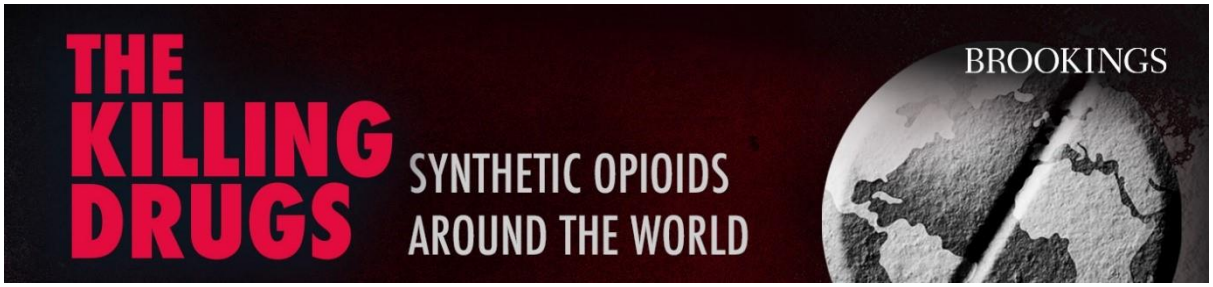

The Brookings Institution

***The Killing Drugs* podcast**

"Fentanyl's impact on Native American communities and paths to recovery"

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Guest:

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Episode Summary:

Vanda Felbab-Brown speaks with Philomena Kebec, economic development coordinator for the Bad River tribe, about the particularly devastating impact of the fentanyl epidemic on American Indian and Alaska Native communities. In the United States, Native communities experience the highest drug overdose mortality rates among racial groups, with fatalities far surpassing national averages. But the sheer numbers do not capture the totality of the devastation, such as the cultural losses and community grief. Yet federal and state responses to the fentanyl crisis among Native communities have been profoundly inadequate. Kebec emphasizes the urgent need for greater resources, culturally tailored and evidence-based care, and greater decision-making authority for Native communities.

[music]

FELBAB-BROWN: I am Vanda Felbab-Brown, a senior fellow at the Brookings Institution, and this is *The Killing Drugs*. With more than 100,000 Americans dying of drug overdoses each year, the fentanyl crisis in North America, already the most lethal drug epidemic ever in human history, remains one of the most significant and critical challenges we face as a nation.

In this podcast and its related project, I am collaborating with leading experts on this devastating public health and national security crisis to find policies that can save lives in the United States and around the world.

On today's episode, I am exploring the prevalence of fentanyl use in American Indian and Alaska Native communities. They have been hit particularly hard by fentanyl. My guest is Philomena Kebec. She serves as the economic development coordinator for the Bad River tribe and is a Bloomberg Fellow at the Johns Hopkins School of Public Health.

Philomena, thank you so much for joining me today.

KEBEC: I'm really glad to be here, Vanda.

FELBAB-BROWN: So, Philomena, I already mentioned the tagline that American Indian and Alaska Native communities have been hit particularly hard by opioids and fentanyl specifically. Please give us the details. What's been going on with these communities?

[1:30]

KEBEC: Well, since the last in the last five years, since about 2018, the rate of drug overdose mortality by American Indian people has been rapidly increasing. And at this point, with the best data that we have, the most recent data that we have from the CDC, we're seeing that American Indian and Alaska Natives have the highest drug overdose fatality rate among races within the United States.

And when you really dig down into the numbers, there are several states that have exceedingly high rates of death when we're talking about fentanyl; and then other states where you have high populations, large populations of native people, but much reduced numbers in terms of drug mortality.

So, what's been very helpful about doing this study is to look at some of the trends that we're seeing and start connecting the dots in terms of what are the causes that are driving these really high rates that we're seeing in particular states. I'll highlight a few states. So, the states of Minnesota, Wisconsin, Washington have very high rates of fatal drug overdoses among American Indian people, North Carolina as well.

And to give you some numbers behind what I'm saying—what is high, what is not high? For Minnesota, 2022 numbers recently came out, and it's 215 deaths per 100,000 people for American Indians within this drug overdose. What are those numbers mean? So, for the general population in the United States, it's 30 deaths per 100,000. So, when we're talking about 215 deaths per 100,000 in Minnesota, this

is beyond crisis. This is absolutely devastating to tribal communities. It's a very stark difference.

FELBAB-BROWN: So, beyond the enormity of the personal tragedy, and just the catastrophic death rate that is so much larger in American Indian and Alaska Native communities, and particularly in the places that you identified, like Minnesota, how have communities, Alaska Native, American Indian communities been affected by what's going on?

[3:57]

KEBEC: There's a lot of there's a lot of different impacts to these to our communities. And in my community in Bad River, there are children who've lost both parents, and aunts and uncles who have lost multiple children to this epidemic. Within our communities are very close knit, and people have roles that they have to fulfill, cultural roles, economic roles within communities and families. And when we have all of these young people that are passing away sooner than they really should have, the continuity within community is impacted.

I can think of a young man who passed away in our community in 2022. And he was one of the song keepers, and he knew just thousands of songs that are really critical for our community to know. And his passing was incredibly painful. There were hundreds of people at his funeral. And after his funeral, we had a real spike in COVID cases because there were so many people that came together.

Often, we see that there is multiplication of these harms to community when we have people that have passed, it's loss of culture, it's the trauma that comes with the children and the families who have lost a loved one.

FELBAB-BROWN: So many communities in the U.S. are experiencing the intergenerational trauma, the effect on children losing parents, parents losing children. But obviously, as you say, it's much more amplified because of the history for American Indian community and Alaska Native communities, but also this cultural aspect that you brought in this example of this young man, the song keeper, I believe, you phrased it, is just of a different quality and the extent of the impact is all the larger.

[5:53]

KEBEC: And I think that comes on a backdrop of the losses that we've had to our culture because of the genocide to our communities, and all the cultural loss that happened from boarding schools. So, every one of these people who carries these songs and these traditions, and these stories is that much more important because there's so few of them. So, that's something that is happening all throughout Indian country. The rate of losses and the breadth and the depth of losses as well, puts our communities in a constant state of grief because every time the ambulance goes by, the question that we all have is, who died? And it's a level of vigilance that we're holding within our communities because the losses are coming so quickly.

FELBAB-BROWN: So, among the various things you do, Philomena, in your community is to work in a harm reduction center that serves your nation, the Bad

River Band of Lake Superior Chippewa Indians. I know that your work has been very important and very personally difficult, but can you give us a sense what it's been like working in the center? What is it like in the center on the daily basis?

[7:06]

KEBEC: It's really great to be working here. We're in a double wide modular building in the heart of Odanah, which is the capital of the Bad River Band, and where we provide a lot of things that we've thought that people might need. So, there's a place for folks to take a shower. We're getting a washer and dryer soon so people can wash clothes when they want to. There's a full kitchen full of food. We have all kinds of harm reduction supplies—naloxone, you name it.

And what I appreciated about it is what people say about it. And what I've heard is that this is a safe place to go when you're not using drugs. So, you come here, people aren't going to judge you. It's going to feel good. You can rest. You can get some of the resources that you need.

And we have to have many more of these places for people, because the one of the biggest barriers to getting care and addressing the substance use disorders that are leading to the overdoses in our communities is the stigma and even the self-stigma that people are experiencing. So, having a safe place, having people that they can talk to, having resources that are readily available and specific to their needs is an absolutely critical intervention that we need right now.

FELBAB-BROWN: And I would imagine that in addition to the impact and the reward, being able to help people make them feel they have some support, they have access to just basic daily needs, that in addition to that reward and to that help, it also must be very challenging when you yourself have witnessed a great deal of deaths in the community. And that has been one of the important sources of motivation for you personally to become so deeply involved.

[9:02]

KEBEC: Since I moved back home to Bad River in about 2012, I've been hearing about the real issues that our community has with the criminal justice system and specifically with the jail. And the jail in Ashland County has been a place where many Native people have died. Since the coming of the fentanyl epidemic, what we've seen are people who leave jail—people from our community. They leave jail, they have no resources. They have lost their car, their home, the ability to parent their children, connection, jobs, all of that. And many of the people who upon shortly leaving the jail end up dead of drug overdoses.

There has not been enough attention to that in the literature. I'm not aware of any research that has been done specifically related to the connection between incarceration and death within tribal communities. But one of the things that I saw when I was conducting my ecological epidemiological study is that states with higher rates of incarceration of Native people like Wisconsin—Wisconsin incarcerates Native Americans at a rate of 25 to 1 in relation to white people. It's egregious.

And, again, Wisconsin, Minnesota, other states that have high rates of incarceration are also seeing high rates of drug mortality among Native Americans. And these things are connected. So, it's very important that NIH and other research institutions takes heed, reads this study, and starts investing in looking at these connections. We need to know why Native American people in specific states are dying at such high rates, and then use those data to change policies.

FELBAB-BROWN: Which is an excellent transition to what I want to ask you now, Philomena. So, you know, you have personally done great work. The community has mobilized and facing this catastrophe that is so much more augmented than at the national level in comparison to what white communities are going through. What is the current state of U.S. federal policies or, for that matter, specific state policies to provide support for American Indian and Alaska Native people with opioid use disorder or fentanyl disorder?

[11:39]

KEBEC: I think it's really varied. And one of the long-time problems that we've faced in tribal communities is that the Indian Health Service, which has the trust responsibility to provide health care services for Native Americans, has been underfunded and continues to be underfunded. So, among the three federal health insurance companies within the United States, their health providing entities—so, that's IHS, the Veterans Health Administration, and Medicaid CMS—IHS is funded at the lowest per capita rate. And in many tribes, the health care provision … they're not billing Medicaid. And so, there's a real lack of resources coming back to these communities to provide the targeted response that we need. Other problems are related to—

FELBAB-BROWN: —Before you go to these other problems, I just want to hone in on IHS not billing Medicaid. Please explain to us why that is the case and why that is so critical.

[12:49]

KEBEC: Some tribes run their health care directly through IHS, and people get their services through IHS. Other tribes have engaged in a 638 contract, which means they have taken over their health care systems. And many tribes, like my tribe, wasn't billing any third-party insurance companies, including Medicaid when people used our clinic. And this meant that we were leaving a ton of revenue on the table. And so, tribes who are not doing this need the technical assistance and support to optimize their billing systems so that that reimbursement is coming back and they can invest in better programing.

The other problem—there are many problems—but another problem is that the Medicaid systems are keyed to states, and oftentimes states and tribes do not get along. They have competing interests related to the needs that they're trying to fulfill with their health care systems. So, my tribe has to bill Medicaid according to Wisconsin's policies. And this means that we cannot bill peer support. We cannot bill for the cultural services, for the traditional medicine that is so critical for people to recover. And that we're really tied to these systems that are really only focused on saving money and being efficient when our community has very particular needs.

Our people have a life expectancy that is about a decade less than our white counterparts in our county. And because we have to follow this state Medicaid plan, we're really not able to partake in all of the preventative and culturally specific services that are so desperately needed.

FELBAB-BROWN: Let me just reiterate some of the statistics and we continue talking policy. So, you said incarceration of Native American communities in the specific study, 30 times to one white person; death rate, 210 per 100,000 from fentanyl as opposed to 30 per 100,000 general population; and now, the latest statistics that you brought in shows just another enormous disparity, a decade less life expectancy than for white counterparts. So, tremendous needs, tremendous policy failure.

Let's talk about policy. So, you spoke about the lack of resources, the barriers, and complications in accessing resources, such as for treatment, for which insurance is so critical, as we heard on the episode with Professor Harold Pollack and Professor Nicole Gastala. The access to providing treatment, the mechanics of getting to treatment is as important as treatment itself. On other episodes, such as with Professor Regina LaBelle and Doctor David Holtgrave, we heard about a cascade of care and other associated services, such as housing. What does this look like for Native American communities?

[16:05]

KEBEC: There's a lot there. I mean, for Native American communities, we're talking about different metrics and a different measurement of success in terms of our health care systems. The opioid use disorder cascade of care is probably really great for other communities, but it's very linear, and it does not provide enough context related to the social determinants of health that are critical for Native people.

So, one thing that I highlighted in my paper was the opioid use cascade of care that was developed by the White Earth Nation, and it uses a completely different framework in order to measure success. And instead of measuring patient success by how many people have achieved sobriety within six months, how many people have been connected to care, have had their first appointment—those things are important. But the Anishinaabe cascade of care really looks like the ability of programs to connect people with community, with culture, with their families. And these things are these things are the measures of success and the optimum outcomes for our people because we know that if people don't get connected with community, if they're not able to get back with their family, and if they don't have that cultural connection, that they're much more likely to continue to use in a way that is problematic.

So, I think it's really important that we are we're using our own measures when we're talking about success in tribal communities.

FELBAB-BROWN: And I want to delve more into the experimentation, the policies that tribes themselves are developing. But before we go to that, let's get some important context here. You're talking about current policy failures, policy challenges at the federal level. But of course, the current failures simply compound, intersect with historic injustice, historic policy failure—in fact, genocide as you yourself

appropriately phrased it. Please explain to us how these long-term injustice legacies are harmful to American Indian and Alaska Native communities today, specifically in terms of opioid use disorder, in terms of fentanyl challenges.

[18:38]

KEBEC: It's really hard to talk about that in a short segment, but I will do my best. So, imagine your children being taken from you because you speak your language. Imagine your children being taken from you because you work at a corporation, and you watch Netflix, and you listen to podcasts. That's what happened to our people. Our children were taken from us because they engaged in Anishinaabe culture, because they engaged in wild rice harvesting and fishing, and going to their own ceremonies, and giving their children Anishinaabe names that related to their spiritual purpose. And then imagine that the only way that you could keep your children with you is if you aligned with a foreign nation and pledged allegiance to them.

And those were the choices that people had. Those were the choices that my great grandparents had. Either go along with your culture and have your children ripped from you, and not see them until they're 18 again. And I'm talking about three- and four-year-olds having someone else raise them, having them be abused and malnourished, and hit, and sexually molested. That was what was happening. Or else you have to be an American and stop speaking your language and turn away from your culture and turn other people in.

And that kind of fascism is what our community had to experience. And either choice you made was shameful. Either choice you made was shameful. And it rocketed our communities into this economic despair. And people didn't have therapy to go to. People weren't able to talk about things because then they would be criminalized and punished. And God forbid, if you did continue to exercise your culture, and hunt deer, and go fishing, you'd end up in jail. So, you're just trying to feed your family, you are in jail for 30 days.

And that's when the cycle of incarceration of our people began. And the county, and the state, they farm our people out for economic development. Our people are incarcerated at higher rates because that creates jobs in non-Indian communities that have health insurance, that have stability. When they're taking all that stability and the economic strength away from us, and people are wrung out of value and come back—and I'm not saying that people who are incarcerated don't have value—but they're cut off from those connections, they're cut off from a future, they're cut off from job opportunities. Oftentimes their children have been removed because they can't demonstrate safe and stable housing. And there's very little support.

When I first came back to my community in the 2010s, I was working as an attorney doing child welfare cases, and I did it for about three years. And then I couldn't do it anymore because I find the system completely repugnant. And there continues to be a lack of thought into how this system is affecting the health of our people.

This year in Ashland County, there are ten suspected opioid overdose deaths. Sixty percent of them are Native American women. I believe a large proportion of them, a large proportion of the people who have died have had recent experience within the

justice system. And those connections are not being made. They are not providing ready access to medication for opioid use disorder for the people who are incarcerated. And this is a major problem within my community and communities throughout the country.

FELBAB-BROWN: You've already articulated many of the impediments to providing much better access to opioid use disorder treatment, care prevention for American Indian and Alaska Native communities. But please, if you can go into that further, including the importance of medication assistance for opioid use.

[23:18]

KEBEC: Sure. You know, one of the real challenges for writing the piece was the lack of research. And so, we really need to do better in terms of care and attention to these issues. But there's several papers that discuss the limited access that Native American people have to the best available treatments for opioid use disorder. And the best available treatments today are medications, specifically methadone and suboxone. Those are the gold standard medication treatments for opioid use disorder that have shown the best results.

FELBAB-BROWN: And something that was strongly emphasized by Harold Pollack and Nicole Gastala in their work and in the paper for this series.

KEBEC: And oftentimes in tribal communities, naltrexone is the only medication for opioid use disorder that is available. Naltrexone has been proven effective, but its efficacy has issues because of adherence. People have been shown in studies to just not come back for more treatments with naltrexone. Buprenorphine is more widely available in tribal communities, but it's not available everywhere. And methadone is distinctly unavailable in many tribal communities throughout the United States, especially the ones that are in rural areas. The lack of access to methadone in rural communities is a very big problem, and it's something that regulators need to start addressing.

And I think for tribal communities, it's very important to combine these medications with access to cultural services, with peer support, with the provision of a full bevy of care, including nutrition. And also, housing—supportive housing is a critical need for tribal communities. One of the real issues that we have had in tribes is that tribal public housing agencies, they're not administered by HUD, but they're they use HUD funding. And because of that, the HUD bans on drug use and drug convictions apply in many tribal communities. And this seriously impacts the ability of tribal members who are trying to recover from opioid use disorder and other substance use disorders from getting housing.

FELBAB-BROWN: And one of the points that was really striking in your work, and that you emphasize a lot, is the lack of legal empowerment for communities to design their programs and to provide input into their programs. Please explain that to us.

[26:00]

KEBEC: So, I touched on this about the Medicaid issue, that the tribes have to go through a state, have to adhere to Medicaid policies that have been developed by states in order to bill for services that have been provided. This is an anathema. Tribes have civil regulatory authority. This means on any subject in which there's no prohibition. So, I mean, we couldn't authorize people to engage in homicide, but because that's criminal. And within Wisconsin, there's a Public Law 280, and we don't regulate homicide or punish homicide at this point. But we do regulate our gaming facility. So, there's a gambling facility. We make money on that. The tribe regulates that. The tribe regulates traffic. The tribe regulates child welfare, all sorts of other topics that fall within this civil regulatory ambit.

But for some reason, we're not regulating health care. We're not licensing doctors. We're not scheduling medicines. We are not engaging in all those other regulatory areas that we really could and should. And so, I would love to see tribal leaders and tribal attorneys moving forward to better contain and regulate our tribal communities.

There's other areas. Like, I also talked about in our paper, the problem of Public Law 280. Public Law 280 was passed in 1953 by Congress that wholesale gave up tribal criminal regulatory authority to states. And this occurred in several states including Minnesota, Washington, Wisconsin, California. All of these states are states where we're seeing very high rates of drug overdose mortality.

And what we've seen with studies related to Public Law 280 is that this drastically diminishes public safety and the ability of tribal communities to regulate and control policing. And, I think in our community what we've seen is just police running amok, not listening to the community, and nickel-and-diming tribal members, sending them back and forth to jail. It's just this revolving door of jail. And very little results in terms of a reduction in recidivism.

FELBAB-BROWN: Well, let's now delve in the last segment of the show into some of the more hopeful aspect. And it is specifically that several tribal nations, like the White Earth Nation, the Confederated Tribes of Grand Ronde, the Lumbee Nation, and Alaska Native Tribal Health Consortia are engaging in the research that you also recommended on policy effectiveness, on policy innovation for drug poisoning, and improving access to effective treatment, and treatment that is suited and contextualized for Native American communities. Please tell us about this work and their findings.

[29:14]

KEBEC: And again, I'm going to say what I said before. We need more research, because tribes across the nation are doing incredible work, and I just don't think it's showing up in the peer reviewed studies at this point. But certainly, White Earth Nation has been a long-standing leader in this field. The White Earth Nation engages in health care services in three different jurisdictions. So, on the reservation within Duluth, and then also within Minneapolis, White Earth was one of the first tribes in the nation to run a harm reduction program, and they offer harm reduction in a low barrier manner to everyone in the community.

And this is the same for the Confederated Grand Ronde nation as well, that the provision of services is not just simply for Native Americans, but there's a real effort to address this issue globally. We understand that people use drugs together. They have to heal together. And so, we have to provide these services in a way that that reaches a broader demographic.

So, the Confederated Tribes of Grand Ronde are engaging in a mobile methadone and buprenorphine clinic that services more than one community. It's this bus that they developed during the COVID epidemic. It's outfitted to be compliant with the very heavy regulations regarding methadone. But they make several stops on a daily basis. And they're engaging with communities at those stops so that they're bringing people in, and they can do inductions right there. They can do dosing, counseling, other kind of services.

[30:57]

This is really critical because one of the biggest barriers that people have is transportation. So, bringing the clinic to the people is just a brilliant solution to overcome that. I have a friend in Alaska, Annette Hubbard, who recently started a buprenorphine clinic that is also mobile in Alaska. And I think it travels about 50 miles a day, and it's doing the same thing. There's inductions that are happening right there. People are getting connected with services.

And, you know, sometimes when we're doing these things, when we're doing these interventions, it's really important that there's flexibility built in. That's one of the things that I've learned from harm reduction. Because not everybody is the same. And they have, like, these tailored situations that need particular care.

And we have to develop systems that are not simply everybody runs through the same thing. And that's what a lot of FQHCs [Federally Qualified Health Center] do. Everybody has to do this intensive outpatient program. And I'm not sure whether they need to do it because the people actually need it or whether it's needed because that's what makes fiscal sense for the FQHC. So, we have to have billing systems that provide flexibility for providers to listen to people's needs and then to help them.

FELBAB-BROWN: On several of the episodes and today, again, we learned very much about the importance of context specific policies, learning from best evidence and applying that across the board, but at the same time allowing care, allowing access treatment, to be customized to specific context, to specific communities, and in fact, with specific clients, to specific patients and individuals with need. And it is all the more true in the context of Native American communities, other minorities that come in with such particular and particularly traumatic historic background, particularly traumatic and extensive deficiencies in terms of access and policy support that has been longstanding.

So, thank you so much, Philomena, for the excellent work you're doing for your community and our nation highlighting this egregious situation and the need to do much better. Thank you so much for your contribution to the opioid project, to the fentanyl project that we are running at Brookings. And absolutely terrific having you on the show today.

[music]

KEBEC: Vanda, it's been my pleasure. Thank you so much for asking me, inviting me to participate.

FELBAB-BROWN: *The Killing Drugs* is a production of the Brookings Podcast Network. Many thanks to all my guests for sharing their time and expertise on this podcast and in this project.

Also, thanks to the team at Brookings who makes this podcast possible, including Kuwilileni Hauwanga, supervising producer; Fred Dews, producer; Gastón Reboredo, audio engineer; Daniel Morales, video editor; and Diana Paz Garcia, senior research assistant in the Strobe Talbott Center for Security, Strategy, and Technology; Natalie Britton, director of operations for the Talbott Center; and the promotions teams in the Office of Communications and the Foreign Policy program at Brookings. Katie Merris designed the compelling logo.

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I am Vanda Felbab-Brown. Thank you for listening.