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NATIONAL COUNCIL *of*
URBAN INDIAN HEALTH

UNDERSTANDING URBAN INDIAN SUBSTANCE MISUSE AND OVERDOSE PREVENTION:
A MIXED-METHODS ANALYSIS

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NCUIH also would like to acknowledge that our national office and nearby activities are situated on the traditional homelands of many Native nations. Some of the communities in the surrounding area include the Piscataway, Pamunkey, Nentego, Mattaponi, Chickahominy, Monacan, and Powhatan peoples. These lands have deep historical, cultural, and spiritual significance to Native peoples, and we are grateful to them.

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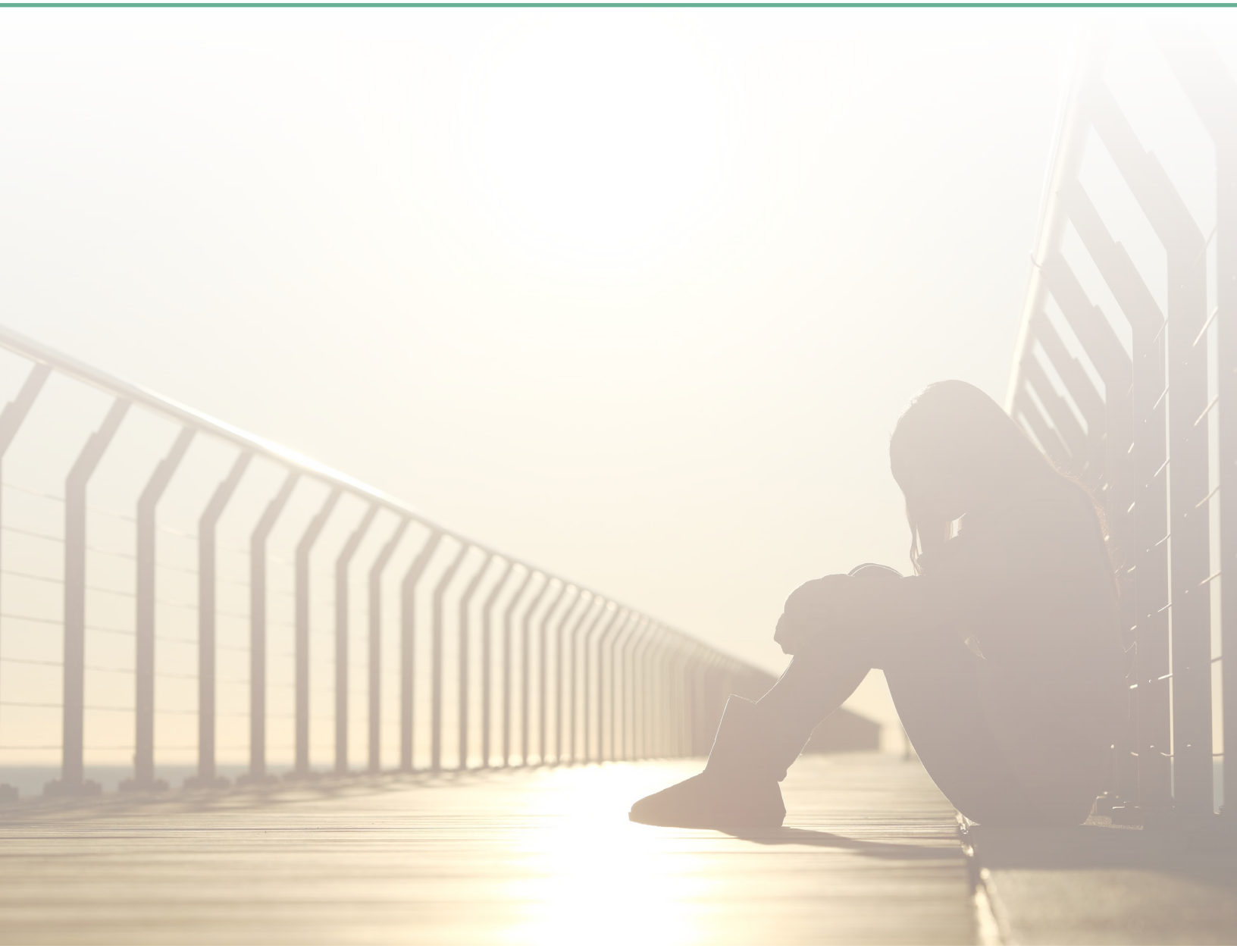
EXECUTIVE SUMMARY

The National Council of Urban Indian Health (NCUIH) completed a needs assessment between 2023-2024 to analyze the impacts of substance misuse and opioid overdoses on Urban Indian Organizations (UIOs) and the urban American Indian and Alaska Native (AI/AN) populations they serve. NCUIH utilized a combination of quantitative and qualitative methods, including a review of literature and policies, an environmental scan, key informant interviews, and a live virtual dialogue to collect and analyze data on how substance misuse affects urban AI/AN populations and the role that UIOs play in addressing substance misuse. Results indicate that the majority of UIOs offer behavioral health services, which can play a role in overdose prevention, with many UIOs offering substance misuse counseling, Naloxone/Narcan services, and other key harm reduction services. Findings from this needs assessment highlight the need for improved investment in the behavioral health workforce, strengthened partnerships between stakeholders in overdose prevention to better support AI/AN populations, improvements to the availability and sustainability of funding opportunities for substance misuse prevention, and overall increased support for urban AI/AN populations through legislative and health care-related actions.



ACRONYMS

Acronyms or abbreviations used in open-ended free response qualitative data are not all included in this acronym list, as the researchers who analyzed this qualitative data do not want to inaccurately presume the intended meanings of research participants' responses. Please note that the following report uses the term "substance misuse" to refer to the inappropriate use of substances such as drugs, alcohol, and tobacco (American Public Health Association, 2024). While the majority of this needs assessment focused on the inappropriate use of opioid drugs, opioids are not the only substance impacting urban AI/AN populations, and many of the insights collected through this needs assessment are relevant to additional substances that are commonly misused. Additionally, because not all use of substances (such as opioids, alcohol, or tobacco) is considered inappropriate, this report utilizes the term "misuse" when applicable to differentiate appropriate use of substances (e.g., correct use of prescribed opioids) from inappropriate misuse of substances.

- **AI/AN** – American Indian and Alaska Native
- **CARE** – Comprehensive Addiction Resources Emergency
- **CARES** – Coronavirus Aid, Relief, and Economic Security
- **CDC** – Centers for Disease Control and Prevention
- **DEA** – Drug Enforcement Administration
- **DHHS** – Department of Health and Human Services
- **DNA** – Deoxyribonucleic Acid
- **FDA** – Food and Drug Administration
- **FMAP** – Federal Medical Assistance Percentage
- **FY** – Fiscal Year
- **HIPPA** – Health Insurance Portability and Accountability Act
- **HRSA** – Health Resources and Services Administration
- **HRSN** – Health Related Social Needs
- **I/T/U** – Indian Health Service, Tribes, and Urban Indian Health Programs
- **IHCIA** – Indian Health Care Improvement Act
- **IHS** – Indian Health Service
- **LAC** – Licensed Addiction Counselor
- **LCDC** – Licensed Chemical Dependency Counselor
- **LPC** – Licensed Professional Counselor
- **MAT** – Medication-Assisted Treatment
- **MOUD** – Medications for Opioid Use Disorder
- **NCHS** – National Center for Health Statistics
- **NCUIH** – National Council of Urban Indian Health
- **NHSC** – National Health Service Corps
- **NHW** – Non-Hispanic White
- **NVSS** – National Vital Statistics System
- **OD** – Overdose
- **ODMAP** – Overdose Detection Mapping Application Program
- **OTP** – Opioid Treatment Program
- **OUD** – Opioid Use Disorder
- **PHE** – Public Health Emergency
- **SAMHSA** – Substance Abuse and Mental Health Services Administration
- **SDOH** – Social Determinants of Health
- **SUD** – Substance Use Disorder
- **SUPPORT** – Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities
- **UIO** – Urban Indian Organization

BACKGROUND ON THE OPIOID CRISIS IN INDIAN COUNTRY

The following section of the report summarizes key background information on Urban Indian Organizations, policies related to substance misuse, and the impacts of substance misuse on American Indian and Alaska Native (AI/AN) populations.

I. Introduction to Urban Indian Organizations

Urban Indian Organizations (UIOs) are a critical part of the Indian health system, which is comprised of the Indian Health Service (IHS), Tribes, and UIOs (collectively known as the "I/T/U system"). The 41 UIOs operate over 85 facilities in 38 urban areas in 11 of 12 IHS areas. UIOs are Native-led organizations by law, and they provide critically-needed primary care, behavioral health, traditional medicine, and social and community services to AI/AN patients from over 500 federally recognized Tribes who are living in urban areas (Indian Health Service, 2021).

II. Overview of Academic Literature

Current policies and action plans to address opioid misuse in the United States are ill-equipped to address the underlying vulnerabilities to substance misuse present in AI/AN populations (Whelshula et al., 2021). Specific risk factors for opioid misuse that have been identified for AI/AN populations include loneliness, lack of social support, adverse childhood experiences, cultural disconnection, and historical trauma (Dickerson et al., 2022; Hirchak et al., 2023; Qeadan et al., 2021).

In 2021, the AI/AN population had the highest rate of fatal opioid overdoses of any group in the United States (Centers for Disease Control and Prevention, Injury Center, 2024). The prevalence of opioid overdoses among the AI/AN population has seen a marked escalation over the past two decades, with a substantial surge recorded in 2020 amid the onset of the COVID-19 Pandemic (Centers for Disease Control and Prevention, Injury Center, 2024; Mack et al., 2017). Fatal overdose rates within the AI/AN population also vary further between urban and rural AI/AN populations, with the highest rate of fatal overdoses among urban AI/AN people compared to their rural and/or non-Hispanic White (NHW) counterparts, as illustrated in Figure 1 (Hirchak et al., 2023; Mack et al., 2017).

Figure 1. Rates of Fatal Overdoses for Rural and Urban AI/AN and NHW Populations, 2017 (Mack et al., 2017, p. 201)

Location	AI/AN Population	NHW Population
Urban Population	22.1 per 100,000 people	21.4 per 100,000 people
Rural Population	19.8 per 100,000 people	19.2 per 100,000 people

Health care deficiencies may contribute to opioid addiction in AI/AN populations, such as through the overprescription of opioids in these communities (Whelshula et al., 2021). Uninsured people and patients in economically depressed areas are more likely to be prescribed opioids for pain management. Opioids are typically a cheaper form of pain management and are more likely to be covered by insurance than more expensive treatment options such as corrective surgery (2021). Additionally, in AI/AN populations, these issues are compounded by the chronic underfunding of the Indian health system, which further limits treatment options available to AI/AN patients who are dealing with pain due to prioritization and coverage of patients in critical

conditions where "life and limb" are at immediate risk (2021). Other patients with conditions not considered at risk for loss of "life and limb," and not covered for treatment options that would address the underlying cause of pain, are instead often prescribed opioids as a form of pain management (2021).

AI/AN populations urge that the utilization of multidimensional models that target all factors that may influence opioid misuse or prevention efforts within a community are better suited to address the opioid crisis in AI/AN populations (Dickerson et al., 2022; Hirchak et al., 2023; Northwest Portland Area Indian Health Board, 2023a). Multidimensional models target not only current behaviors of opioid misuse, but also target the larger socioeconomic and political contexts – such as lack of adequate health care, housing instability, lack of familial and social support systems, mistrust of health care professionals, stereotype threat, poverty, historical trauma, and criminalization of substance misuse – but also help to prevent future opioid misuse and better current treatment efforts (Hirchak et al., 2023; Whelshula et al., 2021). Additionally, prevention and treatment strategies for opioid misuse need to be mindful of the frequent comorbidity of opioid use disorder (OUD) with other mental health/substance misuse disorders (Ellis et al., 2023; Lillie et al., 2021; Santo et al., 2022). For example, AI/AN youth with co-occurring mood/anxiety disorders were more likely to maintain buprenorphine/naloxone use, but youth with other substance use disorders in combination with OUD were associated with higher rates of discontinuation of the same treatment (Lillie et al., 2021). Multidimensional models would address root causes of trauma and other mental illnesses that may be risk factors for future opioid misuse or comorbid with existing OUD, as well as providing housing stability, transportation to care, help with employment, or other non-biological factors that affect someone's ability for harm reduction, receiving care, and recovery for OUD. Additionally, addressing pain management strategies in health care settings, pharmaceutical companies' influence on providers, and the criminalization of people with OUD should also be incorporated into these multidimensional models to combat OUD (Whelshula et al., 2021). Models to address opioid misuse in communities that solely address the physical and biological effects of opioid misuse are suggested to be ill-suited for AI/AN populations (Hirchak et al., 2023; Whelshula et al., 2021).

Best practices for addressing opioid misuse in AI/AN populations include centering intervention strategies around AI/AN culture and family and integrating traditional healing, ceremony, and other cultural practices into engagement and recovery strategies (Hirchak et al., 2023). Strengths in AI/AN populations such as traditional healing practices should be emphasized, and health care providers, researchers, and other opioid crisis community stakeholders need to engage in conversation and ensure that trust is established with AI/AN populations and AI/AN people with OUD to improve OUD research and OUD treatment and prevention program design and engagement (Hirchak et al., 2023; Komro et al., 2023; Whelshula et al., 2021). Engaging with AI/AN populations ensures the cultural integrity of Indigenized OUD program design by incorporating traditional healing into care. The favored models within AI/AN populations for addressing OUD incorporate cultural and traditional approaches to healing (Dickerson et al., 2022; Hirchak et al., 2023; Komro et al., 2023; National Council of Urban Indian Health, 2023; Whelshula et al., 2021). This is especially important for urban AI/AN populations, as living away from Tribal lands often means living in separation from that culture and traditional healing, as well as often experiencing stigmatization as AI/AN people in urban areas (Dickerson et al., 2022). Disconnect from culture and social isolation for urban AI/AN people can lead to self-medication to cope with those and other stressors (2022). Traditional healing and other culturally-based opioid prevention/treatment programs can bridge this cultural gap and build social connections among urban AI/AN people in their communities (2022). A previous meta-analysis indicated significant improvements in general health outcomes, including substance use cessation, when traditional healing was used as an intervention method (National Council of Urban Indian Health, 2023). Additionally, a traditional healing approach to a women's circle at one UIO residential and treatment facility demonstrated improvements in participants opioid and other substance misuse behaviors, employment status, housing status, education status, improved quality of life, and decreased encounters with the justice system twelve months after program initiation (Saylors, 2003). Making these programs accessible via virtual services can also help to further meet the demand for culturally based opioid programs that resonate with urban AI/AN audiences (Dickerson et al., 2022).

III. Overview of Recent Opioid Public Policy

Over the last decade, Congress has enacted legislation to address the opioid crisis (Rep. Bonamici, 2016; Rep. Walden, 2018; Sen. Inhofe, 2019, tit. LXXII; Sen. Scott, 2021; Sen. Whitehouse, 2016, sec. 6610). This legislation includes language to provide grant eligibility for Tribes and Tribal Organizations (UIOs are not eligible), with one bill incorporating a five percent Tribal set-aside for State Response to the Opioid Abuse Crisis and giving priority to Tribes for Comprehensive Opioid Recovery Centers (Rep. Walden, 2018). The purpose of this legislation was to address the overprescription and misuse of opioids, expand substance use disorder prevention and treatment capacities, bolster drug diversion capabilities, and enhance international drug interdiction, counternarcotics cooperation, and sanctions efforts (Congressional Budget Office, 2022). Additionally, these legislations aim to respond to the opioid crisis by:

"Reducing the demand for opioids by preventing and treating opioid use disorder; reducing the supply of opioids by limiting the inappropriate and nonmedical use of prescription opioids and the supply of illegally produced opioids; and reducing the harm from Opioid Use Disorder (OUD) by supporting the health of people with OUD until they are ready to seek treatment." (Congressional Research Services, 2022).

During this time, federal funding has increased for evidence-based initiatives such as medication-assisted treatment (MAT), including new requirements for state Medicaid plans to cover MAT services under the *Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (also known as the *SUPPORT Act*) (Congressional Budget Office, 2022, p. 21; Rep. Yarmuth, 2021, sec. 2706; SAMHSA, 2023). This includes funding to eliminate the X waiver in the *2023 Consolidated Appropriations Act*, which required Drug Enforcement Administration (DEA) registration for a practitioner to prescribe for treatment of OUD (Edward L. Holloran, III et al., 2023). Within the *SUPPORT Act*, a five percent set aside was provided to Tribes for the state opioid grant response program. Additionally, Congress has appropriated $1 billion annually since FY2018 to the Substance Abuse and Mental Health Services Administration (SAMHSA) to support the State Opioid Response grant program (Congressional Budget Office, 2022; Rep. Connolly, 2022; Rep. Jeffries, 2022). This program is aimed at providing resources for increasing access to medications approved by the Food and Drug Administration (FDA), as well as supporting prevention, harm reduction, treatment, and recovery support services for OUD and other substance use disorders (SAMHSA, 2024b). UIOs are not eligible for these grants, but Tribes are eligible under the Tribal Opioid Response grant program to address OUD in Tribal communities (SAMHSA, 2024c). Congress has also recently passed various legislations in support of harm reduction strategies for substance use disorder, such as the syringe services programs and community-based overdose prevention programs provided in the *American Rescue Plan Act of 2021* (Rep. Yarmuth, 2021). Grants for these programs are available to Tribes, Tribal Organizations, and nonprofit community-based organizations, which include UIOs.

During the height of the COVID-19 pandemic, federal policies were expanded permanently or temporarily to improve access to OUD medication treatment, including temporarily relaxing restrictions to accessing OUD medication treatment via telehealth (Saunders & Panchal, 2023). On February 2, 2024, the Department of Health and Human Services (DHHS) released a final rule that modified and updated provisions of regulations related to Opioid Treatment Program (OTP) accreditation and standards for treatment of OUD with Medications for Opioid Use Disorder (MOUD) in OTPs (Federal Register, 2024). The compliance date was October 2, 2024, and it included making certain flexibilities that had emerged during the Public Health Emergency (PHE) permanent, as well as expanding access to care and evidence-based treatment for OUD (2024). The final rule would reduce burdens and provide benefits to providers, as it supports OTPs in the provision of equitable and evidence-based care to patients with OUD, who are often members of marginalized communities (2024).

Many federal regulations have also been amended and updated to minimize public health and safety risks for OTPs by requiring that practitioners prescribe in a qualified practice setting that accepts third-party payments

(Enomoto and Burwell, 2016). Tribes are eligible to apply for and receive accreditation to operate their own OTP, and UIOs are not eligible to apply (Federal Register, 2024). Through SAMSHA, DHHS released a final rule in February 2024 regarding regulations that guide OTPs, which would increase access to lifesaving, evidence-based MOUD and advance retention in care through the promotion of patient-centered, compassionate interventions (Federal Register, 2024; SAMHSA, 2024a). These revisions to the rule went into effect in October 2024, and SAMHSA will work with stakeholders to assist with implementation (SAMHSA, 2024a).

Notably, the *SUPPORT Act* expired on September 30, 2023 (U.S. Senate Committee On Health, Education, Labor & Pensions, 2023). Therefore, Congressional authorization for funding and programs that support prevention, treatment, and recovery under the *SUPPORT Act* has also expired. In response, legislation has been introduced during the 118th Congress to reauthorize the *SUPPORT Act* and further address the ongoing opioid crisis. The Support for Patients and Communities Reauthorization Act (H.R. 4531) would reauthorize grants, *SUPPORT Act* programs, and activities that address substance use and misuse while also making permanent the requirement that Medicaid programs cover medication-assisted treatment (Rep. Guthrie, 2023). The bill does not include any mention of UIOs, but does provide grants to Tribes in Section 117, "Grant Program for State and Tribal response to Opioid Use Disorders" (2023).

In addition, the *Safer Response Act* (H.R. 4089) would authorize a grant program to train and provide resources for first responders to respond to opioid overdoses (Rep. D'Esposito, 2023). It amends the *Public Health Service Act* (42 U.S.C. 290ee—1[h]), which provides grants to Tribes and Tribal Organizations; UIOs are not eligible (2023). More recently, on May 9, 2024, the *Comprehensive Addiction Resources Emergency (CARE) Act* (S.4286/H.R. 8323) was introduced, which provides emergency assistance for areas disproportionately impacted by substance use disorder (Warren, 2024). It provides $125 billion in federal funding for FY 2025-2035, awarded to state and local governments for recovery and support services as well as harm reduction services (2024). The legislation specifically provides a Tribal set aside of ten percent for each fiscal year for grants to Tribes and UIOs (2024). Although many federal regulations have expanded and become more flexible, there are still states that impose greater restrictions on OTPs. For example, there is a federal stability criterion to receive take-home medication, but ten states impose additional criteria which limit its access (The Pew Charitable Trusts, 2022). Some states have also placed limits on how many OTP facilities can be opened. For example, Indiana limits the number of new facilities, while West Virginia has implemented a legal moratorium disallowing any new OTPs (2022).

IV. Community Consensus Overview

From August 22-24, 2023, NCUIH joined Tribes and community members from across the United States to convene at the National Tribal Opioid Summit in Tulalip, Washington (Northwest Portland Area Indian Health Board, 2023a). This summit aimed to address the current opioid crisis and the compounding effect of the COVID-19 pandemic in Native communities (2023a). Insights shared by attendees and community members highlighted many needs specific to the Native opioid crisis, such as utilizing holistic approaches to address the opioid crisis, improving data sovereignty, and ensuring that culturally tailored care is provided and reimbursable by third-party billing systems (2023a). Policy recommendations based on the summit include to: declare a national emergency on the opioid epidemic, ensure that Tribal practices (including traditional medicine) are reimbursable by third-party payers, provide additional and proactive technical assistance to Tribal nations, increase behavioral health providers in Indian Country, improve federal standards for data collection and reporting related to opioid and fentanyl use, and more (Northwest Portland Area Indian Health Board, 2023b). Additional information on this conference can be accessed at the National Tribal Opioid Summit Resource Hub at https://www.npaihb.org/national-tribal-opioid-summit/ (Northwest Portland Area Indian Health Board, 2024).

ENVIRONMENTAL SCAN

The following section summarizes the key findings from the environmental scan component of this needs assessment. The environmental scan included an analysis of available data on UIO services related to substance misuse from NCUIH's UIO Program Profiles and UIO websites/social media in order to identify key services related to overdose prevention and how common these are at UIOs. Data reflected that all UIOs offer at least one type of service related to substance misuse, with the most common service offered being substance misuse counseling. Additional programs commonly offered by UIOs include community education (offered by 63 percent of UIOs), coordination with a primary care provider (offered by 59 percent of UIOs), transportation to care (offered by 34.1 percent of UIOs), and housing assistance (offered by 34.1 percent of UIOs). The services offered at UIOs often demonstrate a holistic approach to addressing not only substance misuse but also additional comorbidities or socioeconomic challenges that can affect substance misuse, such as housing status, problems with the legal systems, and access to care. These efforts by UIOs also highlight the need for stigma reduction, culturally tailored care options, and an overall increase in efforts to prevent substance misuse.

An additional component of this environmental scan was to analyze existing county-level drug overdose death counts and UIO locations to understand overdose trends in areas served by UIOs. Findings from this environmental scan also indicated that UIOs are often located in areas with high counts of overdose fatalities. In the first six months of 2023, the average number of overdose mortalities per UIO county was 2,056[1], while the average number of overdose mortalities per overall U.S. county was 209. Increased resources and funding should be shared with UIOs to better prevent and address OUD for urban AI/AN populations.

I. Services at UIOs

The forty-one UIOs offer a wide variety of services related to substance misuse. The following table (Figure 2) and graph (Figure 3) present a summary of key services related to substance misuse and overall behavioral health that are offered at UIOs. This data is based on NCUIH's UIO Program Profiles, UIO websites, and UIO social media. For more information on UIOs, visit NCUIH's UIO Directory. Please note that services at UIOs are subject to change, and the following data may not accurately represent all current UIO services.

1. UIO counties included all service area counties as indicated by UIOs, besides the UIO located in Dallas, Texas [Texas Native Health]. Texas Native Health's service area included all counties within Texas (National Council of Urban Indian Health, 2022). For the averages reported above, only the six counties within the city of Dallas were included in consideration for UIO counties (Collin, Collingsworth, Dallas, Denton, Kaufman, and Rockwall) since the majority of counties within Texas (as of 2022) are not within metropolitan statistical areas (i.e., there are 80 metropolitan statical area counties out of 254 total Texas counties) and almost half (123 counties) are non-core based statistical area counties (Green, 2023). The service area for the calculated UIO area was adjusted for Texas Native Health in the reported calculation. The UIO service area OD average for January to June 2023 (including the entirety of the Texas Native Health service area of all counties within Texas) is 562.

Figure 2. Preliminary Summary of Services at UIOs [n (% of N)]

Service	Offered On-Site	Referred Out Only	Not Confirmed or Not Offered
Community Education	26 (63.4%)	--	15 (36.6%)
Coordination with Primary Care Provider	24 (58.5%)	--	17 (41.5%)
Drug-Specific Care	6 (14.6%)	--	35 (85.4%)
Drug Testing	7 (17.1%)	--	34 (82.9%)
Harm Reduction	11 (26.8%)	--	30 (73.2%)
Housing Assistance	14 (34.1%)	--	27 (65.8%)
Inpatient Residential	7 (17.1%)	9 (21.9%)	25 (61.0%)
Legal Help	7 (17.1%)	1 (2.4%)	33 (80.5%)
Medical Detox	1 (2.4%)	2 (4.9%)	38 (92.7%)
Medication-Assisted Treatment (MAT)*	11 (26.8%)	2 (4.9%)	28 (68.3%)
Substance Misuse Counseling	41 (100.0%)	--	--
Traditional Healing-Based Substance Misuse Programs	12 (29.3%)	--	29 (70.7%)
Transportation	14 (34.1%)	--	27 (65.8%)
			Total (N): 41

Figure 3. Preliminary Substance Misuse Services of UIOs

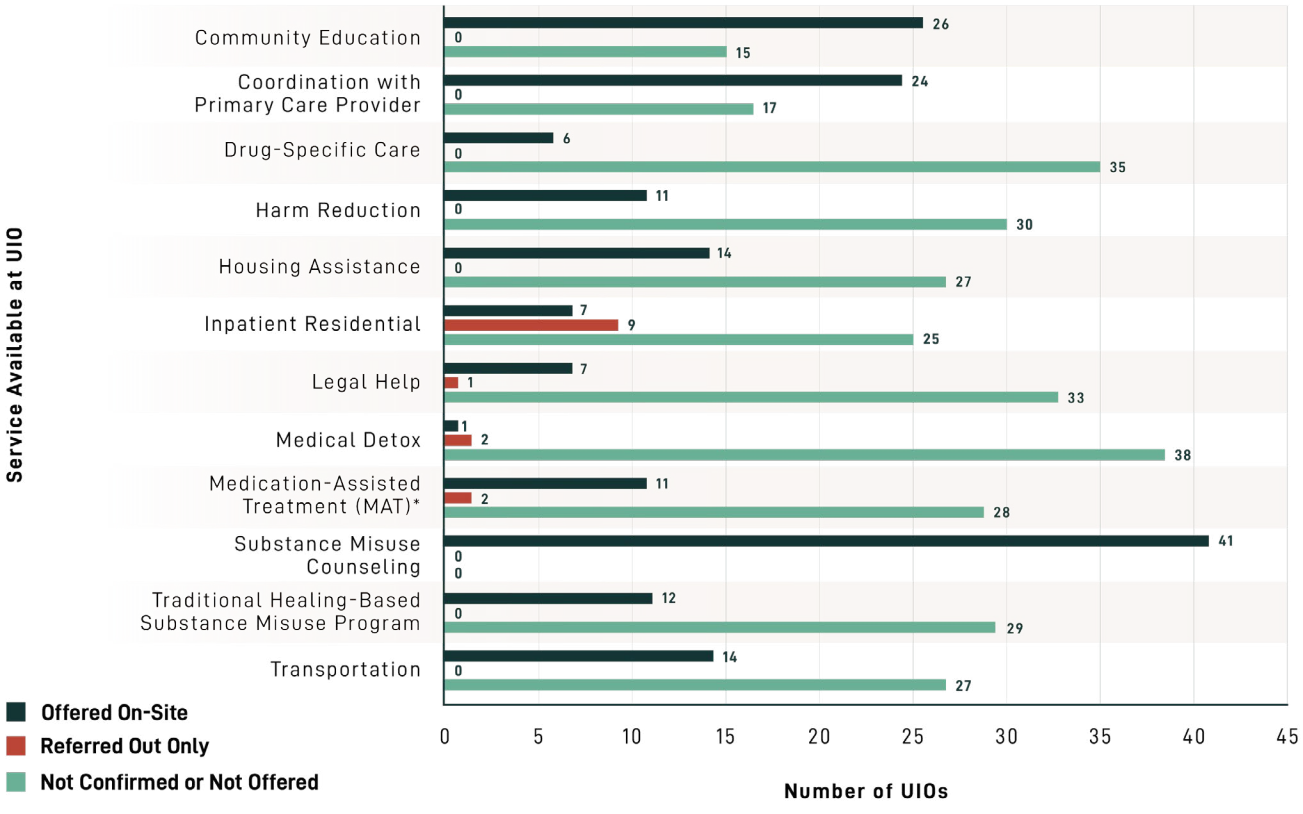


Figure 4 provides detailed information on current services at UIOs related to substance use. This data is also based on NCUIH's UIO Program Profiles, UIO websites, and UIO social media. Please note that services at UIOs are subject to change, and the following data may not accurately represent all current UIO services.

Figure 4. UIO Characteristics and Substance Misuse Services

UIO Name	State	Program Type	HRSA Status	Substance Misuse Counseling	Inpatient (Residential)	Harm Reduction	Medical Detox	Legal Help	Drug-Specific Care	Drug Testing	Coordination with Primary Care Provider	Community Education	Housing Services	Transportation to Care	Medication-Assisted Treatment (MAT)*	Pharmacy	Traditional Healing-Based Substance Misuse Programs
All Nations Health Center	MT	Limited Ambulatory	HRSA 330	Y						Y	Y	Y		Y			
American Indian Council on Alcoholism	WI	Residential or Outpatient Treatment Center	Non-HRSA	Y								Y					
American Indian Health & Family Services	MI	Full Ambulatory	Non-HRSA	Y	R						Y	Y					
American Indian Health & Services	CA	Full Ambulatory	HRSA 330	Y	R									Y			
American Indian Health Service of Chicago	IL	Limited Ambulatory	Non-HRSA	Y	Y	Y	Y	R	Y			Y					
Bakersfield American Indian Health Project	CA	Outreach and Referral	Non-HRSA	Y	R				Y			Y		Y			Y
Billings Urban Indian Health & Wellness Center	MT	Full Ambulatory	Non-HRSA	Y				Y									Y
Butte Native Wellness Center	MT	Limited Ambulatory	Non-HRSA	Y		Y		Y			Y			Y			
Denver Indian Health and Family Services	CO	Full Ambulatory	Non-HRSA	Y		Y				Y	Y				Y	Y	
First Nations Community HealthSource	NM	Full Ambulatory	HRSA 330	Y		Y		Y	Y	Y	Y	Y	Y		Y	Y	
Fresno American Indian Health Project	CA	Outreach and Referral	Non-HRSA	Y								Y		Y			Y
Friendship House Association of American Indians of San Francisco	CA	Residential or Outpatient Treatment Center	Non-HRSA	Y	Y	Y											Y
Gerald L Ignace Indian Health Center	WI	Full Ambulatory	HRSA 330	Y							Y		Y			Y	Y
Helena Indian Alliance	MT	Full Ambulatory	HRSA 330	Y		Y		Y			Y	Y			Y		
Hunter Health	KS	Full Ambulatory	HRSA 330	Y	R					Y		Y			Y	Y	
Indian Family Health Clinic	MT	Limited Ambulatory	Non-HRSA	Y	R						Y	Y					
Indian Health Board of Minneapolis	MN	Full Ambulatory	HRSA 330	Y		Y			Y		Y	Y			Y		
Indian Health Care Resource Center of Tulsa	OK	Full Ambulatory	Non-HRSA	Y	R		R		Y	Y	Y	Y	Y		Y		
Indian Health Center of Santa Clara Valley	CA	Full Ambulatory	HRSA 330	Y							Y	Y			Y		

UIO Name	State	Program Type	HRSA Status	Substance Misuse Counseling	Inpatient (Residential)	Harm Reduction	Medical Detox	Legal Help	Drug-Specific Care	Drug Testing	Coordination with Primary Care Provider	Community Education	Housing Services	Transportation to Care	Medication-Assisted Treatment (MAT)*	Pharmacy	Traditional Healing-Based Substance Misuse Programs
Juel Fairbanks	MN	Residential or Outpatient Treatment Center	Non-HRSA	Y	Y								Y				Y
Kansas City Indian Center	MO	Full Ambulatory	Non-HRSA	Y							Y	Y					Y
NARA of the Northwest	OR	Residential or Outpatient Treatment Center	HRSA 330	Y	Y			Y			Y	Y	Y			Y	
Native American Connections	AZ	Full Ambulatory	Non-HRSA	Y	Y						Y	Y	Y		Y		Y
Native Americans for Community Action	AZ	Full Ambulatory	Non-HRSA	Y	Y							Y		Y			Y
Native American Health Center	CA	Outreach and Referral	Non-HRSA	Y							Y		Y		Y		
Native American LifeLines	MD	Residential or Outpatient Treatment Center	Non-HRSA	Y		Y					Y						
Native Directions	CA	Full Ambulatory	Non-HRSA	Y	Y								Y		R		
Native Health	AZ	Full Ambulatory	HRSA 330	Y									Y	Y			
The NATIVE Project	WA	Full Ambulatory	HRSA 330	Y							Y					Y	
Nebraska Urban Indian Health Coalition	NE	Full Ambulatory	Non-HRSA	Y	Y				Y				Y	Y	R		
Nevada Urban Indians	NV	Limited Ambulatory	Non-HRSA	Y		Y					Y	Y	Y	Y			
New York Indian Council	NY	Outreach and Referral	Non-HRSA	Y	R							Y					
Oklahoma City Indian Clinic	OK	Full Ambulatory	Non-HRSA	Y						Y	Y	Y	Y	Y	Y	Y	
Sacramento Native American Health Center	CA	Full Ambulatory	Non-HRSA	Y		Y					Y	Y					Y
San Diego American Indian Health Center	CA	Full Ambulatory	HRSA 330	Y													Y
Seattle Indian Health Board	WA	Full Ambulatory	HRSA 330	Y							Y		Y			Y	Y
South Dakota Urban Indian Health	SD	Full Ambulatory	Non-HRSA	Y	R						Y			Y	Y		
Texas Native Health	TX	Full Ambulatory	Non-HRSA	Y	R	Y	R	Y	Y			Y			Y	Y	
Tucson Indian Center	AZ	Limited Ambulatory	Non-HRSA	Y				Y		Y	Y	Y		Y			
United American Indian Involvement	CA	Limited Ambulatory	Non-HRSA	Y							Y	Y	Y		Y		
Urban Indian Center of Salt Lake	UT	Full Ambulatory	Non-HRSA	Y								Y					

II. Maps of Drug Overdose Mortalities in the United States and Urban Indian Organization Service Areas

A. Methodology

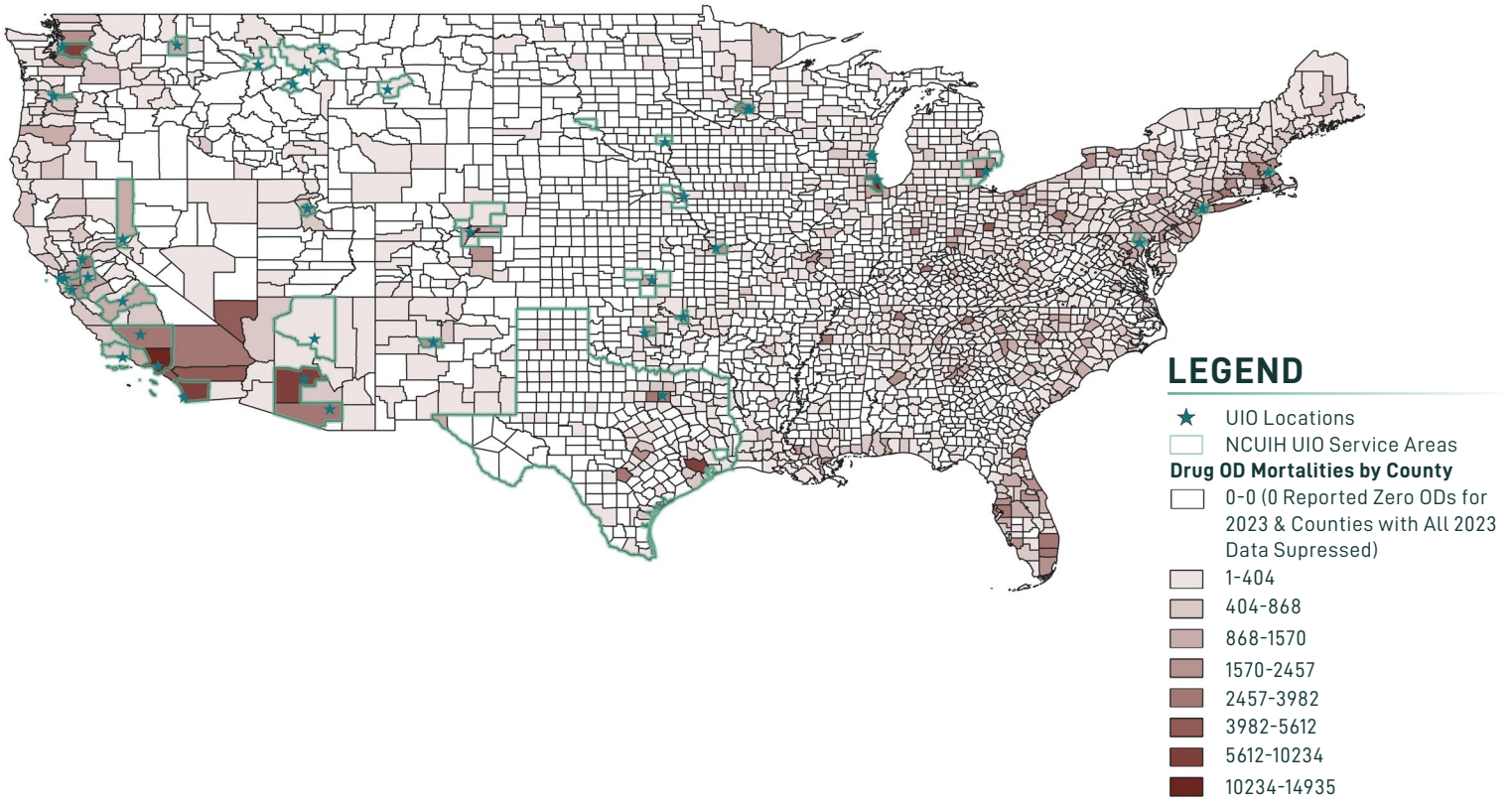
The dataset used for the following maps was provided by the Centers for Disease Control and Prevention (CDC) National Vital Statistics System (NVSS) Provisional County-Level Drug Overdose Death Counts website (Ahmad et al., 2024). This dataset was downloaded on January 19, 2024. This data represents all racial/ethnic groups and is not specific to only AI/AN overdose mortalities. Additionally, this data corresponds to overdoses from any drug type, such as opioids or other drug categorizations.

However, the majority of drug overdose mortalities in the United States in recent years have involved opioids, with over 75 percent of overdose mortalities involving opioids in 2021 (Centers for Disease Control and Prevention, 2023). There is an overall lack of data on consistent and timely drug-specific overdoses by local, state, and national vital statistics databases. Some municipalities such as California (California Department of Public Health, n.d.), Montana (Montana Department of Public Health & Human Services, n.d.), New York (New York State Department of Health, 2024), King County in Washington (King County Department of Public Health, 2024), and the city of Austin in Texas (Austin Public Health, 2023) have made efforts to make dashboards and aggregated data for their communities available. However, drug overdose data aggregated by race/ethnicity is not widely available. Furthermore, when race/ethnicity is available in these datasets and dashboards, a breakdown of AI/AN people is rarely included (Kansas Department of Health and Environment, Division of Public Health, n.d.; King County Department of Public Health, 2024; New York State Department of Health, 2024). The Overdose Detection Mapping Application Program (ODMAP) is a resource that maps reported overdoses and uses of Narcan, and although this may be a helpful option to address gaps in available data, data collected through this platform is only available to government agencies due to *Health Insurance Portability and Accountability Act* (HIPPA) standards and is not aggregated by race/ethnicity (Overdose Detection Mapping Application Program [ODMAP], n.d.). Given that the AI/AN population experienced the highest fatality of opioid overdoses and other substance misuse disparities in outcomes related to substance misuse, Native communities need access to timely data on their populations to better understand the issues and intervene accordingly (Centers for Disease Control and Prevention, Injury Center, 2024).

B. Maps

1. Unadjusted Data

Figure 5. Map of Urban Indian Organizations and Provisional Overdose Mortalities by County, 1/1/2023-6/30/2023 (Ahmad et al., 2024)



Note: Map of Provisional Overdose Mortalities* by Counties from January 01, 2023-June 30, 2023, with Urban Indian Organization Locations and Service Areas**

*Data for suppressed months/counties not adjusted and counted as zero.

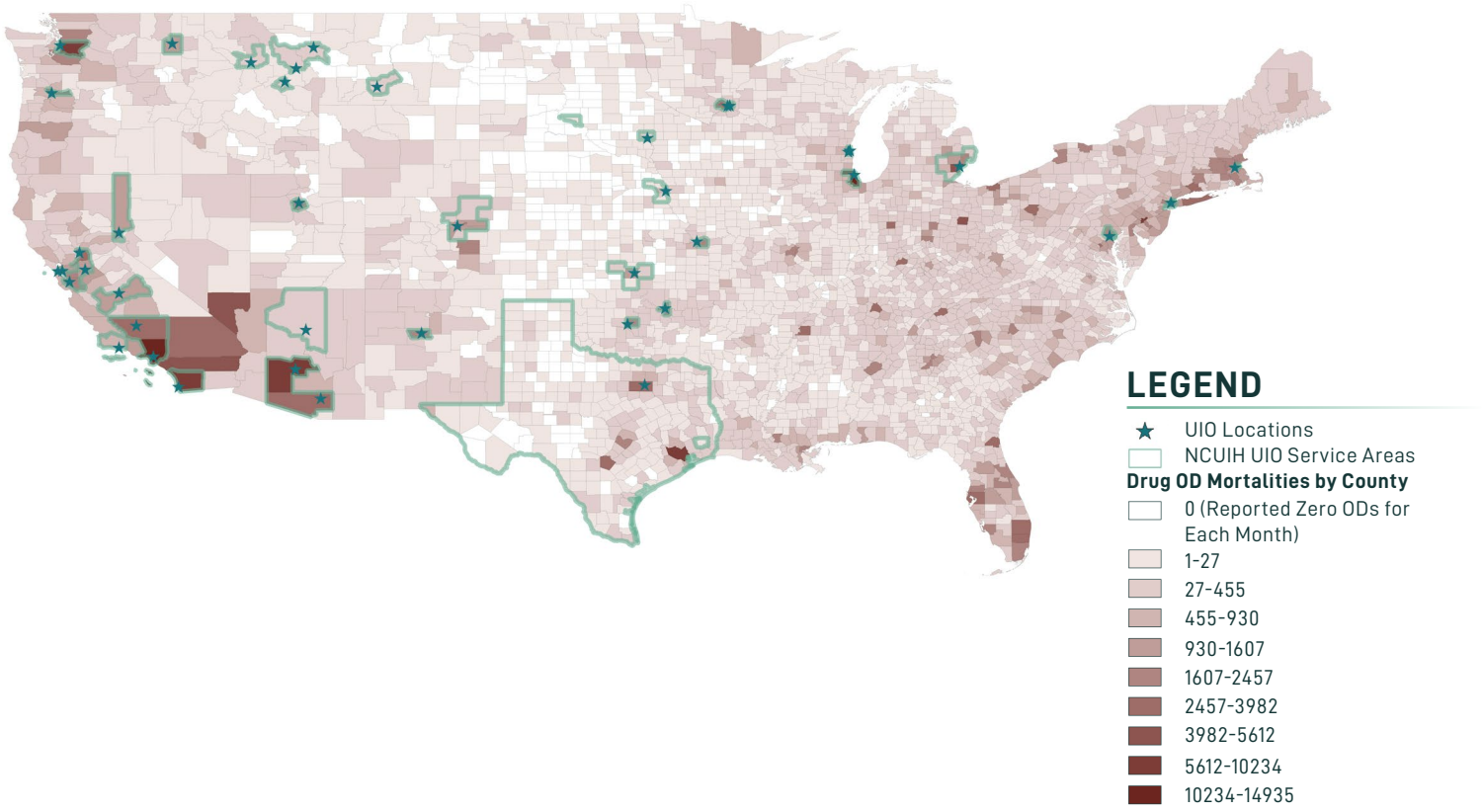
**UIO service areas based on NCUIH Program Profiles 2022 (National Council of Urban Indian Health, 2022)

To take a closer look at this map, visit https://ncuih.org/wp-content/uploads/UNADJUSTED_2023-Provisional-OD-Map-PDF-File.pdf.

To learn more about UIOs, visit the NCUIH UIO Directory at https://ncuih.org/uio-directory/.

2. Adjusted Data

Figure 6. Map of Urban Indian Organizations and Provisional Overdose Mortalities by County, 1/1/2023-6/30/2023 (Ahmad et al., 2024) [Adjusted for Data Suppression]



Note: Map of Provisional Overdose Mortalities by Counties from January 01, 2023- June 30, 2023 (Adjusted Data*) with Urban Indian Organization Locations and Service Areas**

*Data adjusted for average value imputation for suppressed months/counties.

**UIO service areas based off NCUIH Program Profiles 2022 (National Council of Urban Indian Health, 2022)

To take a closer look at this map, visit https://ncuih.org/wp-content/uploads/ADJUSTED_2023-Provisional-OD-Map-PDF-File.pdf.

To learn more about UIOs, visit the NCUIH UIO Directory at https://ncuih.org/uio-directory/.

C. Notes on the Dataset and Limitations

As stated previously in the environmental scan findings, mapping and analysis of this data indicates that in the first six months of 2023, the average number of overdose mortalities per UIO county[1] was 2,056, while the average number of overdose mortalities per overall U.S. county was 209. These findings highlight that increased resources and funding for UIOs are crucial to prevent and address OUD for urban AI/AN populations. Additional notes and limitations on this data are listed below.

1. Data Completion

Data shown in the maps provided previously are provisional-level data for the given available months of 2023 (01/01/23-06/30/23). Data was available in the dataset from January 2019 to June 2023 (Ahmad et al., 2024). Due to shifting drug use patterns over time, only the most recent 2023 data was used in our analysis. However, a number of counties were noted within the dataset of having "completeness of provisional 2019 data under 90% after 6 months" (2024). Given that 2019 data was still incomplete in 2024 for the given counties, it should be restated that the dataset used was provisional and not yet finalized for overdose mortality totals for every United States county.

2. Data Suppression

By definition, the CDC National Center for Health Statistics (NCHS) data privacy standards suppressed the public dataset for counties that reported between 1-9 overdose mortalities in a given month (Ahmad et al., 2024). Counties with suppressed data for a given month were left with a blank cell, and a footnote was made for that county stating that "one or more data cells have counts between 1-9 and have been suppressed in accordance with NCHS confidentiality standards" (2024). Counties that reported zero mortalities in a given month were marked as having zero mortalities. Since there was a clear distinction between suppressed county data and counties with reported zero mortalities, the data in Figure 5 was adjusted to better demonstrate mortalities across counties. In order to not conflate counties with months reporting zero overdose mortalities with counties with suppressed data and thus being shown as zero mortalities, the data for a county with suppressed data for a given month was assigned an average value imputation of 4.5. This is standard practice for suppressed data at NCUIH.

3. Data Limitations

Of all counties in the United States, 17.3 percent (545 counties) were noted with "completeness of provisional 2019 data under 90% after 6 months" (Ahmad et al., 2024). County-level data that was suppressed for any given month was replaced with a median value of 4.5 (overdose mortalities) for the data visualization.

KEY INFORMANT INTERVIEWS

Another key component of NCUIH's needs assessment was to conduct key informant interviews with staff from UIOs to gain insights into the services, challenges, and successes of addressing substance misuse in AI/AN populations. Overall, findings from interviews with five UIOs highlighted the need for increased access to harm reduction resources and substance misuse treatment, as well as further efforts to reduce stigmatization of those seeking care for substance misuse.

I. Recruitment

Data from the environmental scan conducted previously in the needs assessment was used to create a list of five target UIOs for interview recruitment, as well as a backup target UIO for each primary target UIO. Targeted recruitment was based on data collected previously in the environmental scan component of this needs assessment. Target UIOs were selected to reflect a variety of UIO program types, services, and locations. The final key informant interview sample of five UIOs represented five out of eight NCUIH regions, five out of 50 states, and all four major program types of UIOs.

NCUIH specifically requested that at least two UIO staff attend each key informant interview: one representing a leadership role (i.e., chief executive officer, executive director, chief medical officer, director of behavioral health programs) and at least one additional staff member with in-depth knowledge of their UIO's opioid-related services (i.e., substance abuse counselors, behavioral health specialists, peer navigators/counselors, registered nurses, community health workers). Two to four NCUIH staff members facilitated each key informant interview. Each UIO was offered $500 as a financial incentive for their participation.

II. Methodology

The key informant interview questions encompassed four key themes: overall perceptions, substance misuse services, harm reduction, and community and policy impacts. NCUIH staff administered key informant interview questions orally and through the Microsoft Teams meeting chat. Follow-up questions were skipped if deemed irrelevant by NCUIH interview staff (e.g., if the question had already been answered unintentionally by the participants or if a follow-up question was deemed irrelevant based on what the participants had already expressed, etc.). The specific key informant interview questions prepared by NCUIH staff are listed in the table below.

Figure 7. Key Informant Interview Questions

Section	Question
Overall Perceptions	**1.** How would you describe the current state of substance use and drug overdoses among the American Indian and Alaska Native (AI/AN) communities that your organization serves? **2.** What do you believe are the most significant gaps in substance use care (which refers to services related to prevention, treatment, and recovery for problems or conditions related to substances like illegal drugs or alcohol) for American Indians and Alaska Natives (AI/ANs)? **3.** What do you believe are the greatest priorities for improving the access to, and quality of, substance use care for Urban Indian populations?

Section	Question
Substance Misuse Services	**4.** Please describe any services that your facility provides related to substance use prevention and care. Examples may include prevention programs, treatment services, and referrals. **4a.** Does your organization offer any culturally tailored interventions for AI/ANs, such as traditional healing services related to substance use care? If so, can you describe them? **5.** Are there any services related to substance use care that your organization would like to provide but do not have the resources to do so? **5a.** Can you identify or describe any gaps in service areas (for example, medically supervised withdrawal services, medication-based treatment for Opioid Use Disorder [e.g., MAT], residential facilities, and/or detox centers)? If so, what resources does your organization need to address these barriers? **6.** How does your organization measure the successes and impacts of your substance use services? **7.** Does your organization have a process for screening patients for substance use disorder? If so, please describe this process further. **7a.** Are patients screened for substance use risks at visits that are not specific to substance misuse? **7b.** What is your organization's process for follow-up after screening for substance use risks? **8.** How does your organization address comorbidities or other simultaneously occurring health issues related to substance use, such as mental health issues?
Harm Reduction	**9.** Are there any unique protective factors related to substance use among the populations served by your UIO, and if so, how does your UIO address these? Protective factors can refer to characteristics that are associated with lower likelihoods of negative outcomes, or that reduce the impacts of a risk factor. **10.** Please describe any substance use harm reduction techniques or services (e.g., Naloxone distribution and education, needle exchanges, or safe injection sites) that are provided by your organization. **10a.** Are there any substance use harm reduction techniques or services that your organization would like to provide? If so, what barriers are preventing your organization from providing these services? **10b.** How does your organization train your staff on drug overdoses and the use of harm reduction techniques and resources, such as Naloxone use? **10c.** Is your organization involved in any efforts to educate members of the communities you serve (such as first responders or frontline workers) on drug overdoses and the use of harm reduction techniques and resources (e.g., Naloxone)?
Community & Policy Impacts	**11.** Are there any legislative or policy changes which have affected your organization's provision of substance use services? **11a.** What legislative/policy changes have made your organization's provision of substance use care more difficult, if any? **11a.i.** How have these legislative/policy changes affected your organization's provision of substance use services? **11b.** What legislative/policy changes have made your organization's provision of substance use care easier, if any? **12.** Has your organization established any partnerships with other stakeholders to address substance use among AI/ANs? If so, please describe these partnerships. **13.** Does your organization conduct outreach to inform the community about available services related to substance use? If so, please describe these outreach efforts.

Key informant interview transcripts were automatically generated by Microsoft Teams and then edited for grammar and clarity. Cleaned transcripts were uploaded to the qualitative coding program Dedoose and analyzed for key themes.

III. Findings

Three key themes were identified from the analysis of interview transcripts: 1) Key UIO Services, Personnel, and Partnerships; 2) Key Barriers/Challenges; and 3) Successes, Benefits, and Protective Factors. The following sections describe the key findings related to each of these themes.

A. Key UIO Services, Personnel, and Partnerships

The key on-site services related to the prevention of substance misuse and opioid overdoses mentioned by UIOs throughout the five interviews are displayed in the table below. Please note that the following table summarizes services as described by interview participants, and this data does not necessarily reflect all services offered or referred by the UIO interviewed, as it only describes those key services that were explicitly mentioned by participants in NCUIH's interviews. One hundred percent of UIOs interviewed described offering Naloxone/Narcan and group services (e.g., support groups, recovery groups, group therapy) on-site. While only 20 percent of UIOs interviewed offer medication-assisted treatment (MAT) on-site, 60 percent expressed interest in offering on-site MAT services. In addition to the services listed below, 20 percent of interviewed UIOs described currently screening patients specifically for substance use risks at non-behavioral health visits. One hundred percent of interviewed UIOs described having an established process for follow-up after screening to refer patients to relevant medical/behavioral health services.

Figure 8. On-Site Services at UIOs Described by Interview Participants

Service	Offered On-Site	Referred Out Only	Not Offered But Interested
Cookers or sterile waters for harm reduction	1 (20%)	--	--
Cookers or sterile waters for harm reduction	--	2 (40%)	--
Drug/syringe disposal services	3 (60%)	--	2 (40%)
Forensic drug test strips	3 (60%)	--	1 (20%)
Medication-Assisted Treatment (MAT)	1 (20%)	--	3 (60%)
Naloxone/Narcan	5 (100%)	--	--
Outpatient care	1 (20%)	--	--
Pharmaceutical services	3 (60%)	--	--
Primary care	3 (60%)	--	--
Residential (inpatient) care	1 (20%)	3 (60%)	1 (20%)
Support/recovery group and/or group therapy	5 (100%)	--	--

One hundred percent of interviewed UIOs described offering at least one traditional healing program. The following table summarizes the key culturally tailored services described by interviewed UIOs. In addition to these key services listed in Figure 9 below, 20 percent of interviewed UIOs also mentioned providing opportunities to patients to create/access cultural items such as earrings, ribbon skirts, and/or medallions through their programs.

Figure 9. Culturally Tailored Services Related to Substance Use Care Offered at UIOs

Culturally Tailored Service	n (%)
Beading	2 (40%)
Ceremonial activities	2 (40%)
Drum-making and/or drumming circles	4 (80%)
Plant medicine, medicine bundles, and/or herbal pharmacy	3 (60%)
Red Road to Wellbriety programming	3 (60%)
Smudging	1 (20%)
Storytelling programs	1 (20%)
Sweat lodge	2 (40%)
Talking/healing circles	4 (80%)

Interviewed UIOs also shared insights into their staff training and collaborations. For example, 80 percent of interviewed UIOs specifically ensure that their staff are trained in how to use Narcan/Naloxone. All interviewed UIOs mentioned at least one collaboration with an organization serving AI/AN populations (such as the IHS, Tribes, or local cultural organizations), as well as with another medical and/or behavioral health organization. Specifically, 60 percent of interviewed UIOs described collaborating with an advisory committee, council, or other specific behavioral health entity to promote behavioral health. Forty percent of interviewed UIOs mentioned collaborations with educational institutions, and 40 percent also described partnerships with local and/or state health departments.

"We, as Native Americans, are very much a community–based culture. We're very much a collectivist culture, so I definitely have to agree that outreach is one of the most important ways that we can connect to the community and show them that we're familiar and build those connections. That way, they can feel more comfortable to come to us for services whenever they need it."

– UIO Key Informant Interview Participant A

One hundred percent of interviewed UIOs also had substance misuse services/processes related to community outreach. Twenty percent of interviewed UIOs described using social media and newsletters as a form of behavioral health outreach. One hundred percent of interviewed UIOs described conducting behavioral health outreach at community events (e.g., school events, health fairs, and/or powwows). Eighty percent of interviewed UIOs specifically described conducting behavioral health outreach at medical committees/associations or medical schools. One hundred percent of interviewed UIOs conduct forms of education on Naloxone/Narcan use outside of their organization.

"I don't think that enough of our population knows about the collective trauma and grief that is actually developed within our DNA. And I think when you have that understanding, along with [an] understanding [of] all the other difficult life circumstances that are at play, – when you can understand that at a biological level, we're predisposed to higher levels and chronic stress, – I think it just adds another layer of understanding of why we experience the things that we do, including why we might use substances."

– UIO Key Informant Interview Participant B

B. Key Barriers and Challenges

Analysis of the five key informant interviews revealed key barriers and challenges identified by UIOs at three levels. The tables below summarize each of these levels of barriers and challenges, as well as the number (N) of interviewed UIOs who described the barrier/challenge and the corresponding percentage (%) of total interviewed UIOs who described the barrier/challenge. **Please note that the barriers and challenges in Figures 10-12 are based on thematic analysis of transcripts and do not represent exact quotes from all interviewed UIOs.**

Figure 10. Level 1 – Key Barriers/Challenges at the Level of State/Federal Agencies, Policies, and/or Institutions

Barrier/Challenge	n (%)
Availability of, and access to, urban AI/AN data related to behavioral health	4 (80%)
Lack of legalized accessible needle exchanges, safe injection sites, and/or drug disposal sites	4 (80%)
Continuous and/or confusing changes to legislation and policies	3 (60%)
Insufficient or unclear insurance coverage of substance misuse services	3 (60%)
Inadequate urban AI/AN representation in local, state, and federal agencies and policies	1 (20%)
Insufficient pathways for improving AI/AN representation in the public health workforce	1 (20%)

Figure 11. Level 2 – Key Barriers/Challenges at the Level of Communities and their Socioeconomic Norms/Trends

Barrier/Challenge	n (%)
Lack of knowledge of issues and resources related to substance misuse, overdose prevention, and harm reduction	4 (80%)
Stigmatization and misconceptions related to harm reduction and substance misuse	4 (80%)
Transience of populations affected by substance misuse (e.g., due to homelessness or travel for care)	3 (60%)
Lack of trust, comfort, and/or safety for AI/AN individuals seeking care, particularly from non-Native medical providers	3 (60%)
Shifts in drug use trends (e.g., increased diversion from street drugs to prescription opioids, increased fentanyl abuse) and/or populations most affected by substance misuse (e.g., increased substance misuse among youth)	1 (20%)
Reliance on substances to cope with co-occurring socioeconomic stressors and other comorbidities	1 (20%)

Figure 12. Level 3 – Key Barriers/Challenges at the Level of UIOs and Other Health Care Providers

Barrier/Challenge	n (%)
Insufficient capacities for services such as sober living, inpatient care, and/or medical detoxification	4 (80%)
Unsustainable and/or ineffective funding mechanisms for behavioral health services	4 (80%)
Limited behavioral health workforce due to issues such as turnover, licensing, or training	3 (60%)
Heavy administrative burdens related to opioid policies/programming	3 (60%)
Difficult timelines for patient care (e.g., wait times for accessing care, minimum hours of sobriety required to enter care, and short stays in care)	1 (20%)
Legal/financial barriers to medication-assisted treatment (MAT) provision	1 (20%)

"Treatment programs were taking Natives off reservations. There was trafficking. People were being discharged and left in an unfamiliar area[s] where they had no support, no family, no money."

– UIO Key Informant Interview Participant C

C. Successes, Benefits, and Protective Factors

Interviewed UIOs were also asked about how they measure the successes and impacts of their services related to substance misuse. Findings from these responses are displayed in the table below. Data evaluation and reporting procedures were mentioned by the majority of interviewed UIOs as a way to measure the success of their services. In addition to these key measures, 20 percent of interviewed UIOs also described maintaining connections to patients after recovery by continuing engagement through alumni programs and/or hiring former patients.

Figure 13. Measures of Success for UIO Services

Measure Mentioned by Interviewed UIO	n (%)
Collection of patient feedback	2 (40%)
Implementation of community needs assessment	1 (20%)
Data evaluation and reporting procedures	3 (60%)
Tracking of harm reduction resource provision	2 (40%)
Tracking of patient programs, referrals, and/or outcomes	4 (80%)
Quality improvement initiatives	1 (20%)

Interviewed UIOs were also asked if there were any legislative or policy changes that positively impacted their substance use services. Findings from these responses are displayed in the table below. In addition to these key changes, policies which improve overall funding for substance use services were mentioned in UIO responses, such as the *CARES Act*.

Figure 14. Legislative/Policy Changes Benefitting UIO Substance Misuse Services

Legislative/Policy Change Mentioned by Interviewed UIO	n (%)
Elimination of sobriety clauses related to hepatitis C treatment	1 (20%)
Expansion of medication-assisted treatment (MAT)	2 (40%)
Expansion of harm reduction tools and/or trainings	1 (20%)
Improvements to Tribal budget formulations	1 (20%)

When asked about unique protective factors related to substance use among the populations served by their organization, all interviewed UIOs described how connection to culture was a protective factor. Specifically, 60 percent of interviewed UIOs also described how having a diverse local community of Indigenous organizations/groups can serve as a protective factor for urban Native populations. Additionally, 20 percent of interviewed UIOs mentioned how emphasizing healthy habits such as exercise helped to serve as a protective factor against substance use for their populations served.

VIRTUAL DIALOGUE

On June 5, 2024, the National Council of Urban Indian Health (NCUIH) hosted a live virtual event "Prevention Perspectives: Substance Misuse and Overdose Among Urban Native Populations" to summarize preliminary needs assessment findings and collect additional insights from UIO staff. The event recording and presentation slides can be accessed here. The objectives of this event were to:

1. Increase awareness of resources and services related to substance misuse and overdose prevention;
2. Enhance understanding of successes, challenges, and needs of UIOs providing services related to substance misuse and overdose prevention; and,
3. Foster connections between UIOs and facilitate conversations on insights and best practices.

I. Registration & Attendance

Of the 102 event registrants who were not NCUIH staff, 49 (48 percent) attended the event, including staff from 11 UIOs. The greatest proportion of these attendees were from the states of California (18.4 percent), Arizona (10.2 percent), and New Mexico (10.2 percent). The majority of attendees (53.1 percent) first learned about the event from the NCUIH email promotions.

Figure 15. Summary of Event Metrics

Metric	n (%)
Total Registrants	113
Total Non-NCUIH Registrants	102
Number of Unique UIOs Registered	21
Total Attendees	59
Total Non-NCUIH Attendees	49
Number of Unique UIOs in Attendance	11
Percentage of Non-NCUIH Registrants Who Attended	48%

Figure 16. State/Province of Non-NCUIH Attendees

State/Province	n (% of N)
Arizona (AZ)	5 (10.2%)
California (CA)	9 (18.4%)
Colorado (CO)	2 (4.1%)
Georgia (GA)	2 (4.1%)
Kansas (KS)	1 (2.0%)
Maryland (MD)	4 (8.2%)
Michigan (MI)	1 (2.0%)

State/Province *(Continued)*	n (% of N)
Missouri (MO)	1 (2.0%)
Montana (MT)	3 (6.1%)
Nebraska (NE)	1 (2.0%)
New Mexico (NM)	5 (10.2%)
New York (NY)	2 (4.1%)
Puerto Rico (PR)	1 (2.0%)
South Dakota (SD)	1 (2.0%)
Utah (UT)	3 (6.1%)
Washington (WA)	4 (8.2%)
West Virginia (WV)	1 (2.0%)
Total Non-NCUIH Attendees (N):	49

Figure 17. Non-NCUIH Attendee Responses to "How did you find out about this event?"

Response Option	n (% of N)
Instagram	1 (2.0%)
NCUIH Email	26 (53.1%)
NCUIH Newsletter	7 (14.3%)
Other	10 (20.4%)
Website	3 (6.1%)
Total Non-NCUIH Attendees (N):	49

II. Poll Everywhere Discussion

The platform Poll Everywhere was used to facilitate the open discussion with attendees during the live virtual event. Respondents were permitted to join the poll anonymously through an Internet browser or via text. Respondents were also allowed to submit more than one response to each open-ended question. Please note that the discussion ran longer than expected, and there was less time available for attendees to respond to the last few discussion questions, which may have contributed to a decline in the number of responses.

The largest proportion of Poll Everywhere participants at baseline were from California (20 percent), and 41 percent of participants worked at a UIO. Common issues related to substance misuse which were expressed by participants throughout the discussion included homelessness and housing issues, inadequate access to care, inaccessible or ineffective funding mechanisms, and staff capacity and training. Specific resources/tools that participants expressed would help to better support their organization included collaborations with other programs, curricula to reach AI/AN populations, additional grants and funding for culture-based programs and substance misuse overall, a comprehensive source for navigating treatment facilities and their availability, and resources to reduce stigmas. Additional insights from discussion participants can be found in the tables below.

Figure 18. Responses to "What state are you joining us from today? (Use abbreviation if more than 1 word!)"

State/Province	n (% of N)
Arizona (AZ)	4 (10%)
California (CA)	8 (20%)
Georgia (GA)	1 (2.5%)
Kansas (KS)	1 (2.5%)
Maryland (MD)	1 (2.5%)
Michigan (MI)	1 (2.5%)
Montana (MT)	2 (5%)
Nebraska (NE)	3 (7.5%)
New Mexico (NM)	3 (7.5%)
"No"	4 (10%)
New York (NY)	1 (2.5%)
Puerto Rico (PR)**	1 (2.5%)
South Dakota (SD)	3 (7.5%)
Utah (UT)	5 (5%)
Washington	1 (2.5%)
"Yes"	1 (2.5%)
Total (N):	40

Note: Some respondents may not have understood the question and responded with answers that do not indicate a particular location.
*Responses which included the full state name, partial state name, two-letter state abbreviation, or a specific city are aggregated in the table for analysis.
** Response shared was "PR" and is presumed to indicate that the attendee was from "Puerto Rico".

Figure 19. Responses to "Do you work for one of the 41 Urban Indian Organizations (UIOs) served by NCUIH?"

Response Option	n (% of N)
Yes	11 (41%)
No	16 (59%)
Total (N):	27

Figure 20. Responses to "Did any of the findings shared in today's presentation resonate with you or surprise you? If so, please describe them."

Open-Ended Response (N=16)
As a Cultural Specialist, I resonate with the Traditional Healing services.
I do not work directly in substance misuse, so I found the data really eye-opening regarding the need in our communities.
I thought there would be more UIOs nationwide
No
No
No
No
No : (
No,
No, because there is a lack of support for NA individuals within my area
No--The problem with drugs is overwhelming people in all communities. It is challenging to provide services with inadequate funding and a lack of trained staff.
Nothing was surprising but the most common services resonated a bit, there is so much need to "think outside the box" yet it's not done.
The #'s were a little shocking with regards to demographics ,
Yes
Yes
Yes - the data surrounding the spike in overdoses during the pandemic

Note: Because this question asked about findings that surprised participants or resonated with participants, participants may have responded "Yes" or "No" regarding one aspect of the question but not the other (e.g., findings may not have surprised them but may have resonated with them).

Figure 21. Responses to "How has substance misuse affected your community or the communities you serve?"

Open-Ended Response (N=19)
A need for more shelters
Addiction creates instability among broken individuals lead to broken families, which lead to broken communities.
Homelessness, grandparents raising grandkids, kids ending up in the foster care
Homelessness, more crime, unsafe communities, a drain on funding that could be used for more proactive things
Horrifically - as the numbers rise it affects the whole family not just the user the whole family, and how to heal from the experience of this traumatic epidemic -
I feel that substance "misuse" is the wrong term and adds to stigma around drug use. I also see that lack of economic opportunities and housing leads to substance use

Open-Ended Response (N=19)
I have seen it on a more individual level, and how substance misuse is tied to trauma. I've also seen how much pain it can cause families.
Increase number in drop out rates, DV, and homelessness.
Increase number of people end up being homeless.
Individuals losing their jobs, losing their housing, which as we know negatively impacts their overall health
It has greatly affected our community and there is a lack of current interoperability and sharing of data to help prevention efforts for those suffering with substance use disorder.
Loss of job, children, increased stigma about Native Americans in our community and substance use
Meth has had a devastating impact because the staff has limited exp0erience providing services. The cartels are powerful. More funding is needed.
Need to have more community awareness
So many ways, but one of the most heartbreaking are kids not having their parents or really unstable and unsafe homes
Substance misuse creates a cultural division for the native population I serve. That disconnection can create additional problems in their lives.
Very low self-esteem
Yes

Figure 22. Responses to "Through your professional role, have you experienced any challenges in addressing substance misuse issues among your patients/clients? If so, please describe them."

Open-Ended Response (N=20)
A lack of access to inpatient rehab...I work with individuals experiencing homelessness and many of them express their desire to become sober, however there are barriers in accessing rehabilitation services
A personal experience, my adopted sons birth mother was in rehab for several years, staying sober and seeming to do ok. The program helped her with housing and that was where support stopped
Accessing treatment programs in a timely manner. Clients will come in ready to stop using and then we can't get them into any treatment for days so they end up using and perhaps changing their mind about participating in treatment.
Agreed, lack of detox/medical withdrawal facilities
Barriers to accessing resources due to lack of government fundings
Dealing with housing being dependent on being sober.
Emphasis on sobriety as the only non-stigmatized option
Finding folks with lived experiences who can aid in harm reduction as some are criminalized and marginalized and kept away from roles they could be influential in
Funding is too siloed and doesn't recognize the intersectionality of these issues--e.g., substance use funding often can't be used for housing and homelessness initiatives, but homelessness and substance use often go hand in hand
I don't work with patients and clients but in my work in public health so many programs seem to miss their mark, there is so much stigma and discomfort in addressing things head on. Like communities being dead set against programs like needle exchange, naloxone vending machines, wound care mobile units
It's heartbreaking when someone is struggling but there aren't services to refer them to. I'm thinking specifically about a lack of rehab/detox facilities, particularly those that are affordable and accessible.
Lack of availability of medication for opioid use disorder (MOUD), or too many barriers to accessing MOUD. Stigma around accessing harm reduction services

Open-Ended Response (N=20)
More funding should be used to help homeless purchase the Birth certificates and SSI cards
Most places want Medicaid or insurance but if there homeless they do not have paperwork for personal identification
Patients are not willing to make any changes.
The major challenge is finding training for my BH staff. Cients are are faced with death and dying at unprecedented rates. Grief counseling is important
They are not willing to be open-minded.
Yes! Patients don't have the funds to cover medications such as Suboxone; transportation barriers to get to appointments; having to prioritize basic needs vs. medical care
Yes, lack of resources, and the process is so long to get them into detox/ rehabs and coverage usually wont cover extended stays that are sooo needed, and then after care, support after
Yes, leaving and having to come back because they relapsed

Figure 23. Responses to "Please describe your organization's experience with funding for substance misuse services. (E.g., Are there any funding mechanisms that have successfully supported you? Are there any gaps in funding opportunities that need to be addressed?)"

Open-Ended Response (N=10)
Federal funding is far too prescriptive and limiting
Funding for non-native owned organizations needs more access. The door for allyship needs to have less barriers for urban natives living in areas that have low representations for Native American individuals
Funding opportunities should be more flexible in how it's spent--e.g., supporting homeless work, workforce development, etc.
I'm thankful that we are receiving funds to support the MAT program- this helps support some staff, trainings, but no funding for medications to manage opioid use! That is our need currently.
Mainstream funding opportunities often don't fund culture-based programs or traditional healing
Many orgs and Tribes don't have enough (or any) grant writers and also struggle to have the capacity to complete the required grant reporting. There need to be more funding opportunities that are much more low-barrier both for the application process and the reporting requirements
Often funding does not allow for all the related social impacts
Opioid funding is available to every state. Being at the table when decisions are made is the challenge.
SUB Awareness events.
We are funded by federal health grant and the tribal opioid response grants

Figure 24. Responses to "Are there any programs/strategies at your organization that are working well to address substance misuse? If so, please describe them."

Open-Ended Response (N=7)
At [organization name redacted], something that is helping us with our MAT services is also having a "same-day" service. We can get patients into care much faster as we have daily appointments available. With the goal of transitioning to their PCPs
My org is not a direct services provider but I've seen positive impacts from culture-based programs in other orgs that do provide services
Not my own program but chatting with a friend this weekend and learning there are a lot of ex drug user/ex convicts that sign up to be wildland firefighters and that work has kept them sober and healthier. I thought that was really interesting
Our local organization promotes fitness, has brought down barriers for gym access and has cultivated a recovery community based around physical fitness. It seems to work very well.
Using Community Health Workers has worked well. Also providing Transitional Housing works well.
We provide educational materials and local resources to access care
Wellbriety is our newest program that is addressing substance misuse.

Figure 25. Responses to "Are there any specific resources/tools that would help to support your organization in better addressing substance misuse? If so, please describe them."

Open-Ended Response (N=8)
agreed! learning from others
Collabrating with other programs
Curriculum that is for Native Americans but provided by a non-native foundation. Barriers I speak of are requirements to have a CIB to teach a curriculum.
Grant fundings that help with substance misuse such as Abuse Prevention Programs
Having a website that listed in-treatment sites and a mostly up-to-date availability at each.
I work in chronic disease management, and we do not talk about substance use at all, and we really need to! My assumption is that this is due to stigma, so any resources on stigma among care providers re: substance use would be helpful.
Low barrier funding opportunities; funding opportunities that support culture-based programs
SUD funding opportunities that address issues that are interconnected with substance use (e.g., workforce development + SUD; housing + SUD)

Figure 26. Responses to "What do you believe is the highest priority for improving the state of substance misuse in your community or the communities you serve?"

Open-Ended Response (N=8)
Awareness
Harm reduction services
Harm reduction services
Low-barrier housing
More resources
Need to address social impacts that result in substance use
Outreach programs targeting elementary and high school students
Resources

III. Event Feedback

An anonymous Qualtrics survey was distributed to event participants to collect feedback on the event. This survey was shared as a link and QR code in the event presentation slides, the live Zoom chat, and via email following the event. Of the 49 event attendees who were not NCUIH staff, 12 (24.5 percent) individuals responded to the feedback survey. Approximately 42 percent of respondents work at a UIO, with 33.4 percent working as a behavioral health director or provider. Fifty percent of respondents learned about the event from the NCUIH email promotions.

Over 83 percent of respondents somewhat agreed or strongly agreed that their knowledge of substance misuse and overdoses increased after the event, and 100 percent of respondents were satisfied or very satisfied with the overall event. One hundred percent of respondents were somewhat likely or extremely likely to recommend the event to a colleague, and 83.3 percent felt engaged with the event. Seventy-five percent of respondents believe the event to be helpful in supporting their work, as well as helpful in supporting their organization's mission. Issues related to substance misuse which were mentioned by respondents included insufficient funding, stigma, homelessness, and access to care. Improvements to funding and destigmatization were common areas of improvement desired by respondents. Additional insights from survey respondents are displayed in the tables below.

Figure 27. Summary of Event Feedback Metrics

Metric	n/%
Total Non-NCUIH Attendees	49
Total Number of Feedback Survey Responses	12
Percentage of Non-NCUIH Attendees Who Responded to the Feedback Survey	24.5%

Figure 28. Responses to "Are you a facility or staff member of an Urban Indian Organization?"

Response Option	n (% of N)
Yes	5 (41.7%)
No	7 (58.3%)
Total (N):	12

Figure 29a. Responses to "What is your primary role in the community?"

Response Option	n (% of N)
Administrator/Executive Director	--
Board of Directors	--
Health/Medical Director	--
Behavioral Health Director	2 (16.7%)
Wellness/Outreach Director	--
Medical Provider	--
Behavioral Health Provider	2 (16.7%)
Case Manager/Care Coordinator	(8.3%)
Community Education/Outreach Support	2 (16.7%)
Other	5 (41.7%)
Total (N):	12

Figure 29b. Responses to "Please specify your primary role in the community."

[Note: Question was only prompted for respondents who selected "Other" in previous question in Figure 28a]

Open-Ended Response (N=5)
Health, Youth, and Culture Board Secretary
Public health
Public Health Analyst
Public Health nurse and Case manager for Behavioral Health
Technical Advisor

Figure 30. Responses to "How did you learn about this webinar?"

Response Option	n (% of N)
NCUIH email	6 (50%)
NCUIH newsletter	2 (16.7%)
Referred by my Executive Director/CEO	1 (8.3%)
Social media	--
Friend or colleague	3 (25%)
Total (N):	12

Figure 31. Responses to "How much would you agree or disagree with this statement: My knowledge on substance misuse and overdoses has increased after this event."

Response Option	n (% of N)
Strongly disagree	--
Somewhat disagree	--
Neither agree nor disagree	2 (16.7%)
Somewhat agree	7 (58.3%)
Strongly agree	3 (25%)
Total (N):	12

Figure 32. Responses to "How satisfied were you with the following?"

Response Option	n (% of N)		
	The Topic of the Presentation	**The Length of the Presentation**	**Overall Event Satisfaction**
Very Unsatisfied	--	--	--
Unsatisfied	--	--	--
Neutral	--	--	--
Satisfied	6 (50%)	4 (33.3%)	5 (41.7%)
Very Satisfied	6 (50%)	8 (66.7%)	7 (58.3%)
Total (N):	12	12	12

Figure 33. Responses to "How likely would you be to recommend this event to a colleague?"

Response Option	n (% of N)
Extremely unlikely	--
Somewhat unlikely	--
Neither likely nor unlikely	--
Somewhat likely	6 (50%)
Extremely likely	6 (50%)
Total (N):	12

Figure 34. Responses to "Please answer the following questions about your experience."

Response Option	n (% of N)		
	Did you feel engaged with the event?	**Was this event helpful in supporting your work?**	**Was this event helpful in supporting your organization's mission?**
Yes	10 (83.3%)	9 (75%)	9 (75%)
Maybe	1 (8.3%)	2 (16.7%)	2 (16.7%)
No	1 (8.3%)	1 (8.3%)	1 (8.3%)
Total (N):	12	12	12

Figure 35. Responses to "What did you like most about today's event, and/or how will you use the event's information?"

Open-Ended Response (N=7)
Being able to collaborate with other facilities and learn about their challenges and successes
Engaging
I liked the balance of presentation and crowd-sourced answers.
learning more about resources
Maps Demographics
The knowledge will help me teach patients and also go out in the community to educated the public
Visual map

Figure 36. Responses to "What topics would you be most interested in for future events?"

Open-Ended Response (N=5)
Ethics
Focus on Fentanyl abuse prevention
maybe a panel of people doing overdose prevention, harm reduction, or substance use work at UIOs
Open boarders/ Drugs
Open to any

Figure 37. Responses to "What are the greatest barriers/challenges to preventing overdoses in your community?"

Open-Ended Response (N=6)
▸ Lack of funding for programs (especially culturally appropriate programs or programs that address issues that intersect with substance use) ▸ Stigma ▸ Housing and homelessness issues, financial issues / lack of economic opportunities are contributing factors to drug use (not drug use causing these issues, necessarily)
Community myth that fentanyl is less harmful than heroin. Normalizing narcan being available to anyone.
Culture
Lack of ability to reach out to the homeless population
Lack of support for harm reduction
Low barrier housing, harm reduction and stigma surrounding it

Figure 38. Responses to "What are the greatest barriers/challenges to your organization's provision of behavioral health services?"

Open-Ended Response (N=6)
NA
Need more funding for more behavioral health clinicians. However, it is also challenging to recruit for this role as several clinicians are not yet familiar with behavioral health-primary care integration.
Need to have patient awareness of what our organization offers
Small, new agency
Unfortunately, the AZ State Medicaid system in authorizations to provide services.
We're not a direct services provider, but restrictions on how funding can be spent

Figure 39. Responses to "What resources, programs, and/or strategies have demonstrated the greatest success in your organization's efforts to address substance misuse?"

Open-Ended Response (N=7)
NA
Normalizing the family role in tx including keeping families together as clinically appropriate with social services approval when they are involved.
Not my organization, but I think culture based programming, especially when it's meeting people where they're at rather than requiring sobriety and stigmatizing continued substance use, is really powerful. Housing First approach is also really helpful: provide people with housing before providing them with the resources they want to address other things in their lives such as drug use
Outpatient tx, dually trained clinicians in mental health and substance use, nonjudgmental approach, harm reduction
Outreach programs
Permanent supportive housing for individuals experiencing chronic homelessness
Program for kids of opioid using parents

Figure 40. Responses to "What would be most helpful to improve the state of substance misuse in your organization and/or community?"

Open-Ended Response (N=6)
Funding
Having state medicaid health plans recognize 30 days in a residnetial substance use tx facility is not enough time to address an extensive hx of addiction.
Low-barrier housing, harm reduction programs, affordable treatment programs, stigma reduction
More Gov't fundings
The work we're doing isn't focused on substance "misuse" necessarily--here's something a colleague wrote up about this terminology: "'Misuse' has been a commonly accepted word. Important to note that not all misuse or risky use involves addiction or SUD. Also, misuse can be technically inaccurate as it is often used to portray use of any illicit drug as misuse, although, a person may be using that drug exactly as they intend to." I personally think it's helpful to NOT describe this as "substance abuse" or "substance misuse" because these terms can help perpetuate stigma, possibly suggesting that this is a choice or a moral failing. Stigma around substance use is already so strong in many Native communities, and I really want to be mindful about how we talk about this so that our relatives who use drugs feel welcomed into the community, not further pushed out, which just worsens the situation. I prefer "substance use disorder," "SUD," "substance use issues," or "substance use condition." I think addressing some of the roots of the issue would be very helpful to improve the overdose crisis in Indigenous communities. Focusing on addressing intergenerational, historical, and personal traumas is helpful. Creating opportunities for people to feel connected with (and welcomed to connect with or practice) their cultures would be helpful. I also think increasing access to MOUD and addressing barriers to accessing MOUD would be helpful. Breaking down stigma is also important.
Unsure at this time

DISCUSSION

Given the disproportionate impacts of opioid misuse and overdoses on urban AI/AN populations, UIOs are uniquely positioned to mitigate these disparities through their culturally tailored approaches to behavioral health care. Further legislative reform to improve the access to and quality of behavioral health services related to MAT, Naloxone/Narcan, and other harm reduction services which can prevent overdoses. Based on findings from this needs assessment, three key strategies have been identified to better address and prevent substance misuse among urban Indian communities:

1. Improve investment in the behavioral health workforce, particularly for aspiring AI/AN health professionals

The greatest barriers to substance misuse care provision described by UIOs who participated in the key informant interviews were related to their organizational capacities, with 80 percent specifically describing challenges with their limited behavioral health workforce due to issues such as turnover, licensing, or training. Specific areas of need highlighted by interview participants include the accessibility of pathways to behavioral health careers (e.g., financial barriers to behavioral health worker certifications) and insufficient funding for UIOs to hire and retain behavioral health staff through sustainable mechanisms. Issues with staff capacity were also mentioned by virtual dialogue discussion participants and virtual dialogue feedback survey respondents, with responses expressing the need for more funding for behavioral health clinicians and more accessible training for behavioral health staff. Increasing behavioral health providers in Indian Country was also a key recommendation which emerged from the National Tribal Opioid Summit in 2023 (Northwest Portland Area Indian Health Board, 2023a). Further investment to support the behavioral health workforce and mitigate these barriers and challenges can help to improve behavioral health care accessibility and ultimately improve overdose prevention. Legislation can be used to address behavioral health workforce needs. For example, the *Bipartisan Primary Care and Health Workforce Act* included an amendment to the Health care workforce innovation program, which would give priority to applicants that use funds to support models that increase the number of individuals from underserved and disadvantaged backgrounds working in health care professions (Sen. Sanders, 2023).

As identified in the review of academic literature in this needs assessment, best practices for addressing opioid misuse in AI/AN populations include to integrate traditional healing and cultural practices into intervention strategies to foster a connection to culture (Hirchak et al., 2023), as disconnect from culture and social isolation for AI/AN individuals in urban areas can lead to self-medication to cope with these stressors (Dickerson et al., 2022). All UIOs who participated in the key informant interviews also offered at least one traditional healing program to offer culturally tailored care to their patients, and all interviewed UIOs described connection to culture as a protective factor for the populations they serve. The importance of both traditional healing services and the unique perspectives of those with lived experiences were also discussed by virtual dialogue discussion participants and feedback survey respondents, such as the need to mitigate stigmas that prevent individuals with lived experiences from serving in roles that can aid in harm reduction and the need for additional funding for traditional healing. Given the importance of traditional healing programs in serving Urban Indian populations, it is important to ensure that pathways for behavioral health careers are specifically accessible to those from AI/AN populations, such as aspiring AI/AN health professionals who can bring unique lived experiences and cultural insights into their provision of care.

Additionally, the language of the IHCIA includes to "ensure the highest possible health status for Urban Indians" (GovInfo, 2021) . In order to achieve this, UIOs must be incorporated into legislation as eligible

entities to receive grants and be included in programs providing essential health care services to AI/AN people. By not only including UIOs in legislation, but going further to provide set-asides, the government meets the requirement to fulfill its trust responsibility. The trust responsibility is a legal obligation where the United States "has charged itself with moral obligation of the highest responsibility and trust," which has been extended to requiring the federal government to be responsible for ensuring AI/AN people receive health care services (Indian Health Service, 2013; U.S. Department of the Interior Bureau of Indian Affairs, 2017). As authorized by IHCIA, 25 U.S.C. § 1616a, the IHS has created a Loan Repayment Program (LPR) for health professional loans that serve as full-time clinicians (Federal Register, 2020). Eligibility is provided for those who work at UIOs and for those in the field of behavioral health such as clinical psychologists, counselors, psychologists, and social workers (Indian Health Service, n.d.-a). HRSA has created the National Health Service Corps (NHSC) Loan Repayment Program, which is also offered to clinicians at Urban Indian Health Programs (Indian Health Service, n.d.-b). Those eligible, in behavioral and mental health, are Allopathic and Osteopathic physicians, Nurse Practitioners, and Physician Assistants (National Health Service Corps, 2024). For both programs, eligibility should be extended to include all positions within behavioral health, especially those who focus primarily on opioid-related services. This would make the positions more appealing for recent graduates and could help programs grow and expand in the services provided to the communities they serve.

2. Strengthen partnerships and collaborations between UIOs, the Indian Health Service (IHS), Tribal entities, and other stakeholders in overdose prevention

As stated previously, the review of academic literature highlighted how multidimensional models that target the larger socioeconomic and political contexts of opioid misuse can be beneficial to addressing the opioid crisis among AI/AN populations (Dickerson et al., 2022; Hirchak et al., 2023; Northwest Portland Area Indian Health Board, 2023a). While many UIOs offer services that can comprehensively address many different socioeconomic factors and comorbidities, collaborations can help to bridge gaps and further mitigate socioeconomic stressors to improve overdose prevention. Findings from the key informant interviews conducted in this needs assessment highlighted that all interviewed UIOs described at least one collaboration or partnership that their organization was engaging in to address substance misuse in the communities they serve. Interview participants shared many unique insights about the value of these collaborations and partnerships, such as promoting Narcan training and distribution in different workplace settings or establishing cohesive referral systems that ensure that patients can easily access different types of care. Additionally, all interviewed UIOs described the importance of their community outreach to their work in preventing substance misuse, such as conducting behavioral health outreach at local school events or at medical schools. Virtual dialogue discussion participants and virtual dialogue feedback survey respondents also highlighted how learning from others, collaborating with other programs, and sharing challenges and successes with other facilities are valuable.

In addition to helping to address socioeconomic factors and comorbidities that affect substance misuse and overdoses, partnerships, and collaborations can also help to improve data on urban AI/AN overdose prevention. The improvement of data sovereignty was identified as a key priority at the National Tribal Opioid Summit in 2023, with a key policy recommendation emerging to improve federal standards for data collection and reporting related to opioid and fentanyl use (Northwest Portland Area Indian Health Board, 2023a). Data sovereignty refers to the right of Indigenous nations and communities to control the collection, ownership, and application of their data, and these policy recommendations emphasize the need for states and federal agencies to consult with tribes on the collection and ownership of data related to race, ethnicity, and tribal affiliation (2023a). The environmental scan conducted in this needs assessment also highlighted that there is an overall lack of data on drug-specific overdoses available through local, state, and national databases, with limited availability of data aggregated by race/ethnicity, particularly for AI/AN populations. Additionally, 80 percent of UIOs who participated in the key informant

interviews for this needs assessment identified accessibility to urban AI/AN behavioral health data as a challenge, and the lack of data sharing to support overdose prevention efforts was expressed as a challenge during the virtual dialogue discussion. Strengthening partnerships and collaborations between stakeholders and improving the availability and accessibility of AI/AN overdose data can help to better inform intervention strategies to improve overdose prevention. Establishing data sharing agreements between stakeholders can further enhance the flow of information, ensuring that relevant data is shared in a secure and structured manner, which would support more accurate and responsive overdose prevention efforts. Data sharing and data use agreements can help to inform overdose prevention and response efforts, while also assisting in developing policy at the state or federal level (Centers for Disease Control and Prevention, 2023; Ussery et al., 2024). Examples have already been developed as to how data sharing can be used to answer key questions about overdose crises at the local level (Public Health and Safety Team, 2022).

3. Increase sustainable state and federal funding opportunities for substance misuse treatment and prevention resources such as medication-assisted treatment (MAT), Naloxone/Narcan, and fentanyl test strips

As highlighted by the review of academic literature conducted in this needs assessment, the Indian health system is chronically underfunded, which contributes to limited treatment options for AI/AN patients and prioritization of coverage for patients in critical condition over others (Whelshula et al., 2021). While the review of recent opioid public policies revealed many legislative improvements to improve overdose prevention, this analysis also highlighted how funding and restrictions for opioid services vary between jurisdictions and facility types. Insufficient and inflexible government funding mechanisms for overdose prevention resources were also expressed as a challenge by many virtual dialogue discussion participants and feedback survey respondents, with participants specifically mentioning issues such as federal funding being too prescriptive and limiting, a lack of funding available for medications to manage opioid use, a lack of funding available for traditional healing services, insufficient staff capacities to address the grant reporting requirements for many funding opportunities, and a lack of AI/AN representation in decision-making related to government funding.

One option for UIOs to receive more funding to cover these services is Medicaid waivers, such as the Section 1115(a) demonstration waiver that allows states to change their Medicaid program if aligned with promoting objectives of the Medicaid program. These are often utilized when addressing social determinants of health (SDOH) or health-related social needs (HRSN). Substance misuse can be treated through addressing SDOH, or the nonmedical factors and conditions of life that interact and influence health outcomes (Office of Disease Prevention and Health Promotion, n.d.). This is done by addressing the root causes of health disparities that may influence one to turn to substance misuse (Minnesota Department of Health, 2024).

Needs assessment findings also highlighted many specific funding-related challenges that UIOs experience in their provision of treatment and prevention resources. Eighty percent of UIOs who participated in the key informant interviews for the needs assessment described unsustainable and/or ineffective funding mechanisms for behavioral health services as a challenge, with many interviewed UIOs describing specific barriers in the provision of treatment and resources related to substance misuse. For example, 60 percent of interviewed UIOs described that they did not offer MAT but were interested in offering MAT, and 60 percent of interviewed UIOs also expressed that they experienced legal or financial barriers to MAT provision. Additionally, while all five interviewed UIOs described offering harm reduction resources such as Naloxone/Narcan through their organization, all interviewed UIOs also described lack of knowledge and stigmas in the community as barriers or challenges to the provision of harm reduction

resources. Sixty percent of interviewed UIOs also offer forensic drug test strips, and 20 percent expressed interest in offering these. These insights demonstrate the need for the expansion of accessible, effective, and sustainable funding mechanisms for services to reduce urban AI/AN overdoses.

Additionally, insights collected from this needs assessment also highlighted the need for clear, consistent, and destigmatizing language surrounding the harmful use of substances. For example, some key informant interview participants preferred the term "substance misuse" over terms like "substance use" (which is not always interpreted as clearly differentiating the correct use of substances like prescription medications from harmful misuse) or "substance abuse" (which can be stigmatizing towards the person using the substance, as it frames them as an "abuser"). In contrast, some of the responses shared by virtual dialogue attendees in the live discussion and feedback survey expressed that the term "substance misuse" can also be misleading, as a person may be using the substance exactly how they intended to.

In conclusion, further research is necessary to better understand the many socioeconomic, political, and cultural factors that affect substance misuse among urban AI/AN populations. Additional improvements in urban AI/AN representation for future legislative decision-making and policies are necessary to reduce and ultimately eliminate disparities in substance misuse and overdoses.

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