



National American Indian & Alaska Native

ATTC

Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration



Tribal Opioid Response (TOR) Technical Assistance Meeting: April 10-12, 2019



Prepared by JBS International, Inc.,
under Contract No. 1 H79 T1026800-001

Prepared for the U.S. Department of
Health and Human Services, Substance
Abuse and Mental Health Services
Administration, Center for Substance
Abuse Treatment



ACKNOWLEDGMENTS

The National American Indian and Alaska Native Addiction Technology Transfer Center (ATTC) would like to thank all of our presenters: Harold Tarbell, Captain Cynthia Gunderson, Joel Chishol, Daniel Dickerson, Captain Ted Hall, Roger D. Walker, Matthew Ignacio, Melvina McCabe, Pamela Baston, Clyde McCoy, Shelly Campo, Paul Gilbert, James Ward, and Frank LaMere; the members of the Advisory Council for the National American Indian & Alaska Native ATTC; staff from JBS International; and the National American Indian & Alaska Native ATTC staff: Kate Thrams, Jeff Ledolter, Sean Bear, Anne Helene Skinstad, Monica Dreyer Rossi.

The National American Indian and Alaska Native Addiction Technology Transfer Center is funded by the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.



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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.

In September 2018, the Substance Abuse and Mental Health Services (SAMHSA) provided Tribal Opioid Response (TOR) funding to 134 American Indian/Alaska Native tribes. Through this grant, tribal substance abuse treatment programs were provided funding to conduct needs and capacity assessments, implement evidence-based treatments (such as MAT), develop prevention strategies for OUD, and incorporate culturally informed, knowledge-based practices.

The National American Indian & Alaska Native Addiction Technology Transfer Center (ATTC) has been funded to provide technical assistance to these TOR grant recipients. 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. This report is based on a technical assistance meeting the ATTC conducted in April 2019 for many of the recipients of the TOR grant. The purpose of the meeting was to provide an overview of the most recent findings and experiences from implementing evidence-based practices, as well as the combined wisdom of native behavioral health leaders.

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.

Anne Helene Skinstad, Ph.D.

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Meeting Overview

MEETING PURPOSE AND PARTICIPANTS

In September 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA) provided Tribal Opioid Response (TOR) funding to 134 American Indian/Alaska Native (AI/AN) Tribes. TOR grantees are required to implement evidence-based treatment, including medication-assisted treatment (MAT), and culturally appropriate practices to address the opioid crisis in AI/AN communities. Tribes are expected to use the results of a current needs assessment or carry out a strategic planning process to conduct needs and capacity assessments to identify gaps and resources from which to build prevention, treatment, and/or community-based recovery support services.

Many TOR grantees have never directly or indirectly provided MAT or other opioid prevention or treatment programming, and many are first time SAMHSA grantees. The technical assistance (TA) meeting was convened by the National AI/AN Addiction Technology Transfer Center (AI/AN ATTC) and its subcontractor, JBS International, Inc. (JBS) to provide grantees with foundational opioid content and strategies to assist them with their TOR implementation.

Approximately 179 registrants participated in this TA meeting held at Mystic Lake in Prior Lake, MN. On the first day, an introductory time was allotted for one designee from each Tribe to share their service populations and geographic areas of focus and TOR grant goals with their fellow meeting participants. Some grantees represented large Tribal nations, while others served smaller Tribal communities. Many grantees were just beginning a MAT program, while a few had several years of MAT implementation experience. Most grantees were seeking feedback and assistance with cultural integration of traditional practices in their opioid treatment work and in creating sustainable programs. Several grantees stated challenges with serving large, rural areas; challenging terrain; and isolation. Many grantees stated they were seeking better integration with other systems within their area (both Tribal and outside providers). The majority of grantees were seeking help with improving case management, co-occurring substance use disorder (SUD) and mental health services, and peer recovery and other recovery support options, particularly following MAT. Some grantees were seeking to improve life skills with young people and to focus on prevention, while others were seeking to improve communications with the Indian Health Service (IHS) and the Tribal health department through data collection and analysis. Several grantees were seeking to expand their naloxone program and to provide community training on its use.



Mystic Lake Casino & Hotel, Prior Lake, Minnesota

The second and third days of the meeting included the opportunity to learn more about best practices and basis for data collection. Also notable was infusing bicultural (western and traditional practices) into treatment for AI/AN populations. Grantees were looking to each other to identify ways to incorporate



Native American traditional healing practices into their treatment programs. Currently, there are only anecdotal reports of traditional healing available to support the Native American population. Grantees made an appeal to have more outcomes-driven research completed with Native Americans as the tide of opioid use disorder (OUD) continues to grip Tribal communities. Additionally, grantees engaged with panel members to discuss areas of cultural practice and relevancy, including using spiritual beliefs, such as the Seven Beliefs, into a best-wise practice (a fusion of evidence-based and knowledge-based practice).

MEETING DESIGN

The TA meeting brought together Humberto M. Carvalho, MPH, Public Health Advisor, SAMHSA's Project Officer (PO) responsible for TOR grantee TA; AI/AN ATTC staff; subject matter experts; and TOR grantees, Tribal leaders, evaluators, and treatment providers for 2½ days of learning sessions and networking opportunities. Meeting participants shared approaches, knowledge, and promising practices to guide continued provider improvements to assist Tribal members with OUD. This was accomplished through keynote presentations; sessions comprised of brief presentations that served as catalysts for interactive discussions and activities including networking and group discussions.

OVERARCHING MEETING OBJECTIVES

1. Develop peer-to-peer networking opportunities to be sustained over time
2. Identify the key components of the IHS response to the opioid crisis
3. Identify ways to create a sustainable program, including using performance measurement, data collection best practices, and effective screening techniques
4. Identify ways to infuse cultural relevancy and humility into care
5. Use lessons learned from the meeting to modify, as necessary, the existing work plan that will guide enhanced service delivery, promote sustainability, and identify the need for training and TA

An abbreviated, high-level summary of the TA meeting is provided below. Complete presentations can be accessed at: <https://attcnetwork.org/centers/national-american-indian-and-alaska-native-attc/tor-resource-page>

DAY 1 SESSIONS

MORNING SESSION: KEY THEMES AND LESSONS LEARNED

The Opioid Epidemic, Medication-Assisted Treatment (MAT), and Provider/Stakeholder Voices

1. THE OPIOID EPIDEMIC: THE INDIAN HEALTH SERVICE RESPONSE TO A NATIONAL CRISIS

Captain Cynthia Gunderson, PharmD, Vice-Chair, IHS Heroin Opioid and Pain Efforts Committee

Session Overview, Key Themes and Lessons Learned

From 2011-2015, Native Americans and Alaskan Natives experienced a 500 percent increase in opioid-related mortality. More recently (2016), however, there has been a decrease in prescription overdose death. To address this continuing epidemic, the IHS National Committee on Heroin,



Opioids and Pain Efforts (HOPE) was formed. HOPE works with Tribal stakeholders to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment. The link to the committee's findings is at <https://www.ihs.gov/opioids/hope/>

The IHS strategy to combat opioid abuse, misuse, and overdose aligns with the Department of Health and Human Services' (HHS) Five-Point Strategy to end the opioid crisis, which can be found at <https://www.hhs.gov/opioids/about-the-epidemic/hhs-response/index.html>.

Core goals of the HHS Five-Point Strategy are providing better addiction prevention, treatment, and recovery support services and strengthening public health data reporting. IHS is aligning its strategy with the overarching goals of HHS. IHS seeks to find parallel goals and improve outcomes.

a) **Expansion of MAT as part of a holistic approach to treatment and recovery.** The MT Special General Memo requires IHS sites to:

- Identify local MAT resources and to develop a plan for coordinating care
- Screen for OUD
- Train the workforce
- Provide acute withdrawal services and access to Naloxone
- Support free Drug Addiction Treatment Act Waiver training, which focuses on “culture today,” not “traditional culture”
- Include MAT be on the core formulary (i.e., can no longer say that “we do not stock medicine for MAT”).
- Offer MAT via telemedicine
 - ▶ Access to an Internet-Eligible Controlled Substance Prescriber exemption
 - ▶ No requirement that a patient has to be in a Drug Enforcement Agency (DEA)-waived clinic or in the presence of another DEA-licensed provider (i.e., the person with the patient can be a non-DEA-licensed clinician/paraprofessional.)

b) **Following of American College of Obstetrics & Gynecology Maternal Child Health Interventions.** Recommendations to IHS:

- Enhance screening
- Use culturally informed recommendations

c) **Metrics:** IHS is creating two dashboards for opioid prescribing:

- MME for chronic pain management
- Co-prescribing benzodiazepines

d) **Pain Management:** Strengthen a chronic non-cancer pain policy, which aligns with CDC guidelines (https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf)

- Co-prescribing naloxone (see Indian Health Manual's Chapter 32 – Prescription Drug Monitoring Program at <https://www.ihs.gov/ihtm/pc/part-3/p3c32/>)
 - ▶ IHS not required to participate, but this policy reflects IHS's DESIRE to engage in this effective practice
 - ▶ Establishes a requirement for IHS pharmacies to engage in prescription drug monitoring program (PDMP) activities



- ▶ Managing acute dental pain
- ▶ Guideline is available
- Staying connected (<https://www.ihs.gov/opioids/>) and reviewing various trainings available on the website
- e) **Harm Reduction Strategies:**
 - Naloxone safe houses
 - Increasing of access to disposal services
 - Safe syringe services
- f) **Research:** IHS is not doing research, but how do we support research (e.g., create an opioid coordinating group)
- g) **Other:**
 - Recognizing the role of Tribal Epidemiology Centers (Epicenters)
 - Seeking and providing opioid stewardship resources

2. MEDICATION-ASSISTED TREATMENT IN A NATIVE COMMUNITY

Joel Chisolm, MD, Member of Bay Mills Band of Ojibwe Tribe

Session Overview, Key Themes, and Lessons Learned

Dr. Chisolm shared a reminder to all grantees that there are many psychosocial issues but, also, significant health issues related to SUD. He advises that, as providers, “We can get hung up on treating the addiction, forgetting the health of the patient” (e.g., when a patient enters into a detox program, it is vital to address all health care needs, including the patient’s dental needs). Dr. Chisolm encouraged providers to be respectful of all teams: “Treating opioid addiction is very difficult work,” and it can feel broadsiding. “Opioids have come in fast and hard.” Dr. Chisolm recommends that grantees “focus not just on opioids, but on the continuum of care within care delivery models.” The following describe various delivery models.

- a) **Health Systems:**
 - The health care system should use community and clinical provider feedback to determine what is needed within the community; base your action plan on that feedback.
 - It is imperative to have a system set up to engage all parts of the health care team in the continuum of care; address and continually improve how staff collaborates.
 - In an integrated health system, the staff goes out into the community; there are many barriers in front of patients as they attempt to access care, so making the path to treatment easier improves patient outcomes.
 - The behavioral health community should be proactive with primary care providers; communication is the key to a successful continuum of care.
- b) **Task Force Recommendations/Peer Recovery Specialists:**
 - A recovery community is difficult to start and must be developed from “the ground up.”
 - It is important to support the peer recovery specialists and to help mentor those recovery specialists that are only a year in recovery.



c) **Acute Medical Management:**

- We need to make sure resources are appropriately placed and utilized.
- In transition from the emergency department (ED) to detox service, provide help with opioid withdrawal.
- Assess what do they need for induction (e.g., What worked before, if in relapse? What is the severity of their disease?)

d) **MAT:**

- MAT evidence shows results in the reduction of both recidivism and disease transmission.
- There are three traditional treatments, some of which work better than others depending on the person and situation (e.g., co-occurring pain)
 - ▶ Methadone: Benefit is that the patient will receive clinical care every day; Dr. Chisolm states, “Some people need daily contact and will achieve a higher success rate with this treatment regimen” and “Patients with co-occurring pain do better on methadone.”
 - ▶ Buprenorphine (e.g., Suboxone, Subutex): Patient does not experience a euphoric effect and cannot overdose on buprenorphine.
 - ▶ Naltrexone (e.g., Vivitrol®): This is also effective, especially with patients seeking abstinence following full detox; injectable format is especially effective.

e) **Suboxone Treatment:**

Dr. Chisolm states that the “patient cannot overdose on Suboxone.” Citing an anecdotal experience in Cherokee, NC, where Dr. Chisolm practices, he discusses that the primary care providers were “giving Suboxone away everywhere,” so the health system implemented programming with a more restrictive recommendation for use of Suboxone. After the revised implementation time had passed, Dr. Chisolm believed the Suboxone treatment availability had become too restrictive, which was not ideal for successful treatment. After review, it was recommended that a treatment program with less restrictions on Suboxone availability would provide an improved continuum of care allowing patients to return for more treatment options.

The Eastern Band of Cherokee Indians developed its own treatment curriculum for Suboxone. Observations and feedback were evaluated to conclude and develop best practices as follows:

- Originally, the clinic was set up to pay for the first 6 months of suboxone; however, the providers discovered once the 6-month payment program was completed and patients transitioned to self-pay, many patients suffered relapse. Programming now includes indefinite Suboxone treatment, which supports a sustained recovery and provides an opportunity to receive access to recovery services.
- The treatment clinic is set up with four providers working 4 half-day clinics. Based on the patient’s severity of disease, she or he will see the provider on 1 half-day, and therapy will be on another day. This program was designed to increase services and to provide more opportunities, rather than fewer, to support patients. Additional staff is employed to help overcome barriers (e.g., childcare).
- The Cherokee Hospital Suboxone treatment center helps with transportation (i.e., patients are given transportation passes)
- The clinic provides more intensive services for longer, including for those patients with high-relapse rates.



Dr. Chisolm recommends careful dosing with Suboxone with patients that have been detoxed (e.g., participated in detox while incarcerated); otherwise “suboxone induction can be very euphoric.” He advises a reduced dosing.

a) **Inpatient Program:**

- A cultural component significantly increases success (inpatient and outpatient).
- It provides a work-study/job-training program during inpatient treatment.
- There is moderate re-entry and staff do not “push people through”; they continually evaluate where patients are in their recovery.
- Dr. Chisolm recommends delaying family involvement until the patient gets more engaged with the program.
- When statistics show that an ED experiences a “volume of overdoses,” it is time to consider the need for an inpatient unit (e.g., 80 overdoses per month for Cherokee Hospital).



b) **Transitional Housing:**

- In Cherokee, they are now building transitional housing, but they have faced some barriers. As Dr. Chisolm notes, “Folks don’t want transitional housing in their back yard.”
- Transitional housing is a community Resource, because it keeps clients engaged and busy during recovery (boredom is a big cause of relapse) and provides opportunity for those in recovery to communicate with others in recovery.

c) **Narcan®:**

- Narcan should be widely available.
- Education about its use is important.
- The effect of a dose only lasts 10 minutes, so be sure to get the patient to the ED or call ambulance, because he or she may “go back into an overdose situation.”

d) **Needle Access Program:**

- Seek harm reduction.
- Appeal to those that oppose a needle access program with the platform of the seriousness of the nation’s opioid epidemic.

3. PANEL DISCUSSION ON MAT TREATMENT

- Daniel Dickerson, DO, MPH, Inupiaq
- Captain Ted Hall, PharmD, BCPP, RPh
- Joel Chisolm, MD, Member of Bay Mills Band of Ojibwe Tribe

Opening Statements by Panelists

Daniel Dickerson, DO, MPH

Diversity that exists within the people we serve is exemplified by our own backgrounds. There are often “two worlds,” and each “world” can help the other: One “world’ represents the traditional side (i.e., elders and Tribal community, which may not understand treatments, the science of addiction, or the



medications that can help communities), whereas, the scientific “world” may need help with receptivity to traditional teachings and the healing properties within these teachings. This dual role to treatment will need more of a team approach. “It can feel like you are a lone soldier out there as a provider,” so understanding methodologies and culture respective of groups (elders versus clinicians) is important. We need to help our leaders understand the importance of providing medication to help our patients; working together will help emphasize and create action with system and Tribal leaders.

Captain Ted Hall, PharmD, BCCP

In his 17 years as an advanced practice pharmacist, as well as running a MAT program, Captain Hall has learned to emphasize a systems approach to care and to spark collaborations; to help create and foster the bridges to health integration; and to bring teams together and cross educate. Captain Hall states, “What we do in our facilities is important, but minor. We discover sometimes the best treatment, and counseling may not be enough. One person in the community can unravel the whole system if they [sic] are influential on that person seeking help.” Sustaining partnerships and integration can help prevent this unraveling of our patients’ work and our care.

In his current practice, Captain Hall serves 16 counties (not a defined reservation). He must integrate with two distinct health care teams. In order to achieve integration within the systems, his efforts began as a grassroots plan. As Captain Hall states, “One provider saw success with treatment and shared this success with another provider...and one-by-one, with each success, they (MAT providers) came on board.” As he emphasized, behind this replication of success was the fundamental goal to “meet the person where they [sic] are.” As Captain Hall points out, this can happen in many areas of the continuum of care, including patient registration ... “they are the key frontline access to the clinic.” Showing compassion at every station, including patient registration, can help connect patients to resources to address their needs.

Joel Chisolm, MD

Dr. Chisolm believes everyone’s community is different—population, location, cultural community barriers, and intensity of addiction. Sometimes some evidence-based programs may not apply to each community, so he encourages providers to use the community and all folks involved as their resources (e.g., bring in an elder; invite those in recovery, children, clinical staff, and family members). These members or influencer groups may not all agree ... “They are not supposed to because opioid addiction is not easy stuff.” Dr. Chisolm recommends cultivating collaboration BEFORE starting a program, i.e., “Don’t start the program, and hope everyone is on board.” He recommends community collaboration on the front end of strategic planning so that collaboration and buy-in occurs early. Dr. Chisolm states, “When you create a program without a front-end approach, you can get siloed very quickly.” He also refers to the silo effect as “going up the ladder (e.g., making assumptions about stuff).” He recommends engaging different perspectives from all groups, including the justice system.



Dr. Chisolm: “The response needs to be internal, but sometimes this is not possible as people do fall through the cracks because they don’t have a connection to the Tribe anymore. In some cases, outside facilities (providers outside the Tribal community) may not have any follow-up, causing huge gaps in care once the patient is released to the reservation. There is essentially no tracking of this patient. We must all seek ways to communicate with other (outside) facilities.”

Audience Comment:

“When in the community, there must be an advocate for the patient—a person must stay with the person that overdosed all the way through until they [sic] can get the services they need. Also, we need to make sure (the) family is ok, too. This advocacy need is a huge gap in reservation-based services versus urban care. Our community-based advocates for the individual and the family know the family, the community, and the language, but they can’t comprehend the terminology. How do we overcome this barrier?”

Dr. Dickerson: If possible, seek to employ a caseworker that can stay in constant communication with the team and identify other health care needs, such as dental needs. We must develop a way to link up these providers to the reservation.

Audience Comment:

“In our area, MAT is not a familiar treatment. How can you have MAT without the tools beyond it? There are no tools in place, afterwards, to help them stop using (i.e., have abstinence).”

Dr. Dickerson: “Just like telling someone to lose weight—they get a gym membership for 6 months but that doesn’t do it—it’s a life-long journey. Or if you want to become spiritual, you go to church for 3 months and expect change. This is not realistic; you need to go the rest of your life. MAT is the same—you have to keep participating in a program after MAT; this may be a lifelong intervention for some.” Dr. Dickerson recommends seeking ways to keep the patient/client connected to cultural interventions. He stated, “It is frustrating, and we need to develop strategies for the long haul.”

Captain Hall: MAT is to create stabilization. In the meantime, the patient should be in behavioral health counseling to develop social restructuring. Medication not to be used in place of these changes. There patient must have space and ability to develop the life skills to cope and to restructure social life.

Dr. Chisolm: Abstinence-based programs will not work for everyone. We must look at OUD as a chronic disease (e.g., you don’t take insulin away from diabetic). Statistics demonstrate that if a patient is taken off MAT, a higher incidence of relapse occurs. As care providers, we have to be more aggressive with treatment because of the “opioid epidemic taking over our country.”

Dr. Chisolm states that “not one shoe fits all; we have to look at treatment from a very broad spectrum. Medication is one small part of the program. We must help our patients get trust and honor back in their life, help them get their families back and reunited with their children. Recovery is NOT the medication; recovery is life.”



AFTERNOON SESSION: KEY THEMES AND LESSONS LEARNED

Co-Occurrence of Mental Health and Opioid Use Disorders, HIV/HCV: Harm Reduction for Opioid Users, Performance Measurement, and Provider/Stakeholder Voices

1. CO-OCCURRENCE OF MENTAL HEALTH AND OPIOID USE DISORDER

Roger D. Walker, MD, Western Band of the Cherokee Nation

Session Overview, Key Themes, and Lessons Learned

As Dr. Walker states, “You have an opportunity to be unique resources in one of the most challenging treatment areas of all of medicine. You are tasked with making a difference. This is an honor to all of your Tribe.” Dr. Walker believes treating SUD and mental health issues are the hardest areas to practice in medicine. These co-occurring disorders are chronic diseases, and each disorder can exacerbate the other. The statistics for co-occurring disease are staggering: Overlapping lifetime history; 72 percent of the time, people who use drugs have an overlap with mental health and alcohol. Forty-three million have mental health disease, 19 percent have SUD, and 41 percent have mental health issues. Those with disruptive disorders (e.g., attention deficit hyperactivity disorder [ADHD]) are at high risk for drug problems (23 percent of people with ADHD). These statistics make behavioral health work imperative.

Dr. Walker implored all those that work in these practice areas to help reduce the stigma to improve the patient/client outcome. He stated that we must, also, work to integrate care for our patients. Integration will work to reduce or minimize barriers (e.g., poverty, stress, trauma, poor nutrition, lack of access to healthy foods or safe shelter), which threaten access to OUD treatment and mental health issues.

Comorbidity will increase as the social determinants stack up against the patient; use of services will be increased, including health treatment costs, poor outcome, and suicide risk. Left untreated, these disorders may lead to overdose, and, in some cases, these overdose deaths are suicide. Often, when treating these comorbidities, you will need to discern between best practice versus evidence-based practice: often you will need to deploy the “best-wise practice.” “a technique or methodology that, through experience and research, has proven reliable to lead to the desired result.”

The same disorders of Native Americans exist in the general population, but, in the Native American population, the disorders exist with greater severity and prevalence and less access to care. All stakeholders must seek to provide opportunity, empowerment, security, control, and dignity and look at the AI point of view. We must empower them!

There are many headwinds, including the drug cartels and the pharmaceutical manufacturers. “Drug cartels are like Target, Lowe’s, or Walmart, only they are bigger and have more resources.” Cartels move a lot of product; they assess their market and respond quickly to market demand/trends, while looking for ways to expand their user profile and current user use (e.g., heroin producers realized methamphetamine was undercutting their product, so they made a stronger product, marketed towards children, and increased distribution to all targets). Pharmaceutical manufacturers are equally aggressive with their campaigns to expand prescription growth.





Native American youth have higher incidence of comorbidities than the general population. They also do not have a gateway drug, i.e., they will begin drug experimentation with what is available. Heroin is about the same cost as alcohol, so youth may try heroin just as often as alcohol.

Cultural relevance is much more important for Native Americans than the general population. The Native American social context has disintegrated; treatment must focus on their Native American identity, which will require working with process across traditional groups.

Some challenges to effective treatment are the lack of integrated care, under-trained professionals, lack of wholistic funding, and patients routinely underdiagnosed.

2. HIV/HCV: HARM REDUCTION FOR OPIOID USES

Matt Ignacio, MSSW, Tohono O'odham

Session Overview, Key Themes, and Lessons Learned

Harm reduction is a perspective and a set of practical strategies to reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use to abstinence. Cessation of drug use does not have to be the first goal of intervention. Service providers can be effective helpers anywhere along the continuum of drug use.

Mr. Ignacio encourages grantees to seek feedback and engagement – meet clients where they are, not where you would like them to be. He states, “You want people to have a real voice in change.” He recommends changing some aspect of the drug use to reduce harm -infuse their culture wherever there may be an opportunity: “Culture is medicine”. For example, you can create a forum and engage in discussion on using online dating apps and how to be safe as you use these apps. Within this group discussion, you can infuse the conversation with safer sex and harm reduction practices, reminding forum members that alcohol and drug use interferes with safer practices. This type of forum/conversation can ensure that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.

a) Individual Approach/Client-Centered Approach:

Meet the clients where they are in their course of change. Identify their strengths by assessing their strengths and environment. Be nonjudgmental, recognizing that it may take several attempts for them to change. Remember, it is a sign of trust for individuals to return to therapy after an absence. Learning how to pick ourselves up and having the courage and strength to try again is part of the process of learning new skills and behaviors. Remind patients that change is incremental, invisible, and a lifelong process.

b) Organizational Approach:

User involvement in the planning, mobilizing, and implementing of services is critical for success. Use certain dates as ways to hold events (e.g., May is hepatitis awareness month) and engage your community. Use targeted messaging as a strength. Exercise cultural humility (beyond cultural competency). Be inclusive of spiritual, traditional, and cultural needs.

3. PANEL DISCUSSION ON CO-OCCURRING DISORDERS

- Roger D. Walker, MD, Western Band of the Cherokee Nation



- Matt Ignacio, MSSW, Tohono O’odham

Dr. Roger Walker’s Opening Statement

“We must bring indigenous knowledge into the discussion. We must engage the community and individual’s theory on what caused the problem (opioid addiction); if we miss this conversation, we miss the problem. The patient’s theory for their [sic] problem can lead to good medical care.”

Dr. Walker: Embrace the philosophy of “nothing for me without me.” Ask open-ended questions, such as “Is someone here that can help you support a change? What triggers you?”

Matt Ignacio: Provide support services for gay men and women, and engage where they are in their community, including Tinder or Grindr. Offering opportunities to engage may give rise to discussions on harm reduction; allow discussion to encourage patients to share what they want to do and how and why they want to change.

Audience Comment:

“How can I get patients to use case management or how do I encourage them to get counseling?”

Audience/Grantee Responses to best practice ideas:

“In order to attend our programs, our patient would need to engage in counseling or group services. Be sure medication is not the only focus – it is only part of the treatment.”

“In our program, the patient must be participating in behavioral health services and see a case management nurse so he or she can coordinate services back and forth with providers.”

“If the patient doesn’t want therapy, it can be repackaged into something therapeutic.” For example, in his/her clinic, the patient must attend therapy by the third visit in order to continue treatment. The clinic case manager is reaching out to clients and delivering therapy in a way that the patient sees value in it (e.g., the therapist may grind meat during hunting season with the patient or help with repairing a transmission.) Once this connection is secured, they see the patient then going to family services.”

“What is being taught to our children? For example, our youth are being taught that Christopher Columbus discovered America. Where are these ideas coming from? Western culture? Children must be given a purpose. Every purpose in life will have a good outcome if they know where they come from.”



Dr. Walker: This begs the question, “How do we report these problems better?” It varies across the country; it is difficult to keep up with information when we don’t have efficient and ample systems. He advises that when there are no systems, you must be sure to document what you are doing! Another question he proposes to consider: “What can we learn from your program that may help other people?” For

Audience Comment:

“Entire states are under-reporting. We see this in the pathology reports—deaths are recorded as respiratory failure or, in the case of meth use, it is recorded as cardiac arrest. There is definitely under-reporting by pathology.”

example, in one AI community, there was no accounting for death rates/suicide rates although, there was a reported 16 suicides – the social workers knew of the suicides, but the deaths were not recorded as suicide. Dr. Walker feels that perhaps there was not the money to record these statistics and/or a database in which to record them. Additionally, he surmises, these suicides were not recorded because of other reasons, such as embarrassment or pain with each suicide. He feels the care providers and community have “become numb from talking about it each week.” You must make recording a priority. We need to know (MUST record), and we need to feel more comfortable talking about hurt and pain. This matter is difficult and real.

Audience Comment:

“With regards to the issue of under reporting, how do we not make that happen? How do we not under report?”

4. PERFORMANCE MEASUREMENT

Harold Tarbell, Mohawk Nation at Akwesasne

Session Overview, Key Themes, and Lessons Learned

If there is the ability to provide a behavioral health screening, it is helpful because, generally, there are co-occurring issues. Seek to learn the barriers to care; resistance is considered a barrier. A screening diagnosis app is often helpful. Kiosks for screenings would help patients with barriers.

a) Strategic Visioning Process:

- Preparing
- Exploring and learning
- Agreeing on current realities
- Opening to a vision
- Creating strategies
- Implementing change
- Living the vision

b) Getting Ready:

Who will do the work? What are the issues? What is the research needed?

c) Developing a Vision and Mission:

- Purpose
- Change
- Focus
- Business

d) Assessing the Environment:

- Trends most relevant to the organization to which the strategic plan will respond
- Trend-informed issues and strategies



e) Agreeing on Priorities:

- Critical strategic issues
- Core strategic goals and objectives

f) Writing the Strategic Plan:

- What will you accomplish?
- How will you accomplish?
- Profile
- Vision
- Mission
- Values
- Core strategies
- Goals/objectives



g) Implementation:

- How informed?
- What contributes to achievement (e.g., operational, program goals and activities)?

h) Monitoring and Evaluation:

In the relationship with the funder, this is most often expressed as a compliance conversation; from a staff point of view, this is often perceived as an appraisal process. Monitoring and evaluation should be done quarterly, annually, and every 3-5 years thereafter. In evaluating and measuring performance, you can create a balance scorecard and designate an owner of each strategic objective. This entails the following:

- Engage a continuous improvement process
- Translate strategy into measurable results
- Use the most relevant and meaningful measures
- Get buy-in from stakeholders
- Document the process (e.g., data, analysis, reporting)
- Interpret the gaps between current and performance target
- Design engaging and useful reports
- Make necessary adjustments

i) What to Measure:

- Continuum of care (i.e., prevention, education, recognition, treatment, maintenance)
- Quality (i.e., structure, process, outcomes, access, patient experience)

j) Other Requirements:

- Implement workforce development activities to ensure individuals working in Tribal communities are well versed in strategies to prevent and treat OUD.
- Develop effective prevention strategies.
- Implement service delivery models that enable the full spectrum of treatment and recovery support services.
- Incorporate culturally appropriate and traditional practices in program design and implementation.



- Support innovative telehealth strategies in rural and underserved areas.
- Address barriers to receiving MAT.
- Develop and implement tobacco-cessation programs.

k) Optional Activities:

- Peer recovery and/or recovery housing
- Assistance with treatment costs
- Treatment transition and reentry assistance
- Work with Tribal Epidemiology Centers to assess impact of grant

DAY 2 SESSIONS

MORNING SESSION: KEY THEMES AND LESSONS LEARNED

The Power of Knowledge-Based/Western Practices, Creation of Sustainable Programs, Data Collection Best Practices, and Provider/Stakeholder Voices

1. TAKING THE JOURNEY TOGETHER: THE POWER OF KNOWLEDGE-BASED/WESTERN PRACTICES

Melvina McCabe, MD, Navajo Nation

Session Overview, Key Themes, and Lessons Learned

Dr. McCabe challenged grantees with the questions: How do we integrate knowledge-based evidence and western practice? Can we integrate western ways with Native American ways? She reminds Native Americans and the audience that “our ways are very powerful.”

Begin with “Why are there health disparities?” Perhaps there are misunderstandings between the western and Native American worlds. This lack of understanding for these two entities should be an overarching reason for integration. Also, historical trauma is cause for disparity – we must overcome with resilience and respect for the land, community, and water.

Can these two philosophies of care, knowledge-based evidence and western practices, co-exist?

Within the umbrella of evidence-based plus standardization of care for all populations, we must focus on the individual. Dr. McCabe believes knowledge-based care is broader in scope. She recommends evaluating an acculturated/assimilated broad spectrum of care but remember to serve Native American people. We must not singularly serve those that are only traditional. She believes grantees must also serve those that are assimilated.

a) Defining Evidence-Based Practice

By definition, evidence-based practice is predicated on well-designed studies and is outcomes based. Evidence-based care is intended to provide guidance. Dr. McCabe recommends looking to indigenous world views (e.g., customs) versus clinical world versus psychology and science.

“HOW DO YOU MERGE
EVIDENCE-BASED PRACTICE
WITH BEST-WISE PRACTICE?”



Merging these practices adds clinical knowledge, when appropriate. You must also infuse epistemology, the study of knowledge. Dr. McCabe believes western science and research are not the only methods of knowing. Dr. McCabe suggests that when treating Native Americans, you cannot dismiss the natural ways.

b) The Seven Teachings

To encourage and understand Native American natural ways, Dr. McCabe shared a video, “Our Seven Teachings” (e.g., who we are, defined by our seven major teachings). The video begins by acknowledging the elders; elders always remind people how we should be behaving. Prayers invoke spirits and grandfathers to protect and lead us. Everything is connected to the Higher Power; the Higher Power created everything we are.

1. Respect (Buffalo) is to know how to care. The buffalo gave of themselves to help people survive and gave every part of their being for survival of the people.
2. Love (Eagle) is the essence of the spirit within each of us. We are created through unconditional love through the spirit. The three most powerful words, “I love you,” are powerful words to say. Love is the spirit and energy of life.
3. Courage (Bear) is to have courage is to do the right thing; there is only one way to the right thing, which is expressed in the heart. “Grandfather, help me have courage to do the right thing.”
4. Honesty (Bigfoot) is to learn to speak from heart and to get out of your head/mind. To be honest is to be true to your word; elders would agree by a handshake – no agreement/contract needed.
5. Wisdom (Beaver) is to know you have a gift. If you want to build a better life, use gifts that we have; once you know your gift, you serve the people (family and community). The beaver uses his two sharp teeth to cut trees; if beavers don’t use their teeth, then their teeth would become long, and the beaver would become sick and die. Use your gift.
6. Humility (Wolf) is to acknowledge a higher power. Wolves stop and bow their heads when they see a human. Always think of others before yourself.
7. Truth (Turtle) cannot be lived until you know the teachings. The turtle leaves a trail that we are to follow; the turtle is carrying the teachings. Richness comes in the knowledge.



“Teachings reflect the identity of the spirit in each of us, and we will have the genetic knowledge to know the teachings. What a gift the creator gave us.” (End video)

Dr. McCabe shared a personal story: She attended an Apache Purity Ceremony. One of the songs was the calling of the eagles. People were circling and supporting the woman for whom the purity ceremony was conducted; as they circled her, four eagles flew above them.



The Native Ways of Knowing are achieved by observation (contextual) and demonstration. Competency is tied to survival. Cultures are adaptable and relational; they are dynamic. The Native ways of knowing also include concepts of physics, chemistry, astrology, botany, pharmacology, psychology, weather, and the sacred interlocking and relational nature of all. The Native ways are shared and continued through storytelling.

Native American culture reflects the research for her practice and teachings. Ethnic identity is important to self-esteem and well-being. When Native Americans have bicultural competencies, there is less hopelessness. Bicultural competencies provide strength and confidence, which can lead to academic success. Dr. McCabe believes grantees must get the youth back to Native American teachings. Examples of Native American teachings/traditional medicine in western practice include:

- Red Road to Wellness Study – key concepts for SUD prevention programs
- Integrated and holistic approach – use of western (e.g., Alcoholics Anonymous) as a framework, along with and aboriginal practices
- Medicine wheel – firekeepers empowering healthy lifestyles
- Mindfulness – came about recently through Native American cultures (i.e., we are to be mindful of our surroundings)
- Improved outcomes in therapy – counselor not judgmental but understanding and encouraging and allowing talk without interruption (e.g., approximately every 30 seconds to 1 minute, the western physician interrupts.)

c) Factors Impeding Native American/Traditional Practices:

- Arrogance (i.e., “ivy tower syndrome”) is an impediment. They don’t know about Tribal medicine; they need to come to us to learn.
- A tripartite mission is not enough; the concept changing (e.g., social determinants).

d) Ways to Improve and Increase Traditional Practices:

- (Funding agency recommendations) Liberate best practices; don’t keep them narrowed. Include other people’s practices. Change internally (i.e., “do not harm and stop subjugation systems”). Lack of cultural knowledge is harmful. (example where Native American knowledge led to discovery: re: the Hantavirus: The medicine man suggested a mouse brought the virus to the land; the Centers for Disease Control and Prevention tested and found that mice were source.
- (Efficacious programs in Indian Country). Provide a positive impact on treatment programs. Develop a website at SAMHSA, making the process easy for research (e.g., make searching guidelines in each area of concern in lay terms concisely presented within an AIAN section. Prioritize research for native groups.
- Improve research specific to traditional practice. Currently, there is no rigorous research for Native Americans, just anecdotal reports.
- Create a “Collective Across the Ages” group, which explores what has happened to our ancestors, youth, and geriatric population. The program would be supportive. Include Native Americans at the onset when developing evidence-based practices
- Infuse Wisdom, Clarity, Strength, and Beauty in research/programming.





2. PANEL DISCUSSION ON HEALTH PRACTICES INTEGRATION

- Melvina McCabe, MD
- Roger D. Walker, MD
- Joel Chisolm, MD

Opening Comments

Dr. Chisolm: “Integration” is an often used catch phrase in medicine. Integration should go along the whole spectrum of care and connects the whole health care system. Dr. Chisolm concurs that trying to have health care and all organizations within the health care system work with us is challenging and a battle to effective practice. The challenge is communication; the key function is to communicate within all areas of an organization. Our patients need access to counseling, nutrition, and physical care (i.e., wraparound care) in one visit. Our patients have too many barriers to burden with multiple appointments.

Audience Comment:

“Have to teach our children where they come from and who they are...stewards of the land.”

Dr. Walker: We can achieve integrated care in a variety of ways; you must get out into the field (e.g., school/teachers, Tribal council, medicine people, recreation therapist/reach kids). “Chronic illness is the single-most area of failure in the country/across all populations; this failure lives in mental health.” We need to change our thinking and training, talk to the power and the leaders, and act collectively to stop the issue. Seek to understand the elders’ theory of why an issue is happening.

Dr. McCabe: Many of Dr. McCabe’s students ask, “How do I get back to my ways?” Seek traditional ways ... “Learn your Indian-ness.” Dr. McCabe uses her daily morning prayer to seek spiritual connection and traditional ways.

Dr. Walker: There are models with western-trained physicians that are trying to take steps to integrate spirituality into practice; orientation for behavioral health aides in Alaska is unique and spirituality based. Due to the success of this practice, IHS is considering behavioral health aid use across the Native country. The Navajo Medical School has learned a lot from the medicine people. The government provides money to Indian country per capita. Problems like suicide are not dealt with well with this model; the issue is treated as a fad. “Steps on ladder [are] not raised until you share what works.” Tell the government what you want; do not let Congress tell you.

Audience Comment:

“We must infuse prayer and seek the creator – integrate spirituality back into practice. Everything is connected (creator, land); acculturation led to the shame of our own culture, which then led to hatred and disconnect. Have you seen a successful integration of spirituality into practice?”

Audience Comment:

“Do you recommend a large-scale or individual implementation of spirituality into practice?”

Dr. McCabe: Individual. One of the teachings (Navajo) is always to respect other ways/religions; when we start realizing we can change in our heart – get rid of colonialism in our heart – we should be what we were taught. Things will then change in our outlook, and our actions will be more respectful. Because of deeply integrating culture with elders (e.g., food, culture, attitudes, art), an emergency room (ER) has seen a 30 percent reduction in visits.



A suicide prevention program continues to receive funding because of its effectiveness in incorporating Tribal leaders. An elder response was “we don’t talk about suicides,” but all elders were brought together (12), and the presidents of nations did a “Suicide 101” training. Following this training, and on a more powerful level, we brought in a group of students to speak to elders. They said that “we need you to listen to us, and one of those issues is we need to talk about is suicide.” You need to listen to youth. Following the discussion, the elders said, “We heard you, and we will change this.” Lead by example.

Audience Member Personal Testimony

“I BROUGHT DRUGS AND ALCOHOL INTO MY HOME AND FAMILY.”

A Native young man shared his story of how he brought traditional spirituality into his life to overcome his substance abuse; his grandparents/mothers were medicine people, and he watched them. From this experience, he can understand getting connected back to Mother Earth and Creator. He states, “It’s in our DNA – the younger generation needs us. We have to go back to our past to move forward”.

His Journey

He states, “When we were moved back to the reservation, the man could not provide for his family. We could not hunt, gather, teach our sons, connect to Mother Earth. Fathers could not provide for the family; mothers couldn’t teach their [sic] child how to be a mother in her home. At this time, we became dependent on alcohol. This is when children were taken to boarding schools and were told they were bad (e.g., mental, physical, sexual abuse).

[A] father couldn’t be a father and was mad, which led to domestic violence; if child came back, there was more abuse. [The] child watched the abuse (e.g., alcohol, physical, domestic). We need to be an example for our people.” He shares that while in prison, they asked him to carry the pipe. He states, “As Native people, we have the spirituality. We communicate in dreams and visions.” He changed his life through traditions. “We, as fathers, have to teach this to our children – as Native men, we must teach our children.” He believes his ancestors are pushing him to help his people by integrating spirituality into the healing of our people and our nation.

He shares, “Our spirituality is universal; the veil will begin to lift. Live in harmony with nature, and make friendships with the spirit nation, and that’s how we heal. Creator wants to see how you help people. People are attracted to your spirit; we are all made of a spirit. Learn from our spirits.”

3. CREATING SUSTAINABLE PROGRAMS

Pamela Baston, MPA, MCAP, CPP

Ms. Baston acknowledged that, based on her numerous technical assistance (TA) consultations with grantees attending the conference, many grantees are struggling with the issues of workforce turnover. She noted, “In fact, many of you are just days into your new position and have been given the job to



execute the TOR grant.” Other grantees are contending with the issue of deliverables and prioritizing their efforts. To begin implementation of your grant, you can assess strengths and areas of possible sustainability.

Consider these points:

- Everyone is in a different place in their programs.
- New grantees may make a lot of mistakes. Don’t hide your failures; learn from them, because this is a difficult population to serve.
- To maintain your program and benefits over time, “it is okay to get rid of what’s not working.”
- A common denominator to success is passion – have a willingness to embrace challenges.
- Your “data tells you something happened but not necessarily why it happened.” Data are helpful, but sometimes you may need to adjust your course to be sustainable and effective. Ms. Baston shared an example from a parenting class she offered while serving as a live-in advisor in public housing: She received feedback from the parents, which indicated that her class was “good,” but the parenting lessons were too abstract. She was missing something important – the kids! The parents wanted more hands-on experience with their children while in the class. Ms. Baston was following a format that was not completely meeting the needs of the parents she was serving. Ms. Baston concludes, “Sometimes data say to do it one way, but you may need to pivot to meet the true needs of population you are serving.”
- There are ways to simulate a level of care without spending a lot of money, such as using existing public housing infrastructure or apartment buildings.
- Stigma, shame, and blame are huge; disdain is huge. You will need to work against these paradigms, so it may take time to explain to potential partners the impact of opioid use on collective (e.g., community, business) goals.

Ms. Baston mentioned that she had intended to cover multiple sustainability domains, but her early interactions at this meeting with grantees resulted in the need to focus on one domain more thoroughly – partnerships. “Partnerships are often your referral pipelines. These pipelines can be what sustains your program, because you may provide benefits to them, too. Take time in the beginning of the grant process to understand partnership opportunities and their needs. Work synergistically with the partners you cultivate. Listen to their feedback, and adjust where needed and feasible.”

Ms. Baston shared the following anecdotal story to emphasize responsiveness to partnership needs/feedback (a report from a care provider in the ER of a hospital):

The hospital employee shared, “We don’t have a lot of experience with recovery coaches in the ER. We understand they have a lot of passion for what they do, but they (peer recovery specialist) can experience a workflow challenge. They don’t understand that the ER is not like Grey’s Anatomy; it’s more like a horror movie, and we don’t have time to become immersed in the passionate plea of the recovery coach.”



Ms. Baston noted how this anecdotal report demonstrates how two systems with the same goal can have an opposite course. It is important to have these two systems work together, because they have a common goal: prevent another overdose, thereby saving a life, as well as keeping the patient out of emergency room. Keep in mind, however, ER staff often report that the workload for their staff would be cut in half if wasn't for meth and opioids. They may lack the same passion as a recovery coach because of feeling overwhelmed by the workload and lack of solutions in their department for the

patient with SUDs. Ms. Baston states, "Unlike recovery coaches who have the benefit of seeing positive outcomes and changed lives, ER and other hospital staff often just see the wreckage of SUDs. We have to find ways through our partnerships to share the hopeful, life-changing experiences we see every day in SUD recovery."

Audience Comment:

"Can ATTC set up a blog? Or can SAMHSA? This could demonstrate commitment and offer effectiveness in getting the word out." (Ms. Baston and other presenters concurred that this is excellent idea.)

Ms. Baston recommends assessing your population needs carefully, particularly early in the process, to ensure you leverage your partnerships to meet the "whole-person" needs of the patients. The pathways individuals travel during their SUD development are very complicated and require individualized analysis. Remember, they need to have a role in decision-making; avoid "bumper sticker treatment" (i.e., knowing what we think they need without understanding their

circumstances or oversimplifying their needs or "detox and go"). Also, avoid "drive-by treatment" (i.e., getting them in and out). Our patients need our compassion and navigation within the systems of care – these are all our families. Our communities need this because we lost a whole generation of young men due to significant use of opioids.

4. DATA COLLECTION BEST PRACTICES

Clyde McCoy, PhD., Eastern Band of the Cherokee Nation

Data collection will not always be standardized and needs to account for unique features of the population with which you are working. Data collection and evaluation should be participatory. Create your hierarchy of need to do good. At each level of data collection, you must have the responsibility and challenge to reach meaningful outcomes. Data should be collected to accomplish what the people need. The data collected should be a way to help us identify or reinforce the priorities of the community. Features of your data should:

- Assure accuracy; accuracy requires ingenuity and monitoring.
- Meet the challenges of today, including cultural borders. Our identity as AI/AN becomes increasingly important to us; the data should demonstrate this theme.

Include a cultural adaptation to your data: We all grew up as storytellers – "Stories are just data with a soul." Don't let the data discourage or overwhelm you; data are information to help you do good with the people you serve. Benefits of data collection include:

- Can't move forward if you can't wrap your arms around what's going on
- Can't be frightened by it ... must acknowledge it
- Must be able to monitor the credibility of the data to ensure that you are telling the truth
- Utilize key informant interviews to provide substance to your data



Note: Several afternoon speakers were unable to attend the conference due to blizzard-like conditions. Many flights were cancelled, and roads were impassable. Two speakers were unable to attend the conference. Afternoon sessions were extended to allow grantee engagement with speakers. Also, several TA sessions were re-scheduled during this afternoon block so that some attendees could leave early before departing flights were cancelled for several days.

5. BEHAVIORAL HEALTH SCREENING BEST PRACTICES IN INDIAN HEALTH CARE

James Ward, MBA, Choctaw Nation of Oklahoma

Mr. Ward highlighted several barriers to screening best practices. Challenges with staff screening and assessment include:

- The is not enough staff to always complete screenings.
- Staff does not receive adequate training and/or may be resistant to screening.
- There is a lack of a standardized process.
- Patients don't always answer screening questions truthfully.
- Community norms often don't see the problem.
- Referral resources are sometimes limited.
- Patients lack transportation, leading to a lack of or inconsistent follow-up visits.
- Coding and data entry mistakes occur.

Mr. Ward made several recommendations to improve screening outcomes. Best practices include:

- Consistently require staff to screen patients
- Standardize the screening process
- Train staff on screening procedures
- Improve staff communication
- Screen all patients during each visit
- Screen patients, even if referral resources are unavailable
- Educate patients
- Create opportunities for staff to work together



Mr. Ward's company has developed a product to improve screening opportunities and outcomes. ScreenDox includes the following features:

- Touchscreen kiosk or wireless option
- System settings
- Integrated care features
- Reports

A participant asked Mr. Ward if he knew the cost for the kiosk, and he replied that it was a reasonable cost (about \$13,000 – a minimal cost to help cover extensive initial development costs) and that by having a self-administered assessment kiosk, organizations can eliminate a full-time equivalent staff position.



DAY 3 SESSIONS

MORNING SESSION: KEY THEMES AND LESSONS LEARNED

The Ghosts Of Whiteclay – A Continuing Odyssey; A Day in the Life of an Opioid-Using Parent: Supporting Parents and Children and Provider/Stakeholder Voices

- Umberto Humberto M. Carvalho, MPH, Public Health Advisor (SAMHSA PO responsible for TA to TOR grantees)
- Ramon Bonzon, Courtney West, and Amy Romero (TOR POs)

Opening Remarks

There is a new Government Performance and Results Act (GPRA) tool to collect data; however, it is being revised under the U.S. Office of Management and Budget. Mr. Carvalho states, “You are not under any obligation to collect data using that tool. If you are already providing a service, you can collect data using whatever data collection tools your Tribe typically uses.”

If you are having difficulty communicating with your PO, please contact Mr. Carvalho to seek assistance with improving communication.

Return rates on GPRA are 52 percent because of the length of the tool (i.e., clients say not have time, cannot force client to complete). Mr. Carvalho states, “You will not get in trouble with SAMSHA if [you are] not meeting required response.”

Audience Comment:

“Accucare is using another system in another region in providing care. May we use its data instead of GPRA?”

Mr. Carvalho: Some use additional data systems/tools; you can use your own data collection system to collect data. When the tool becomes available, you will be obligated to use the new GPRA tool and merge data points together. Speak to your PO for more explanation.

Mr. Carvalho: Due to requirements, you will be required to use GPRA.

Audience Comment:

“We are doing double work with some of our data collection programs and GPRA, which causes the patient to be discouraged to come back to clinic?”

Audience Comment:

“Can we be part of the new GRPA?”

Mr. Carvalho: Sixty days after publication of GPRA was your opportunity to provide comments. He said he thinks that by summer or the beginning of next year, TOR grantees will be required to use the revised tool. Mr. Carvalho states, “If you think changes need to be made, propose [them] to your PO.”



1. THE GHOSTS OF WHITECLAY – A CONTINUING ODYSSEY

Frank LaMere, Winnebago Tribe of Nebraska

Old attitudes and ideas are still harbored; these ideas get in the way of progress. As we work for change, we should tell our young people what we learned. Think about things told to you by elders.

There is an importance of trust with those trying to connect with us. “You may be part of someone’s defining moment. Acknowledge those that want to heal. Celebrate those things they want to change.” Mr. LaMere shared a personal story to emphasize this point about change:

He attended the Heroes and Heroines of the Great Alcohol Massacre Celebration (a Native American celebration of sobriety). It was his third year of sobriety. Mr. LaMere was feeling very confident about his change. A peer, also in attendance at ceremony, was 25 years sober. He offered his 25-year pin to Mr. LaMere, with a message of “don’t be so full of yourself; change takes a long time.” He took this message to heart. At his 25-year anniversary of sobriety, he took out the pin, given to him by the man, and held it with great gratitude and significance for his sobriety.

Mr. LaMere reminds the group that with healing, always be mindful that it gets better every day. The work never stops when seeking a sober life. Also, remember the “ghost families” - those that still suffer from alcoholism. Try to be role models for those healing. He provided an example of a program in Winnebago, which follows traditional teachings and teaches humility and love:



SEEK HUMILITY IN
YOUR WORK AND
IN THE
COMMUNITIES.
YOUR MODALITIES
AND “HEALING
METHODS MUST
BE GROUNDED IN
HUMILITY.”

There is a class taught within a series of classes for securing parental rights (the parental rights restoration program, Actions not Words) called *Drama Queens and Drama Kings*. This class helps identify issues with anger and the need for anger management. One of the exercises of the class is to share something kind about your spouse in a face-to-face situation. Mr. LaMere shares this story about a couple in this class seeking to restore parental rights:

When the wife is instructed to say something nice to her spouse, she says the following: “He is always the first one over at Labor Ready. He gets work every day.” The husband is instructed to do the same. He says, “Sometimes we have very little food in the cupboard, and she can make it into a wonderful meal for the whole family to enjoy.” Now the wife is to say something she has never said to her husband before. She says, “I have dreamed about owning my own house, getting a GED, and my children getting a good education. He’s the only one who believes in my dream.”

Mr. LaMere concludes that the wife has taught us something in this statement – she speaks to the general lack of trust in accomplishments of Native Americans and in others (she only trusts her husband to believe her goals). He states, “On our best days, we fail to connect. We have to connect at the beginning.”



He shares his personal story at Whiteclay. Whiteclay is 50 miles from the Nebraska state line. The Tribe is one of the most disenfranchised of all of the Tribes: 4,000,000 cans of beer are sold per year in the only legal place to drink; 4 small bars sell all this beer. Mr. LaMere states, “We took on ‘the blood man’ (big alcohol) and prevailed.” On September 29th, we will celebrate the Supreme Court Decision. Finally, after 20 years, we shut them down! He shares these lessons from the Whiteclay story:

- Some are going to be asked to take a step from here to here (demonstrated crossing a line as he did at the state line); most won’t take the step, because they are going to consider many things, such as family, career, and community. If you cross line, the Creator may help you make a change for others.
- Carry this in your work: “When you think you know everything – we are part of something that is preordained.”
- Do all this so that one young man or lady can live, grow, and flourish. “Tomorrow is better than today.”

2. DAY IN THE LIFE OF AN OPIOID-USING PARENT: SUPPORTING PARENTS AND CHILDREN

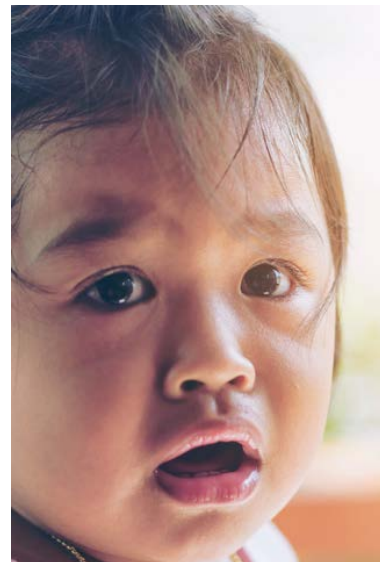
Pamela Baston, MPA, MCAP, CPP

a) Immediate Considerations of a Parent With an OUD:

- What is the capacity of the parents? What is happening to child?
- Could intimate partner violence be an issue in maintaining the OUD?
- Is the OUD causing a lack of responsive care, resulting in toxic stress for the baby or child?

b) Consider the Day in the Life of an Opioid-Using Parent:

- They will wake up in withdrawal (dope sick). Their next thought is “How will I alleviate this dope sickness?”, which leads to **opioid preoccupation** (don’t typically stash opioids; if there, they will use it. Therefore, there is a scramble to get their next amount of opioid.) What happens to kids in this phase? Normally, if the parent was not in the preoccupation phase would be an opportunity to bond with the children. Instead, in the preoccupation, this opportunity is cast aside (i.e., neglect during this period); neglect more common with opioids.
- **Diverted finances.** Parents may trade sex for drugs or train children to get drugs for them. The primary obsession is to not be dope sick, rather than to seek the high of the drug; it is often the alleviation of the dope sickness, rather than the high, that causes parents to lose their home, dignity, children, and family. Diverted finances/resources are a descent into a place full of shame and a difficult life; what depths of despair are they experiencing? Grantees and partners must seek to line up responses with the severity of what the patient/client is experiencing.
- **Opioid procurement:** What is happening with their children during opioid procurement? Usually, the children are not safe (i.e., the proximity to drug dealers and unsafe neighborhoods/houses). There are lot of dangers around procurement; parents will have





different levels of protective capacities (i.e., some parents may try to do the best they can do to keep their child safe and comfortable when procuring, while others give no regard to safety and comfort).

- **Opioid consumption:** Caps on needles can be choking hazards. The length of the high can vary considerably. Now that they have procured, they most likely are going to use the drug immediately after procuring rather than waiting until they are back home with the child.

c) Immediate Effects on Child Upon Parent Using Opioid After Procurement:

- If the user nods off, the child may have trauma from observing the parent in this state or, worse, finding the parents have overdosed.
- If the parent goes to jail or dies, the child goes to foster care. This can cause feelings of abandonment, which, in some cases, could be worse for him or her than seeing the parent use.
- There is shame and blame. Blame thoughts may include, “If my parents loved me, they wouldn’t have done this.” Shame thoughts may include, “They used drugs and died . Did I cause this?”

An overarching goal: Reinforce hope! Develop family-focused, holistic, whole-person approaches with your programs. Remember, those that use opioids didn’t seek this lifestyle. A series of life traumas and/or underlying mental health issues accumulated, leading to this point. Keep your compassion alive, and see the humanistic side of the issue. Use this platform to seek exchanges with partners and collaborative approaches.

SUMMARY

The first TOR Grantee TA meeting provided participants opportunities to learn about ways to implement MAT, while, at the same time, integrating traditional cultural practices, cultural relevancy, and humility into care. Grantees learned about the importance of cultivating and leveraging partnerships within and external to the Tribe (if needed), including partnerships that support traditional healing. Grantees were reminded to educate partners about MAT as a life-saving effective treatment, the benefits and hope of recovery, and the role stigma plays as a barrier to treatment access and retention. Grantees were exposed to information about the prevalence of co-occurring substance and mental health disorders, data collection issues, and more. Many inspirational presentations were made to reinforce the importance of the work grantees are doing and can still do. Grantees also had the opportunity to develop peer-to-peer networks to be sustained over time.

MEETING OUTPUTS

- ▶ Grantees will leverage the information from the grantee meeting to update their existing work plans, including their plans for sustaining gains made under their grants post award.
- ▶ SAMHSA will use information from the grantee meeting to develop a Grantee Best Practice Directory to serve as a TA resource.
- ▶ SAMHSA and grantees will enhance the existing peer-to-peer networks (i.e., Evaluators Peer Group, Tribal Grantee Peer Group), as well as potentially develop new ones.