



TRIBAL OPIOID RESPONSE



STRATEGIC PLAN
Rocky Mountain | 2020-2022



Rocky Mountain Tribal Leaders Council

2929 3rd Avenue North, Suite 300, Billings, Montana 59101

Ph: (406) 252-2550

Fax: (406) 254-6355



Dear Rocky Mountain community members and partners,

The opioid epidemic has impacted all communities in our Nation. As this epidemic continues, we have seen the impacts strike too close to our homelands. Opioids are powerful substances that makes it difficult for our family members, friends, and relatives to regain control. In response to the opioid epidemic, the Rocky Mountain Tribal Leaders Council (RMTLC) has updated our Opioid Strategic Plan to reduce the prevalence of opioid overdose, opioid use disorder, and stimulant use disorder among our American Indian populations residing in the Rocky Mountain region.

Our Tribal Opioid Response (TOR) project team has spent the past three-months reviewing data, disseminating questionnaires, and collecting personal stories from those impacted by opioids and stimulants misuse and those who provide direct/in-direct services. As we move forward, our goal is to maintain a community-centered, culturally based program that builds on numerous efforts from our Tribal, Urban, non-profit, City, County, State, and other partners/entities.

We hope this document provides valuable in-sight as we help bridge the gap in reducing opioid and stimulant misuse.

Sincerely,

William F. Snell, Jr.

RMTLC Executive Director

Rocky Mountain Tribal Leaders Council

We would like to thank our Tribal and urban American Indian populations, leaders, health directors, executive directors, and RMTLC staff for their feedback during this strategic planning process. American Indian populations are resilient and resourceful, especially during times of difficult situations. The Tribal Opioid Response Strategic Plan Rocky Mountain Region 2020-2022 was produced by the Rocky Mountain Tribal Leaders Council (RMTLC) Tribal Opioid Response (TOR) project with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Opioid Response grant (award no. 6H79TI083252). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the funders.

CONTACTS

William F. Snell, Jr., RMTLC Executive Director
william.snell@rmtlc.org

Pharah D. Morgan, TOR Project Director
pharah.morgan@rmtlc.org

Lacey Gonzales, TOR Project Coordinator
lacey.gonzales@rmtlc.org

Leah Big Hair, TOR Administrative Assistant
leah.bighair@rmtlc.org

Lani Paulson, RMTLC TEC Health Data Analyst
lani.paulson@rmtlc.org

For more information about RMTLC,
the TOR project and their services visit
www.rmtlc.org

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ABBREVIATIONS/ACRONYMS LIST

NAME	ACRONYM
American Indians and Alaskan Natives	AIAN
Centers for Disease Control and Prevention	CDC
Drug Enforcement Administration	DEA
Emergency Medical Services	EMS
Epidemiology Data Mart	EDM
Food and Drug Administration	FDA
International Statistical Classification of Diseases and Related Health Problems	ICD
Indian Health Service Billings Area Office	IHS-BAO
Medication Assisted Treatment	MAT
National Survey on Drug Use and Health	NSDUH
Opioid Use Disorder	OUD
RMTLC Tribal Epidemiology Center	RMTLC-EC, RMTEC
Rocky Mountain Tribal Leaders Council	RMTLC
Stimulant Use Disorder	SUD
Strengths, Weaknesses, Opportunities, Threats	SWOT
Substance Abuse and Mental Health Services Administration	SAMHSA
Tribal Opioid Response	TOR
Tribal Epidemiology Center	TEC
Tribal Epidemiology Center Public Health Infrastructure	TEC-PHI
Public Health Workforce Expansion in Indian Country	PHWEIC

EXECUTIVE SUMMARY

ABOUT US

The Rocky Mountain Tribal Leaders Council (RMTLC) is a Tribal organization that serves more than 100,000 American Indians in the States of Montana, Wyoming, Idaho, and the Piikani Nation. RMTLC is dedicated to improving the health, economic development, and education for Tribes and their members through a variety of programs, policy recommendations, and Tribal Leaders meetings. The Tribal Opioid Response (TOR) project is a two-year Substance Abuse and Mental Health Services Administration (SAMHSA) funded grant to address the opioid crisis in Tribal and urban communities. Below are the key findings of the RMTLC TOR Strategic Planning processing that identifies focus areas and recommendations for reducing AI opioid misuse prevalence in the Rocky Mountain region.

KEY FINDINGS

In our approach to reducing the prevalence of opioid misuse among Rocky Mountain AI populations: SWOT analysis identified our need to strengthen existing partnerships and increase the number of cultural activities that instill a sense of culturally belong and identity.

Partner questionnaire. With regard to data access, there is a need to establish site-specific databases to increase timeliness and tracking of substance misuse trends. For prevention, we need to increase in the number community drug take back events and increase access MAT prescribing for individuals with opioid misuse. Although naloxone certification has increased the number of individuals who carry naloxone for reducing overdose deaths, referral systems should allow individuals with substance misuse to access to cultural, spiritual, and peer support services.

Community questionnaire. Community respondents reported knowing signs of opioid misuse and overdose. However, based on measures, there is a need for culturally tailored educational materials that reduce stigma with person-first language.

RECOMMENDATIONS

- The following overarching themes to address opioid and stimulant misuse:
1. Prevention—increase number of cultural activities, educational materials
 2. Treatment—reduce barriers to Medication Assisted treatment.
 3. Harm Reduction and Recovery Support—promote harm reduction strategies of fentanyl test strip availability, information for accessing safe syringe services/programs, drug disposal, and peer support services.
 4. Monitoring—establishing partnerships for more timely access to opioid data.

Other multifactorial recommendations in addressing opioid and stimulant misuse:

- ♦ Racial misclassification—the data show disparities where AI individuals are classified as other racial/ethnic groups.
- ♦ De-stigmatizing approaches and strategies

As we move forward, the TOR project will remain community-based by promoting evidence-based strategies and recognize the importance of self-belonging. We are committed to strengthening our partnerships with Montana Urban Indian Health Centers and Tribal Nations.



The Rocky Mountain Tribal Leaders Council (RMTLC, formally the Tribal Chairman Association-1994 and the Montana-Wyoming Tribal Leaders Council-2015) is a Tribal organization that serves more than 100,000 American Indians (AI) in the States of Montana, Wyoming, Idaho, and the Piikani Nation of Canada. RMTLC is dedicated to improving the health, economic development, and education for the Tribes we serve, and their members, through a variety of programs, policy recommendations, and Tribal Leaders meetings. For over 20 years, RMTLC’s mission has been to preserve the homelands, defend the rights of the Indian Treaties with the United States, speak in a unified voice, offer support to AI people, offer a forum in which to consult with, and enlighten, each other about AI people, and to otherwise promote the common welfare of all the Indian People of Montana, Wyoming, and Idaho. RMTLC is governed by a Board of Directors which is representative of the Tribes we serve. Our board is comprised of Tribal Leaders from the following Tribes: Blackfeet Tribe, Chippewa Cree Tribe of Rocky Boy, Fort Belknap Indian Community, Northern Cheyenne Tribe, Crow Tribe, Little Shell Tribe of Montana, Confederated Salish & Kootenai Tribes, Eastern Shoshone Tribal Council, Northern Arapaho Tribal Council, Shoshone Bannock Tribes of Fort Hall of Idaho, and the Piikani Nation of Canada.



INTRODUCTION

TRIBAL OPIOID RESPONSE PROJECT

The Tribal Opioid Response (TOR) project is a two-year SAMHSA funded grant awarded to RMTLC (award no. 6H79TI083252) to address the opioid crisis in Tribal and urban AI communities by increasing access to culturally appropriate and evidence-based treatment, including Medication-Assisted Treatment (MAT) services. In addition, the intent is to reduce the unmet treatment need and opioid overdose-related deaths by increasing prevention, treatment, and recovery support services for opioid use disorder (OUD) and other stimulants (cocaine and amphetamines). The focus population for this grant funding are urban AI populations served through Urban Indian Health Centers and the Little Shell Tribe of Chippewa Indians of Montana.

RMTLC previously received TOR funding (2018-2020) to provide training for Tribal TOR grantees and chemical dependency staff through strategic planning, implementation of various cultural activities, and development of partnership networks in the Rocky Mountain region.

ROCKY MOUNTAIN TRIBAL LEADERS COUNCIL EPIDEMIOLOGY CENTER

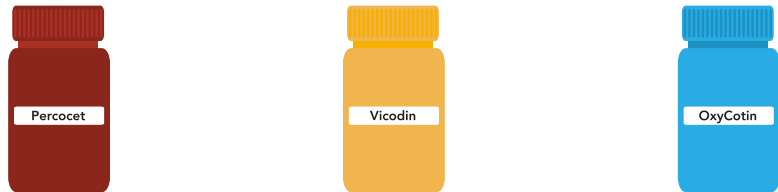
Housed under RMTLC, the Rocky Mountain Tribal Leaders Council, Epidemiology Center (RMTLC-EC or RMTEC), is a community participatory epidemiology center established in 2005 under a cooperative agreement with the Indian Health Service (IHS). RMTEC determines the health priorities of the region through surveillance, data collection, and public health interventions to further target health disparities and improve health outcomes of the American Indian population in Montana and Wyoming.

The CDC 1704: Tribal Epidemiology Center Public Health Infrastructure (TEC-PHI, award no. NU58DP006386-04-01) grant is a CDC cooperative agreement that complements IHS funding to increase Tribal Epidemiology Center (TEC) public health capacity and infrastructure. The purpose of TEC-PHI is to reduce programmatic silos within TECs and expand their ability to perform their core functions by building data infrastructure, increasing staff capacity and establishing partnerships. The CDC 1704: TEC-PHI Opioid supplement grant provides funds to TECs to support data infrastructure and epidemiologic surveillance, improve racial classification, expand data sharing to prevent fatal and nonfatal opioid overdoses, and improve death certificate data to reflect opioid-related deaths.



OPIOIDS

Opioids, also known as narcotics or opiates, are a class of drugs that work in the brain to dull the senses and relieve pain (Abuse, 2020a). Opioids are available as prescription medications (i.e., painkillers) or alternatively as street drugs (i.e., Heroin). Natural opioids are sourced from the poppy *Papaver somniferum* plant while other synthetic opioids are laboratory made with higher potency (i.e., meperidine, fentanyl, and methadone) (Narcotics (Opioids) | DEA, n.d.). Opioid use can result in feelings of relaxation, pain reduction and can become addictive if not used as prescribed. Common side effects can include constipation, nausea, confusion, and drowsiness, and/or slowed breathing may occur. The most common opioids are:



- ♦ Common prescription opioids: OxyContin, Vicodin, and Percocet
- ♦ Semi-synthetic opioids, containing natural opium: morphine, codeine, heroin (illegal drug), oxycodone, hydrocodone, and hydromorphone.
- ♦ Synthetic opioid: fentanyl (50-100 times stronger than morphine)

Many risks are associated with continued use or not using medications as prescribed. Prolonged use can lead to opioid use disorder (OUD) since tolerance and dependence increase overtime. Opioids impact breathing at higher doses and place individuals at risk of fatal overdose.

OPIOIDS HISTORY AND EPIDEMIC

Since the Civil War (1861—1865), opioids were used to treat pain, setting the stage for future addictions and dependencies. Between 1910—1920s, the U.S. passed formal narcotics restrictions that required written prescriptions for access as well as outlawing heroin use (Georgetown Law, 2020). The current opioid use epidemic stems from three waves; first, during the 1990s, an increase in opioid prescribing (natural and semi-synthetic opioids and methadone) with a resulting increase in overdose-related deaths was observed (Vital Signs, 2011); second, an increase in overdose-related deaths due to heroin use occurred (Increases in Heroin Overdose Deaths — 28 States, 2010 to 2012, 2014); and third, an increase in the use of synthetic opioids, manufacturing of illicit fentanyl, as well as an increase of counterfeit pills and cocaine became prevalent (Gladden, 2016; O'Donnell, 2017b, 2017a). Various efforts and policies have targeted over-prescribing and aggressive marketing, efforts have also focused on revising prescribing practices to properly identify pain before prescription treatment, using medication assisted treatments (MAT), and reducing fatal overdoses through harm reduction practices and services (Georgetown Law, 2020). Despite extensive documentation on opioids, the opioid epidemic in the United States remains a national public health crisis (Lyden & Binswanger, 2019).

The National Survey on Drug Use and Health (NSDUH, 2019), an annual population-based survey, reports prevalence of prescription misuse among individuals 12 years and older was 3.5% (or 9.7 million people), where individuals 18-25 years, reported highest use (5.2% or 1.8 million people) (Lipari, 2019). NSDUH collects information regarding the misuse of the prescription drugs hydrocodone, oxycodone, tramadol, codeine, morphine, prescription fentanyl, buprenorphine, oxymorphone, and hydromorphone. The Centers for Disease Control and Prevention (CDC, 2016) estimates opioid overdose deaths were higher in men (18.1 per 100,000 deaths) than women (8.5 per 100,000) and among those 25-34 years (25.9 per 100,000) and 35-44 years (24.1 per 100,000) (Hoots et al., 2018). However, prevalence differs regionally. The number of US overdose deaths (2015) is estimated to be 52,404 deaths, of which 63.1% were attributed to opioid use (Seth et al., 2018). The research has observed men are disproportionately impacted by opioid use more than women (Jones et al., 2015).

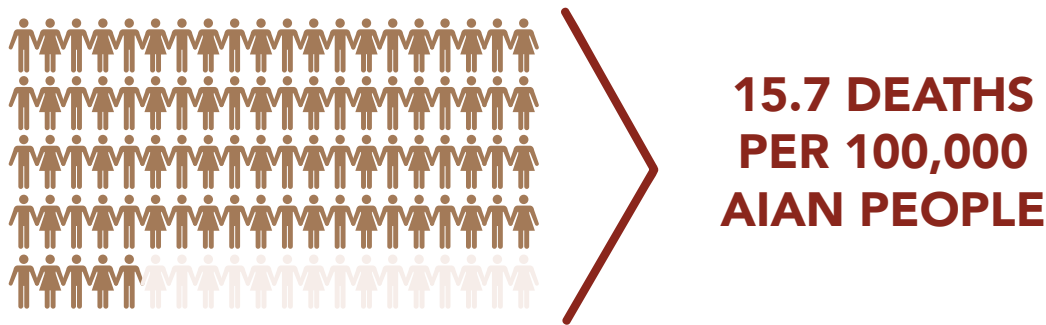
According to Agency for Healthcare Research and Quality, in 2017 the national rate of opioid-related inpatient stays was 299.7 per 100,000 people (Agency for Healthcare Research and Quality, n.d.). Estimates for Montana (294.4 per 100,000 people) and Wyoming (127.6 per 100,000 people) were slightly below national estimates. Drug overdose is the fourth leading cause of injury-related death in Montana (Montana EMS and Trauma Systems Section, 2021a). Between 2014-2019, 712 Montanans died and 37.5% of those deaths were attributed to opioids (Montana EMS and Trauma Systems Section, 2021b).

COVID-19 AND OPIOIDS

The novel Coronavirus disease 2019 (COVID-19) health pandemic has not only impacted the world but has worsened the opioid crisis where estimated overdose rates have increased by 22.8% from July 2019 to July 2020 (Mace et al., 2021). However, the impacts of the pandemic have created unique ways of addressing the opioid crisis by operational changes, supply distributions, technology adaptations, resources and tools, and focusing on partnerships and collaborations.

OPIOIDS IMPACT ON INDIAN COUNTY

American Indians and Alaskan Native (AIAN) populations have the second highest opioids overdose rates (15.7 deaths per 100,000 people) among all US racial/ethnic groups (Mattson, 2021). Despite national reports of AIAN populations are disproportionately impacted by opioid use and a paucity of region-specific information on AIAN opioid misuse is a gap. Many factors could explain these gaps such as untimely reporting, gaps in surveillance, or racial misclassification (Environmental Scan of Tribal Opioid Responses: Community-Based Strategies and Public Health Data Infrastructure, 2019).



AI URBAN POPULATIONS: PRESCRIPTION DRUGS AND ILLICIT DRUG USE

An estimated 0.8% of AIANs populations reside in various urban city centers across the US where 40.0% are under the age of 25 (UIHI Community Health Profile 2016 Aggregate Report, 2016). Compared to Non-Hispanic Whites (NHWs), AIANs experience over two times higher unemployment (15.8% vs. 7.4%) where many have income below the federal poverty line. With regard to prescription misuse and dependence, urban AIANs have approximately three times higher past year use compared to NHWs (2.3% vs. 0.8%) (UIHI Community Health Profile 2016 Aggregate Report, 2016). Data from the 2009-2014 National Survey on Drug Use and Health report illicit drug use from the following substances: hallucinogens, inhalants, tranquilizers, cocaine, heroin, nonmedical use of pain relivers, stimulants, and sedatives (Lipari, 2019). Illicit drug use among urban AIANs is higher than NHWs in the past month's use (7.0% vs. 3.7%) (UIHI Community Health Profile 2016 Aggregate Report, 2016).

ROCKY MOUNTAIN AI TRIBAL COMMUNITIES

As shown in Table 1, the majority of opioid prescriptions from 2016-2019 were: hydrocodone, tramadol, and codeine. Hydrocodone was consistently prescribed as the top opioid prescription (2016: 35.8%, 2017: 35.1%, 2018: 36.3%, and 2019: 36.1%) followed by tramadol and codeine within Rocky Mountain AI Tribal communities. Most recently, oxycodone has become the fourth most prescribed opioid (9.2%, 2016, and 13.4%, 2019) (RMTEC, 2021). Although opioid exposure among individuals has reduced since 2016, opioid use remains prevalent (Table 1 below).

Table 1. Top 5 Opioid Prescriptions 2016 - 2019

2016	Hydrocodone	Tramadol	Codeine	Morphine	Oxycodone
2017				Morphine	Oxycodone
2018					
2019					

Note: Data provided by Rocky Mountain Tribal Leaders Council Epidemiology Center from Indian Health Service —National Data Warehouse (Fiscal Years 2016 - 2019) for Billings Area Office (BAO) Tribes for all age groups.

From 2016-2019, there has been a total of 1,558 healthcare encounter drug-related visits within Billings Area IHS service units and 9.6% is attributed to opioid poisoning. Many of these encounters have observed higher healthcare visits among AI women than men and higher prevalence among individuals 18-29 years (49.7%) and 30-44 years old (23.9%) than all other age groups (RMTEC, 2021).

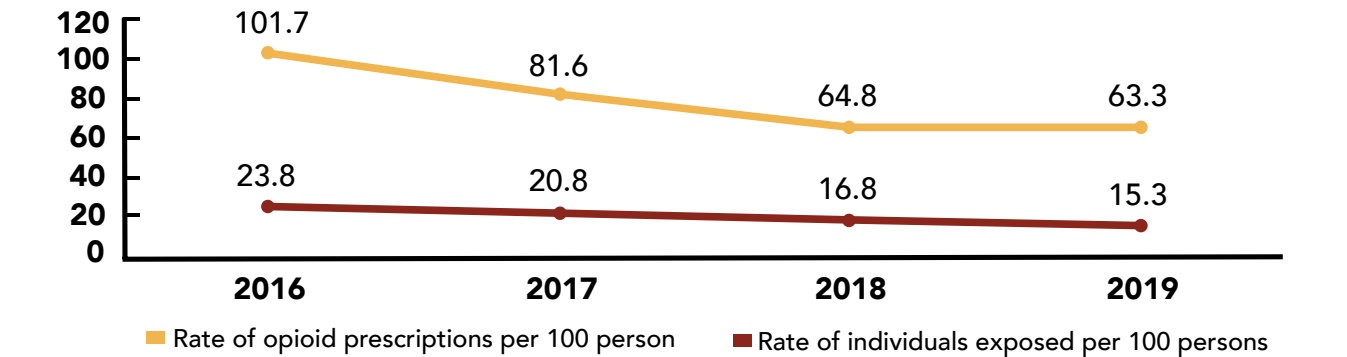


Figure 1. Age-adjusted rates of opioid prescriptions and persons exposed to opioids among American Indians self-reporting residence in the Billings Area Service Unites, Fiscal Years 2016-2019, Indian Health Service National Data Warehouse.

Drug overdose is the fourth leading cause of injury-related death in Montana (Montana EMS and Trauma Systems Section, 2021a). Between 2014-2019, 712 Montanans died and 37.5% of those deaths were attributed to opioids (Montana EMS and Trauma Systems Section, 2021b).

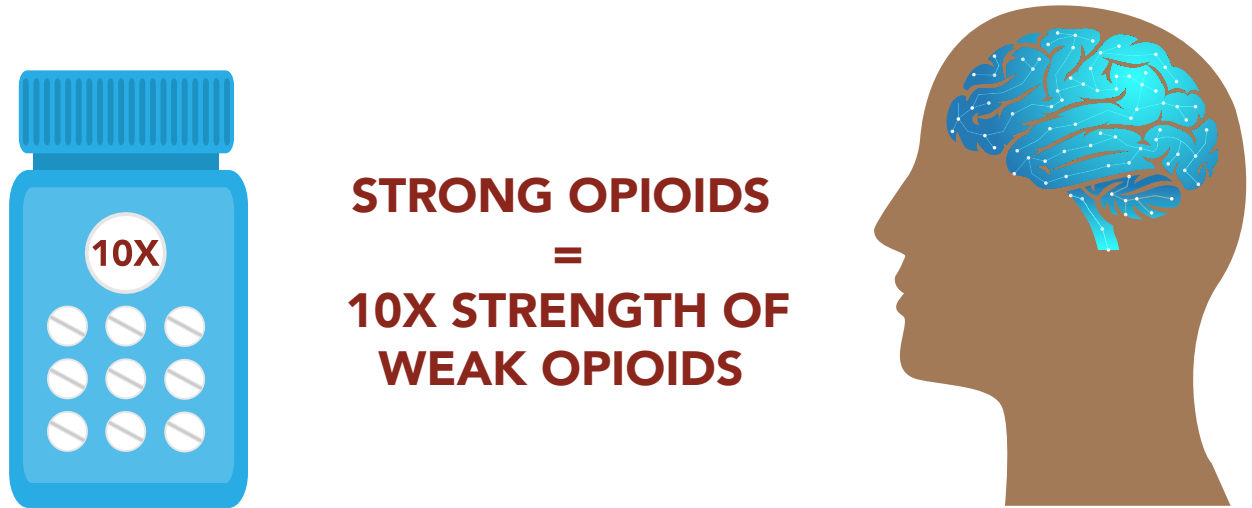
TREATMENTS AND HARM REDUCTION

Naloxone, also referred to as NARCAN or Evzio, is a pharmaceutical medication used to reverse an opioid overdose (Abuse, 2020b). Naloxone works to block the effects of opioids on brain receptors in order to “counteract the life-threatening impacts of decreased functioning of central nervous system and respiratory systems to restore normal breathing”(“Understanding Naloxone,” n.d.). There is no potential for abuse and there are various modalities available to administer naloxone. The Food and Drug Administration (FDA) has three approved naloxone forms: injectable, auto injectable, and prepackaged nasal spray (Abuse, 2020b). Naloxone is available through emergency medical services (EMS), hospital/clinic emergency departments, public safety officers, or individuals that have completed naloxone certification to carry and administer.

Various evidence-based treatment approaches to drug addiction are available to assist individuals in abstaining from opioid and stimulant misuse. These approaches are often used for other forms of substance misuse (i.e., alcohol use, commercial tobacco use, etc.) and are divided into two categories: pharmacotherapies and behavioral therapies (National Institute on Drug Abuse, 2012). Pharmacotherapy is defined as medical treatment using pharmaceutical drugs.

The FDA has approved three MAT (Medication-Assisted Treatment) medications for opioid addiction and misuse: methadone, buprenorphine, and naltrexone. MAT medications work in the brain by interacting with the same brain receptors that are targeted by opioid misuse. Each treatment medication is based on the level of opioid dependence and is safe for short- or long-term use.

Opioid use causes feelings of euphoria by stimulation of brain receptors in quick and short bursts, to counteract this, opioid medications act in various forms: agonist, partial agonist, or antagonists. Agonists are compounds that bind to activate a receptor in the brain to produce a biological response. Partial agonists are similar to agonists but have a weaker effect, and antagonists will block receptors in the brain.



STRONG OPIOIDS
=
10X STRENGTH OF WEAK OPIOIDS

Methadone. Methadone is a long-acting synthetic opioid agonist that prevents withdrawal symptoms and reduces cravings, blocks effects of illicit opioids, it is taken orally by adults and offered only through licensed opioid treatment programs it is available in all states except three. Adherence increases when paired with counseling services. Unfortunately, methadone is harder to find and not always available. In addition, methadone is primarily taken by those considered middle aged (i.e., 40-50 years of age). (National Institute on Drug Abuse, 2012)

Buprenorphine. Buprenorphine is a synthetic opioid that acts as a partial agonist of opioid receptors with no reported euphoric feeling, reduced/eliminated withdrawal symptoms, and has a low overdose risk. Since 2002, physicians can prescribe buprenorphine through Drug Enforcement Administration (DEA) training and DATA waivers. Currently, there are more urban physicians with DEA DATA waivers than rural physicians. As noted in various studies, buprenorphine has several advantages: (1) increased availability; (2) it is as effective as methadone; (3) the FDA has approved its use for those as young as 16 years old; and (4) it is effective at reducing neonatal abstinence syndrome when taken by pregnant women with OUD. Counseling services from mental health professionals (i.e., psychologists, social workers, peer counselors/mentors, psychiatrists, and addiction specialists) is generally recommended with a buprenorphine prescription. (National Institute on Drug Abuse, 2012)

Naltrexone. Naltrexone is a long-acting synthetic opioid antagonist that blocks the binding of opioid receptors to prevent euphoric effects. Naltrexone has no potential for abuse; however, compliance is a barrier. Therefore, it is recommended for those who are highly motivated to quit. Currently, there are no primary care setting studies that demonstrate compliance rates among AIs with OUD since the majority of study populations are those recently incarcerated. (National Institute on Drug Abuse, 2012)

MAT is effective for treating OUD since: (1) it decreases opioid use among people with substance use disorders; (2) survival rates are improved among those individuals with opioid addiction; (3) treatment retention rates are increased; (4) individuals are better able to find jobs and remain employed; and (5) it is safe for pregnant women with opioid addiction leading to improved birth outcomes.

Behavioral therapy is used to treat mental health disorders by identifying unhealthy behaviors and engaging individuals to modify their behaviors. These approaches can include options such as providing a motivational incentive, teaching skills to handle stressful situations and learning to identify cues that trigger substances misuse. A brief description of types of therapies are described below.

Cognitive Behavioral Therapy (CBT). Individuals learn to identify problematic behaviors and apply coping strategies to stop substance abuse, which remain after the completion of treatment. This therapy has been applied in alcohol, stimulant, opioid, marijuana, and nicotine use.

Contingency Management Interventions/Motivational Incentives. Based on positive reinforcement in which the individual is given incentives/rewards for abstinence. Rewards vary, such as participants receiving a voucher or item for every drug-free urine sample or attending weekly counseling sessions. This therapy is used in alcohol, stimulant, opioid, marijuana, and nicotine use.

Community Reinforcement approach plus vouchers. An intensive outpatient therapy where individuals attend counseling sessions that focus on family relationships, coping strategies, building positive and supportive social networks, and individual engagement. This therapy is most often used to address alcohol, cocaine, and opioid use.

Matrix Model. In this model, individuals learn about addiction and relapse, and the therapists' function in role of teacher or coach to reinforce positive behavior change. It promotes patient engagement and is often used to address stimulants (i.e., methamphetamine and cocaine) misuse.

12-Step Facilitation Therapy. The focus is to understand that drug addiction is chronic and can result in lower levels of autonomy. Abstinence is the only alternative promoted and requires active involvement in meetings/activities. It is most often used to address alcohol, stimulants, and opioid misuse.

Family Behavioral Therapy. Used among both adults and adolescents, it combines contingency management as well as entering into a behavioral contract. It also addresses other factors that promote substance misuse and instead sets goals and teaches coping skills.

Harm reduction is a person-centered approach that meets people where they are. Harm reduction uses practical strategies to reduce the harms of substance use with the ultimate goal being to improve the health and function of each individual (Harm Reduction Learning Lab, n.d.). Various opioid programs use harm reduction strategies such as safe syringe needle exchange, prescription drug disposal programs, fentanyl test strip availability, and naloxone availability.

PURPOSE

In response to the opioid epidemic in Indian Country, the purpose of the 2020-2022 Tribal Opioid Response Strategic Plan is to update the previous strategic plan (dated: November 2018) by understanding opioid use prevalence, determine existing available resources in the Rocky Mountain region for addressing the opioid epidemic, increase cross-sector collaborations, identify and address opioid workforce gaps, and provide a guided approach to reducing opioid prevalence among AI populations. RMTLC TOR project has reviewed existing information, generated surveys from both the general population and cross-sector partners, and incorporated feedback from Tribal leaders in producing this document.





OBJECTIVES

The overall objective of the Tribal Opioid Response 2020-2022 Strategic Plan is to develop a strategic approach that meets the needs of Rocky Mountain’s ten AI Tribal communities and urban AI populations to address the opioid epidemic. The intent is to develop a community focused framework that integrates:

- ◆ Existing, available opioids information
- ◆ Input from respective Tribal Leaderships, Tribal Health Departments, and urban Montana Indian Health Centers
- ◆ Capture and understand the available resources from regional opioid-related workforce
- ◆ Understand general AI population’s knowledge, awareness, and stigma towards opioids, opioid use disorder (OUD) and stimulant use disorder (SUD).

Our strategic planning process involved four phases to produce the Rocky Mountain Tribal Opioid Response 2020-2022 Strategic Plan.

METHODS

PHASE 1: REVIEW EXISTING RESOURCES, AVAILABLE DATA, AND SWOT ASSESSMENT

The first phase of our strategic planning process was to understand the existing opioid-related data specific for AI populations, determine available resources (i.e., behavioral/mental health counseling, naloxone/NARCAN availability, MAT, etc.) and understand our organizational capacity to address the opioid epidemic in the Rocky Mountain region.

We reviewed available information from various entities (January—February 2021): Montana Department of Public Health and Human Services (DPHHS), State of Wyoming Department of Health (DOH) Prevention Depot, Montana urban city centers (i.e., Billings, Butte, Great Falls, Helena, and Missoula), Indian Health Service Billings Area Office (IHS-BAO), data from the RMTLC Tribal Epidemiology Center (RMTEC), Seven Directions, and nationally available datasets or summary reports on AI opioid and stimulant prevalence from the Centers for Disease Control and Prevention (CDC), Drug Enforcement Administration (DEA), and National Survey on Drug Use and Health (NSDUH). These sources provide a foundation of the general resources that are available and painted a picture through data.

From February—March 2021, RMTLC paired each program/project with a strategic planning consultant, Action Strategy. The TOR project had four working sessions (in-person and virtual) with a strategic planning consultant to identify the strengths, weaknesses, opportunities, and threats (SWOT analysis). The SWOT analysis approach allows an organization to assess their current position before proceeding to new strategies and to recognize/address any barriers/challenges that may arise. Specific sections of SWOT address internal (strengths and weaknesses) and external factors (opportunities and threats). The results are summarized below.



PHASE 2: RAPID NEEDS ASSESSMENT—PARTNERS

The second phase of the process (February—May 2021) involved reviewing literature on existing questionnaires and assessment tools related to opioid resources availability. We adapted an existing questionnaire generated by the Inter-Tribal Council of Arizona TEC White paper report, *The Opioid Epidemic in Indian Country: What Tribal Leaders need to know* (2018) (Reports & Publications | Inter Tribal Council of Arizona, n.d.). In addition, our team developed a list of topics that needed more information than was available from phase 1 reviews. Through several working meetings with TEC-PHI and TEC Data Management Team (DMT) staff, we generated and finalized questions to disseminate via SurveyMonkey. The final questionnaire was designed for regional opioid-related workforce individuals in Tribal Health Departments; Tribal Leadership; urban Indian Health Centers; public safety at county, city, and Tribal locations; courts systems in county, city, and Tribal locations; and behavioral/mental health organizations. The final 25 item questionnaire contained site demographics, measures on opioid data access/availability, access to MAT treatment, existing harm reduction activities, and existing policy. The answer choices were a mixture of multiple choice, multiple selection, yes/no, and open answer.

We used existing RMTLC email listservs to send the survey link to Tribal Health Departments and Tribal Leadership, urban Indian health centers staff, and Tribal Courts participants. To reach entities outside of our listserv, we called those affiliated with county and city court systems and public safety individuals using contact information on their respective websites. For those who did not immediately respond to the survey link, our team sent weekly email reminders. During this process, we offered a 1 in 10 chance drawing for an incentive available to participants, valued at no more than \$10.00 to increase response rates. A separate survey that collected demographic information for incentives was linked separately. Data collection took place between April—May 2021.

We gathered responses from 17 individuals during the data collection period. The TOR project worked with RMTEC’s TEC-PHI Opioid Supplement project to clean and analyze data using SPSS version 25.0. The data were tabulated for 15 respondents after reviewing inclusion criterion with counts and percentages.

PHASE 3: COMMUNITY KNOWLEDGE AND AWARENESS QUESTIONNAIRE

The third phase of the process (February—April 2021) was implemented simultaneously with the phase 2 efforts. Most of the existing instruments were tailored to populations that regularly participated in primary care services in large urban cities. Our team adapted questions from several existing instrument tools to create a question bank. Through various working sessions with TEC-PHI staff, the final 20 question instrument contained an inclusion criterion, demographics, and measures on opioid content concerning basic knowledge, awareness, and stigma. The question-and-answer options were a mixture of multiple formats; True/False, multiple option selection, sliding scale rating, and multiple choice. The questionnaire was specifically tailored to collect information from those who self-identified as AI, resided in the states of Montana and Wyoming, and were 18 years and older.

Our team developed various communication flyers for Facebook, Instagram, and our organization’s website that included images of diverse age ranges of AIs, tailored opioid prevention messaging, and access to a SurveyMonkey link. To increase the survey’s reach, we contacted respective Tribal Health Departments and Tribal Colleges to post our Facebook communication information and outside organizations to post survey information. The community knowledge and awareness questionnaire was an anonymous survey in which participants could decline participation or withdraw at any time. An incentive was also offered to participants where a 1 in 10 chance drawing to receive a \$10.00 gift card and exclusive RMTLC mug. Responses were not linked to respondents contact information provided for the incentive. To further increase response rates, we placed duration restrictions on Facebook posts for limited time availability in four-day increments at the beginning of the week. Another method used to increase survey responses was to encourage sharing of the survey through Facebook shares or via an email link. Data collection took place during the last two weeks of March 2021.

We gathered over 900+ responses during the four-day period. The TOR project worked with RMTEC’s TEC-PHI project to clean and analyze data using SPSS version 25.0. After removing incomplete and ineligible criterion responses, 290 respondents were tabulated with counts and percentages for descriptive statistics and questionnaire responses. For qualitative responses, thematic analysis was used for summarizing main findings.

PHASE 4: FEEDBACK AND FINAL OVERVIEW

The TOR project reviewed findings from phases one, two, and three to collectively identify goals, strategies, and metrics. During this session, a thematic analysis was conducted that identified four general themes: (1) Prevention: Opioids Misuse; (2) Treatment: Medication Assisted Treatments; (3) Harm Reduction and Recovery Services; and (4) Monitoring. Results are below.



SWOT ANALYSES

The results from the SWOT analysis were incorporated into the strategic plan to assist the RMTLC TOR project in identifying internal and external factors for project implementation, activities, and cross-sector partnerships.

Strengths: RMTLC is committed to addressing disparities impacting AI populations by promoting Tribal Best Practices, providing timely data, understanding the importance of cultural diversity, and collaborating with Tribal Leaders.

Weaknesses: A need to strengthen existing partnerships to improve AI health in region.

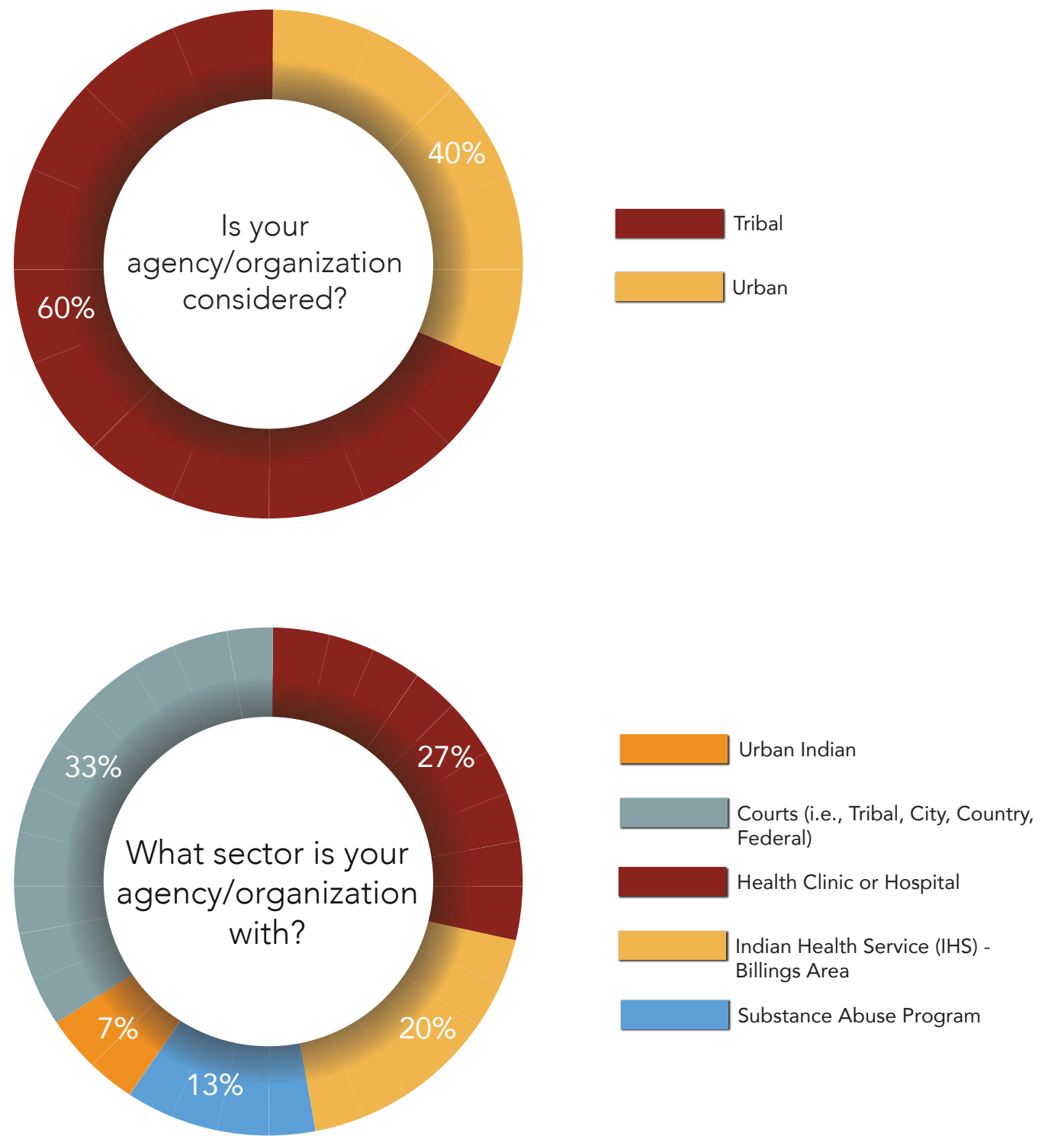
Opportunities: Understand the importance of multifactorial opportunities, traditional teachings, and culture to enhance existing projects/programs to address the prevalence of opioid misuse.

Threats: RMTLC is committed to expanding funding opportunities that address AI health and improving communications that enhance collaborations.

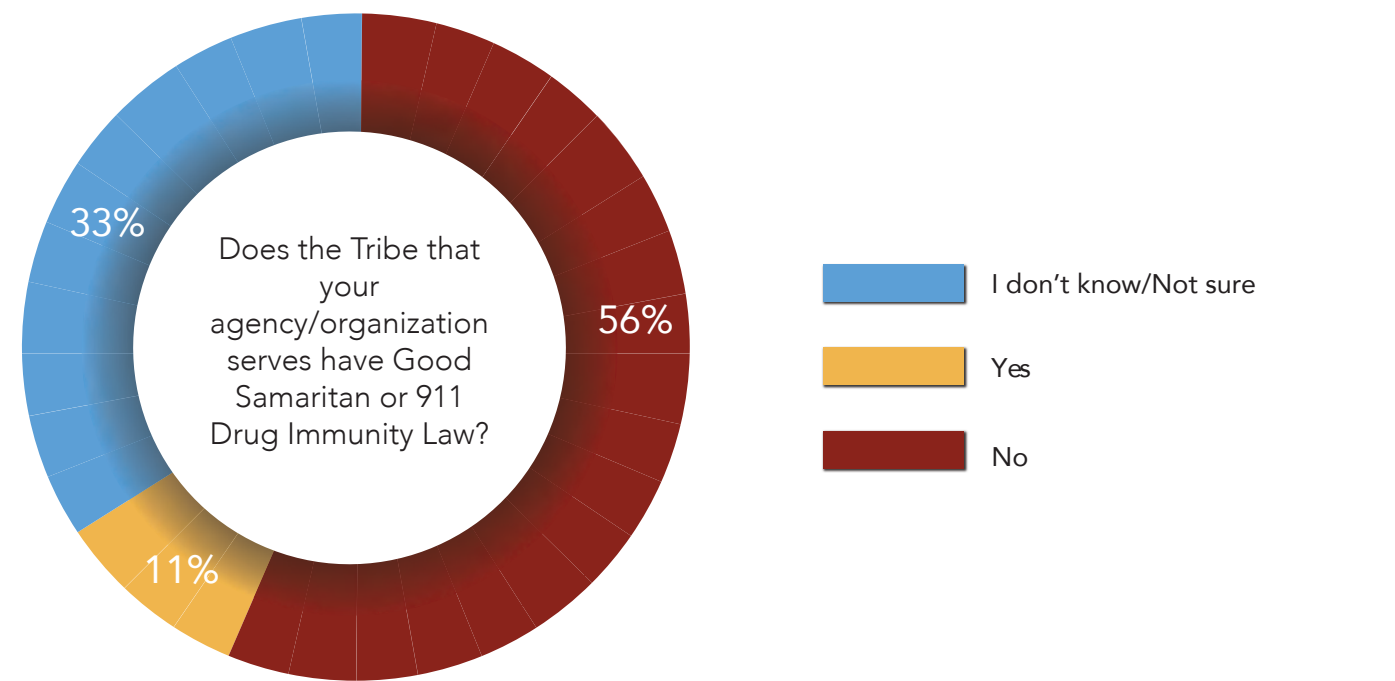


PARTNERS SURVEY

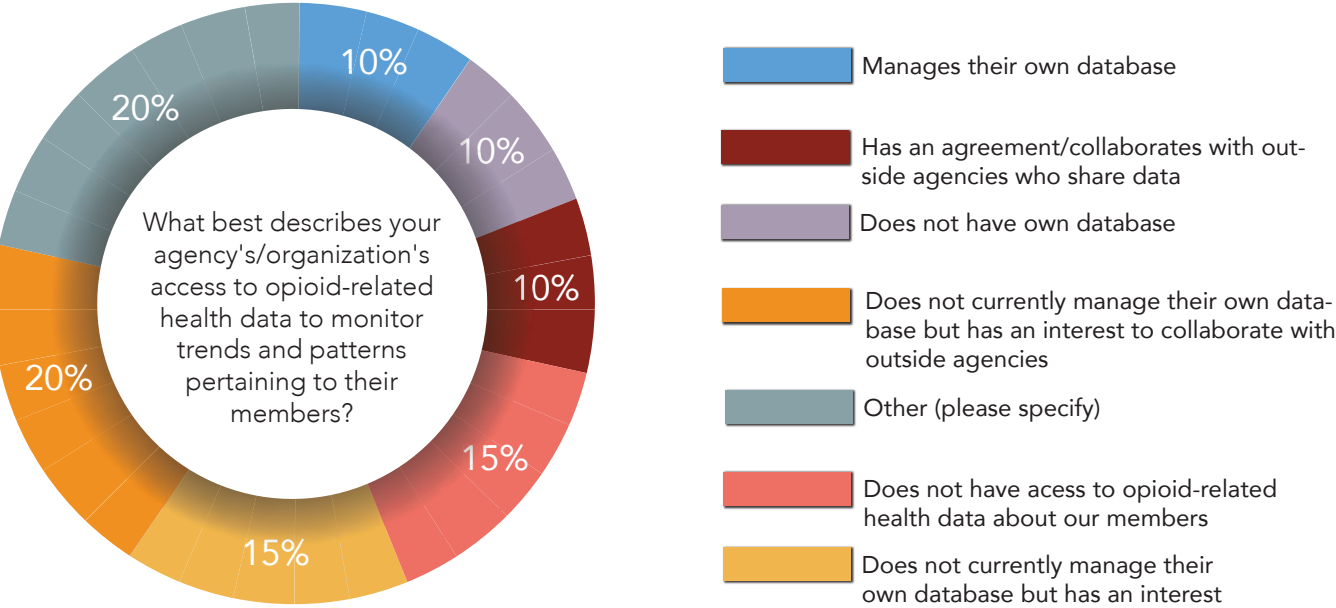
Demographics. A total of 15 respondents participated in our opioid workforce questionnaire assessment. The majority of respondents were affiliated with Tribal agencies/organizations (60%) and various court systems (33%) or Health Clinic/Hospitals (27%).



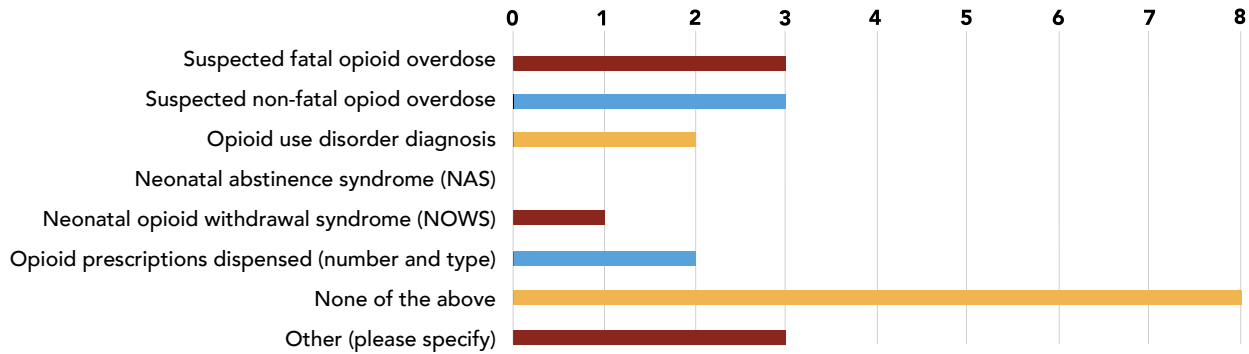
Good Samaritan or 911 Drug Immunity Law. Tribal Nation's respondents were asked if they were aware of any Good Samaritan or 911 Drug Immunity Laws in their community. The majority reported "no/I don't know/not sure" on whether these laws existed in their communities (89%).



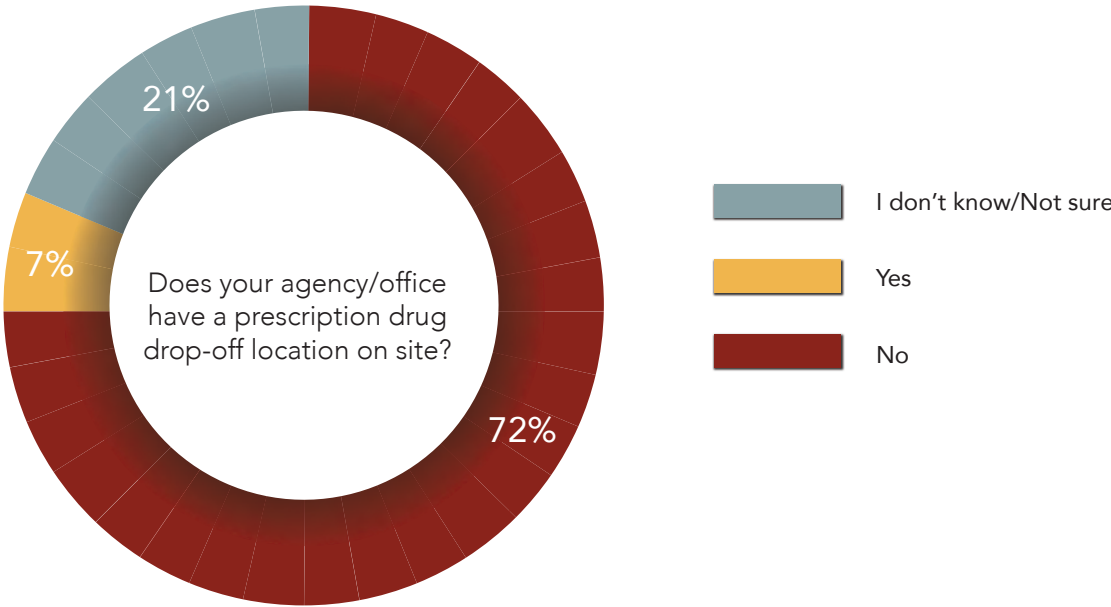
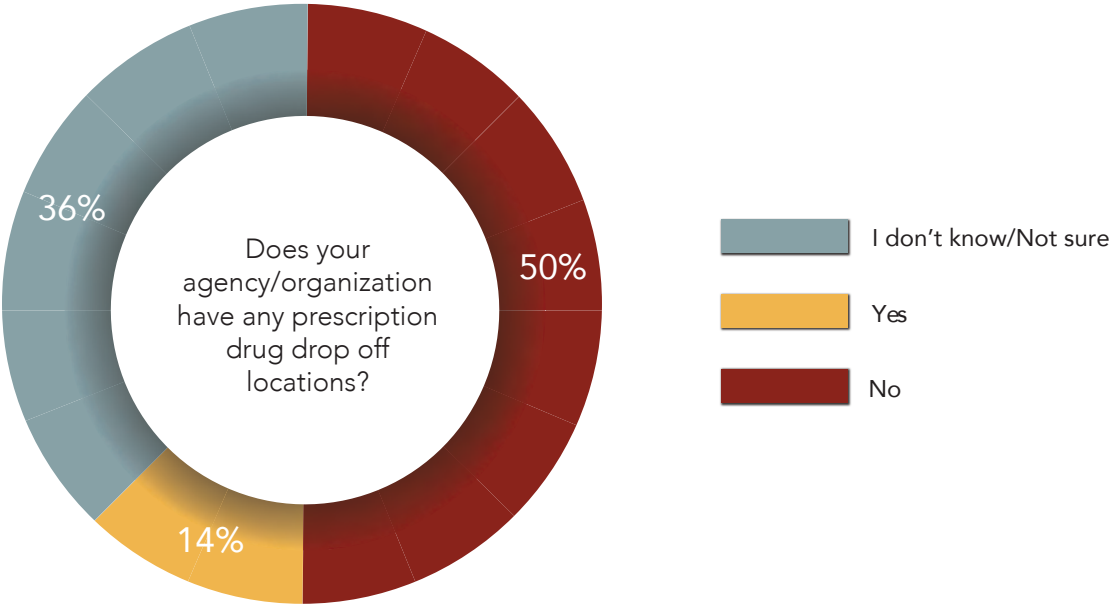
Access to opioid-related health data. Respondents were asked about access to opioid-related data for monitoring local trends and patterns. The majority reported not having their own database, interest in wanting to establish a database, and working with other partners to obtain data (below). Many reported access to fatal/non-fatal overdose data, prescription medication prevalence, and reports on neonatal opioid withdrawal syndrome for infants (below).



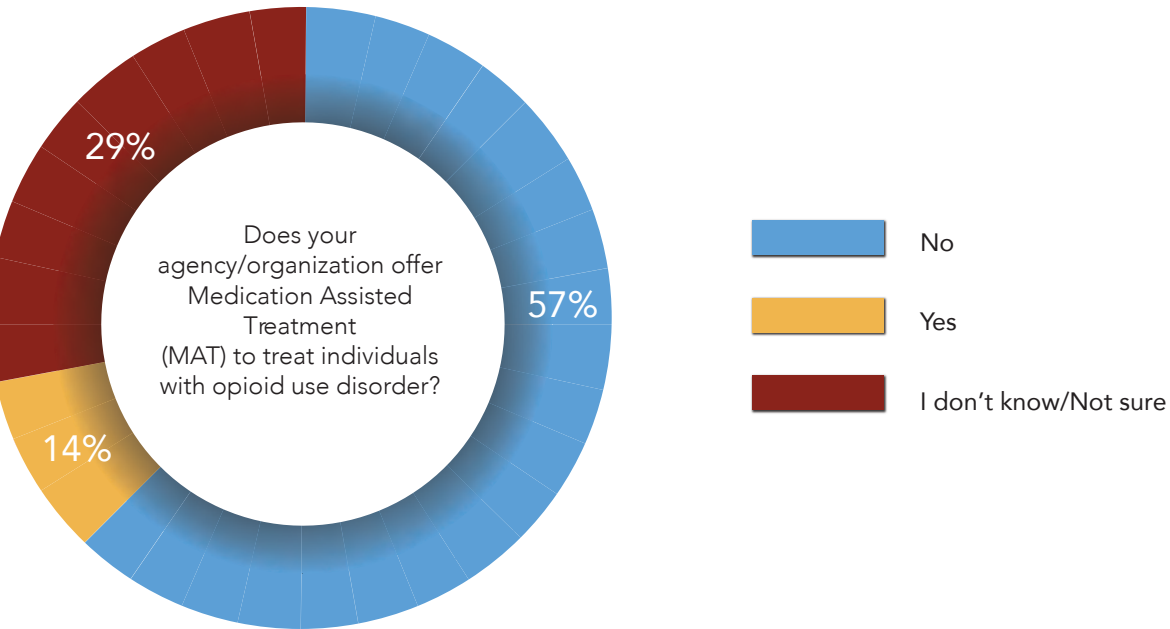
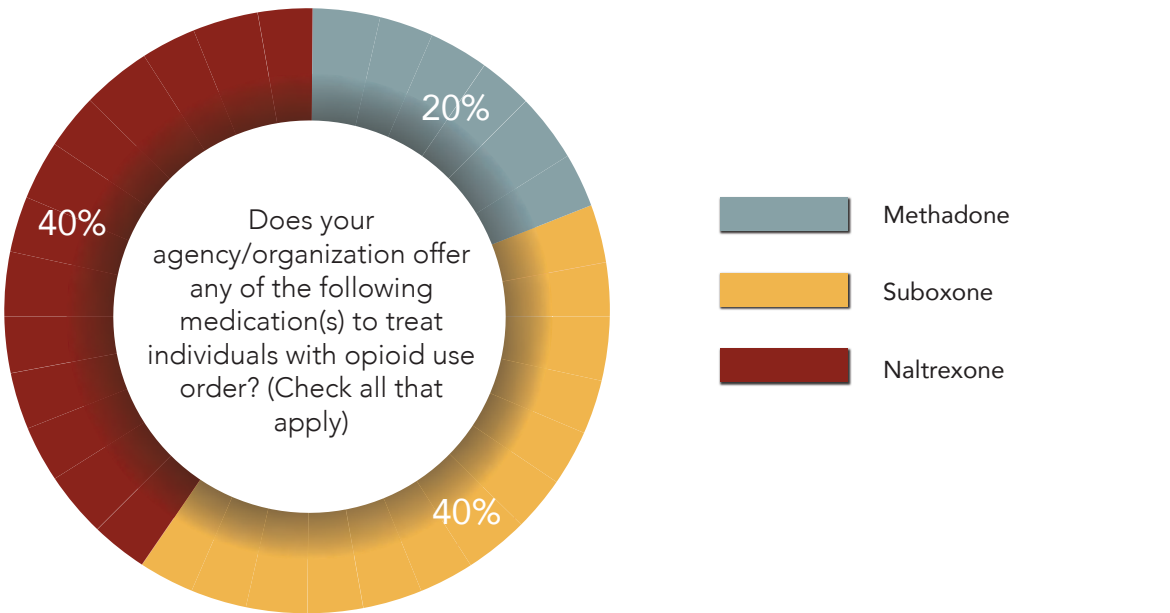
What types of opioid related health data does your agency/organization have access to? (check all that apply)



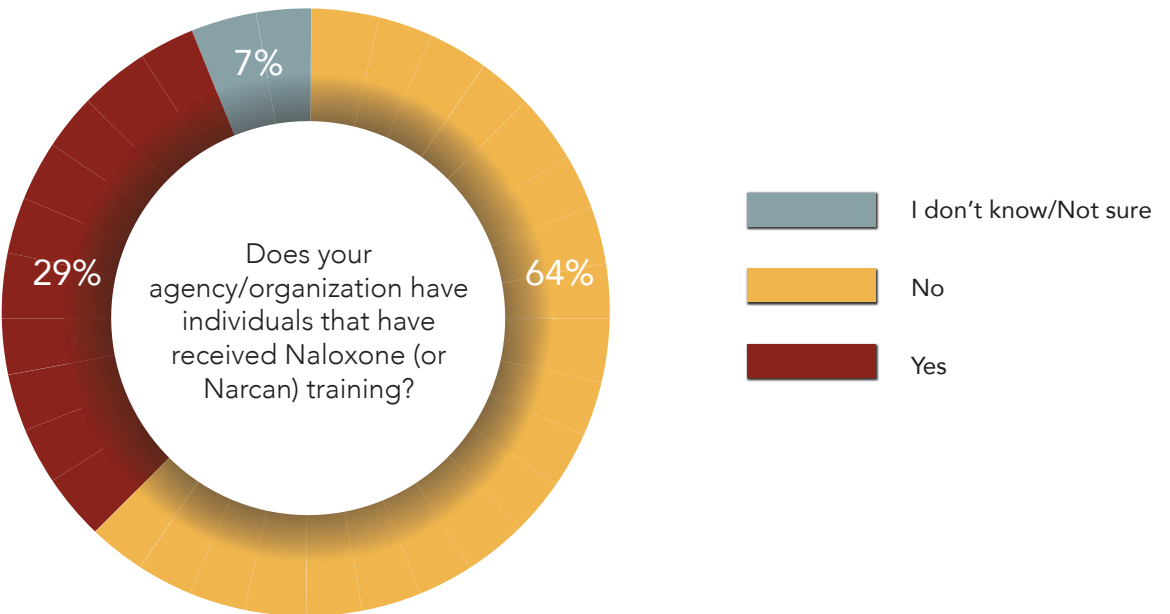
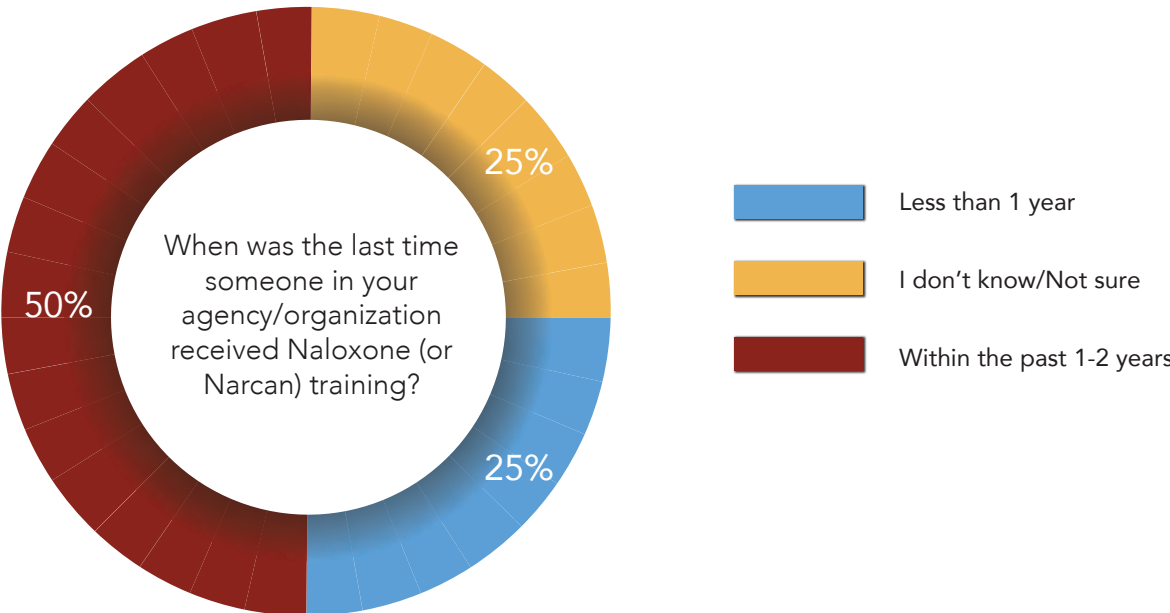
Prescription Disposal. About half of respondents reported that their agency/organization does not have a prescription drug drop-off location and does not serve as a site for disposal. The majority of respondents report currently they do not host community drug take back events (53%, not shown, see appendices).



Medication Assisted Treatment. Currently, MAT access among Tribal and Urban communities report limited access. Of those who provide MAT, naltrexone and suboxone are offered to individuals with opioid use disorder and have at least one provider (not shown).

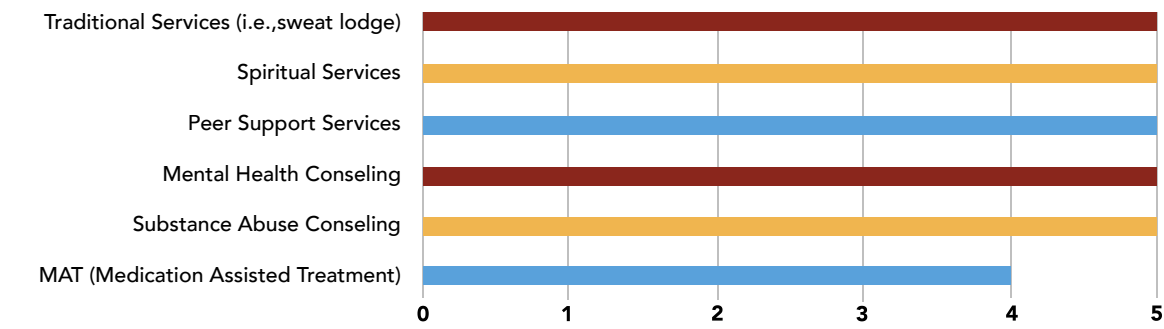


Naloxone. Naloxone, also known as NARCAN, is the lifesaving drug used to reverse the symptoms of an opioid overdose. Respondents were asked if individuals in their agency/organization received naloxone training. The majority of respondents work for an agency/organization that does not have individuals trained to administer naloxone (64%). Of those respondents who reported having an individual on staff with naloxone certification, 50% received certification within the past 1-2 years. In addition, half reported receiving training to administer and carry naloxone as either nasal spray (57%), auto injectable (29%, i.e., EpiPen), or injectable syringe (14%) (see appendices).



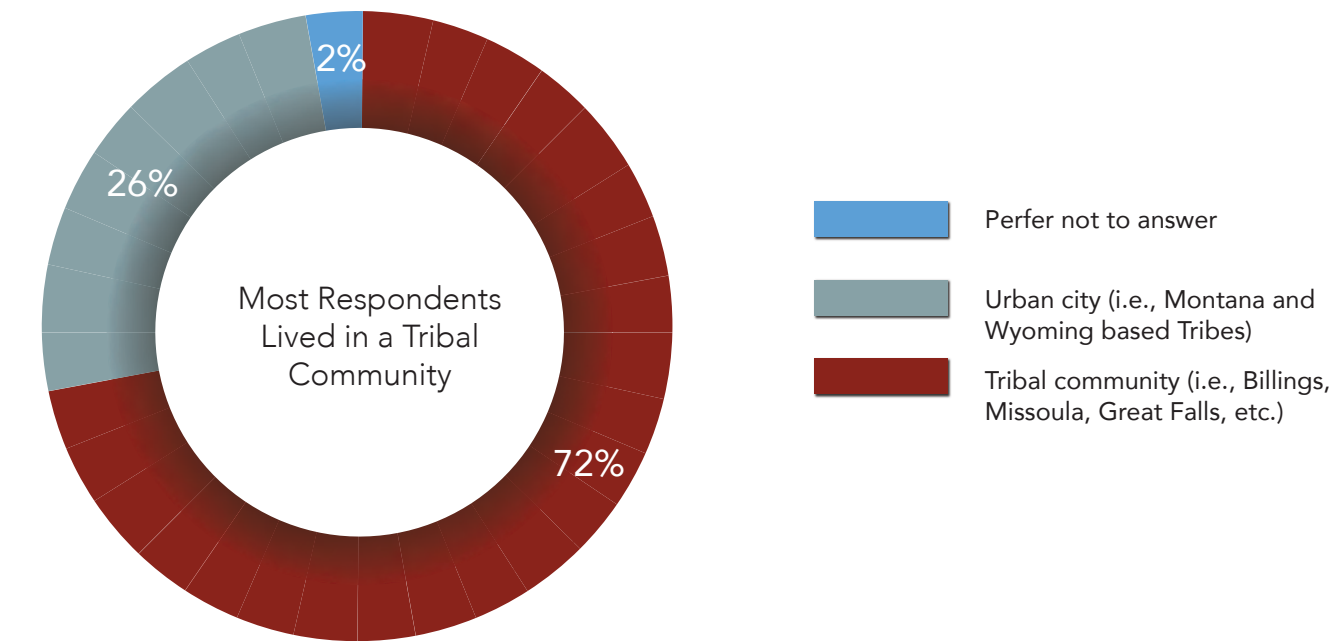
Referral Systems. Respondents were asked if their agency/organization have a referral system, such as a policy or protocol, for individuals with suspected opioid use disorder and/or suspected opioid overdose. Of those respondents who reported existing policies/protocols, many included a diverse multifactorial referral approach. These included incorporation of traditional services (i.e., sweat lodges), spiritual services, peer support services, mental health counseling, substance-specific abuse counseling, and/or medication assisted treatments

What referral systems (policies/protocols) does your agency/organization have for persons with suspected opioid use disorder (OUD) and/or opioid overdose? (check all that apply)

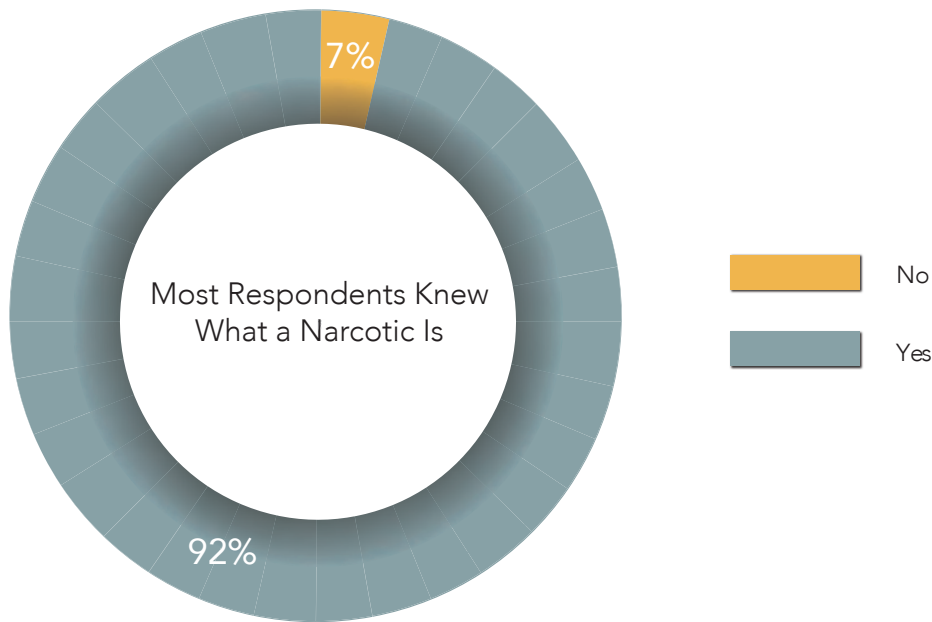
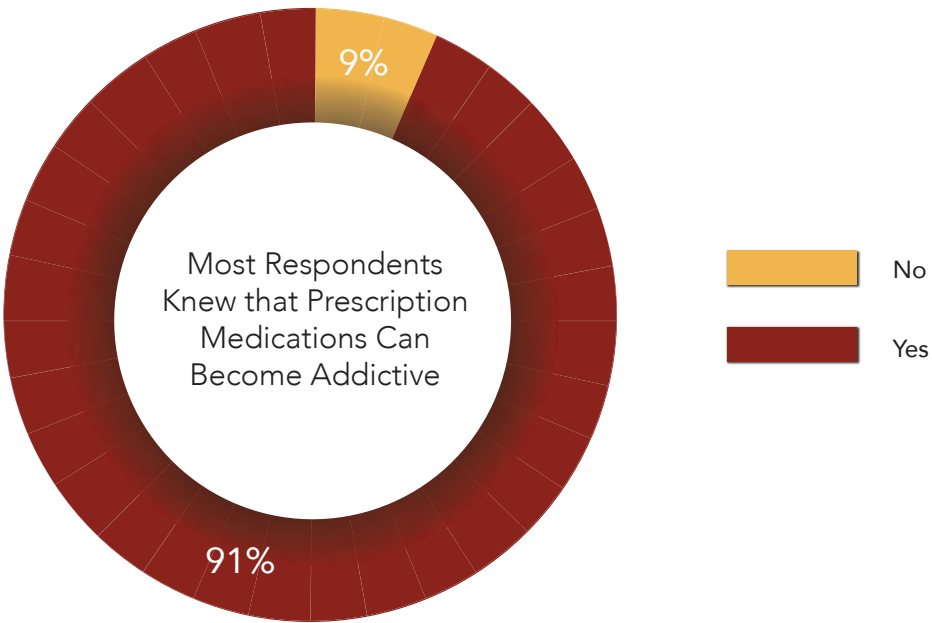


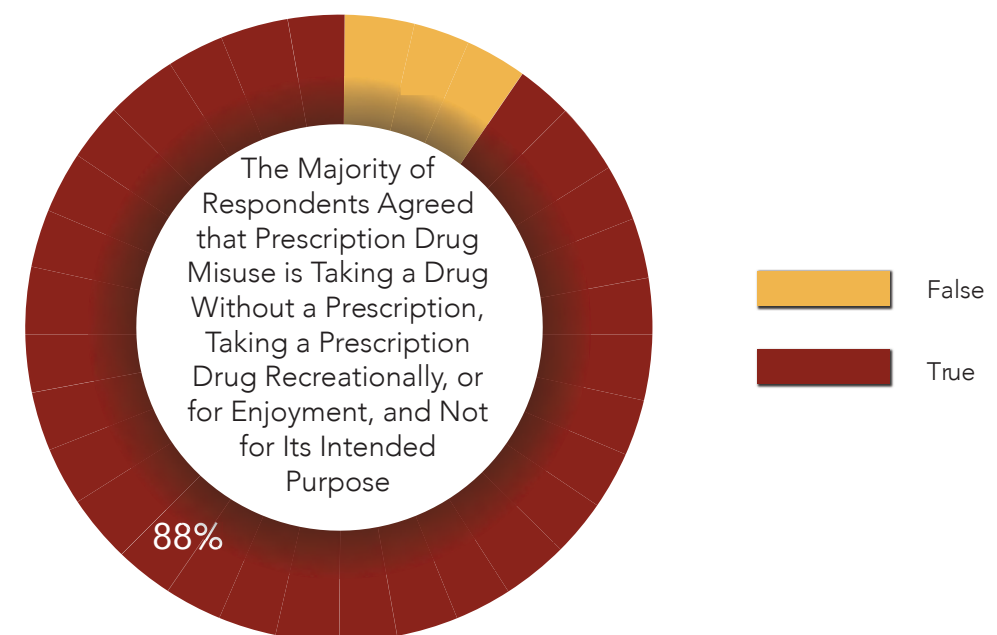
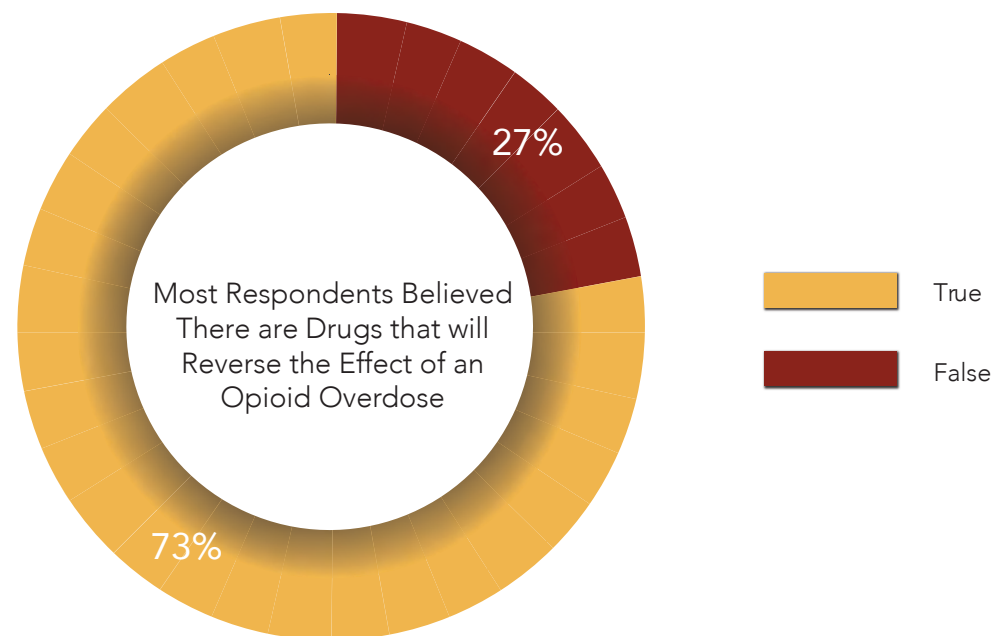
COMMUNITY PERCEPTIONS SURVEY

Demographics. A total of 290 respondents participated in our opioid knowledge and awareness questionnaire. The majority of respondents were 65 years and older (50%), male (61%), highest level of education was some college or technical school (28%) and resided in Montana and Wyoming Tribal communities (72%).



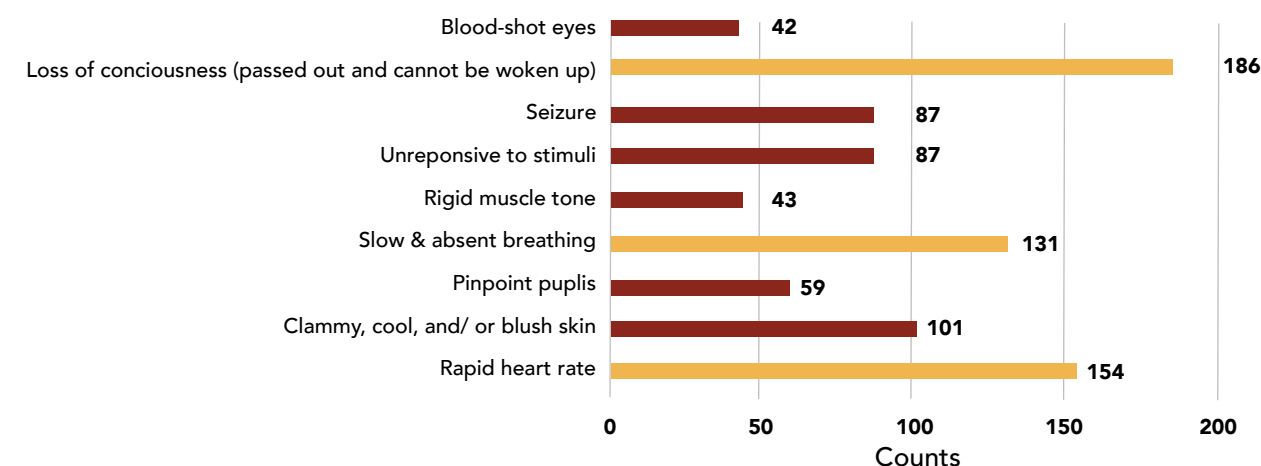
Opioid knowledge/awareness. Respondents were asked basic opioid knowledge questions on addiction perceptions and beliefs. The majority of respondents reported knowing prescription medications can become addictive (91%) and knew what a narcotic was (93%). Respondents also reported the belief that all overdoses were deadly (80%) and the belief that drugs were available to reverse the effects of an opioid overdose (73%). Lastly, the majority of respondents agreed that prescription drug misuse is taking a drug without a prescription, taking a prescription drug recreationally, or for enjoyment, and not for its intended purpose (88%).





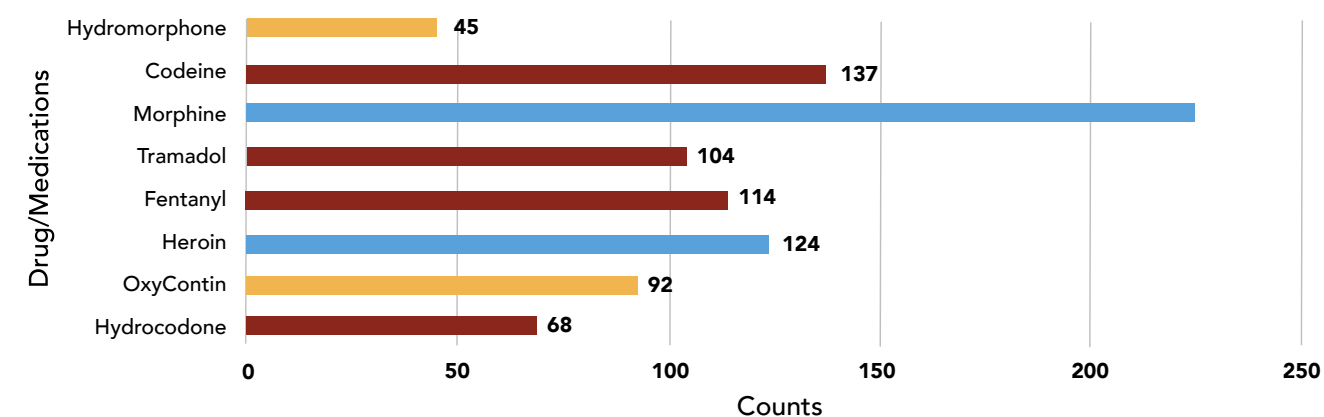
Opioid Overdose. Respondents were to select the following signs of an opioid overdose. Most respondents reported the top following signs of an opioid overdose: loss of consciousness (passed out and cannot be woken up), rapid heart rate, and slow or absent breathing.

Which of the following are signs of an opioid overdose? Check all that apply.



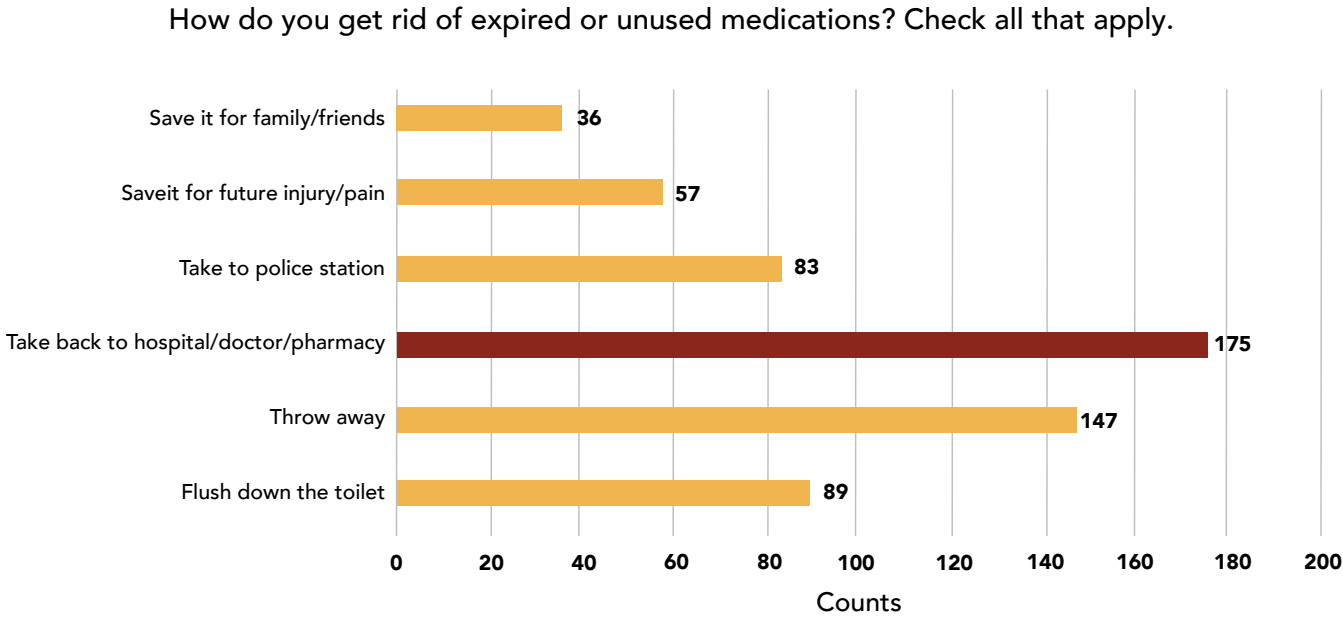
Types of opioids. Respondents were asked to select from the following drugs and/or medications which ones were classified as an opioid. Most respondents recognized morphine as an opioid followed by codeine and heroin.

Which of the following are examples of opioids? Check all that apply.

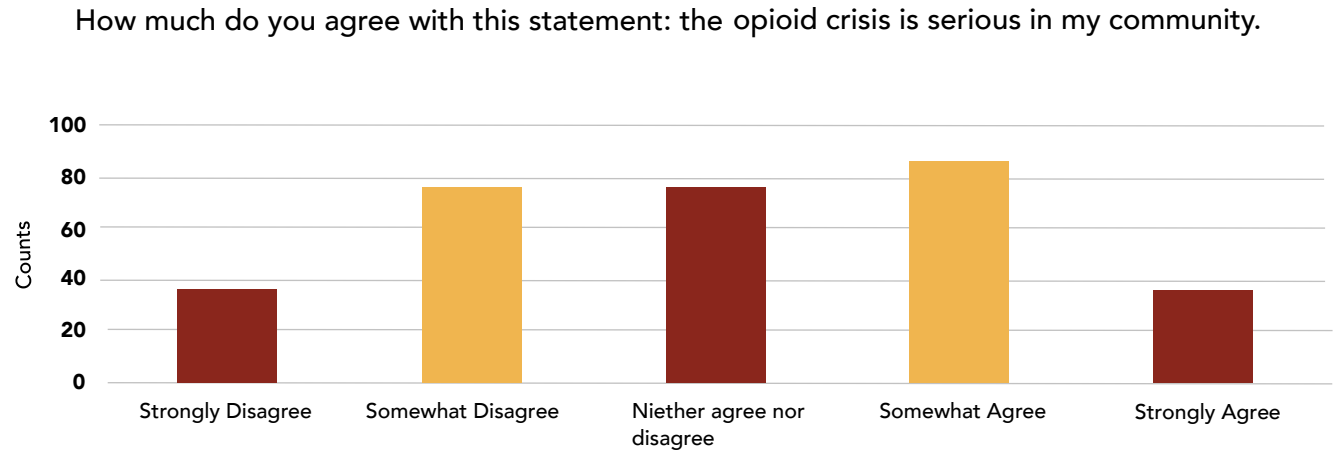




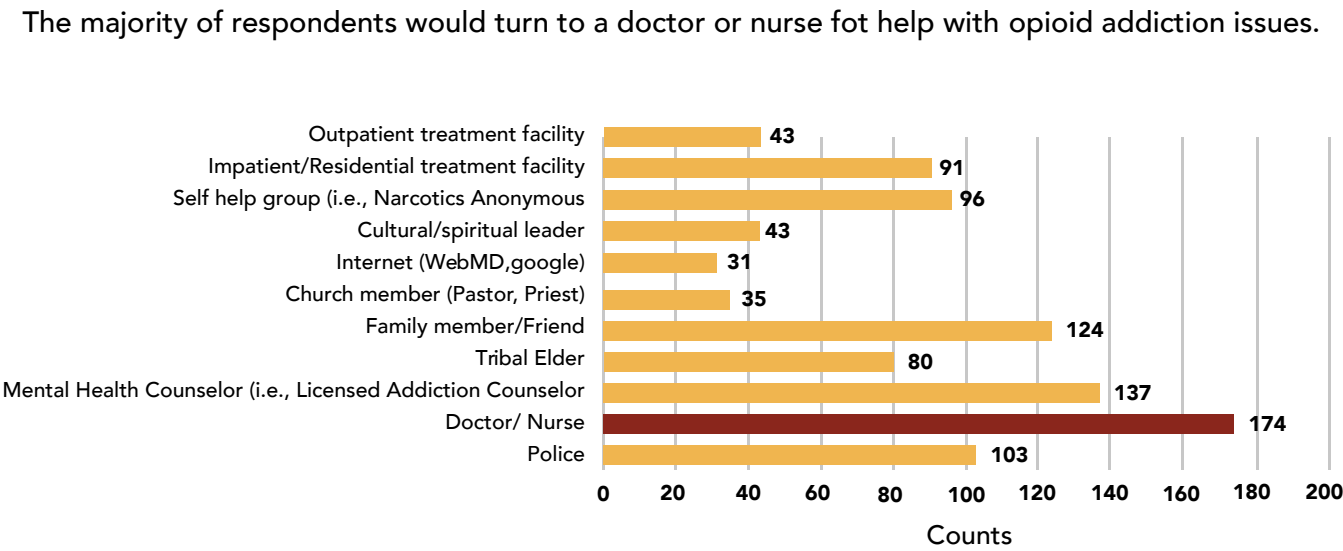
Medication Disposal. Most respondents reported disposing of expired or unused medications by taking them back to the hospital, doctor, and/or pharmacy.



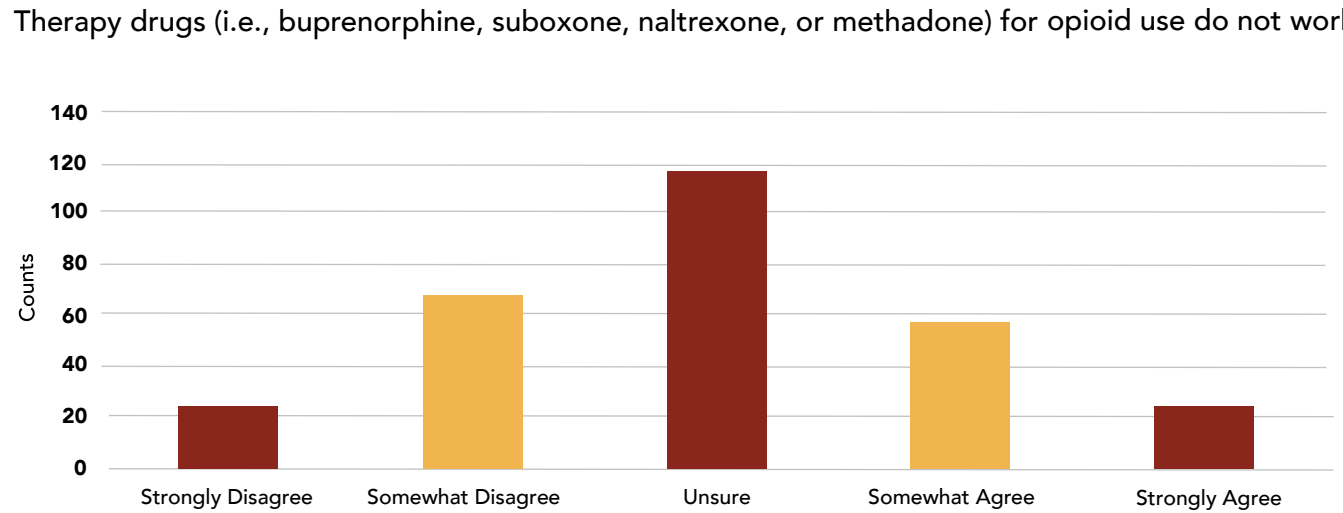
Perception of opioids in community. Respondents were asked how much they agree with the following statement, “the opioid crisis is serious in my community”. Respondents were also asked to estimate the percentage their community suffers from opioid use addiction (25.3%, not shown). With regard to abuse of prescription medicines, the majority of respondents disagreed that people of any age, income, education level, and gender (see appendices). In addition, the majority of respondents agreed that a person who is addicted to opioids is to blame for his/her problems (see appendices).



Asking for help. Respondents were asked who they would contact for help with opioid addiction issues. The majority of respondents identified reaching out to a doctor/nurse for help with opioid addiction followed by mental health counselor (i.e., licensed addiction counselor) and family member/friend.



Treatment. Respondents were asked how much they agree with the statement that therapy drugs (i.e., buprenorphine, suboxone, naltrexone, or methadone) for opioid use work and if they only replace one addiction for another. The majority of respondents were unsure if therapy drugs for opioid use work.





RECOMMENDATIONS

Based on reviews of existing data, resources, data collection, and working sessions, the following overarching goals, strategies, and metrics have been identified (Table 2) :

PREVENTION: OPIOIDS MISUSES In order to reduce the prevalence of opioid and stimulant misuse, we need to increase the number of cross-sector collaborations/partnerships and increase access/availability to culturally appropriate activities/materials. From our community opioids knowledge questionnaire, population knowledge on opioids and effective treatments needs to increase along with ensuring a culturally competent workforce.

TREATMENT: MEDICATION ASSISTED TREATMENTS Numerous barriers have been identified as access to treatment services, such as transportation costs, high copays, or not enough MAT medical providers. Our project is actively working with urban Indian Health Clinics and regional healthcare providers to bridge the gaps in seeking treatment.

HARM REDUCTION AND RECOVERY SERVICES Through conversations with direct/in-direct services providers, individuals with opioids and/or stimulant misuse behaviors are often not ready to quit and need small steppingstones toward cessation behaviors. Our project is actively working with urban Indian Health Clinics and various harm reduction entities to increase access/availability to harm reduction strategies, locations to properly dispose of unused medications, and knowledge/awareness of harm reduction benefits.

MONITORING Access to timely data is important in monitoring and addressing the opioid epidemic in Indian Country. At this time, there is no opioid-specific surveillance system for AI populations in the region or nationally. In addition, many national, state, county, or Tribal databases, health departments, or organizations often rely on annual or biennial data collections for various substance use behavior measures. Established drug taskforces and/or working groups need to actively recruit Indigenous knowledge gatekeepers and/or community members to provide insight in data interpretations to holistically address the opioid epidemic.

Compared to the 2018-2020 TOR Strategic Plan (see Appendices), we have built and expanded our project’s reach to include working with Montana Urban Indian Health Clinics (i.e., Butte, Great Falls, Missoula) and the Little Shell Tribe in addressing opioid and stimulant misuse among AI populations.

Table 2. Tribal Opioid Response II Project Goals, Strategies, and Metrics

GOALS	METRICS
<p>PREVENTION: OPIOIDS MISUSES</p> <ul style="list-style-type: none">♦ Strategy 1: Cross-sector partnerships and collaborations♦ Strategy 2: Culturally appropriate prevention activities♦ Strategy 3: Education and awareness♦ Strategy 4: Workforce development♦ Strategy 5: Prescription drug disposal	<ul style="list-style-type: none">♦ Increase the number of cross-sector collaborations to address opioids and stimulant misuse among State, Tribal, Urban, Private, and/or Foundation entities♦ Increase the number of culturally appropriate prevention and recovery activities that remain community centered♦ Increase prevention efforts that reduce opioid and stimulant misuse in Tribal Nations and urban communities for AI populations, such as prescription drug disposals♦ Reduce the number of leftover available prescription opioid drugs among individuals prescribed opioids♦ Increase access to naloxone to reduce the number of opioid overdoses♦ Increase prevention of opioid and stimulant misuse through education and awareness♦ Increase support of workforce development activities to address opioids and stimulants misuse
<p>TREATMENT: MEDICATION ASSISTED TREATMENTS (MAT)</p> <ul style="list-style-type: none">♦ Strategy 1: Increase access to MAT in urban MT city centers♦ Strategy 2: Increase retention of those seeking MAT services for OUD/SUD	<ul style="list-style-type: none">♦ Increase the number of people with OUD/SUD to enroll in MAT♦ Increase the number of people with OUD/SUD to remain enrolled in MAT
<p>HARM REDUCTION AND RECOVERY SERVICES</p> <ul style="list-style-type: none">♦ Strategy 1: Harm reduction strategies access♦ Strategy 2: Culturally appropriate recovery activities♦ Strategy 3: Peer to Peer recovery support services	<ul style="list-style-type: none">♦ Increase fentanyl testing strip availability♦ Increase the number of prescription disposal drop off sites♦ Increase the number of culturally appropriate prevention and recovery activities that remain community centered♦ Increase the number of peer-to-peer recovery support services
<p>MONITORING</p> <ul style="list-style-type: none">♦ Strategy 1: Opioid and stimulant misuse surveillance system	<ul style="list-style-type: none">♦ Establish an opioid and stimulant misuse surveillance system♦ Increase the number of communication modalities to convey timely information for Tribal Leaders, health organizations, and social services♦ Increase the number of cross-sector partnerships and collaborations recovery activities that remain community centered♦ Increase the number of peer-to-peer recovery support services

CULTURAL INFLUENCES AND IMPACTS

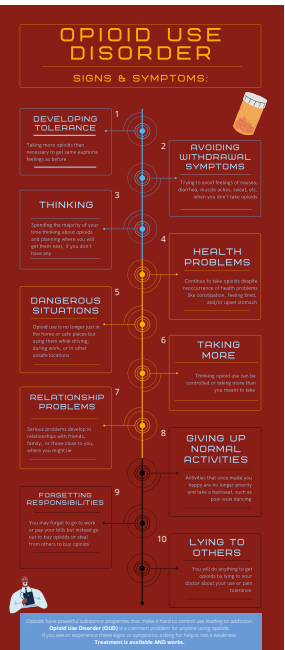
Taking a holistic approach to substance misuse prevention requires integrating AIAN cultural customs, practices, and traditions. The National Tribal Behavioral Health Agenda framework (2016) recognizes the inclusion of culture into various strategies for addressing behavioral health needs among AIANs. These foundational elements include the following: youth, identity, culture, individual self-sufficiency, and data (The National Tribal Behavioral Health Agenda, 2016). In addition, an assessment conducted by Health Management Associates on current gaps in SUD treatment facilities of Montana, identified the need to develop existing SUD facilities and integrate culturally-relevant approaches in care and recovery services (Raney & Kellenberg, 2021). With this in mind, the TOR project has included culture as a core component in the strategic plan goals, strategies, and metrics. Our project is actively collaborating with various urban Indian Health Centers on planning and implementing cultural and prevention activities focused on all age groups. We recognize the large cultural diversity in the region and many activities include beading, smudging practices, quilt making, painting, etc. For more information on site specific events, please contact the TOR project and/or reach out to respective Montana urban Indian health centers.

AVAILABLE OPPORTUNITIES AND AWARENESS MATERIALS SAMPLES

Naloxone certification: The State of Montana DPHHS provides opportunities to individually carry naloxone after participation in certification course along with opportunities to become master trainers. Reach out to respective Tribal Health Departments, urban Indian Health Centers, local public safety, etc. for other ways to become involved.

National Harm Reduction Coalition provides free educational materials to understanding harm reduction strategy benefits, locations to access safe syringe programs, or incorporate de-stigmatizing approaches in your community.

RMTLC TOR project provides access to downloadable print materials on opioids, harm reduction strategies, other risk factor prevention materials, and welcomes everyone to participate in our many cultural/prevention and recovery activities. Check out our website for dates, locations, and times.





RESEARCH NEEDS

RACIAL MISCLASSIFICATION

The availability of complete and accurate race information is vital for understanding and addressing the many documented health disparities experienced by AIAN. However, race is often incompletely or inaccurately captured in public health data sources (Jim et al., 2014; Joshi, 2018). Numerous studies have shown high rates of racial misclassification or missing race data for AIAN in public data sources such vital statistics and cancer registries (Harwell et al., 2002; Jim et al., 2014; Joshi, 2018).

Harwell et al. (2002) found that 91% of AI Montana residents who died in 1996 – 1998 were consistently classified as AI on their death certificates. For those individuals whose race was not classified correctly, 99% were misclassified as White. Harwell et al. (2002) also found that only 70% of AIs living in counties not on or near a reservation were classified correctly on their death certificate. Cause of death misclassification was also found to be overestimated for alcohol-related deaths and underestimated for suicides (Harwell et al., 2002).

Record linkage studies provide an effective method to improve race data in a variety of sources, ultimately improving the accuracy of health surveillance data (Jim et al., 2014; Joshi, 2018). RMTEC's aims are to improve the validity of AI race data in public health data systems and increase the availability of accurate health status data for Rocky Mountain tribal communities. These efforts will ultimately support public health decision-making and efforts to eliminate health disparities for AI populations in Montana and Wyoming.

DE-STIGMATIZATION APPROACHES

Besides documented AIAN health disparities, stigma is a large contributing factor. Stigma is the "labeling, stereotyping, separation, status loss, and discrimination of and against people with a particular social identify" (A Movement to End Addiction Stigma, 2021; Link & Phelan, 2001). Stigma's impact on the opioid epidemic has been well-documented to impact the following key areas: (1) marketing/overprescribing practices; (2) heroin and fentanyl access; (3) lack of treatment facilities; (4) education; (5) continued criminalization of individuals with SUD; (6) limited health care coverage; (7) shame; (8) those with addiction behavior's avoiding help; and (9) societal views of those in recovery (A Movement to End Addiction Stigma, 2021). Stigma is often expressed in several forms: public, structural, self-, and stigma against medications for opioid use disorder (MOUD).

Given the impact of stigma, it is important to integrate de-stigmatized practices at all levels. First, increase education by correcting misinformation and creating literacy campaigns. Second, facilitating activities that are inclusive to those who are non-substance users and substance users. Third, increase peer to peer services such as narcotics anonymous. Fourth, implementing legislative and policy changes to have larger structural impacts. As an organization, the TOR project is taking steps to design communications materials that support person first language and using supportive non-judgmental words. For example, avoiding words of "drug problem, dependence, or drug habit" and replacing words with "substance use disorder, misuse, or risky use"(Addiction Language Guide, 2021).





REGIONAL EFFORTS ON OPIOIDS

The State of Montana Department of Health and Human Services (DPHHS), Montana and Wyoming counties and cities have provided data, funding, certification/trainings, and various resources to address substance use disorders, chronic and infectious diseases. Below are a snapshot of various Tribal Nations, Grassroots, urban Indian Health Centers, and Tribal Colleges/Universities' response to the opioid crisis.

TRIBAL HEALTH DEPARTMENTS/GRASSROOT EFFORTS

The following Tribal Nations are recipients of SAMHSA's TOR funding mechanisms: Blackfeet (2020-present); Confederated Salish & Kootenai Tribes of Flathead (2018-present); Crow Nation (2020-present); Eastern Shoshone (2018-present); Fort Belknap Tribes of Gros Ventre and Nakoda (2018-2020); Northern Cheyenne (2018-2020); and Rocky Boys of Chippewa Cree (2018-2020). Tribal TOR programs have established robust MAT programs or established partnerships to bridge the treatment gap, provide various cultural and recovery activities on a daily or weekly basis, implemented harm reduction strategies, provide naloxone (i.e., NARCAN) trainings, and developed various culturally appropriate materials to increase community knowledge and awareness of opioids and effective treatments.

URBAN INDIAN HEALTH CENTERS

RMTLC TOR project is actively working with various urban Indian Health Centers to increase the number of culturally appropriate prevention activities, harm reduction strategies, peer support services, and ultimately access to MAT services. RMTLC TOR project will continue funding allocations to each participating urban Indian Health Center for TOR funding duration.

TRIBAL COLLEGE AND UNIVERSITY EFFORTS

Rocky Mountain Tribal Leaders Council Epidemiology Center and Montana State University Office of Rural Health

Four-year funding grant from the Health Resources Services Administration to "provide training that will address the care needs of youth and families impacted by opioid/substance use disorder in Montana." The funding opportunities work specifically to train Community Health Workers, Peer Support Specialists, and other behavioral health-related professionals. RMTLC-EC is tasked with direct community engagement along with building Tribal community trust.

FOR MORE INFORMATION CONTACT: RMTLC EPIDEMIOLOGY CENTER

Helen Tesfai
RMTLC-EC Director
Helen.tesfai@rmtlc.org

Brook McDonald
Project Coordinator
[Brook.mcdonald @rmtlc.org](mailto:Brook.mcdonald@rmtlc.org)

TRIBAL COMMUNITY COLLEGE RESPONSE TO OPIOIDS EPIDEMIC

PUBLIC HEALTH WORKFORCE EXPANSION IN INDIAN COUNTRY (PHWEIC) PROJECT

The Rocky Mountain Tribal Leaders Council (RMTLC) PHWEIC program is grant funded through the CDC (Award no. 1NU38OT000275). PHWEIC’s goal is to create and strengthen partnerships between Tribal Colleges, Tribal Health Departments, and the University of Montana to engage current Tribal college students to enter into public health-related professions. PHWEIC collaborates with each Montana Tribal College on developing community-based opioid overdose prevention projects, also known as Quick Impact Projects (QIPs).

PURPOSE OF QUICK IMPACT PROJECTS

Develop one 6–9-month timeline project at each participating Tribal College location per student.

Introduce Tribal College students to public health functions and competencies under the mentorship of subject matter experts, public health consultants, and Indigenous health and social services consultants.

Students are provided ten learning sessions/workforce development opportunities in public health, epidemiology, grant writing, budgets, community-based strategies, data management, and Institutional Review Board (IRB) processes.

The impact of the COVID-19 health pandemic on student QIPs allowed the project to think of creative ways to increase awareness and reach on opioid prevention, risk reduction strategies, addressing policy and system changes, and allowed students to work collaboratively on one QIP for a multifactorial approach.

FOR MORE INFORMATION CONTACT:

RMTLC PHWEIC Project
David Porter - Project Director David.porter@rmtlc.org

Lauren Big Hair - Project Coordinator
Lauren.bighair@rmtlc.org

Letesia Left Hand - Administrative Assistant
Letesia.lefthand@rmtlc.org

TRIBAL COLLEGE	ACTIVITIES/PROJECT
Chief Dull Knife College	Implementing drug disposal prevention activity (Deterra drug disposal bags) through various community events.
Little Big Horn College	Increased community awareness and knowledge of opioid crisis by creating posters and pamphlets. In addition, delivered care packages during COVID-19 pandemic.
Salish Kootenai College	Collected data on community opioids, implemented harm reduction activities, created prevention plans, and tailored messaging to increase knowledge and awareness.
Fort Peck Community College	Focused on culturally approach to opioid overdose prevention through strengths, traditions, and practices.
Aaniih Nakoda College	Increase awareness on opioid misuse at health fairs by handing out pamphlets and hosting prevention drug disposal event (Deterra drug disposal bags).
Blackfeet Community College	Community swimming pool mural in honor of ancestors, promoting resiliency, and strength.

Note: All participating Tribal colleges have set up Facebook, murals, handling out COVID-19 prevention supplies, and educational pamphlets on opioid.

- 1 Lame Deer, MT—Northern Cheyenne Reservation
- 2 Crow Agency, MT—Crow Reservation
- 3 Pablo, MT—Flathead Reservation
- 4 Poplar, MT—Fort Peck Tribes Reservation
- 5 Agency Harlem, MT—Fort Belknap Reservation
- 6 Browning, MT—Blackfeet Reservation

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APPENDICES

For more in-depth information or copies of survey instruments, please contact RMTLC Tribal Opioid Response project by email: info@rmtlc.org or phone: 406.252.2550.

Strategic Plan 2018-2020 (November 2018)

GOALS

1. Complete a comprehensive Opioid Strategic plan
2. Develop a community opioid prevention and overdose strategy
3. Create an actionable strategic plan to address data issues as related to the opioid overdose epidemic
4. Expand on existing peer mentor programs
5. Collaborate with existing Native American focused MAT programs to establish availability of MAT services in Billings
6. Development of a comprehensive special report focused on opioid issues
7. Increase the public health workforce among AI populations to address the opioid crisis in their communities
8. Development of a sustainability plan

OPIOID PROJECTS/PROGRAMS IN MONTANA

For complete access to this document, please visit www.rmtlc.org, Tribal Opioid Response (TOR) Project, and "Other Partners". This document provides a brief overview of other entities working to reduce the prevalence of opioid, stimulants, and other substances misuse.

AIAN OPIOID-RELATED DATABASES

Below is a list of various opioid-related databases that collect information from AIAN populations. This is not a comprehensive list but provides general details on purpose of survey and types of opioid-related measures.

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS) - MONTANA

The primary focus of these surveys is health-related risk behaviors, chronic health conditions, and use of preventive services and to identify behaviors that are linked with leading causes of death and other important health issues. Opioid-specific data from 2017 includes prescription opioid use and misuse.

CDC WIDE-RANGING ONLINE DATA FOR EPIDEMIOLOGIC RESEARCH (WONDER)/MULTIPLE CAUSE OF DEATH DATA

This data set is based on death certificates for US residents and can go down to the county level. Each death certificate contains a single underlying cause of death, up to twenty additional multiple causes, and demographic data. The number of deaths, crude death rates and age-adjusted death rates can be obtained for opioid associated deaths by using ICD codes.

DRUG ABUSE WARNING NETWORK- DAWN – SAMHSA

This surveillance system is currently being reinstated. It had been a nationally represented public health surveillance system that monitored drug-related visits to hospital emergency departments (EDs). DAWN will capture ED visits that are directly caused by drugs and those in which drugs are a contributing factor, but not the direct cause of the ED visit.

EMERGENCY MEDICAL SERVICES DATA SYSTEM (EMS)

This dataset consists of documentation collected by emergency care providers during each patient encounter. Patient care documentation for includes dispatch and response, patient demographics, circumstances of the incident, condition of the patient, any interventions done (i.e., Naloxone administered), and transport/disposition.

EPIDEMIOLOGY DATA MART (EDM) – INDIAN HEALTH SERVICES (IHS)

IHS, Tribal and Urban Indian facilities send raw healthcare data files to the National Data Warehouse (NDW) at IHS. The raw data from these files are parsed into specific components and forwarded to the General Data Mart (GDM). The GDM tables are then copied to the EDM, partially deidentified, and shared with region specific Tribal Epidemiology Center. Opioid-related data that can be found in the EDM includes number and type of opioids prescribed by facility/IHS region, incidence of Neonatal Abstinence Syndrome, number of encounters attributable to drugs with the potential for abuse and dependence, and number of encounters attributable to opioid poisoning.

MENTAL HEALTH CLIENT-LEVEL DATA (MH-CLD) AND MENTAL HEALTH TREATMENT EPISODE DATA SET (MH-TEDS) - SAMHSA

Provides information on mental health diagnoses and mental health treatment services, outcomes, and demographic and substance use characteristics of people in mental health treatment facilities. This information comes from facilities that report to individual state administrative data systems. The raw data includes one record for each individual served in the MH-CLD. In the MH-TEDS data set there is one record for each admission to, and discharge from, a service type or setting (referred to as a treatment episode) within the client's treatment history during the reporting period. The data sets include race and state variables for opioid use co-occurring with mental health disorders by type.

MONTANA BOARD OF CRIME CONTROL DATA SYSTEM/ NATIONAL INCIDENT-BASED REPORTING SYSTEM (NIBRS)

This dataset is voluntarily collected by most law enforcement agencies across the state, except for Tribal jurisdictions. This data is part of a larger dataset, NIBRS. In depth demographic, temporal, and circumstantial information about crime victims, arrestees/offenders, and property data and the incidents and offenses committed by or against them. Data is available for the number of drug (methamphetamine, cocaine, heroin/opiate, marijuana, etc.) related crimes and the number of arrests for drug related crime.

MONTANA HOSPITAL DISCHARGE DATA SYSTEM

The Montana Department of Health and Human Services (MT DPHHS) has a memorandum of agreement with the Montana Hospital Association (MHA) to receive a subset of inpatient admission (2000 onward) and ED visit (2010 onward) data elements. Opioid-related data includes ED visits related to opioid poisonings, ED visits involving opioid-related disorders, inpatient admissions related to opioid poisonings, inpatient admissions involving opioid-related disorders, and Neonatal Abstinence Syndrome.

MONTANA INDICATOR BASED INFORMATION SYSTEM (MT-IBIS) – MT DPHHS

MT-IBIS is interactive query system for data and information on Montana's priority public health issues. Users may query public health surveillance systems such as inpatient hospital admissions, population, vital statistics birth and death, the Montana BRFSS, and the Montana Cancer Tumor Registry by year, geography, age, and race.

NATIONAL OPIOID MISUSE COMMUNITY ASSESSMENT TOOL

This is an interactive data visualization of national county-level drug overdose mortality rates that includes overlays for social determinants of health, reservation boundaries.

NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH) - SAMHSA

This is the leading source of statistical information on the use of illicit drugs, alcohol, and tobacco and mental health issues for individuals aged 12 or older in the US. The survey tracks trends in specific substance use and mental illness measures and assesses substance use disorders and treatment for these disorders.

NATIONAL SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES (N-SSATS) - SAMHSA

The (N-SSATS) is an annual survey of facilities providing substance abuse treatment. Data collected includes the location, characteristics, services offered, and number of clients in treatment at alcohol and drug abuse treatment facilities (public and private) throughout the US.

POISON CENTER DATA SYSTEM

This dataset includes calls that are categorized either as "Exposure" or "Information", and are associated with poisons including illicit drugs, pharmaceuticals, non-drug substances (cosmetics, cleaning supplies, etc.), inhalants/fumes, plants, and more.

STATE UNINTENTIONAL DRUG OVERDOSE REPORTING SYSTEM (SUDORS)

Montana's Unintentional Drug Overdose Reporting System is an extension of the Montana Violent Death Reporting with additional data elements specific to drug overdoses. Detailed information on the drug(s), drug history, route administered, emergency medical care, and locations where the event occurred are included in this dataset.

SUBSTANCE ABUSE PREVENTION PLANNING AND EPIDEMIOLOGY TOOL (SAPPET) – SAMHSA

The SAPPET is an online data tool designed to help SAMHSA-funded prevention grantees access and use data to guide their prevention planning efforts. SAPPET contains 151 behavioral health key indicators from 11 national data sources and makes these data available by state. Indicators are categorized into substance-related consequences, consumption patterns, and associated risk and protective factors.

SYRINGE SERVICE PROVIDER (SSP) DATASET

The SSP dataset is a newer (2020 – present) dataset from MT DPHHS that includes data on type of drugs used, route administered, self-reported naloxone use for opioid overdose reversal, overdose history, injection frequency, history of drug treatment, pregnancy status, number of syringes returned, number of syringes required, and referrals made.

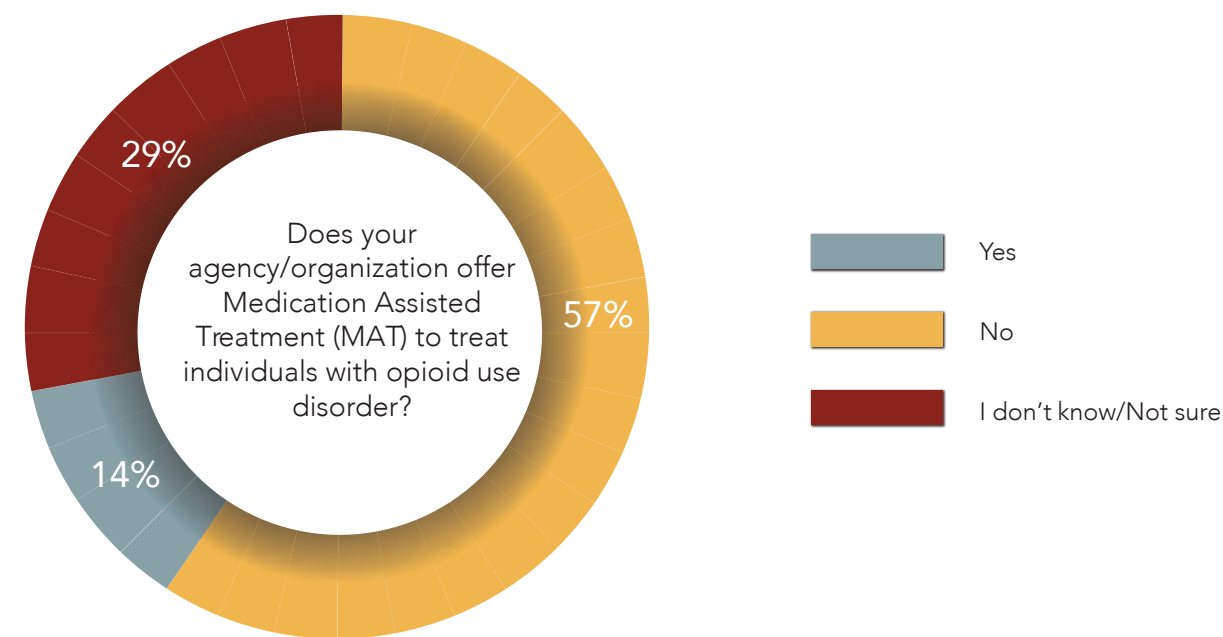
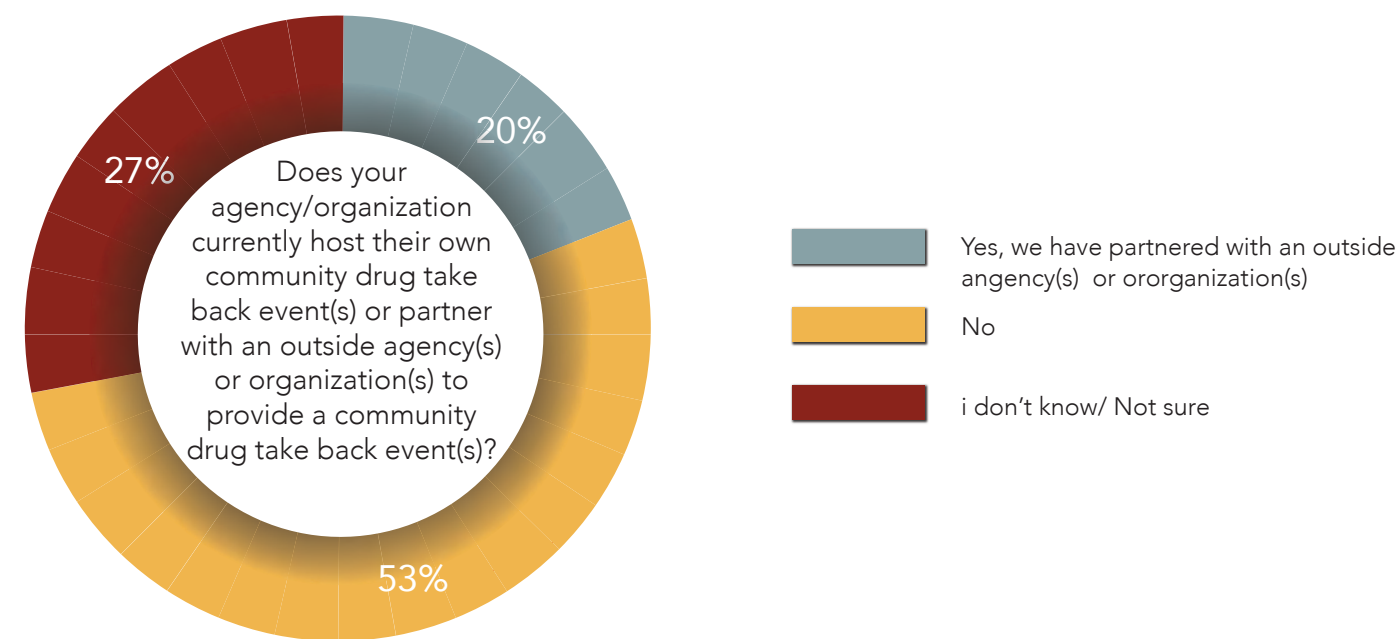
UNIFORM DATA SYSTEM (UDS) – HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Each year HRSA-funded Health Center Awardees are required to report core set of information, including data on patient demographics, services provided, clinical indicators, utilization rates, costs, and revenues.

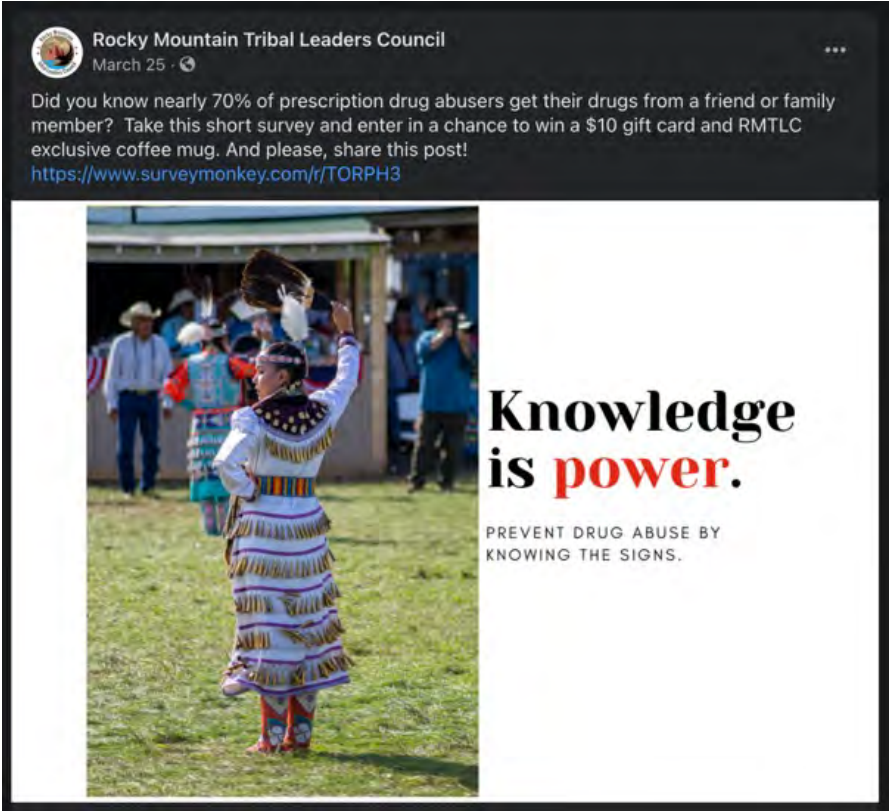
YOUTH RISK BEHAVIOR SURVEY (YRBS) AND THE YOUTH RISK BEHAVIOR SURVEILLANCE SYSTEM (YRBSS) – CDC

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System (YRBSS). The YRBS is used to monitor six categories of health-related behaviors that contribute to the leading causes of death and disability among youth, including alcohol and drug use. The State of Montana uses the acronym YRBS, whereas the State of Wyoming uses the acronym YRBSS.

Additional Phase 2 Survey tables and figures



Additional Phase 3 Survey Recruitment Flyers





Copy of Survey Instruments
Phase 2 Questionnaire:

The Rocky Mountain Tribal Leaders Council (RMTLC) Tribal Opioid Response (TOR) project is collecting information related to regional needs and resources available for opioid epidemic in Indian Country. We have selected you as a key individual to contribute to this information. We will be asking questions about your agency/organization access to data and available resources. The results of this questionnaire will be used to inform the Rocky Mountain region regarding opioid misuse.

The questionnaire should take no more than 5-10 minutes to complete, and your responses will be combined and remain anonymous. At the end of the questionnaire, you can enter to win 1 of 10 exclusive RMTLC mugs.

* 1. Is your agency/organization considered:

<input type="radio"/> Urban	<input type="radio"/> Private - off a Reservation
<input type="radio"/> Tribal	<input type="radio"/> Private - on a Reservation
<input type="radio"/> State	<input type="radio"/> I don't know/not sure
<input type="radio"/> Federal	

Phase 3 Questionnaire:

Tribal Opioid Response Program Questionnaire

The Rocky Mountain Tribal Leaders Council (RMTLC) Tribal Opioid Response (TOR) project is collecting information on the opioid crisis in the Rocky Mountain region. The results of this questionnaire will be put together to create prevention activities for opioid misuse. The questionnaire should take no more than 3-5 minutes to complete, and your responses will remain anonymous.

To be eligible you must be over 18 years old, self-identify as American Indian or Alaska Native, and reside in the States of Montana or Wyoming. Enter for a chance to win 1 of 10 gift cards (value: \$10) and an exclusive RMTLC coffee mug.

* 1. What is your age (in years)?

<input type="radio"/> Under 18	<input type="radio"/> 45-54
<input type="radio"/> 18-24	<input type="radio"/> 55-64
<input type="radio"/> 25-34	<input type="radio"/> 65+
<input type="radio"/> 35-44	<input type="radio"/> Prefer not to answer

* 2. Do you identify as American Indian/Alaska Native?

☐ Yes

☐ No

☐ Prefer not to answer

* 3. Do you reside in the States of Montana or Wyoming?

☐ Yes

☐ No

☐ Prefer not to answer

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Rocky Mountain Tribal Leaders Council
Tribal Opioid Response (TOR) Project

2929 3rd Avenue North, Suite 300
Billings, MT 59101

Phone: 406.252.2550

Email: info@rmtlc.org

www.rmtlc.org