Indigenous Harm Reduction: Doing Harm Reduction Work in Tribal Communities

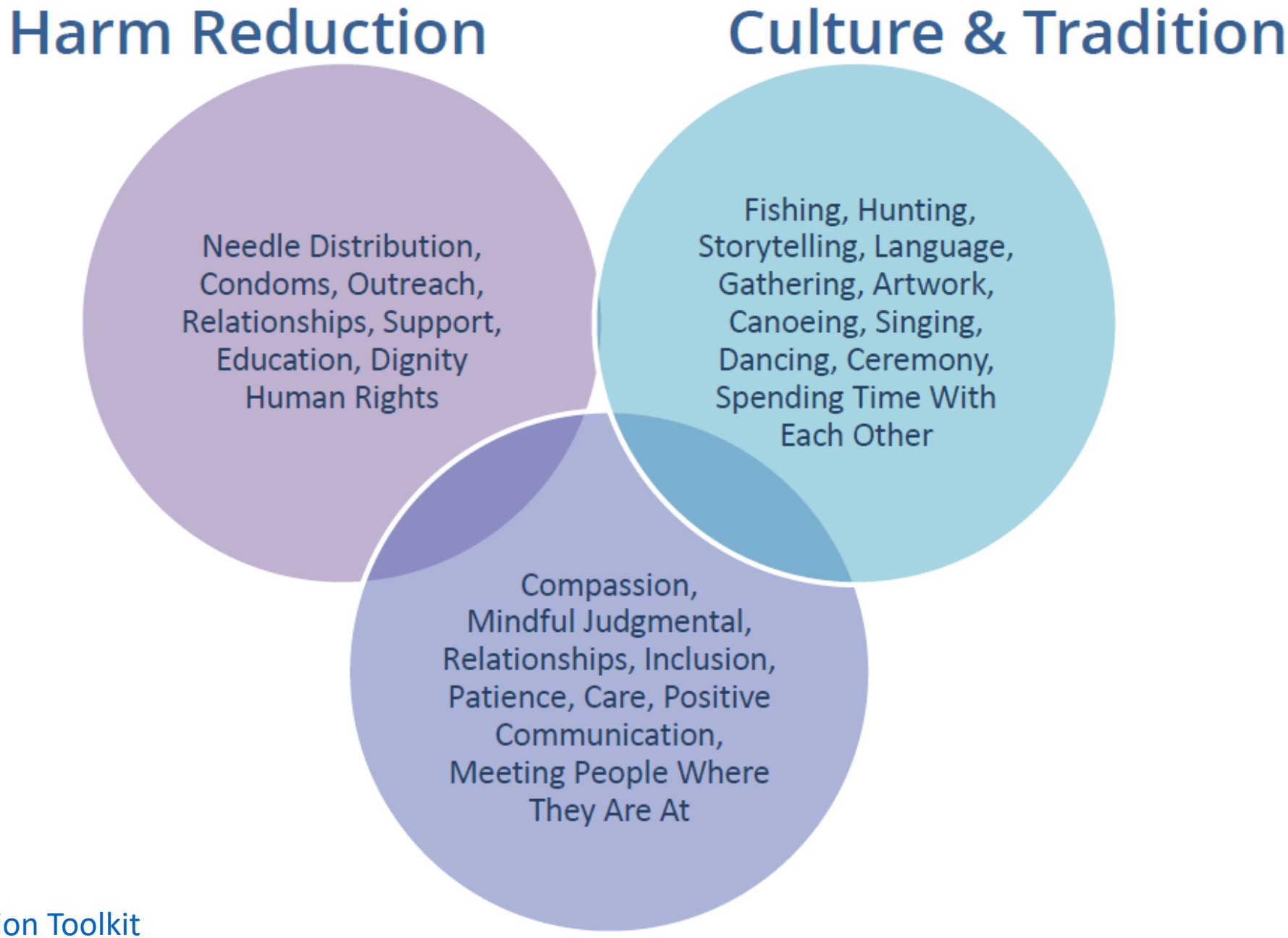
Annette Hubbard

Financial Disclosure

- I have nothing to disclose

About Me

- Behavioral Health Aide/MAT Case Manager/TOR Project Director for Ninilchik Traditional Council
- TA provider for NASTAD-PNW, Plains, Tribal
- Volunteer/Board Member at the Homer Syringe Exchange- currently the only rural syringe exchange in Alaska
- Co-facilitator of the Alaska Drug User Harm Reduction Network (4A's, Interior Aids Association, Alaska Native Tribal Health Consortium, State of Alaska)



ANTHC Harm Reduction Toolkit

Country	Term	Definition *	% Population
Global	Indigenous	Peoples with pre-historical ties to a land, prior to colonization.	370 million, world wide [3]
United States (US)	American Indian/Alaskan Native (AI/AN)	Approximately 561 tribes are recognized by the US government.	1.2% of US population (2011) [4]
	Alaskan Native	Peoples indigenous to Alaska. Alaskan Natives include Eskimos such as the Yupik, Inupiat and Aleut. The term Eskimo is used since it is inclusive of Inuit and non-Inuit peoples. In addition to the Eskimo, there are 11 Athabaskan tribes or language groups.	14.9% of Alaska's population (2011) [5]
	American Indian	Peoples indigenous to the continental US, includes Athabaskan and a wide variety of other tribal groups	Approximately 1.2% of US population [4]
Canada	Aboriginal or First Peoples	All individuals of indigenous ancestry within Canada	3.7% of Canada (2011) [2,6]
	Inuit	Peoples indigenous to the four northern regions of Canada: Nunatsiavut (Labrador), Nunavik (northern Quebec), Nunavut, and the Inuvialuit Settlement Region in the Northwest Territories. Formerly referred to as Eskimo. Also found in Alaska, Greenland and Russia. In Alaska they are included in the designation Alaskan Natives.	4% of Aboriginals [2,7]
	First Nation (FN)	Indigenous peoples with and without Indian Registered Status according to Indian Act of Canada (613 bands). Includes a large number of Athabaskan and as well as other tribal groups. Also referred to as Indian, although this term has fallen into disuse since the 1980s as "Indian" is linguistically incorrect. Nonetheless, "First Nation" is not a legal term, whereas "Indian" is. Akin to the US term American Indian.	60% of Aboriginals [2]
	Métis	Historically Métis Nation ancestry implies "children of the fur trade". However, broadly this term has also has come to include self-identified Aboriginal individuals of mixed indigenous ancestry who are not considered Inuit or First Nation. Note: Inuit and First Nation individuals can also be of mixed ancestry.	36% of Aboriginals [2,8]
Greenland	Inuit	Ancestors migrated from Canadian North.	89% of 57,695

- NCBI

Values

Anglo-American

- Success
- Ownership
- “Number One”
- Youth Oriented
- Learning is found in school Look to the future
- Work for retirement
- Be structured & aware of time Oriented to house, job, etc
- Look ahead, not to the past
- A critic is a good analyst
- “What are you – some kind of animal” This is America, speak English
- I’ll raise my own; you do the same
- The law is the law!
- Have a rule for every contingency Religion is for the individual

American Indian/Alaska Native

- Happiness
- Sharing
- Tribe and extended family first, before self
- Honor your Elders
- Learning is through legends/stories
- Look to traditions
- Work for purpose and the common good
- Time is only relative
- Oriented to land
- Cherish the memories of youth
- Don’t criticize your people
- Live like the animals; they are your bothers and sisters
- Cherish your language
- Children are gift of the Great Spirit to be shared with others
- Consider the relative nature of a crime, the personality of the individual, and the conditions of the offense

Alaska Native Cultural Values

Show	Show Respect to Others - Each Person Has a Special Gift
Share	Share what you have - Giving Makes You Richer
Know	Know Who You Are - You Are a Reflection on Your Family
Accept	Accept What Life Brings - You Cannot Control Many Things
Have	Have Patience - Some Things Cannot Be Rushed
Live	Live Carefully - What You Do Will Come Back to You
Take	Take Care of Others - You Cannot Live without Them
Honor	Honor Your Elders - They Show You the Way in Life
Pray	Pray for Guidance - Many Things Are Not Known
See	See Connections - All Things Are Related

Harm Reduction and Indigenous Values

American Indian/Alaska Native

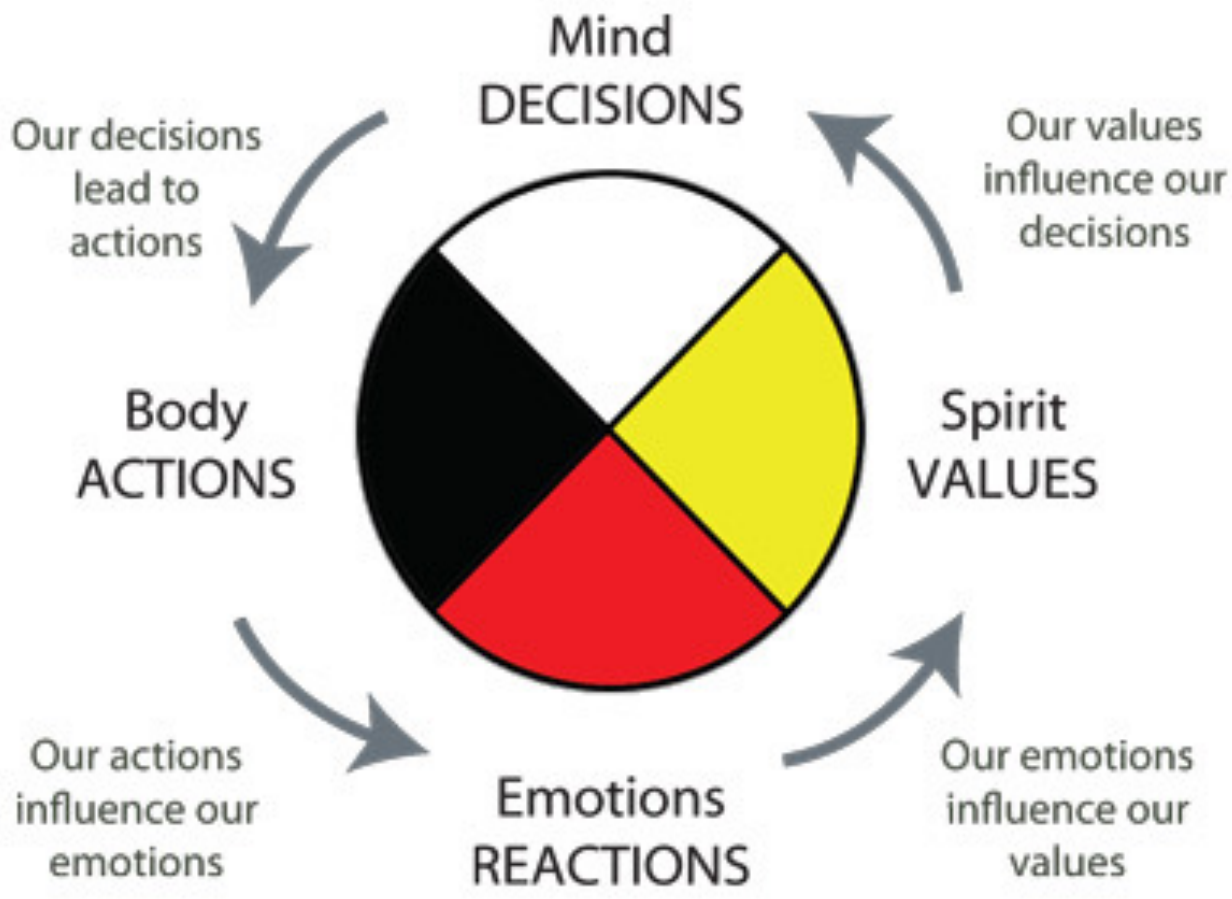
- Happiness
- Sharing
- Tribe and extended family first, before self
- Honor your Elders
- Learning is through legends
- Look to traditions
- Work for purpose
- Time is only relative
- Oriented to land
- Cherish the memories of youth
- Don’t criticize your people
- Live like the animals; they are your bothers and sisters
- Cherish your language
- Children are gift of the Great Spirit to be shared with others
- Consider the relative nature of a crime, the personality of the individual, and the conditions of the offense.

Harm Reduction

- Affirms people who use drugs (PWUD) themselves as the primary agents of reducing the harms of their drug use and seeks to empower PWUD to share information and support each other in strategies which meet their actual conditions of use (Sharing, Learning is through legends, Don’t criticize your people)
- Accepts, for better or worse, that licit and illicit drug use is part of our world and chooses to work (together) to minimize its harmful effects rather than simply ignore or condemn them (Tribe and extended family first, time is only relative, consider the relative nature of a crime)
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe use to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others (Happiness, Sharing, Don’t criticize your people)
- Establishes quality of individual and community life and well-being — not necessarily cessation of all drug use — as the criteria for successful interventions and policies (Happiness, Sharing, look to traditions, Work for purpose, Don’t criticize your people, Consider the relative nature of a crime)
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm (Sharing, Honor your elders, look to traditions, work for purpose, time is only relative, Don’t criticize your people)
- Ensures that people who use drugs and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them (Sharing, Learning is through legends, Don’t criticize your people, cherish your language)
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination, and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm (Tribe and extended family first, before self , Don’t criticize your people)
- Does not attempt to minimize or ignore the real and tragic harm and danger that can be associated with illicit drug use (Sharing, Don’t criticize your people , Consider the relative nature of a crime)

While Western efforts toward treatment emphasize the role of the individual, a Native perspective emphasizes connections with others (Voss, Douville, Little, & Twiss, 1999). Western models of healing generally isolate individuals from social, physical, and spiritual environments and then reintroduce them after treatment has been completed and wellness has presumably been achieved (Coates, Gray, & Hetherington, 2006). Traditional Native American healing is interconnected and seeks to balance emotional, physical, mental, and spiritual aspects of people, their environment, and the spirit world

"The opposite of addiction is connection"



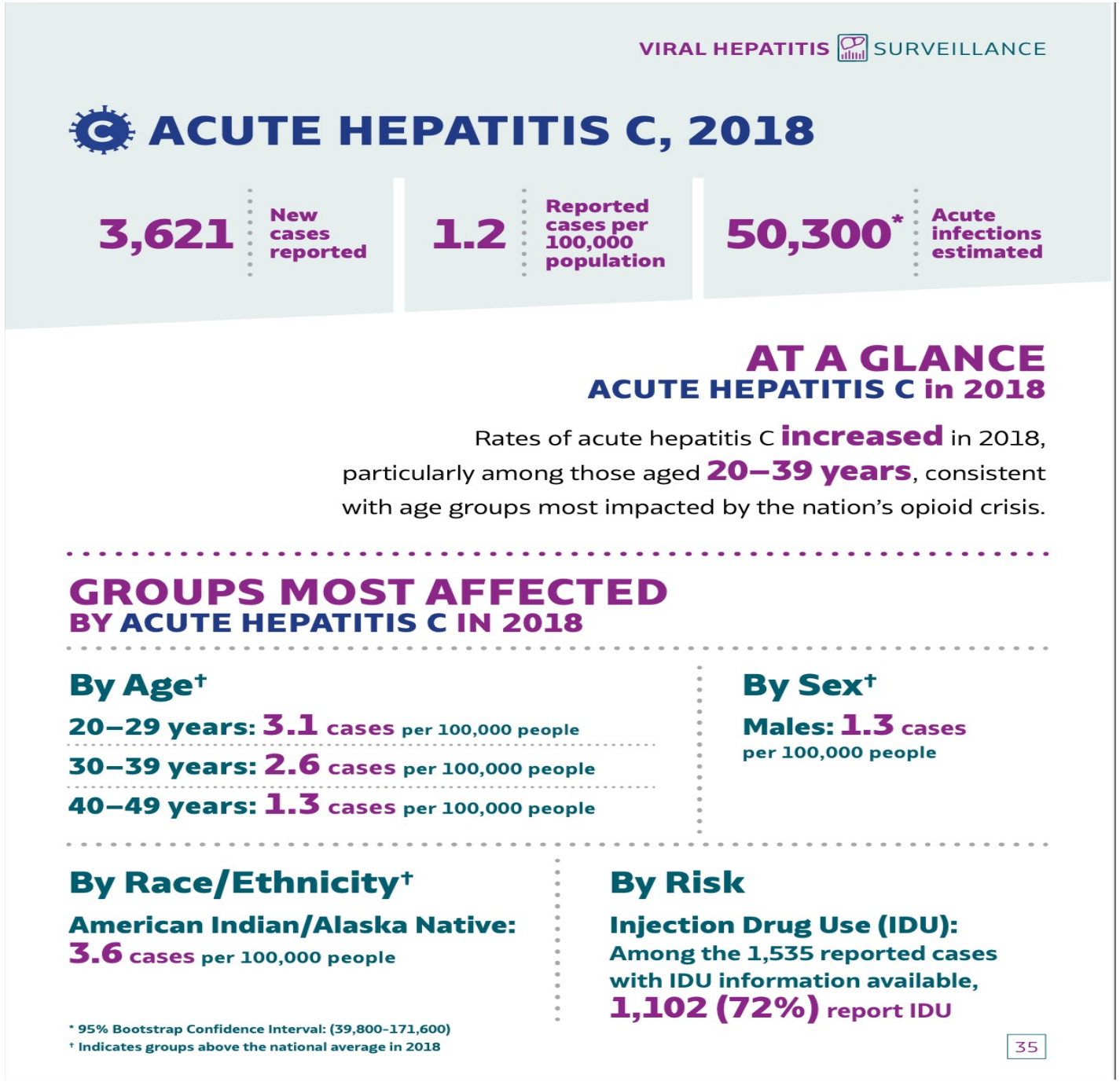
Integrating Spiritual and Western Treatment Modalities in a Native American Substance User Center

Why we need harm reduction services in tribal communities

American Indian and Alaskan Natives (AI/ANs) show higher rates of substance use compared to the general population and have historically been subject to a number of risk factors that are known to increase the likelihood of substance use. AI/ANs also experience increased risk for infectious diseases that are transmitted via injection drug use and/or sexual activity. Harm reduction approaches have been shown to be effective for decreasing risk of disease transmission in at-risk populations and may be well suited for AI/AN injection drug users residing in rural reservation communities.

Hep C and AI/AN population

- According to the CDC 2018 Viral Hepatitis Surveillance study, males age 20-39 who are AI/AN and IDU are at higher risk of contracting Hep C.



Comparing the rates of reported acute Hep C by state 2014-2018

Increased .5 in 4 years

- Access to testing
- Access to substance treatment services
- Increase in harm reduction services

Table 3.1. Number and rate* of reported cases of acute hepatitis C, by state or jurisdiction — United States, 2014–2018

State	2014		2015		2016		2017		2018	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Alabama	35	0.7	70	1.4	32	0.7	17	0.3	52	1.1
Alaska	N	N	N	N	N	N	N	N	N	N
Arizona	U	U	U	U	U	U	U	U	U	U
Arkansas	13	0.4	2	0.1	—	—	1	0.0	10	0.3
California	73	0.2	59	0.2	60	0.2	103	0.3	114	0.3
Colorado	33	0.6	40	0.7	35	0.6	42	0.7	46	0.8
Connecticut	—	—	—	—	17	0.5	9	0.3	10	0.3
Delaware	U	U	4	0.4	25	2.6	4	0.4	U	U
District of Columbia	U	U	U	U	U	U	U	U	U	U
Florida	93	0.5	126	0.6	236	1.1	357	1.7	435	2.0
Georgia	57	0.6	84	0.8	93	0.9	100	1.0	84	0.8
Hawaii	—	—	—	—	—	—	—	—	—	—
Idaho	6	0.4	4	0.2	7	0.4	8	0.5	4	0.2
Illinois	27	0.2	31	0.2	21	0.2	39	0.3	93	0.7
Indiana	122	1.8	138	2.1	146	2.2	191	2.9	266	4.0
Iowa	U	U	U	U	U	U	U	U	U	U
Kansas	28	1.0	22	0.8	15	0.5	19	0.7	13	0.4
Kentucky	176	4.0	119	2.7	103	2.3	83	1.9	164	3.7
Louisiana	22	0.5	24	0.5	5	0.1	7	0.1	8	0.2
Maine	31	2.3	30	2.3	25	1.9	21	1.6	23	1.7
Maryland	42	0.7	38	0.6	35	0.6	32	0.5	38	0.6
Massachusetts	228	3.4	249	3.7	424	6.2	327	4.8	110	1.6
Michigan	78	0.8	83	0.8	107	1.1	152	1.5	142	1.4
Minnesota	40	0.7	37	0.7	51	0.9	57	1.0	60	1.1
Mississippi	U	U	U	U	U	U	U	U	U	U
Missouri	6	0.1	8	0.1	24	0.4	49	0.8	74	1.2
Montana	13	1.3	15	1.5	20	1.9	14	1.3	8	0.8
Nebraska	2	0.1	8	0.4	2	0.1	2	0.1	2	0.1
Nevada	6	0.2	12	0.4	16	0.5	35	1.2	19	0.6
New Hampshire	N	N	N	N	N	N	25	1.9	25	1.8
New Jersey	113	1.3	130	1.5	122	1.4	125	1.4	96	1.1
New Mexico	16	0.8	40	1.9	18	0.9	16	0.8	22	1.0
New York	126	0.6	121	0.6	179	0.9	188	0.9	236	1.2
North Carolina	111	1.1	144	1.4	82	0.8	114	1.1	149	1.4
North Dakota	—	—	—	—	1	0.1	1	0.1	10	1.3
Ohio	105	0.9	122	1.1	187	1.6	159	1.4	282	2.4
Oklahoma	45	1.2	35	0.9	32	0.8	46	1.2	28	0.7
Oregon	15	0.4	13	0.3	19	0.5	35	0.8	14	0.3
Pennsylvania	69	0.5	129	1.0	225	1.8	224	1.7	249	1.9
Rhode Island	U	U	U	U	U	U	U	U	U	U
South Carolina	4	0.1	5	0.1	10	0.2	13	0.3	15	0.3
South Dakota	—	—	—	—	20	2.3	19	2.2	19	2.2
Tennessee	123	1.9	173	2.6	150	2.3	142	2.1	157	2.3
Texas	47	0.2	48	0.2	40	0.1	35	0.1	46	0.2
Utah	38	1.3	30	1.0	76	2.5	81	2.6	120	3.8
Vermont	4	0.6	1	0.2	5	0.8	9	1.4	4	0.6
Virginia	54	0.6	52	0.6	43	0.5	62	0.7	47	0.6
Washington	82	1.2	63	0.9	62	0.9	52	0.7	101	1.3
West Virginia	62	3.4	63	3.4	94	5.1	102	5.6	70	3.9
Wisconsin	49	0.9	64	1.1	103	1.8	94	1.6	134	2.3
Wyoming	U	U	U	U	U	U	5	0.9	22	3.8
Total	**2,194**	**0.7**	**2,436**	**0.8**	**2,967**	**1.0**	**3,216**	**1.0**	**3,621**	**1.2**

Source: CDC, National Notifiable Diseases Surveillance System.

* Rate per 100,000 population.

† For case definition, see https://wwwn.cdc.gov/nndss/conditions/hepatitis-c-acute/

—: No reported cases. The reporting jurisdiction did not submit any cases to CDC.

N: Not reportable. The disease or condition was not reportable by law, statute, or regulation in the reporting jurisdiction.

U: Unavailable. The data are unavailable.

Reported cases by demographics 2014-2018

- Age 20-39-1.8 (increase)
- Male- .5 (increase)
- AI/AN- 2.3 (increase)

Table 3.2. Number and rate* of reported cases† of acute hepatitis C, by demographic characteristics and region — United States 2014–2018

Demographic characteristic	2014		2015		2016		2017		2018	
	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*	No.	Rate*
Total§	**2,194**	**0.7**	**2,436**	**0.8**	**2,967**	**1.0**	**3,216**	**1.0**	**3,621**	**1.2**
Age group (years)										
0–19	88	0.1	99	0.1	86	0.1	103	0.1	81	0.1
20–29	918	2.2	999	2.4	1,135	2.7	1,189	2.8	1,310	3.1
30–39	643	1.7	682	1.7	868	2.2	937	2.3	1,070	2.6
40–49	282	0.7	337	0.9	452	1.2	441	1.1	494	1.3
50–59	166	0.4	240	0.6	264	0.6	332	0.8	366	0.9
60+	70	0.1	77	0.1	141	0.2	185	0.3	295	0.4
Sex										
Male	1,167	0.8	1,334	0.9	1,627	1.1	1,775	1.2	2,012	1.3
Female	1,025	0.7	1,093	0.7	1,310	0.8	1,431	0.9	1,605	1.0
Race/ethnicity										
American Indian/ Alaskan Native	29	1.3	39	1.7	70	3.1	67	2.9	83	3.6
Asian/Pacific Islander	11	0.1	16	0.1	25	0.1	23	0.1	29	0.2
Black, Non-Hispanic	74	0.2	112	0.3	130	0.3	202	0.5	231	0.6
White, Non-Hispanic	1,569	0.8	1,724	0.9	2,109	1.1	2,227	1.2	2,405	1.3
Hispanic	124	0.2	148	0.3	191	0.4	234	0.4	280	0.5
HHS Region¶										
Region 1	263	3.0	280	3.2	471	3.8	391	2.8	172	1.2
Region 2	239	0.8	251	0.9	301	1.0	313	1.1	332	1.2
Region 3	227	0.8	286	1.0	422	1.4	424	1.4	404	1.4
Region 4	599	1.0	721	1.2	706	1.1	826	1.3	1,056	1.7
Region 5	421	0.8	475	0.9	615	1.2	692	1.3	977	1.9
Region 6	143	0.4	149	0.4	95	0.2	105	0.2	114	0.3
Region 7	36	0.3	38	0.3	41	0.4	70	0.6	89	0.8
Region 8	84	0.8	85	0.8	152	1.4	162	1.4	225	1.9
Region 9	79	0.2	71	0.2	76	0.2	138	0.3	133	0.3
Region 10	103	0.8	80	0.6	88	0.7	95	0.7	119	0.9

Source: CDC, National Notifiable Diseases Surveillance System.

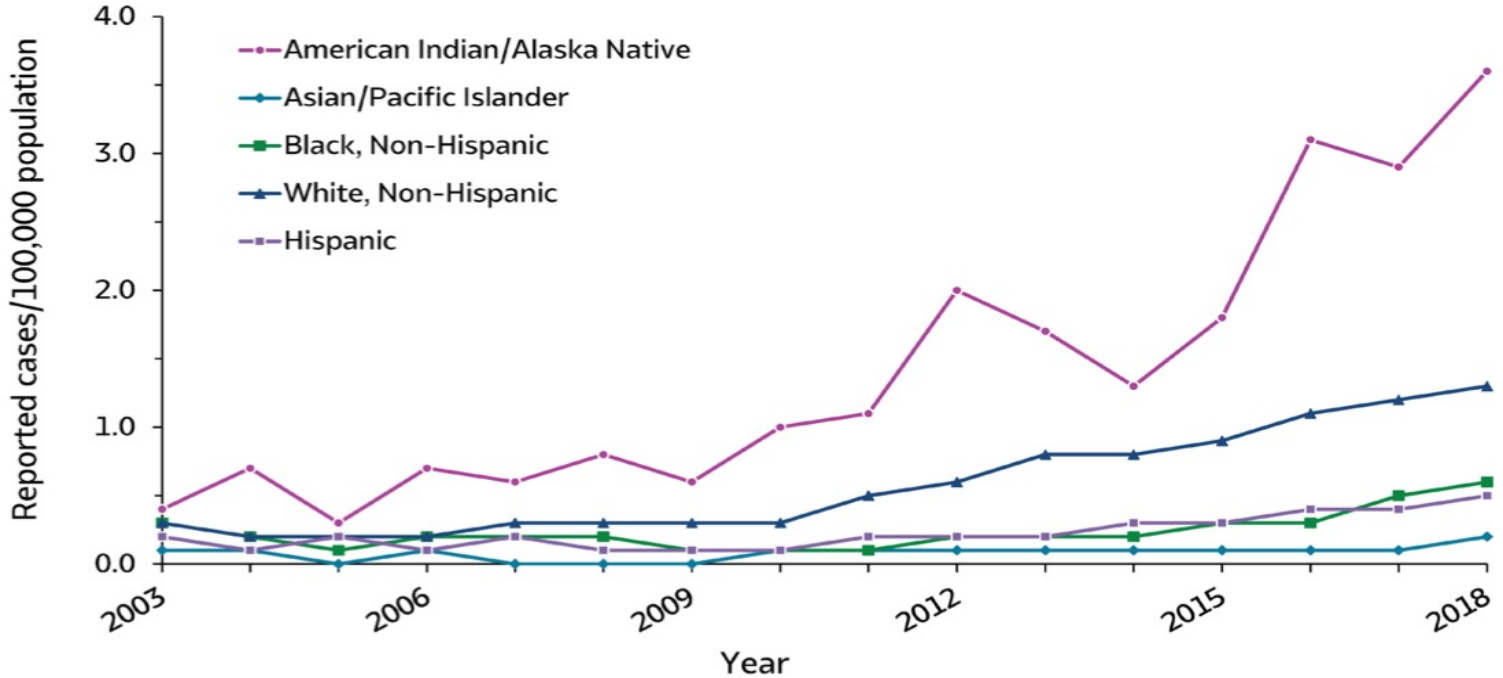
* Rate per 100,000 population.

† For the case definition, see https://wwwn.cdc.gov/nndss/conditions/hepatitis-c-acute/

§ Numbers reported in each category may not add up to the total number of reported cases in a year due to cases with missing data or, in the case of race/ethnicity, cases categorized as "Other."

¶ Health and Human Services Regions were categorized according to the grouping of states and U.S. Territories assigned under each of the ten Department of Health and Human Services regional offices (https://www.hhs.gov/about/agencies/iea/regional-offices/index.html). For the purposes of this report, regions with U.S. territories (Region 2 and Region 9) contain data from states only.

Figure 3.6. Rates of reported acute hepatitis C, by race/ethnicity — United States, 2003–2018



Race/ Ethnicity	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
American Indian/ Alaska Native	0.4	0.7	0.3	0.7	0.6	0.8	0.6	1.0	1.1	2.0	1.7	1.3	1.8	3.1	2.9	3.6
Asian/Pacific Islander	0.1	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2
Black, Non-Hispanic	0.3	0.2	0.1	0.2	0.2	0.2	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.5	0.6
White, Non-Hispanic	0.3	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.5	0.6	0.8	0.8	0.9	1.1	1.2	1.3
Hispanic	0.2	0.1	0.2	0.1	0.2	0.1	0.1	0.1	0.2	0.2	0.2	0.3	0.3	0.4	0.4	0.5

Source: CDC, National Notifiable Diseases Surveillance System.

HEPATITIS C
RISK BEHAVIORS AND EXPOSURES

Figure 3.7. Availability of information on risk behaviors/ exposures* associated with reported cases of acute hepatitis C — United States, 2018

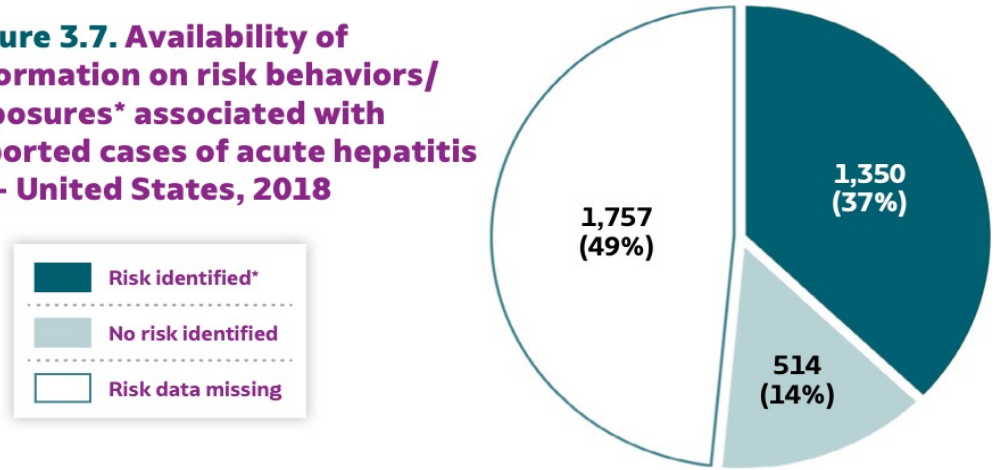


Table 3.3. Reported risk behaviors/exposures† among reported cases of acute hepatitis C — United States, 2018

Risk behaviors/exposures	Risk identified*	No risk identified	Risk data missing
Injection drug use	1,102	433	2,086
Multiple sex partners	212	462	2,947
Surgery	124	832	2,665
Sexual contact§	105	278	3,238
Needlestick	91	781	2,749
Men who have sex with men¶	33	277	1,702
Household contact (non-sexual)§	30	353	3,238
Dialysis patient	18	1,041	2,562
Occupational	7	1,145	2,469
Transfusion	1	956	2,664

Source: CDC, Nationally Notifiable Diseases Surveillance System.

* Case reports with at least one of the following risk behaviors/ exposures reported 6 weeks to 6 months prior to symptom onset: 1) injection drug use; 2) sexual contact with suspected/confirmed hepatitis C patient; 3) men who have sex with men; 4) multiple sex partners; 5) occupational exposure to blood; 6) dialysis patient; 7) receive blood transfusion; and 8) underwent surgery.

† Reported cases may include more than one risk behavior/exposure.

§ Cases with more than one type of contact reported were categorized according to a hierarchy: (1) sexual contact; (2) household contact (non-sexual).

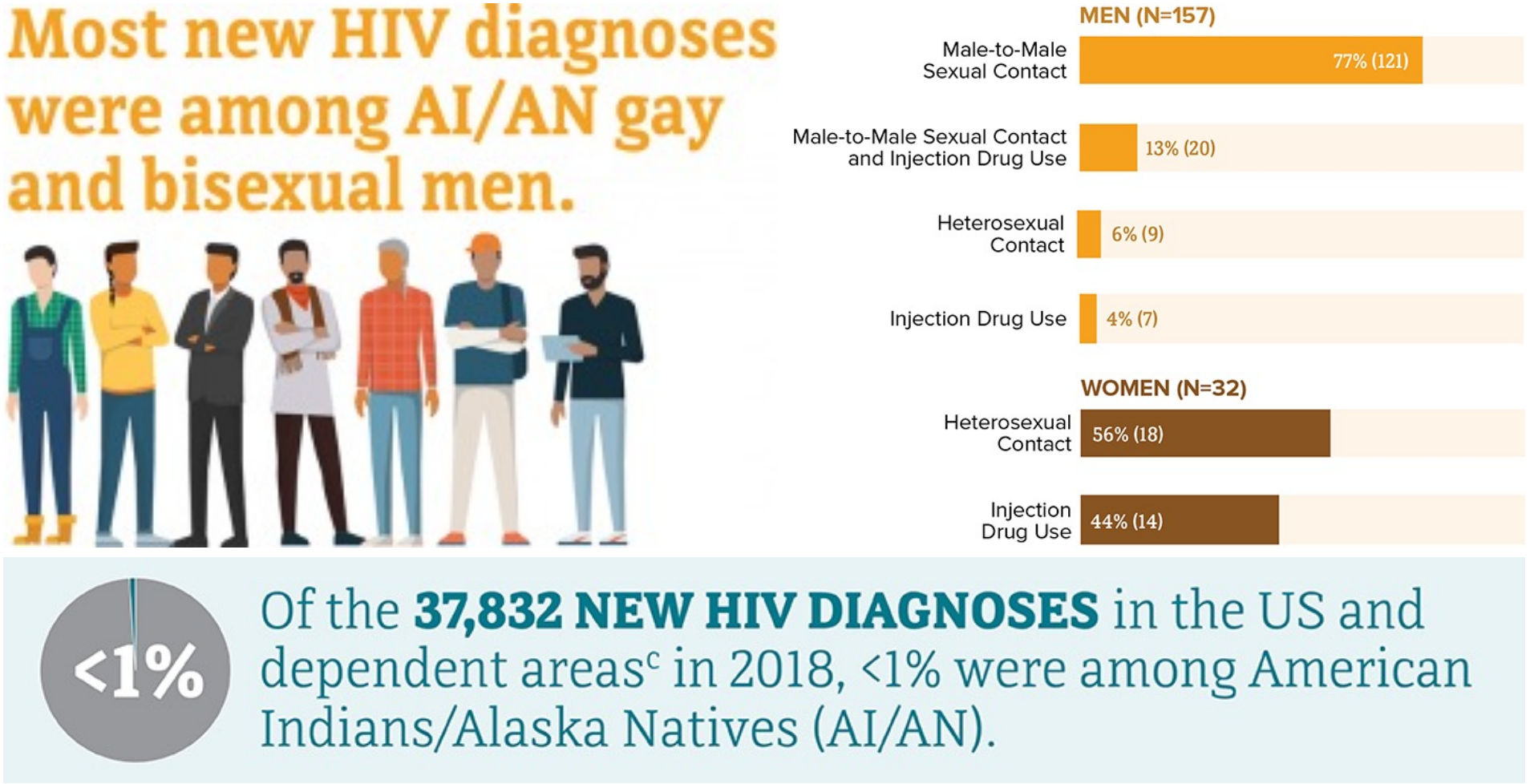
¶ A total of 2,012 acute hepatitis C cases were reported among males in 2018.

How much does Hep C Treatment Cost?

Generic name	Brand name	Manufacturer	Date of FDA approval	Approximate cost for 12-week therapy	Approximate cost for 8-week therapy
Glecaprevir/pibrentasvir	Mavyret	AbbVie Inc.	8/17	—	$26,400
Elbasvir/grazoprevir	Zepatier	Merck Sharp & Dohme Corp.	1/16	$55,700	—
Sofosbuvir/velpatasvir	Epclusa	Gilead Sciences, Inc.	6/16	$75,000	—
Sofosbuvir/velpatasvir/voxilaprevir	Vosevi	Gilead Sciences, Inc.	7/17	$75,600	—
Ombitasvir/paritaprevir/ritonavir	Technivie	AbbVie Inc.	7/15	$78,100	—
Dasabuvir/ombitasvir/paritaprevir/ritonavir	Viekira Pak	AbbVie Inc.	12/14	$83,300	—
Ledipasvir/sofosbuvir	Harvoni	Gilead Sciences, Inc.	10/14	$94,800	—

State of Alaska-Hep C Treatment

Healthline


Most new HIV diagnoses were among AI/AN gay and bisexual men.
MEN (N=157)
Male-to-Male Sexual Contact
77% (121)
Male-to-Male Sexual Contact and Injection Drug Use
13% (20)
Heterosexual Contact
6% (9)
Injection Drug Use
4% (7)
WOMEN (N=32)
Heterosexual Contact
56% (18)
Injection Drug Use
44% (14)
<1%
Of the 37,832 NEW HIV DIAGNOSES in the US and dependent areas[c] in 2018, <1% were among American Indians/Alaska Natives (AI/AN).

HIV

CDC

Considerations for American Indian/Alaska Native and Tribal Populations

- American Indian/Alaska Native (AI/AN) populations and tribal communities are more likely to report certain types of substance use disorders (SUDs) when compared to other racial and ethnic groups. Data from the National Survey on Drug Use and Health shows that AI/ANs aged 18 and older were more likely to receive SUD treatment in the past year (4.8%) than any other racial and ethnic population.
- There are still a number of barriers to treatment in tribal communities, including limited resources, stigma, and fear of arrest. Tribal communities may not have naloxone available or people who are trained to administer naloxone. Additionally, there is a lack of education about how to help someone who is overdosing. Documentation of substance misuse, including opioid use disorder and overdose, may also be underestimated if neighboring communities provide emergency medical services and do not identify tribal status in records. This lack of data impacts the ability of tribes to apply for funds to support SUD treatment programs and track their success in implementing these programs.
- Programs addressing SUD in AI/AN populations should take into consideration the effects of historical trauma on SUD behaviors. Populations experience historical trauma across generations due to an event of oppression. AI/AN populations have experienced historical trauma due to European colonization of the United States beginning in the 1400s that resulted in loss of land, population, and culture. The trauma from these events has persisted through generations and contributes to mental and behavioral health conditions, including SUD. Rural SUD treatment programs should provide AI/AN populations with historical trauma-informed care. The Indian Health Services offers a series of presentations on historical trauma, including the intersection of trauma and SUD.
- Rural communities may consider strategies to engage AI/AN individuals and families in need of SUD prevention or treatment services. One rural SUD treatment program serving tribal populations contracted with a Native project coordinator who had existing relationships with contacts at partner tribes. Programs have also invested in social marketing campaigns to ensure that the messages of the program are tailored to the culture of the community. Programs that address tobacco use should understand that tobacco has traditional, medicinal, or sacred connotations in some tribal communities.
- The University of Washington also conducted an environmental scan of tribal opioid overdose prevention responses that provides an overview of community-based strategies. Other resources to address SUDs include the Northwest Tribal Substance Abuse Action Plan.

Rural Health Info Hub

An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure

Prepared by Seven Directions: A Center for Indigenous Public Health
September 2019

Key Takeaways

- AI/AN people living on reservations and in urban areas are experiencing the second highest fatality rate from opioid overdose with 13.9 deaths per 100,000 people
- Issues of racial misclassification are on-going challenges to accurate reporting.
- Many localized efforts are often carried out in coordination with federal partners, including SAMHSA, NIDA, CDC, and IHS. Information about these partnerships, however, is not easily available.
- Comprehensive efforts to address the opioid epidemic in AI/AN communities rely on strong partnerships between tribal governments and local, state, and federal entities.
- Additional community-based surveillance, treatment, and prevention efforts to respond to the epidemic across diverse tribal and urban AI/AN communities is critically needed.
- TECs, IHS clinics, I.T. departments of various institutions, and tribal health departments and organizations conduct surveillance specific to opioid-related outcomes and focus on public health impacts – but that information is not readily available.
- Data dashboards and other tools and technologies could provide accessible platforms to disseminate strategies and promising practices being implemented to address opioid misuse across AI/AN communities.

Syringe Exchange Models

- **Fixed Site Exchanges**
  The exchange is located in an established, consistent location. It could be a storefront, office or other similar fixed, accessible space.
- **Mobile/Street-Based Vehicle Exchange**
  Syringe exchange is conducted out of a vehicle, van or RV that travels to different sites or neighborhoods according to a regular, established schedule.
- **Delivery or Peer-Based Exchange**
  People interested in receiving or returning syringes contact an exchange to arrange delivery of supplies and/or services. Delivery can be at the participant's home or another agreed-upon site. Delivery can occur on a regular schedule or by appointment.
- **Integrated Syringe Exchange**
  An existing organization adds syringe exchange to their ongoing provided services.
- **Combining Models**
  Exchanges can combine models to maximize benefits and use and minimize limitations. A fixed site may also offer delivery or peer-based exchange; an integrated exchange may have the resources to operate a mobile exchange. Evaluate and expand models based on need, funding, resources (including staff and/or volunteer experience and expertise), and other environmental or context changes.

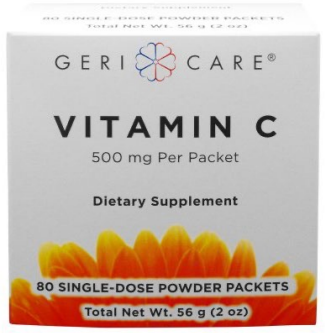
NALOXONE/NARCAN

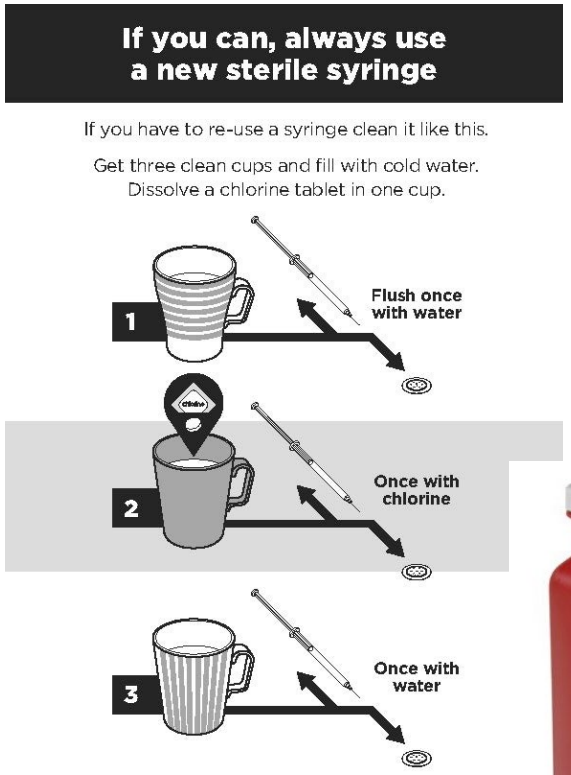
- NARCAN is an opioid overdose reversal medication. It will only work on OPIOIDS. It is a safe medication. It (mostly) comes in the form of a nasal spray. Anyone who receives a prescription for opioids, buprenorphine, uses drugs (including meth), has a family member who is in any of these categories, should be provided with NARCAN
- NARCAN® Nasal Spray is not a treatment for opioid addiction or dependency

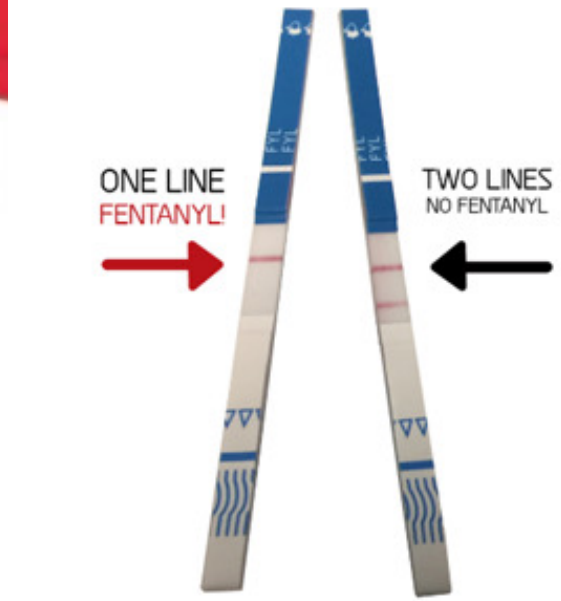
- Get Naloxone Now
- NEXT Distro

Offer overdose prevention/Safe supplies/Education and advertise it

- NARCAN- (carry some with you at all times)
- Fentanyl Testing Strips
- Chlorine Tablets
- Safe disposal containers- different sizes
- Vitamin C Tablets
- Shoot first- talk about other safe injection practices
  - Harm Reduction Coalition Safe Injection Practice







Phone APPS/Hardware

- Canary
- BeBrave- App/Hardware
- Iphone app search- ”OVERDOSE”
  - Sorry I don’t know much about Android phones
- Never Use Alone

Mutual Aid Groups/Peers

- Getting NARCAN out
- Safe Injection Practices- how and where
  - Us taking care of us

Medication assisted treatment for Opioid Use Disorder

Table 1

FDA-Approved Drugs Used in MAT[21]

Medication	Mechanism of action	Route of administration	Dosing frequency	Available through
Methadone	Full agonist	Available in pill, liquid, and wafer forms	Daily	Opioid treatment program
Buprenorphine	Partial agonist	Pill or film (placed inside the cheek or under the tongue)	Daily	Any prescriber with the appropriate waiver
		Implant (inserted beneath the skin)	Every six months	
Naltrexone	Antagonist	Oral formulations	Daily	Any health care provider with prescribing authority
		Extended-release injectable formulation	Monthly	

Tribal Syringe Exchange Programs

- **Syringe Exchange/Access Programs**

Needle or syringe exchange programs are harm reduction practices used to provide safe, judgement-free services and to help prevent injection-related infections and diseases. Though syringe exchange programs are not legal in all states,142 many tribal health organizations have incorporated this service into their harm reduction strategies. They offer locations where clients can dispose of used needles and acquire sterile injection equipment. Many also provide access to confidential HIV and Hepatitis C virus (HCV) testing, counseling services and education, and referrals for SUD treatment programs.

Eastern Band of Cherokee Indians (NC and TN): Syringe Service Program is a community-based public health program that provides participants with sterile syringes and sterile injection equipment

Port Gamble S'Klallam Tribe (WA): Tribal Healing Opioid Response (THOR) includes the Behavioral Health Department, Health Department, and Re-Entry Program offering syringe and needle exchange

Ho-Chunk Nation (WI): Safe Sharps (Needle) Disposal partnership between the Ho- Chunk Nation and Together for Jackson County Kids to provide safe disposal drop boxes

Lummi Tribal Health Center (WA): Started a Needle Exchange Program in 2013
- Program ended in its first year but was restarted in 2015
- Currently called the Primary Integrated Care Syringe Service Program which allows patients to anonymously receive safe injection equipment and HCV screening and treatment

Muckleshoot Behavioral Health (WA): Needle Exchange Program began in February of 2016
- Through July of 2017, served 406 (duplicated) Tribal/Community Members and exchanged 20,771 needles

Blackfeet Action Committee (MT): Blackfeet Tribal Health Department and Blackfeet Action Committee provides sterile syringes to IV drug users to reduce the spread of Hepatitis C
- Strictly confidential needle exchange and HCV testing

Indigenous Peoples Task Force Syringe Exchange (MN): has seen positive effects of the program
- Over 65,000 exchanges
- Provides counseling services, HIV/HCV testing, and Narcan distribution as well as sterile equipment

White Earth's Harm Reduction Coalition hosts an Annual Harm Reduction Summit to focus on indigenous harm reduction by addressing indigenous harm reduction principles, decolonizing chemical dependency, wound care for harm reductionists, vulnerability and resiliency along with other intersecting health equity and social justice-related topics to indigenous health.

Tribal TA

- NPAIHB ECHO
- NASTAD Regional/Tribal TA Calls