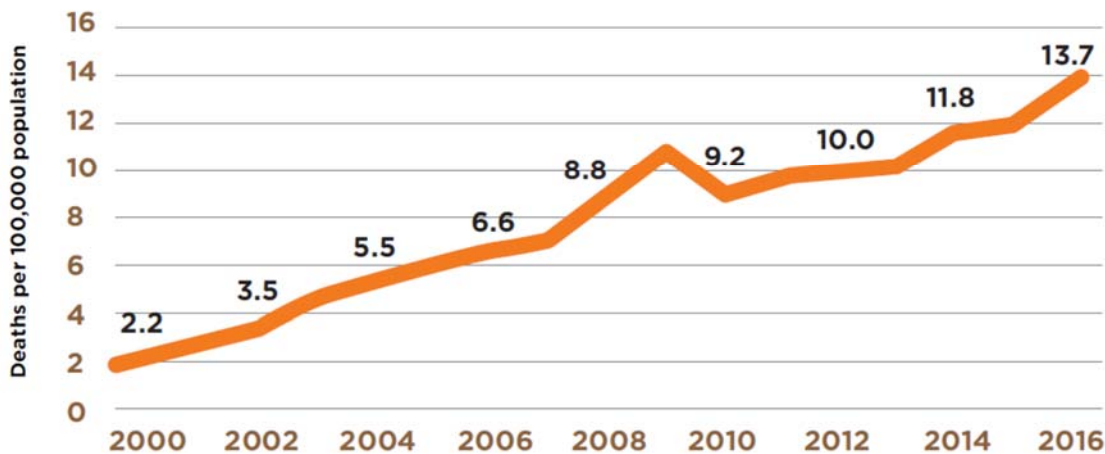
challenges facing AI/AN tribal communities. This update also includes looking beyond prescription drug use to include other opioids such as heroin and fentanyl and concurrent stimulant use that continues to threaten vibrant AI/AN communities.

The third source for the update was grantees who shared their experiences of engaging in an opioid-focused strategic planning process – a requirement of their TOR grant implementation. Harold Tarbell from the Mohawk Nation at Akwesasne facilitated this component and contributed greatly to the learnings associated with this effort.

The fourth and final source for the summit’s update report involved an AI/AN ATTC regional meeting held in September 2019 in Roseville, California. At this meeting, tribes from California, Idaho, Oregon, and Washington State provided an overview of their tribes’ activities tackling the opioid epidemic.

Although this update to the June 2012 summit is not an exhaustive review of all activities tribes are implementing to address the opioid epidemic, it provides many inspiring examples of actions tribes are taking to prevent and treat the adverse impacts opioid use has had on AI/AN communities across the country. This update expands the focus beyond prescription drug use to include other opioids such as heroin and fentanyl as well as concurrent stimulant use, which continues to threaten thriving AI/AN communities. The reason for this expansion is evident in the two graphs below that display the increasing rates of overdose deaths that are due to all opioids, not just prescription opioids, on Native Americans across the country.

### OVERDOSE Deaths Involving Opioids among Native Americans U.S. 2000-2016

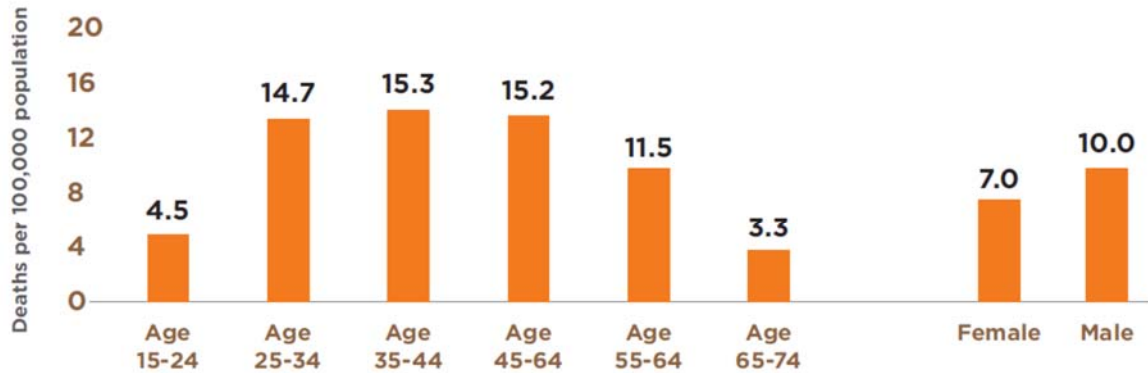


Source: Centers for Disease Control and Prevention (CDC). WONDER database (1999–2016). Retrieved from:

<https://Tribalepicenters.org/wp-content/uploads/2018/03/AASTE- opioids-fact-sheet.pdf>



### OPIOID Overdose Deaths among Native Americans by Sex & Age, U.S. 2014-2016



The opioid overdose death rate among Native American males significantly exceeds the rate among Native American females (10.0 per 100,000 vs. 7.0 per

100,000). Opioid overdose deaths are significantly more common among Native Americans between the ages of 25-64.

Source: CDC. WONDER database (1999–2016). Retrieved from <https://Tribalepicenters.org/wp-content/uploads/2018/03/AASTECC-opioids-fact-sheet.pdf>



## PILLAR UPDATES

### PILLAR 1: EDUCATION

One area where many tribes have successfully integrated 2012 summit findings into practice for Pillar 1: Education is consumer education about the risks of opioids and overdose. Many tribes indicated methamphetamine is on the rise and is often coupled with opioid use. The Confederated Tribes of Warm Springs has the largest land mass reservation in the State of Oregon. To address the issue of polydrug use in the rural area, they have created a Native American Opioid Training Academy, sending approximately 40 providers to training workshops. The training uses a phrase “pain in the brain” to help bring awareness to the issue of opioid and meth use in tribal communities. The Tribes work to bring a coalition of MAT providers, yoga instructors, mental health providers, first responders, and pharmacists to trainings and infuse these practitioners’ collective experiences to amplify messages throughout the rural area.



THE CONFEDERATED TRIBES OF WARM SPRINGS CONDUCTS A NATIVE AMERICAN OPIOID TRAINING ACADEMY USING THE CATCH PHRASE “PAIN IN THE BRAIN” TO DRAW ATTENTION TO THE RISK OF OPIOID USE.

CONFEDERATED TRIBES OF WARM SPRINGS

In another example, Adam Kartman, MD, of the Lummi Nation designed a bumper sticker for those community members who carry Narcan; the bumper sticker reads, “I Care About My Community: I Carry Narcan.” In addition, the Lummi Nation releases alerts to the community about potentially contaminated drugs circulating in the area when a sharp increase in overdoses occurs. The alert gives suggestions to users about how to care for one another such as not using alone, staggering use with friends so someone can always respond if needed, and testing drug potency by using small amounts to evaluate tolerance, especially if the person hasn’t used in a few days.

Other tribal nations have implemented culturally appropriate marketing campaigns to address the risks of opioids and overdose. For example, the Yakima Nation created a Tribal radio advertising campaign to reach youth with an effective message about the dangers of opioids and the need to avoid using opioids. This culturally appropriate public campaign was titled “Not on My Res” and expanded outreach to include distribution of Narcan kits at a “Not on My Res” walk attended by 400 tribal members. At this walk, a presentation was delivered advocating for those with OUD to seek treatment.



THE YAKIMA NATION CREATED A RADIO CAMPAIGN CALLED “NOT ON MY RES” TO TEACH YOUTH ABOUT THE DANGERS OF OPIOIDS.

TRIBAL RADIO PERSONALITY: YAKIMA NATION

To address the concerns of neonatal abstinence syndrome, the Marina/Quileute Tribe of Washington State developed a billboard campaign to create awareness of the EMERGE program to educate pregnant women with OUD about MAT availability and the benefits of MAT for a safe and healthy pregnancy.



Prevention education with youth is a common outreach activity among tribes because significant concern exists that youth do not fully understand the grave dangers of opioids. The Mille Lacs Band of Ojibwe in Minnesota has been exceedingly successful in informing youth of the dangers of opioids, as well as offering opportunities to connect those with OUD to peer recovery specialists. An organically developed youth organization named itself the “Sober Squad” and coupled education efforts with fun outreach events such as soccer, volleyball, kickball, potlucks, smudge walks, and other AI/NA cultural activities to create highly visible opportunities to embed in and connect with the tribal community. This organization has become so respected and visible that many have sought to become involved in the group and wear the “Sober Squad” T-shirt. Wearing the T-shirt is considered a privilege; those wearing are stating, “I want to be part of that organization and movement!” The Sober Squad Facebook page can be accessed at <https://www.facebook.com/groups/359588741119973/about/>.

Elders support this and other creative prevention education outreach programs. They are becoming part of the conversation and the community’s links with youth. Work remains in connecting with those in extremely isolated areas and removing psychosocial and economic barriers. Moreover, while experts in the addiction field are discussing the return of methamphetamine and other stimulants, most tribes report that meth never left and continues to undermine the stability of their communities, especially with regard to contaminated housing – an important basic resource. There has never been a more important time to collectively address the opioid epidemic and other crises caused by substance use disorders (SUDs) that threaten the health, safety, and vibrancy of AI/AN communities in a way that respects the attitudes, issues, and concerns of Native populations.

## **PILLAR 2: PRESCRIPTION DRUG MONITORING**

Many tribes have successfully integrated 2012 summit findings into practices that address Pillar 2: Prescription Drug Monitoring. The implementation and required use of prescription drug monitoring programs (PDMPs) have successfully identified “doctor shoppers” – the practice of patients seeking narcotic pain medications and opioids from multiple providers – and patients who are being prescribed other substances that may increase risks of opioid use. However, a widespread belief exists that an unintended consequence from the restriction of opioid and other narcotic medications for chronic pain management is an increase in use of “street drugs” including extremely lethal heroin and fentanyl. More training is needed for healthcare providers, including medical students, residents, and future prescribers, to improve opioid-prescribing practices. There is also a need to seek non-narcotic ways to manage patients’ chronic pain.

CDC publishes information to help prescribers understand how to use PDMPs, reconsider when to prescribe opioids, and know what to do if they have concerns about patients listed in the PDMP database. This information is available at [https://www.cdc.gov/drugoverdose/pdf/pdmp\\_factsheet-a.pdf](https://www.cdc.gov/drugoverdose/pdf/pdmp_factsheet-a.pdf).

## **PILLAR 3: SAFE DISPOSAL**

This update of the 2012 summit expands the review of tribal actions on Pillar 3: Safe Disposal. Tribal groups have worked to reduce dangerous access to medications, including opioids. The California Rural Indian Health Board (CRIHB) has assisted in training the tribal elders and





Indian community of Tule River Indian Tribe of California in Narcan use. This training includes a safe medical disposal workshop for elders. CRIHB also has helped organize a training program for pharmacists of the Sonoma County Indian Health Project on safe disposal of medications.

Many tribes have discovered that youth have access to opioid prescriptions filled for family members or friends. To limit access and possession of dangerous medications, a few tribal healthcare providers have proposed the installation of secure medication drop-boxes at provider locations with law enforcement oversight (to prevent drug diversion). However, Drug Enforcement Administration (DEA) restrictions have impeded implementation of this secure drug take-back option. Currently, only DEA-approved take-back programs and locations are permitted.

DEA continues to sponsor nationwide take-back events in the spring and the fall. It will continue to encourage local law enforcement to implement additional take-back efforts in accordance with regulations. The following links provide IHS and DEA information on medication disposal, including a public fact sheet for drug take-back programs:

- IHS Medication Disposal: <https://www.ihs.gov/opioids/prevention/disposal/>
- DEA Diversion Control Division: [https://www.deadiversion.usdoj.gov/drug\\_disposal/index.html](https://www.deadiversion.usdoj.gov/drug_disposal/index.html)
- DEA Disposal Act, General Public Fact Sheet: [https://www.deadiversion.usdoj.gov/drug\\_disposal/fact\\_sheets/disposal\\_public\\_06222018.pdf](https://www.deadiversion.usdoj.gov/drug_disposal/fact_sheets/disposal_public_06222018.pdf)

#### **PILLAR 4: LAW ENFORCEMENT**

The work to inform the summit update revealed only a few examples of tribal actions on Pillar 4: Law Enforcement. Some tribal communities reported challenges aligning law enforcement efforts with collaborative approaches to reduce opioid overdoses; however, progress is being made in prevention outreach and identification of at-risk Native people and families. Narcan training for emergency medical services (EMS) and law enforcement often includes a culturally appropriate component of prevention as encouraged by the Heroin Opioids and Pain Efforts (HOPE) Committee. Some tribes, such as Shoshone–Bannock Tribes, have coordinated with first responders to provide Narcan training. They have also developed an identification card to obtain Narcan at IHS clinics. Information on IHS naloxone training for EMS responders and the HOPE Committee is at <https://www.ihs.gov/opioids/naloxone/firstresponders/>.

Tribal members report an improvement in tribal drug court options and elder understanding of the importance of connecting MAT to traditional healing via family drug courts. For example, Ho-Chunk Family Healing to Wellness Court and Jackson County Family Treatment Court have successfully linked tribal members and their families to early intervention. Creating a holistic and family-based program is important to the success of the wellness program and elder understanding of early intervention programs.



“CREATING A HOLISTIC AND FAMILY-BASED PROGRAM IS IMPORTANT TO THE SUCCESS OF THE WELLNESS PROGRAM AND ELDER UNDERSTANDING OF EARLY INTERVENTION PROGRAMS.”

HO-CHUNK NATION



## BARRIERS TO IMPLEMENTATION OF BEST PRACTICES

Substance use, including use of opioids, disproportionately impacts AI/AN communities in the United States. While experiencing greater health disparities, AI/AN populations have historically experienced less access to effective interventions and treatments for their disorders than persons in the general U.S.

population. Although the inventory of evidence-based policies, practices, and programs for substance use problems is substantial, less attention has been paid to how traditional practices are incorporated into AI/AN programs. Structural barriers such as inadequate funding and a workforce that is not trained to deliver EBPs may limit the ability of these programs to identify, implement, and maintain their use. This difficulty may be compounded by a lingering distrust of approaches associated with Western standards of care among clinicians and their AI/AN clients that can be traced to the negative effects of colonization (Gone, 2008; [http://gonetowar.com/wp-content/uploads/2013/11/ethos\\_intro.pdf](http://gonetowar.com/wp-content/uploads/2013/11/ethos_intro.pdf)) and preferences for drawing on indigenous rather than biomedical healing traditions (Calabrese, 2008), while recognizing the broad regional and tribal diversity in these communities (<https://anthrosource.onlinelibrary.wiley.com/doi/abs/10.1111/j.1548-1352.2008.00018>).

TO REDUCE TREATMENT COSTS, THE YAKIMA NATION MAKES ALL PATIENTS APPLY FOR MEDICAID TO CONFIRM ELIGIBILITY. THIS PROCESS HELPS IDENTIFY PATIENTS WHO OTHERWISE MAY NOT HAVE BEEN ABLE TO AFFORD TREATMENT.

Despite these barriers, AI/AN community programs are actively using and adapting EBPs for OUD, most notably MAT. MAT is gaining broad acceptance among tribes, particularly where tribal leaders support prescription medication to treat other chronic illnesses, such as diabetes, and where there is a strong understanding and acknowledgment among tribal leaders that OUD is a chronic disease. Tribal providers are gradually recognizing MAT as an effective EBP, particularly when they hear success stories of patients reconciling with their families, returning to work, reengaging in their communities, and getting their lives in order. There is a strong movement to merge Western medicine (i.e., EBPs) with traditional healing practices when there is no contraindication to merging these two practices. Blending these practices together must be approved by a licensed medical provider. Some tribes on the





leading edge of merging the “scientific world” of Western-based medicine with traditional healing are seeing the power of bringing both “worlds” together rather than applying one practice over the other. A Lummi Nation representative may have stated it best: *“The cultural aspect of Indian Country is we don’t want to be closed off to any journey – we are all seeking the same source of light, we just go about it in different ways.”*

Despite more providers receiving a waiver to provide MAT, it has been reported that some are not providing MAT within their medical practices. Reasons for why MAT is not being prescribed include the stigma still associated with MAT, practice concerns over diversion of narcotic medications used in OUD treatment, extensive cost and measures required to stock MAT medications, and the exclusion of MAT on broader healthcare system formularies. Some tribal representatives at a September 2019 regional meeting expressed a resistance by Tribal leaders and traditional healing practitioners to use MAT for OUD because they believe MAT “may break the spirit” of the person, as well as remove the purity of a ceremony if a person receiving MAT attends a healing (purity) ceremony. It was anecdotally reported that some tribes with a strong focus on traditional-based practices may offer abstinence-based options such as 12-Step recovery programs and/or Native American traditional healing as the single method to treating OUD because of spiritual impurities of MAT. *One tribal representative said this is uniquely called “The Indian Factor.” He described it as coming from “a desire to be separate and have sovereignty.” Essentially, by using MAT, tribes have given up their Native American power – or more specifically, “a sense that we don’t need this medicine because we never needed medicine before.”*

Although progress has been made in understanding OUD as a chronic and life-threatening disease, some tribes do not accept the science of OUD as a disease. Some tribal members and elders remain steadfast that OUD is a disease of the spirit only – and not of the body. To expand the conversation and introduce other EBPs such as MAT, it is important to continue to educate elders and tribal communities that opioid use is a chronic disease and that not one treatment fits all individuals’ needs. Offering a broad-spectrum approach to treatment of OUD, which includes MAT but is not singularly MAT, is important. Creating opportunities for elders to learn that MAT helps stabilize individuals with OUD so that other healing interventions, including traditional healing, can be employed is an approach many tribes are now taking. Conveying that OUD is a disease and that treating it is a life-long journey is important to long-term recovery.

A challenge of comprehensive payment programs for MAT remains. Some third-party payers reimburse for MAT; others do not allow this treatment on site or do not provide MAT on the formulary. Although some programs may make MAT available on the formulary, stringent protocols for use may create obstacles that deter patients from seeking MAT. Many tribes report improvement is needed in the area of treatment reimbursement. To reduce treatment cost to patients, the Yakima Tribe makes all patients apply for Medicaid to confirm eligibility. This process helps identify patients who otherwise may not have been able to afford treatment.

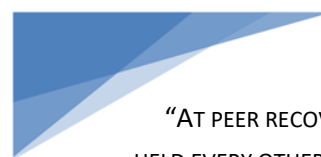
The Confederated Tribes of Warm Springs works with several tribal coalitions including the Native Aspiration Coalition to promote protective factors using activities to engage participants and volunteers in bringing awareness to OUD. In addition, the Confederated Tribes of Warm Springs have been merging the state statute of EBP with Tribal-based practices, such as Canoe Journey, Nine Tribes Camp, Outward Bound, and yoga. The organization uses measurements



for traditional practices to support EBP quotas while collecting successful traditional practice outcomes measurements to seek future reimbursement for these traditional practices.

The Shoshone-Bannock Tribe has implemented a successful program to support its MAT patients. In addition to developing procedures for intake including consent and agreement to try MAT, the MAT team has coordinated a comprehensive care program that includes meeting with a mental health therapist, scheduling medical appointments, and providing transportation as needed for patients. Equally important, it has implemented a Medicated Assisted Treatment Anonymous Support Group that is facilitated by a community member who has personal MAT experience and is in recovery from OUD. The Tribe employs four recovery coaches who attend appointments with patients to help reduce their feelings of shame and stigma. The peer recovery coaches encourage clients to attend groups and follow up with clients regularly. They also develop networks in the community that provide support for clients. The peer recovery coaches attend a Recovery Coach Academy training every other month. At this training, they help build a peer recovery network called “Smudge Me. Don’t Judge Me.” *This peer recovery group has been helpful to the MAT team and other clinical staff. The clinical staff feels the peer recovery team can reach much farther into the community than the medical staff can reach.*

An area of significant struggle for MAT acceptance as an evidence-based standard of practice is in the treatment of OUD among pregnant women, for which there is considerable stigma. Many tribal leaders consider the fetus sacred and medication as harmful to the spirit of the child. Many tribal leaders are therefore reluctant to endorse providing MAT to pregnant women with OUD and this remains a significant spiritual hurdle. Providers expressed a need for multiple treatment pathways to prevent negative outcomes. Reducing the stigma of OUD and MAT with pregnant women is critical for a healthy pregnancy and good outcomes for the mother and newborn. The White Earth Nation Tribe created a program called, Maternal Outreach and Mitigation (MOMS). This program focuses on healing rather than on MAT specifically, although MAT is an option in the program. Indicating that women are part of the MOMS program rather than just opioid users reduces stigma for the women with OUD. The program creates a climate of trust and nonjudgement, and the rules are clear for the group: no one may be criticized or judged for her choices. With the success of the group, it became “a badge of honor” to be part of MOMS. In fact, the success of this program was so resounding that every single mother who had been engaged in MOMS during delivery was able to take her baby home with her. A tribal representative from the program stated, “Culture is organic. It is not something you can write down or create a policy around. It is how we interact with each other, greet each other is culture. Culture is more than just ceremonies available. Culture is coveted and is protected like a secret or special privilege.”



“AT PEER RECOVERY TRAINING HELD EVERY OTHER MONTH, PEER RECOVERY SPECIALISTS BUILD A NETWORK CALLED “SMUDGE ME. DON’T JUDGE ME.”

Shoshone-Bannock Tribe

A common argument heard from tribes across the country is that just because an approach has not been studied and affirmed as an EBP by a national registry or clearinghouse does not mean that its services are not effective; rather it means that the approach has not been studied by social scientists. For example, although no scientific studies have been conducted of AI/AN





sweat lodge ceremonies, thousands of tribal people will attest to being helped by the practice. These testimonials reinforce generations of stories, teachings, and oral history. Many tribes voiced that outside evidence and scientific studies are not always necessary if something is known to be an effective helping practice and there is a culturally based evidence. Some practitioners term this fusion of EBP and traditional healing as “the best wise practice.”

Improving acceptance of effective and successful intervention methods that are complementary to AI/AN cultural values found in both urban and rural tribal communities is a priority, but challenges exist. Many AI/AN communities face significant challenges in conducting program evaluation, particularly if evaluation criteria require programs to establish EBPs that need significant time and infrastructure. Understanding the barriers and how to overcome them while respecting the traditions of these communities is important to the continuation of work in this area. Methods used to evaluate AI/AN community programs need to be culturally appropriate. A one-size-fits-all approach is not effective. A common concern among tribal representatives is screening – in particular, the duplicity across systems related to behavioral health screening and the time required to complete screening assessments. With workforce inefficiencies, including high attrition and workforce fatigue, these screenings and data collection requirements take an excessive amount of time to complete, creating a barrier for patients. tribal providers seek to improve this process while allowing for data collection to be entered and accessed more effectively.

A significant workforce challenge is the shortage of a clinically skilled and culturally competent behavioral health workforce for tribal communities. One solution is to seek out AI/AN individuals in recovery, such as peer recovery specialists, which offers chances to harness a real passion for helping those with OUD. While the peer recovery model is gaining traction in Indian Country, one challenge in using this model to create a ready and willing workforce involves the extra supervisory oversight required. Moreover, by the very nature of their past OUD, peer recovery specialists have difficulties passing rigorous background checks required by most human resource departments. There is also a need to improve the pathways for Native young people to seek accessible educational and training options and a college education.

Transportation remains a challenge in many tribes that serve large areas with vast rural terrain. Many opportunities to expand tele-behavioral health in Indian Country remain underutilized. A few tribes are using telehealth with success; however, some believe AI/NA populations affected by OUD will see better results if the onboarding and early counseling sessions are completed face-to-face before initiating a tele-behavioral health format. Adjunct telehealth can also be used during recovery for clients as they demonstrate meaningful steps to healing, particularly in isolated areas of Indian Country.



## STRATEGIC PLANNING AND SERVICE INTEGRATION

Some tribal representatives participating in the 2012 summit, as well as those from many tribes that did not participate, have accessed assistance in opioid-related strategic planning from Tribal Epidemiology Centers (TECs). Created 20 years ago by IHS, TECs support IHS-funded organizations that serve AI/AN tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities. TECs work in partnership with the local or area tribes to improve the health and well-being of their tribal community members by offering culturally appropriate approaches that work toward eliminating health disparities faced by AI/AN populations. TECs work with a coordinated approach with the tribes, IHS and other federal agencies, state agencies, and academic institutions throughout the country (<https://Tribalepicenters.org/about/>).

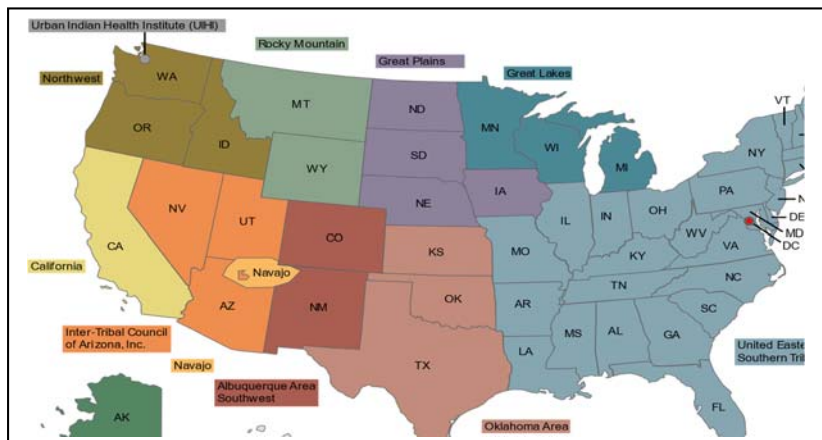


TECs provide TA to tribal health programs and individual tribes. Examples of TA requests include gathering relevant health statistics, reviewing sections of grant applications that discuss collecting health data, developing data collection instruments, and providing assistance in analyzing data. TECs monitor reported disease clusters/outbreaks through national and state health alert networks and maintain a capacity to conduct cluster investigations on behalf of tribes, including collaborative efforts with other public health entities.

As reflected in the map below, 12 TECs currently serve all 12 IHS areas and the urban Indian population. Types of support and services provided by TECs vary because of the TECs' structure, divisions, tribal populations, and mission and goals.

In 2018, SAMHSA encouraged its first cohort of TOR grantees to reach out to their respective TECs to obtain valid and reliable data for their AI/AN populations to inform the creation or updating of strategic plans to address their local opioid crisis. SAMHSA's AI/AN ATTC reinforced this resource by creating six strategic planning webinars (see top slide sample next page) to assist TOR grantees in strategic planning efforts and in completing a comprehensive strategic plan, based on the most current epidemiological data for the tribe, to address the gaps in opioid prevention, treatment, and recovery services identified by the tribe.

The AI/AN ATTC also provided strategic plan templates (see





sample below right) to assist its 134 grantees in this important effort. SAMHSA created a new TOR funding opportunity in 2019 and is similarly requiring its new cohort of 30 tribes to create a strategic plan that addresses the opioid crisis.

SAMHSA also supports a Tribal training and TA center that works with the Office of Indian Alcohol and Substance Abuse to offer training and TA on mental and substance use disorders, suicide prevention, and mental health promotion using the Strategic Cultural Framework including assistance to tribes in developing Tribal Action Plans (TAP). In 2019, this center collaborated with CRIHB, a 2018 TOR grantee, to offer tribal coalitions a workshop on 1) understanding TAP guidelines established in response to the Tribal Law and Order Act; 2) identifying individual, tribal-specific elements that make up a TAP to prevent and reduce the impact of alcohol and substance misuse; and 3) developing an outline of a TAP. Topics included the significance of community-based, stakeholder engagement that is informed by current, local data. Participants received resources, data, and tools, including a TAP template to assist them in development. They also obtained information on receiving follow-up TA on TAP development and submission of TAPs to the SAMHSA Indian Alcohol and Substance Abuse Interdepartmental Coordinating Committee.

CRIHB also worked with its TEC coalition partners to provide a partnership with tribes and stakeholders to improve opioid overdose surveillance. It conducted this research via an opioid overdose surveillance dashboard. This surveillance, coupled with epidemiology research including a review of individual death certificates, improved the racial classification of opioid overdoses across AI/NA systems. Specifically, CRIHB worked to improve the classification of nonfatal overdose data collection and fatal overdose data collection to improve not only outcomes for coalition members but also access to specific grant-funding earmarked for AI/NA OUD treatment and prevention programming.

In addition, CRIHB worked with coalitions in TEC using Tribal SMEs to help local tribes create a Tribal Action Plan of community readiness, including creating MAT champions who provide coaching for other tribal communities. These champions work with SMEs to recommend and implement safe prescription practices and guidelines, including ways to expand access to non-opioid pain management. CRIHB provides community-based culturally appropriate prevention strategies, including strategies for youth.

The many planning resources provide opportunities for Tribes to be strategic in their efforts to prevent and treat opioid use and misuse in their tribal communities.

Rapid Strategic Planning  
Tribal Opioid Response (TOR) Grantees  
Environmental Scan, SWOT Analysis, Capacity Considerations  
& Priority Setting  
November 9, 2018

*Behavioral Health is Essential to Health* | Prevention Priority | Substance Use | Opioids | High Priority

Tribal Opioid Response Strategic Activities Plan

Required Activities				
Objective 1	Activities	Responsible Party(ies)	Target Date	Date Completed
	What specific activities need to be completed to meet the objective?			
	1.1.1:			
	1.1.2:			
	1.1.3:			
Objective 2	Activities	Responsible Party(ies)	Target Date	Date Completed
	What specific activities need to be completed to meet the objective?			
	2.1.1:			
	2.1.2:			
	2.1.3:			
Objective 3	Activities	Responsible Party(ies)	Target Date	Date Completed
	What specific activities need to be completed to meet the objective?			
	1.1.1:			
	1.1.2:			
	1.1.3:			



## SUMMARY

Clearly, AI/AN Tribes across the country are making significant progress in addressing the opioid epidemic affecting their tribal communities. More Tribes than ever before are actively implementing the four “pillars” of a comprehensive public health strategy to combat prescription drug diversion and opioid misuse. Tribes are working hard and in creative ways to eliminate stigma, a significant barrier to OUD treatment. While not abandoning effective traditional culturally relevant tribal practices, a growing number of Tribes are concurrently implementing lifesaving MAT with significant success.

Despite this success, many challenges remain. Examples include expanding the clinically skilled and culturally competent behavioral health workforce for tribal communities, especially by improving the pathways for Native young people to seek accessible educational and training options and college education. A Tribal representative from the Yakima Nation suggested creating incentives for AI/NA college students to focus their studies on SUD. Also, seeking out those on a continuum of recovery, such as peer recovery specialists, offers chances to harness real passion for helping those with OUD.

While transportation remains a challenge in many Tribes that serve large areas with vast rural terrain, opportunities to reduce this barrier through expansion of tele-behavioral health remain underutilized. Adjunct tele-behavioral health can also be used during recovery for clients as they demonstrate meaningful steps to healing.

As CRIHB’s Research and Public Health Director shared with tribal representatives “the need to connect is a prominent theme in our collective work. Whether it is youth voicing the need and desire for more tribal gatherings or elders sharing the importance of healing that comes from attending ceremonies, connecting to each other is seen as necessary to build resilience, practice spirituality, and create a social support system. We need to connect youth to youth and youth to elders.”

Based on collective discussions of tribal representatives, there is agreement that AI/NA cultural connection needs to be at the heart of healing. Each individual and Tribe may have its own powerful ways to seek healing, but universally agreed among the tribal representatives is that lasting healing comes from the “core of each person’s spirit.”



Although SAMHSA’s TOR initiative has paved the way for more than 160 Tribes to have dedicated funding to address the opioid epidemic, this process needs time to take root in tribal communities, and sustainability after federal funding ends remains an issue. Ideas for sustainability are varied and tribal representatives seek input from their peers with addressing this challenge. Generally, all Tribes agree creating linkages with key stakeholders and partners is important to sustainability; however, identifying and providing relevant data to achieve key stakeholder buy-in can be time-consuming and difficult. The barriers in Indian Country that contribute to the opioid epidemic are significant and will take time, resources, and commitment to resolve.