National American Indian & Alaska Native
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Prevention

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Prevention as Response to the Opioid Crisis

National American Indian & Alaska Native Prevention Technology Transfer Center
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DIRECTOR'S CORNER

Welcome to the National American Indian and Alaska Native Prevention TTC's Spring 2021 newsletter. We are relieved that we are seeing the light at the end of the tunnel when it comes to COVID-19, even though we are not out of the woods yet. Native communities across the country have experienced extensive losses of tribal members to the pandemic, and have also felt the impact on their infrastructure, school system, and lack of access to services and resources. However, like so many times before, Native communities have rallied around their community members, supported each other and have been able to vaccinate a major portion of their tribal members. With the high vaccination rate, hopefully the contraction rate of COVID-19 will go down and we can hopefully have some of our initiatives be conducted face-to-face beginning in Fall 2021.

In this issue we have focused on prevention of opioid use disorders in Native communities. The main article is written by Professor Emeritus Ken Winters, a colleague we have worked with for many years. Under the umbrella of the Native Center for Behavioral Health we have two additional programs that focus on opioid use disorders; 1) The National AI & AN ATTC and 2) the Tribal Opioid Response (TOR) Technical Assistance (TA) Center; both these programs provide TA to tribal providers offering psychosocial treatment, implementing medication assisted treatment (MAT) and integrating knowledge and experienced based practices into MAT approaches.

Notably, several tribal communities have implemented prevention initiatives in addition to their MAT program and we want to give our readers a taste of all the exciting prevention efforts we have seen. Pam Baston and JoAnn Roser, our collaborators with JBS International, have written the article on prevention of OUD in TOR supported communities. We are also delighted to share an overview of the Indian Health Service (IHS) prevention and harm reduction initiatives contributed by Dr. Tana Triepke of the Harm Reduction IHS HOPE Committee.

Screening, Brief Intervention and Referral to Treatment (SBIRT) continues to be a very important method of preventing substance use from developing into a serious disorder. Because of popular demand, our center has offered this training to three different cohorts since January 2021, and we intend to continue providing this training coupled with TA going forward. Dr. Kathy Tomlin of the Cheyenne River Sioux Tribe and an expert on the use of MI with Native providers, is leading this effort.

The Substance Abuse Prevention Skills Training (SAPST) continues to be offered, and has been adapted to a virtual platform by our colleagues from the Tribal TTA Center, Connie O'Marra, MSW, Citizen Potawatomi/Irish, and David Brave Heart, Oglala Lakota/Hunkpati Dakota, who have been our trainers for this program as well. The Tribal TTA center has continued to collaborate with us on providing monthly trainings: Connecting Prevention Specialists to Native Communities.

COVID-19 restrictions have limited our options for our Leadership Academy, but our mentees and mentors have continued to work diligently on their projects. We are currently planning a face-to-face session with them in October 2021 as long as it is safe to do so.

Our staff has been inspired and encouraged by the work we have seen happening in programs across the country over the last year, and we are grateful to witness the efforts you are making to help your people. We look forward to continuing this journey with you as we see what the future holds for us.

Anne Helene Skinstad, PhD
Program Director

PREVENTION AND OPIOID ABUSE

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Introduction

In prior newsletters from the Native Center for Behavioral Health, we detailed the devastating effects of the opioid crisis on Native Americans and Alaska Natives (*Volume 3 Issue 3, September 2016: Opioid Response and Recovery*; *Volume 6 Issue 2, Winter 2020: Origins of the Opioid Crisis*). Overt and covert racism, economic hardship, poor access to health care are among barriers to health and exacerbate the opioid epidemic in Native communities.[1] Dealing with physical pain is "as much social as it is physical."[2]

Experts cite several co-occurring reasons for the origins of opioid epidemic: the medical profession's intent to seek better medicines for pain; flagrant under-estimation by researchers and FDA officials as to the powerful addictive potential of approved pain medications; influences by the medical and pharmacy professional organizations to facilitate access by patients to these medications; marketing strategies from the pharmaceutical industry to maximize profits; a slow-to-respond regulatory system to the early warning signs of the crisis; and an opportunistic black market proliferating illicit synthetic opioids like fentanyl and carfentanil that have a dangerous risk of lethality.[3]

Prevention as Response

The United States' opioid epidemic continues to be a public health problem in Native communities, which have seen disproportionate numbers of overdose deaths compared to the rest of the country.[5] Yet rays of hope exist with this crisis, of which many examples have been profiled in prior newsletters by the Native Center for Behavioral Health. We highlighted several efforts that tribes have taken to respond to the opioid epidemic, such as those by Blood Tribe/Kainai First Nation, Cherokee Nation in Oklahoma, Mille Lacs Band of Ojibwe, the Lac du Flambeau community, White Earth Nation, Cook Inlet Tribal Council, and the Lummi Nation's Healing Spirit Opioid Treatment Program.

This column will extend our Center's attention on the opioid abuse with a focus on prevention. Several noteworthy prevention efforts and initiatives that are making a difference are highlighted in the following pages.

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Compounding matters among those of all races and ethnic backgrounds is that misuse of opioids is associated with an increase in the risk for misuse of other prescription or illicit drugs. Data collected from 2016 to 2018 from the Add Health study showed that individuals who misused prescription opioids were more likely to also misuse prescription sedatives, tranquilizers, and stimulants, compared to those not misusing prescription opioids. Those misusing prescription opioids were also more likely to misuse non-prescription drugs, including heroin, crystal meth, and cocaine.[4]

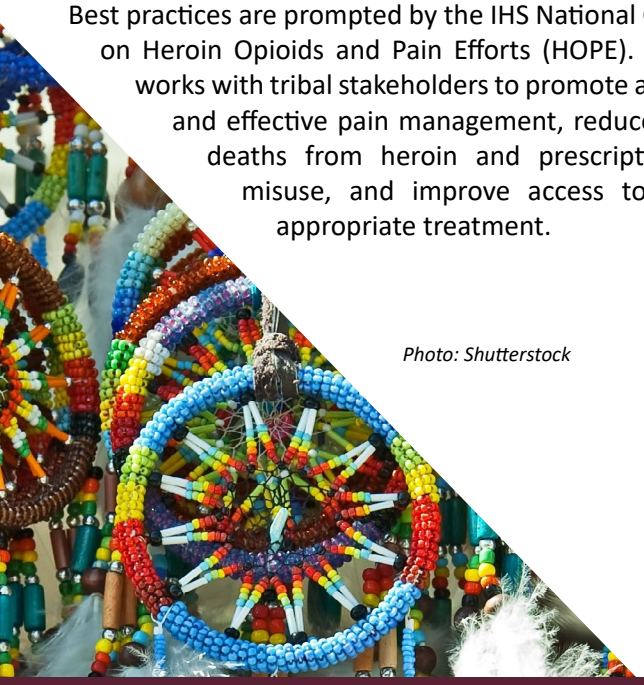
Indian Health Services (IHS) and the Response to the Opioid Crisis

IHS is committed to prevention strategies that ensure safe access to opioid medication and reduce the risk of prescription misuse, overdose, and diversion. IHS opioid prevention policies include the following:

- Increase provider and workforce training opportunities for prescribers and frontline clinicians pertaining to evidence-based practices and how to effectively utilize data to make improvement decisions.
- Increase community awareness surrounding use of opioids and opioid use disorders.
- Increase access to and use of clinical decision-making tools and technical resources to improve patient safety.

IHS' resources span several features – opioid crisis data, funding opportunities, technical assistance, and promoting best practices. A recent technical assistance opportunity is the *IHS Refresher Training on Pain & Addiction (RTPA) course*. This is an on-demand 90-minute training that offers CME credits for prescribers. The training focuses on providing knowledge on pain management, risk factors, and opioid and non-opioid treatments for pain. Case examples and role-playing supplement the learning.

Best practices are prompted by the IHS National Committee on Heroin Opioids and Pain Efforts (HOPE). This group works with tribal stakeholders to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment.



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Perspectives by Experts on Preventing Opioid Abuse in Native Communities

A team of California researchers sought to describe the needs of Native communities with respect to preventing and treating opioid abuse. Zeledon and her research team interviewed key informants in the state of California to identify community-based strengths and weaknesses for addressing Native opioid use disorder. Specifically, the researchers conducted structured interviews with 21 California-based healthcare professionals from urban Native health programs, tribal clinics, and community-based organizations. The interview assessed the following: (1) barriers to accessing services; (2) risk factors; (3) protective factors; (4) community substance use description; (5) SUD and OUD services available; and (6) service system needs.

The authors' interviews identified numerous barriers to accessing opioid abuse services. As shown in Table 1 *(page 5)*, barriers fell into these categories: external (e.g., waitlisted for services), internal (e.g., stigma), risk factors (e.g., mental health comorbidities), absence of protective factors (e.g., lack of family support), community substance use (e.g., easy access to drugs), lack of opioid abuse services (e.g., lack of medication-assisted treatment), and lack of service system needs (e.g., lack of sober living options).

The authors found that the key informants focused on cultural factors as the major facilitator of services. Recommendations included traditional healers becoming an integral part of a prevention or treatment program; use of the Wellbriety concept, which emphasizes being sober and a holistic perspective congruent with Native cultural beliefs and practices; use of cultural activities, which helps build safe spaces for clients, builds trust, and improves connection with others; and addressing the impact of historical trauma.

In sum, the authors noted two major ingredients for preventing and treating opioid abuse among Native people: (1) the importance of comprehensive and culturally centered care, wrap-around services, which include addressing risk factors for mental illness, and (2) the need for Native programs to integrate traditional and cultural activities into western health services.[7]

An example of a HOPE-supported program is the use of medication lock boxes. A team in the Phoenix area through collaboration with the IHS Division of Environmental Health Services distributed medication lock boxes for the homes of community members. Medication lock boxes complement clinic-based activities aimed at addressing the opioid epidemic by reducing improper access and securing storage. The team installed fifty-five lock boxes, including eight tribal communities.[6]

Table 1: Sources of Barriers to Accessing Services to Address Opioid Abuse[7]

External	
Transportation	Lack of insurace coverage
Waitlisted for services	Unstable living conditions
Lacking multiple entry points	Lack of sober living conditions
Privacy	
Internal	
Lack of personal readiness	Stigma
Risk Factors	
Polysubstance use	Economic stressors
Historical and intergenerational trauma	Poor case management and integrated care
Normalization of drug usage	Mental health comorbidities
Family dysfunction	Poor cultural cohesion
Lack of management of relapse	
Community Substance Use	
Increased use overall	Easy access to substances
Lack of Opioid-Related Services	
Lack of medication-assisted treatment (MAT)	Lack of traditional healing services
Lack of Native inpatient/ residential treatment facilities	Lack of Native sober living facilities
Absence of re-entry aftercare programs	

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Opioid Use Disorder Cascade of Care

This public health program provides communities with a framework for measuring a range of prevention and treatment indices associated with opioid abuse, including population-level abuse risk, treatment engagement, treatment retention, and recovery outcomes.[8] Quantifying these service-related stages provides a needs assessment for optimizing ways to prevent and treat opioid abuse.

Application of this approach was conducted in Minnesota. The researchers used existing state data to identify estimates of some of indices for a tribal nation in Minnesota. The data base indicated 269 individuals in the target tribal community in 2018 received treatment for opioid abuse or an opioid use disorder (OUD). Other treatment features: an estimated 65-99% received medications for an OUD and an estimated 13-41% received treatment for at least 6 months.[9]

Addressing the Opioid Crisis Among Native Youth

Preventing opioid abuse by Native youth living on or near reservations is the focus of a recent study. The researchers identified predictors of opioid abuse by applying a new type of exploratory data analysis, Machine Learning, to data from a large epidemiological survey (N = 6482). These salient protective factors were associated with no use of opioids during the past 30-days: no prior use of a narcotic; infrequent binge drinking; being older when alcohol was used the first time; and having fewer friends exerting pressure to use illicit drugs. One unexpected and moderate-level protective factor was minimal or no use of Snapchat.[10]

Health Professionals as Prevention Agents

Health care providers across disciplines have an important role in addressing the opioid health crisis. Collaborating with colleagues to reduce over-prescribing opioid medications, supporting prevention messages to clients about opioid misuse, assisting with training and availability of the antidote medication for an overdose event (naloxone), striving to expand addiction treatment, and educating patients about addiction risk and drug diversion are initiatives that providers can take.[11]

Among health care professions, pharmacists have received the most attention as prevention agents. An editorial in the March-April 2017 issue of the Journal of the American Pharmacists Association called for enhanced education of pharmacists about regarding the signs and symptoms of addiction, the benefits of naloxone, and to strengthen curriculum about opioid abuse in pharmacy training programs.[12]

Continuing education programs for pharmacists are being cited as one important vehicle for prevention. One promising example is a 3-hour opioid abuse and overdose prevention training program developed for pharmacists by a team of researchers at North Dakota State University. Delivered to 43 community pharmacists, the training consisted of five modules addressing the opioid use disorder, risks associated with opioid abuse, the nature of accidental overdose, the role of naloxone, safe practice in opioid dispensing, and effective strategies to communicate with patients about risks of taking an opioid. A post-program survey showed that several perceptions significantly changed as a result of the program: greater appreciation that opioid addiction can be outside the full control of the affected person; more acknowledgment of the role of family history with prescription drug abuse; greater value of the importance of counseling to support patients at risk of prescription opioid abuse; greater appreciation of the value of screening tools of risk factors for opioid abuse and accidental overdose; and more agreement on the importance of understanding the client's perspectives about pain and opioid abuse risk.[12]

Policy Makers and Health Professionals: Prescription Drug Monitoring Programs

States have broad authority to influence and regulate the prescribing and dispensing of opioid medications. Guidance from CDC provides data and resources to assist states regarding strategies and regulations that help prevent high-risk prescribing practices.

A common governmental policy approach is the prescription monitoring program (PMP). These are state-run electronic databases that track opioid and other prescriptions of controlled substances (e.g., benzodiazepines). By tracking prescription patterns, opioid prescribing can be improved and risk of patient opioid overdose can be reduced. To strengthen their effectiveness, some states have implemented polices that require providers to check a state PMP system prior to prescribing opioids, and provide regular, updated reports to authorized prescribers to protect patients at the highest risk (e.g., those taking both benzodiazepines and opioids), and to identify inappropriate prescription-seeking trends. Although findings are mixed, evaluations of PMPs tend to show favorable changes in prescribing behaviors and reductions in the use of multiple providers by patients.[13]

The Wellbriety approach acknowledges the unique history of Native people and is offered in some tribal and urban Native health clinics across the US. It has been used with clients who accept both western medicine and traditional healing treatments to develop coping skills, reconnect with their Native identity, and engage in their community and with family members.

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Can Cannabis Prevent Opioid Abuse?

The value of the active, intoxicant ingredient in the cannabis plant, THC, to reduce non-cancer pain continues to be debated among researchers and policy makers. Many states with medical cannabis laws include non-cancer pain on their approved list of conditions, and there are many credible reports from pain sufferers that cannabis offers effective pain relief.

Is THC effective pain medication? Some observers to speculate that THC's intoxicating effects provide a temporary psychological distraction to pain or that some are experiencing positive benefits due to a placebo effect. The scientific literature is equivocal. In the Institute of Medicine's (IOM) most recent report on cannabis, it was concluded there is a moderate level of evidence that cannabis is medicine for pain.[14]

A recent literature review that included more research studies than available to the IOM committee was conducted by Stocker and colleagues. They reviewed a 104 studies from 91 publications involving a total of 9,958 participants. About half (47 studies) were randomized controlled trials; the rest (57 studies) were observational.

The studies included numerous sources of chronic non-cancer pain (CNCP): neuropathic pain, fibromyalgia, rheumatoid arthritis, multiple sclerosis-related pain, visceral pain, and a mix of different kinds or undefined kinds of chronic non-cancer pain. The authors concluded based on their review: "It seems unlikely that cannabinoids are highly effective medicines for CNCP" (p. 1951).[15]

A related question is whether legalizing cannabis serves to prevent opioid abuse or opioid overdoses. Two early studies supported this position but more recent and rigorous studies raise doubts that legalizing cannabis for medical or commercial purposes will reduce the prevalence of opioid abuse and overdose deaths.[16,17] One example was a study that examined opioid overdose rates from 1999–2017 and found that states with medical cannabis laws experienced a 22.7% increase in overdose deaths. The researchers concluded that "research into therapeutic potential of cannabis should continue, but the claim that enacting medical cannabis laws will reduce opioid overdose death should be met with skepticism" (p.1).[18]

Summary

Prevention efforts to address any complex public health problem require a comprehensive approach. For the opioid crisis, the approach should include a strong PMP program that follows best practices, public health messages about the abusive potential of opioids, increased access to treatment of individuals with an opioid use disorder, public policy measures that reduce the likelihood of over-prescribing, expanded research on alternative pain management strategies, and increased education and training programs for health care professionals.[19,20] These efforts require contributions from policy makers, health officials, educators, and prevention and treatment professionals. Ingredients for Native communities to meaningfully address the opioid crisis will require optimal commitments and use of effective culturally appropriate approaches.

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Building Resilience through Prevention

PAMELA BASTON, MPA, MCAP, CPP and JOANN H. ROSER, BS

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Programs, practices, and innovations rooted in Native values, wisdom, and traditions are helping to prevent substance use and mental health challenges in Native American and Alaska Native people and communities throughout the country. While these communities have experienced a disproportionate burden with COVID-19 illness during the pandemic, many have found ways to continue their fight with substance use and mental health disorders that threatened their safety and wellbeing. Many of these efforts were made possible in part by funding made available from the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's Tribal Opioid Response (TOR) grants currently provide funding to approximately 120 federally recognized tribes and tribal organizations to support prevention, treatment, and recovery support services for opioid use disorder (OUD) and, if needed, stimulant misuse and use disorders. The examples below are planned or being implemented as part of this tribal initiative (aligned with evolving COVID-19 policies):

- Working with community partners to provide equine access for school aged youth to care for horses and talk about resilience as a way to heal from trauma and prevent high-risk behaviors including peer pressure to use drugs;
- Creating drive-through trainings to distribute Narcan overdose reversal kits;
- Working with tribal councils to distribute DETERRA drug deactivation bags and lock boxes to elders and placing medication lock boxes in the community;
- Using peer recovery specialists and others to create and disseminate culturally appropriate substance use and other educational packets along with personal protective equipment (PPE) in the community and on doorsteps or through outdoor porch visits;
- Tribal and youth advisory groups are regularly meeting (virtually) to share prevention information and play fun trivia games, some using GONA (Gathering of Native Americans) goals;

While the programs and practices highlighted here vary in many ways, they incorporate common cultural protective factors such as spirituality, the wisdom of elders, and family relationships.

- Creating a Zoom training (from what was a live presentation) for "Spot the drug use risks in this bedroom," a great prevention resource for parents, family members, and caregivers;
- Producing a substance abuse treatment and prevention resource book to hand out to new and established community partners;
- Using GoodHealthTV in clinic areas to relay by-Native-for-Native messages that include the risk of using opioids to manage stress and depression and during pregnancy;
- Creating drive-through COVID testing centers which use clear plastic screens/ shower curtains as a barrier behind which members can safely pray with spiritual leaders;
- Hiring a cultural coordinator to teach others about how historical trauma can separate Native people from their resilient culture and change the narrative to "I am Native and I am resilient."

PREVENTION AND HARM REDUCTION INITIATIVES

A conversation with Tana Triepke from the IHS HOPE Committee

What are some past/current IHS opioid prevention and harm reduction initiatives?

IHS has developed a 5-point strategy to address the opioid epidemic. This includes expanding access to SUD prevention, treatment, and recovery services; expanding harm reduction interventions to increase education and improve access to naloxone; developing an interdisciplinary approach for treatment of acute and chronic pain; reducing perinatal substance exposure for future generations; and providing better data extraction and metrics to support informed decisions surrounding opioid use disorder (OUD) and pain management. Under these strategies, the IHS has recognized that good pain management is prevention; culture is prevention; and awareness that increased access to medications for opioid use disorder (MOUD) is a harm reduction strategy. *The IHS strategy and resources are captured nicely in this infographic that focuses on five key strategies.*

What role does culture play in implementation of harm reduction initiatives in Native communities?

Cultural competency in the community that you serve is an integral component for a successful program and supports positive health outcomes and prevention. Partnerships with key stakeholders such as community faith groups and/or tribal programs can help support harm reduction initiatives and meet the needs of the community. IHS practitioners who use cultural humility are often more impactful and open doors to discussions that inform strategies and improve resource utilization.

Can you share some successful outcomes from these initiatives?

Below are a few of IHS's key outcomes:

- From 2013 to 2018, Buprenorphine treatment of OUD in IHS increased by 95%.
- In 2015 the IHS-BIA MOU was signed resulting in all BIA officers trained and equipped with naloxone. *First Responders | Naloxone (ihs.gov)*
- IHS naloxone procurement increased from 2015 to 2019 as a result of the training and resources for naloxone co-prescribing within the naloxone toolkit. *Naloxone Training Toolkit | Naloxone (ihs.gov)*
- From 2013 to 2018, total daily Morphine Milligram Equivalents (MMEs) prescribed per 100 prescriptions decreased by 40% in IHS facilities due to the interdisciplinary approach for the treatment of pain.

For further examples of IHS sites increasing access to Naloxone please visit the following links:

HOPE October 2020 Newsletter (ihs.gov)

HOPE Committee Newsletter October 2019 (ihs.gov)

Can you describe some challenges or barriers in the field and recommendations for overcoming these barriers?

I think the biggest challenge is overcoming people's perceptions and beliefs associated with substance use and making harm reduction a priority. Competing priorities and time constraints are another barrier. Education is key in overcoming these barriers. Find a champion locally to lead your efforts to implement change and spearhead the education of staff and patients.

Additional resources:

https://www.ihs.gov/opioids/hope

https://www.ihs.gov/opioids/opioidresponse/

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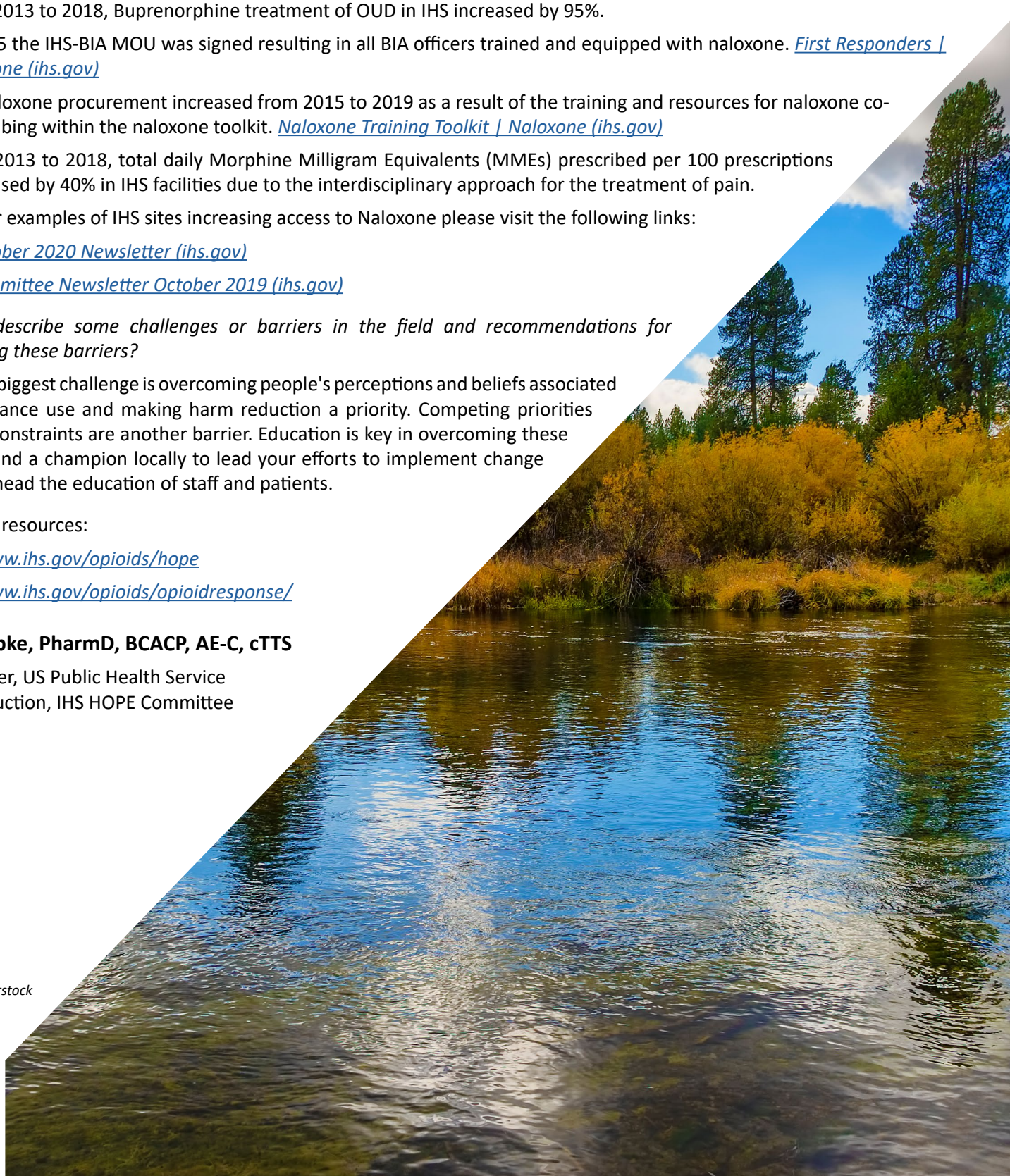

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Within the midst of
despair, all seems hopeless;
We struggle to move forward,
not knowing what lies ahead.

Though the Valleys are deep and
the mountain so high
An echo of the past whispers, do
not give up, nor give in.

Persevere through this, and you
will gain more than you realize

Suffering is not about
enduring pain, but the
road to peace.

- Sean Bear and
Lena Thompson

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RECENT ACTIVITIES & UPCOMING EVENTS

All of the events and opportunities listed below will be announced on our email list. *Join our mailing list to make sure you receive these announcements!*

Presentation Development and Design Training - This training is taking place on May 13. For more information or to register, *click here.*

Connecting Prevention Specialists to Native Communities in Times of Crisis: Listening Sessions - This session will continue in collaboration with the Tribal TTA Center on the third Friday of each month. *Click here to register.*

Prevention Webinar Series - We host a webinar on prevention practices in Native American communities on the fourth Wednesday of each month. *Click here for information on this month's session.*

Developing Health Promotion Campaigns - We are currently working with multiple tribes on health promotion campaigns based on needs they identified in their communities.

Screening Brief Intervention and Referral to Treatment (SBIRT) Technical Assistance Opportunity for Providers in Native American Communities - We began this series of trainings and booster sessions with four cohorts in January. For information on this program, please contact Cindy Sagoe: *cindy-sagoe@uiowa.edu*

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