INDIAN COUNTRY'S CONTINUED STRUGGLE WITH THE OPIOID CRISIS: FOCUSED PROBLEM AREAS, THE FEDERAL GOVERNMENT'S RESPONSE, AND WHAT MORE CAN BE DONE

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Introduction

Tribes are "running out of homes" for children whose parents are battling opioid use, and increased rates of babies are born with neonatal abstinence syndrome—a postnatal withdrawal syndrome from in utero opioid exposure.[1] Tribes feel "preyed upon" by pharmaceutical companies who have fueled the "worst drug epidemic in American history" and, as of 2020, 169 civil suits were brought on behalf of the federally recognized tribes.[2] Indian Country experiences the impact of the opioid crisis more than nonnatives. However, when tribal communities take steps to establish facilities and programs to help the crisis as a whole, they are blocked by individuals who not only experience the effects at a decreased rate, but who have significantly greater access to resources.[3] The federal government has invested billions of dollars into roughly fifty-seven different treatment and recovery efforts in response to the opioid crisis since its designation as a public health emergency in 2017.[4] Yet, five years later, the crisis was still a pervasive problem. The opioid crisis presents a myriad of complexities that require a multifaceted approach to properly confront and overcome. In 2020, "nearly 75% of overdose deaths . . . involved an opioid"—a figure

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1. Courtney Columbus, *Battling Opioid Addiction in Indian Country*, CRONKITE NEWS (Oct. 17, 2016), https://cronkitenews.azpbs.org/2016/10/17/battling-opiods-in-indian-country/; *see* Jean Ko et al., *Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013*, 65 MORBIDITY & MORTALITY WKLY. REP. 799, 799 (2016).

2. Sari Horwitz et al., *As Opioids Flooded Tribal Lands Across the U.S., Overdose Deaths Skyrocketed*, WASH. POST (June 29, 2020), https://www.washingtonpost.com/graphics/2020/national/investigations/native-american-opioid-overdose-deaths/.

3. *See* Debbie Cenziper et al., *A Native American Tribe Plans to Build an Opioid Treatment Center, but Neighbors Have Vowed to Block It*, WASH. POST (June 18, 2020), https://www.washingtonpost.com/graphics/2020/national/investigations/native-american-opioid-treatment-center/.

4. BIPARTISAN POL'Y CTR., TRACKING FEDERAL FUNDING TO COMBAT THE OPIOID CRISIS (Mar. 2019), https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2019/03/Tracking-Federal-Funding-to-Combat-the-Opioid-Crisis.pdf.

further exacerbated by the COVID-19 epidemic; thus, an expansion of currently effective programs and reallocation of funds to newly effective solutions is essential now, more than ever.[5]

Part I of this Comment will discuss the extensive history of the opioid crisis and, thereby, highlight the necessity of taking new, unique steps to ameliorate its impact. Part I will also establish the direct impact of the opioid crisis in Indian Country and the specific concerns raised in relation to these communities.

Part II will lay out two focused problem areas: tribal jurisdiction and mental health, to which proposed solutions will be particularly crafted. The first section will establish key areas of tribal jurisdictional precedent that can potentially provide tribes with powerful tools to assert control over matters that directly affect their communities. The second section will explain the mental health issues that influence and are influenced by the opioid crisis, particularly illuminating substance use and opioid use disorders. Mental health concerns specific to the American Indian/Alaskan Natives (AI/AN) communities will be discussed at length to accurately depict the harrowing situation these communities are enduring.

Part III will discuss the federal government's response to the crisis by analyzing two regulatory agencies, the Substance Abuse and Mental Health Services Administration (SAMHSA) and Indian Health Service (IHS). A review of each agencies' grant programs that provide funding specifically for treatment, prevention, and recovery services for opioid use disorder is conducted. A consideration of the benefits of grants and reasons for why they may not be the best solution for AI/AN communities is also discussed. Finally, Part III will overview two relevant pieces of legislation, (1) the Comprehensive Addiction and Recovery Act of 2016 and (2) the 21st Century Cures Act, which also acts as sources of federal funding.

Part IV will consist of additional potential solutions to the opioid crisis outside of the primarily relied upon grant process. This part will argue that drug consumption rooms, mobile narcotic treatment program units, telehealth services, and jurisdictional control are all solutions apt to address not just the opioid crisis in general but to specifically and immediately mitigate notable concerns facing AI/AN communities as well.

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5. *The Drug Overdose Epidemic: Behind the Numbers*, CTR. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/opioids/data/index.html [https://perma.cc/5XCL-5YX3] (last reviewed May 8, 2023).

I. History

Life expectancy in the United States has been consistently declining since 2015 due to increased rates of drug overdose and suicide associated with the use of opioid drugs.[6] Drug overdose deaths have "more than tripled between 1999 and 2017" with those related to opioid use "increase[ing] almost sixfold" in that same timeframe.[7] This crisis is commonly described as containing three phases. The first phase began with an honest intention to progress pain management and overzealous marketing by pharmaceutical companies.[8] The second phase is denoted by a shift in the use of prescription medications to use of heroin in response to changing circumstances in regulations, product availability, and drug dependency.[9] The third and current phase revolves around the introduction and use of fentanyl as well as the rapid response of increased death rates.[10]

Prior to the 1980s, opioids were only prescribed for short-term relief post-surgery or for those with a terminal illness. Problematic studies conducted in the 1980s, however, shifted the perspective on utilizing opioids in pain management: opioids were only addictive when used recreationally, not for treating pain.[11] This perspective was bolstered in 1995 when the American Pain Society announced pain as a fifth vital sign, like heart rate and blood pressure, and the Federal Drug Administration (FDA) approved OxyContin as a safe alternative.[12] In fact, opioid prescriptions did not see a drastic climb until OxyContin was promoted heavily by pharmaceutical companies as "safe[], eff[ective] and [having] low potential for addiction."[13] The Federation of State Medical Boards, among other administrative organizations, released policies that encouraged the prescription of opioids, shielded doctors from being regulated for prescribing narcotics, and even sanctioned doctors for undertreating pain.[14] The structure of the health care system also indirectly incentivized the

6. Sarah DeWeerdt, *Tracing the U.S. Opioid Crisis to Its Roots*, 573 NATURE S10, S10 (2019).

7. *Id.*

8. *See id.* at S11-12.

9. *Id.*

10. *Id.*

11. *Id.* at S11.

12. *Timeline of the Opioid Epidemic in America*, AM. ACAD. OF PEDIATRICS, https://downloads.aap.org/DOPA/Opioid_Epidemic_Visual_Timeline.pdf (last visited July 1, 2023).

13. DeWeerdt, *supra* note 6, at S11.

14. *Timeline of the Opioid Epidemic in America*, *supra* note 12.

alarming increase in overprescription of pain medication. Private medical practitioners thrive financially by maintaining a large client base and securing patient satisfaction, both actions motivate overprescription.[15] Insurance policies more readily covered pain medication over pain management treatments, like physical therapy, during this time.[16] Health care culture—by reason of direct advertising of pharmaceuticals to consumers—induced patients to expect prescriptions, or even request specific drugs from their doctor after a visit for a medical concern.[17]

A new phase of the opioid crisis was marked by a series of factors. The 2007 FDA lawsuit against Purdue Pharma—which resulted in a $634.5 million payout for misrepresentation of the addictive properties of OxyContin—signaled possibilities of legal repercussions for harmful marketing.[18] The FDA, in 2010, approved a new formulation of OxyContin that claimed to contain "abuse deterring qualities," making it more difficult to crush and inhale.[19] More vigilant control by federal agencies on prescription medications left many individuals unable to get the opioids their bodies had become dependent on. Simultaneous to this prescription reform, an unexplained price drop in heroin generated an increased supply.[20] Even if patients could still receive prescription medication, most habitual users were developing tolerances and needed a more potent source.[21] These factors combined to spark an increased use of heroin that tripled the rate of overdose deaths between 2010 and 2015.[22]

The crisis entered its current phase in 2013 with the emergence of fentanyl. Fentanyl is a very powerful synthetic opioid and much more potent than morphine and heroin.[23] Due to its increased potency, fentanyl is more deadly.[24] Subsequently, this shift in the opioid crisis is marked not by

15. DeWeerdt, *supra* note 6, at S11.

16. *Id.*

17. *Id.*

18. *Timeline of the Opioid Epidemic in America*, *supra* note 12.

19. DeWeerdt, *supra* note 6, at S12; *Timeline of the Opioid Crisis*, COLUMNHEALTH BLOG, https://columnhealth.com/blog_posts/timeline-of-the-opioid-crisis/ (last visited July 1, 2023).

20. DeWeerdt, *supra* note 6, at S12.

21. Nabarun Dasgupta et al., *Opioid Crisis: No Easy Fix to Its Social and Economic Determinants*, 108 AM. J. PUB. HEALTH 182, 183 (2018).

22. *Id.* at 182.

23. *What Is Fentanyl?*, NAT'L INST. ON DRUG ABUSE (June 2021), https://www.drugabuse.gov/publications/drugfacts/fentanyl; DeWeerdt, *supra* note 6, at S12.

24. DeWeerdt, *supra* note 6, at S12.

an increase in the number of users, but by an increase in deaths.[25] The Center for Disease Control (CDC) reported that between 2013 and 2016, deaths that resulted from fentanyl increased by 88% per year.[26] Of the 47,600 opioid-affiliated deaths by overdose in 2017, 59.8% involved synthetic opioids—fentanyl and fentanyl analogs.[27] Specific guidelines[28] for prescribing opioids were published by the CDC in 2016, which both ameliorated and exacerbated the issue. Doctors drastically decreased prescribing opioid medication, aiding in the reduction of prescription abuse. However, individuals, now reliant on opioid medication, were forced to find alternative methods for pain relief. The CDC quantified the severity of the crisis with data from a 2016 report showing that "116 people died every day from opioid-related drug overdoses."[29] The Center for Behavioral Health Statistics also shed important quantifying light, indicating that "1.7 million people in the United States suffered from substance use disorders . . . and 652,000 suffered from a heroin use disorder."[30] In response, President Donald Trump declared opioid-related drug overdose a public health emergency in 2017.[31]

The opioid crisis has drastically impacted Indian Country. AI/AN are second to whites in fatal opioid overdose as of 2018.[32] White individuals are recognized as the group with the "'privilege' of unparalleled access to prescription opioids."[33] White individuals have a disproportionate risk for opioid abuse due to: (1) higher rates of opioid prescribing and (2) the

25. *Id.*

26. *Id.*

27. Kumiko M. Lippold et al., *Racial/Ethnic and Age Group Differences in Opioid and Synthetic Opioid–Involved Overdose Deaths Among Adults Aged ≥18 Years in Metropolitan Areas — United States, 2015–2017*, 68 MORBIDITY & MORTALITY WKLY. REP. 967, 967 (2019).

28. *See* Deborah Dowell et al., *CDC Guideline for Prescribing Opioids for Chronic Pain — United States*, 2016, 65 MORBIDITY & MORTALITY WKLY. REP. 1 (2016).

29. *Timeline of the Opioid Epidemic in America*, *supra* note 12.

30. *Opioid Crisis and Substance Misuse*, CTR. ON POSITIVE BEHAV. INTERVENTIONS & SUPPORTS, https://www.pbis.org/topics/opioid-crisis-and-substance-misuse (last visited July 1, 2023).

31. *Timeline of the Opioid Epidemic in America*, *supra* note 12.

32. Megan S. Schuler et al., Racial/Ethnic Differences in Prescription Opioid Misuse and Heroin Use Among a National Sample, 1999-2018, at 1, 2 (Feb. 13, 2021) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8026521/pdf/nihms-1665461.pdf (HHS Public Access author manuscript).

33. Helena Hansen & Julie Netherland, *Is the Prescription Opioid Epidemic a White Problem?*, 106 AM. J. PUB. HEALTH 2127, 2127 (2016).

under-treatment of chronic pain in minority groups.[34] While high rates of clinical prescribing are a known risk factor for white individuals, there is limited information about these rates for AI/AN individuals.[35] Despite readily identifiable risk factors, when compared to white individuals, AI/AN had higher rates of prescription opioid misuse from 1999–2018.[36] However, the true prevalence of this problem in AI/AN communities is largely unknown because of underreporting, complications of race misclassification, and a deficiency of studies examining the impact of opioid use in these communities.[37] Despite the underreporting, AI/AN have suffered the largest increase in opioid-related mortality rates compared to any other racial/ethnic group.[38]

Further exacerbating this crisis in AI/AN communities is the common comorbidity of alcohol and opioid use. Individuals who use alcohol are at an increased likelihood to misuse opioids.[39] That risk is significantly increased in relation to frequency of binge drinking.[40] Alcohol contributes significantly to opioid-related overdose deaths and alcohol can impede treatment for opioid use disorder (OUD).[41] Individuals who use alcohol during OUD medication-assisted treatment (MAT) experience unchanged or even increased rates of alcohol use.[42] Further, mortality increases substantially when alcohol and opioids are used together.[43] Alcohol substance dependency, as well as deaths related to alcohol abuse, are higher for AI/AN than any other racial/ethnic group.[44] The 2018 National Survey

34. Schuler et al., *supra* note 32, at 2.

35. *Id.* at 12.

36. *Id.* at 4–5.

37. *Id.* at 2, 7; Nana Wilson et al., *Drug and Opioid-Involved Overdose Deaths—United States, 2017-2018*, 69 MORBIDITY & MORTALITY WKLY. REP. 290, 296 (2020).

38. Sujata Joshi et al., *Drug, Opioid-Involved, and Heroin-Involved Overdose Deaths Among American Indians and Alaska Natives*, 67 MORBIDITY & MORTALITY WKLY. REP. 1384, 1384 (2018).

39. Press Release, Ctrs. for Disease Control & Prevention, More Than Half of People Who Misuse Prescription Opioids Also Binge Drink (June 10, 2019), https://www.cdc.gov/media/releases/2019/p0611-people-opioids-drink.html.

40. *Id.*

41. Katie Witkiewitz & Kevin E. Vowles, *Alcohol and Opioid Use, Co-Use, and Chronic Pain in the Context of the Opioid Epidemic: A Critical Review*, 42 ALCOHOLISM CLINICAL & EXPERIMENTAL RSCH. 478, 478 (2019).

42. *Id.* at 482.

43. *Id.* at 480.

44. *American Indian and Alaska Native Substance Abuse Treatment Admissions Are More Likely Than Other Admissions to Report Alcohol Abuse*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN.: THE TEDS REPORT (Nov. 18, 2014), https://www.samhsa.

on Drug Use and Health established that AI/AN alcohol use disorder (AUD) is the highest in the United States population and that AI/AN adolescents experience the highest rate of alcohol use out of all racial/ethnic groups.[45] With some of the most significant rates of alcohol use and abuse, AI/AN communities are at an elevated risk of engaging in opioid misuse.

II. Focused Problem Areas

A. Tribal Jurisdiction

Tribal jurisdiction involves an interworking of complexities, and a lengthy discussion of the intricacies is not warranted for the narrowed focus of opioid crisis litigation. However, a brief overview of relevant precedent is necessary to appreciate the valuable possibilities for tribal communities in this domain. The Marshall Trilogy established the building blocks of tribal jurisdictional authority and recognized inherent tribal sovereignty.[46] *Worcester v. Georgia* acknowledged tribal sovereignty in that "Indian nations [have] always been considered . . . distinct, independent political communities retaining their original natural rights . . . ."[47] *Cherokee Nation v. Georgia* restrained that power, establishing tribes as "domestic dependent nations," to formulate the guardian-ward relationship between the federal government and the tribes.[48] The Supreme Court, since the Trilogy, has waxed and waned between respecting tribal courts' sovereignty and exercising plenary power.[49] This discordant and clouded jurisprudence provides power to place significant limitations on tribal jurisdictional

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gov/data/sites/default/files/TEDS-Spot146-AIAN-2014/TEDS-Spot146-AIAN-2014.htm; Norma Gray & Patricia S. Nye, *American Indian and Alaska Native Substance Abuse: Co-Morbidity and Cultural Issues*, 10 AM. INDIAN & ALASKA NATIVE MENTAL HEALTH RSCH. J., no. 2, 2001, at 67, 68, https://coloradosph.cuanschutz.edu/docs/librariesprovider205/journal_files/vol10/10_2_2001_67_gray.pdf.

45. *Risks of Alcoholism Among Native Americans*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/alcoholism-treatment/native-americans (last updated Sept. 14, 2022).

46. *See* Matthew L.M. Fletcher, *A Short History of Indian Law in the Supreme Court*, HUM. RTS. MAG., Spring 2015, at 3, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/2014_vol_40/vol--40--no--1--tribal-sovereignty/short_history_of_indian_law/.

47. 31 U.S. (6 Pet.) 515, 519 (1832).

48. 30 U.S. (5 Pet.) 1, 10 (1831).

49. *See* Fletcher, *supra* note 46; Matt Irby, Comment, *The Opioid Crisis in Indian Country: The Impact of Tribal Jurisdiction and the Role of the Exhaustion Doctrine*, 43 AM. INDIAN L. REV. 353, 369 (2018-2019).

authority.[50] *Montana v. United States*[51] and the exhaustion doctrine, first highlighted in *National Farmers Union Insurance Companies v. Crow Tribe of Indians*,[52] are the most potentially advantageous areas of precedent to allow tribes to regulate and control the devastation laid by the opioid crisis. *Montana* is frequently utilized to undermine tribal court jurisdiction, though the exceptions could grant a valuable way to greater tribal control, while *National Farmers* is a clear support of tribal court jurisdiction and inherent tribal sovereignty.[53]

Montana centered around whether the Crow Tribe of Montana's inherent sovereignty provided the Tribe with the power to regulate and prohibit activity around the banks of the Big Horn River.[54] Ultimately, the Court discouraged the idea of inherent sovereignty in the regulation of non-Indian activities on non-Indian fee land on the reservation.[55] Notwithstanding the significant limitation on inherent sovereignty, the Court recognized two exceptions where a tribe may regulate conduct by non-Indians: (1) where a consensual commercial relationship exists between the non-Indian and the tribe or its members, and (2) when non-Indian "conduct threatens or has some direct effect on the political integrity, the economic security, or the health and welfare of the tribe."[56] However, it has been especially difficult for tribes to satisfy these exceptions as the burden of proof lies with "the party seeking to [invoke] tribal jurisdiction."[57]

National Farmers involved a suit in tribal court initiated by a tribal member against a non-Indian.[58] The non-Indian attempted to remove the suit from tribal court to federal court. The Supreme Court held that "exhaustion is required before such a claim may be entertained in a federal court"[59] and that "question[s] [of] whether a tribal court has the power to exercise . . . jurisdiction over non-Indians . . . should be conducted in the first instance in the Tribal Court itself."[60] The seemingly broad exhaustion doctrine was limited by four exceptions:

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50. *See* Irby, *supra* note 49, at 369–72.
51. 450 U.S. 544 (1981).
52. 471 U.S. 845 (1985).
53. Irby, *supra* note 49, at 373.
54. *Montana*, 450 U.S. at 557, *cited in* Irby, *supra* note 49, at 372–73.
55. *Montana*, 450 U.S. at 555, *cited in* Irby, *supra* note 49, at 373.
56. *Montana*, 450 U.S. at 566, *quoted in* Irby, *supra* note 49, at 364.
57. Irby, *supra* note 49, at 363.
58. Nat'l Farmers Union Ins. Co. v. Crow Tribe of Indians, 471 U.S. 845, 847 (1985), *cited in* Irby, *supra* note 49, at 374.
59. *Nat'l Farmers*, 471 U.S. at 857, *quoted in* Irby, *supra* note 49, at 375.
60. *Nat'l Farmers*, 471 U.S. at 855–56, *quoted in* Irby, *supra* note 49, at 374.

> (1) where "an assertion of tribal jurisdiction is motivated by . . . harass[ment] or . . . bad faith," (2) "where the action is patently violative of express jurisdictional prohibitions," . . . (3) "where exhaustion would be futile because of the lack of an adequate opportunity to challenge the court's jurisdiction," . . . [and] (4) where it is clear that the tribal court lacks jurisdiction and that judicial proceedings would serve "no purpose other than delay" . . . .[61]

Both the exhaustion doctrine and the exceptions to the *Montana* rule have been utilized in prior and pending opioid litigation cases. Courts have not favored applying the *Montana* exceptions but seem to readily apply exceptions to the exhaustion doctrine.[62] As these doctrines contain broad language that allow for nuanced reasoning, courts are able to dismiss tribal jurisdiction under questionable justifications. However, as the opioid crisis continues to greatly impact these communities and the federal court system receives increasingly more opioid crisis-related litigation, these doctrines may be granted more force.

B. Mental Health

The opioid crisis and mental health issues are deeply integrated. In the current Diagnostic and Statistical Manual of Mental Disorders, the American Psychiatric Association recognizes OUD and several other substance use disorders (SUD) as mental health disorders.[63] SUD exists where there is uncontrolled use of a substance to the point that functioning in day-to-day life is impaired, and this use persists even when the user knows the use is causing or will cause problems.[64] The most extreme SUD is classified as an addiction.[65] OUD contains the same criteria as that of

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61. Thlopthlocco Tribal Town v. Stidham, 762 F.3d 1226, 1238 (10th Cir. 2014) (citations omitted) (quoting *Nat'l Farmers*, 471 U.S. at 857; Nevada v. Hicks, 533 U.S. 353, 369 (2001)); *see* Irby, *supra* note 49, at 364.

62. *See* McKesson Corp. v Hembree, No. 17–CV–323–TCK–FHM, 2018 WL 340042 (N.D. Okla. 2018); Irby, *supra* note 49, at 362.

63. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483-85, 541-56 (5th ed. text rev., 2022).

64. *What Is a Substance Use Disorder?*, AM. PSYCHIATRIC ASS'N (Dec. 2020), https://www.psychiatry.org/patients-families/addiction/what-is-addiction.

65. *Id.*; *Substance Use and Co-Occurring Mental Disorders*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health [https://perma.cc/KM3E-RHMN] (last reviewed Mar. 2023).

SUD but for the specific use of opioid-related substances.[66] All substances interfere with the brain's chemistry via neurotransmitters.[67] This interaction causes changes not just in mental and physical behavior during substance use, but can even permanently change how the brain functions in persistent users.[68] Addiction, therefore, is not a character defect, but a physical change in brain chemistry that produces difficult-to-change thoughts and behaviors. Many mental health related issues also fuel and are fueled by misuse of substances.[69] SUD is frequently diagnosed alongside other mental health diagnoses, most commonly with anxiety, depression, bipolar, schizophrenia, and personality disorders.[70] SUD also corresponds with a drastic increase in risk of suicide, where alcohol and opioid use is associated with the greatest risk.[71] The suicide rates for AI/AN individuals are at a significantly elevated rate for ages fifteen through forty-four compared to the overall United States population.[72] However, this data is underreported due to cultural ideologies about the definition of suicide, lack of tribal surveillance or investigation into these kind of deaths, and even lack of reporting due to fear of misuse.[73] Understanding the mental health concerns that face tribal communities is therefore essential in the fight against the opioid crisis.

AI/AN communities are in a unique position in regard to their mental health needs due to their history.[74] These communities tend to have a

66. *Opioid Use Disorder*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/addiction/opioid-use-disorder [https://perma.cc/PVV9-XRF3] (last reviewed Dec. 2022).

67. *Introducing the Human Brain*, NAT'L INST. ON DRUG ABUSE (July 2020), https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain; *What Is a Substance Use Disorder?*, *supra* note 64.

68. *Introducing the Human Brain*, *supra* note 67; *What Is a Substance Use Disorder?*, *supra* note 64.

69. *Substance Use and Co-Occurring Mental Disorders*, *supra* note 65.

70. *Id.*

71. Michael Esang & Saeed Ahmed, *A Closer Look at Substance Use and Suicide*, AM. J. OF PSYCHIATRY RESIDENTS' J., June 2018, at 6, 6-7, https://psychiatryonline.org/doi/epdf/10.1176/appi.ajp-rj.2018.130603.

72. *American Indian and Alaska Native Populations*, SUICIDE PREVENTION RES. CTR., https://sprc.org/about-suicide/scope-of-the-problem/racial-and-ethnic-disparities/american-indian-and-alaska-native-populations/ (last visited July 2, 2023).

73. *Id.*

74. DEP'T OF HEALTH & HUM. SERVS., MENTAL HEALTH: CULTURE, RACE, AND ETHNICITY: A SUPPLEMENT TO MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 23 (2001) [hereinafter SUPPLEMENT TO REPORT OF THE SURGEON GENERAL], https://www.ncbi.nlm.nih.gov/books/NBK44243/pdf/Bookshelf_NBK44243.pdf.

general mistrust of many governmental services and entities because of the unacceptable treatment these groups experienced through past government policies.[75] This prior treatment not only created a breakdown in the trust relationship but also acts as a major source for mental health issues stemming from historical and generational trauma, poverty, high levels of unemployment, discrimination, and racism.[76] Historical and generational trauma are major risk factors for mental health concerns.[77] Historical trauma encompasses the psychological effects of: the forced relocation and loss of spiritual land; assimilation practices and disconnection with spirituality, language, and culture; and other traumas inflicted on Indigenous communities that are still prevalent in survivors and their families.[78] Generational or intergenerational trauma is the passing of the grief associated with historical trauma between generations.[79] AI/AN communities are plagued by high rates of violence and low education levels, which also significantly contribute to increased risk of mental illness—specifically SUD and addiction.[80] These communities are also in a unique position due to the increased cultural stigmatization of mental health and the appropriate ways in which an individual identifies these problems and seeks treatment for them.[81] This is why entities like SAMHSA and IHS have a strong focus on supplying culturally appropriate treatment mechanisms which include options for traditional healing systems and integration of culturally specific ideals about family, spirit, community, and identity.[82] The lack of culturally appropriate diagnoses and treatment is actually a risk factor for onset of mental health problems.[83] Because of the

75. *Id.* at 7.

76. *Id.* at 23; Michael Kaliszewski, *Alcohol and Drug Abuse Among Native Americans*, AM. ADDICTION CTRS., https://americanaddictioncenters.org/rehab-guide/addiction-statistics/native-americans (last updated Sept. 12, 2022).

77. *Stress and Trauma Toolkit*, AM. PSYCHIATRIC ASS'N, https://web.archive.org/web/20230529094711/https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/indigenous-people (last visited July 2, 2023).

78. *Id.*

79. *Id.*

80. Kaliszewski, *supra* note 76.

81. AM. PSYCHIATRIC ASS'N, MENTAL HEALTH DISPARITIES: AMERICAN INDIANS AND ALASKAN NATIVES (2017), https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-American-Indian-Alaska-Natives.pdf.

82. *Id.*; SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., TIP 61, BEHAVIORAL HEALTH SERVICES FOR AMERICAN INDIANS AND ALASKA NATIVES 61 (2018) https://store.samhsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf.

83. *Stress and Trauma Toolkit*, *supra* note 77.

lack of studies with a focus on these communities, precise and representative data is scarce, but, of the research available, it is shown that these communities are suffering from high rates of mental illness concerns from a wide range of potential risk factors.[84]

Mental health issues, specifically in relation to SUD, have also greatly impacted adolescents in these communities. AI/AN youth report more depressive symptoms than other ethnic minorities and report increased rates of discrimination, generalized anxiety, and initiated substance use compared to white individuals.[85] AI/AN youth are first becoming involved with substances around the ages of ten to thirteen years old and are more likely than their peers to continue substance use and engage in polysubstance use.[86] One major factor contributing to the high incidence rate of substance use in AI/AN youth is the large rate at which they see their family members struggling with their own SUD.[87] Other major factors are social integration, generational trauma, perceived discrimination, and exposure to deviant peer relationships.[88] In light of the strong presence of trauma and mental health concerns for adolescents in these communities, the Senate Committee on Indian Affairs held an entire 2016 session hearing on addressing and combating these concerns.[89]

Not only do AI/AN youth face increased rates of mental health concerns, but there is also a disproportional presence of AI/AN youth in the child welfare system. Specifically, AI/AN youth are in the system at a rate 2.6 times more than their proportion of the population, as compared to a rate .09 times less than population proportionality for white children.[90] Accordingly, AI/AN youth are significantly overrepresented in the child

84. SUPPLEMENT TO REPORT OF THE SURGEON GENERAL, *supra* note 74, at 83-84; Schuler et al., *supra* note 32, at 2, 7; Wilson et al., *supra* note 37, at 296.

85. Kelly Serafini et al., *A Comparison of Early Adolescent Behavioral Health Risks Among Urban American Indians/Alaska Natives and Their Peers*, 24 AM. INDIAN ALASKAN NATIVE MENTAL HEALTH RES.: J. NAT'L CTR., no. 2, 2017, at 1, 12, https://perma.cc/T6C8-D8FK.

86. *Id.* at 2-3.

87. *Id.* at 3.

88. *Id.*

89. *Addressing Trauma and Mental Health Concerns in Indian Country: Field Hearing Before the S. Comm. on Indian Affs.*, 114th Cong. (2016), https://www.govinfo.gov/content/pkg/CHRG-114shrg22689/pdf/CHRG-114shrg22689.pdf.

90. *What Is Disproportionality in Child Welfare?*, NAT'L INDIAN CHILD WELFARE ASS'N (2019), https://www.nicwa.org/wp-content/uploads/2019/08/Disproportionality-Table-2019.pdf.

welfare system.[91] The prevalent history of systemic bias in this system prompted the enactment of the Indian Child Welfare Act (ICWA).[92] Although ICWA has done considerable work in limiting complete removal of AI/AN youth from their communities, it has been unevenly applied and is frequently not complied with.[93] Further, even after the implementation of ICWA, AI/AN youth are still moving through the child welfare system at alarming rates.[94] The opioid crisis further exacerbated this issue via a spike in the number of children taken into tribal custody due to parent OUD.[95] The majority of these children were placed into non-native homes because of an insufficient number of tribal families to act as foster homes.[96] Such an extensive presence in the child welfare system creates a seemingly unbreakable cycle of trauma and mental health concerns for these communities. Children removed from their communities are also removed from the strong protective factors within them, even in homes where mental health concerns are present, and thereby are more likely to suffer from mental health concerns themselves.[97] This further perpetuates generational trauma and isolates Native youth from the connections to their cultural ideologies and heritage. Moreover, half of the children of all ethnic groups removed from their homes never return, resulting in the tribe permanently losing their Native youth.[98] Consequently, to reduce the incidence of mental health concerns in AI/AN youth—and the community as a whole—serious focus must be placed on reducing this disproportionality.

The risk factors highlighted above stress the connection between cultural and social factors with incidence of mental health issues. Therefore, some of the most valuable protective factors center on restoring cultural identity, working through historical trauma, and reintegrating the individual into

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91. *Id.*

92. DAVID E. SIMMONS, NAT'L INDIAN CHILD WELFARE ASS'N, IMPROVING THE WELL-BEING OF AMERICAN INDIAN AND ALASKA NATIVE CHILDREN AND FAMILIES THROUGH STATE-LEVEL EFFORTS TO IMPROVE INDIAN CHILD WELFARE ACT COMPLIANCE 2 (Oct. 2014), https://www.nicwa.org/wp-content/uploads/2016/11/Improving-the-Well-being-of-American-Indian-and-Alaska-Native-Children-and-Families.pdf.

93. *Id.* at 7.

94. *Id.*

95. Christine Vestal, *In Cherokee Country, Opioid Crisis Seen as Existential Threat*, STATELINE (Sept. 9, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/09/09/in-cherokee-country-opioid-crisis-seen-as-existential-threat.

96. *Id.*

97. SIMMONS, *supra* note 92, at 1; SUPPLEMENT TO REPORT OF THE SURGEON GENERAL, *supra* note 74, at 89.

98. Vestal, *supra* note 95.

their social networks and community.[99] A greater emphasis has been placed on the study of these protective factors and their success with substance abuse prevention, instead of identifying risk factors and how they ultimately lead to SUD and other related mental health issues.[100] Ultimately, to promote and secure positive outcomes for these communities, cultural and community integration must be employed in addition to the individual psychological interventions successful in other ethnic groups, like cognitive behavioral therapy and medication-assisted treatment.

III. Federal Government's Response

The federal government has provided support for the opioid crisis to tribal communities through two avenues: established federal agencies and congressional legislation. A federal agency, defined in 42 U.S.C. § 5122(9), is a department or organization, under the executive branch, designed to address a specific purpose, such as resource management, national security, or fiduciary duties. The two major agencies through which the federal government has provided tribal support are SAMHSA and IHS. Both agencies are subsects of the Department of Health and Human Services (HHS). The federal government has also enacted specific legislation to further assist tribal communities beyond what these agencies allocate. The 21st Century Cures Act as well as the Comprehensive Addiction and Recovery Act of 2016 are vital pieces of legislation in response to the opioid epidemic.

A. Substance Abuse and Mental Health Services Administration

SAMHSA was established by Congress in 1992 to ensure the availability of substance use and mental health information, research, and services.[101] SAMHSA declares their mission as "reduc[ing] the impact of substance abuse and mental illness on America's communities."[102] The prominent way in which SAMHSA provides aid to tribal communities is through

99. Nancy Rumbaugh Whitesell et al., *Epidemiology and Etiology of Substance Use Among American Indians and Alaska Natives: Risk, Protection, and Implications for Prevention*, 38 AM. J. DRUG & ALCOHOL ABUSE 376, 378-79 (2012).

100. *Id.* at 379.

101. *About Us*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/about-us (last updated June 28, 2023).

102. *Id.*

grants, but it also supplies tribal technical assistance and consultation.[103] SAMHSA provides many grants rooted in combating substance use and supporting mental health. This section will focus on five specific grants; the first four grants are either entirely exclusive to tribes and tribal organizations or reserve a certain allotment of grant awards solely for these entities. Because the grant process is technical and contains multiple stages, a brief overview of this process is necessary prior to discussion of the grants.

Application for a SAMHSA grant requires registration with two different systems, the System for Award Management and Grants.gov.[104] Applications require electronic submission, with the limited caveat of receiving an approved waiver to utilize other methods.[105] There are also multiple eligibility requirements in place: an organization must be a domestic public or private non-profit entity, and meet any additional application requirements of the specific grant sought.[106] After an entity successfully applies for a grant, the application enters the grant review process.

The Division of Grant Review (DGR) conducts the first screening process and eliminates the applications that fail to meet administrative and programmatic requirements of the Notice of Funding Opportunity.[107] Every application is subject to a first level peer review and some grant programs require a second level review by the SAMHSA National Advisory Council.[108] Each level of review is guided by: (1) DGR established principles, to ensure detailed and equitable review as well as to avoid any conflicts of interest, (2) budget review, and (3) a 0-100 scoring scale.[109] Once a grant is awarded, entities are subject to financial and compliance oversight reviews by the Office of Financial Advisory Services.[110] During

103. *Tribal Affairs and Policy*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/tribal-affairs (last updated Mar. 24, 2023).

104. *How to Apply for a SAMHSA Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/applying (last updated June 5, 2023).

105. *Id.*

106. *Id.*

107. *Grant Review Process*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grant-review-process (last updated Oct. 15, 2021).

108. *Id.*

109. *Id.*

110. *Grants Oversight*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/oversight (last updated May 3, 2021).

implementation of the grant, the grant recipient will collaborate with SAMHSA to guarantee progress and efficient use of federal funds.

The first type of grant available to AI/AN communities are the Tribal Opioid Response (TOR) grants. TOR grants are available to federally recognized AI/AN tribes or tribal organizations, and the grants are designed to "increase[] access to culturally appropriate and evidence-based treatment" in tribal communities.[111] These grants focus on reducing opioid-related deaths and overcoming unmet treatment needs by providing preventative treatment and recovery activities for OUD.[112] These grants were first established in 2018, and the 2022 fiscal year budget request was $2.3 billion.[113] The total anticipated funding and the approximate number of grant awards varied per fiscal year, but for the 2021 fiscal year, there was a total of $37,647,916 for 150 grant awards.[114] For the 2022 fiscal year, there was a total of $55,000,000 for 150 grant awards,[115] The TOR grant runs for a length of two years and tribes were able to apply for consecutive year TOR grants until the 2021 fiscal year application.[116] The 2020 fiscal year TOR grant was awarded to ninety-two tribal entities, the 2021 fiscal year TOR grant has been awarded to forty, and the 2022 fiscal year TOR grant has been awarded to 102.[117]

Second, the Tribal Behavioral Health grant program, known as Native Connections, contains specified eligibility criteria in addition to being

111. *Tribal Opioid Response Grants*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA) (Dec. 18, 2020), https://www.samhsa.gov/grants/grant-announcements/ti-21-007 [hereinafter *Tribal Opioid Response Grants* (Dec. 18, 2020)].

112. *Id.*

113. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DEP'T OF HEALTH & HUM. SERVS., FISCAL YEAR 2022: JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES 270-71 (2022) [hereinafter SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES], https://www.samhsa.gov/sites/default/files/samhsa-fy-2022-cj.pdf.

114. *Tribal Opioid Response Grants* (Dec. 18, 2020), *supra* note 111.

115. *Tribal Opioid Response Grants*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA) (Apr. 27, 2022), https://www.samhsa.gov/grants/grant-announcements/ti-22-006.

116. *Tribal Opioid Response Grants* (Dec. 18, 2020), *supra* note 111.

117. *Grants Dashboard [TI-20-011 Individual Grant Awards]*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/awards/2020/TI-20-011 (last visited Oct. 3, 2021); *Grants Dashboard [TI-21-007 Individual Grant Awards]*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/awards/2021/TI-21-007 (last visited Oct. 3, 2021); *Grants Dashboard [TI-22-006 Individual Grant Awards]*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grants-dashboard?f%5B0%5D=by_nofo_number%3ATI-22-006 (last visited July 29, 2023).

available to federally recognized AI/AN tribes and tribal organizations, Urban Indian Organizations (UIOs), and those in a partnership with tribes or tribal organizations.[118] Native Connections is focused on prevention and mitigation of suicidal behavior and substance use in AI/AN individuals through age twenty-four.[119] This program calls for the formation of integrated services to assist AI/AN youth in their transition to adulthood while navigating the traumas associated with these communities.[120] Native Connections greatly encourages the community to be active participants in grant activities to ensure optimal success. This grant program was first available in 2014, and the 2022 fiscal year budget request was $21.2 million.[121] Native Connections, a five-year grant, focuses more on implementing and maintaining a network of services and support for AI/AN than the TOR grants, as TOR focuses on supplying OUD treatment. Similar to the TOR grants, the anticipated total funding varied according to fiscal year, with $7,185,000 available per an anticipated twenty-eight grant awards in 2021.[122] Forty Native Connections grants were awarded in 2020, in addition to the 121 continuation grants, six new grants were awarded in 2021, and twelve new grants were awarded in 2022.[123]

Third, the Planning and Developing Infrastructure to Promote the Mental Health of Children, Youth and Families in AI/AN Communities grant, known as Circles of Care, is available to AI/AN tribes and tribal organizations, UIOs, those in partnership with tribes and tribal organizations, and tribal colleges and universities.[124] Entities who have received Circles of Care in the past are ineligible to apply for future Circles

118. *Tribal Behavioral Health Grant Program*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grant-announcements/SM-21-011 (last updated June 29, 2022).

119. *Id.*

120. *Id.*

121. *Native Connections*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/native-connections (last updated Jan. 24, 2023); SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 113, at 93-94

122. *Tribal Behavioral Health Grant Program*, *supra* note 118.

123. SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 113, at 94; *Native Connections, supra* note 121.

124. *Planning and Developing Infrastructure to Promote the Mental Health of Children, Youth and Families in American Indian/Alaska Natives (AI/AN) Communities*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA) [hereinafter *Planning and Developing Infrastructure*], https://www.samhsa.gov/grants/grant-announcements/sm-20-010 (last updated Dec. 1, 2020).

of Care funding and applications are subject to a budget limit.[125] This grant has a similar purpose to that of Native Connections, in that, by utilizing "cross-system collaboration," tribal communities will be provided with resources to "plan and design a holistic, evidence and community-based, coordinated system of care to support mental health."[126] The overall aim is to address the gap in mental health services and assist tribal communities in providing adequate access to these crucial services.[127] This program started in 1998, and the 2022 fiscal budget request was $7.2 million.[128] This was the sole grant program focused on tribal communities until Native Connections was established in 2014.[129] Circles of Care is renewed for up to three years and had an anticipated total funding of $5,492,314 per seventeen anticipated grant awards for the last cohort in the 2020 fiscal year.[130] Twenty-two grants were awarded in 2020, and thirteen grants were awarded to the previous cohort in 2017.[131]

Fourth, are the Grants to Expand Substance Abuse Treatment Capacity in Adult and Family Treatment Drug Courts, also known as SAMHSA Treatment Drug Courts. SAMHSA Treatment Drug Courts are available to state, local, and tribal governments that make use of Adult Treatment Drug Court, Adult Tribal Healing to Wellness Court, or Family Treatment Drug Court.[132] There are also specific eligibility requirements related to budget limits and whether an entity has received funding through similarly related SAMHSA grants.[133] This grant is centered around the ideology that individuals with SUD need treatment, rather than incarceration, to address the underlying concerns that placed them in the court system.[134] The program's purpose, therefore, is to "expand [SUD] treatment services in

125. *Id.*

126. *Id.*

127. *Id.*

128. *Circles of Care*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/tribal-ttac/circles-care (last updated Aug. 2, 2022); SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 113, at 39.

129. *Circles of Care*, *supra* note 128.

130. *Planning and Developing Infrastructure*, *supra* note 124.

131. *Circles of Care*, *supra* note 128.

132. *Grants to Expand Substance Abuse Treatment Capacity in Adult and Family Treatment Drug Courts*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grant-announcements/ti-20-003 (last updated May 10, 2021).

133. *Id.*

134. *Id.*

existing drug courts."[135] This five-year grant program was only offered during the 2020 fiscal year with an anticipated total award of $10,000,000 per twenty-five anticipated awards, five of which were exclusively reserved to tribes and tribal organizations.[136] Only two grants were awarded.[137]

The final available grant is not exclusive to tribal communities but is central to helping combat the opioid crisis and itself encourages tribal outreach. The Building Communities of Recovery grant (BCOR) is available to RCOs, which are "non-profit organizations led and governed by representatives of local communities of recovery," in states, territories, or tribes that are managed by individuals of the addiction recovery community.[138] As many of the previous grants require, this grant also establishes eligibility criteria in the form of a budget limit and prohibits those who have received funding under this grant in prior years from reapplying.[139] BCOR also prioritizes rural entities, especially those areas with either drug overdose death rates that exceed the national average or those lacking prevention and treatment services.[140] This three-year grant was first available in 2017, and the 2022 fiscal year budget request was $20 million.[141] BCOR's anticipated total funding has also varied dependent on grant year with the 2021 fiscal year at $5,881,000 per an anticipated twenty-nine awards.[142] The 2020 fiscal year awarded thirteen grants, in addition to the twenty-three continuation grants, the 2021 fiscal year awarded thirty-one new grants, and the 2022 fiscal year awarded forty-five new grants.[143]

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135. *Id.*

136. *Id.*

137. *Grants Dashboard [TI-20-003 Individual Grant Awards]*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/awards/2021/TI-20-003 (last visited June 2, 2023).

138. *Building Communities of Recovery*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grant-announcements/TI-21-004 (last updated Dec. 29, 2020).

139. *Id.*

140. *Id.*

141. SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 113, at 231-32.

142. *Building Communities of Recovery*, *supra* note 138.

143. SAMHSA, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 113, at 232; *Grants Dashboard [TI-22-014 Individual Grant Awards]*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA), https://www.samhsa.gov/grants/grants-dashboard?f%5B0%5D=by_nofo_number%3ATI-22-014 (last visited July 29, 2023).

B. Indian Health Service

IHS launched in 1955 after Native American health services were transferred from the Bureau of Indian Affairs to the Public Health Service.[144] IHS conducts the administration of federal health services to AI/AN communities with a mission to "raise the physical, mental, social, and spiritual health of [AI/AN] to the highest level."[145] IHS provides grant funding in addition to providing health services to federally recognized AI/AN communities. IHS's grant process closely resembles SAMHSA's. IHS grants require electronic submission through Grants.gov and, thereby, require registration with the System for Award Management and Grants.gov.[146] The Division of Grants Management (DGM) oversees the IHS award process as well as the subsequent monitoring of the grant program once awarded to a tribal entity.[147] The seven-step grant management process employed by IHS accomplishes the same goals as SAMHSA's grant process: planning and announcing a grant opportunity, evaluating DGM application, awarding of the grant, and post-award monitoring.[148] The DGM application evaluation also commences in stages. An initial screening to ensure application completeness and conformity to basic requirements, a subsequent objective review of substantive material, and a final business management and cost analysis review.[149] One aspect that distinguishes the IHS application procedure is a negotiation phase that occurs after the review process.[150] This phase allows entities to modify their application to better conform to what the DGM desires for the program prior to an award decision.[151] Post-award monitoring in IHS grants encompass the same interactions under that of a SAMHSA grant albeit seemingly more involved.[152] The relevant aspects of IHS geared toward

144. *Indian Health Service Today*, NAT'L INST. OF HEALTH, https://www.nlm.nih.gov/exhibition/if_you_knew/ifyouknew_09.html (last updated Nov. 23, 2010).

145. *See id.*; *About IHS*, INDIAN HEALTH SERV., https://www.ihs.gov/aboutihs/ (last visited July 2, 2023).

146. *Electronic Application Submission Process*, INDIAN HEALTH SERV., https://www.ihs.gov/dgm/elecprocess/ (last visited July 2, 2023).

147. *Division of Grants Management*, INDIAN HEALTH SERV., https://www.ihs.gov/dgm/ (last visited July 2, 2023).

148. *Discretionary Grants Cycle*, INDIAN HEALTH SERV., https://www.ihs.gov/dgm/policytopics/discgrantscycle/ (last visited July 2, 2023).

149. *Id.*

150. *Id.*

151. *Id.*

152. *Compare id.* (detailing IHS's post-award monitoring process), *with Grants Oversight*, *supra* note 110 (detailing SAMHSA's post-award monitoring process).

combating the opioid crisis are: (1) the National Committee on Heroin Opioids and Pain Efforts (HOPE Committee), (2) the Community Opioid Intervention Pilot Project grants (COIPP), and (3) the National Urban Indian Behavioral Health Awareness grant.

The HOPE Committee was established in 2017, and it is a charter of IHS.[153] This committee consists of five workgroups that collaborate with tribes "to promote appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and improve access to culturally appropriate treatment."[154] The five workgroups consist of: pain management, harm reduction, treatment and recovery, metrics/technical assistance, and communications.[155] The HOPE Committee does not directly supply funding to tribes but, rather, acts as an educational support for tribal stakeholders and the IHS healthcare workforce. The HOPE Committee publishes a series of newsletters that highlight available resources, important updates in IHS's work to impede the opioid crisis, and educational tools for treatment and harm reduction. The HOPE Committee has also formulated five key strategies to help reduce opioid abuse and ensure safe pain management and OUD treatments that are culturally appropriate. The first two strategies focus on broadening access to harm reduction interventions, such as opioid overdose reversal medications and SUD prevention, treatment, and recovery services.[156] The third strategy centers on the interdisciplinary approach to pain management.[157] The fourth strategy aims to reduce perinatal exposure to opioids, and the fifth concerns better data collection efforts to promote informed decisions in response to OUD and pain management strategies.[158]

The COIPP grants were established in 2019 with a program initiation date for 2021.[159] This three-year grant was available to federally recognized

153. Michael D. Weahkee, Indian Health Serv., National Committee on Heroin, Opioids, and Pain Efforts (HOPE), Circular No. 17-04 (July 6, 2017), https://www.hhs.gov/guidance/document/indian-health-service-circular-no-17-04.

154. *IHS National Committee on Heroin Opioids and Pain Efforts*, INDIAN HEALTH SERV., https://www.ihs.gov/opioids/hope/ (last visited July 2, 2023).

155. *Workgroups*, INDIAN HEALTH SERV., https://www.ihs.gov/opioids/hope/workgroups/ (last visited July 2, 2023).

156. *How IHS Is Supporting HOPE*, INDIAN HEALTH SERV. (June 2020), https://www.ihs.gov/sites/opioids/themes/responsive2017/display_objects/documents/supportinghopeinfograph.pdf.

157. *Id.*

158. *Id.*

159. Community Opioid Intervention Pilot Projects, 85 Fed. Reg. 65845, 65845 (Oct. 16, 2020).

tribes, tribal organizations, or UIOs with a specific breakdown in the allotment of awards: twenty-four to each IHS area, six for UIOs, three set aside for populations with a maternal and child health focus, and a total of three awards funding the "highest priority IHS Areas."[160] This grant was created as an element of HHS's five-point strategy in response to the opioid crisis. It aims to increase public awareness and education, create support teams for AI/AN families, and supply MAT to address unmet treatment needs.[161] The total anticipated funding was $16,500,000 per an approximate thirty-three awards.[162] Thirty-five grants were awarded for a total funding of $16,299,448.[163]

The National Urban Indian Behavioral Health Awareness grant is a three-year program that was first offered in 2017 and again in 2020.[164] This grant was offered under the Division of Behavioral Health, a subsect of IHS, which strives to provide a holistic approach to health and wellness, "encompassing all aspects of the mental, physical, emotional, social, and spiritual needs of AI/AN."[165] This grant program designs to improve urban Indian health care via increased "awareness, visibility, advocacy, and education for behavioral health issues."[166] This comports with IHS's 2019-2023 strategic plan goals of: (1) ensuring access to "culturally appropriate personal and public health services," and (2) innovating the Indian health system to provide better care to AI/AN communities.[167] The program is only available to UIOs.[168] The total estimated funding per fiscal year is $75,000, and only one award is issued under this program.[169] This grant takes form in a cooperative agreement, so IHS is more heavily involved in

160. *Notice of Funding Opportunity (NOFO) Information for Tribes, Tribal Organizations, and UIOs*, INDIAN HEALTH SERV. [hereinafter *Notice of Funding Opportunity*], https://www.ihs.gov/asap/coipp/coippnofo/ (last visited June 2, 2023).

161. *See id.*; *see also* Community Opioid Intervention Pilot Projects, 85 Fed. Reg. 65845, 65845 (Oct. 16, 2020).

162. *Notice of Funding Opportunity*, *supra* note 160.

163. *Community Opioid Intervention Pilot Projects (COIPP) Awarded Programs*, INDIAN HEALTH SERV., https://www.ihs.gov/sites/asap/themes/responsive2017/display_objects/documents/coipp2021grantees.pdf (last visited July 2, 2023).

164. Division of Behavioral Health, National Urban Indian Behavioral Health Awareness, 82 Fed. Reg. 23268, 23269 (May 22, 2017); National Urban Indian Behavioral Health Awareness, 85 Fed. Reg. 74354, 74354 (Nov. 20, 2020).

165. *Division of Behavioral Health: About Us*, INDIAN HEALTH SERV., https://www.ihs.gov/dbh/aboutus/ (last visited July 2, 2023).

166. National Urban Indian Behavioral Health Awareness, 85 Fed. Reg. at 74354.

167. *Id.*

168. *Id.*

169. *Id.*

this program compared to other grants.[170] The program was awarded to the National Council of Urban Indian Health for available program years.[171] This entity engages with forty-one UIOs that directly provide health services to AI/AN communities.[172]

Grants provide a source of imperative funding, usually in large sums, for tribal communities, but they are also accompanied with disadvantages. The first major obstacle to grant funding relates to many tribes' remote location. Existing in a remote locality brings about more expensive travel costs—even issues with accessing transportation in general—and decreased access to internet capabilities, both of which result in an inability to connect with funding entities.[173] If tribes are unable to access the internet for the required electronic application submission, they are faced with an additional step of requesting a waiver for this requirement, especially in regard to SAMHSA. Tribal entities are also seemingly barred from applying to IHS grants without internet access as grants are required to be submitted through the Grants.gov system. Inability to access adequate travel or the internet greatly reduces the tribes' knowledge of available grant funding opportunities. While SAMHSA and IHS are well known for providing this type of support to the tribes, the specificities of available grants are unknown without access to their websites detailing what is available. Further, tribes cannot even attempt to call and inquire about grants directly as the relevant contact information for individuals related to tribal grants are also contained on those websites.

Another significant drawback to federal grant funding is that tribes must be considered a federally recognized tribe to be eligible. While there are currently 574 federally recognized AI/AN tribes, there are many others—approximately 400 according to the United States Government Accountability office—that are either unrecognized or have a pending recognition status.[174] The size of tribal communities can also be a hindrance

170. *Id.*

171. *National Urban Indian Behavioral Health Awareness*, TRACKING ACCOUNTABILITY IN GOV'T GRANT SYS. (TAGGS), https://taggs.hhs.gov/Detail/AwardDetail?arg_AwardNum=H723IHS0006&arg_ProgOfficeCode=3 (last visited July 29, 2023).

172. *Id.*

173. *Unique Federal Grants Challenges for Tribal Entities*, MGMT. CONCEPTS: PERSPS. BLOG (Aug. 5, 2015), https://blogs.managementconcepts.com/2015/08/05/unique-federal-grants-challenges-for-tribal-entities/.

174. *See Frequently Asked Questions*, U.S. DEP'T OF THE INTERIOR: BUREAU OF INDIAN AFFS., https://www.bia.gov/frequently-asked-questions (last visited July 3, 2023) (click on question, "What is a federally recognized tribe?"); *Indian Issues: Federal Funding for Non-*

on not only receiving federal grants but also in maintaining them. The smaller the community, the less individuals that are sufficiently knowledgeable to effectively apply for and manage grants. Small communities also run into conflict-of-interest issues more often than larger communities as the limited number of available grant officers increases the likelihood that they will also be individuals who directly benefit from the program.[175] In response to these issues, small tribes may bring in outside help.[176] This help could be of great aid, but there are several instances of abuse by non-tribal entities in this relationship: partnering with tribes solely to gain access to federal funds exclusively reserved to Indians.[177]

The grant process itself can also discourage tribal entities from seeking this form of support. The detail and familiarity necessary to properly formulate a grant application necessitates a specialized knowledge and deters those without this skillset from seeking out the opportunity. Most grants are kicked out in the first stage of review for failing to meet technical requirements and timelines and thereby are eliminated before any substantive review.[178] The application process is also highly competitive, especially when tribes are applying for grants not exclusively reserved to tribes or tribal organizations. Managing grants once awarded is also a daunting task as budgets must be carefully monitored, and the bulk of the execution of the program is left to the tribes. The agency simply supplies the funds and ensures they are being used for the grants purpose.

Finally, arguably the biggest obstacle to receiving federal grant funding is lack of knowledge about them. If tribes are unaware that the funding even exists, it is thereby impossible for them to receive the aid. Therefore, it is more likely that larger tribal communities with greater access to resources will undertake the federal grant process, which may be counterintuitive as the smaller communities with less resources are in the greatest need for this support.

C. Comprehensive Addiction and Recovery Act of 2016

The Comprehensive Addiction and Recovery Act of 2016,[179] or CARA, was signed by President Obama in July of 2016.[180] CARA was developed in

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Federally Recognized Tribes, GOV'T ACCOUNTABILITY OFF. (GAO) (Apr. 12, 2012), https://www.gao.gov/products/gao-12-348.

175. *Unique Federal Grants Challenges for Tribal Entities*, *supra* note 173.

176. *Id.*

177. *Id.*

178. *Grant Review Process*, *supra* note 107.

179. Pub. L. No. 114-198, 130 Stat. 695.

response to the opioid crisis and was designed to address it through six pillars: "prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal."[181] CARA creates a "comprehensive, coordinated, balanced strategy through enhanced grant programs" that expands and promotes prevention, treatment, and recovery efforts.[182] Some of CARA's provisions include: expanding availability of naloxone to first responders to aid in overdose reversal, launching a MAT program, "strengthen[ing] prescription drug monitoring programs," extending resources to incarcerated individuals, and increasing prevention and education efforts.[183] CARA provides around $181 million per year, distributed according to the congressional appropriations process,[184] to fund the battle against opioid abuse in the United States.[185] One of the most significant contributions of CARA was its modification of the Controlled Substance Act, which broadened the ability to utilize narcotics in the treatment of OUD, signaling MAT as a useful and valid form of treatment.[186]

CARA was not a piece of legislation that passed smoothly through Congress, despite the massive, widely recognized effects the opioid crisis was presenting to the United States. CARA, due to its controversial nature, faced many amendments that resulted in slashing through the majority of its proposed funding.[187] Even after CARA passed with bipartisan support, partisan political conflicts about funding within the Act resulted in lackluster implementation.[188] With the legitimate concerns and goals backing CARA unmet by its enacted legislation, the Obama administration sought out another piece of legislation to adequately address the ever-prevalent opioid crisis.[189]

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180. *The Comprehensive Addiction and Recovery Act (CARA)*, CMTY. ANTI-DRUG COALS. OF AM., https://www.cadca.org/cara/ (last visited July 3, 2023).

181. *Id.*

182. *Id.*

183. *Id.*

184. JAMES V. SANTURNO ET AL., CONG. RSCH. SERV., R42388, THE CONGRESSIONAL APPROPRIATIONS PROCESS: AN INTRODUCTION (2016).

185. *The Comprehensive Addiction and Recovery Act (CARA)*, *supra* note 180.

186. Implementation of the Provision of CARA Relating to the Dispensing of Narcotic Drugs for Opioid Use Disorder, 83 Fed. Reg. 3071, 3073 (Jan. 23, 2018) (to be codified at 21 C.F.R. pt. 1301).

187. Leo Beletsky, *21st Century Cures for the Opioid Crisis: Promise, Impact, and Missed Opportunities*, 44 AM. J.L. & MED. 359, 372 (2018).

188. *Id.*

189. *Id.* at 372–73.

D. 21st Century Cures Act

The 21st Century Cures Act[190] addresses more than just the opioid crisis, but the provisions directly related to this issue ensured the legislation's successful approval through Congress and acted as a much-needed support to CARA.[191] The portions of this Act that directly address the opioid crisis augment what was established in CARA.[192] The 21st Century Cures Act faced similar roadblocks in congressional approval as CARA did during its development.[193] However, once the aspects housed in CARA—SUD and mental health provisions—were proposed to be included under the 21st Century Cures Act, it passed with bipartisan support.[194]

The Act allotted one billion dollars, over the 2017-2018 period, to SUD treatment and overdose prevention funding, recommended to be used for: increasing availability of MAT and other treatment services, monitoring opioid prescribing, and training and outreach.[195] The Act designates HHS to oversee allocation of funds and contains no requirements for prioritizing spending.[196] The Act also authorizes grant programs tailored to SUD and mental health treatment and provides reforms and initiatives to Medicaid reimbursement rules, HIPAA patient privacy, and supports the Affordable Care Acts' reporting requirements.[197]

While the Act finally provided a considerable proportion of funding specifically for SUD and mental health treatment, it left execution of the Act to agencies with little guidance on how to proceed. Because of HHS's direct involvement with allocation, SAMHSA was able to quickly establish a grant mechanism, the Opioid State Targeted Response Program, under 21st Century Cures Act funding.[198] This program allotted funding to all fifty states and seven U.S. territories.[199] The program also designed a framework to address the "most glaring gaps" in the U.S. opioid crisis and

190. 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016).
191. Beletsky, *supra* note 187, at 359-60.
192. *Id.* at 372.
193. *Id.* at 372–73.
194. *Id.* at 373.
195. *Id.*
196. *Id.*
197. *Id.* at 373–74.
198. *Id.* at 374-75.
199. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., STATE TARGETED RESPONSE TO THE OPIOID CRISIS GRANTS (OPIOID STR) INDIVIDUAL GRANT AWARDS (2017), https://www.samhsa.gov/sites/default/files/grants/pdf/other/ti-17-014-opioid-str-abstracts.pdf.

was a beneficial first step in ensuring scientifically backed, universal modalities of care to address SUD and OUD.[200]

Legislation faces similar drawbacks as those of grant funding, aforementioned, because legislation typically offers aid by directly funding grant programs or funding agencies that provide their own grants through congressional appropriations. Legislation, however, supports future congressional actions in the area and marks a key starting point for developing and establishing relevant steps to take in the fight against opioids. The 21st Century Cures Act built from the framework of CARA and the SUPPORT for Patients and Communities Act,[201] the most recent opioid crisis focused legislation, built from 21st Century Cures Act. Legislation is necessary to ensure creation and apportionment of requisite funding. Grants are necessary to guide and support funding to the best fit entities. However, much more is needed to make a lasting and meaningful impact in the reduction of opioid abuse, especially in Indian Country.

IV. Proposed Additional Solutions

Federal government support comes in the form of money, a fundamental necessity for any support program, but money alone cannot solve complex issues. Effective, well-orchestrated service programs are essential to execute the requisite action-oriented implementation. Furthermore, as discussed at length in the prior section, federal money in the form of grants comes with many complications for smaller, rural, Indigenous communities. Although the following programs will require funding to be implemented successfully, they are well-established, and, as a result, require minimal planning and organization prior to commencement. This is a welcome benefit in comparison to the daunting development of a service program that results from an allotment of general grant money for an elaborate issue. The following three programs are all potential solutions that have seen significant success despite being relatively newer service projects. These programs can also offer timely support in response to the increase of mental health and substance abuse concerns in light of the COVID-19 epidemic. Drug consumption rooms, narcotic treatment program (NTP) mobile units, and telehealth services are promising programs to stop the escalation of the opioid crisis and deliver needed mental health resources to the vulnerable, seemingly forgotten,

200. Beletsky, *supra* note 187, at 376, 382–83.

201. SUPPORT for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018).

communities in urgent need. Empowering tribal control over tribal civil suits against pharmaceutical companies is another viable solution to the prevailing crisis. Tribal jurisdictional control can better ensure genuine advocacy for tribe specific harms and guarantee restitution directly to the injured communities themselves.

A. Drug Consumption Rooms

Drug consumption rooms are a recent phenomenon established to address the risks associated with unsupervised drug use. These facilities were first established in Europe in the late 1980s and steadily spread throughout the European Union, with roughly ninety facilities in sixty-four cities by April of 2018.[202] Successful facilities established in Vancouver promoted the spread throughout Canada as well.[203] These facilities are either set up to be integrated, attached to other social service programs; specialized, stand-alone units; or mobile facilities.[204] The integrated facilities provide a host of other services—like access to food, clothing, shelter, and counseling and drug treatment—outside of supervised drug consumption.[205] Specialized facilities are narrowly focused on the services directly related to supervised consumption by supplying safe equipment, trained health-care professionals for emergencies and consultations, and a space to remain for observation post-use.[206] These facilities also connect individuals to further healthcare services if not directly provided.[207] About 60-70% of these consumption rooms provide access to primary health care.[208] Different restrictions operate within these facilities based on locality, but most require registry, have age and residency requirements, and typically target drug injectors—though other types of users are being increasingly included in these programs.[209]

Drug consumption rooms confront a multitude of concerns resulting from the risks and consequences associated with unsupervised drug use. Primarily, these facilities were designed to remove drug use from the streets

202. *Drug Consumption Rooms: An Overview of Provision and Evidence*, EUR. MONITORING CTR. FOR DRUGS & DRUG ADDICTION (July 6, 2018), https://www.mass.gov/doc/article-drug-consumption-rooms-an-overview-of-provision-and-evidence/download.

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.*

and reduce overdose deaths.[210] In setting out to accomplish these primary objectives, they also address ancillary matters like intravenous infection rates, community exposure, improperly discarded equipment, and improved access to health and social services.[211] The efficacy of these facilities is backed by a respectable amount of evidence considering the newness in which they have been operating. Not only do these facilities connect and stay in-touch with targeted individuals, but they also contribute to reducing drug-related deaths on a city-level and decreasing the amount of emergency calls related to overdoses.[212] Further, these facilities are associated with decreases in public drug use and publicly discarded syringes and increased rates of detoxification treatments and referrals to addiction care centers.[213]

Opponents argue that operation of these facilities and the seemingly free and open access to drug use will increase crime and/or encourage vulnerable groups to use. However, as aforementioned, drug consumption rooms are not a free-for-all center for exploitative drug use but are operated and function under certain requirements and protocols. The forum in which the facilities operate can and do dictate requirements, by law, that must be followed.[214] Therefore, a forum can establish which groups of individuals, for example children, migrants, or the elderly, could be barred from accessing these facilities should it be contrary to public policy. The facilities themselves also instill safeguards to ensure appropriate use and mitigation of dependency.[215] Evidence also lends support to ease fears centering on crime commission. While studies have not shown that these facilities decrease the crime rate, they are not shown to increase crime as suggested.[216]

Notwithstanding, these facilities do have possible drawbacks. Most facilities are directly limited to intravenous drug use and, thereby, fail to aid a large population of individuals struggling with SUD.[217] These facilities are also unable to assist certain populations due to mandated restrictions, stigma, or localization.[218] Without support from local police or government

210. *Id.*
211. *Id.*
212. *Id.*
213. *Id.*
214. *Id.*
215. *Id.*
216. *Id.*
217. *Drug Consumption Rooms: Global State of Harm Reduction 2018 Briefing*, HARM REDUCTION INT'L (2018), https://www.hri.global/files/2019/03/29/drug-consumption-room-brief-2018.pdf.
218. *Id.*

entities, these facilities will face an uphill battle to even become established and protect the individuals who use their services once in operation—as is evident in the United States.

Even though these facilities have potential complications to overcome, they have been proven to work due to their emphasis on six key factors. First, drug consumption rooms do not advertise abstinence, or that users should simply stop taking drugs, but utilize a public health approach.[219] This encourages both rapport between users and the healthcare staff to facilitate open and honest communication, but also provides beneficial social services for individuals in need. Users are provided with tools and instructed how to use responsibly and linked to vital mental health and welfare programs. Second, these facilities mostly operate on anonymity. Even if a registration requirement is in place, individuals are not required to disclose substantial information that can readily identify them.[220] All that is required is a first name, date of birth, and their drug-use situation.[221] This level of anonymity permits functional tracking by the facility and also encourages participation as individuals are assured no penalties will result from their drug use. Third, facilities participate in drug checking, which is even more important with the rise of fentanyl use.[222] Even with drugs self-supplied, the facility ensures the substances are pure and thereby secures a clean local supply and reduces risk of overdose.[223] Fourth, facility medical staff support safe injecting. Facilities provide clean needles and associated supplies and monitor users post-use to catch overdose before it is too late.[224] Fifth, facilities stock appropriate overdose reversal medications and trained staff to prevent death should overdose occur.[225] Finally, these facilities also provide healthcare services for wound treatment and infection testing.[226] This aspect provides a crucial service to vulnerable communities who may not have access to these services otherwise.

The United States has been, and continues to be, relatively hesitant about installation of these facilities. The first and only operating facilities are located in New York. Coined as "overdose prevention center[s]" (OPC), the

219. Laura Mundy, *Six Reasons Why Drug Consumption Rooms Work*, FRONTLINE AIDS (June 26, 2019), https://frontlineaids.org/6-reasons-why-drug-consumption-rooms-work/.

220. *Id.*

221. *Id.*

222. *Id.*

223. *Id.*

224. *Id.*

225. *Id.*

226. *Id.*

two locations in Manhattan, both former needle exchange programs, provide supervised injection services.[227] On the first day of opening, the facilities served a combined total of seventy-two individuals and prevented two overdose deaths.[228] Similar facilities have been sought out in other U.S. cities, such as San-Francisco, Boston, Seattle, and Philadelphia, but have yet to be established due to the moral and legal culture in the country.[229] In response to a proposed facility in Philadelphia, the Third Circuit held that while "innovative solutions" to the opioid crisis were imperative, those "local innovations may not break federal law."[230] Officials in New York are unaware of any current legal challenges to block the OPCs, but the Mayor of Manhattan recognizes possibilities of a federal suppression.[231] Federal "war on drugs" statutes constitute the legal complications to the implementation of these facilities. The Controlled Substances Act bans possession of illicit substances and, specifically, a piece commonly referred to as the "crack house statute," bars knowingly opening, maintaining, and using any place for distributing and using a controlled substance.[232] The social and moral ideologies that sprung from the war on drugs movement, as well as partisan outlooks about the provision of healthcare services, most likely contribute to the hesitation of employing drug consumption rooms in the United States. These policies are also a significant barrier to effectuating this solution in tribal communities, since they receive a majority of their health care funding through the federal government. Legal reforms and legislative amendments are a "necessary but insufficient step" in addressing these issues and securing widespread availability of these facilities.[233]

Despite the hesitation present in the United States, drug consumption rooms are a viable strategy to stop and even reverse the ever-growing number of individuals suffering from OUD and opioid-related deaths. An

227. Jeffery C. Mays & Andy Newman, *Nation's First Supervised Drug-Injection Sites Open in New York*, N.Y. TIMES (Nov. 30, 2021), https://www.nytimes.com/2021/11/30/nyregion/supervised-injection-sites-nyc.html.

228. *Id.*

229. *Id.*

230. Brian Mann & Caroline Lewis, *New York City Allows the Nation's 1st Supervised Consumption Sites for Illegal Drugs*, NAT'L PUB. RADIO (Nov. 30, 2021), https://www.npr.org/2021/11/30/1054921116/illegal-drug-injection-sites-nyc; United States v. Safehouse, 985 F.3d 225, 229 (3d Cir. 2021).

231. Mann & Lewis, *supra* note 230.

232. 21 U.S.C. § 856.

233. *See generally* Kelly K. Dineen & Elizabeth Pendo, *Ending the War on People with Substance Use Disorders in Health Care*, 21 AM. J. BIOETHICS, no. 4, 2021, at 20.

almost instant benefit from these facilities would be to ensure that substances were pure and not laced with fentanyl. This is an ever-important discovery as the crisis remains in its third phase, which is marked by high death rates because of the introduction of fentanyl. Another drastic and seemingly instant benefit would be the decrease of intravenous infections that had seen a steady rise in correlation with the opioid crisis.[234] By providing a secure place and safe equipment, needle sharing and public disposal of drug equipment would significantly decrease, as was shown in the European and Canadian facilities. A major benefit, which has not been significantly studied due to less powerful stigmatization of drug use in European countries, would be reducing the stigma associated with drug use. This, in turn, could also aid in users seeking mental health services. The pressure felt from stigmatization can exacerbate the mental health issues drug abusers face and can isolate them from wanting to seek help and believing help even exists.[235] A reduction in stigma not only promotes the seeking of services and better engagement in those services, but it would also facilitate the social movement necessary to overcome the harsh "war on drugs" policies that impeded these programs' rapid development in the first place. Finally, drug consumption rooms can be multifaceted entities. They can be geared to address more than just unsafe drug consumption. Should these facilities act as shelters, treatment centers, and providers of basic healthcare services, similar to integrated systems in Europe, communities may be more inclined to support them, and governmental funding may be more readily supplied.

Research demonstrating how drug consumption rooms impact specific ethnic groups and the rate in which different ethnic groups partake in these services are lacking—as efficacy is the central focus at present. However, it is generally accepted that disparities exist in substance abuse treatment outcomes for different ethnic groups.[236] These studies have focused primarily on Black and Hispanic populations, leaving AI/AN populations essentially in the dark. Yet, it is safe to assume, based on both the elevated rates of OUD in AI/AN populations compared to the overall U.S.

234. *See Supervised Injection Sites Are Coming to the United States: Here's What You Should Know*, UNIV. OF S. CAL. DEP'T OF NURSING: NURSING@USC BLOG (May 2, 2019), https://nursing.usc.edu/blog/supervised-injection-sites/.

235. Lauren Villa, *Addiction and Stigma*, AM. ADDICTION CTRS. (June 29, 2022), https://web.archive.org/web/20221004173331/https://drugabuse.com/addiction/stigma/.

236. Fabiola Arbelo Cruz et al., *Racial Inequities in Treatments of Addictive Disorders*, AAAP NEWS (Am. Acad. of Addiction Psychiatry, East Providence, R.I.), Summer 2021, at 10, https://www.flipsnack.com/aaapnewsletter/aaap_newsletter_summer_2021.html.

population and the ever-present disparities that exist with access to health care services in general for AI/AN, that the disparities in SUD treatment outcomes are present in these communities as well. This is especially true when considering the under-resourced mental health care in these communities.[237] Drug consumption rooms could be a solution to address disparities in both SUD treatment outcomes and in the overall provision of mental and physical healthcare in these neglected communities. One facility on a reservation or a mobile unit dedicated to running rural routes would be a sufficient start to closing the gap in accessibility. For these facilities to deliver the most impact in these communities, culturally appropriate treatment methodology and ideology should be implemented in the treatment regime.[238]

B. Narcotic Treatment Program Mobile Units

Implementation of a pharmaceutical strategy in OUD treatment is considered "best practice," and this MAT is known to be "the most effective treatment for OUD."[239] MAT is the combination of psychosocial therapy, like cognitive behavioral therapy or other counseling regimes, and FDA approved pharmaceuticals to treat OUD.[240] There are currently three approved medications for the treatment of OUD.[241] Each drug interacts with the brain chemistry in different ways to either relieve withdrawal symptoms or block the effects of opioids.[242] Each drug also has specific requirements for how it can be prescribed and used.[243] Methadone and buprenorphine are both used for withdrawal management, while naltrexone is used for relapse prevention or abstinence-based treatment.[244] Methadone and buprenorphine

237. Victoria M. O'Keefe et. al., *Increasing Culturally Responsive Care and Mental Health Equity with Indigenous Community Mental Health Workers*, 18 PSYCH. SERVS. 84, 85–86 (2021).

238. *Id.* at 86.

239. *Toward Improving Opioid Use Disorder Treatment for American Indian/Alaska Native Individuals*, RECOVERY RSCH. INST., https://www.recoveryanswers.org/research-post/toward-improving-opioid-use-disorder-treatment-american-indian-alaska-native-individuals/ (last visited July 3, 2023); *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, PEW CHARITABLE TRS. (Nov. 22, 2016), https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder.

240. *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, *supra* note 239.

241. *Id.*

242. *Id.*

243. *Id.*

244. *Id.*

are both drug agonists, they bind to and activate opioid receptors, while naltrexone is an antagonist, it blocks the receptor and prevents activation.[245] Methadone is a full agonist and will completely fill the opioid receptor, resulting in longer lasting effects that prevent the "peaks and valleys associated with drug-seeking behavior."[246] "Buprenorphine is a partial agonist" that results in a ceiling effect, making the dosing process more complex.[247]

Any institution that desires to provide methadone treatment must be a certified opioid treatment program in accordance with SAMHSA's regulations.[248] Institutions must obtain a waiver under the Drug Addiction Treatment Act of 2000 to prescribe buprenorphine, and any institution that is authorized to dispense medications can prescribe naltrexone.[249] Harsher restrictions exist for the agonistic drugs out of concerns of drug diversion—the illegal acquiring and use of prescription drugs.[250] However, evidence suggests that diversion of these medications are for the purpose of controlling withdrawal and not for getting high.[251] Additionally, diversion of these medications make up around 15%, while diversion of oxycodone and hydrocodone constitute 67%.[252] Despite MAT's notable effectiveness in OUD treatment, there is a considerable treatment gap.[253] Lack of properly certified medical professionals to prescribe the medications and the expense, due to insurance companies severely limiting what they will reimburse, are the major reasons why individuals in need are not seeking and receiving valuable care.[254]

In light of this treatment gap, the Drug Enforcement Agency (DEA) authorized a waiver of the dual-registration requirement for facilities, already authorized to dispense MAT medications, that sought to establish mobile NTP.[255] This waiver greatly simplified registration processes and

245. *Id.*
246. *Id.*
247. *Id.*
248. *Id.*
249. *Id.*
250. *See* NAT'L INST. ON DRUG ABUSE, MEDICATIONS TO TREAT OPIOID USE DISORDER RESEARCH REPORT 3–4, 10, 13 (Dec. 2021 rev.), https://nida.nih.gov/download/21349/medications-to-treat-opioid-use-disorder-research-report.pdf.
251. *Id.* at 10.
252. *Id.*
253. *Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder*, *supra* note 239.
254. *Id.*
255. Registration, 21 CFR § 1301.13(e)(4)(i) (2022).

thereby allowed any authorized NTP to automatically operate mobile units. The DEA intended this waiver to assist with broader access to available OUD treatment by enabling facilities to reach out to rural, underserved communities.[256] These mobile units not only provide access to communities who lack adequate transportation, but also reduce the long wait times and high service fees associated with the few brick and mortar NTPs.[257]

The NTP mobile units could be especially impactful for AI/AN communities. While the availability of MAT medication in facilities that serve AI/AN was similar, albeit slightly lower, than facilities that do not exclusively serve AI/AN, the availability of the agonist medications for ongoing treatment was actually lower.[258] In contrast, AI/AN use of medication for OUD was higher compared to other ethnic groups.[259] This signals that AI/AN are using medication for withdrawal purposes as opposed to ongoing treatment and are doing so more than any other ethnic groups.[260] One study found that this disproportionate use of MAT medication was not a result of education, unemployment, comorbidities, frequency of use, or age at time of first use as was the case for other ethnic groups.[261] Accordingly, access to facilities that supply the MAT medication is a major factor impeding the AI/AN communities from receiving the most effective OUD treatment. NTP mobile units could deliver a consistent supply of MAT medications to AI/AN individuals in need. These mobile units can deliver all three MAT medications and could easily run consistent routes based on a dosage schedule, as some medications can be delivered in bulk for at home use, or only need to be used on a weekly, as opposed to daily, basis. The increased access to the agonistic drugs could drastically improve the retention rate of AI/AN in ongoing treatment, which is a better way to address the profound OUD in these communities as opposed to the current utilization solely for a withdrawal or overdose prevention basis. These services could also easily be combined with the use of telehealth services to ensure that the combination of medication and psychosocial services are delivered as intended in MAT. Because MAT effectively

256. *DEA Finalizes Measures to Expand Medication-Assisted Treatment*, U.S. DRUG ENF'T ADMIN. (June 28, 2021), https://www.dea.gov/press-releases/2021/06/28/dea-finalizes-measures-expand-medication-assisted-treatment.

257. *Id.*

258. *Toward Improving Opioid Use Disorder Treatment for American Indian/Alaska Native Individuals*, *supra* note 239.

259. *Id.*

260. *Id.*

261. *Id.*

reduces opioid use and OUD-related symptoms, mortality, risk of infectious disease transmission, and criminal behavior associated with drug use, while simultaneously increasing the likelihood of individuals remaining in treatment, it is imperative that all communities—especially the most vulnerable—have adequate access to receive and engage in this therapy.[262]

C. Telehealth Services

Telemedicine has been used as a health care strategy since the 1950s.[263] Based on technological limitations of the time, telemedicine was primarily in the form of sharing medical imaging and, with the assistance of NASA, utilization of satellite technology to connect rural localities to larger urban hospitals.[264] Telehealth services started to gain greater traction in the 1990s–2000s with both the expansion of technology and legislation allocating federal and state funding.[265] Telehealth services were extremely expensive and only those institutions that could receive funding were able to access this form of health care.[266] Telemedicine only became widely and easily accessible more recently, into the 2010s and beyond, because compatible technology is common among the general population, and infrastructure is better developed to support the demand.[267]

Since telehealth services are primarily funded by the federal government, it has placed numerous restrictions on the appropriate methodology required to receive funding. The federal government codified four telehealth methods: (1) live video, the use of a live, two-way, interactive audiovisual system; (2) store-and-forward, the transmission of videos and digital images through an electronic communication system; (3) remote patient monitoring, where personal health data is collected from the individual and transmitted to the provider in another location; and (4) mobile health, the use of smart-device applications that are programed to send health information between the patient and provider.[268] In addition to the restrictions on the methodology employed, there are also regulations about what technological systems can be used, where the patient needs to

262. NAT'L INST. ON DRUG ABUSE, *supra* note 250, at 4.

263. Thomas S. Nesbitt & Jana Katz-Bell, *History of Telehealth*, *in* UNDERSTANDING TELEHEALTH 3, 6 (Karen Schulder Rheuban & Elizabeth A. Krupinski eds., 2017).

264. *Id.*

265. *Id.* at 7.

266. *See id.*

267. *See id.* at 10–12.

268. Telehealth Services, 42 C.F.R. § 410.78 (2021); Renae Rossow, *The Different Types of Telehealth*, ISALUS HEALTHCARE: BLOG (Aug. 15, 2018), https://isalushealthcare.com/blog/the-different-types-of-telehealth/.

be located to receive care, what type of provider can provide the service, which medical services are covered, reimbursement rates, and much more.[269]

However, in response to the Public Health Emergency created by COVID-19, many of these requirements were significantly relaxed to ensure compliance with social-distancing and quarantining policies established by the CDC.[270] One requirement relaxation allows providers to use a wider range of technological platforms to engage in live video services without fear of violations under the Health Insurance Portability and Accountability Act (HIPAA), so long as it is performed in good-faith.[271] Another allows for patients to engage in telehealth services from their home as opposed to having to travel to an originating site.[272] These relaxations also expanded the medical services and qualified providers available for covered telemedicine.[273] In direct relation to the opioid crisis, the DEA and SAMHSA have both loosened restrictions on prescribing controlled substances to clients in need of MAT via telehealth services.[274] Traditionally, a practitioner working in an opioid treatment program could only treat a new patient with MAT if that patient had the first visit in person.[275] The exemptions by SAMHSA and the DEA waived the in-person examination requirement for patients treated with buprenorphine, but not methadone.[276]

AI/AN individuals can access covered telehealth services if they are either covered under Medicare or Medicaid or receive services through

269. 42 C.F.R. § 410.78.

270. *See* Telehealth Services During Certain Emergency Periods Act of 2020, Pub. L. No. 116-123, § 102, 134 Stat. 146, 156.

271. *Id.*; Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, 85 Fed. Reg. 22024, 22025 (Apr. 21, 2020).

272. Telehealth Services During Certain Emergency Periods Act of 2020, § 102, 134 Stat. at 156.

273. *Id.*

274. *See* Letter from Thomas Prevoznik, Deputy Assistant Adm'r, Dep't of Just., to Drug Enf't Agency Qualifying Pracs. & Drug Enf't Agency Qualifying Other Pracs. (Mar. 31, 2020) (on file with author); *also see FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (SAMHSA) ((Apr. 21, 2020), https://www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

275. Federal Opioid Treatment Standards, 42 C.F.R. § 8.12(f)(2) (2021).

276. Letter from Thomas Prevoznik, *supra* note 274; *see FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency*, *supra* note 274.

IHS.[277] Individuals covered by Medicare or Medicaid have access to all the services codified in federal legislation, including all the exemptions in the face of the Public Health Emergency, but individuals receiving services through IHS are more limited to the specific services allotted by IHS.[278] However, this does not severely impact individuals seeking services for mental health as behavioral health services, prescriptions, and medications are viable telehealth services through IHS.[279] The only complications AI/AN communities may face in regard to telehealth is access to the technology and technological infrastructure necessary to employ this form of healthcare. Nevertheless, this complication does not seem as daunting now where cellular data infrastructure is expanding in both speed and geographic region covered, and the prevalence of smart technology is overwhelming. Further, in light of the COVID-19 pandemic, now is the best time to commence and establish telehealth services in rural communities since complying with funding requirements are the simplest they may ever be. Telehealth also eliminates the need to travel long distances to receive health care as individuals can use services in their homes or community centers.

Telehealth can specifically make a drastic impact in providing accessible mental health care to communities without a mental health care provider in the area. There is a "large unmet need for mental health and substance use treatment" in AI/AN communities, but these individuals seem to use services at the same or higher level than the general U.S. population.[280] If AI/AN individuals are using depleted services at the same rate as the general population with adequate services, an increase in available services could result in a significant positive impact on mental health concerns. Telehealth is a viable option to bridge this gap. Telehealth addresses the unmet need as any provider licensed in the state where the individual

277. Telehealth Services, 42 C.F.R. § 410.78 (2021); *IHS Telehealth Programs*, INDIAN HEALTH SERV., https://www.ihs.gov/telehealth/telehealthprograms/ (last visited July 3, 2023).

278. 42 C.F.R. § 410.78; *IHS Telehealth Programs*, *supra* note 277.

279. *IHS Telehealth Programs*, *supra* note 277; *See Patient FAQs*, INDIAN HEALTH SERV., https://www.ihs.gov/telehealth/faqs/patientfaqs/ (last visited July 29, 2023) (click on question, "What types of care can I get using telehealth?").

280. Eunice Park-Lee et al., *Substance Use and Mental Health Issues Among U.S.-Born American Indians or Alaska Natives Residing On and Off Tribal Lands*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN.: CBHSQ DATA REVIEW 3 (July 2018), https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/DRAIANTribalAreas2018/DRAIANTribalAreas2018.pdf.

resides can provide telehealth services.[281] Further, these telehealth services are just as effective as in-person services and even have higher retention rates.[282] Therefore, focusing efforts on supplying telehealth, specifically in communities where there is a deficit in mental health care providers, can greatly aid in supporting these communities with their mental health concerns and thereby reduce substance use disorders and other self-coping tactics.

D. Jurisdiction

Granting tribal jurisdiction over pharmaceutical litigation is a solution that would not only provide tribal control over the methods in which they address the effects of the opioid crisis but would also ensure direct reparations to the affected communities. As mentioned in Part II, courts have been seemingly unwilling to extend jurisdiction to the tribes over these pharmaceutical suits. This revocation of authority imposes severe limitations on inherent tribal sovereignty and results in attendant litigation and the subsequent congestion of courts and delays to the administration of justice. Federal courts are focusing precious energy and effort on complex, nuanced jurisdictional decisions for every tribal pharmaceutical case initiated, which does not need to be the norm. The solution that has been advocated thus far is to combine all the federal opioid litigation claims into one multidistrict litigation, which is assigned in the Northern District of Ohio.[283] However, this solution can fall short in a few ways. First, this method still requires all the time and resources needed to determine if a case is brought in the correct court system. For example, the Cherokee Nation's suit alone was dismissed from tribal court and reinitiated in federal court, dismissed from federal court and reinitiated in state court, removed to federal multidistrict litigation, and sought to be remanded back to state court.[284] Second, this results in a diminished restitution for the tribes involved as the remedy must be split among them, and in some instances, with the states as well.[285] Lastly, this multidistrict litigation could

281. 42 C.F.R. § 410.78.

282. Zara Abrams, *How Well Is Telepsychology Working?*, AM. PSYCH. ASS'N: MONITOR ON PSYCH. (July 1, 2020), https://www.apa.org/monitor/2020/07/cover-telepsychology.

283. Irby, *supra* note 49, at 378.

284. *Id.* at 361–64, 378; Joyce Hanson, *Pharmacies Slam Cherokee Bid to Remand Opioid Claims*, LAW360 (Oct. 14, 2021, 10:38 PM EDT), https://www.law360.com/articles/1430883/pharmacies-slam-cherokee-bid-to-remand-opioid-claims/.

285. *See* Humberto J. Rocha, *Tribes Say States Owe Them Part of Purdue's New $5.5B Deal*, LAW360 (Mar. 9, 2022, 8:15 PM EST), https://www.law360.com/articles/1472045/tribes-say-states-owe-them-part-of-purdue-s-new-5-5b-deal.

negatively impact smaller tribes as they are either forced to settle early, due to limited resources, or fail to secure worthwhile settlements, as larger tribes have more bargaining power and are the primary focus of these pharmaceutical companies.[286]

In light of these wasteful and inequitable complications, adhering to the exhaustion doctrine and/or determining that the relationship between these big pharmaceutical companies and the tribes amounts to a *Montana* exception appears to be the best available remedy. Adhering to the exhaustion doctrine safeguards the tribes' interests in general health and welfare of its members.[287] As the opioid crisis continues to torment Indian Country more than any other group, it is ever more important that the tribes have control over matters directly impacting their communities. Guaranteeing tribal suits are exhausted in tribal courts, thereby securing only suits that legitimately implicate interests outside of the tribes' control are the ones removed to the federal system, will eliminate judicial waste, and yield consistent jurisprudence in an otherwise unclear area. The Tenth Circuit held that "tribal courts must be allowed to exercise their authority over . . . claims occurring within their jurisdiction and alleging injury to tribal members, absent overwhelming countervailing concerns," which supports the proposition that the exhaustion doctrine should be the standard presumption.[288]

Additionally, the unique circumstances at play in the opioid crisis, especially currently, should constitute a situation that rises to a *Montana* exception. Courts have denied granting the first exception, consensual commercial relationships, to pharmaceutical litigation, because the relationships between the tribes and the companies are either separated by third parties or consist of routine consumer transactions and thereby do not amount to the exception.[289] However, this viewpoint gives considerable favor to big pharmaceutical companies as the specific factual circumstances of tribal health care systems, even if executed via third-party contracts, could arise to the intentional relationship described in the first exception. Despite whether a factual situation could potentially meet the requirements of the first exception, the devastation that has been rendered to Indian Country by the opioid crisis surely should amount to conduct that

286. *See* Andrew Westney, *Tribes Reach $590M Opioids Deal with J&J, Distributors*, LAW360 (Feb. 1, 2022, 12:28 PM EST), https://www.law360.com/articles/1460722/tribes-reach-590m-opioids-deal-with-j-j-distributors.

287. Irby, *supra* note 49, at 376.

288. Kerr-McGee Corp. v. Farley, 115 F.3d 1498, 1508 (10th Cir. 1997).

289. Irby, *supra* note 49, at 363–65.

"threatens or has some direct effect" on either the tribes' economic security or health and welfare.[290] Courts have been reluctant to grant jurisdiction on this exception because it was intended to be narrow, in that the conduct must be "catastrophic for tribal self-government."[291] It is hard to imagine what could be more catastrophic to tribal self-governance than an epidemic that disproportionately affects tribal members and has been ultimately left unaided through the trust relationship with the federal government, notwithstanding the compounding effects of comorbid mental health crises and COVID-19. This becomes even more damaging where the conduct is from large companies engaging in permissible underhanded tactics to gain profit. Shifting jurisprudence in this realm not only aids in securing just resolution for opioid crisis related litigation but can ensure that tribes have the necessary control over similar health and welfare matters tormenting their communities. There is no question about the respect given to the state government's ability to control these consequential matters themselves, and tribal governments should be no different.

Conclusion

Indian Country has seen the greatest impact of the opioid crisis in the United States. The multifaceted complexities that contribute to the devastation experienced in these communities center around mental health concerns that have been prevalent within them long before the incidence of the opioid crisis. It is clear that solutions geared towards addressing these overwhelming mental health concerns are long overdue and will be imperative to any meaningful resolution of the damage caused by the opioid crisis.

While the federal government has allocated notable avenues for assistance in response to this crisis, a reconsideration of priorities and desired outcomes is something paramount to be considered at every level—individual to systematic. A long-oppressed community is once again signaling for help. This Comment seeks to present a few of the accessible, effective approaches that could greatly increase access to essential resources and restore faith and balance to the deep-rooted federal government tribal trust relationship. While no solution is perfect on its own, and each contain drawbacks in their own regard, implementation of these

290. Montana v. United States, 450 U.S. 544, 566 (1981).

291. McKesson Corp. v Hembree, No. 17–CV–323–TCK–FHM, 2018 WL 340042, at *8 (N.D. Okla. Jan. 9, 2018).

proposed solutions show promise to mitigating the effects of the opioid crisis in tribal communities.