



**ADDRESSING THE OPIOID CRISIS IN
AMERICAN INDIAN & ALASKA NATIVE
COMMUNITIES IN CALIFORNIA:
A STATEWIDE NEEDS ASSESSMENT**

SEPTEMBER | 2019



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DISCLAIMER: To keep the confidentiality of people, Tribes, and regions, the Final Report will de-identify names of agencies and participants.

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EXECUTIVE SUMMARY

Background: In the United States from 1999 to 2009, death rates involving opioid pain relievers were higher among American Indians and Alaska Natives (AIAN) than among any other racial or ethnic minority group. California has the largest AIAN population in the US, with over 720,000 AIAN individuals representing approximately 2% of the California population. Reflecting national trends, AIANs have the highest death rates involving opioid use. *Addressing the Opioid Crisis in American Indian & Alaska Native Communities in California: A Statewide Needs Assessment* report recognizes the need to address the opioid overdose crisis in AIAN communities in California and aims to identify gaps in prevention, treatment, and recovery services (including medication-assisted treatment, or MAT) targeted to these communities.

Over the course of nine months (March-November 2018), a collaborative research team comprising American Indian researchers, urban Indian agency partners, Tribal entities, students and staff from the University of Southern California, as well as community liaisons engaged in qualitative focus groups and key informant interviews. A participatory action research (PAR) approach was utilized to gather community perspective from Tribal and urban AIAN populations in California.

The goals of the needs assessment and this subsequent report were to 1) identify the most common substances used in their community, 2) survey the availability and access of MAT and other opioid use disorder/substance use disorder (OUD/SUD) treatment and recovery services, 3) understand the impact of culturally centered services on OUD/SUD prevention, treatment, and recovery, and 4) capture recommendations to improve OUD/SUD prevention, treatment, and recovery services.

Results: Overall, 279 AIAN individuals (33 key informants, 163 adults, and 83 youth) participated in key informant interviews or focus groups. The needs assessment finds high prevalence and accessibility of substances in AIAN communities. Notably, the decrease in prescription of opioids

resulting from increased prescription oversight has led to a subsequent progression from opioid to heroin use when individuals are unable to access prescribed opioids. AIAN youth are found to have greater access to a variety of substances than in the past, and family substance use is pervasive. Community and individual stressors are risk factors to opioid use while historical and intergenerational trauma remain significant drivers of both mental health issues and substance use among AIAN populations. Barriers to treatment include individual stigma and shame in seeking services, and structural ones including cost, lack of or insufficient insurance coverage, unstable housing, fragmented service delivery, and a lack of residential treatment facilities for substance use disorders. Youth prevention programs and services are also lacking in AIAN communities in California. Providing culturally centered activities and treatments to prevent and/or treat OUD/SUD can provide healing modalities to develop the spiritual, mental, and physical strength of an individual. These services address the need to maintain resiliency in the community by emphasizing cultural connectedness, cultural services, positive role models, and having available supportive services and programs. Lastly, several noted service system needs are recommended to enhance prevention and recovery services to reduce OUD/SUD in AIAN communities.

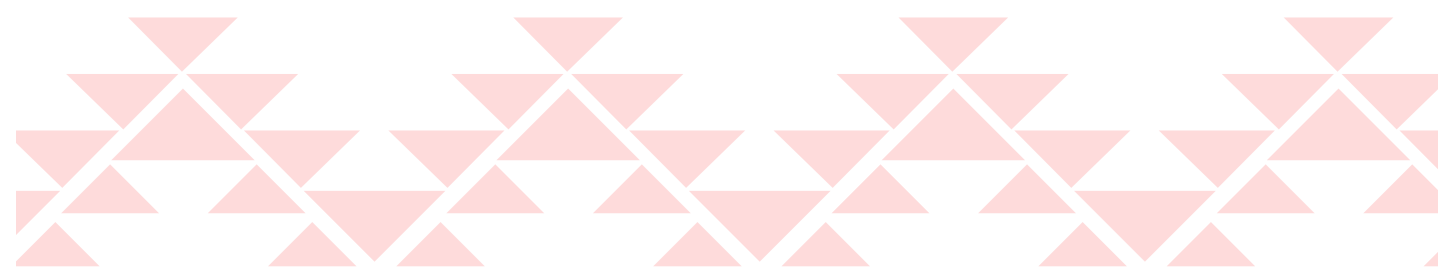
Conclusions: In summary, there is considerable need for attention to OUD/SUD in AIAN communities in California. The development and implementation of opioid and substance use services that address specific individual and community-level challenges enumerated in this report, that expand and better integrate treatment services such as MAT, and that include cultural and traditional approaches appropriate to Tribal entities, are critical steps in reducing the burden of opioid-related mortality among these highly vulnerable communities.

SUMMARY OF RECOMMENDATIONS

This needs assessment uses the Socio-Ecological Model as a tool to organize the recommendations to improve access and availability of OUD/SUD prevention, treatment, and recovery services in AIAN communities. Gaps and limitations in OUD/SUD services were identified across five nested levels of the Socio-Ecological Model: **individual, interpersonal, organizational, community, and policy**. This approach improves opportunities for targeted services informed by the appropriate level-specific factors or utilization of all five levels for a comprehensive approach to service delivery.

INDIVIDUAL	
Influential Factors	Recommendations to Address Limitations
Address Stigma	<ul style="list-style-type: none"> Provide educational materials on: <ul style="list-style-type: none"> » Pathology of addictions » Existing treatment options and how they function to treat addictions- especially for MAT services Include individuals who have gone through the process of recovery to destigmatize and normalize conversations on recovery services
OUD Prevention for Youth	<ul style="list-style-type: none"> Continue to educate AIAN youth with culturally centered prevention programs on substance use, particularly opioid use, and for more positive youth development

INTERPERSONAL	
Influential Factors	Recommendations to Address Limitations
Address Stigma	<ul style="list-style-type: none"> Create social media campaigns on addictions targeting social networks Educate on the harmful effects of stigma on seeking treatment Share positive narratives of AIAN individuals in OUD/SUD recovery Create interventions targeting social stigma Implement peer support services Include friends and family in the treatment/recovery process



SUMMARY OF RECOMMENDATIONS

ORGANIZATIONAL

Influential Factors	Recommendations to Address Limitations
Address Stigma	<ul style="list-style-type: none"> Standardize screening for OUD/SUD in clinic visits Create and provide educational pamphlets on addictions and available treatment services placed in lobbies, inside examination rooms (for privacy), or to be provided by healthcare providers Educate providers on non-judgmental communication
OUD Prevention Education in Health Care Settings	<ul style="list-style-type: none"> Educate healthcare providers about: <ul style="list-style-type: none"> Guidelines for opioid prescription Screening for addiction and referring patients to services Collaborating with behavioral health departments to manage chronic pain and comorbid OUD
Integrative & Collaborative Systems of Care	<ul style="list-style-type: none"> Develop a System of Care (SOC) Model: Identify individuals entering the system and assign a case manager who oversees that patient's entire comprehensive treatment plan, including: <ul style="list-style-type: none"> Emergency detox Inpatient rehabilitation Outpatient OUD/SUD treatment as well as outpatient psychotherapy for any co-occurring mental health issues Placement in sober living Traditional AIAN healing services Connection to a recovery support group Integration for patient-centered care: <ul style="list-style-type: none"> Behavioral health consultant can be embedded within the medical clinic to provide direct care as needed with a medical patient Integration of traditional healers can also benefit the whole person by providing cultural wisdom, guidance, and non-Western healing Warm handoffs can be made from the integrated care team to SUD counselors and psychotherapy specialists to address opioid addiction Provide connections to culturally-based services <ul style="list-style-type: none"> Implement an AIAN coordinated service system Employ cultural consultants to help connect the patient to culturally-based services and/or advocate for the need for the incorporation of cultural understanding and sensitivity
MAT Services	<ul style="list-style-type: none"> Address the need for MAT and buprenorphine trainings for providers serving AIAN communities
Native Youth in the Foster Care System	<ul style="list-style-type: none"> Ensuring adequate resources are developed for these youth and their families to heal and remain connected to their cultures is critical in addressing prevention and early intervention

SUMMARY OF RECOMMENDATIONS

COMMUNITY

Influential Factors	Recommendations to Address Limitations
Address Stigma	<ul style="list-style-type: none"> Create community level health campaigns to raise awareness of OUD/SUD including: <ul style="list-style-type: none"> Information on addictions as a treatable health condition Information on the addictiveness of opioids and other pharmaceuticals (e.g., benzodiazepines) Information on MAT, how it works, and available MAT/Tele-MAT centers
OUD Prevention Education	<ul style="list-style-type: none"> Develop and disseminate culturally appropriate resources (i.e., media messages, fact sheets, health prevention programs) to reach Tribal and urban AIAN communities
Coordination of MAT Services	<ul style="list-style-type: none"> Residential treatment programs should receive necessary support and technical assistance to utilize MAT services in conjunction with residential programming
MAT Services	<ul style="list-style-type: none"> Develop resources for mothers whose recovery depends on their children also receiving residential placement and access to supportive services Establish referral networks to methadone and MAT programs Build partnerships between existing providers, programs, and consortiums to create and disseminate lessons learned in MAT implementation
Integrative & Collaborative Systems of Care	<ul style="list-style-type: none"> Educate providers across California on the resources available to their AIAN community members and the resources and materials that they can use with their AIAN patients
Recovery Training & Workforce Development	<ul style="list-style-type: none"> Increase access to training and workforce development programs Formally evaluate existing workforce development programs
Culturally Centered Recovery Programs	<ul style="list-style-type: none"> Increase funding for programs that incorporate AIAN traditional practices and cultural values in recovery treatment models (e.g., White Bison, Sweat Lodges, Healing Ceremonies)
Residential, Detox & Sober Living Facilities	<ul style="list-style-type: none"> Incorporate MAT treatments with residential services Create residential programs and facilities that provides support to parents undergoing OUD/SUD recovery services and their children Coordinate non-Native providers referrals to Indian Health Programs (IHPs) Engage adults in recovery and outreach Create training and workforce development programs to seamlessly transition recovering adults with the desire to gain the skills and certifications to enter the recovery workforce Evaluate existing workforce programs and determine best practices Provide additional culturally centered detox for Tribal and urban AIAN Provide transitional housing and develop a network of transitional housing program experts and consultants
Harm Reduction	<ul style="list-style-type: none"> The creation of a California AIAN Harm Reduction Workgroup could provide recommendations to Tribal and urban AIAN health programs, Department of Health Care Services (DHCS) and the state of California

SUMMARY OF RECOMMENDATIONS

Executive Summary

POLICY

Influential Factors	Recommendations to Address Limitations
OUD Prevention & Funding	<ul style="list-style-type: none"> Educate Tribal governments on the importance of creating practices to help prevent opioid-related overdoses and deaths
OUD Prevention Education in Health Care Settings	<ul style="list-style-type: none"> Provide funding for the implementation of MAT services Boost access to MAT through utilization of the Internet Eligible Controlled Substance Provider (IECSP) designation policy to expand the use of telemedicine in rural or remote areas
Integrative & Collaborative Systems of Care	<ul style="list-style-type: none"> Recognize and fund community defined evidence practices (CDEPs): <ul style="list-style-type: none"> Statewide recognition of and funding dedicated to cultural and traditional practices that are determined by communities to reduce health disparities associated with OUD/SUD
State Policy	<ul style="list-style-type: none"> Remove prior authorization requirements and limits on insurance coverage for AIAN living in California to increase access to MAT services Provide financial incentives to medical providers to become MAT certified in order to increase the number of waived providers in Indian Health programs and help close the gap in access Charge a fee on opioid sales to be deposited in a recovery fund in order to reach many AIANs affected by the ongoing opioid crisis Increase rigor on reporting requirements for the Controlled Substance Utilization Review and Evaluation System (CURES) database in order to help limit access to more addictive substances such as opioids Adopt policies supporting longer provider-patient interaction at each visit (i.e., greater than 20 minutes)
Funding & Resource Development	<ul style="list-style-type: none"> Inclusion of Urban Indian Health Programs in federal opioid response dollars and all federal opioid grants Urban Indian Health Programs, including residential treatment centers, should have access to Tribal Opioid Response Grants (TORG) and other funding allocated to AIANs Funding for participation in or support of local, regional, statewide and national opioid coalitions Allocation of funding specifically available for Tribal nations, Tribal Health Programs and Urban Indian Health Programs for prevention, intervention and treatment of OUD/SUD Increase in subcontractor/contractor services, allowable expenses, and travel budgets to: <ul style="list-style-type: none"> Alleviate the need for community expertise Provide training and information sharing Increase technical support for OUD/SUD programs
AIAN Homelessness & Housing Insecurity Associated with OUD/SUD	<ul style="list-style-type: none"> Fund further research regarding the impact of homelessness/home insecurity on AIAN individuals and families
Native Youth in the Foster Care System	<ul style="list-style-type: none"> More funding and attention are needed to understand the link between the opioid crisis and AIAN youth in foster care

SUMMARY OF RECOMMENDATIONS: SOCIO-ECOLOGICAL MODEL

Executive Summary

POLICY

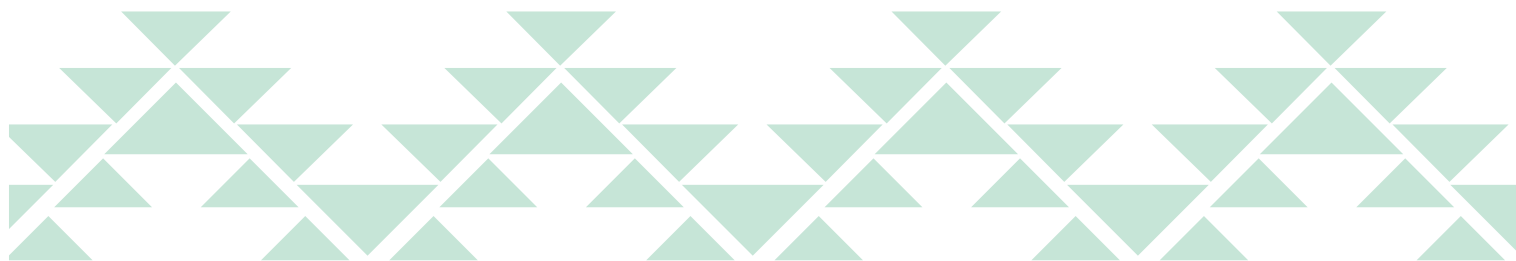
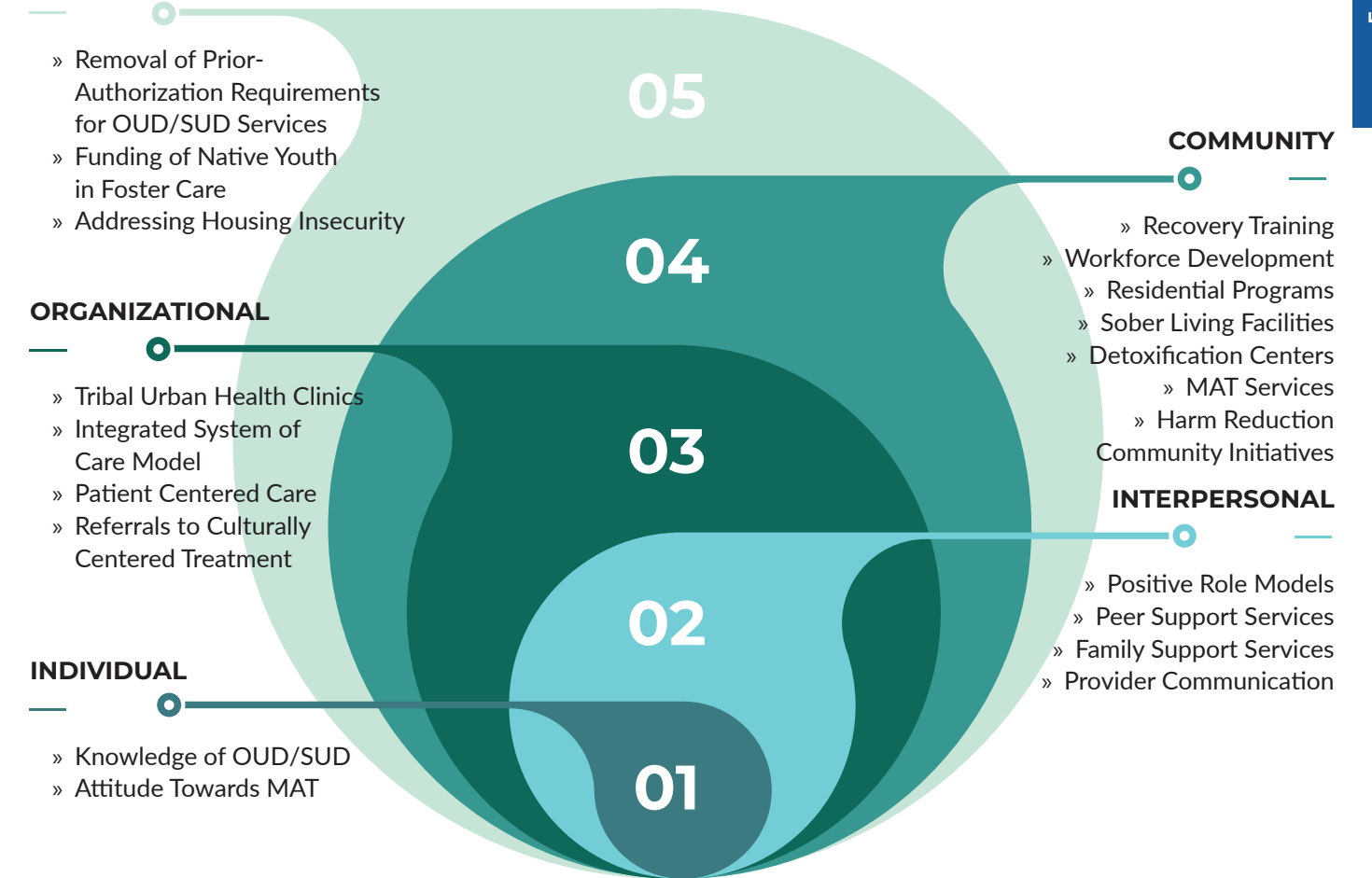
- » Removal of Prior-Authorization Requirements for OUD/SUD Services
- » Funding of Native Youth in Foster Care
- » Addressing Housing Insecurity

ORGANIZATIONAL

- » Tribal Urban Health Clinics
- » Integrated System of Care Model
- » Patient Centered Care
- » Referrals to Culturally Centered Treatment

INDIVIDUAL

- » Knowledge of OUD/SUD
- » Attitude Towards MAT





INTRODUCTION

In 2018, a statewide needs assessment was conducted to meet the specific needs of California's American Indian and Alaska Natives (AIAN) urban and rural communities to reduce opioid use disorders (OUD) and substance use disorders (SUD). This project was funded by the California Department of Health Care Services (DHCS) Tribal Medication-Assisted Treatment (MAT) Project to increase access and availability of MAT services. The overall goal is to reduce opioid overdose-related deaths in AIAN communities in California by identifying gaps in prevention, treatment, and recovery services. Tribal MAT is a subproject of DHCS's larger effort, the California MAT Expansion Project, which was made possible by the Substance Abuse and Mental Health Service Administration (SAMHSA) Opioid State Targeted Response (STR) grant.

This California needs assessment report includes perspectives from key informant interviews (KIIs) with healthcare providers from Tribal Health Programs (THPs) and Urban Indian Health Programs (UIHPs) and focus groups held with AIAN adults and youths who have been impacted by OUD/SUD.

Goals include:

- Identifying the most common substances used in California AIAN communities
- Surveying availability and access of MAT and other OUD/SUD treatment and recovery services
- Understanding the impact of culturally centered services on OUD/SUD prevention, treatment, and recovery
- Capturing recommendations to improve OUD/SUD prevention, treatment, and recovery services

Focus areas for these goals include:

1. Community Substance Use Descriptions
2. Risk Factors
3. Resiliency
4. OUD/SUD Services Available
5. Acceptability of Existing Services
6. Barriers to Accessing Services
7. Service System Needs

OPIOID FACT SHEET

What are Opiates/Opioids - The term 'opiates' describes drugs derived from the plant opium. The term 'opioids' is used to describe all opiates including naturally-derived and man-made drugs. Both terms are commonly used interchangeably to describe a highly addictive class of drugs that includes the illegal drug heroin as well as powerful pain relievers available by prescription.

Commonly Used Opioids

Commonly prescribed opiates are:

- oxycodone (OxyContin®, Percodan®, Percocet®)
- hydrocodone (Vicodin®, Lortab®, Lorcet®)
- diphenoxylate (Lomotil®)
- meperidine (Demerol®)

• morphine (Kadian®, Avinza®, MS Contin®)
Commonly used illegal opiates are:

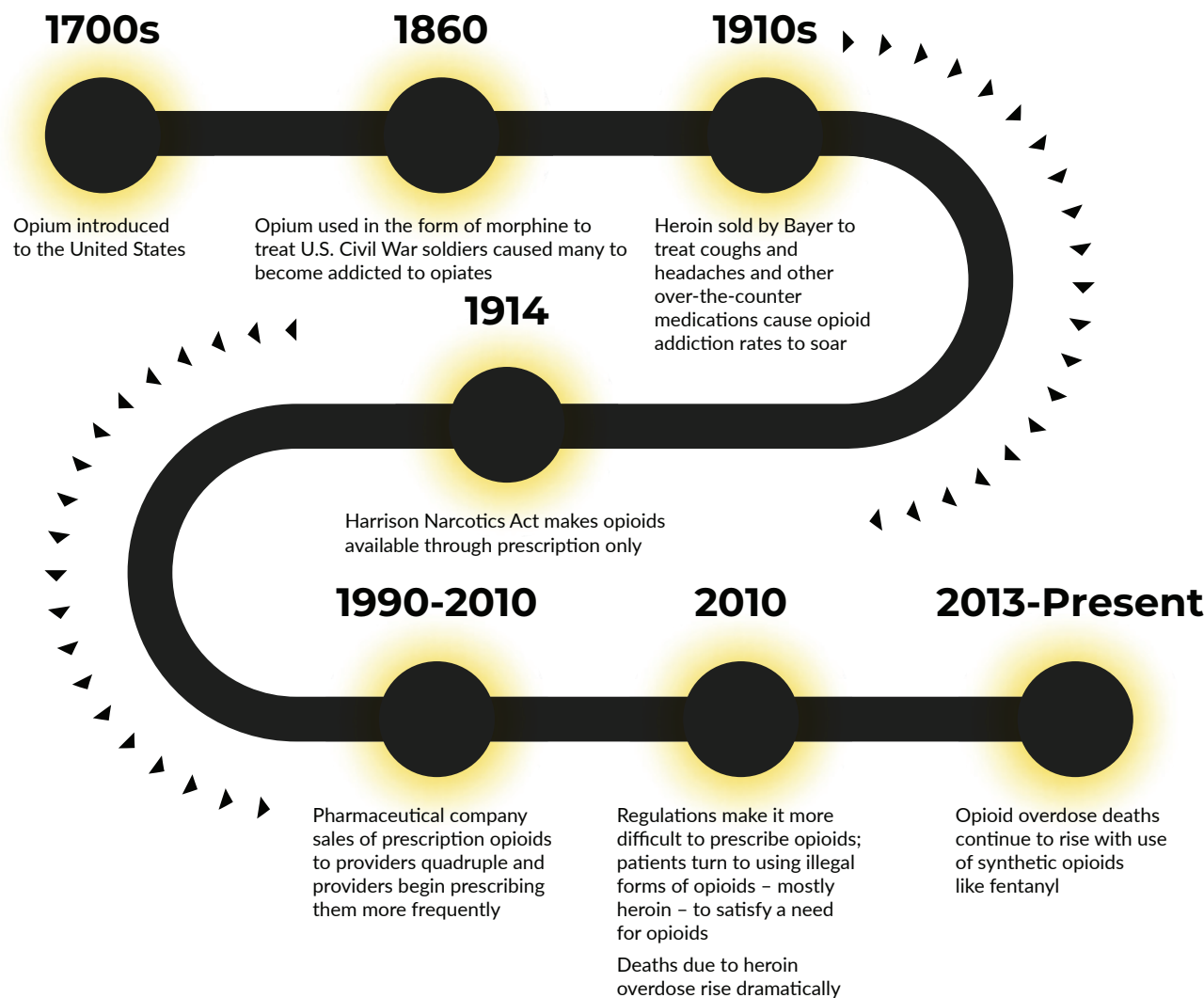
- heroin
- fentanyl (Duragesic®)

Medications used in Medication-Assisted Treatment (MAT) - Sometimes these are referred to as medications used to treat pain management, but these medications are used as one of the main approaches to address opioid use disorder (OUD).

Commonly used MAT medications:

- methadone
- buprenorphine (Suboxone®)
- naltrexone

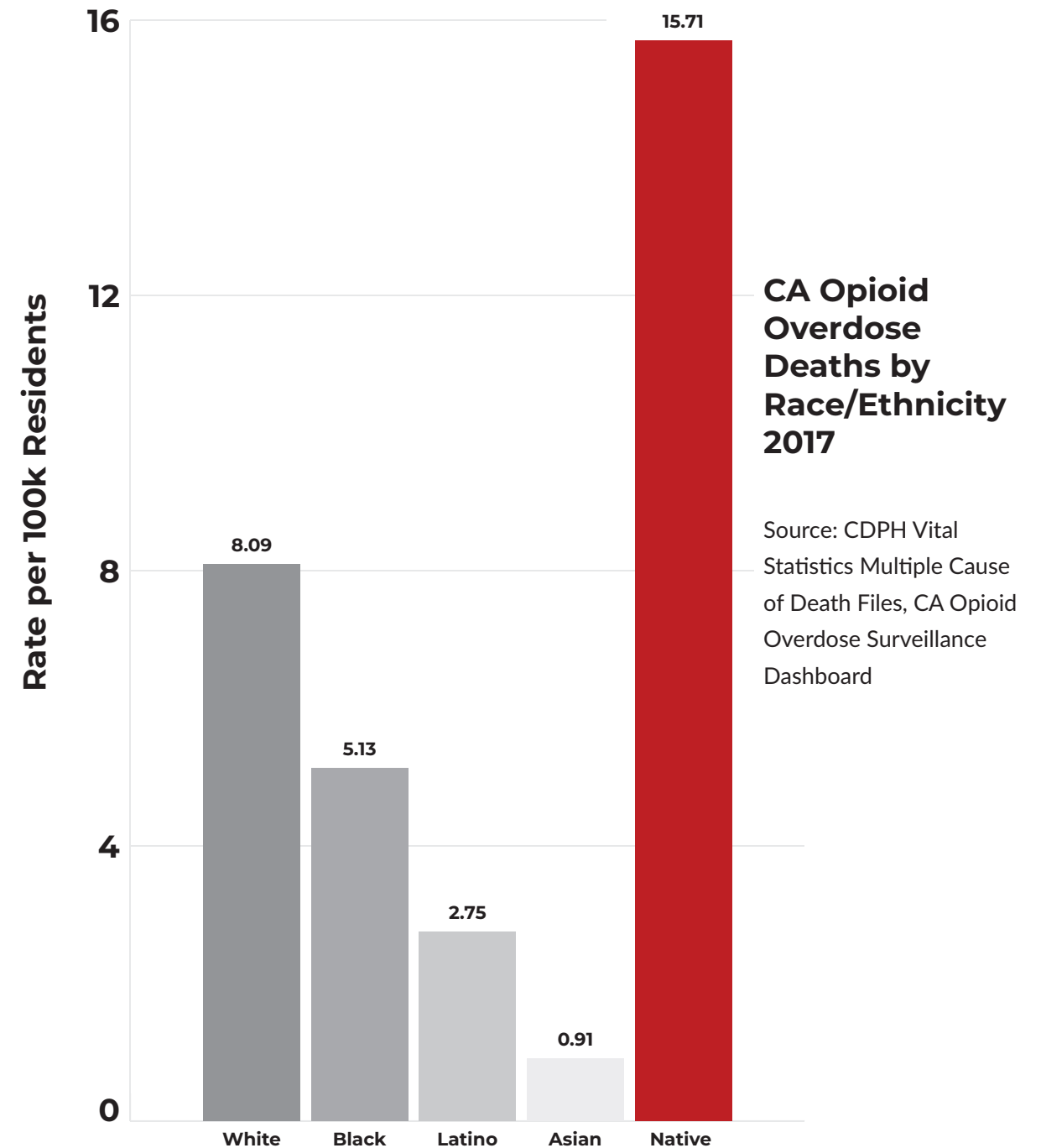
Brief History of Opioid Use and Epidemic in the United States ^{1,2}



PART 1. OPIOID CRISIS IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

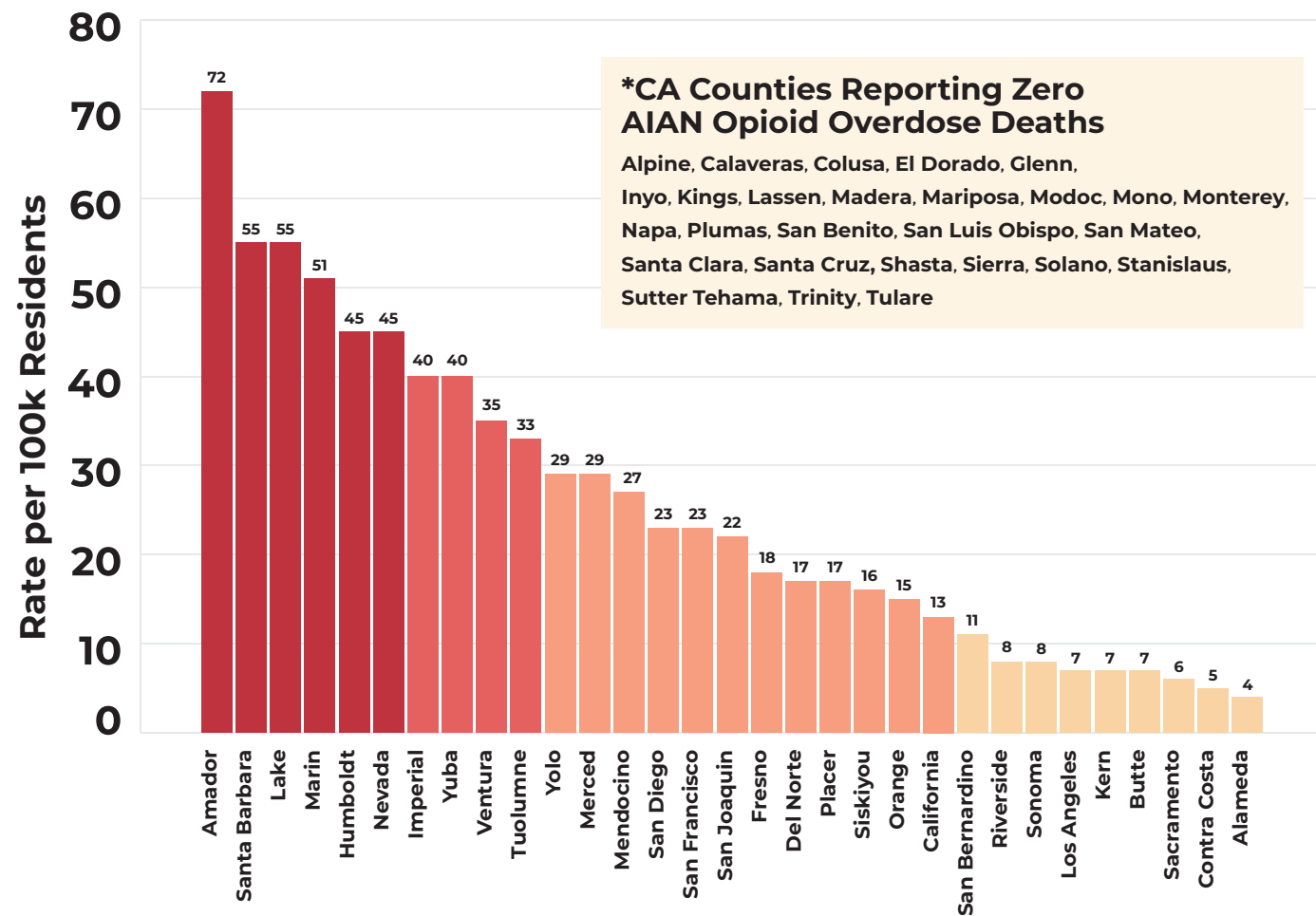
OPIOID USE DISORDER (OUD) EPIDEMIC AND SUBSTANCE USE DISORDER (SUD) AMONG AIAN COMMUNITIES

From 2006 to 2012, nearly 80% of AIAN drug overdose deaths in Washington, Idaho, and Oregon resulted from prescription opioids (e.g., hydrocodone, oxycodone, oxycodone extended-release).³ In the US from 1999 to 2009, death rates involving opioid pain relievers were higher among AIANs than among any other racial or ethnic minority group.⁴ To put these numbers into context, West Virginia has the highest statewide opioid-related death rate in the country, with a rate of 50 per 100,000 residents.⁵ In California, AIAN death rates in Amador, Santa Barbara, and Marin Counties actually surpass West Virginia's rates, and Humboldt and Nevada Counties are not far behind.⁶



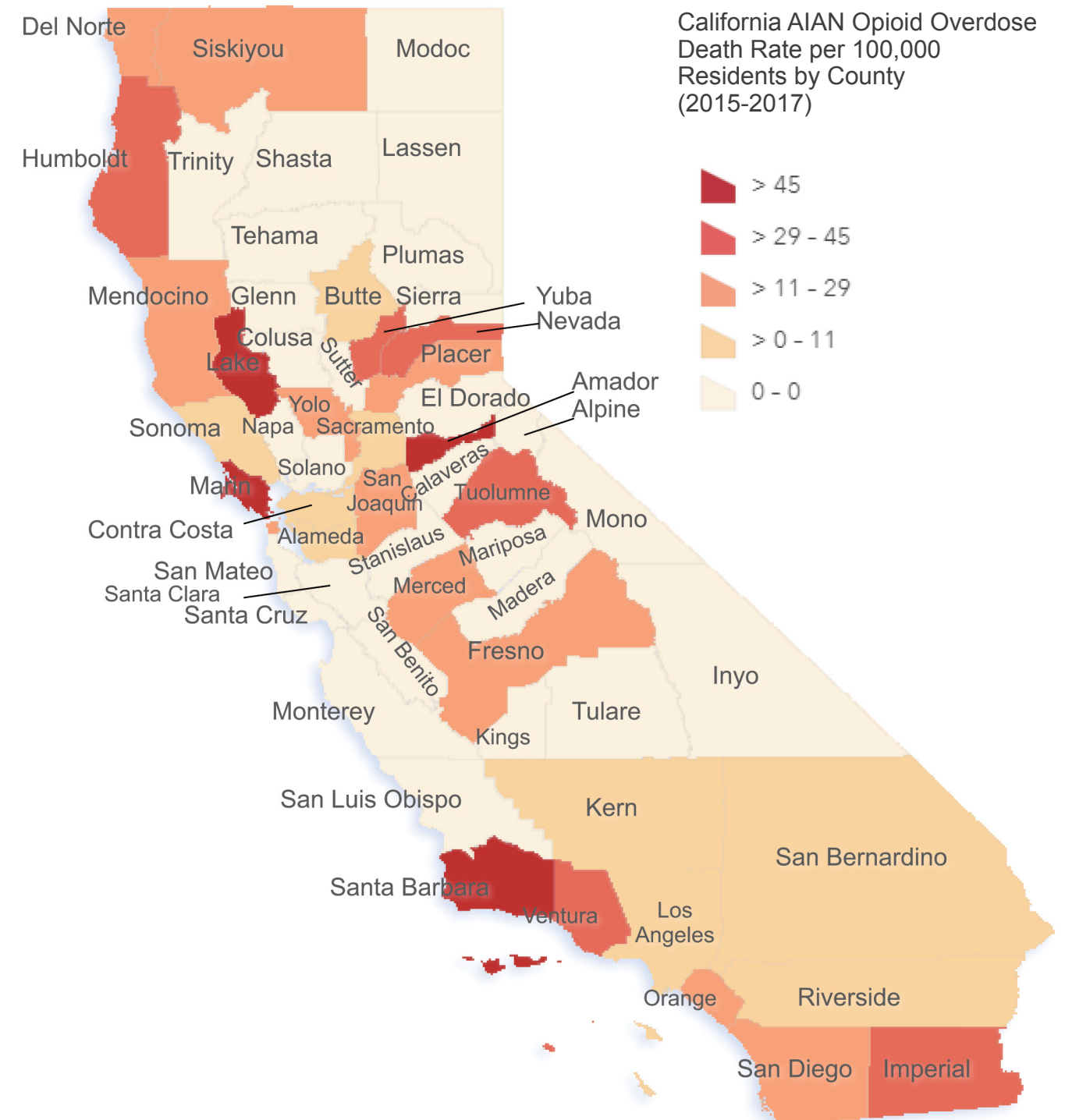
Opioid Crisis in AIAN Communities

2015-2017 AVERAGE CALIFORNIA AIAN OPIOID OVERDOSE DEATH RATES BY COUNTY



These data originate from death certificate records and depend on the accuracy of information provided by informants and clinicians. Death certificate data routinely undercount AIAN deaths due to consistent underreporting or misreporting of race and ethnicity, particularly among AIAN populations.⁷ The death rates reported here are, therefore, likely underestimates and counties reporting zero deaths may have had AIAN deaths that were not recorded as such.

Opioid Crisis in AIAN Communities



(Source: CDPH Vital Statistics Multiple Cause of Death Files, CA Opioid Overdose Surveillance Dashboard)

TREATING OPIOID USE DISORDER (OUD) WITH MEDICATION-ASSISTED TREATMENT (MAT) IN AIAN COMMUNITIES

WHAT IS MAT?

Medication-assisted treatment (MAT) uses prescribed medications along with behavioral counseling to help treat opioid use disorder (OUD) and to avoid an opioid overdose. It helps to treat addiction to opioids such as heroin and prescription pain medications like OxyContin® and Vicodin® (oxycodone and hydrocodone).⁸ In the United States, 2.3 million people meet the criteria for experiencing OUD, which is defined as a *problematic pattern of opioid use leading to clinically significant impairment or distress*.⁹ For individuals experiencing OUD, there is strong evidence supporting the efficacy and cost-effectiveness of MAT. MAT has shown increased patient retention in treatment, improved social functioning, and reduced risk of overdose.¹⁰

Methadone, buprenorphine, and naltrexone are the three medications approved by the Food and Drug Administration (FDA) for the treatment of OUD.¹¹ Due to buprenorphine's partial opioid-agonist treatment profile, generic availability, and high success rates in decreasing overdose mortality and opioid relapse rates over time, it has become a popular choice for many contemporary MAT programs.^{12,13} In addition, combinations of buprenorphine and naloxone have been developed for those in OUD/SUD recovery, thus using the opioid-blocking effects of naloxone to help prevent the chance of overdose in case of relapse or substance misuse while within a MAT treatment continuum.¹⁴

EFFECTIVENESS OF MAT IN INDIGENOUS COMMUNITIES

Studies have shown MAT to be effective with Indigenous communities, particularly in Australia and with First Nations in Canada. In Canadian First Nation communities, studies assessing OUD treatment programs using MAT in combination with traditional healing methods have shown high retention rates, low illicit opioid use, increase in school attendance, and decreases in suicide, crime rates, and child protection cases.^{15,16} In Australia, studies found MAT programs had higher acceptance by Indigenous communities when they were culturally tailored.^{17,18}

INCREASING THE ACCEPTABILITY OF MAT IN AIAN COMMUNITIES

A common myth contributing to stigma in AIAN communities around MAT is that using buprenorphine or other MAT-identified compounds for OUD is merely a means of “switching one drug for another.” This is an inherently flawed and potentially harmful assumption that fails to acknowledge the nature of buprenorphine as a medication while ignoring the body of evidence displaying the therapeutic and social value MAT brings to those experiencing OUD.^{19,20}

In 2017, the National Institute on Drug Abuse (NIDA) called together several key stakeholders from the AIAN community to discover crucial perspectives on the acceptability and uptake of MAT for OUD treatment in AIAN communities.²¹ This gap in knowledge exists because Western-based services (i.e., evidence-based practices) rarely reflect the diversity of cultures in California's AIAN communities in that they are not culturally, spiritually, linguistically, and geographically representative in prevention, intervention, and treatment modalities. Five key themes were highlighted:²¹

1. A mismatch between secular Western medicine and the AIAN holistic traditions
2. A need to integrate MAT with AIAN traditional approaches
3. A conflict between standardized MAT delivery and a traditional AIAN desire for healing to be medication-free
4. Systemic barriers including intergenerational trauma and economic isolation
5. A need to improve research with AIAN communities using culturally relevant methods

With the diversity of AIAN populations in CA, it is imperative to understand the existing services for OUD/SUD and ways to improve treatment services and reduce systemic barriers. Therefore, this report is an effort to understand community needs and develop impactful research in collaboration with AIAN communities to address OUD health gaps and disparities.

INDIAN HEALTH PROGRAMS IN CALIFORNIA

INDIAN HEALTH PROGRAMS SERVICING AIAN POPULATIONS IN CALIFORNIA

California has the largest AIAN population in the US with over 720,000 AIAN individuals (approximately 2% of the California population). There are 109 federally recognized Tribes in California, as well as numerous state recognized Tribes and non-federally recognized Tribes.^{22,23} There are an estimated 78 state Tribes petitioning for federal recognition.²⁴ AIANs in California, including California Indians and AIANs who relocated from other states, are dispersed throughout rural and urban areas around the state.²⁵ This was primarily due to the US government policies that relocated AIANs from reservations to urban areas.²⁵ The Indian Health Service (IHS), an agency within the US Department of Health and Human Services, provides direct medical and public health services to federally recognized Tribes.²⁶ Access to healthcare services can be complicated for AIAN populations because IHS facilities in California are limited.²⁶ The diversity of Tribal and urban Indian organizations providing resources for opioid use disorder treatment vary regionally in California. There are 35 Tribal Health Programs (THP) and Tribal treatment centers based on or near reservations and rancherias within the California Area Indian Health Service, as well as three THPs within California's borders that are overseen by the Phoenix Area Indian Health Service.²⁷ There are 10 Urban Indian Health Programs (UIHP) which serve AIAN people in select cities with a range of services including community health, residential treatment, and comprehensive primary health care services.²⁸

TRIBAL HEALTH PROGRAMS IN CA

Congress initially funded Indian health care and defined the federal government's responsibility in providing health care to American Indians in the Snyder Act of 1921.²⁹ Federally-funded health care services were withdrawn in the 1950s, as federal policies of termination led to Tribes across the United States, particularly in California, being stripped of their federal recognition.³⁰ The termination was challenged in a series of court cases and appeals to the federal government, which led to the restoration of many Tribes' federal recognition; however, some Tribes that were terminated have yet to regain their federally recognized status.³¹ The Indian Self Determination and Education Assistance Act of 1975 (also known as Public Law 93-638) and its subsequent amendments legislated the authority of federally recognized Tribes to decide how they wanted healthcare to be provided to their people. Options included receiving healthcare directly from the IHS, contracting with IHS “to administer individual programs and services the IHS would otherwise provide,” or compacting with the IHS “to assume control over health care programs the IHS would otherwise provide.”³² There are no healthcare facilities directly operated by the IHS in California, and thus no hospitals that provide emergency and inpatient care specifically for AIANs. Although this type of care is unavailable in California facilities, existing THPs can provide medical, dental, behavioral health, and preventative services. Some THPs serve only one federally recognized Tribe, while others are consortia of Tribes providing services to their members. The governance of THPs is guided by their health boards which are comprised of Tribal leaders who oversee the operations and services of the facilities to ensure that the unique needs of their Tribal communities are being met. While THPs receive funding through the IHS, they may also obtain supplemental funding to expand the programs and services offered.

TRIBAL/URBAN INDIAN HEALTH CENTERS

The following tables list Tribal and urban Indian health centers serving AIAN in California. If the location of the health center is not explicitly a part of its name, it is noted in parentheses.

TRIBAL CLINICS AND TREATMENT CENTERS		
1. Central Valley Indian Health, Inc. (Clovis)	14. Mathiesen Memorial Health Clinic (Jamestown)	25. Sonoma County Indian Health Project (Santa Rosa)
2. Chapa-De Indian Health Program, Inc. (Auburn)	15. Northern Valley Indian Health, Inc. (Willows)	26. Southern Indian Health Council, Inc. (Alpine)
3. Colusa Indian Health Community Council	16. Pit River Health Service, Inc. (Burney)	27. Strong Family Health Center (Alturas)
4. Consolidated Tribal Health Project, Inc. (Redwood Valley)	17. Quartz Valley Program (Fort Jones)	28. Susanville Indian Rancheria
5. Feather River Tribal Health, Inc. (Oroville)	18. Redding Rancheria Tribal Health Center	29. Sycuan Band of the Kumeyaay Nation (El Cajon)
6. Fort Mojave Indian Health Center (Needles)	19. Riverside/San Bernardino County Indian Health, Inc. (Banning)	30. Table Mountain Medical (Friant)
7. Fort Yuma Indian Health Center (Winterhaven)	20. Rolling Hills Clinic (Corning)	31. Toiyabe Indian Health Project, Inc. (Bishop)
8. Greenville Rancheria Tribal Health Program	21. Round Valley Indian Health Center, Inc. (Covelo)	32. Tule River Indian Health Center, Inc. (Porterville)
9. Indian Health Council, Inc. (Valley Center)	22. Santa Ynez Tribal Health Clinic	33. Tule River Tribe (Porterville)
10. Karuk Tribe (Happy Camp)	23. Shingle Springs Tribal Health Program	34. Tuolumne Me-Wuk Indian Health Center (Tuolumne)
11. K'ima:w Medical Center (Hoopa)	24. Sierra Tribal Consortium, Inc. (Fresno)	35. United Indian Health Service, Inc. (Arcata)
12. Lake County Tribal Health Consortium, Inc.		36. Warner Mountain Indian Health Program (Ft. Bidwell)
13. MACT Health Board, Inc. (Angels Camp)		37. Washoe Tribal Health Center (Woodfords)

URBAN CLINICS AND TREATMENT CENTERS
1. American Indian Health & Services Corporation (Santa Barbara)
2. Bakersfield American Indian Health Project
3. Fresno American Indian Health Project
4. Friendship House Association of American Indians (San Francisco)
5. Indian Health Center of Santa Clara Valley (San Jose)
6. Native American Health Center, Inc. (San Francisco Bay Area)
7. Native Directions, Inc. (Manteca)
8. Sacramento Native American Health Center, Inc
9. San Diego American Indian Health Center
10. United American Indian Involvement, Inc. (Los Angeles)

URBAN INDIAN HEALTH PROGRAMS IN CA

The passage of the Indian Health Care Improvement Act (IHCA) of 1976 greatly expanded the authority of IHS. The IHCA broadened the Snyder Act, allowing IHS to contract with Urban Indian Health Programs (UIHP) for healthcare services. Cultural barriers, healthcare provider prejudice, and a lack of understanding of AIAN health issues are among the reasons that justified the creation of UIHPs.³³ The first UIHP in California was the

Native American Health Center, established in San Francisco in 1972. There are ten UIHPs in California, including six direct health care programs, two access and referral programs and two residential treatment facilities. Historically, funding for UIHPs has been around one percent of the total IHS budget. This limited funding requires UIHPs to seek funding from other federal agencies to expand their capacity and diversify their services to meet the needs of urban AIANs.³⁴

Indian Health Programs

California Tribal Epidemiology Center

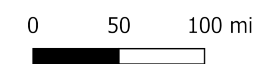


Map created by Jillian Jetter and Yeoun-Jee Rengnez, California Tribal Epidemiology Center (June 2019)



Legend

- Tribal Health Program (34)
- ▲ Urban Indian Health Program (10)
- Phoenix Area IHP (3)



Resources for above:
<https://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx>
<https://www.ihs.gov/aboutihs/organizationalstructure/>

WHAT IS TRIBAL SOVEREIGNTY?

TRIBAL SOVEREIGNTY

As California continues to develop prevention and treatment programs for AIANs, it is critical to acknowledge the unique role of California Tribes. Tribes are sovereign nations with the ability to enact laws and policies to address the opioid crisis. In California, there are 109 federally recognized Tribes; each has its own constitution, elected Tribal leaders and federally contracted health clinics. In addition to healthcare, many Tribes in California contract with the federal government for the delivery of services including, but not limited to, land and water management, roads, education, and housing.

Tribal sovereignty is the inherent right for Tribal governments to govern their members and Tribal lands.³⁵ Therefore, when conducting community based participatory research with Tribes, data sharing agreements must meet Tribal ethical requirements so that Tribes have full authority and ownership of all data collected.³⁶ As sovereign nations, Tribal governments protect the cultural and intellectual property of their communities.



- » Each Tribe has the inherent right to govern their Tribal members and Tribal lands.
- » Laws of the state do not necessarily apply to Tribal governments.
- » The federal government works with Tribes on a government to government basis.
- » Tribal leaders (e.g, Chairman, Governor, President) are elected by their respective Tribal members.

PART 2. PARTICIPATORY ACTION AND COMMUNITY-BASED PARTICIPATORY RESEARCH TO IMPROVE TREATMENT OF OUD/SUD AMONG AMERICAN INDIAN AND ALASKA NATIVES

OVERVIEW OF PARTICIPATORY ACTION AND COMMUNITY-BASED PARTICIPATORY RESEARCH: HISTORY AND CORE PRINCIPLES

Participatory action research (PAR), often used interchangeably with community-based participatory research (CBPR), methods were used to inform this needs assessment to engage community participants in continual cycles of reflection and action with regard to developing and implementing a needs assessment.^{37,38} To address OUD in AIAN communities, gathering community perspective is key to learning about the strengths, challenges and available resources to identify unmet needs and generate evidence to support systems change. This process can build leadership, group cohesion, and a sense of local community involvement. By using PAR methods, community participants were empowered by the research process to contribute their expertise and influence the improvement of OUD treatment and other systems change needs in AIAN communities.

PAR describes an approach to conducting research that equally involves community members and agency partners in all aspects of the research process (See Table 1).³⁹

APPLICATION OF PAR/CBPR TO MENTAL HEALTH AND SUBSTANCE USE DISPARITIES RESEARCH

PAR/CBPR is a valuable public health approach because it can assist in development, implementation, and dissemination of effective interventions across diverse communities through engaging strategies to reduce power imbalances, facilitate mutual benefit between community and academic partners, and promote reciprocal knowledge translation by drawing on community theories and practice.⁴⁰ PAR/CBPR is highly relevant to substance use prevention and intervention because communities experience diverse demographic, social, historical, cultural, and health-related determinants relevant to the understanding of and development of effective treatment for community members. The most influential way to understand the unique determinants of substance use in diverse communities is to directly engage and partner with members of those communities who represent the experts on the historical, cultural, and social norms driving the experience of substance use. For example, our needs assessment focus groups included people in recovery from OUD/SUD, families impacted by OUD/SUD, and current substance users.

RELEVANCE OF PAR/CBPR TO RESEARCH IN AIAN COMMUNITIES

Previous research in AIAN communities has demonstrated that methodological approaches must be culturally-driven and leverage AIAN cultural strengths, belief systems, and competencies.⁴² Such a research approach is most likely to be achieved when researchers and communities form partnerships that are founded on mutual respect, collaboration, equal authority in decision-making, and open communication. PAR/CBPR may be especially critical in AIAN communities because of the long history of inappropriate and even abusive research practices with AIAN communities. As a result, AIAN communities are often unsure whether or not to engage in any sort of research with “outsiders,” even those that promise a collaborative approach. Experts have argued that research and science itself is inherently not “value-free” as it has evolved within the cultural context of mainstream Western society.⁴³ Thus, the very process of partnering with AIAN communities may involve determining how the Western scientific approach can work with Indigenous ways of knowing in order to effectively address the research question of importance to the community. Cochran et al.⁴³ note that there is an urgent need for more ethical research approaches based on consultation, strong community participation, and methods that acknowledge Indigenous ways of knowing in order to obtain new knowledge and understanding related to health problems and to evaluate interventions that can help to address the health needs of AIAN communities.

TABLE 1: APPLICATION OF PAR/CBPR IN CURRENT NEEDS ASSESSMENT STUDY

The following table highlights the methods and processes used by the needs assessment study project described in this report to ideally follow the principles of Participatory Action and Community Based Participatory Research (PAR/CBPR).

Key Principles of PAR/CBPR	How the Needs Assessment Study Utilized PAR/CBPR Key Principles
(1) Recognizes community as a unit of identity	» Recruited and partnered with urban and Tribal communities throughout CA to ensure adequate representation of the many unique AIAN communities
(2) Builds on strengths and resources within the community	» Developed relationships with key Tribal partners and stakeholders within many CA Tribal and urban AIAN communities and engaged them as members of the research team
(3) Helps to build collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that addresses social inequities	» Partnered with community stakeholders and members in research activities including: recruitment, conducting focus groups and interviews, analyzing and interpreting qualitative data, preparing manuscripts and reports, presenting and disseminating data » Helped to make clear that community members and stakeholders have equal roles in activities whenever feasible
(4) Creates an environment of co-learning and capacity building among all partners	» Facilitated training in research methods, qualitative data collection, and analysis for Tribal research team members » Learned from Tribal research members about community-based methods and processes critical to research success
(5) Achieves a balance between research and action for the mutual benefit of all partners	» Assessed necessary action items and policy changes to address community-identified needs
(6) Emphasizes public health problems of local relevance and also ecological perspectives that recognize and attend to the multiple determinants of health and disease	» Established local understanding and meaning around OUD/SUD issues » Developed interview and focus group guides through a collaborative process with AIAN community members to ensure that cultural factors and important health related topics were represented
(7) Involves systems development through a cyclical and purposeful process	» Engaged in consistent interchange and re-evaluation with all research team members and community partner representatives to revise and adapt research methods and analytic approaches
(8) Shares findings and knowledge gained to all partners and involves partners in the sharing of information to the communities	» Created a dissemination plan to share findings with communities that involved input and feedback from communities about the meaning of findings and next steps for action
(9) Requires a long-term process and commitment to sustainability	» Placed findings into context of necessary policy and practice changes to promote long term sustainability

PART 3. METHODOLOGY

Our study methods utilized a participatory action research approach (PAR/CBPR- outlined in Part 2-Table 1) for the research design and implementation process. This approach facilitated the engagement of AIAN community members and agency partners in all aspects of the research process. The Tribal MAT Needs Assessment Team consisted of American Indian researchers, urban Indian agency partners, Tribal entities, USC PhD students, USC staff, and community liaisons. The methods for our needs assessment report were as follows:

CREATING A NEEDS ASSESSMENT TOOL

- The Tribal MAT Needs Assessment Team created a key informant interview (KII) questionnaire, an adult focus group guide, and a youth focus group guide.
- The KII tool and focus group questions assessed seven major categories of substance use which included:
 1. Community Substance Use Description
 2. Risk Factors
 3. Resiliency
 4. OUD and SUD Services Available
 5. Acceptability of Existing Services
 6. Barriers to Accessing Services
 7. Service System Needs

The interview tools and questionnaires were pilot tested with two adult focus groups, two youth focus groups, and five key informant interviews. Based on community/participant feedback, each tool was revised and finalized for use in the statewide needs assessment (See Appendix A for Key Informant Interview Questions and Appendix B for Focus Group Question Guide, pgs. 103-105).

DATA COLLECTION

- Data was collected from rural, Tribal, and urban communities in ten counties throughout California from March to November 2018.
- A total of 33 KIIs were conducted with healthcare providers.
- Focus groups were conducted among adults (18-65 years) and youth (13-17 years). A total of 21 adult focus groups with 163 participants and 15 youth focus groups with 83 participants were conducted.
- Each participant reviewed and signed a study consent form and completed a short survey including demographic information and questions capturing substance use prevention or treatment services available in their local areas.
- Focus groups were held at: Urban Indian Health Programs (UIHPs), American Indian youth centers, Tribal health organizations, American Indian recovery centers, and Tribal social services with each lasting approximately two hours.
- All KIIs and focus groups were led by a trained facilitator and notetaker and were audio-recorded where all participants consented.
- Focus groups began and ended with an optional prayer or opening expression to honor the land, participants, and local community.

A STATEWIDE NEEDS ASSESSMENT

PARTICIPANTS

Key informants were selected if they served in:

1. Indian Health Programs (IHPs) or community-based organizations that provide health services to AIAN populations; and/or
2. Programs that are currently utilizing MAT or OUD/SUD recovery services at some level (i.e., prevention, treatment, educational programming)
3. 18 years of age or older

Adult focus group participants were included if they met the inclusion criteria:

1. Self-identified as AIAN
2. 18 years of age or older
3. Resided in CA

Youth focus group participants were included if they met the inclusion criteria:

1. Self-identified as AIAN
2. Between the ages of 13-17 years
3. Resided in CA

ANALYSIS AND CODING

- All audio-recorded interviews were transcribed using transcription software, and a professional transcription service. A team of five researchers created a codebook based on the predetermined seven domains, and within each domain, the team used an inductive approach to discuss the emerging themes.
- Each transcript was analyzed by two or more coders and the coding team met with members of the writing team to discuss codes and reach a consensus on a final codebook and coding process.
- The coders met to discuss homogeneity of analyses, the emergence of any new themes, and understanding of codes in context. The Needs Assessment team members reviewed the results of coding and analysis to assess face validity from an AIAN community perspective. Thus, codes were decided upon using an iterative and collaborative process.
- All qualitative coding analyses were conducted using NVivo® software.
- Additional data included a brief survey of demographic information, past substance use, and OUD/SUD recovery status.




For more details and information on methodology, please refer to publication:

Zeledon, I., West, A., Antony, V., Telles, V., Begay, C., Henderson, B., Unger, JB., Soto, C. (2019). *Statewide collaborative partnerships among American Indian and Alaska Native (AI/AN) communities in California to target the opioid epidemic: Preliminary results of the Tribal Medication Assisted Treatment (MAT) key informant needs assessment. Journal of Substance Abuse Treatment. doi:10.1016/j.jsat.2019.04.003*

PART 4. RESULTS AND LIMITATIONS

The results section consists of demographic information (See Tables 2-4) and main findings of 33 key informant interviews with healthcare providers and 246 community members (adult and youth) who participated in focus groups. There are seven a priori domains with emerging sub-themes. Each domain is organized to provide a narrative of the results highlighting relevant community quotes pertaining to each domain. Quotes from each participant group (key informant, adult, and youth) are identified by a distinct color (See Participant Quotes Key below).

Participant Quotes Key

	Key Informant
	Youth Focus Group Participant
	Adult Focus Group Participant



A STATEWIDE NEEDS ASSESSMENT

1. Community Substance Use Description

Substance Use Trends & Access

- » Substance Access
- » Emerging SUD Trend
- » Youth Initiation Age
- » Polysubstance Use
- » OUD/SUD within Families
- » Opioid Prescription Oversight

Perceptions of people with SUD by Adults & Youth

- » Negative Consequences of Substance Use

2. Risk Factors

Community Stressors

- » Historical Trauma & Disconnection
- » Intergenerational Trauma
- » Regional Differences

Family Stressors

Economic Stressors

- » Poverty
- » Homelessness
- » Funding for Services

Mental Health

- » Trauma-related
- » Depression & Anxiety

Peer Pressure/Social Norms

- » Family Influence
- » Social Media
- » Peer Influence
- » Gateway Drugs

3. Resiliency

Community Strengths

- » Programs & Services
- » Community Connection
- » Recovery from Trauma
- » Spirituality

Cultural Connectedness

- » Sense of Community (Regional Differences)
- » Cultural Practices
- » Cultural Connectivity

Cultural Services

- » Traditions & Ceremony
- » Wellness & Recovery Services

Positive Role Models

- » Peer Role Models
- » Family
- » Sober Role Models

Supportive Services & Programs

- » Information & Education
- » Treatment Services

4. OUD and SUD Services Available

Pharmacotherapy

- » MAT and Tele-MAT Programs

Behavioral Health Treatments

Counseling Services

- » Individual Counseling
- » Family Wrap-around Program

Education

- » Parenting Classes
- » School-based Prevention Programs
- » Community-based Programs

OUD/SUD Recovery/Treatment Programs

- » Inpatient & Residential Treatment Programs

Culturally Centered Treatment

- » Providing Spaces & Resources for Cultural Events
- » Cultural Services
- » Wellbriety & Red Road

Regional Differences in Access to Services

- » Rural Areas
- » Urban Areas

5. Acceptability of Existing Services

Access to Services

- » Accessibility
- » Diverging Perspectives

Cultural Sensitivity

- » Strength of Culturally Centered Services
- » Culturally Sensitive Treatment Approaches
- » Lack of Culturally Sensitive Treatment
- » Cultural Integration

Quality of Service

- » Western-based Services
- » System Improvements
- » Culturally-based Services
- » Educating Providers

Traditional Healing

- » Impact
- » Regional Availability

6. Barriers to Accessing Services

External Barriers

- » Location
- » Cost
- » Lack of Services
- » Common Factors

Internal Barriers

- » Stigma
- » Lack of Readiness
- » Lack of Trust in Providers
- » Gaps in Services

7. Service System Needs

Community Awareness

Information & Education

- » OUD/SUD as a Disease
- » Addictiveness of Substances
- » Critical Age for Prevention
- » School-based Prevention

Economic Opportunities & Life Skills Programs

Maintenance Support Systems

Treatment Facilities & Services

Strategies for Integrating Services

- » Chronic Pain Management/Pain Management Contract
- » Active Case Management
- » Management of Relapse
- » Treating Mental Health Comorbidities alongside OUD/SUD
- » Including Traditional Healers
- » Referrals
- » Multiple-Entry Points into OUD/SUD
- » Transportation

Youth Programs

Mental Health Services

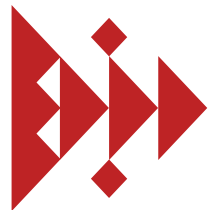




TABLE 2. DEMOGRAPHIC INFORMATION OF KEY INFORMANTS (N=33)

Gender	N=33	Percent (%)	Organization Type	N=33	Percent (%)
Male	18	55	Urban Indian Health Program	12	37
Female	15	46	Tribal Indian Health Program	10	30
Race			California Tribal TANF Partnership	3	9
American Indian/Alaska Native	17	52	Residential Treatment Program	3	9
Other	16	49	County Services	2	6
Occupation			Indian Health Council	2	6
Substance Abuse Counselor	8	25	Indian Education Center	1	3
Case Manager	2	6	County		
Medical Director (IHP)	2	6	Los Angeles	7	21
Psychologist	2	6	Sonoma	6	18
Youth Specialist	2	6	San Diego	5	16
Associate Clinical Social Worker	1	3	Alameda	3	9
Associate Director (SUD Treatment)	1	3	Mendocino	3	9
Behavioral Health Director	1	3	Lake	2	6
Behavioral Health Therapist	1	3	Sacramento	2	6
Chief Medical Officer	1	3	Tulare	2	6
Clinical Psychologist	1	3	Inyo	2	6
Director of Clinical Services (IHC)	1	3	Fresno	1	3
Director of Operations (IHC)	1	3			
Indian Health Center Director	1	3			
Medical Provider	1	3			
Nurse Practitioner	1	3			
Pharmacy Director	1	3			
Program Manager (IHC)	1	3			
Psychiatric Social Worker	1	3			
Registered Nurse	1	3			
Residential Program Director	1	3			
SUD Treatment Intern	1	3			

TABLE 3. DEMOGRAPHIC INFORMATION OF YOUTH PARTICIPANTS (N=83)

Age Range (Years)	Mean in Years (SD)	
13-17	14 (1.58)	
Occupation		
	N	Percent (%)
Male	38	46
Female	45	54
AIAN Identity		
AIAN	77	93
Other	6	7
First Substance Ever Used		
Marijuana	16	19
Alcohol	4	5
Tobacco	1	1
Other	2	2
Never Used	50	60
Preferred Not to Answer	10	12
In Active SUD Recovery		
Yes	2	2
No	79	95
Preferred Not to Answer	2	2



COMMUNITY SUBSTANCE USE DESCRIPTION

TABLE 4. DEMOGRAPHIC INFORMATION OF ADULT PARTICIPANTS (N=163)

Age Range (Years)	N	Percent (%)
18 to 24	18	11
25 to 34	31	19
35 to 44	47	29
45 to 54	33	20
55 to 64	19	12
65 or older	9	6
Did not report	6	4
Gender		
Male	76	47
Female	73	45
Did not report	14	9
AIAN Identity		
AIAN	141	87
Other	14	9
Did not report	8	5
First Substance Ever Used		
Alcohol	54	33
Marijuana	31	19
Tobacco	17	10
Methamphetamine	4	2
Cocaine or Crack	2	1
Pain Killers	1	1
Other	21	13
Never Used	10	6
Preferred Not to Answer	23	14
In Active SUD Recovery		
Yes	89	55
No	57	35
Did not report	17	10

Substance Use Trends & Access

- » Substance Access
- » Emerging SUD Trend
- » Youth Initiation Age
- » Polysubstance Use
- » OUD/SUD within Families
- » Opioid Prescription Oversight

Perceptions of People with SUD by Adults & Youth

- » Negative Consequences of Substance Use

1. COMMUNITY SUBSTANCE USE DESCRIPTION

Participants (key informants, adults, and youth) were asked about their perceptions of substance use in their community including the most prevalent substances, access to and availability of substances, as well as differences in utilization and substance use trends between youth and adults. Below we identify the most prevalent themes identified by participants including: (1) Substance Use Trends & Access, (2) Perceptions of People with OUD/SUD by Adults & Youth, and (3) Negative Consequences of Substance Use.

Substance Use Trends & Access

- Substance Access:** All participants (key informants, adults, and youth) reported that substances such as alcohol, marijuana, heroin, opioids, and methamphetamine were extremely accessible in their community. Key informants primarily discussed the progression from opioid use to heroin use when individuals were unable to access prescribed opioids. Frequently mentioned sources of access to substances included family members (i.e., elders with prescribed opioids, parents, siblings, cousins) and peers (via social networks).
- Emerging SUD Trend:** Youth reported the use of benzodiazepines (e.g., Xanax®), antidepressants, cough syrup, vaping (e.g., JUUL®), marijuana, and cocaine.
- Youth Initiation Age:** Key informants and adults reported that youth substance use initiation is younger than in previous years and that there is a higher availability and variety of substances than in the past.
- Polysubstance Use:** Polysubstance use was reported by both youth and adults. Key informants and adults described polysubstance use resulting from a primary prescription opioid addiction. When opioids were no longer prescribed, individuals progressed to heroin or other substances that were readily available in the community. Youth reported polysubstance use as a form of experimentation (i.e., the use of benzodiazepines or cough syrup and alcohol).
- OUD/SUD within Families:** Family substance use (See *Results-Risk Factors*, pgs.36,39) was pervasive among both adults and youth. Youth described easy access to prescription drugs through family members. Adults described exposure to substances from other family members who were using. This also complicated attempts for sobriety.
- Opioid Prescription Oversight:** Prescription drugs such as opioids or benzodiazepines were reported to be less accessible than other drugs. Key informants discussed the decrease in prescription of opioids resulting from increased prescription oversight through the use of the California Medical Board's Controlled Substance Utilization Review and Evaluation System (CURES).



My mom did a good job of keeping me away from the neighborhood, away from gangs, away from all that stuff on the streets. The only problem is that I had it in my house with my brothers. Can't run from that. I had a brother that was hooked on heroin, oldest brother. I had another brother that was using marijuana and meth. And I did a good job of getting away from that, you know, for a long time. Can't get away from my family, though, because they're right in front of me...I didn't have to go to the parks, I didn't have to go inside the hood or the crack house...I didn't need the streets, I had it in the house.

[Adult Focus Group Participant]



In my community, I've seen it go from like seniors and juniors to freshman and my grade, and I just see people, they talk about it and my friends but a lot of them are being hurt and it's just hard because you know they're doing it and you don't want them to do it but they still do it. And it's just gotten younger so like, my brother is still going to school, I know a bunch of his friends did it but they were seniors and it was all good but like freshmen now they're doing it and just more interactive with them...And it just felt weird because...I didn't see that when I was younger, I didn't see no freshmen, but now we're freshmen and like it's weird.

[Youth Focus Group Participant]



I would say that, with it being a small community and us, you know, having a large amount of elders in the community, normally it kind of starts out with, you know, pain use. And then I know recently with the laws being affected, that, you know, they're pulling back on giving out medications and doing alternative treatments. So now, you know...it's kind of like now it's going on to the other side of it where they're searching for other ways of relieving pain. So now like pills are being sold, stuff like that. So...on the youth side of it it's more of, you know, them taking from, you know, mom, dad, grandma, grandpa, in order to kind of catch that high and use pills.

[Case Manager, TANF Partnership]



Perceptions of People with OUD/SUD by Adults & Youth

- **Supportive:** Some participants viewed people with OUD/SUD compassionately and in need of assistance to recover.
- **Stigma:** Other participants viewed substance use as a choice rather than a mental health issue. This view contributed to the stigma surrounding OUD/SUD, indicating that interventions targeting community awareness of addictions and the recovery process are needed to decrease stigma.



Where I live, it's just like, everybody does it. My neighbors- I come out of my car and see all my neighbors outside all drinking and smoking. And it's just like, there's no stopping to it. It's just, that's just- I feel like maybe the only way you can get away from it if you just- you do you, but not every kid's not going to have the mentality.

[Adult Focus Group Participant]



I think definitely people do it to put off a persona that's not really them and to seem cooler, but- yeah, a lot of people I know that do it just do it because they have a bad relationship with their parents, or...they're not really looked out for by anybody, so they just like, "Why not?" I guess.

[Youth Focus Group Participant]



Well, honestly, I know more than one person that like abused, like substance abuse, but I don't necessarily see those people as bad people because they're not the ones that created these drugs. They're handed to them and given to them, they feed it to them, like all this stuff, like it's like set up to bring us down. And like I don't blame them for that but then it comes to a certain point where it's just like you need to take responsibility for your actions and try to stop the cycle. So I, I hurt for them, I feel bad about it, I wish there was a, I'm not saying that there's not a way to end this but it's not just up to us, it's up to them being willing to change their life. And, yeah, I just give my sincere love to all the people that have, abused drugs and are struggling with that.

[Youth Focus Group Participant]

A STATEWIDE NEEDS ASSESSMENT

Negative Consequences of Substance Use

- **Community Impact:** Both adults and youth discussed how OUD/SUD had negatively impacted their communities. This included increased violence, family disintegration, domestic violence, suicide, and high overdose deaths.
- **Overdose:** Adults shared the prevalence of overdose experiences for people with OUD/SUD. Often, those that were resuscitated with naloxone continued to use opioids right after.



Well, I think my grandpa, I think he used to do meth. I remember my mom told me that. Like they used to do that. He passed away though. And then my dad, too, he passed away, too. But I'm not sure...it could have been because of drugs because people were telling me that, oh, he wasn't all there anymore. And he had committed suicide, but like, I never met him, so I can't say how he was, I can't give you that perspective. But I did know people said that he used to do drugs with like mom, I guess.

[Youth Focus Group Participant]



Well, you can't get a domestic violence report that doesn't involve alcohol or drugs. You can't get a child abuse report that doesn't involve alcohol or drugs. I am active in the recovery community, but I have been at fifteen CPS family hearings in the last two weeks. That's more than one a day, and every one of them revolves around drugs and alcohol.

[Adult Focus Group Participant]



And I don't think it was intentional, but they didn't even consider the fact that they almost just died...Any one of the people I've seen overdose [inaudible]. They just go back right for it, yeah...Mad because you hit them with some Narcan.

[Adult Focus Group Participant]



I actually have this, well, it was my mom's friend and she was Native and she had a daughter. And she was clean. And then she started to use drugs again and she was really addicted to meth. That's why I keep saying meth. And then also, too, my family, they use meth, too. So she started to use that and she had her daughter taken away from her. And it's sad because we know her as how she was and not how she is now, like all messed up. And I hear now that she lives under a bridge or something. But it's sad. That's why I think, that's how it's affecting our Native community. Like kids are getting taken away from her, their parents. I can only imagine how that little girl is going to feel when she's older, like what her mom did to her.

[Youth Focus Group Participant]

Results

Results

RISK FACTORS

Community Stressors

- » Historical Trauma & Disconnection
- » Intergenerational Trauma
- » Regional Differences

Family Stressors

Economic Stressors

- » Poverty
- » Homelessness
- » Funding for Services

Mental Health

- » Depression & Anxiety
- » Trauma-related Mental Health Issues

Peer Pressure & Social Norms

- » Peer Influence
- » Family Influence
- » Gateway Drugs
- » Social Media



2. RISK FACTORS

Participants (key informants, adults, and youth) were asked about potential risk factors such as physical or mental health problems, chronic illness, spiritual problems, developmental problems, stressful life events, poverty, neglect, abuse, racism, trauma, intergenerational trauma, and internalized oppression. Participants identified community, family, and economic stressors, mental health issues, and peer pressure/social norms as the primary risk factors.

Community Stressors

This section describes community level systemic issues that are risk factors such as intergenerational trauma, lack of community/connectivity, internalized oppression, and historical trauma. Key informants also uniquely highlighted community stressors that resulted from the loss of community members (e.g., natural causes, suicide, or overdose), adverse childhood experiences (ACEs), geographical isolation, and cultural disconnection that contributed to OUD/SUD.

- **Historical Trauma & Disconnection:** Youth and adult participants discussed historical trauma as the loss of culture due to Western influences and colonization and the current impact this has on cultural connectedness and interpersonal relationships both within the family and in the community as a whole.
 - Urban adult participants and key informants spoke about the traumatic impact of relocation on out-of-state and in-state AIANs, causing modern day disenfranchisement and cultural disconnection felt by many who are without a landbase or were forcibly removed from their ancestral lands and placed on the lands of other AIANs.
- **Intergenerational Trauma:** Youth spoke of the impact of a loss of family bonding through intergenerational trauma and the suffering caused by a lack of a nurturing bond with immediate family as a contributing factor in OUD/SUD in their community. All participant groups spoke frequently of a community that “self-medicates” to numb against the pain of historical, intergenerational trauma, and post-traumatic stress disorder (PTSD).
- **Regional Differences:** In rural areas, isolation is mainly geographical as communities tend to be small, disconnected from other communities, and limited in infrastructure (e.g., lack of police or patrol services, lack of fire and medical emergency services and lack of access to foods/food deserts). AIANs in urban areas described emotional and cultural isolation as a result of forced relocation that led to a loss of their land base, ancestral connection, language, cultural practices, and Tribal members from their original geographical community.



I think, yeah, I think we could become addicted very easily because back, you know, years ago they gave our people alcohol and drugs to kill them off to take, you know, their land and take over. So because we have that, you know, way back in the past, it has to do with today and addiction. If our children try, you know, one time and go, then yes, some of my kids are addicted and some of them are not, so the other ones that are not and they say, 'We know this, if we're aware then easily if I drink alcohol I might become an alcoholic.' And that's why I didn't become an alcoholic, because I was afraid of that.

[Adult Focus Group Participant]



Yeah. The interaction, how it's done. And I think it's historical, too. Right? I believe it's historical and things were lost and they're barely coming back. Right? And that's a loving, nurturing bond and family.

[Youth Focus Group Participant]



I also think that it's [historical trauma] a risk factor because someone from my generation, you know, my mother was treated or grew up a certain way because her grandmother and her parents were placed in boarding schools or they saw different events happened to American Indians, in terms of loss of language, and land, and spirituality, etcetera. So I think that it's just the transmission of trauma onto another person and a person and another person until you figure out how to manage your own emotions and your own situations so that you cannot traumatize other people. So yes, I think people use substances to deal with the emotion and just chaos and learned behavior.

[Clinical Psychologist, Mental Health Clinical Program Head]

Family Stressors

All participant groups described the need for supportive family services to break the cycle of unhealthy family dynamics. Youth, in particular, spoke of the desire to escape because of the negative impact from family stressors by engaging in substance use.



So early trauma has a lot to do with their childhood. They didn't have mom and dad in the home, or they did have mom and dad in the home, but mom and dad were dealing with their own substance use disorder. But at the time it wasn't titled 'substance use disorder', it was just everything being thrown into the pot of being an alcoholic, and since my mom and my dad and, they're all alcoholics, that is considered something that we dealt with. And children are having to find their own way, and in finding their own way it forces them into gangs and it forces them into other things.

[Psychiatric Social Worker, AIAN Residential Treatment Facility]



It's like there's so many different angles to go at that question because it's like people, they stop trying to control their kids, they stop caring. And then even if they do care it's like, "Oh, well, I can't do anything about it." And then the law doesn't do anything. And then some parents want to punish their kids and then that just makes them rebel more. And then you know it's like nothing works anymore.

[Youth Focus Group Participant]



I know what happens, too. There are generations through generations, it just continues to continue because of all the trauma that our grandparents had. They drink, and then their kids drink. Because I grew up around that, alcohol and drugs. They would go in and out of treatment, my mom and my uncle they would drink and do drugs and then go right back in. When you're in a home like that, you end up doing the same thing. And especially because my sister, she said, "I'm going to be just like them," as a little girl seeing that, eight, nine, seven...there is a certain age I did drink every weekend. And I did, not the drug that they've done but other drugs. So it trickles down from generation to generation to generation. It keeps going.

[Adult Focus Group Participant]

Economic Stressors

- **Poverty:** High rates of poverty were highlighted as reasons for increased prevalence of OUD/SUD, with unemployment and lack of employment opportunities being primary among the reasons for increased risk of OUD/SUD among adults.
- **Homelessness:** Youth and adult participants stated that homelessness was a significant risk factor for, but not a primary cause of, OUD/SUD.
- **Funding for Services:** Participants expressed a concern that clinics and treatment facilities often lack adequate funding or have no funding for necessary OUD/SUD treatment services in local communities.



So for me, you know, it's mostly emotional reasons that I, I use drugs. And, because I suppose I don't know how to deal with my emotions properly. And it also sometimes comes down to economic factors, you know, like I'm not going to have enough money to pay my rent, [expletive], what am I going to do? Well, I'm going to get high, that's what I'm going to do, you know.

[Adult Focus Group Participant]



And, yeah, just in general like not normalize drugs, like not portray it as an amazing thing. And having more job opportunities, like because, like I said before, like a lot of people feel like they're obligated to go out and sell, sell drugs because they need the money. So, yeah, I guess that's, that's the biggest thing.

[Youth Focus Group Participant]



I think if, you know, some of the people that are here (urban area) may have come on their own accord off a reservation to get a job. You know that could be different where some people may have come during relocation and things could have been difficult for them. So, if you have a grandparent you know who is under stress or maybe unemployed...Any way I guess it's just like trying to work through psychosocial issues so that you can resolve them and be a better parent or a better grandparent. And when you haven't resolved those issues, that's a risk factor for the children.

[Clinical Psychologist, Mental Health Clinical Program Head]

Results

Mental Health

- **Depression & Anxiety:** Youth were more likely to report mental health issues as a risk factor in relation to OUD/SUD in their communities than were adults. Youth mentioned depression and anxiety as contributing factors. (See *Community Substance Use Description-Substance Use Trends & Access*, pg. 29).
- **Trauma-related Mental Health Issues:** Key informants, adults, and youth reported mental health as an OUD/SUD comorbidity (often self-reporting), with current substance use trends stemming from intergenerational trauma, PTSD, anxiety, and historical trauma.



Most people would, like he was saying, because he would do it because they tell...what happened, like depression, things that happened in life, like if they wanted to get, someone broke up with them, they lose their job, they lose a family member, a friend, or like just because they just want to do it because other people are doing it, or because they get hooked on it because their parents did it when they were young so they thought it was a good idea.

[Youth Focus Group Participant]



There was the boarding schools, you know what I mean? The trauma from that was passed on generation to generation. All of our historical, all of our traditions, not taken from us, but we were forbidden to use them. So how were we supposed to heal? How are we supposed to mend anything when we don't have what we know- you know what I mean? Like I know that spirituality runs in my veins...it can come back. But when you're not allowed to practice it and those type of things- I'm sure there's some people who had good boarding school experiences, but for the most part, probably 90% of them were traumatic. You just get angry. That's the biggest thing, I think, in my family, where I'm from, is anger. Anger is like, it's a trait, you know what I mean? It's something you have to. If you don't have that, then you don't- it's a weakness, you have no defense because that's the only thing growing up I knew.

[Adult Focus Group Participant]



Yeah, there's, some Natives, you know, they come in and it's, with bipolar and they don't know what that is or they just know that they have serious highs and serious lows. And there's, with the Native community mental health is still kind of a stigma with that because they're like, "I'm not crazy, I'm not crazy," but to educate them on the matter of it's not crazy, it's what happens when you mix, you know, trauma and substance abuse disorder, it turns into something. And we have to identify it and kind of let them know that, you know, "You are okay and you're not going crazy, this is just what happens when you use substances and we don't process certain things." Also, I think that's the main thing, is, you know, depression and bipolar disorder.

[Psychiatric Social Worker, AIAN Residential Treatment Facility]

Results

Peer Pressure & Social Norms

- **Peer Influence:** Youth also highlighted the difference between direct (i.e., directly pressured by peers) and indirect (e.g., “everybody is doing it”) forms of peer pressure in OUD/SUD trends.
- **Family Influence:** Youth, more frequently than adults, highlighted the challenges of having family members who are current substance users as a negative influence on their future or current use of substances.
- **Gateway Drugs:** Youth spoke of substances such as marijuana and alcohol as being “gateway drugs” that potentially lead to youth using harder substances and illicit pharmaceutical drugs.
- **Social Media:** Youth uniquely described peer pressure, popularization of substance use in the media, and “looking cool” as primary risk factors for engaging in substance use.



Yeah, and it's kind of hard to say no because it's like peer pressure. It's something that you learn in elementary school going on, it, peer pressure is very, like they drill it into your head that, “Oh, if you don't do this we won't be your friends,” type of thing, but I, I kind of stay away from those people now because I know what it does. Because like I said, my family, I've lost some family members to it. And it's just the willpower to say no.

[Youth Focus Group Participant]



Kids just either want to escape or they want to look cool.

[Youth Focus Group Participant]



But it's definitely a social thing. Sometimes you see little kids taking shots of water with their parents, like it's cool. They have gum cigarettes. There's all kinds of different things that happen in your early age that you don't even know are prepping you to do something like that, to embrace a substance or a behavior.

[Adult Focus Group Participant]

RESILIENCY

Community Strengths

- » Programs & Services
- » Community Connection
- » Recovery from Trauma
- » Spirituality

Cultural Connectedness

- » Sense of Community
- » Cultural Practices
- » Cultural Connectivity

Cultural Services

- » Traditions & Ceremony
- » Wellness & Recovery Services

Positive Role Models

- » Peer Role Models
- » Family
- » Sober Role Models

Supportive Services & Programs

- » Education & Information
- » Treatment Services



3. RESILIENCY

Participants (key informants, adults, and youth) discussed community strengths, cultural cohesion, cultural services, positive role models, and services/programs available to the community.

Community Strengths

This section describes participants' perceptions of services, programs, and community support that enhance well-being and reinforce cultural connectedness.

- **Programs & Services:** Youth focused on programs that bring them together and requested more programs where the youth naturally congregate (i.e., school settings, summer camps) to eliminate or reduce existing barriers to services such as transportation. Key informants focused on cultural traditions and practices (i.e., sweat lodges, Powwows, California Big Times, beading, sage, cooking, talking circles, dancing, regalia making) as community strengths contributing to resilience.
- **Community Connection:** The Tribe or community at large behaving as extended family (regardless of actual kinship) was the most frequent community strength mentioned by all participant groups. Key informants, specifically, identified cultural connectedness, sense of community, culturally-sensitive services and positive role models (i.e., elders, parents, grandparents) as protective factors.
- **Recovery from Trauma:** Adults highlighted the individual's recovery from historical trauma and intergenerational trauma as a strength that contributes to overall resilience in the community. Providing ways for an individual to heal helps break the cycle of substance use for future generations.
- **Spirituality:** Key informants, adults, and youth frequently mentioned spirituality/prayer as a powerful tool towards maintaining recovery or preventing substance use.



It's a wounded person and we have to support that person. That's our job as a community, that's who we should be, that's who we've always been as Indians, as Tribal people, that's who we are. We, nobody moves, they, they showed this video of a wolf pack moving and the fastest are at the back, the strongest are at the back, the weakest are at the front because nobody gets left behind. That's a Tribe. But we don't act like a Tribe, we,

"Oh, well, you're drunk, get out of here."

[Adult Focus Group Participant]



Yeah, we're all like family basically...So even though we're not blood, like you're still my family and I'm going to look out for you.

[Youth Focus Group Participant]



So the strengths seem to be local communities, like the ones we have here at the clinic where they have groups for youth to participate in, like activities, input from other Native Americans. The families. And older family members or friends who have been through this because I see a lot of- it seems to be a trend where I see patients in their 40s or 50s who are recovering and now unfortunately, actually like a lot of them are taking care of their grandkids... so once they're, those grandparents or parents are engaged, they're really supportive of trying to get their kids or their relatives off of drugs having been through it themselves. And I see some, I have a couple patients here who are definitely involved in being mentors. So those are the real strengths.

[Nurse Practitioner, Indian Health Clinic]



Say someone from my generation, my mother was treated or grew up a certain way because her grandmother and her parents were maybe placed in boarding schools where they saw different events happen to American Indians in terms of loss of language and land and spirituality, et cetera. So, I think that it's just the transmission of trauma onto another person, another person, another person, until you figure out how to kind of manage your own emotions and your own situation so that you cannot traumatize other people.

[Psychologist, Community Organization]

Cultural Connectedness

Discussions were focused around programs and practices that create a sense of community, belonging, pride in cultural identity, and cultural connectedness within the community.

- **Sense of Community:** Creating opportunities for the community to gather together and take pride in their heritage, receive guidance from elders, and be reminded of their cultural values were all described by key informants, adults and youth as strengths against OUD/SUD that needed to be further supported.
 - **Regional Differences:** Urban individuals expressed the need for a sense of community and belonging with other AIAN individuals due to loss or lack of connection to their Tribe(s).
- **Cultural Practices:** Youth felt that cultural and traditional practices (i.e., dancing, beading, Powwows, California Big Times, sweat lodge, weaving, regalia making) were important in preventing future substance use among their peers and an effective means by which to get sober and be supported while maintaining sobriety.
- **Cultural Connectivity:** Key informants highlighted the importance of cultural connectedness and cohesion in facilitating recovery. They discussed that through traditional practices (e.g., talking circles and sweats) and Native-specific healing resources (e.g., White Bison), AIANs suffering from OUD/SUD have the opportunity to heal through a holistic approach (i.e., physically, mentally, spiritually), which individuals have described as critical to their recovery and sobriety.



I see us all sitting here because we had enough and we had enough of death and it, it touches my heart to see what happened to our community. [crying] I remember when I was a child, the whole community got together on a monthly basis, had a potluck, and we all laughed, and we all gathered together. We don't even do that no more, let alone our families doing that. We don't do it and we have to start somewhere.

[Adult Focus Group Participant]



I just feel like it's a good way to stay sober and stuff because you could be at a ceremony, praying and learning about your culture, and knowing our way instead of like, focusing on a crackhead house or drugs or whatever.

[Youth Focus Group Participant]



So we offer Red Road classes, we do the White Bison like I was saying earlier at the school. We do sweats, we do dances. You know and I think getting the community members, especially the Natives, to realize that in learning the culture and traditions and practicing it that there is no place for drugs and alcohol in that and that they have to be pure when they go into these ceremonies and do these events and do these activities and it's for their own well-being. So that, in itself, I think you know that education helps them for those that really want to move forward with it.

[Director of Behavioral Health, Indian Health Center]

Cultural Services

Key informants, adults, and youth discussed the importance of cultural services within their community to reinforce culture and cultural practices.

- **Traditions & Ceremony:** Ceremonies and other traditional community gatherings (e.g., Powwows and California Big Times) were frequently mentioned by key informants, adults, and youth as a way to bring multiple Tribes together in one setting as a whole to bond and form familial connections in a drug-free, alcohol-free environment. Adults and youth emphasized that time with peers and positive adult role models who share cultural norms, traditions, and arts (i.e., beading, regalia making, drumming) was the most important aspect of being involved in cultural programs.
- **Wellness & Recovery Services:** Youth highlighted programs that help keep them active both in their day-to-day lives as well as actively engaging in their cultural traditions or practices. In addition to those cultural and community activities mentioned above, key informants described cultural services such as White Bison, culturally sensitive treatment and recovery centers, Wellbriety meetings, talking circles, sweat lodges, traditional healers, and individual, family, and community health and wellness centers as effective, community-based prevention and treatment services.



We have a lot of powerfully based interventions now and curriculum-based that are helping a lot of our communities here...But we also have, one of the things we have in our community now, usually back in the day when I was a kid, there was like one sweat lodge. And sometimes it was invitation-only and if you weren't invited you couldn't go. Or you just didn't feel like you belonged. But now there's sweat lodges in all directions of the city now. We have lodges. We have round house ceremonies, we have dance families...Powwow, Big Head, Shake Head, Sun Dance. We have all those things now in our community. For me, going back to the culture and having healthy cultural places to go, that's the biggest strength we have. Language, our language is coming back.

[Adult Focus Group Participant]



This program called TANF. And just like went from there. This lady helped me, she's like a Powwow dancer and helped me make my regalia. Yeah, I feel like that helped me because, I'm going to admit it, I did smoke weed before, but I wasn't a big, old, like- I wasn't a big, old "I need weed," I just did it because I was peer pressured. And I was trying to be cool. I was trying to get this guy to like me. That's the only reason why I did it. And I didn't even like it; I hated it. But so, I was in that world and I wanted to get out of it because I don't want to end up like my family. During that time, that's when I started to work on my regalia. And then I just kind of like just went away from all that and I just like got into the Powwow world and beading. And that's like all I do now.

I don't even care about anything else.

[Youth Focus Group Participant]



We have a traditional healer. We provide cultural competency training. We do youth activities, GONAs. We do rites of passage camp. We have our Indian Days. We have our health fairs. So there's a lot of things that we are doing to educate our community on their cultural values and traditions.

[Certified Alcohol Drug Counselor II- Director, Indian Health Clinic]

Positive Role Models

- **Peer Role Models:** Adults and youth emphasized that time with peers and positive adult role models who shared cultural norms, traditions, and arts (i.e., beading, regalia making, drumming) was the most important aspect of being involved in cultural programs. Youth self-identified as role models within their social networks and family connections in that they would intervene and present alternative activities for those who might be at risk for OUD/SUD.
 - Youth uniquely spoke about the impact of those positive role models in shaping healthy norms and beliefs about avoiding substance use.
 - Support systems via clean and sober community members acting as mentors who helped connect individuals back to their cultural ways was a common theme with adults and youth.
- **Family:** Parents, guardians, siblings, extended family, friends, local artists, and community project staff were frequently mentioned as positive role models in their communities. Youth reported the beneficial effects of AIAN-specific parenting groups as a form of positive role modeling for adults and youth with families.
- **Sober Role Models:** Adults and youth spoke of the necessity of clean and sober role models to help in both prevention and treatment aspects of OUD/SUD. Key informants and adults highlighted the important role of elders (e.g., aunties, uncles, grandparents) who have been through similar experiences as resources or “sources of wisdom” for those suffering from OUD/SUD.



I would talk to them and be like, “You shouldn’t do that, you have a future, there’s always another way to do stuff,” and things like that instead of just letting them do it and be like, “Oh, why don’t you go to rehab?” and sit there and talk to them and make sure it’s in their head that like that’s bad for you.

[Youth Focus Group Participant]



And I think, you know, it’s kind of goes to like, just taking the chemical out of your body, you know, the heroin or whatever. Doesn’t mean you’re going to stay sober, and there’s a big hole, a void, you know, an emptiness inside where a lot of real addicts and alcoholics, that it needs to be filled. And I think becoming a part of something, learning about who you are and your culture, your ways, and having the community support you in that. You know, we’re all brothers here and we come from all different walks of life, and we really create a family here, or a community here, and it’s important to me and I know it’s important to a lot of other people here. You know, we value that, that bond and then we have aunties, uncles, grandmas, that have come into our lives and given us family and taught us. And it’s been quite an experience for, for myself and I think a lot of others, and helps fill that void and give us, gives us direction on where we want our lives to go, and a way to go about doing that.

[Adult Focus Group Participant]

Results



I think right now we do have some parents that are stepping up that are trying to be more of a parent rather before a lot of these kids are allowed to run and come and go as they please, do their own thing. But I think more so now parents are working on their own recovery. They’re trying to you know walk the walk and show their children that it’s OK to not do drugs and alcohol that are always out there. So I think for the most part the parents are really stepping up.

[Certified Alcohol Drug Counselor II-Director, Indian Health Clinic]

Supportive Services and Programs

- **Education & Information:** All participant groups expressed that preventive education regarding the harmful effects of the addictiveness of substances could inform their communities about OUD/SUD.
- **Treatment Services:** Adult participants shared how programs that keep an open-door policy allowed for OUD/SUD patients to engage with services when ready, as well as reducing the stigma by allowing patients the freedom to return to services if/when relapse occurs. Adults and youth stated the importance of keeping those in recovery from OUD/SUD occupied in healthy activities, commonly stating that “keeping them busy” has shown to keep their minds off their addictions. Participants believe that providing access to activities (i.e., non-clinical, cultural activities and services open to the general public, not just those in recovery or treatment) can reduce external stigma towards individuals in recovery.



Yeah, because if it wasn’t for TANF or (urban AIAN Centers), like Native kids wouldn’t be able to meet each other and stuff like that. And like, because, you know, we all live in different areas so we all could come together and like know other Native kids because, you know, we’re so rare, like I’m pretty sure everyone here is like the only Native kid at their school. Am I wrong? You know, like, so that’s why like places like this, it’s cool to like meet other Native kids.

[Youth Focus Group Participant]



[Regarding an Urban Center which provides AIAN outreach through community engagement at cultural gatherings and via other agencies] So we are one resource where people can come for mental health counseling and linkage, help with linkage into treatment centers. And sometimes you know clients coming in just being able to talk about what’s going on is a relief and does set people on the right stage to recovery or healing at least you know some level of healing, getting their life back on track.

[Clinical Psychologist, Mental Health Clinical Program]

Results

OPIOID USE DISORDER & SUBSTANCE USE DISORDER SERVICES AVAILABLE

Pharmacotherapy

- » MAT & Tele-MAT Programs

Behavioral Health Treatments

Counseling Services

- » Individual Counseling
- » Family Wraparound Programs

Education

- » Parenting Classes
- » School-based Prevention Programs
- » Community-based Programs

OUD/SUD Recovery/Treatment Programs

- » Inpatient & Residential Treatment Programs

Culturally Centered Treatment

- » Providing Spaces & Resources for Cultural Events
- » Cultural Services
- » Wellbriety & Red Road

Regional Differences in Access to Services

- » Rural Areas
- » Urban Areas

A STATEWIDE NEEDS ASSESSMENT

4. OPIOID USE DISORDER & SUBSTANCE USE DISORDER (OUD/SUD) SERVICES AVAILABLE (NOT AN ALL-INCLUSIVE LIST)

Key informants, adults and youth were asked about OUD/SUD treatment services and programs available within AIAN communities or available to AIAN individuals outside of their communities (when services were lacking within their communities). Participants were also asked about their perceptions regarding access to and the quality of such services (See *Acceptability of Services*, pg. 55 and *Barriers to Accessing Services*, pg. 62). **This is not a comprehensive list of services available and access to these services varies by communities and within communities.**

Pharmacotherapy

Key informants and adults discussed their knowledge and perceptions of available pharmacotherapy related to MAT programs and Tele-MAT services.

- **MAT & Tele-MAT Programs:** Key informants and adults discussed how these programs varied in availability and accessibility to both individuals and communities. Some challenges remain due to limited capacity.

Behavioral Health Treatments

Adults and key informants reported behavioral/mental health diagnostic assessments, cognitive behavioral therapy, and dialectical therapy as some examples of behavioral health treatments.

Counseling Services

- **Individual Counseling:** Adults and key informants identified examples of individual counseling, such as motivational interviewing, talking circles, and dialectical therapy.
- **Family Wraparound Programs:** Participants (key informants, adults, and youth) discussed family wraparound programs as examples of counseling services.

Education

This section describes the educational services available to participants, including healthy parenting, OUD/SUD prevention, and cultural practices.

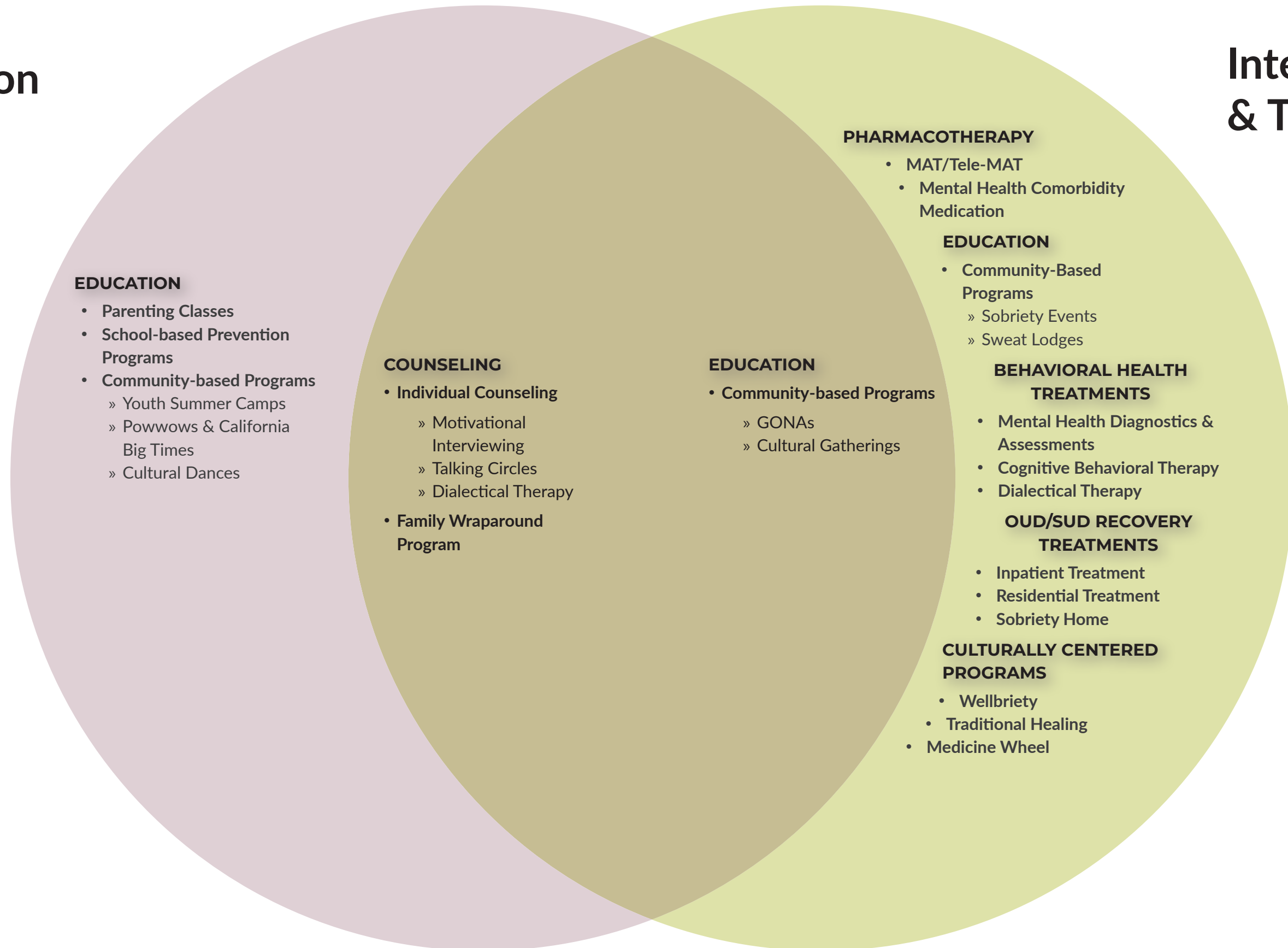
- **Parenting Classes:** Both youth and adults reported the benefit of parenting classes in improving parent-child communication and family dynamics.
- **School-based Prevention Programs:** Youth discussed the delivery of prevention programs (e.g., Red Ribbon Week) available in schools, but also highlighted the desire for novel approaches to substance use prevention programs (See *Service System Needs: Information and Education*, pg. 69).
- **Community-based Programs:** Programs reported as effective within the community by participants included Gathering of Native Americans (GONAs), youth summer camps, Powwows, California Big Times, cultural dances, sobriety events, sweat lodges, and cultural gatherings.

FIGURE 1. PREVENTION AND INTERVENTION & TREATMENT

PROGRAMS AVAILABLE FOR AIAN COMMUNITIES

Prevention

Intervention & Treatment



ODU/SUD Recovery Treatment Programs

Key informants and adults were asked about available recovery treatment programs.

- **Inpatient & Residential Treatment Programs:** Key informants and adults mentioned that few inpatient and residential treatment programs specifically for AIAN individuals exist in California. They stated the need for more such services, especially for AIAN women only, where young children can reside with their mothers. Frequently mentioned was the need for more long-term, sober living opportunities for recovering individuals.



I think that it's unfair to us as Natives that we are Indigenous to this land but when these types of facilities that's for the mainstream, it's set aside as if it's not important. I think that it should be mandatory that there is a Native component to all these mainstream facilities so that when the Natives come there they can plug in to their roots, their ancestral roots. Because this is not just something that we're doing, this is, this is our way of life, this is sacred, this is very important to what we believe in our ancestors and going to the future with our children...So I think that should be something that should be pushed, you know, because this is our land and if it fits our land then we should have the same honor and respect from any foreigners that come here. And when we have mainstream facilities like this, they have their own little special little stuff for them but not for us. So I think that's what needs to be put into place.

[Adult Focus Group Participant]



We should contextualize that [redacted] sees only Native patients. So we're extremely lacking in our ability to provide substance use counseling to anybody non-Native at this point. That all has to happen externally, with the exception if they're engaging in therapy here, but not necessarily focused on substance use disorders. So the patient would work with [redacted] to get referred into treatment and so that's typically either at [urban indian clinic] or Friendship House in San Francisco. And then there are some residential programs not necessarily Native-affiliated that we work with in the area as well, like Crash, McAllister, a handful of other ones.

[Medical Director, Indian Health Clinic]

Culturally Centered Treatment

Key informants and adults discussed the utilization of culturally centered treatments/programs by community members. Adult participants shared their perception of these services.

- **Providing Spaces & Resources for Cultural Events:** Re-connecting individuals to their culture and community was reported as a major component to successful treatment. Key informants recommended funding to provide community events such as crafts and cultural dances, and partnering with other organizations in the community that provided cultural services.
- **Cultural Services:** Participants identified culturally-based services as important in transmitting life lessons and values that contribute to connecting to AIAN community members to their cultures. For example, sweat lodges and talking circles were mentioned as ways to connect and engage.
- **Wellbriety & Red Road:** Adults and key informants reported the utilization of culturally-based healing principles in recovery, such as incorporating the Red Road to Wellbriety concept in their treatment services (walking the Red Road to Wellbriety means living a substance abuse free life). Key informants identified the importance of incorporating Wellbriety principles and cultural ceremonies into treatment and recovery.



Well the teepee...With the North American Tribes it actually was home, inside that teepee. There was life, there was birth, there was love...Also, the other part of the teepee is there are actually 18 poles. When I build the teepee, I tell these guys that one pole cannot hold up the whole teepee. So when we start intermingling all the poles together it becomes strength. It becomes strong. We have to depend on each other when the poles are leaning against each other and tied off, that teepee will withstand probably 60 mile winds. Its strength is togetherness. Cohesiveness. And that's where the family is. That part of teaching is what I teach. So it does relay that. And that was told by my father and his father told him and his father told him. So the responsibility comes to me to provide for my family. To provide shelter, food.

[Director, County DHHS/Mental Health]



Yeah, we have, you know, in the morning they wake up with elder's meditation through the Wellbriety movement. We also have the White Bison...here, and it's, it's consistent, it's every week.

[Substance Abuse Counselor, TANF Partnership]

Results

Results



Regional Differences in Access to Services

Key informants, adults, and youth from rural communities reported either limited resources or dispersed services that required extensive travel.

- **Rural Areas:** Key informants reported the use of referrals to mitigate lack of services offered within communities.
- **Urban Areas:** While in some urban communities resources may be more readily available than in rural areas, AIAN individuals may live dispersed within urban areas. Unlike other ethnic groups, urban AIAN individuals tend not to have geographic enclaves that allow for the centralization of services. Therefore, even though more service facilities may be available within urban areas, transportation is still a barrier to access.



I think that it's difficult to access the services that are currently being provided due to like eligibility. Like if Native Americans are coming off the reservation here. Like in order to get the services they'll need to get a California ID. And if, you know, when you're out in your addiction, you lose all your documents. So it can take a while to get those documents, to get California ID. Sometimes we lose them in the process or they become frustrated with the intake process because it can be pretty lengthy. And residential treatment nowadays is like 30 days. So I mean it'll take longer than that to get everything that they need. Just to be able to access support and resources. The location of services is pretty sparse. I mean we got [redacted 3 urban areas] but that's a great difference between agencies and if people are on the bus, which they more than likely are, it can be pretty difficult to access. And then there's a huge wait...huge wait waitlist for services. So you know we lose people that way.

[Therapist, MSW, Urban Indian Clinic]



I think it would be nice if we had a rehabilitation center of our own. Because I think also like if you're a parent and you're struggling with addiction you probably don't want to leave your family behind, you would like to be somewhere close to home, close enough to home.

[Youth Focus Group Participant]



Okay, [Name of Organization redacted], and that's all the way in [Rural City]. We have nothing in town, however, my son, like I was talking about, they released from prison, and according to his parole officer there was no beds open in [redacted] County. She was putting in, because he was out there, he had no, for his mental health issues, no treatment, and no treatment, no bed was open they told me for [redacted] County so they were seeking other places and they had to place my son all the way in [City 50 miles away], which he was unsafe. He left and didn't even know where he was and kind of made his way back home. But in between that, of course because the experience and he had drug issues...and he has schizophrenia, suffers from schizophrenia, he'd call me from every spot he went to but he wouldn't stay long enough for me to call him back because he was in his manic mode and a little, you know, it's frantic. But from my understanding there was nothing in [redacted] County available, they were waiting for [residential treatment redacted] to open a bed anywhere, and they told me it could be from [up to 72 miles away from home-three cities redacted] whatever came first. And at that time my son [went] back in on a violation because he was heavily under the influence, and my mom lost, we lost our home, our housing. That's one of the reasons why we're homeless.

[Adult Focus Group Participant]

ACCEPTABILITY OF EXISTING SERVICES

Access to Services

- » Accessibility
- » Diverging Perspectives

Cultural Sensitivity

- » Strength of Culturally Centered Services
- » Culturally Sensitive Treatment Approaches
- » Lack of Culturally Sensitive Treatment
- » Cultural Integration

Quality of Services

- » Western-based Services
- » System Improvements
- » Culturally-based Services
- » Educating Providers

Traditional Healing

- » Impact
- » Regional Availability



5. ACCEPTABILITY OF EXISTING SERVICES

Participants were asked about their perspective of the acceptability and availability of existing services (e.g., “Were providers competent?”, “Were services high quality?”, “Were providers sensitive to their needs?”), including a perceived or actual lack of accessibility due to incompatible/non-cultural services.

Access to Services

- **Accessibility:** Key informants discussed accessibility to services as varying depending on several factors, such as eligibility, insurance coverage, geographic location, and rural or urban status.
 - **Knowledge/Awareness:** Individuals learn about available services via word of mouth, from others active in recovery/treatment, friends and family, and community outreach by service providers.
 - **Entry Points:** Key informants discussed different entry points for individuals seeking services such as eligibility screening, referrals, Community Health Representatives (CHRs), incarceration, and county services.
- **Diverging Perspectives:** Although some key informants described their services as being accessible and easy to navigate, the majority of participants (adults and youth) discussed difficulty accessing services because of a lack of awareness about services and/or a general lack of services/programs available to the community (See *Barriers to Accessing Services*, pg.62).



Anybody who has Medi-Cal or Medicare or is indigent can receive services with [Urban Mental Health Services] and because we are affiliated with the county we’re not requiring people to show certificates of Indian blood or any type of proof of Tribal enrollment. So we see everyone. We also see clients who are non-Native. But the cool thing about us is we don’t expect documentation so we see Natives from all over the place, you know different levels of acculturation, different levels of being in the city, reservation, etc.

[Clinical Psychologist, Mental Health Clinical Program]



But it’s not being communicated, either how to access it [services] or the fact that it’s available. Like most people don’t even know, if you have Medi-Cal you can see any therapist in this county, any therapist. And I even tell White people all the time that and they say, “What?”

[Adult Focus Group Participant]

Cultural Sensitivity

- **Strength of Culturally Centered Services:** All participant groups (key informants, adults, and youth) identified strengths and discussed the importance of incorporating AIAN cultural practices and traditions in prevention, treatment, and recovery services to prevent future OUD/SUD while facilitating the recovery of individuals currently experiencing OUD/SUD.
 - Youth specifically highlighted how existing cultural services (e.g., AIAN-specific wellness camps) were important to engage youth in alternative activities as a means of prevention or intervention.
 - Adults highlighted the need for culturally-specific programs to keep them engaged in recovery and maintenance by first being acknowledged as a Native person rather than an individual with OUD/SUD.
- **Culturally Sensitive Treatment Approaches:** All participant groups emphasized that incorporating culturally sensitive treatment approaches (i.e., Wellbriety, cultural ceremonies, sweat lodges, talking circles, and traditional healers) were critical to the treatment/recovery process (See *Traditional Healing*, pg. 60).
- **Lack of Culturally Sensitive Treatment:** In addition to the general lack of OUD/SUD services, adults and key informants also discussed the scarcity of culturally centered treatments, absence of cultural sensitivity within existing services, and need for AIAN service providers.



So I would say one in general just lack of substance abuse treatment for general population. Ones that are probably more in tune, certainly there aren't very many that are in tune with Native American culture. And then a lot of the places that you can go for substance use disorder it seems to me, I mean I understand the process, but they can be very rigid in that you can't have a phone, you can't talk a lot of times to outside family members, you've got to be kind of isolated for 30 days. Or whatever it is. And that seems to me very hard for Native Americans who rely very strongly on family.

[Physician's Assistant, Indian Health Clinic]



I've seen a lot of really good community programs that try to teach history about your culture and expose children to it. Whether it's going into the forest or jungle or down to the beach, I mean, it's like doing things that, and learning about their environment, their history, their culture, their beliefs and that kind of stuff. Kind of like a grandparent would or a family member, father or whatever will pass it down to their kids, but sometimes the community picks up that slack and create programs. I've seen them be very successful. You know, it helps I think children have a sense of being and, and understand who they are and where they come from and there's way too many lost children out there that are empty inside, they don't know who they are and where they're from.

[Adult Focus Group Participant]



It's [cultural activities] very effective because it allows them to connect to their spirituality that, you know, was lost during their substance abuse. One thing I noticed is that a Native person, if they are a dancer, if they drum and everything, once they start using all of that stops. And then when they stop using they need that to bring them back up to their balance. You know, they need that, they need to understand that, you know, they can sing again, they can drum again, they can dance again.

[Adult Focus Group Participant]

- **Cultural Integration:** All participant groups spoke about the benefits of integrating cultural practices and traditions into Western treatment/recovery modalities (See *Discussion-Examples of Culturally Centered Treatment Programs*, pgs. 83-86). Adults specifically spoke of the disadvantage of attending programs that do not embrace or misunderstand their cultural practices (e.g., being denied the right to pray with traditional medicines).



I was at (Western recovery service). And they are actually, one of the counselors there, she's (AIAN) and she runs a spiritual program. I believe that no matter where I'm at, like if I carry it with me, I can spread it. And just because I'm around people who aren't Native American, there still can be- like everyone can use this program, you know what I mean? And I've noticed that when I walk on my Red Road that like other people see me, and not just in my community, but in recovery. You know what I mean? So I know (Western recovery service) isn't Native American-based, but they do have someone coming in once a week and teaching Wellbriety. And they do have a counselor that meets one-on-one. Like she met one-on-one with me and went over the Red Road with me. I don't know, I could just find it anywhere, you know what I mean. Just like I make sure I can find it anywhere like I could find my drugs.

[Adult Focus Group Participant]



They focus on the White population. Even though White (Bison) isn't what you would expect it to be. I sat through a few of those and read through the book and it's White centered, White man's point of view. "Yeah, we'll just splash this in there. Yeah, a little dream catcher and we're good."

[Adult Focus Group Participant]

Quality of Services

- **Western-based Services:** All participant groups described Western-based services (i.e., evidence-based practices) as not reflective of the diversity of cultures in California’s AIAN communities in that they are not culturally, spiritually, linguistically, and geographically representative or respectful in prevention, intervention, and treatment modalities. In addition, they reported Western-based services as limited in availability and not easily accessible. Those who used Western-based services often reported less success in recovery than in culturally-based services.
- **System Improvements:** In regards to AIAN-specific OUD/SUD services, the majority of key informants provided a positive, subjective view on the overall quality of services, but identified areas for improvement, such as the need for additional training for staff, more funding and resources, infrastructure improvements, more AIAN providers, integration of services, and traditional healing (See *Service System Needs*, pg. 66).
- **Culturally-based Services:** A majority of adult focus group participants were very satisfied with culturally centered OUD/SUD services and reported that they were more effective than Western treatment in facilitating recovery.
 - Youth participants were generally content with AIAN-specific services and programs, but expressed their desire for more education and information around OUD/SUD and its impacts on the individual and family. In addition, they voiced the need for more youth programs and services to keep youth busy and prevent them from engaging in substance use. Youth also highlighted the importance of including AIAN cultural practices in those services as a means of prevention.
- **Educating Providers:** Key informants discussed educating providers on utilizing best practice standards for pain management, training physicians on alternative treatments for pain management, and setting treatment goals.



Yeah, taking it into the rehabs, the recovery centers. Because like when we went into our program...there was no information available to us about anything. We had to bring it to them. And then we had to let them know that smudging ourselves and prayer and with our medicine, we couldn't even have our medicine with us- they locked our medicine up.

[Adult Focus Group Participant]



I think that was huge for me, personally, in my recovery. Because I've been to different programs...that aren't Native American-based, and then relapsed, didn't take it seriously. Then to go to (Urban recovery facility) and that completely changed my path to where I am now.

[Adult Focus Group Participant]



I think it brings up a very interesting and important point in that disconnect of care really is very collaborative care, should be collaborative care and interdisciplinary. So the ability to be within a shared EHR environment where the primary care provider and behavioral provider can share notes and monitor the patient's progress and even collaborate on the treatment plan, I think the in-house model can be very effective because of interoperability challenges within the EHR, that when you have someone receiving MAT in a primary care environment, and also receiving counseling and supportive services at another mental health provider at another agency, there's just no interoperability of the health record, right? So they're not collaborating. I think our model and the other(s)...that are working towards integration offer much longer-term success.

[Program Manager, Indian Health Clinic]

Traditional Healing

This section captures discussion of traditional healing or integration of traditional values into mental health services.

- **Impact:** Key informants and adult participants agreed that traditional healing (i.e., sweat lodges, ceremonies, traditional medicines) has been effective in helping individuals connect to their spirituality and culture and was a major component in helping with substance abuse prevention, treatment, and recovery.
 - Some traditional healing resources that were highlighted by all participant groups were: talking circles, traditional healers, cultural ceremonies, Gathering of Native Americans (GONA), community wellness gatherings, and cultural activities (e.g., beading, drumming, dancing, teepee constructing, regalia making).
- **Regional Availability:** Key informants stated that traditional healing and cultural activities were often offered on site and through referrals or word of mouth in the community. However, both key informants and adults stated that traditional healing and cultural practices are often underutilized because of limited availability, lack of awareness, and lack of integration with behavioral health and primary care.



We have...medicine men and medicine women. These elders and council members, Tribal leaders that we could speak to about these things and they want us to, but we are usually in our shame and guilt and we can't get there. But there's so many things in our community that will help you stray away from that and help you remember who you are and see inside yourself. You know, we have...ceremonies, you know, all these ceremonies that we can go to and, remember and, and become one again. You know, but we just don't get there.

[Adult Focus Group Participant]

Results

Results



The other thing that's not supported and we don't know how to do it well would be to support our Native healers to our Native communities that do healing apart from drug abuse. I think healing in general would be a means of appropriately supporting the many Native healers that we have and would go a long way. And there's no established, really good way of doing that right now that I know of, but figuring out how we could integrate, you know, the traditional and spiritual treatment for patients in with our behavioral health and medical health would be awesome.

[Physician, Tribal Health Clinic]



I think it's very important. I mean, the basis of healing is spirituality, and so therefore, having a connection, being able to work through things through sweats, through talking circles, it's almost like the same premise as going to an NA [Narcotics Anonymous] meeting but more of a spiritual connection to it. So me, personally, I would, I think it's very effective.

[Substance Abuse Counselor, Tribal TANF Partnership]

BARRIERS TO ACCESSING SERVICES

External Barriers

- » Location
- » Cost
- » Lack of Services
- » Common Factors

Internal Barriers

- » Stigma
- » Lack of Readiness
- » Lack of Trust in Providers
- » Gaps in Services

6. BARRIERS TO ACCESSING SERVICES

Participants discussed what kinds of services are accessible or not accessible to children and families in their community. Any discussion of difficulty accessing services (e.g., lack of insurance, waitlists, cultural insensitivity, stigma, transportation, lack of culturally sensitive providers) was captured for the purposes of this section. Participants were asked to identify barriers that AIAN adult and youth might face when trying to access any sort of OUD/SUD prevention, treatment, or recovery services in the community. Barriers mentioned were categorized into external (to the individual) and internal (intraindividual) barriers.

External Barriers

- **Location:** Key informant and adult participants discussed difficulty accessing services because they are often geographically dispersed and located far from their home communities. In addition, both groups identified limited availability of transportation to and from services as an external barrier.
- **Cost:** Key informants, adults, and youth highlighted that service access was hindered by high costs often not covered by insurance. Lack of insurance coverage or inadequate coverage was commonly reported by adults.
- **Lack of Services:** Youth participants in particular mentioned a lack of youth prevention programs and centers as an external barrier. The majority of adults identified being wait-listed for services, fragmented services and limited treatment/recovery services (e.g., sober living opportunities and residential treatment centers) in their communities or available to their community members as external barriers.
- **Common Factors:** Generally pervasive factors identified by key informants and adults were unstable living conditions, privacy, eligibility requirements (i.e., lack of federal recognition, lack of California identification, Tribal disenrollment), homelessness, and lack of health literacy.



The current policy on DHCS does not allow us to bill for two visits in the same day. It's a huge barrier because the patients who are coming in and receiving care, in primary care, they've taken some time off from work. They've solved their transportation dilemma; they've gotten here. It would be much more effective if they could be seen by their behavioral health provider on the same day. But current regulations prohibit

from billing for two visits. And that's a giant barrier.

[Program Director, Indian Health Clinic]



Well, you have to have, practically be dying, you know, for them, for you to be accepted in a home. And it's hard for them to just say, "Come on in." Or you have to be clean for three or four days before they can accept you. You know, it's, it's a process and sometimes, you know, that victim never gets that far.

[Adult Focus Group Participant]



More financial backing, that is definitely the biggest issue. There are plenty of Native therapists and doctors and, and psychologists and, and counselors who want to help, but don't know how to get involved and don't have facilities or the places to do these things. If we could get more government grants and private investors to help open these facilities it could definitely be much more easily accessible for Native peoples.

[Adult Focus Group Participant]



Yeah, I think the barriers are one of transportation or, you know, people just aren't ready for what, you know, a whole host of reasons. I don't know why but none of us...just that people tend to come in when they're hitting the bottom rather than, you know, when they're comfortably floating around the middle and don't think that there's a problem yet.

[Substances Use Counselor, IHS]

Internal Barriers

- **Stigma:** All participant groups (key informants, adults, and youth) identified stigma as an internal barrier to accessing treatment. References to stigma included shame and privacy concerns associated with being identified by others in the community, thus preventing the individual from reaching out for services. A specific concern reported by all participant groups was stigma/shame surrounding relapse and readmission into treatment/recovery programs after readmission.
 - Adults and key informants specifically described a particular stigma surrounding MAT as a treatment option for OUD/SUD, as it is not viewed by many AIAN communities as a form of sobriety. The pervasive belief in many communities is that replacing one substance with another, even in the form of maintenance and recovery, is still seen as substance use.
- **Lack of Readiness:** Participants unanimously described lack of readiness and lack of self-efficacy as internal barriers to seeking and continuing through treatment and recovery services. The process to recovery was described as an individualized experience which one would not embark on until ready to do so for themselves. In regard to those currently suffering from OUD/SUD, youth participants specifically discussed an individual's denial about their own addiction as a barrier to seeking treatment.
- **Lack of Trust in Providers:** Key informants, adults, and youth agreed that lack of trust in providers was an internal barrier for accessing and continuing through services. A generalized distrust of Western treatment modalities and non-AIAN providers exists in many AIAN communities as an artifact of historical trauma.
- **Gaps in Services:** Perceived gaps in treatment/recovery services exist in the form of individuals' lack of belief in the efficacy and positive outcomes of such services. Youth held a common belief that such programs are ineffectual for community members currently suffering from OUD/SUD.



SERVICE SYSTEM NEEDS

Community Awareness

Information & Education

- » OUD/SUD as a Disease
- » Addictiveness of Substances
- » Critical Age for Prevention
- » School-based Prevention

Economic Opportunities & Life Skills Programs

Maintenance Support Systems

Treatment Facilities & Services

Strategies for Integrating Services

- » Chronic Pain Management/Pain Management Contract
- » Active Case Management
- » Treating Mental Health Comorbidities alongside OUD/SUD
- » Including Traditional Healers
- » Referrals
- » Multiple-Entry Points into OUD/SUD
- » Transportation

Youth Programs

Mental Health Services



I don't think you can help anybody unless they themselves want to change themselves, and they're going to go seek help. But you can't force someone to get help because they're not going to do it. So, you could put all those classes out and...no one's going to do anything about it, no one's going to go to it.

[Youth Focus Group Participant]



I can give you just a few data points with individual patient experiences, but I really don't know what the sentiment is on the whole of our patient population who have opioid use disorders and what their preferred mode of treatment is. I know we have several patients who go to methadone clinics. There's a lot of stigma around that. Often times they don't tell their primary care providers that they're taking methadone. So there's a lot of work to be done in education, reducing stigma, drawing people into treatment and then obviously being able to provide the treatment. I know that there are patients who are interested in Suboxone®, and there are patients, a lot of patients who are not interested in using MAT in the way that it is clinically recommended. For example, not wanting to do maintenance and wanting to use Suboxone®, for example, as just a detox medication to completely get free of opioids and then not having any of the tools in place when they get stressed out again to not relapse.

[Medical Director, Tribal Indian Health Clinic]



Sometimes people are not trusting since it's been so far along that, you know, they're just negligent and, and then they just would throw you something else to be addicted on. So I think trusting is a big issue.

[Adult Focus Group Participant]

7. SERVICE SYSTEM NEEDS

Participants were asked what services were available in their community and/or to their community members. Any discussion of gaps in services and/or lack of available services/programs, including lack of accessibility were recorded. An identified system need was the request for information regarding substances (e.g., their addictive nature, harms to the body), especially for medications dispensed by physicians (e.g., opioids, benzodiazepines) to be shared with community groups or with the community at large. Increasing community awareness of the pathology of OUD/SUD and its impacts can help to decrease stigma in individuals seeking services.

Community Awareness

Key informant and adult participants discussed the need for raising awareness within their communities of: OUD/SUD, the addictive nature of substances like opioids, availability of prevention programs for youth, resources available for treatment recovery and sober living, mental health (e.g., suicide, trauma), and the history of their Tribes.



I would also say like education and awareness, both about like the issue of substance use but also the, the cultures on the whole and the history. You know, it must come as a great relief that there's, we're actually talking about it now as a society, about the harm and the violence that was inflicted over such a long period of time. And, you know, and, and like the Native stigma about, from, I mean, I'm from here, we never talked about the local Tribes growing up in, in primary school, middle school, we never, I never learned about the different histories of each Tribe, the languages, the differences in culture. And it wasn't until I was 22 at (university) where I had my first experience with like a formal education on the history of this land, you know, and this area. And just, I think that's a strength, all these leaders. Still a ton that needs to be redressed but at least we're talking about it. You know, because when I was growing up there was just a lot of negative stigma associated with the Native people, and also the, the reservations on the whole. You know, like they're all bad news or whatever, you know, full of people that have just given up essentially, is what I was taught when I was little. And, you know, obviously that's very untrue.

[Adult Focus Group Participant]



I think more- it's made me think just more education, more awareness of opioid addiction so that it's talked about more. Communicating kind of helps with prevention.

[Substance Abuse Counselor, Urban Indian Clinic]



I think personally that we should focus a bit more on mental health because lots of people turn to drugs because of depression, anxiety.

[Youth Focus Group Participant]



I work a lot so mine would be more awareness. To have people out in the community putting out flyers and going and speaking or letting people know what services are offered to the Native community. Because I'm not from here...and when I came here, I was homeless and I came to my program. So like, I don't know what services are offered and I don't know what's available to me. So just having people out there putting maybe flyers or having- letting the community know what events are going on more...I don't see nothing Native come through my store. And a lot of people ask me about, because I'm Native, they'll ask me about like what events are going on. I can't tell them what's going on because I don't know what's going on. So when I go, like I look at the boards a lot and I see a lot of flyers of like all kinds of events that are going on. But I hardly ever see any Native flyers out there.

[Adult Focus Group Participant]





Results

Information & Education

Adults and youth reported wanting more instructional or educational services regarding OUD/SUD. Adults and youth advocated for more prevention services to be made available for youth to help them understand addiction and the negative consequences of substance use on their communities, relationships, and body.

- **OUD/SUD as a Disease:** Adults in recovery also discussed providing education to people with substance use disorders about the pathology of addiction to help them understand how it impacts their brain, body, and behaviors.



Mostly teaching people to don't do drugs and tell them about how much pain they're giving their body.

[Youth Focus Group Participant]

- **Addictiveness of Substances:** Both adults and youth expressed wanting more information and education on substances and their addictiveness. Adults being prescribed medications expressed a desire to be fully informed by their medical providers of the addictive risks of prescription drugs.
- **Critical Age for Prevention:** Participants emphasized the importance of having educational services on OUD/SUD for youth as it was described as a critical age for prevention.
- **School-based Prevention:** Youth requested both culturally-tailored programs and school-based programs. Youth expressed the desire for novel approaches to modern activities (i.e., vaping, cough syrup/lean, benzos) as they are not seeing effective outcomes from outdated prevention curriculum (i.e., D.A.R.E., Red Ribbon Week).



I'd say implement better stuff in the schools because that's like a big place where there's a lot of drug use like this.

[Youth Focus Group Participant]



Teach us not to do bad things. Talk to us and tell us like, it's like bad for us and everything like that.

[Youth Focus Group Participant]

Results

Economic Opportunities & Life Skills Programs

Key informants and adults discussed the need for a holistic approach to the treatment of OUD/SUD. These types of programs could include life skills, resources to gain employment, and provide basic needs, such as food and housing.



Like in substance abuse, arrest, and addiction is only one part, you know. People have to learn life skills and engage in like new healthier activities so the cultural activities are really important. As the substance use providers we have to be able to provide them with the resources to get established, so like housing and food, gifts cards. Of course, whenever you're having these meetings, to have food.

[Substance Use Counselor, Urban Indian Clinic]



Maybe more, more places to get, like after you come out of rehab, more places to get you a job, you know, not just to look down on you, you know what I mean. Like I'm a, I'm an ex-con and like I was a drug addict for a long time. I mean, nobody wanted to hire me when I was doing good because they didn't know me. I mean, they just knew I was a drug addict and I had bad habits, you know what I mean. So if we could open that up and get somewhere where maybe once they come out of rehab they go to, I mean, these rehabs aren't that long no more, you know, like I've been to a 90, I've never even been to an 18-month program and I've just done 90 days. And what does 90 days get you? That gives you sleep, eat, healthy again, and then you go back out and try to leave off where you left off, and most people don't make it past that.

[Adult Focus Group Participant]



Open up some centers for education, but not only just for education, like for job searches, stuff to get our people into positions where they could help others of our people.

[Adult Focus Group Participant]



I think I would have work readiness, careers, housing, mentors, just the whole thing, recovery, community centers, meetings. I mean just everything for the Native people, and housing, especially housing for low income people like me. I'm low income. So yeah, everything.

[Adult Focus Group Participant]

Maintenance Support Systems

Key informants and adults discussed the importance of having a sober social network and community to support their sobriety while reintegrating into their community after treatment or incarceration. In addition, sober living spaces were not readily available which often led many to return to living arrangements which exposed them again to substances. Suggestions were made for sober living, sobriety support groups (i.e., sweat lodges, talking circles), culturally centered 12-step groups, and cultural activities that are conducive to supporting and creating new behavioral patterns to maintain sobriety.



Yes, that would really help. Because a lot of us complete, a lot of them complete programs, but you complete a program and you did all this, and then you find out you have nowhere to go at the end. Where are you going to go home to? What's next after treatment? That's where I feel like a lot of people struggle with because they don't have that environment to go to, that safe structure, that same mentality. You're going back into old behaviors, old mentality, and being in recovery, we can't go back into old environments, old places and things because those old memories that we're healing from will start to rise back up.

[Adult Focus Group Participant]



Environment, okay. That kind of goes back to, just to backtrack a little bit on the previous question, like what are contributing community factors that contribute to substance use is when you talk about (OUD/SUD services), not having one that is Native-specific in the sense that getting through recovery and going back to those environments, then you can find yourself, if that's all around you and you don't have a support network right with you there, then it can be very challenging to slip back into those behaviors of using because that becomes right immediately around you and not having that support network there where a Native-specific (OUD/SUD service) could be more appropriate for a Native population whether through, you know, obviously the commonalities or beliefs or fellow

Tribal members, just that more of a connection.

[Adult Focus Group Participant]



And even though I finished the outpatient, I still come back to these groups. And it's been four years. So it's like, the community, the Native community, they have support there for us to help us with things. I wish that they would come up with (services) for us Natives...because we walk out of treatment, and I noticed, I've been in treatment with a lot of people, I've been in the circle group with a lot of people and I see a lot of us have to go back to where they come from. And one thing about being a recovered addict, you can't go back into the same playground thinking that you got it, you got it, you got it. Because eventually something's going to happen where you're going to get triggered or you're going to pick up and you're going to use. So it's having that foundation. If they created that—as soon as I stepped out of treatment, the (program) was there for me.

[Adult Focus Group Participant]

A STATEWIDE NEEDS ASSESSMENT



I would just add when, a lot of times when the kids come home from being involved in an inpatient treatment program they come back to a family that is using, or a peer group that is using, and there's very limited opportunities for them to engage in clean and sober activities and wellness gatherings.

[Substance Abuse Counselor, Tribal Clinic]

Treatment Facilities & Services

Key informants and adults reported limited AIAN residential treatment facilities. Rural areas had less access to these services and often individuals needed to be referred outside of their communities. For the services that did exist, many reported that length of stay was not sufficient to help individuals maintain sobriety while transitioning back into the community. Recommended services mentioned by participants to treat OUD/SUD in AIAN communities included: mental health services, behavioral health services, AIAN treatment centers/facilities, and Wellbriety.

- AIAN treatment centers/facilities differ significantly from Western facilities in that they encompass traditional practices or beliefs, engage with traditional healers, and provide cultural resources. The approach taken in such services seeks to heal the whole individual and not just the disease.



Rehab centers, like I know there's not a lot of those but like it costs money and people don't have the money to like, to do that. Or if they can't then they won't, I know there's like some programs around the city that will do like little get-togethers and, you know, like try to help you out, bring you food and shelter and they'll do that, but like they won't help them, they'll just get you somewhere to stay and eat and just somewhere to be safe for the night.

[Youth Focus Group Participant]



I think that we need more residential treatment programs. [Organization redacted] is only for men so having one for women at least. For women and children. We need more...I would like to see more sober livings for Native Americans.

[Substance Abuse Counselor, Urban Indian Clinic]



I think in the community that's underserved, that I would have to spend time, go to jail, pay fines, and, you know, get my driver's license taken, all these things that stop me from being productive when I'm suffering from a disease that is, it's a medical, it's a clinical disease that needs to be dealt with like cancer or, you know, any kind of terminal illness. You know, I have a disease that doesn't allow me to make rational decisions. So rather [than putting] me in jail, I need to be somewhere like a place like this so I can learn more about the disease to the reason why I, I make decisions and don't even understand why I'm not making decisions because I'm intoxicating myself with these, with these drugs and alcohol. So I think the justice system needs to change their approach on that, which a lot of us are here today because of that reason, but it's, it's still more that needs to be done.

[Adult Focus Group Participant]

Strategies for Integrating Services

Key informants discussed the importance of integrated services for retention, increased compliance, and more effective treatment of AIAN individuals. Integrated behavioral health care is a team effort of health care professionals working together with patients and families to provide patient centered care. Below we highlight existing strategies reported as facilitating individuals in continuing OUD/SUD treatment:

- **Chronic Pain Management & Pain Management Contracts:** Key informants reported the importance of proper pain management for patients with chronic pain to avoid opioid dependence. Pain management contracts were discussed as a strategy to prevent or treat opioid dependence. Key informants reported that pain management contracts were successful if the physician prescribing the medication and the behavioral health provider worked closely to determine individualized treatment. Otherwise, pain management contracts can be viewed as punitive and can interfere with their effectiveness. Managing treatment closely with behavioral health and primary care physicians may help prevent abrupt changes in medications or discontinuity if contracts are breached.



Pain management contracts are successful if there's a close relationship with the physician prescribing medication and the behavioral health provider. Patients can often see pain management contracts as punitive and this can interfere with their effectiveness. Managing patients closely with behavioral health and primary care physicians will help prevent abrupt changes in their medications or discontinuity in medications if contracts are breached.

[Substance Use Counselor, Rural Tribal Clinic]

- **Active Case Management:** Key informants reported the importance of having active case management to ensure tailored treatment and increased adherence. Active case management involves building a team of medical physicians, behavioral health providers, and a health navigator that checks-in with individuals and provides support as needed.



Case management, aftercare, education. You know implementing and using a MAT program, but also getting them the proper treatment. I mean there are some clients...We are an outpatient facility, but there are some clients that most benefit, they don't know either...and they need that extra push to go into residential. So having that available as well.

[Director, Rural Indian Clinic]

A STATEWIDE NEEDS ASSESSMENT

- **Treating Mental Health Comorbidities alongside OUD/SUD:** A risk factor discussed by key informants, adults, and youth of OUD/SUD included co-occurring mental health disorders. Therefore, key informants recommended that integrated care be inclusive of treating the underlying co-occurring mental health disorders in addition to OUD/SUD treatments.



We have a robust program right now for specifically addressing opioid dependence and, use and abuse, and also with chronic pain. We have a multidisciplinary program that involves a clinical pharmacist, behavioral health, medical personnel, as well as a medical social worker. Our team in the clinic includes the provider as well as the medical assistant and the case manager or nurse that have identified who our substance use patients are and doing protective work in terms of making sure that treatment is being offered and followed, as well as treatment through referrals to behavioral health and addressing substance use as a medical problem, or polysubstance abuse, dual diagnosis as a medical problem that includes referrals to behavioral health. Unfortunately, there's not enough support in terms of monies and availability for specific psychiatric help, which is problematic for mental illness, which includes things like ADHD for, ADD for kids, as well as polysubstance abuse and other mental illness problems.

[Physician, Rural Indian Clinic]

- **Including Traditional Healers:** Recommendations were made to integrate traditional healers (where available) into the MAT team, to have traditional healers compensated for their time, and have some guidelines to integrate traditional healing modalities into a clinical setting. Traditional healing and cultural activities were often offered either on site or through referrals in the organizations. While it was reported as an important resource of a culturally centered program, challenges still exist regarding how to best integrate traditional healing with behavioral health and primary care.



There is a lot of access so I mean predominantly if we were on a reservation. We would only have one traditional healer for the Tribe. But out here we have to pass it on to our son, our uncle, or to somebody that understands. Like I said, you know the cycle of life is continuing and our elders, there's not too many Native American males stepping up to these needed things.

[Director, County DHHS/Mental Health]



Well, we do a lot of warm handoffs when folks are seeing [omitted], who are our addiction therapists, and there's a mental health issue going on. We'll, they'll pull me in and I'll meet the individual, and vice versa if I'm working with somebody with a substance use issue, I'll do a warm handoff, get them acquainted, making appropriate referrals. We're working on becoming a little more integrated over on the primary care side.

[Psychologist, Tribal Clinic]

- **Multiple-Entry Points into OUD/SUD Services:** Key informants highlighted that treatment of substance use disorders is an individualized trajectory of rehabilitation. As such, multiple entry points into OUD/SUD services were recommended to provide more opportunities to engage in treatment.



You know, because not everybody will acquiesce to services and recovery is a multistep process and we don't expect everybody to recover on the first try, and so there has to be multiple opportunities for people to access these services. And a lot of people wind up in lots of different programs for different periods of time.

[Director, Tribal Clinic]

- **Transportation:** Given the remote locations of many Tribal areas and the dispersion of available services, key informants and adults reported the need for more transportation to connect individuals to available services.



It gives them, it gives them access to, you know, rides is really, really tough, getting you to and from places. You know, a lot of Natives live in remote areas. And, I mean, to even drive to [local services], I mean, I have my own vehicle and it seems so damn far.

[Adult Focus Group Participant]



That's one thing we don't got is a bus picking up all these kids and taking them somewhere. A lot of parents, they don't got a transportation. They got single mothers out there, "Why don't you come pick my kids up?"...because I can name a lot of kids that get left behind. They always want to be- like I got (family) and they live in (a rural, remote) area and they don't ever get a chance to go nowhere, really. You know what I mean? And they would love to go to a ceremony. If I find a bigger vehicle, I would love to take them, you know what I mean?

[Adult Focus Group Participant]



Okay, it would be transportation. Because like I said, a lot of parents, they can't keep their kids somewhere when they're at work. When any of their kids want to go, transportation, man, bus drivers, man. They should have a spot where all the kids go. And if they can't make it there, go to their house and pick them up. When I was a little kid, they used to have a little church bus and they'd just pick all the kids, white kids up and take them to church and all this other stuff. Man, why can't we do that with our Native people? We need a bus.

[Adult Focus Group Participant]

Youth Programs

All participant groups (key informants, adults, and youth) described the importance of having more programs available for youth. Youth were considered to benefit most from early prevention or early intervention before any existing substance use had the potential to become a long-term OUD/SUD. Adults currently engaged in OUD/SUD recovery services expressed a desire to intervene or prevent OUD/SUD in future generations by sharing their personal stories with youth. The most frequently suggested prevention/intervention services were afterschool or summer activities, programs involving positive adult role models and elders, and programs which help youth cope with mental health and trauma.



I think that also there's kids that do drugs and do pills and stuff because they're having problems at home or they're being abused or something like that. I feel like we should have something for kids to go to that are either younger or older that can talk about that or go to something like counseling with their parents or something so that they can get help so that they won't have to feel like they need to do pills or drugs or something to relieve that pain.

[Adult Focus Group Participant]



More youth activities. Because a lot of the addiction I think starts from a younger age, so I think if there are more things to fill our free time up with then it could lower that.

[Youth Focus Group Participant]



Prevention. I'm not sure that there are a whole lot of prevention services other than grade school and high school education modules that, that talk to kids about the risks of substance abuse. Maybe churches, maybe Boys & Girls Clubs, but most of what happens for people comes after the fact of being busted or incarcerated or overdosing and being revived or being caught selling or possessing substances.

[Director, Tribal Indian Clinic]

Mental Health Services

Given the high rates reported by all participant groups of co-occurring mental health disorders with OUD/SUD there is an identified service system need for both prevention and treatment of OUD/SUD was access to mental health services. Mental health services as prevention were especially recommended for youth who were perceived to be at higher risk for OUD/SUD if they had untreated mental health disorders or unstable family dynamics.



Well, there seems to be a higher percentage of people that are diagnosed with bipolar disorder in our community. I'm not sure that that's accurate. There's a lot of situational anxiety in our community that is overmedicated and not treated with cognitive behavioral therapy. And what I mean by situational anxiety is that there's food anxiety, there's shelter anxiety, you know, the rates of homelessness or underhoused or underfed seems to be higher in our community. So the situational anxiety tends to be medicated away, which leads to, you know, more problems than it solves.

[Physician, Indian Health Services]



They need a lot of mental health because a lot of them suffer from depression because of using all the drugs and they just continue tumbling down. And they were depressed and started using the drugs because they were depressed and it just progressively got worse.

[Adult Focus Group Participant]

Limitations

Limitations to this study include that all participants may not be representative of all California AIAN populations, Tribal communities, and OUD/SUD service providers in California. The study data is also limited to self-reporting by participants who shared their perspectives in focus groups and key informant interviews. However, the results of the statewide needs assessment report provide unique stories and shared observations about AIAN populations to understand identified existing cultural services systems and treatment needs to address the opioid epidemic among California AIAN communities.

Results

PART 5. DISCUSSION

The statewide needs assessment was an opportunity to understand the opioid epidemic among AIANs living in California. Perspectives came from adult and youth community members, individuals in recovery, individuals currently using substances, and key informants such as health care providers and substance use counselors. This report addresses the opioid epidemic affecting AIAN communities throughout California by furthering our understanding of current resources available and treatment programs reaching AIANs. It also addresses the challenges inherent in responding to individuals and communities in need of prevention, treatment, and recovery programs. When developing appropriate interventions to address the opioid epidemic among AIANs living in California, policy makers and healthcare professionals must consider the diversity of Tribal beliefs, cultural values, history of trauma, and the resulting diversity of needs to approach OUD treatment and services.

This report highlights seven domains:

1. Community Substance Use Description
2. Risk Factors
3. Resiliency
4. OUD/SUD Services Available
5. Acceptability of Existing Services
6. Barriers to Accessing Services
7. Service System Needs



PART 5. DISCUSSION

1. COMMUNITY SUBSTANCE USE DESCRIPTION

Participants described a wide variety of substances (e.g., alcohol, marijuana, heroin, opioids, and methamphetamine) as highly available in the communities. Family members and peers were reported to provide the easiest access (intentional or unintentional) to opioids and other substances. Substance use was reported to be pervasive in family systems, greatly increasing access to substances and risk for abuse. Key informants observed that when opioids became unavailable to users, they progressed to heroin use. Youth are initiating substance use at younger ages because they have easy access to substances; they also experiment with benzodiazepines (e.g., Xanax®), antidepressants, cough syrup, vaping (e.g., JUUL®), marijuana, and cocaine. Younger age of initiation, easy access through family and peers, and the accessibility of multiple substances has resulted in higher rates of polysubstance use than in previous years. The pervasiveness of use among their recovery family systems and throughout communities was perceived to complicate attempts at recovery and sobriety. Participants noted that stigma surrounding opioid and substance use also complicated access to and utilization of treatment in that, while some understood substance abuse (including the abuse of prescription medication) as a mental health issue, most people viewed it as a personal choice. Participants stated that stigma may be perpetuated by a lack of accurate awareness about SUD and treatment approaches. Finally, OUD/SUD significantly impacts the culture and functioning of the community. Participants described links to increased community violence, domestic violence, family disintegration, suicide, and death by overdose, all placing substantial stress on community members and increasing risk for various other poor health outcomes. In sum, participants noted that: OUD/SUD were highly prevalent; substances very easily accessed; use was pervasive among family and community systems; youth initiated substance use earlier in their developmental trajectory; polysubstance use was common and highly stigmatized. All of the above impeded the transmission of accurate information and utilization of services. These findings suggest

there is considerable need for attention to OUD/SUD in AIAN communities in California, and that the development and implementation of OUD/SUD services address these specific community-level challenges described by study participants.

2. RISK FACTORS

Participants described numerous risk factors for OUD/SUD including community stressors, economic stressors, mental health problems, peer pressure and social norms, and historical and intergenerational traumas. Community level systemic issues such as historical trauma and intergenerational trauma are risk factors because they add to current daily stressors of family loss, adverse childhood experiences, and geographical isolation. Historical trauma among AIANs is “a legacy of chronic trauma and unresolved grief across generations”⁴⁴ that results from traumatic events such as forced assimilation, extermination and genocide, relocation and containment, and the boarding school era.⁴⁵ Intergenerational trauma is the passage of these experiences to subsequent generations who may also share similar mental and physical health outcomes.⁴⁶ Self-medication to numb the pain from these traumatic events due to Western influences has impacted cultural connectedness and interpersonal relationships. Substance use, including opioid use, is knowingly used as a coping mechanism. Economic stressors were addressed with high rates of poverty, homelessness, and lack of funding for services as reasons for increased OUD/SUD in AIAN communities. Reports of mental health issues, such as depression, anxiety, and the comorbidity of substance use and mental disorders are particular risk factors for OUD/SUD. It is important to note that risk factors impact individuals in different ways, depending on their other internal and external resources and life experiences. Participants expressed the need for community healing and youth prevention and interventions that focus on family, school, and community for positive youth development to reduce the risk of initiation and later OUD/SUD. Support for existing services and for additional services are needed to address the effects of historical trauma and to improve and nurture the cultural connectedness and interpersonal relationships with family and the greater community.

3. RESILIENCY

Participants of all types (key informants, adults, and youth) noted that AIAN individuals and communities possess resilience factors including community strength, cultural connectedness, cultural services, positive role models, and available supportive services and programs. Gatherings of family and community to participate in cultural activities, such as Powwows and traditional dances create a sense of cultural connectedness and build community strength along with cultural values and cultural identity. Opportunities for cultural connectivity are particularly important among urban AIANs, who live away from their Tribal communities, as they expressed the need for a sense of community and belonging. In terms of substance use prevention, youth shared the significance of cultural and traditional gatherings to dance, bead, weave, and make regalia as ways to stay clean and sober and to reduce the influence of their peers. For individuals in recovery, traditional practices (e.g., talking circles, sweat lodges) and Native-specific healing resources (e.g., White Bison) provide an individual an opportunity to practice and connect to their cultural ways as they work on and build positive coping mechanisms. Another resiliency emphasis mentioned, particularly by adults and youth, was having positive sober role models who shared cultural norms and beliefs about avoiding substance use. Positive role models help in prevention and treatment aspects of OUD/SUD, as key informants highlighted the importance of elders (e.g., aunts, uncles, grandparents) to be essential in building resilience with their shared experiences from OUD/SUD impacting either themselves and/or their family and community. Supportive cultural services and programs also provide prevention education regarding the harmful effects of OUD/SUD. Lastly, treatment services that keep an open-door policy for OUD/SUD patients are fundamental to allowing patients to return if relapse occurs, reducing external stigma towards individuals in recovery. Supporting culturally-based programs serving AIAN populations to support OUD/SUD treatment, provide education and information on OUD/SUD, offer positive role models, engage youth, and involve cultural/traditional practices are essential for maintaining resiliency in the community.

4. OUD AND SUD SERVICES AVAILABLE

The importance of culturally centered activities and treatments to prevent and/or treat SUD, particularly OUD, was highlighted by adult and key informant participants. They recommended that MAT programs incorporate traditional healers and traditional practices/beliefs to provide culturally-based sources of healing and to develop the spiritual, mental, and physical strength of the individual. Treatment programs for AIANs that integrate cultural activities, such as sweat lodges, drumming, singing, beading and regalia, into the treatment are critical to the success of an individual in recovery. These were described as ways to work towards successful treatment, to provide relief from distress, and to strengthen individual and community support systems to heal. Prevention programs are also essential for OUD/SUD among AIANs and should include awareness and education on the impact of both. Providing prevention programs that incorporate traditional healing activities, promote community involvement, and encourage healthy values of AIAN identity may increase overall well-being and improve other healthy behaviors by addressing sources of stress linked to cultural identity, stigma, and community connections.

5. ACCEPTABILITY OF EXISTING SERVICES

Major themes emerging related to the acceptability of existing services included access, cultural sensitivity, quality, and traditional healing. Participants noted that access varied widely according to factors such as eligibility, insurance coverage, geographic location, and whether the potential client resides in a rural or urban area. Potential clients typically learn about services through word of mouth, from others active in recovery/treatment, friends and family, and community outreach by service providers. Other entry points noted were eligibility screening, referrals, community outreach, and incarceration. Interestingly, although key informants generally described their services as being accessible and easy to navigate, while the majority of adult and youth focus group participants discussed difficulty accessing services because of a lack of awareness and availability. All participant groups described the importance of incorporating AIAN cultural practices and traditions in prevention, treatment, and recovery services for OUD/SUD and noted that culturally-based services were not readily available. Participants noted that culturally-based services such as talking circles, ceremony, and traditional healers need to play a more central role in the recovery process. These services can be delivered in an integrated way with Western medical practices in order to be optimally effective for engaging and effectively treating OUD/SUD in AIAN communities. Western services alone were described as being difficult to access, not reflective of the cultural diversity among AIAN communities in California, and not effective as integrative or cultural approaches. The majority of key informants identified structural and systems changes needed to increase the acceptability and utilization of current

services, including the need for additional training for staff, more funding and resources, infrastructure improvements, more AIAN providers, integration of services, and traditional healing. Youth also expressed the need for more programs designed to increase awareness and education about the effects of substance use on health, social and emotional development, and family functioning, as well as more general positive development programs to keep them busy and away from substances.

6. BARRIERS TO ACCESSING SERVICES

Participants described external and internal barriers to accessing services. Adults and key informants highlighted external barriers to accessing services including communities being geographically dispersed far from clinics, lack of transportation, lack of insurance coverage, unstable living conditions, privacy concerns at clinics, extensive eligibility requirements, lack of health literacy, wait-listed services, limited sober living opportunities, and homelessness. The youth particularly highlighted the lack of youth prevention programs and centers to provide opportunities to engage, learn, and provide safe spaces. Internal barriers included stigma and shame, perceptions of MAT as substituting one addiction for another, lack of readiness among substance users, and lack of trust in providers. These barriers hinder attempts to get appointments and continue with the care regimen. Greater attention to the numerous barriers is essential to enhance access, availability, and the desire by individuals who seek the recovery services and resources that are available. For example, transportation is a critical need in both rural and urban areas for individuals and communities who are geographically dispersed to improve access to services and maintain ongoing appointments for continual care.

Substance use stigma is another barrier that could benefit from stigma reduction interventions geared towards opioid users, at-risk youth, and healthcare professionals. These interventions could educate providers and potential patients about the benefits of MAT programs to improve patient survival, increase retention in treatment, reduce the need for inpatient detoxification services, and prevent an opioid overdose. Supporting sobriety with sober living housing and connecting individuals to a wide range of cultural recovery services is only the beginning of an intricate process to fully support an individual in their recovery and sobriety stages. With the strong desire of our AIAN population to regain their identity, well-being, cultural ways, and connections to family and community, it is critical to address many of the highlighted external and internal barriers. This is especially important for our youth, who highly recommended creating more youth programs with available services and educational resources to provide positive development opportunities, to build trust and improve connection with each other in safe spaces.

7. SERVICE SYSTEM NEEDS

Participants identified a wide-range of OUD-specific as well as more general services system needs to enhance prevention and recovery services related to OUD/SUD. These needs include increasing education and awareness; providing prevention, outreach, and other nonspecific community programs to enhance overall wellness and holistic health; more accessible and effective treatment programs; and working towards more integrated services across the range of case management, mental health, and physical health issues associated with OUD/SUD. With regard to education and awareness, participants noted the need for more opportunities to receive accurate education and information about OUD/SUD, addiction, and resources available for prevention and treatment. In particular, youth and adults noted the need for more education about the pathology of addiction, addictive substances, and the impact of addiction on physical, mental, emotional, and social well-being. In addition, they discussed the need for education efforts to target youth at risk before they started down a trajectory to abuse and addiction, the introduction of school-based and culturally-tailored programs to help educate youth about OUD/SUD,

and education and support for parents to help them contribute to the physical and emotional health of their youth and prevent risk factors associated with OUD/SUD. Key informants also discussed the need to educate providers about practice standards for pain management and opioid alternatives to manage acute and chronic pain. Related to prevention, participants also noted the need for general prevention and wellness programs to support youth in establishing healthy practices and coping strategies early in life to prevent OUD/SUD. These could include positive youth development and/or life skills programs, as well as employment resources, and case management resources to help with transportation and stable living situations. With regard to treatment services, participants noted the significant need for increased number, availability, and accessibility of treatment services, particularly those that specifically cater to the unique cultural needs of AIAN individuals and incorporate traditional healing and other culturally-based services. In addition, participants noted the need for more services to support the transition from treatment back to community life, including options for sober living and continued community supports to optimize recovery once acute treatment has ended. With regard to integration services, participants noted a critical need for the service system to be better integrated across the range of services the support OUD/SUD recovery. Particular services identified were pain management, case management, relapse prevention, treatment for co-occurring mental health issues (e.g., depression, anxiety, trauma exposure), and traditional healing services. It was noted that OUD/SUD clients are often given referrals to other services, but there is no infrastructure in place to actually help them navigate the system and access these other kinds of services, contributing to significant barriers in receiving coordinated services. Services need to be more available and accessible; be culturally-based; incorporate prevention, education, and wellness approaches, particularly focused on youth; include case management, mental health treatment, and relapse prevention to support long-term sobriety; and be better integrated into a coordinated service system structure to prevent clients from having to navigate disparate and fragmented services.

EXAMPLES OF CULTURALLY CENTERED TREATMENT PROGRAMS

The following are examples of culturally centered treatment programs that are practice-based evidence currently being implemented throughout AIAN communities in California. These programs can be adapted to meet the needs of AIAN communities based on cultural values, and urban and Tribal differences.



Discussion



THE WELLBRIETY MOVEMENT

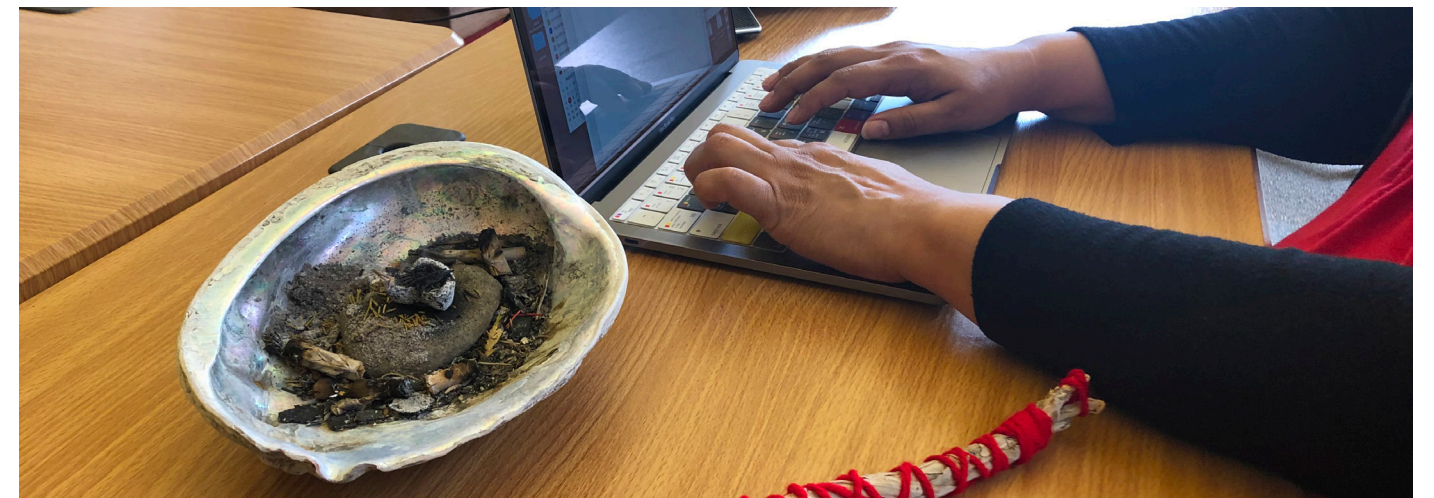
The Wellbriety Movement is a grassroots SUD recovery movement, developed by members of the AIAN community as a culturally adapted approach to the 12-step recovery model. Wellbriety trainings and events happen throughout Tribal and Urban AIAN communities. Established programs like White Bison provide individuals with essential skillsets in a Wellbriety approach to recovery, for both youth and adults. The “Well” part of Wellbriety is the inspiration to go on beyond sobriety and recovery, committing to a life of wellness and healing every day.

The mission of the movement is to share and foster culturally-based recovery principles, values, and teachings to support healthy community development and servant leadership while supporting the healing from alcohol, substance abuse, co-occurring disorders, and intergenerational trauma.⁴⁷



TRIBAL MEDICATION-ASSISTED TREATMENT (MAT)

There are medication-assisted treatment (MAT) programs in Tribal Health Programs (THPs) and Urban Indian Health Programs (UIHPs) throughout California that offer an evidence-based MAT program with trauma-informed care for OUD/SUD patients. MAT sites are integrating and developing a Native specific recovery approach with the utilization of traditions and culturally-based components. For example, some clinics have the White Bison recovery program (a culturally specific program for healing and recovery that is utilized by many AIAN communities), American Indian therapists, and therapists with special training to treat historical and intergenerational trauma. Ideally, treatment provides supportive recovery care for the ‘whole’ person to heal and reduce opioid and substance use.



TELE-MAT

Tele-MAT is a model of MAT related services using telehealth technologies with the ultimate goal of providing a high level of care and access to under-served communities using a screen to screen interface between clinician and patient, ideally mitigating geographic and transportation-related barriers. An example of a Tele-MAT program is the TeleWell Indian Health Program (IHP). The TeleWell IHP has three main components: educational (monthly webinars for providers and ongoing case consultation), technical assistance (capacity building, best practice training and general technical assistance to programs developing and sustaining their own MAT programs), and TeleMedicine direct care for MAT (buprenorphine/Suboxone[®] regiment) and behavioral treatment of co-occurring conditions.

Discussion



MOTIVATIONAL INTERVIEWING AND CULTURE FOR URBAN NATIVE AMERICAN YOUTH (MICUNAY)

The Motivational Interviewing and Culture for Urban Native American Youth (MICUNAY) is a substance use prevention intervention for AIAN youth. This program was designed for urban AIAN adolescents and integrates motivational interviewing (MI) with AIAN traditional practices.⁴⁸ It is comprised of three 2-hour sessions. The first hour includes a MI group session incorporating AIAN concepts and traditions. The second hour is comprised of a traditional activity that also emphasizes lessons learned from the first hour. MICUNAY utilizes the Medicine Wheel to deliver and provide education on emotional, mental, physical, and spiritual aspects of well-being and to provide participants with a visual representation of session content. Preliminary data has revealed the potential benefits of utilizing culturally centered interventions to aid in substance use prevention among urban AIAN adolescents.⁴⁸

Discussion



GATHERING OF NATIVE AMERICANS (GONA)

The Gathering of Native Americans (GONA) is a culture-based healing curriculum that focuses on belonging, mastery, interdependence, and generosity. AIAN spirituality, traditions, and values are woven into the curriculum to reduce and prevent alcohol and other substance abuse in AIAN. The GONA curriculum was developed by a consensus of Native American professional educators and clinicians convened by the Center for Substance Abuse Prevention (CSAP) at the Substance Abuse and Mental Health Services Administration (SAMHSA) in the early 1990s.



DRUM-ASSISTED RECOVERY THERAPY FOR NATIVE AMERICANS (DARTNA)

A promising substance use treatment intervention that may help address OUD/SUD among AIANs is the Drum-Assisted Recovery Therapy for Native Americans (DARTNA). DARTNA is a substance use treatment intervention that utilizes drumming as its core component of treatment.⁴⁹ Participants attend six sessions twice weekly. Each session incorporates traditional teachings, drumming, and a talking circle. DARTNA uses the conceptual approach of the Medicine Wheel and 12-step program, developed by White Bison, Inc., and introduces participants to the four quadrants of the Medicine Wheel. This program is designed to be an introduction or review of AIAN traditional concepts of wellness. Drums are provided to participants and participants also have the opportunity to make their own personal or group Powwow drum (depending on their local Tribal traditions) that they may use during their treatment. This was planned to offer participants an educational opportunity to learn the cultural significance of drum making and to provide them with their own personal connection to their AIAN identity and commitment towards recovery. DARTNA was designed to accommodate a wide variety of Tribes and the protocol emphasizes that facilitators use their own local Tribal traditions as it relates to drumming, cultural teachings, and traditions.

Discussion



RECOMMENDATIONS

The following recommendations are based on the voices of the AIAN community members and service providers in rural and urban settings where key informant interviews and focus groups were held. Based on these perspectives, in combination with the analysis of the needs assessment team, these recommendations can assist AIAN populations in CA, policy makers, and other stakeholders to strategize achievable goals to reduce the opioid crisis.



1. Addressing Stigma for OUD in AIAN Communities
2. Address the Need for OUD Prevention in AIAN Communities
3. Increase the Availability & Access to MAT Treatment Programs
4. Increase the Availability of Culturally Centered Recovery Programs
5. Increase the Availability of Residential, Detox & Sober Living Facilities
6. Develop a More Integrated & Collaborative Systems of Care
7. Policy Recommendations to Address OUD for AIANs in California
8. Addressing Home Insecurity
9. Harm Reduction

RECOMMENDATIONS

Acceptability and efficacy of these recommendations vary by communities and selection of strategies and/or recommendations to implement should be decided by the community.

1. ADDRESSING STIGMA FOR OUD IN AIAN COMMUNITIES

The results of the needs assessment found significant challenges for youth, adults and providers regarding internal and external stigma associated with OUD/SUD. Community and provider perceptions of stigma can impact services available and utilization by communities. Several resources exist to better understand and measure stigma in communities regarding OUD/SUD. These findings can inform state policies and provide specific direction for community-based campaigns that work to reduce stigma and increase access to care. Strategies that specifically target youth, family and elders should be considered when addressing individual and interpersonal approaches to stigma reduction.

1a. Individual level - Internalized stigma of OUD/SUD (e.g., self-stigma and shame about one's own addiction) is a common internal barrier to seeking social support and recovery treatment services. Strategies to help reduce stigma for individuals with OUD/SUD included:

- Provide educational resources on the pathology of addictions, currently existing treatment options, and how they function to treat addictions.
- Address the myth that MAT services "substitute" one addiction for another when in fact prescribed medication (e.g., buprenorphine) can stabilize a patient who would otherwise have difficulty functioning without opioids.
- Include, whenever possible, individuals who have gone through the process of recovery- this would destigmatize and normalize conversations about recovery services and an individual's path to recovery as sharing personal stories can be a therapeutic process.

1b. Interpersonal Level - Stigma at the interpersonal level (i.e., negative perceptions of people with OUD/SUD, belief that opioid/substance users have control over their disorder) can have adverse impacts on those individuals with OUD/SUD. Fear of being stigmatized by others was often reported as an internal barrier to seeking treatment. Efforts towards de-stigmatizing OUD/SUD are critical in creating a respectful environment where people with addiction feel comfortable seeking the help they need. Some strategies to reduce interpersonal stigma in AIAN communities included the following recommendations.

- Utilize social media campaigns to educate about addiction and change negative attitudes towards those suffering from OUD/SUD.
- Educate about the harmful effects of stigma surrounding OUD/SUD and its adverse impact on the individuals who want to seek help.
- Share positive narratives of AIAN individuals suffering from OUD/SUD with permission.
- Interventions that target social stigma around OUD/SUD.
- Implement peer support services.
- Include family and/or friends in the treatment and/or recovery process.
- Encourage and provide home visits to deliver care and case management.



Recommendations

1c. Provider & Indian Health Clinic Level -

A critical component to reduce stigma of OUD/SUD is the patient-provider partnership. The following recommendations are possible strategies to create a safe, judgment-free environment at the Indian Health Clinic level and with health care providers included:

- Standardize screening for OUD/SUD in clinic visits.
- Create and provide educational pamphlets on addictions and available treatment services to be placed in lobbies, inside examination rooms (for privacy), or handed out by healthcare providers.
- Educate dental providers, pharmacists, nurses, and other medical staff with educational opportunities to communicate in non-judgmental ways which include an awareness of inherent bias, non-judgmental listening, modeling with verbal and non-verbal behavior-acceptance, genuineness, and empathy. While these modalities are currently used by mental health providers, training healthcare staff and providers at all levels of care can decrease stigma and create safe environments focused on wellness.

1d. Community Level - Create community level health campaigns to raise awareness and reduce stigma of OUD/SUD with information on the following topics.

- Information on addictions as a treatable health condition.
- Information on the addictiveness of opioids and other pharmaceuticals (e.g., benzodiazepines).
- Information on MAT, how it works, and available MAT/Tele-MAT centers in local area.

2. ADDRESS THE NEED FOR OUD PREVENTION IN AIAN COMMUNITIES

There is a need to increase an awareness of the opioid crisis within the AIAN communities in California. Prevention education is needed at multiple levels to reach AIAN youth, AIAN communities, health-care providers, and Tribal governments. Youth programs, culturally-specific materials, trainings, and funding mechanisms are recommended as ways to increase prevention efforts and raise awareness of the opioid crisis in AIAN populations.

2a. Youth Prevention Programs - Increase funding for and access to AIAN culturally centered youth prevention programs on substance use, particularly opioid use, for more positive youth development opportunities. Youth participants made the following recommendations.

- Increase availability of school-based prevention programs.
- Increase culture-based activities that keep youth engaged in wellness.
- Increase the availability of AIAN youth centers and programming.
- Increase culturally centered activities with positive adult role models from the community.
- Increase educational opportunities to understand substances, how they impact the human body, and understanding OUD/SUD as a health condition.
- Develop and support youth-specific mental health and trauma-informed support programs.
- Increase youth engagement on the national level regarding peer to peer recovery outreach and knowledge sharing (i.e., AIAN youth conferences, mental health conferences).

2b. Community Engagement - Participants reported the desire for youth, adult, and community involvement in educating and spreading awareness about OUD/SUD prevention. Recommendations to engage the community in raising awareness about the need for OUD prevention include the following efforts.

- Develop community forums, local coalitions, parent coalitions, youth coalitions that address issues related to OUD/SUD in the community.
- Encourage and support elder involvement in prevention strategies targeting opioid and/or substance use.
- Coordinate with city, Tribal, and county health departments to develop community gatherings (i.e., forums, coalitions) to build community partnerships and build awareness on OUD/SUD prevention.
- Invite agencies and allied groups to hear from community members about what is happening in the community and how to work together to create local strategies for addressing the needs of AIAN communities.

2c. Educate Health Care Providers - Identify ways (e.g., on-site trainings) to educate health care providers about best practices for pain and prescribing opioids, including risks and benefits of opioids and opioid alternatives.

2d. Engage Tribal Governments- Provide pipeline to funding for Tribal governments and Tribal/ Indian Clinics to create community driven best practices to help prevent future opioid-related overdoses and deaths in their communities. Give opportunities for Tribal leaders to give input and provide open dialogue on OUD topics specific to their communities. Provide education to Tribal governments to help guide prevention efforts and to create best practices to help prevent opioid-related overdoses and deaths.

2e. Culturally Appropriate Materials - Resources are needed to engage Tribal and urban AIAN communities to ensure that media messages, fact sheets, and health promotion materials are created from the community perspective. Provide funds to support local AIAN health programs and Tribes to provide culturally appropriate language and imagery, pilot testing, reproduction, and dissemination. One example is to develop a culturally specific patient education tool to be available in clinics and pharmacies to educate about the risks and benefits of prescribed medications.

3. INCREASE THE AVAILABILITY & ACCESS TO MAT PROGRAMS

There was an expressed need for additional MAT programs in local Indian Health Clinics to be available as a recovery care option. MAT is an evidence-based and trauma informed care for OUD/SUD patients. Currently, assistance to help implement a MAT program at an urban or Tribal clinic site is available through Telewell Behavioral Medicine. More efforts are needed to get clinics to connect with Telewell and access to services. Below, specific recommendations are listed to help improve availability and access to MAT treatment programs.

- Provide support for the implementation of MAT.
- Address the need for MAT trainings and buprenorphine trainings for providers serving AIANs throughout California.
- Boost access to MAT through utilization of the Internet Eligible Controlled Substance Provider (IECSP) Designation policy by IHS by expanding the use of telemedicine in rural or remote areas.
- Establish referral networks to methadone clinics and other MAT programs as needed within AIAN communities.
- Build partnerships between existing providers, programs, and consortiums currently developing best practices in expanding MAT availability within AIAN communities.
- Create and disseminate lessons learned in MAT implementation.

Recommendations



4. INCREASE THE AVAILABILITY OF CULTURALLY CENTERED RECOVERY PROGRAMS

Incorporating AIAN traditional practices and cultural values to recovery treatment models can increase opportunities for an individual to heal, improve well-being, reconnect to traditions, and increase spiritual recovery to aid in attaining/maintaining sobriety. All participant groups emphasized the importance of connecting patients to their traditional culture to reconnect them to their families, communities, and most importantly to themselves. Rebuilding trust and relationships facilitates empowerment and self-esteem for the patient to achieve sobriety. Listed below are culturally specific programs that are used in some communities.

4a. White Bison - Funding and provision of resources for recovery programs that are culturally specific for AIAN communities are essential and needed to achieve sobriety and abstinence from substance use. Wellbriety is vital to being sober and well, signifying recovering by returning to an individual's values of traditional AIAN culture to create a better life for the individual, their family and their community. It allows an individual to heal and work on well-being. The White Bison was mentioned as a culturally specific program for healing and recovery that is used by many AIAN communities. The White Bison, Inc. offers sobriety, recovery, and wellness programs based on Wellbriety, which is helping people attain sobriety while concentrating on the spiritual, mental, emotional, and physical aspects of one's well-being through cultural healing. Culturally appropriate recovery programs include the Medicine Wheel and the 12-step program for men, women, and youth with a series of modules

focused on character and values that include 1) honesty, 2) hope, 3) faith, 4) courage, 5) integrity, 6) willingness, 7) humility, 8) forgiveness, 9) justice, 10) perseverance, 11) spiritual awakening, and 12) service. Teachings of the Medicine Wheel incorporate concepts for health and healing with the four components of the wheel being represented by the different colors and symbols depending on Tribe. Also, participants share their insights and experiences in a talking circle. These available programs are valued recovery approaches and resources for AIAN communities in recovery and should be considered. For more information on White Bison programs, visit <http://www.whitebison.org>.

4b. Sweat Lodges - Sweat lodges are one way that some AIAN recovery centers and organizations treat and heal individuals working towards recovery, sobriety, and wellness. Including sweat lodges into integrative recovery programs is essential to support AIAN individuals who used this tradition or are interested in including it as a treatment option. A sweat lodge is a place of purification where ceremony is practiced by many AIAN who seek to heal, gain wisdom, and to give gratitude and pray for others. Traditionally, a sweat lodge uses intense heat where some use heated stones placed inside the lodge with water poured over the rocks to produce steam, while others may use a dry heat from a very hot fire. Ceremonial prayers and songs that are unique to Tribal beliefs and practices of the specific sweat lodge and community are conducted. This tradition is used by recovery centers serving AIANs to help with an individual's recovery process for mental and physical healing. Sweat lodges have been shown to increase an individual's spiritual and emotional well-being, particularly those in recovery with SUD.⁵⁰

4c. Healing Ceremonies - While too extensive and diverse to list here in full, the use of ceremonies in the recovery process is central and integral to AIAN communities in California. Ceremonial spaces offer AIANs safe, sober and supportive gathering spaces to express traditional forms of healing practices. These approaches to healing are as diverse as the Tribal individuals practicing them. These can include sweat lodges, talking circles, prayers, smudging, and meetings with traditional/spiritual healers. However, the commonalities of ceremonial practice and outcomes on AIAN individuals in recovery are central to respecting and supporting the fullness of healing from the effects of OUD. All efforts should be made to acknowledge, respect and support the revitalization of these ceremonial practices with the utmost reverence and flexibility for how communities implement these practices. Particular efforts should be made to educate funders and agencies on the importance of ceremonial practices and emphasize community-based evaluation approaches to traditional forms of healing.

5. INCREASE THE AVAILABILITY OF RESIDENTIAL, DETOX & SOBER LIVING FACILITIES

Residential, detox, and sober living programs serving AIANs in California represent critical infrastructure in the treatment life cycle for OUD/SUD. Working with community members and providers, the needs assessment identified several important improvements to residential programs and systems in California.

5a. Residential Program Coordination of MAT Services - Community members and providers discussed challenges associated with ongoing MAT during residential treatment including provider stigmas, community stigmas regarding sobriety

and MAT, treatment protocols for individuals receiving MAT, availability of MAT services and follow-up care. Residential treatment programs should receive necessary support and technical assistance to utilize MAT services in conjunction with residential programming.

5b. Women & Children Residential Programs and Facilities - Access to recovery services for AIAN mothers impacted by OUD/SUD remains a significant challenge that must be addressed in a statewide approach to combating the opioid epidemic. Mothers may delay or forego treatment because of this barrier, thereby placing the individual and family in greater risk of the harmful effects of OUD/SUD. Tribal and urban residential programs need support in developing resources that provide access to supportive services and housing for mothers and their children. Removing this barrier to treatment could increase the utilization of OUD/SUD recovery and provide essential prevention and support services to children affected by addiction in the family.

5c. Coordination of non-Native provider programs referrals to IHPs - Increasing access for AIANs to culturally centered services within the Indian Health system in California is critical for ongoing OUD/SUD recovery and support services. Developing statewide strategies for non-Native provider referrals to AIAN specific resources may produce higher levels of utilization of OUD/SUD resources. Additionally, linkages and plan development with appropriate resources may be a billable service in some counties. Educating providers across California on the resources available to their AIAN community members and the resources and materials that they can use with their AIAN patients will be a critical next step in addressing the opioid crisis for AIAN communities in California.

5d. Engaging Adults in Recovery & Outreach

A central outcome of the recovery process is a commitment by the individual in recovery to serve and support other individuals in recovery. Community members expressed a strong commitment to this principal and the need to develop programs that leverage this commitment to outreach to other AIANs currently in or seeking recovery across California. Engaging the knowledge and expertise of AIAN adults in recovery should be included in community, school, and provider forums. AIAN community members in recovery should be included in the planning, development, and implementation of statewide strategies addressing OUD recovery and outreach efforts.

5e. Substance Use Recovery Training & Workforce Development

To bolster the strategies aimed at increasing engagement of AIAN adults in recovery, the following were recommended to address the need to develop 'what's next' for those 'graduating' from residential or sober living programs.

- Training and workforce development programs to more seamlessly transition recovering adults with the desire to gain the skills and certifications to enter the recovery workforce.
- Existing workforce programs should be evaluated, and best practices made available to emerging programs.
- Statewide funding resources should be developed to support communities in developing programs and connecting to California resources for ongoing implementation technical assistance to sustain these efforts.

5f. Provide Additional Culturally Centered Detox for Tribal & Urban AIANs in California

One of the critical components missing from the Indian Health network in California are detox

facilities that coordinate, on a system level, with Tribal and Urban Indian Health Programs. Many community members shared their challenges accessing appropriate services during the detox process. While culture-based residential programs exist, detox centers operating on the county level often lack coordination with these residential programs or lack the resources to refer AIAN individuals to culturally based services and recovery supports. Developing Tribal and urban based detox centers for AIANs would ensure a more integrated and coordinated continuum of recovery for the treatment of OUD/SUD. Culturally informed early interventions would also provide access to traditional AIAN practices and medicines for their wellness at one of the most critical junctures in the recovery life cycle. With the integration of AIAN detox centers in California, AIANs would be able to enter the recovery ecosystem and transition more seamlessly to residential and transitional/sober living programs to sustain recovery.

5g. Sober Living & Transitional Housing for Tribal & Urban AIANs in CA

The need for sober living and transitional housing for Tribal and urban AIANs was a consistent theme throughout the needs assessment. Many community members expressed the challenge of graduating from a residential or other outpatient treatment program only to be confronted with those same challenges and patterns when rejoining their home communities. Transitional housing in Tribal and urban areas provides a safe, culturally centered recovery experience for individuals to integrate recovery tools into their home and community settings.

- Transitional housing programs based in Tribal areas offer individuals ongoing recovery support while also building skills through workforce development and job placement. Such programs can provide long term, sustained recovery while bringing more

individuals into the recovery treatment workforce. Many community members expressed a commitment to helping other AIAN people recover from OUD/SUD. However, the availability of job training and SUD recovery workforce programs is limited. Connecting newly recovered individuals with these resources can fulfill a need for more substance use recovery professionals, while at the same time, help to sustain recovery and prevent relapse.

- Due to the unique nature of Tribal health delivery, the need to develop a network of transitional housing program experts and consultants is critical. Professionals in partnership with community members should develop a task force to better understand the barriers, needs, and facilitators of developing a statewide strategy for implementing transitional housing programs in Tribal and urban areas. Funding, in conjunction with ongoing technical assistance, will be necessary to assist Tribes with implementing transitional housing programs and provide critical access to state resources and continuous evaluation and quality improvement measures for program success. Developing transitional housing is an essential step in creating a continuum of recovery services that is currently lacking in the Indian healthcare delivery system.

6. DEVELOP A MORE INTEGRATED & COLLABORATIVE SYSTEMS OF CARE

Fragmented services contribute to gaps in communication among providers from different disciplines and along different phases of the recovery continuum (e.g., detox, inpatient, outpatient, transition), creating lapses in services or insufficient follow-up that place the patient at risk for relapse. One such model to improve patient care services is the system of care model (SOC). The SOC philosophy proposes a

coordinated network of community-based services and supports that are organized to promote recovery and healing from mental health and substance abuse problems. A SOC approach to OUD/SUD services in the California AIAN population would identify individuals entering the system and assign a case manager who oversees that patient's entire comprehensive treatment plan, including emergency detox, inpatient rehabilitation, outpatient OUD/SUD treatment and outpatient psychotherapy for any co-occurring mental health issue(s), placement in sober living, traditional AIAN healing services, and connection to a recovery support group.

6a. Implement an AIAN System of Care (SOC) Navigators Program (case managers) - The case manager would be responsible for facilitating progression through the different treatment settings, as well as communication between various providers and agencies involved in the patient's continuum of care, taking the pressure off the patient to be responsible for navigating and coordinating a complex set of interventions and services. Below are strategies to integrate services outlined by key informants (See *Service System Needs*, pg. 66).

- Chronic pain management/pain management contracts
- Active case management
- Management of relapse
- Referrals
- Treat mental health comorbidities alongside OUD/SUD
- Include traditional healers and cultural Practices
- Multiple-entry points into OUD/SUD services

6b. Integration for Patient Centered Care - Integrated behavioral health care is a team effort of health care professionals working together with patients and families to provide patient centered

care. It is often referred to as a “medical home” providing expanded types of care with the whole person, mind, and body. Health care professionals involved with integrated care include physicians, nurses, medical assistants, pharmacists, traditional healers, and a behavioral health consultant. The behavioral health consultant can be embedded within the medical clinic to provide direct care as needed to a medical patient. Integration of traditional healers can also benefit the whole person by providing cultural wisdom, guidance, and non-Western healing. Warm handoffs can be made from the integrated care team to SUD counselors and psychotherapy specialists to address opioid addiction.

6c. Provide Connections to Culturally-based Services - An AIAN coordinated service system, such as an SOC approach, would also help ensure that services remained in harmony with cultural approaches to recovery from a strengths-based and integrative/holistic perspective. Such a system might even employ cultural consultants to help connect the patient to culturally-based services and/or advocate for the need for the incorporation of cultural understanding and sensitivity throughout all the services the patient is receiving.

6d. Recognizing & Funding Community Defined Evidence Practices (CDEPs) - Many AIAN programs use substance use prevention and treatment services for AIANS that are community-defined evidence practices that are accepted by the community, but are not empirically proven.⁵¹ Most funding sources for treatment, such as Medi-Cal, require the use of evidence based practices (EBPs) and do not fund cultural and traditional practices. Efforts such as Drug Medi-Cal IHP-ODS (listed above) would include these as billable services. However, there needs to be statewide recognition and funding dedicated to cultural and traditional practices that are determined by communities to reduce health disparities associated with OUD/SUD. Practices such as GONA and DARTNA have significant research and evaluation efforts that demonstrate efficacy with AIAN people, yet are currently not accepted EBPs.

7. POLICY RECOMMENDATIONS TO ADDRESS OUD FOR AIANS IN CALIFORNIA

Tribal nations, Tribal Health Programs and Urban Indian Health Programs should be consulted in

all aspects of OUD recovery service delivery and system change efforts. Funding and resource development should follow a model similar to the DHCS approach, which prioritizes Indian Health Program driven planning and strategies regarding how best to allocate resources.

7a. State Policy - The California State Legislature has proposed many changes to state law over the past few years to address the opioid crisis. Progress has been made in terms of increasing regulations of the CURES database, securing how prescriptions are written, submitted, and reviewed, and giving physicians more options to become MAT certified. However, more can and should be done on both the state and federal levels. Listed below are many other approaches that California could use to address the opioid crisis for AIAN communities.

- Removal of prior authorization requirements and limits on insurance coverage for AIANS living in California. This would increase access and utilization of MAT services by AIAN community members by reducing barriers to access and treatment services.
- Due to a significant shortage of prescribing physicians, providing financial incentives to medical providers to become MAT certified would increase the number of waived providers in Indian Health Programs and help close the gap in access.
- Charge a fee on opioid sales to be deposited in a recovery fund in order to reach many AIANS affected by the ongoing opioid crisis.
- Tighten reporting requirements on the CURES database in order to help limit access to more addictive substances such as opioids.
- Adopt policies supporting longer provider-patient interaction at each visit (i.e., greater than 20 minutes).

7b. Additional Policy Recommendations - Below are additional advocacy and coordination efforts that must be made to leverage federal resources and funding.

- Inclusion of Urban Indian Health Programs in Federal opioid response dollars and all federal opioid grants.
- Urban Indian Health Programs, along with residential treatment centers, should have access to Tribal Opioid Response Grants (TORG) and other funding allocated to AIANS.

A STATEWIDE NEEDS ASSESSMENT

- Funding for participation in/support of local, regional, statewide and national opioid coalitions.
- Allocation of funding specifically available for Tribal nations, Tribal Health Programs and Urban Indian Health Programs for prevention, intervention and treatment of OUD/SUD.
- Increase in subcontractor/contractor services allowable expenses and travel budgets to alleviate the need for community expertise, to provide training and information sharing, and to increase technical support for OUD/SUD programs.

8. ADDRESSING HOME INSECURITY

Performing outreach to the homeless/home insecure population proves challenging due to their transient nature and lack of resources; therefore, this population is often under-studied and has reduced access to services.

8a. AIAN Homelessness/Housing Insecurity Associated with OUD/SUD - Funding for further research is needed regarding the impact of homelessness/home insecure on AIAN individuals and families.

8b. Native Youth in the Foster Care System - Many AIAN youth enter the foster care system as a result of parents affected by OUD/SUD who subsequently lose custody. More funding and attention is needed to understand the link between the opioid crisis and AIAN youth in foster care. Ensuring adequate resources are developed for these youth and their families to heal and remain connected to their cultures is critical in addressing prevention and early intervention program development.

9. HARM REDUCTION

Harm reduction is a grass-roots and “user-driven” set of compassionate and pragmatic approaches to reducing the substance-related harm and improving quality of life without requiring abstinence or use reduction. Providers and community members discussed the importance of programs and resources that protect families and individuals (and their families) that are currently using opioids or other substances by providing a sense of safety (e.g., reducing the harms associated with drug use) and access to recovery

resources. One example of a harm reduction strategy includes the availability and distribution of naloxone and other opioid overdose reversal drugs to current substance users, their families and community members at large. Programs like naloxone distribution recognize substance use as a mental health issue instead of a criminal justice issue only. The creation of a California AIAN Harm Reduction workgroup could provide recommendations to Tribal and Urban AIAN Health programs, DHCS and the State of California. Listed below are potential areas of exploration.

- Safe use supplies and their availability in AIAN communities.
- Regular safe use workshops that are free and open to community (1-2-hour safer use trainings).
- Harm reduction-based support groups for families affected by OUD/SUD.
- Mandatory, regular staff trainings on harm reduction best practices (e.g., free webinars through Harm Reduction Coalition available).
- Once or twice a year host a ceremony for people who are currently using drugs (i.e., in MAT programs) where individuals do not have to be sober to attend.
- Outreach health workers for hard to reach populations and current users.
- Coalition-building with non-Native harm reduction groups to give mutual trainings and disseminate best practices.
- Paid (stipend) opportunities for participants who use drugs and participants experiencing houselessness to facilitate or co-teach workshops about health and culture. These opportunities can help these individuals make some money which affirms that their knowledge is valuable and provides them opportunities for healthcare experience to potentially get employment in the field.
- 12-week healthy community building cycles, intended to empower and entrust a small group of recurring OUD/SUD participants (including the often underserved population of women and two spirit individuals), including the following: paid participation; subsidized meals; meeting space; facilitator training; and group autonomy.

CALIFORNIA FUNDED PROGRAMS ADDRESSING OUD IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

[Tribal MAT]

A unified response to the opioid crisis in California Indian Country

The California Tribal Medication-Assisted Treatment (MAT) Projects are funded by the Department of Health Care Services to promote opioid safety, improve the availability and provision of MAT, and provider wide access to naloxone to AIAN populations in California. There are five funded Tribal MAT AIAN agencies (listed below).

For more information:

- www.californiamat.org/matproject/tribal-mat-program/



CCUIH - The California Consortium for Urban Indian Health is the statewide organization serving Urban Indian communities across California. They support health, wellness, and access to culturally centered services and programming by providing advocacy, technical assistance, subject matter expertise, and health education resources regarding urban Indian health in California. Under the Tribal MAT, CCUIH has the following activities to support Urban Indian Health Programs:

- Launching a community opioid campaign
- Distributing a training on naloxone
- Serving as MAT Champions
- Supporting opioid safety coalitions

For more information:

- <http://ccuih.org/>
- (415)-345-1205



CRIHB - The California Rural Indian Health Board (CRIHB) is a network of Tribal Health Programs to provide a central focal point in the Indian health field in California for planning, advocacy, funding, training, technical assistance, coordination, fund raising, education, development and for the purpose of promoting unity and formulating common policy on Indian health care issues. Under the Tribal MAT, CRIHB has the following activities to support Tribal Health Programs:

- Launching a community opioid campaign
- Distributing a training on naloxone
- Serving as MAT Champions
- Supporting opioid safety coalitions

For more information:

- <https://crihb.org/>
- (916) 929-9761



TeleWell Behavioral Medicine - Telewell is partnering with California Indian Health clinics and AIAN populations to provide psychiatric and addiction medicine services using telehealth technology. With the integration of culturally sensitive healing modalities and best practices, they are improving access to MAT to reduce OUD/SUD. Under the Tribal MAT, Telewell has the following activities to support AIAN populations:

- Delivering tele-MAT services
- Offering webinars and clinical consultation
- Providing MAT practice transformation support

For more information:

- <https://www.telewell.org>
- (916) 689-1062

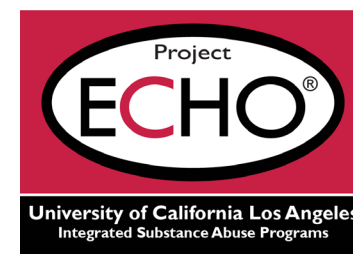


Two Feathers - Native American Family Services is a tribally chartered organization working with AIAN children and families experiencing high levels of trauma and oppression. They provide culturally based interventions to promote holistic health. Under the Tribal MAT, Two Feathers has the following activities in Humboldt County:

- Developing a Tribal Youth and Family Services Consortium
- Evaluating culturally appropriate service modalities

For more information:

- <https://twofeathers-nafs.org>
- (707) 839-1933



Tribal ECHO Project - UCLA is implementing the Project Extension for Community Healthcare Outcomes (ECHO) model to support health care providers in Urban Indian Health Programs (UIHPs) and Tribal Health Programs (THPs) in California to deliver MAT. Under the Tribal MAT, Tribal ECHO has the following supportive activity:

- Monthly 60-minute virtual Tribal MAT ECHO clinics

For more information:

- Beth Rutkowski, BRutkowski@mednet.ucla.edu
- (310) 388-7647



GLOSSARY OF TERMS

GLOSSARY OF TERMS

TERM	DEFINITION
American Indians/Alaska Natives (AIANs)	Individuals whose ancestry is Indigenous to North America
Cycle of Life	Native American traditional teachings about the four main development stages: baby, youth, adult, and elder. During the baby and youth stages, there are eight feelings and eight thoughts an individual should have developed, which are trust, independence, initiative, accomplishment, identity, intimacy, generativity, and integrity. These teachings are a component of Wellbriety.
Controlled Substance Utilization Review and Evaluation System (CURES)	A database monitoring the distribution of prescribed federally scheduled medications in California. The California DOJ database monitors the prescribing of these DEA scheduled medications in all states, including California.
Four Laws of Change	Native American traditional teachings that focus on four principles a person can follow to experience a change in their lives. These principles are changing the self, following a vision of what change can look like, including others to be a part of the change, and creating a continuous pattern of healing.
Evidence-Based Practice	An approach that uses a combination of current research findings, professional expertise, and patients' views to offer the best health services.
Gathering of Native Americans (GONA)	A culture-based healing curriculum that focuses on Belonging, Mastery, Interdependence, and Generosity. Native American spirituality, traditions, and values are woven into the curriculum to reduce and prevent alcohol and other substance abuse in Native American communities.
Health Navigator	A health professional who supports patients by guiding them through the healthcare system. This can include assistance with accessing different types of health services, arranging appointments, and educating patients on the health system. Also, known as a patient navigator.
Historical Trauma	Historical trauma is a cumulative emotional harm that an individual experiences that results from traumatic events such as forced assimilation, extermination and genocide, relocation and containment, and the boarding school era.
Intergenerational Trauma	Intergenerational trauma is considered as the transmission of historical oppression and its negative consequences across generations.
Medication Assisted Treatment (MAT)	A treatment option for opioid use disorders using prescribed medications in combination with behavioral therapy and counseling.

TERM	DEFINITION
Medicine Wheel	The Medicine Wheel incorporates concepts for health and healing with the four components of the wheel being represented by the different colors and symbols depending on Tribe. For example, colors may include yellow, red, black, and white and symbols representing the north, south, east and west.
Mental Health Comorbidities	The coexistence of both a mental illness and a substance use disorder is also common among people in MAT. This is referred to as having co-occurring mental and substance use disorder.
Opioid Use Disorder (OUD)	A chronic health condition developed from the continued use of opioids that negatively impacts one’s health, work, personal relationships, and other areas of life.
Practice-Based Evidence	Practice-based evidence represents practices that come from the local community.
Post-Traumatic Stress Disorder (PTSD)	A mental health condition that may result from an individual experience of a frightening or stressful event, and they are having difficulty coping. Some common symptoms associated with this condition are flashbacks of the event, recurring nightmares, and feelings of anxiety.
Red Road	Red Road is a metaphor that refers to living a substance free life by following the philosophy used by individuals throughout AIAN communities with the goal of living a spiritually connected way of life while “walking the Red Road.” It is intended to capture a deep sense of obligation and creating a meaningful personal commitment to purposefully live your life each day substance free.
Substance Use Disorder (SUD)	A chronic health condition developed from the continued use of alcohol and/or drugs that negatively impacts one’s health, work and personal relationships, and other areas of life.
Sweat Lodge	A sweat lodge is a place of purification where ceremony is practiced by many AIAN who seek to heal, gain wisdom, and to give gratitude and pray for others. Traditionally, a sweat lodge uses intense heat where some use heated stones placed inside the lodge with water poured over the rocks to produce steam, while others may use a dry heat from a very hot fire. Ceremonial prayers and songs are conducted but are unique to Tribal beliefs and practices that are particular to a specific sweat lodge and community. The sweat lodge is designed to provide a safe, sacred place where one can focus on their connection to the spiritual world.
Talking Circle	A traditional healing practice that incorporates culture, knowledge, and values and is similar to group counseling with aspects of community gathering and connections without necessarily having direct therapeutic emphasis. This instills traditional education to respect the views of others by listening without crosstalk or interjections.



TERM	DEFINITION
Traditional Practices	Traditional practices include various approaches, knowledge, and beliefs incorporating healing and wellness using natural and holistic ceremonies with consideration for the cultural and/or Tribal identity of patients.
Tribal Health Programs (THPs)	Tribal Health Programs, are healthcare programs and facilities who provide care to AIAN living in Tribal and rural areas. THPs are controlled and sanctioned by the Indian people, and their Tribal Governments to provide healthcare within their region.
Urban Indian Health Programs (UIHPs)	Urban Indian Health Programs, are health programs and facilities who provide care to AIAN persons living in urban areas.
Warm Hand-Off	An approach used by healthcare professionals when transferring a patient from one health professional to another. This usually takes place in person, so the patient becomes acquainted with their new healthcare provider.
Wellbriety	Wellbriety means to achieve sobriety and maintaining to be substance-use free. This is achieved by healing and finding balance (mentally, spiritually, physically, and emotionally).
White Bison	A nonprofit organization focused on developing culturally tailored healing programs and resources for substance abuse recovery, addiction prevention, and wellness for AIANs.



APPENDIX

APPENDIX A - KEY INFORMANT INTERVIEW QUESTIONS

Key informant interview questions were used to assess substance use trends, protective and risk factors to substance use, availability and treatment and recovery services (e.g., MAT programs), and challenges to addressing the opioid crisis in AIAN populations.

KEY INFORMANT NEEDS ASSESSMENT DOMAIN QUESTIONS

Description of Substance Use in Community

1. What types of substances are most commonly seen in your community's Native American population with substance use disorder?
2. Please name the three most common substances seen in your community.

Risk Factors

1. What are some risks or stressful events that may contribute to substance use disorder in the Native American community?
2. What are some co-occurring mental health conditions in your area which frequently complicate substance use disorder treatment? (For example, use of drugs or alcohol and mental illness (depression, PTSD, anxiety, etc.)

Medication Assisted Treatment (MAT) Programs and Other Available Support Service Systems

1. What *prevention services* for substance use disorder services are available in your community?
2. What substance use disorder treatment and services are available in your community?
3. Have you heard of Medication Assisted Treatment, otherwise known as MAT?
 1. If no, explain what it is and ask if they would like to have MAT offered in their organization.
 2. Probe: What are some perceived barriers of MAT use that patients have shared?
 3. Probe: What are some perceived barriers of MAT implementation in your organization?
4. What additional substance use disorder services are needed for Native Americans in your community?
 1. Probe: Are there any opioid use disorder treatment needs in your community?

Integrating Cultural Way of Life

1. Does the Native American community seek services from traditional healers?
2. What types of cultural and traditional services are currently used by the Native American population in your community to address substance use disorder?

Barriers to Accessing Services

1. What kinds of barriers do Native Americans in your community face when trying to access substance use disorder treatment services?

Factors That Facilitate Effective Treatment

1. Speaking generally to the Native American patients you see and are served by your organization, can you describe what you see as protective and preventive factors from substance use disorder?
 1. Probe: How about opioids specifically?

APPENDIX B - FOCUS GROUP QUESTION GUIDE

Adult and youth focus group questions were used to assess substance use trends, protective and risk factors to substance use, availability and accessibility of treatment and recovery services, and needs and barriers to addressing the opioid crisis in AIAN populations.

YOUTH AND ADULT FOCUS GROUP NEEDS ASSESSMENT DOMAIN QUESTIONS

Questions to Assess Community/Social Norms Around Opioid/Substance Use.

1. What does substance use look like in your community? COMMUNITY CAN MEAN WHERE YOU LIVE, or your local neighborhood. It can also mean your day to day life with your friends and/or your family.
2. Which substances do you think causes the most problems in your Native community? [write answers on white board; next, go around the room and ask each person to provide top 3 substances. Place a check mark next to answers and tally up to determine the top 3 voted by group.]
3. Have substance use problems increased or decreased in your community?
4. (get a show of hands) Do you know anyone who is addicted to opioids or other substances? (write down the number of people who raised their hands)

Questions to assess access to substances.

1. Where do people get substances in your community?
2. Do you think there is anything that could be done to make it harder to access substances?

Questions to assess risk/resilience for substance use

1. What kinds of individual factors you think contribute to substance use in your community?
2. What kinds of community factors you think contribute to substance use?
3. What strengths does the community have to HELP ADDRESS the use of SUBSTANCES?
4. What role (if any) do you think Native culture might play in addressing the problems with substance abuse?

Questions to assess services system needs and barriers

1. What kinds of services are available in your community for people who want help with addiction?
2. What kinds of services would you like to see more of to help with addiction?
3. Are available services being used by people in your community?
4. Are services in your community appropriate for Native people?

Wrap up Question: (go around and have everyone respond)

1. What advice would you give to us as we plan future services for Native people with substance addiction?

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