Foreign Policy at BROOKINGS

THE IMPACT OF FENTANYL ON AMERICAN INDIAN AND ALASKAN NATIVE COMMUNITIES

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Executive summary

Within the United States, fentanyl has disproportionately impacted American Indian/Alaska Native (AI/AN) individuals and communities. There is no evidence of genetic predisposition to opioid use disorder. Instead, the AI/AN populations' vulnerability to fentanyl harms can be traced to historical and contemporary policy failures and ongoing theft of AI/AN resources.

In 2022, AI/AN individuals registered 65.2 drug deaths per 100,000, a rate twice as high as the U.S. national average of 32.6 per 100,000.[1] State-level disparities are even higher. States, such as Minnesota and Wisconsin, analyzed in depth in this paper, are experiencing even greater fentanyl-linked mortality rates for AI/AN individuals.

Beyond these devastating aggregate statistics, more granular AI/AN-relevant data are needed at both the national and state levels to improve policies toward fentanyl and opioid-use disorders. Such necessary information includes AI/AN opioid-use and drug-related mortality rates adjusted for age and county-specific statistics.

Equally lacking are detailed, evidence-based explanations for the disproportionate fentanyl-related harms AI/AN communities are experiencing, as well as variations in the intensity of the harms across AI/AN communities.

This paper identifies some plausible factors that require further examination. They are:

- The application of Public Law 83-280, which confers general criminal jurisdiction over federally-recognized Indian tribes to state-level authorities.
- Incarceration rates of AI/AN persons, which are significantly higher than other racial groups in many states.
- Access to medication treatment for fentanyl, which is substantially lower for AI/AN populations than for other racial groups due to the overregulation of methadone, chronic underfunding of health facilities serving AI/AN people, and economic instability, poverty, and housing instability.

Importantly, Native nations and tribal organizations are increasingly engaging in research and innovating to reduce drug-related harms in AI/AN communities. Their work shows the importance of integrating connectedness to AI/AN culture into the treatment and prevention of mental health and substance use disorders.[2] When combined with improved access to medication treatment for opioid use disorder, such cultural connectedness has shown promising results. Yet significant structural and funding barriers continue to prevent Native nations from exercising self-determination in health care contexts. Some of the structural and funding barriers that will be explored in this paper include: inadequate funding for the Indian Health Service, which facilitates access to health care for AI/AN patients, and Native nations' ability to build and sustain health care systems tailored to their patients' needs.

Learning from what drives suicide within AI/AN populations is also highly relevant for understanding and responding to fentanyl-related fatalities in AI/AN communities. Similar to drug-related fatalities, the rate of suicide fatalities among AI/AN populations exceeds that of all other racial groups within the United States. In both cases, mortality rates vary by state and region. Contemporary factors explaining the very high suicide rates among AI/AN youth include socioeconomic challenges, a history of neglect and abuse, and substance use disorder. Long-running factors include the decades-long forcible placement of AI/AN children into boarding schools and tribal governments' inability to exercise self-determination. Greater exercise of tribal self-determination has been associated with a reduced risk of suicide in AI/AN youth.

Key policy recommendations include:

- Expanded funding for data collection and analysis of the fentanyl crisis' impact on AI/AN communities.
- Additional funding for tribal treatment and prevention programs, including culturally-tailored treatment options.
- Health care and insurance regulatory reforms to improve access to treatment for AI/AN patients and to improve the quality of treatment for substance use disorders available to AI/AN communities.
- State-level assessments to identify barriers faced by AI/AN communities in relation to education, health care, and justice for AI/AN populations, with collaborations formed between tribal, state, and federal governments to address the root causes of health-related disparities.

Preamble

My nation, the Bad River Band of Lake Superior Chippewa, operates from its treaty-established reservation on the southern shore of Lake Superior in the State of Wisconsin. We have suffered tremendous losses since the arrival of fentanyl in 2019, grieving the loss of over 45 individuals in our tight-knit community.

The building in which I work serves as my nation's harm reduction center. It is a busy drop-in center frequented by community members who use a variety of substances. Most are currently reporting regular fentanyl use. Harm reduction program staff, trained and certified in peer support specialization, engage with drop-in participants on how to reduce the risk of overdose through testing the drug mixture composition of the substances they intend to ingest, using drugs with friends who carry the overdose-reversing medication naloxone, and using life-saving medications for opioid use disorder—namely, buprenorphine and methadone.

The Bad River Band faces practical challenges in implementing evidence-backed solutions: only buprenorphine and naltrexone, not methadone, are available locally, and prescribers' willingness to provide long-term medication treatment to patients, who are often unable to refrain from using illegal substances while under their care, varies. Although methadone has been shown to be more effective due to increased retention (i.e., the length of time actively engaged in treatment), it is only accessible for those who move away from our reservation to urban areas.[3] Such a move can disrupt the lives of individuals and their families. Moving away from home-community supports also puts AI/AN women (and men) at increased risk for trafficking and other forms of violence.[4] Being able to provide local, tailored medical care within our nation's clinic by offering all Food and Drug Administration-approved medications for the treatment of opioid use disorder (MOUD) would be highly desirable.

The struggles we face as one Ojibwe Nation in addressing the soul-crushing trends in local drug fatalities, and our work to interrupt these trends, are emblematic of Native nations' experiences nationally. This paper details those massive challenges and the deficiencies of federal and state policies that compound historic injustices. It also provides policy recommendations for improved outcomes.

Introduction

As of 2022, the drug-related death rate among AI/AN populations was twice as high as the U.S. national average, with 65.2 AI/AN people dying for every 100,000.[5] In several states, such as Minnesota, Wisconsin, North Dakota, and Washington, the AI/AN drug-related death rates were even higher.

Facing grave losses, tribal leaders have described AI/AN populations' disproportionately high death rates as "catastrophic," with scores of young Native people dying weekly over the past several years.[6] Many AI/AN families have lost

multiple relatives to fentanyl, with many children burying both parents. The incidence of multiple drug overdose deaths within families and nations increases the severity of grief.[7]

But the vast detrimental effects of these deaths extend beyond the loss of individual AI/AN people, shocking as the scale is. Losing so many individuals so quickly weakens entire AI/AN communities, with tribal communities' close-knit nature heightening the tragedy. Within Indigenous communities, each community member is responsible for carrying out activities related to cultural traditions, community and family care, economic support, and other communal functions. The extreme level of drug-related deaths that tribal communities are experiencing due to fentanyl is leaving critical gaps in many of these roles and responsibilities. Thus, the deaths have had a pronounced, negative cultural impact, including the loss of songs, narratives, and traditions that are vital to AI/AN well-being.

How intensely AI/AN communities have been affected by the fentanyl crisis, lately also intertwined with a methamphetamine crisis, varies across U.S. states. This is not surprising as state policies differ. Indeed, so do the AI/AN communities.

American Indians and Alaskan Natives do not comprise a singular "race," but rather represent a great diversity of nations that pre-existed the United States and continue to exercise political sovereignty. The U.S. government recognizes 574 of these nations, with additional nations recognized by states.[8] Within the United States, AI/AN individuals maintain a political identity and historical connections to their Native nation (or nations) and their peoples' traditional lands and waters, with most (87%) living away from their nation's reservation and in urban areas.[9] The strength of their connection to "home" varies by person, with citizens and descendants of the same Native nation engaging in varying levels of participation in tribal language and cultural traditions and political and economic activities.[10]

AI/AN individuals who are enrolled in their Native nation are represented by duly elected tribal governments, whose purpose is to serve tribal communities—the body politic of Native nations.

While great diversity exists in cultural expression, history, and identity, these nations share a common experience of colonization, which led to the racializing of North America's Indigenous people as "Indians." In broad terms, colonization led to the (ongoing) alienation of tribal lands and resources, the loss of governing authority, and cultural genocide. Native nations' diversity is also reflected in their different responses to fentanyl. While some nations have opened syringe service programs and healing courts to offer care and support to AI/AN individuals struggling with drug use,[11] others have banished or excluded community members who use drugs from their reservations.[12]

Beyond the most important imperatives of saving lives and communities, exploring AI/AN populations' public health trends is also central to identifying how settler-colonialism and racism impact AI/AN groups' well-being and how the promises of full and equal participation in American society have fallen flat.

Yet, in addition to the shared experiences of exploitation, Native nations also share legacies of resistance, expressed in myriad forms: modern Native nations are engaged in cultural and economic renaissance, leading innovations in environmental stewardship, holistic health care, intergenerational healing, and more.[13] These forms of resistance, too, can guide Native and non-Native communities in developing effective interventions to reduce harms from fentanyl- and methamphetamine-related death and disease.[14]

Crafting effective drug policies for Native America requires attention to broad national trends, as well as AI/AN-crafted solutions. It also requires policymakers to heed regional differences and Native nation-specific needs.

Policy solutions for AI/AN communities should originate in Indigenous knowledge and philosophies that respect individual autonomy and decisionmaking. Drug use alone is not indicative of a substance use disorder or a mental health illness, including for AI/AN individuals. Nor is it something that should be, as a result of social conditioning, condemned, judged, or outright pathologized. Behavior designed to acquire and ingest substances to modulate human experience is universal. A baby's first cry is their call for the comfort of their parent's milk.

Due to drug prohibition, many AI/AN individuals are unable to obtain the substances they need for nervous system regulation and pleasure through legal means. As a result, they rely on drug formulations procured in informal markets.[15]

AI/AN ingenuity in managing the use of multiple types of substances, while also navigating post-colonial America, is an example of Indigenous "survivance." The concept of survivance was popularized by the social theorist and White Earth Anishinaabe Gerald Vizenor to describe the dignified and culturally resilient lifeways of urban Indians living on the fringe.[16] Living in unstable conditions, AI/AN people in poverty who use drugs express survivance by using their intelligence and social agency to obtain and combine a variety of substances to achieve a desired effect, transcending their given state.

Yet increasingly, the illicit drug market provides highly potent and dangerous substances, including fentanyl and super-potent methamphetamine, and other unpredictable drug mixtures.[17] Such sourcing, especially when used on a regular and frequent basis, puts individuals, including AI/AN persons, at high risk for drug poisoning events.[18] Improving policy responses toward drug-related fatalities, including the development of pathways for marginalized peoples to obtain regulated sources of the drugs they frequently use, or safe analogs, is thus fundamental to saving AI/AN lives, communities, and cultures.

This paper proceeds as follows: the first section describes the scope of the fentanyl crisis among AI/AN communities and the critical inadequacy of existing data. The second section highlights regional variations in fentanyl/drug poisonings in AI/AN populations and explores a set of possible explanatory drivers, including the adoption of Public Law 83-280, conferring general criminal jurisdiction over the lands of Native nations to state-level authorities, rates of incarceration, and access to medication for treating opioid use disorder. Next, the paper discusses AI/AN innovative responses to the fentanyl crisis, including cultural connectedness and new ways to expand access to medications for opioid use disorder. The paper also explores the existing state and federal obstacles to the design and implementation of these AI/AN factors, thereby explaining the disproportionately high rates of suicide among AI/AN youth, including contemporary socio-economic factors and long-term marginalization and exploitation, and ways to reduce those risks, such as through greater exercise of tribal self-government. The paper concludes with policy recommendations.

The problematic limitations of available data

AI/AN communities have been uniquely impacted by fentanyl. While rates of drug-related fatalities among AI/AN populations had been steadily increasing since the 2000s, these rates increased precipitously in the late 2010s, as fentanyl became available throughout the United States, and further with the onset of the COVID-19 pandemic.[19] The devastating and stark effects among AI/AN populations were significantly higher than among other racial groups and U.S. national trends.

In fact, the highest rate of U.S. age-adjusted fatal drug overdoses in 2020 and 2021 were among AI/AN populations, at 42.5 and 56.6 deaths per 100,000 respectively, in contrast to the U.S. national average of 28.3 and 32.4, respectively.[20] These high rates continued in 2022, when AI/AN registered 65.2 age-adjusted drug overdose deaths per 100,000, a rate twice the U.S. national drug overdose mortality of 32.6 per 100,000.[21]

As Figure 1 shows, AI/AN disparities with the U.S. national average were even more dramatic when disaggregated by state: Minnesota's drug overdose death rate among AI/AN populations was 191.4 per 100,000, while Wisconsin (113.2), Washington (94.7), and North Dakota (84.5), also topped the list of states with the highest incidence in 2022.[22] In contrast, AI/AN drug overdose fatalities in 2022 were relatively low in states such as New York (14.1), California (21.4), and Michigan (25.3).[23] As fentanyl's spread west of the Mississippi River became entrenched, AI/AN communities there were disproportionately impacted. Preliminary 2023 data from California indicates that age-adjusted fentanyl-linked deaths in AI/AN communities increased over 60% from 2022 to 57.3 per 100,000, twice as high as the fentanyl mortality rate of whites in the state.[24] In Washington, the disparities were even starker: the 2022 age-adjusted opioid-caused mortality for AI/AN was 106.8 per 100,000, four times higher than the rate for whites.[25]

FIGURE 1

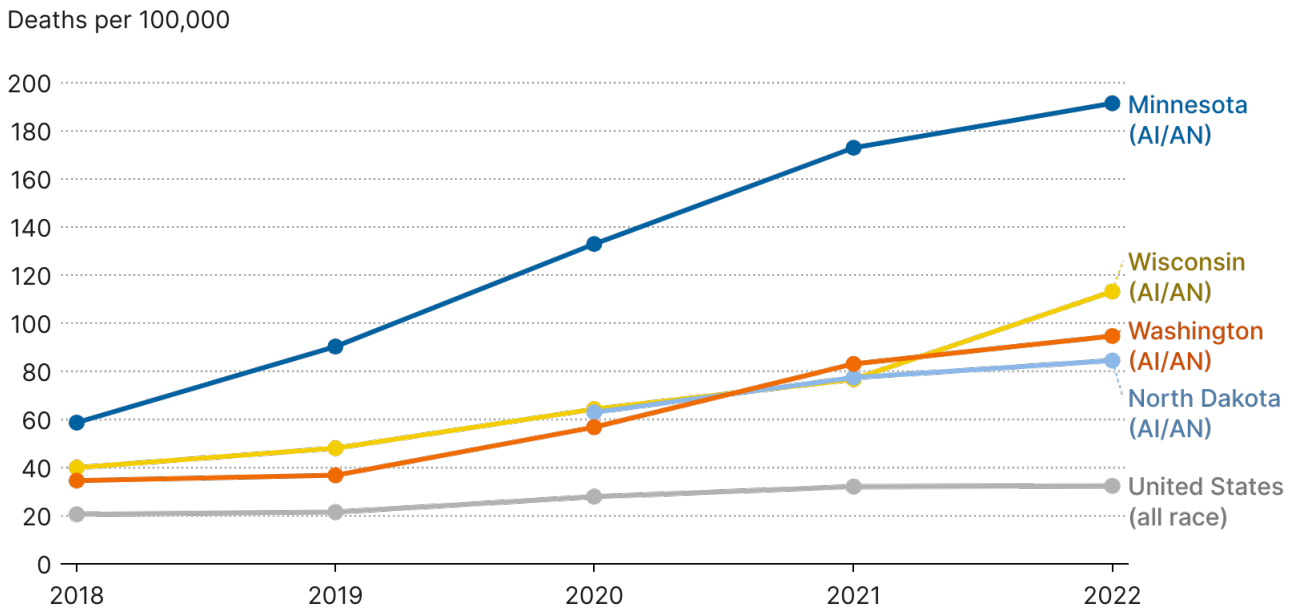

Figure 1: This graph depicts the rate of drug overdose mortality (per 100,000) within AI/AN populations in four selected states (2018-2022), as compared to the change in drug poisoning mortality in United States (2018-2022), all races. Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on August 17, 2024.

Within AI/AN populations, persons aged 25-44 years are at the highest risk for substance-related mortality.[26] In addition to age differences, fentanyl deaths also vary by region. Between 2018 and 2021, AI/AN persons living east of the Mississippi River suffered the highest rates of fentanyl-related deaths (same as white communities), as fentanyl distribution networks and use were slower to be established west of the Mississippi River.[27]

Since 2015, and particularly following the onset of the COVID-19 pandemic, stimulants, most importantly methamphetamine, have begun to compound fentanyl-related deaths among AI/AN populations.[28] Moreover, fentanyl and stimulants such as methamphetamine are increasingly mixed together even as meth's potency has dangerously increased. Stimulants are used in combination with fentanyl for a variety of reasons, with some reporting that stimulants moderate the depressing effects of fentanyl or vice versa, that fentanyl moderates stimulants' effects.[29] The same groups that experience barriers to effective treatment for substance use disorders—i.e., AI/AN and Black populations—are also frequently experimenting with drug combinations to customize their experience.[30] The risk of fatal overdose rises substantially as substances are combined.[31]

The aggregate national-level data are devastating but insufficient and likely inaccurate for effective policy design. Widespread racial misclassification and data suppression policies obfuscate drug trends and drug-death incidences among AI/AN populations. AI/AN people are frequently misclassified as belonging to a different race, thus decreasing the numbers of AI/AN people by as much as 30-60%.[32] Such an undercounting of AI/AN populations compounds the lack of state and federal resources available to these communities, including for adequate responses to the synthetic drug crisis.

Moreover, independent and AI/AN researchers frequently lack access to the most basic data—that of tribal enrollment—which is maintained by tribal governments, and to a certain extent, the Bureau of Indian Affairs. These data are important for confirming an individual's tribal membership, or descendancy, which links them back to their Native nation. Vital records (i.e., birth and death certificates) are maintained separately by county and state agencies, and the individuals completing death record applications may not be adequately trained on the importance of confirming tribal status when completing the required forms.[33] Misclassifying the race of AI/AN decedents has led to undercounting fentanyl-related fatalities and incomplete data for making public health and funding decisions.[34]

Additionally, public health agencies, including the Centers for Disease Control and Prevention and state health departments, suppress data when the total number of incidents (i.e., counts) is too low. While data anonymization is important to protect individuals' privacy, such privacy laws can be abused to serve the interests of state agencies to hide persistent racial disparities in groups with small populations.[35] Privacy protection thus needs to be balanced with the needs of AI/AN communities to obtain information that is critical to appropriately responding to the mortality and morbidity harms caused by fentanyl and methamphetamine.[36]

The quality of data on drug-related mortality of AI/AN populations varies widely by state, with some states providing insufficient information on the racial breakdown of drug overdose mortality. For instance, South Dakota only displays racial differences as percentages of drug overdose deaths, which obscures the impact on tribal communities' mortality.[37] While the percentage of deaths of AI/AN individuals made up only 20% of the total drug overdose deaths from 2013-2022, as compared to 71% of deaths identified as white individuals, the age-adjusted, drug-related mortality rate for AI/AN persons during the same period was nearly triple that of whites.[38]

Additionally, not all states display age-adjusted mortality rates, even though this is a better practice because it accounts for population differences among groups with differing age struc-

tures. This is especially important for tracking disparities that impact AI/AN communities, which often make up a small proportion of state populations. Only a handful of states, such as California, Michigan, North Carolina, Oklahoma, and Washington, display county-level drug AI/AN mortality according to race.[39] Notably, Minnesota, which leads the nation in AI/AN mortality rates, fails to provide age-adjusted drug mortality rates disaggregated by racial group at the county level. Minnesota's AI/AN data are also woefully outdated.[40]

Important differences in the distribution of harms sometimes occur even within areas with prima facie similar characteristics: in the upper Great Lakes region, Minnesota, Wisconsin, and Michigan have comparable AI/AN populations, comprising 2.4%, 2%, and 1.8% of each state's population,[41] respectively, and in all three states, they live in both urban and rural areas, as well as on Indian reservations. Yet drug poisoning events in AI/AN populations in 2022 vastly differed across these states—with 191.4 per 100,000 in Minnesota and 113.2 per 100,000 in Wisconsin, and only 26.9 per 100,000 in Michigan.[42] Understanding what accounts for these differences is crucial for improving policies and saving lives.

Yet such badly-needed, granular (state, county, and age-adjusted) data—and causal explanations of differences—are chronically unavailable.

Explaining regional variations of fentanyl harms on AI/AN

What accounts for these significant differences? It is beyond this paper's scope to provide definite answers, but it is possible to identify some likely factors. They require further examination as definite drivers of the differential impact of fentanyl harms.

PUBLIC LAW 280

One such possible factor is whether Public Law 83-280 (referred to as "Public Law 280"), which conferred general criminal jurisdiction to police the lands of Native nations to state-level authorities.[43] Adopted by the U.S. Congress in 1953, the law requires certain states to enforce state criminal laws on the reservations and trust lands of Native nations, but no new funding was allocated to compensate for the states' expanded jurisdictional responsibilities. Six states were listed in the legislation as mandatory Public Law 280 states: Alaska, California, Minnesota, Nebraska, Oregon, and Wisconsin.[44] A number of states subsequently elected to assume partial or full jurisdiction pursuant to Public Law 280 and have not repealed it, including: Florida, Idaho, Montana, and Washington.[45] Among Public Law 280 states, most reported high rates of mortality among AI/AN in 2022.[46] Only Florida and Idaho reported AI/AN drug-related mortality rates below the national, all-race rate.

For tribal communities, Public Law 280 has led to a reported reduction in the quality of policing services.[47] A recent study found that Public Law 280 is associated with higher crime rates and decreased median AI/AN family income of between 34-36%.[48] Importantly, Public Law 280 has also led to a lack of accountability of law enforcement to tribal communities, with their needs for public safety undervalued. In Public Law 280 states, police have been found to engage in "more overstepping of authority, less communication, and less understanding of tribal cultures" than police in tribal communities not subject to Public Law 280.[49]

The poor quality of policing on reservations controlled by Public Law 280 is also due to its effect of the diminishing funding available for tribal public safety.[50] Tribal police departments in Public Law 280 jurisdictions are woefully and chronically underfunded, with federal funding for county police departments often inadequate to cover the true public safety needs.[51] Since most tribal lands are not subject to property taxes, counties are unable to make up the difference through taxation.

Effectively addressing the fentanyl crisis requires strategies for policing beyond simply warehousing drug users in jail and prison.[52] Policing strategies that are recommended to positively address public safety needs in communities impacted by fentanyl include: improved communication and collaboration with impacted communities; robust partnerships with other public safety programs (i.e., public health, emergency services, etc.); improved capacity to train officers and frontline staff on the opioid crisis and on how to engage in internal evaluation for continuous improvement.[53] These strategies require investments to redesign entire agencies and hire additional staff to take on new roles. In a time where most (75%) police departments are reporting difficulty recruiting qualified applicants,[54] funding deficiencies in Public Law 280 jurisdictions are likely hindering the shifts in policing strategies that are needed for effective responses to the fentanyl crisis. In addition, long-standing conflicts between law enforcement and tribal communities in Public Law 280 jurisdictions have deteriorated the relationships needed for effective community-law enforcement partnerships on drug issues.[55]

In Wisconsin and Minnesota, most Native nations are subject to Public Law 280. In contrast, crimes committed by Indians on the lands of Native nations in Michigan are prosecuted by tribal or federal authorities. Yet Public Law 280 is unlikely to account for all of the differences in fentanyl-related harms experienced by AI/AN communities. North Dakota is not subject to Public Law 280. Washington, also among the states with the highest rates of AI/AN drug-related mortality, was historically subject to Public Law 280 and has engaged in piecemeal retrocession over the past decade.[56] But the changes in the law's application do not appear to have translated into pronounced decreases in fentanyl-related deaths among AI/AN persons there.

THE RATE OF INCARCERATION

A second possible factor partially explaining both the differences in the distribution of fentanyl harms among AI/AN communities and between them and whites in the United States is the rate of incarceration. Broadly, incarceration is associated with poor substance use outcomes, including an increased risk of drug-related fatality and reduced access to medication for opioid use disorder.[57] Yet AI/AN individuals in the United States are incarcerated at three times the U.S. national rate.[58] As Table 1 details, at least some states with high fentanyl fatalities among AI/AN communities, such as Minnesota and Wisconsin, also have particularly high rates of AI/AN incarceration.[59] But once again, the incarceration rates are unlikely to account for all of the differences in fentanyl-related deaths among AI/AN populations. Nevada, for example, has a high incarceration rate of AI/AN persons but is not among the states with high rates of AI/AN drug-related mortality.[60] Thus, it is important to study further whether, how, and under what circumstances incarceration rates drive up fentanyl deaths within AI/AN communities.

TABLE 1

Jurisdiction	Native American incarceration rate per 100,000 (2021)	Relative risk of drug-related mortality: AI/AN to White (2021)
Minnesota*	1,706	9.3
North Dakota	1,627	6.3
South Dakota	2,571	4.2
Montana*	2,315	3.4
Wisconsin*	2,283	2.9
Alaska*	2,387	2.4
Washington*	881	2.4
North Carolina	737	1.7
U.S.	1,147	1.5
Colorado	1,740	1.5
Oklahoma	848	1.4
Arizona	987	1.2
Oregon*	1,043	1.1
New Mexico	352	0.8
Nevada	1,134	0.7
California*	862	0.7
Michigan	599	0.7
Florida*	214	0.5
New York	598	0.4

Table 1: This table lists the proportion of AI/AN individuals incarcerated in prison, ranked by the state's relative risk of drug overdose fatality for AI/AN individuals compared to whites, select states, and the United States in 2021. Incarceration rates greater than the U.S. rate appear in green (rates two times or greater than the U.S. rate appear in dark green). Most states with high disparities in drug-related mortality between AI/AN and whites had a greater than the U.S. average proportion of prison-incarcerated AI/AN in 2021.

States in which Native nations are subject to Public Law 280 are marked with an asterisk.

Sources: Vera Institute of Justice's Incarceration Trends. Accessed at https://trends.vera.org/ on August 17, 2024. Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10-expanded.html on August 17, 2024.

MEDICATION FOR OPIOID USE DISORDER

A third possible factor is access to medication for opioid use disorder (MOUD), which is widely considered the gold standard for the treatment of opioid use disorder (OUD).[61] Within this category of interventions, buprenorphine and methadone, approved for treatment of OUD, have been shown to reduce the long-term risk of death in patients by as much as 50%.[62]

Yet access to these medications is lacking both nationwide and among AI/AN persons specifically. Nationwide, only 1 in 4 Americans with OUD are prescribed medication as treatment.[63] Methadone, which is particularly effective in treating OUD,[64] is only dispensed from federally and state-regulated opioid treatment programs (OTP). The regulatory burden limits the availability of this critical medication. Only 4% of OTPs are located within rural areas and only a few Native nations have established OTPs.[65]

AI/AN are also less likely than other groups to receive standard treatment for OUD (i.e., methadone or buprenorphine prescribed over long periods of time).[66] Within the context of the widespread lack of access, AI/AN patients are, once again, disprivileged, having less access to MOUD for long-term treatment than other racial groups.

Beyond overregulation, the chronic underfunding of the Indian Health Service (IHS) presents practical challenges for Native nations in establishing new programs, including providing MOUD. Fiscal inequities for IHS and other health care providers serving AI/AN populations are one crucial factor: limited budgets reduce AI/AN capacity to engage in community health assessments, program development, evaluation, and improvement. These structural challenges likely contribute to tribal health care facilities' limited access to promising treatments such as methadone.

State funding dedicated to serving AI/AN citizens is also frequently inadequate. Native nations seek to compensate as best they can. For instance, several Native nations provide low-barrier harm reduction services to the general public without receiving state support to sustain these services.[67] However, the insufficient provision of federal and state funds to Native nations leaves profound gaps in needed treatment.

Cultural factors related to historical trauma, including a general distrust of mental health care providers, a lack of access to culturally-centered services, and fear of social services agencies, have been shown to contribute to disparities in AI/AN access to MOUD.[68]

Economic instability, poverty, and housing insecurity likely compound AI/AN persons' insufficient access to MOUD.[69] A study conducted among patients of a rural Minnesota health care network between 2017 and 2021 examined the likelihood that patients received appropriate care following emergency department admissions for acute drug poisoning and other substance use-related events.[70] Overall, 29% of these patients were unhoused, with that number rising to nearly 40% for AI/AN patients and over 50% for Black patients.[71] Of the unhoused patients, approximately 50% experienced previous acute drug poisoning events, 87% had a diagnosis for a mental health disorder, 25% had previous involvement with the criminal justice system, and 18% were living with HIV.[72] Following emergency department admission, only 18% of the unhoused patients were transferred to another treatment facility, while 38% declined further treatment or left the health facility against medical advice. The remaining 19% of unhoused patients received referrals, but no follow-up or support.[73]

These results underscore the vulnerability of patients with minoritized identities and circumstances to drug overdose, and the dearth of evidence-based treatment that is accessible to them. In rural Minnesota, being unhoused and AI/AN or Black, having a mental health disorder, having previous involvement with the criminal justice system, and living with HIV puts people at higher risk for repeated drug overdose events. The Minnesota study's authors hypothesized that more of these patients may have opted for follow-up treatment if a better range of treatment options were offered, including alternatives to abstinence-based treatment, culturally-responsive programming, and connections to community-based harm reduction care and support.

Data from the Michigan Overdose to Action Dashboard offer further important support for the hypothesis that treatment access impacts drug-related mortality among AI/AN populations.[74] This dashboard provides county-specific information on the rate of dispensed buprenorphine and the rate of age-adjusted AI/AN drug overdose mortality ("age-adjusted rate"). In 2023, approximately 600 buprenorphine doses per 1,000 individuals were dispensed statewide, quarterly, in Michigan. The quarterly dispensation rate, however, varies by county, with some counties dispensing fewer than 100 doses per 1,000 individuals, while others dispensed more than 1,200 doses per 1,000 individuals. Several counties with high rates of buprenorphine dispensing include Indian reservations in the northern half of the state. When isolating the counties with higher rates of buprenorphine dispensing (>785), the age-adjusted rate drops to around 18 deaths per 100,000. When isolating for counties where Indian reservations are located, and with lower buprenorphine dispensing rates (<785), the age-adjusted rate increases to over 70 deaths per 100,000.[75]

The lack of similar data availability from Minnesota and Wisconsin prevents a comparable analysis. While Wisconsin's Prescription Drug Monitoring Program offers detailed information on the doses of buprenorphine dispensed statewide and per county, the drug-related AI/AN mortality rate is unavailable for most counties due to a data suppression policy.[76] Yet even at aggregate levels, Wisconsin appears to be behind Michigan in MOUD access. Notably, in 2022, Wisconsin providers dispensed, on a quarterly basis, around 230 fewer units per 1,000 people than Michigan providers. Surprisingly, some Wisconsin counties with Indian reservations had a higher dispensing rate than the state average.[77]

The Minnesota Board of Pharmacy, which administers the state's prescription drug monitoring program, does not offer readily accessible data on units of dispensed buprenorphine. Instead, it lists the number of buprenorphine prescriptions: 44,717 were issued in the first quarter of 2024, with no historical information available.[78]

It is important to study further whether Michigan's buprenorphine policies more robustly benefit AI/AN individuals and communities than such policies in other states. Whether the programs and strategies deployed in Michigan differ from the states experiencing much greater levels of drug-related mortality among AI/AN should also be examined.

Even within states, including those that are much better performing like Michigan, fentanyl use impacts AI/AN communities differently, with some counties, and presumably Native nations, registering much lower lethal overdose rates among AI/AN communities than in the state overall. These include the counties associated with the Keweenaw Bay Indian Community, Sault Ste. Marie Chippewa Community, Bay Mills Indian Community, Hannahville Potawatomi Indian Community, Little Traverse Bay Band of Odawaa Indians, and the Little River Bay Band of Ottawa Indians. It is worthwhile to explore whether these particular Native nations offer more unique or specific treatment modalities, make the overdose-reversing medication naloxone more extensively available, or more robustly deliver drug-use prevention strategies.

AI/AN responses to the fentanyl crisis

Native nations and tribal organizations are engaging in research and innovation for reducing drug poisoning risks among AI/AN communities and improving patient outcomes related to MOUD. Their and others' work shows that connectedness to AI/AN culture helps prevent and reduce mental health and substance use disorders and helps decrease drug death rates in AI/AN populations.[79] These positive outcomes are especially effective when cultural connectedness programming is combined with medication treatment for opioid use disorder.[80]

Cultural connectedness strongly resonates with AI/AN persons.[81] For tribal communities, the phrase "culture is prevention" is deeply meaningful, evoking a multigenerational and intertribal movement to protect and restore tribal cultural traditions. This movement was created to heal AI/AN communities, families, and individuals following centuries of cultural warfare carried out by governmental and religious institutions.[82]

The following section profiles the work of two Native nations and organizations to reduce drug-related fatalities within their communities and improve outcomes for vulnerable AI/AN patients: the White Earth Nation and the Confederated Tribes of Grand Ronde. Each has developed customized models of care to incorporate tribal values into responses to the fentanyl crisis. The section also reviews an important and highly successful innovation by Alaska Native communities—the Community Health Aide program—which, while not specific to opioid use disorder, is highly relevant for it.

THE WHITE EARTH NATION AND THE INTERCONNECTED NATURE OF RECOVERY

The White Earth Nation, part of the Ojibwe or Anishinaabe Nation, is located in what is now northwestern Minnesota. Severely impacted by the introduction of fentanyl, the White Earth Nation formed a partnership with the University of Minnesota, called Aanji'bide ("changing paths"), to learn from individuals who use opioids to improve systems of care and better incorporate cultural traditions within these systems. Through a research partnership funded by the National Institute on Drug Abuse, the Aanji'bide team conducted community-based participatory research, interviewing 20 individuals in 2020 and 2021 who were knowledgeable about treating opioid use disorder in the White Earth Nation.[83] The individuals utilized a model called the Opioid Use Disorder Cascade of Care, which quantifies the needs and receipt of care along a continuum, measuring outcomes of patients who reach specific milestones. The milestones include:

1. Being identified as at-risk for OUD.
2. Being diagnosed with OUD.
3. Initiating MOUD.
4. Staying in MOUD treatment for six months.
5. Achieving long-term recovery/remission from OUD.

Instead of simply adopting this framework, the Aanji'bide team sought to evaluate its effectiveness in a tribal context and adapt it to Anishinaabe cultural traditions and the targeted population.

During feedback sessions, several team members noted that the OUD Cascade of Care model's linearity is incongruent with Anishinaabe concepts of time.[84] Instead of a unidirectional recovery process, the team emphasized the circular nature of time in line with annual seasons and other natural phenomena. Team members noted that progress in recovery is normally multidimensional, with patients positively progressing in some areas, while still struggling in others. This team rejected the OUD Cascade of Care's approach that pathologizes a patient's failure to achieve milestones in a set order.

In addition, the team noted that the OUD Cascade of Care lacked inputs for culture, connection to spirit, and connection to others. Acknowledging the importance of these connections, and how programming impacts them, is crucial for evaluating Anishinaabe patients' progress.

Finally, the team emphasized the need to expand the model to track patient access to basic services, especially housing, which is essential for successful participation in MOUD programs.

FIGURE 2

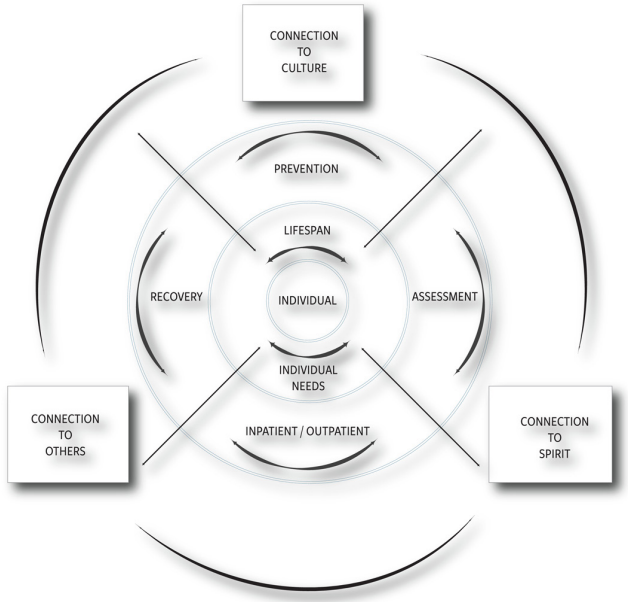

Figure 2: The Aanji'bide (Changing our Paths) model of opioid recovery and change. The final model includes a series of concentric circles. The individual is centered, with measures for lifespan and individual needs measured just outside the individual circle. Progress on recovery, prevention, assessment, and inpatient/outpatient treatment is measured relationally in the next levels of circles. Inputs for connection to others, culture, and spirit are measured at the outermost level.

CONFEDERATED TRIBES OF GRAND RONDE AND RAPID EXPANDED ACCESS TO TREATMENT

A close connection between the community and the clinical staff of the Confederated Tribes of Grand Ronde, a federally-recognized Native nation located in what is now western Oregon, enabled a swift tribal response to an emerging drug crisis.[85] Specifically, the clinical staff was able to rapidly detect the presence of fentanyl in the community's drug supply and identify the need to offer methadone as an overdose prevention strategy. Thus, in 2021, the Confederated Tribes of Grand Ronde opened the Great Circle Recovery OTP, adding a mobile medication unit (MMU) in the summer of 2022, to dispense methadone and buprenorphine at several locations in a rural catchment area.

The MMU visits three rural and underserved communities daily, offering MOUD as well as culturally centered recovery services to tribally-enrolled and non-tribal patients. The mobility of the MMU reduces transportation-related barriers to MOUD for its rural patients. In combining the provision of MOUD with patient and community education and a collaborative approach to care, the MMU's low-barrier approach was designed to address patients' unmet needs for medical, cultural, and social support. The MMU employs several strategies to engage patients who are unable to immediately cease their illicit substance use: making accommodations for patients who continue to use illicit substances and/or miss counseling appointments and offering peer support services as psychosocial support to overcome barriers to care.

ALASKA NATIVE COMMUNITIES AND EXPANDED ACCESS TO HEALTH CARE

Though not designed to reduce drug-related deaths specifically, the Community Health Aide Program ("CHA-P") in Alaska, one of the most effective health care delivery interventions by Alaska Native communities, is highly relevant to the fentanyl crisis. CHA-P was created in the 1970s to eliminate tuberculosis in Alaska Native communities.[86] It was later expanded to encompass dental and mental health care access for remote, rural AN villages. Unlike in most health care programs, community health aides are hired prior to achieving their certification.[87] Community health aide positions are extended to village residents, who engage in paid, on-the-job training programs. Community health aides work with licensed medical doctors on a per-patient basis until they have received a level of mastery in an area and can provide patient care pursuant to a standing order.

Positively, CHA-P provides culturally-centered care to historically underserved communities. Moreover, since health care provided by community health aides is reimbursable through insurance programs, CHA-P also provides workforce opportunities and financially rewards traditional forms of pro-social community care.

CHA-P's financial sustainability for AN communities has benefited from close collaboration between the Alaska Native Health Consortium and the State of Alaska on amendments to Alaska's State Medicaid Plan to reimburse for CHA-P services at a sustainable level.[88] Community Health Aide programs in other states have been stymied due to issues surrounding the credentialling of providers, low reimbursement rates, and other challenges.[89]

Federal and state barriers to AI/AN drug treatment innovation

While effective Indigenous innovation is a reason for celebration, far from all Native nations and tribal health care organizations have the necessary resources and capacity for such innovations and the implementation of effective prevention and treatment programs for OUD.

Not all states collaborate on Medicaid policy as effectively with the Native nations within their borders as the State of Alaska. States effectively control Native nations' ability to collect Medicaid reimbursement for the provision of health care services, as tribal health care entities are only entitled to Medicaid reimbursement for services authorized by their state's Medicaid plan.[90] These barriers to Medicaid reimbursement apply even as the state bears no responsibility for payment (Congress amended the Social Security Act in 1976 to provide states with a 100% Federal Medical Assistance Percentage for tribal claims).[91] This dynamic frustrates Native nations' ability to provide optimal care. While Native nations seek to facilitate access to holistic health care services, state goals for Medicaid spending are often focused on cost-savings.[92]

Restrictions on the reimbursement of services in Centers for Medicare & Medicaid Services (CMS) regulations have also limited Native nations' ability to offer community-based health services. Examples of these restrictions include the "four walls" interpretation of 42 CFR § 440.90, which has limited Medicaid reimbursement to services performed within clinic facilities, and the barriers to Medicaid eligibility for incarcerated individuals.[93] Native nations have successfully negotiated with CMS to extend a COVID-19 exception to the four-walls requirement through February 11, 2025.[94] In October 2024, CMS issued section

1115 demonstration amendment approvals of four state Medicaid plans (Arizona, California, New Mexico, and Oregon) to reimburse traditional medicine services for AI/AN patients.[95] Reducing barriers to offering community-based care, including a permanent fix to the fours-walls restriction, extending coverage for incarcerated people, and universally reimbursing traditional medicine for AI/AN patients, is critical to effectively addressing the fentanyl crisis.[96]

In fact, significant structural barriers have prevented Native nations from exercising self-determination in health care contexts. The lack of funding is a pervasive and crucial problem. The IHS serves multiple critical functions for AI/AN populations: directly providing health services to tribal enrollees and descendants through 127 facilities nationwide; administering self-determination funds for an additional 389 health care facilities operated by Native nations and Urban Indian Organizations; and as an essential public health agency.[97] Additionally, 12 Tribal Epidemiology Centers also receive limited funding from the Centers for Disease Control and Prevention, the National Institutes of Health, and the IHS itself, offering technical assistance, data collection, and analysis to Native nations.[98]

Yet among federal health care providers, the IHS consistently receives the lowest per-capita funding from the federal government for the delivery of health care. In 2021, IHS was only able to spend $4,140 per person on health care spending,[99] while Medicare disbursed $8,651 per person,[100] the Veteran's Health Administration (VHA) disbursed $12,233 per person, and Medicaid disbursed $8,908 per person.[101] Like the VHA, IHS depends on annual appropriations for funding, yet the U.S. Congress consistently fails to fully fund IHS budget requests. The insufficient funding for IHS has several detrimental knock-on effects.

Among other detrimental consequences, it means that the IHS has insufficient funding for Native nations' health care programs, including for substance use disorder prevention and treatment. Thus, AI/AN health care providers depend on the vagaries of grant funding to run programs. The lack of funding predictability makes program design and implementation a challenge. Moreover, funders sometimes seek to dictate how tribal programs operate, often not giving sufficient space for tribal innovation and program design.

States have been able to address funding gaps for prevention and treatment programming through the strategic spending of State Opioid Response (SOR) Grants. In FY2024, the Substance Abuse Mental Health Service Administration (SAMHSA) expects to distribute over $1.4 billion between the states and territories to provide additional resources to address the opioid crisis.[102] Through SOR grants, states have funded initiatives focused on expanded access to evidence-based treatment and prevention initiatives.[103]

SAMHSA requires states to engage in outreach with Native nations and Urban Indian Organizations in the development of state-specific strategic SOR spending plans "to ensure that strategies are implemented to meet their needs."[104] Notably, "outreach" implies unidirectional communication or notification from the state to the Native nations regarding the state's strategic plan and is a method of communication used with stakeholders, not governmental entities. In contrast, consultation has been defined as "two-way, Nation-to-Nation exchange of information and dialogue between official representatives."[105] Federal standards on consultation mandate that information provided by Native nations is meaningfully considered in the formation of policy and that federal agencies strive for consensus with Native nations in achieving outcomes.

While some states have used SOR funds to partner with Native nations in supporting evidence-based treatment programs for AI/AN populations (i.e., North Carolina and Oregon have funded tribal efforts to expand methadone access,[106] and Minnesota has funded the Red

Lake Nation's innovative treatment programs),[107] other states have failed to meaningfully engage Native nations in SOR funding decisions (i.e., Arizona, Alaska, and South Dakota).[108]

SAMHSA also administers a Tribal Opioid Response (TOR) program to provide dedicated funds for Native nations to respond to the fentanyl crisis.[109] TOR grants have been a lifeline for communities, providing flexible funding with minimized reporting requirements. Due to funding constraints, unlike SOR, TOR is a competitive grant program. Only 40 out of 574 eligible Native nations received TOR funding in 2021 (the latest grant recipient data year available).[110] In addition, TOR grant eligibility is limited to federally-enrolled Native nations. This means that Urban Indian Organizations are ineligible to directly receive these funds.

Overall, limited budgets for AI/AN health care providers for addressing the fentanyl crisis reduce their capacity to engage in community health assessments and the development, monitoring, and evidence-based updating of health programs serving AI/AN communities.

Learning from other deaths of despair among AI/AN

While we are beginning to understand that AI/AN individuals in some geographical regions are at higher risk for drug-related deaths, additional research is needed to identify the root causes of these vulnerabilities. This type of research is done best in partnership with Native nations and tribal communities, leveraging their expertise to begin with the right questions. Researchers in suicide in tribal communities have developed the necessary long-standing relationships to understand the dynamics underpinning this crisis. Suicide has been studied for decades and can provide insights into the factors that have rendered certain tribal communities vulnerable to deaths of despair (suicide and overdose) and, therefore, lethal drug-related events. Research conducted on AI/AN suicide could guide researchers in the development of research projects to investigate why AI/AN communities and individuals are more susceptible to drug overdose fatality.

Learning from suicide patterns among AI/AN communities is particularly relevant for several reasons:

First, like with the current fentanyl crisis, AI/AN populations have the highest rates of suicide within racial groups in the United States.[111]

Second, suicide prevalence is not uniform across tribal communities, with higher rates of suicide among Native nations in the Northern Plains and Alaska.[112] Similarly, drug poisoning rates vary by region, with Native nations in some regions experiencing high levels of drug poisoning mortality and much lower rates in other regions.

Third, these two public health crises disproportionately affect the younger age groups within AI/AN populations. Unlike among the U.S. general population, where suicidal behaviors peak in late adulthood, suicidality, i.e., the rise of suicide, peaks between the ages of 15 and 24 among AI/AN populations.[113]

Finally, unlike fentanyl, suicide in AI/AN communities is a phenomenon that has been studied for decades. AI/AN communities have benefited from the long-term investment in research in this area, with many researchers engaging in collaborative research initiatives, and many publications exploring suicide in AI/AN populations using a range of disciplinary approaches.

Both contemporary socio-economic factors and long-term deep-impact causes have been identified to explain the high AI/AN suicide rates.

Factors associated with suicidal behaviors among contemporary AI/AN youth include being male; unemployed; having lower educational attainment; being single and not cohabitating; having a history of abuse, such as family violence, child abuse and neglect, and sexual abuse; and using substances, including alcohol.[114] In a qualitative research study conducted in Inuipat communities in 2001-2002, young men at high risk of suicide described feeling no hope for a positive future, perceiving few opportunities to earn income and provide for a family.[115] While young women in these communities gravitated toward work as tribal administrators, in which employment opportunities abound, young men are often unemployed and feel inadequate.[116] In the settler-colonial economy, in which tribal governments and their economies are organized around administering funds and accounting for the administration of funds, types of work preferred by young men (i.e., trapping and fishing) are unavailable due to economic and policy-related barriers. In comparison to adults and elders, AI/AN youth may not be filtering their hardships through a strengths-based cultural lens, and instead could be framing their experiences of racism and lack of agency in relation to colonization, blaming themselves and others for the consequences of their individual choices.[117]

Research on AI/AN vulnerability to fentanyl-related death is missing an exploration of how economic and social marginalization of AI/AN individuals may be contributing to fentanyl use. While researchers have documented differential rates of drug overdose mortality among minorized groups, including AI/AN, there also do not appear to be any research publications on whether the experience of racism itself and other experiences related to colonialism contributes to fentanyl use among AI/AN populations.[118]

While certain socio-economic factors are associated with higher rates of suicide in AI/AN populations, these factors alone do not explain why AI/AN youth are at a higher risk. Additional research into long-term, deep-impact causes is demonstrating AI/AN persons' vulnerability to suicidality in collective experiences of mass trauma and the erosion of tribal sovereignty.[119] Similar efforts are needed to examine how collective traumas have impacted AI/AN fentanyl use.

The decades-long systematic abuse of AI/AN children in government-sponsored and supported boarding schools, which institutionalized wholesale family separation, has been identified as an important factor driving the current suicide crisis.[120] Beginning in 1819, the U.S. government mounted a violent acculturation campaign against Native nations.[121] For decades, generations of AI/AN children were forcibly removed from their families to be boarded and educated in far-away schools. In Alaska, this abuse was particularly long-running, with boarding schools serving as the only option for Alaska Native families seeking to formally educate their children throughout the 1970s.[122] Finally, in 1976, after AN high school students initiated a class action lawsuit, the State of Alaska agreed to build secondary schools in 126 Native Alaska Villages to allow these children to remain in their communities during high school.[123]

While boarding schools did provide students with skills for participating in the American economy and a broader worldview, the pedagogy emphasized the false supremacy of white culture and effectively suppressed Indigenous peoples' passing along of traditions, values, and languages.[124] Many students also experienced physical and sexual abuse.[125]

The trauma of the boarding school experience has been passed to younger generations and has led to health disparities,[126] including chronic physical ailments and psychological distress, among descendants.[127] Suicidality among AI/AN youth and boarding school survivors emerged as a public health issue in the 1960s, with rates of suicidality steadily increasing over time.[128] Research is needed to determine how the AI/AN boarding school experience has contributed to increased risk for fentanyl-related fatality.

The extent of a Native nation's exercise of self-determination has been shown to impact suicidality among Indigenous youth. In their 1998 study of comparative rates of youth suicide among First Nations communities, Michael J. Chandler and Christopher Lalonde rejected the circular explanation that poor mental health predicted the youth suicide rate.[129] Instead, these researchers sought to examine the community factors that led to high rates of suicide within some First Nations communities in British Columbia and zero incidents in others. Their study examined the frequency of AI/AN youth suicide in relation to each tribal council's "attempted cultural rehabilitation" expressed in terms of self-government, land claims, and the provision of specific governmental services (health care, education, police, fire, and cultural facilities). Each factor was shown to reduce the relative risk of youth suicide, with self-government (defined as "the right in law to a large measure of economic and political independence within their traditional territory) reducing suicide risk by the highest margin (85%)."[130] They also demonstrated the variables' additive effect on reducing suicide risk. Based upon the results of their analysis, the researchers concluded that "active steps to preserve and rehabilitate their own cultures" resulted in reduced risk of youth suicide in the First Nations communities studied.[131]

The variables identified by Chandler and Lalonde closely tally with the long-term root causes of health disparities within AI/AN populations, amplified by the fentanyl crisis. Over the past 500 years, settler-colonial governments have engaged in myriad tactics to undermine tribal communities in attempts to gain control of their resources. These tactics have involved limiting the governmental powers of Native nations, reducing tribal control over their lands, waters, and traditional territories, disrupting tribal economies and food systems, and limiting Native nations' ability to effectively police their communities.[132] The extent to which these assaults on tribal communities and individuals have contributed to the current fentanyl crisis has not been adequately characterized, with additional research desperately needed to determine the cause of AI/AN vulnerability to fentanyl.

Taken together, the United States' colonization of Native nations has impoverished tribal communities, creating a shared perception among AI/AN youth that they have no future. High rates of incarceration and homelessness most certainly add to these perceptions, thus, rendering AI/AN youth vulnerable to deaths of despair: suicide and drug overdose. Addressing these public health crises is not simply a matter of creating new programs or allocating additional funding, it should also involve resetting the relationships among Native nations and state and federal governments to strengthen tribal sovereignty and empower local solutions.

Policy recommendations

Based on the above policy findings, this paper identifies the following categories of priority policy intervention and improvement: improved data; reformed health care and insurance regulations; expansion of access to MOUD; improvements in state-tribal relations; and the restoration of police powers to Native nations. The first three sets of recommendations apply, largely, to Congress and federal agencies; the last set of recommendations is directed to states and Native nations.

Expanded funding for data collection and analysis and tribal treatment and prevention programs

Additional funding is urgently needed for research to better understand how fentanyl is impacting specific groups of AI/AN people and the reasons why some communities are at particularly high risk of death. This funding should be conditioned on a research team's ability to demonstrate robust partnership with impacted tribal communities. Congressional appropriations for Tribal Epidemiology Centers should be increased to support improved data collection and analysis to optimize tribal health practices for overdose prevention. In addition, it is

important to increase federal funding to support substance misuse prevention and the treatment of SUD through tribal, IHS, and Urban Indian Organizations. Such funding could include:

- Tribal set-asides of state substance and mental health abuse grants (i.e., State Opioid Response Grants; Substance Use Prevention, Treatment, and Recovery Services Block Grants; Community Mental Health Services Block Grants, etc.), with the percentage of set-aside funding determined by population and proportionate to the burden of disease.
- SAMHSA should direct states to disburse a portion of state-allocated SOR funding to Native nations that engage in treatment and prevention to mixed tribal and non-tribal populations (i.e., Oregon's allocation of SOR funds to the Confederated Tribes of Grand Ronde for its mobile opioid treatment programs to serve tribal and non-tribal patients).
- Additional congressional appropriations for Tribal Opioid Response Grants, which are currently funded as a competitive grant program, to adequately fund each federally-recognized Indian entity engaging in substance use disorder treatment and prevention programming at sufficient levels to be impactful.
- New congressional appropriations for innovative and multisectoral innovations in tribal communities, including for the development and implementation of a nationwide plan to eliminate drug overdose among AI/AN persons and to fund supportive housing and employment initiatives, tribal-based opioid treatment programs, and similar initiatives.

Health care and insurance regulatory reforms

To reduce the drug-related deaths of AI/AN people and improve patient outcomes, it is necessary to improve both access to treatment and the quality of treatment, aligning it with AI/AN practices. Both require regulatory and insurance payment reforms.

To expand access to treatment:

- Federally-recognized Indian Tribes should be empowered with the authority to submit Native nation-specific Medicaid State Plan Amendments to enable them to offer treatment options tailored to local needs.
- Native nations, IHS, and Urban Indian Organizations should not be subject to the "four walls" interpretation of 42 CFR § 440.90, which has restricted reimbursement for health care services performed in community settings. Tribal entities should be afforded the flexibility to claim reimbursement for the long-term support services needed by patients with SUD and at risk for fatal overdose: peer support, case management, harm reduction services, and services offered by overdose prevention centers. Low-barrier modalities are particularly important to foster the trusting relationships necessary for vulnerable individuals to access higher levels of care.
- CMS should develop a pilot program, waiving restrictions on Medicaid reimbursement for health care services rendered by Native nations, IHS, and Urban Indian Organizations to incarcerated AI/AN persons. These pilot projects should allow the entities latitude to design unique models of service provision, propose reimbursement mechanisms to support sustainability, and include an evaluative component for health-related and fiscal outcomes. Offering continuity of care to AI/AN persons at high risk for fentanyl overdose, throughout periods of incarceration, may lead to reductions in overall costs.
- Reimbursement for community health aides to serve tribal communities should be expanded beyond Alaska, with Medicaid and Medicare reimbursement rates established to make these programs financially sustainable.
- The U.S. Department of Health and Human Services (HHS), through its various divisions, should offer robust technical assistance and financial support to Native nation and Urban Indian Organization health care

entities to expand their capacity to offer community-based health care services, including increased access to mental health and comprehensive care for substance use disorder. Every IHS-funded health care facility should be afforded the opportunity to offer all forms of Food and Drug Administration-approved MOUD.

- The Drug Enforcement Agency and SAMHSA should collaborate with Native nations and IHS to identify and overcome regulatory barriers to methadone and buprenorphine access to improve access for AI/AN individuals.

The importance of Indigenous health determinants to individual health and wellness, including connectedness to AI/AN culture, family, community, and the natural environment, should be reflected in policies governing the reimbursement for services. Several funding and regulatory opportunities to achieve such a policy improvement exist:

- The Social Security Act should be amended to align with other federal regulatory schemes that recognize Native nations' self-determination and inherent self-governing authority. Federally-recognized tribes should be afforded opportunities to adopt their own Medicaid plans or opt into any state's Medicaid plan to ensure adequate coverage of Native nation-specific health care needs.
- CMS should prioritize reforms to allow Native nation, IHS, and Urban Indian Organization entities to receive reimbursement for all forms of treatment offered, consistent with tribal determinants of health. Traditional forms of healing, culturally-centered care, alternative treatment for pain management (i.e., chiropractic, acupuncture, massage, etc.), nutrition, and supportive housing offered to AI/AN patients should be included as Medicaid reimbursable services.

Supporting culturally-tailored treatment for AI/AN people

Infrastructure investments and regulatory reforms are also needed to expand the number of inpatient psychiatric and substance use disorder treatment facilities offered in tribal communities. Tribal patients experiencing acute mental health and substance use crises should not be forced to travel far distances for essential care, including inpatient care for stabilization and safety.

- Congress should appropriate capital funding for additional psychiatric regional care centers, including those serving AI/AN youth, and community-based treatment centers for outpatient care of AI/AN populations.
- Congress should adopt the Modernizing Opioid Treatment Access Act, or similar legislation, to decrease the regulatory burden faced by Native nations in establishing methadone treatment programs.
- Given the importance of stable housing for success in treating substance use disorder and in reducing recidivism among formerly incarcerated individuals, many of whom suffer from substance use disorder, HHS, the U.S. Department of Housing and Urban Development, states, Native nations, and private funders should increase funding allocations for tribal supportive housing. Abundant funding should be made available for both capital improvements and operational costs to sustain the wrap-around services needed to effectively engage supportive housing residents.

Improvements in tribal-state relations

Reforms are urgently needed at the state level. States should engage in an all-of-government assessment related to the inequitable treatment of AI/AN persons. These assessments should include a comparative analysis of justice, health, and educational outcomes, comparing outcomes between Native and non-Native populations. Additionally, the assessments should include

active participation by Native nations within each state to improve data collection and data sharing and guide the development of improved interventions to eliminate persistent disparities. These assessments should be used to creatively address programmatic and funding gaps in collaboration with Native nations and the federal government. At a minimum, these assessments should include:

- An analysis of how AI/AN individuals are systematically misclassified on birth and death records and identifying procedures needed to improve data practices.
- An analysis of equitable spending on state opioid settlement funds.
- An analysis of the criminal justice system's impact on health outcomes, including drug-related mortality and morbidity, and the economic stability of AI/AN populations and communities.
- Collaboration between Native nations and states on workforce development and small business programs, with the goal of full employment for AI/AN youth and those in early recovery from mental health and substance use disorders, and an emphasis on pro-social, community-based job opportunities.

Native nations subject to Public Law 280 should explore retrocession to regain control over public safety within their reservations and villages, improve the quality of policing services, and increase opportunities for the creation of wealth and economic stabilization. Congress should restore public safety funding to Public Law 280 tribes to facilitate improvements in policing and tribal courts needed for effective community-based responses to the fentanyl crisis.

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