DRUG POLICY ALLIANCE.

THE IMPACT OF THE OVERDOSE CRISIS ON NATIVE AMERICAN COMMUNITIES IN THE UNITED STATES

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To date, the United States has lost over one million lives to drug overdose during this crisis. Drug overdoses have affected all communities in all regions across the United States and there are notable racial and ethnic disparities that have emerged over the past 25 years. At different points in the overdose crisis, certain groups experienced more loss than others.

Recognizing racial disparities in overdose deaths can help develop effective policy solutions. This fact sheet describes overdose death trends among the Native American community. It also provides policy recommendations and strategies for how we can save lives.

THE FOUR WAVES OF THE OVERDOSE CRISIS

First Wave- Early 2000s. Prescription Opioids. When the crisis began in the early 2000s, Native American and white people had the highest rates of overdoses compared to other groups. Initially, these deaths were driven by prescription opioids, and it marked the "first wave" of the overdose crisis.[1]

"Second Wave" - 2010- 2014. Opioid prescribing reduced; people turn to heroin. As opioid prescribing and dispensing was reduced, many people transitioned to buying street heroin. The "second wave" of the crisis began in 2010 when heroin overdose deaths increased among all groups.

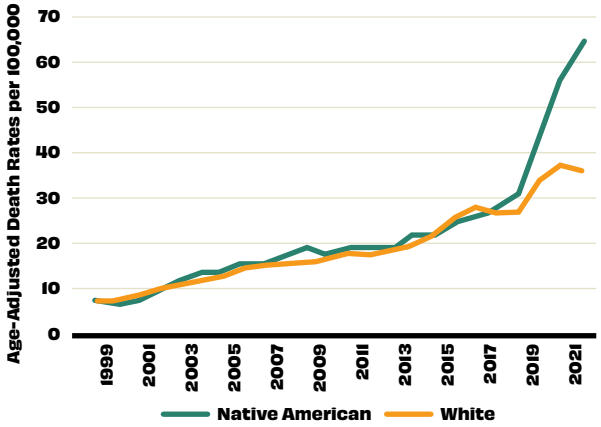
Third Wave- Started in 2014. Fentanyl is introduced to east coast drug supply. Fentanyl, a highly potent opioid, entered the east coast drug supplies after 2014 in response to heroin supply disruptions. Underground drug suppliers saw it was cheaper and easier to produce fentanyl and bring it into the country than heroin. However, people who use drugs were unprepared for the highly potent drug and people began to die of overdose at higher rates. This began the "third wave" of the overdose crisis and overdose deaths rose among all racial and ethnic groups.[2]

Fourth Wave- 2017 to present. Polysubstance overdose deaths from stimulant drugs, often in combination with fentanyl, increase. Overdose deaths involving stimulant drugs such as cocaine and methamphetamine started to increase nationally in 2017. Cocaine-involved overdoses increased on the east coast, while methamphetamine-involved overdoses increased on the west coast. Many of these deaths involve both stimulants and fentanyl.[3] Mixing drugs or using multiple drugs together can increase overdose risk because it places more stress on the body. A small portion of deaths involve stimulants with no opioids.

We are currently still in the "fourth wave" of the crisis.

BETWEEN 1999 AND 2022, THE NATIVE AMERICAN OVERDOSE DEATH RATE INCREASED OVER 10-FOLD.

NATIONAL DRUG OVERDOSE DEATH RATES, BY RACE

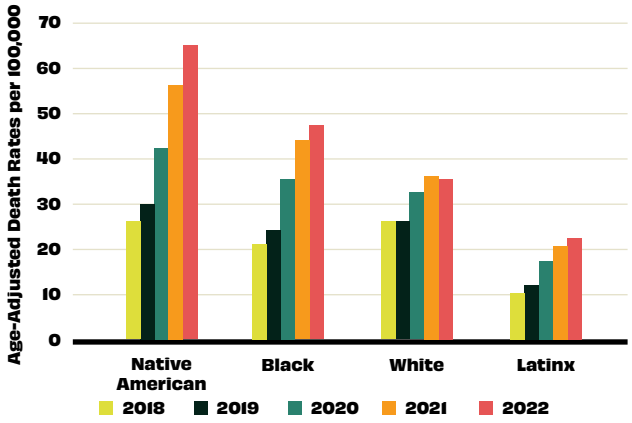


Source: CDC WONDER, 2024

According to data from the Centers for Disease Control, **the Native American overdose death rate was 6.0 per 100,000 in 1999 but increased to 65.2 per 100,000 by 2022.**[4] While overdose death rates among Native people paralleled white overdose death rates for many years, they recently began increasing at a faster rate.

NATIVE PEOPLE HAVE HAD THE HIGHEST RATE OF OVERDOSE DEATHS COMPARED TO ALL OTHER GROUPS SINCE 2018 DUE TO GENERATIONS OF DISINVESTMENT IN STRUCTURAL AND SOCIAL DETERMINANTS OF HEALTH FOR THIS POPULATION.

NATIONAL DRUG OVERDOSE DEATH RATES SINCE 2018, BY RACE

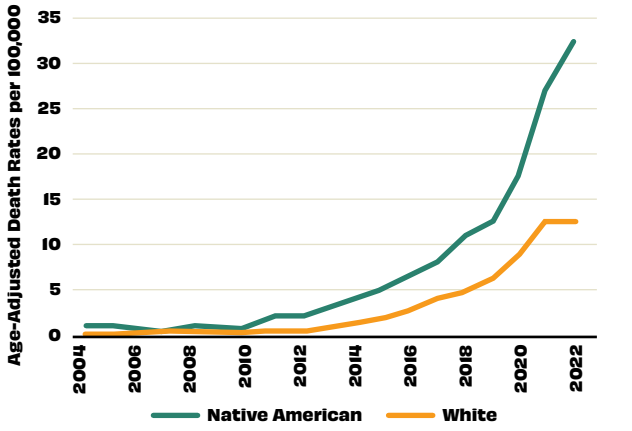


Source: CDC WONDER, 2024

Another notable shift happened again between 2021 and 2022, when the Native American overdose death rate increased by 15% and white rates went down that year.[5] Black and Latinx overdose deaths also increased in that time frame.

Native American people have the highest rates of methamphetamine-involved overdose deaths compared to all other groups. This rate increased 12-fold between 2012 and 2022.[6]

METHAMPHETAMINE INVOLVED OVERDOSE DEATH RATES, BY RACE



Source: CDC WONDER, 2024

Many of these methamphetamine-involved overdose deaths involved other drugs as well. These are known as polysubstance overdose deaths. Using drugs in combination can increase overdose risk due to strain on the body.

In 2021, more than half of the methamphetamine-involved overdose deaths among Native Americans also involved fentanyl.[7]

Although Native American men have the highest rates of overdose overall, Native American women have the highest rates compared to women in any other racial or ethnic group.[8]

WHY OVERDOSE DEATHS ARE SO HIGH IN THE NATIVE COMMUNITY

HISTORICAL AND INTERGENERATIONAL TRAUMA FROM U.S. POLICIES THAT HAVE FORCED DISPLACEMENT AND FAMILY SEPARATION

Historical and current policy factors make Native American people more likely to experience poor mental health, suicide risk, and drug-related harms, including overdose.[9] Many experience intergenerational trauma, the passing of harm and stress across generations. This is due to forced displacement, forced assimilation, and family separation for hundreds of years. Self-medicating with substances is a common response to trauma. Combined with a lack of investment in community supports and services, these factors can contribute to increased risk of substance use and mental health issues.[10]

DIFFICULTY ACCESSING MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

There are two lifesaving MOUD: methadone and buprenorphine. Research shows that they can cut the risk of overdose in half for people with opioid use disorder (OUD).[11] However, both medications are very difficult to access. Patients can only get methadone at an Opioid Treatment Program (OTP). OTPs often require daily or near-daily pick-ups and

observed dosing of medication. Strict attendance requirements, random drug testing, and other restrictive policies discourage or make it very difficult for patients to enroll or stay enrolled in OTPs.

Due to recent policy changes, buprenorphine can be prescribed by many healthcare providers. However, insurance issues, racial disparities in prescribing, out-of-pocket costs, and difficulty filling prescriptions at pharmacies also make it difficult to get buprenorphine.

Unfortunately, many MOUD policies create barriers for people who need these medications the most.

Native Americans are less likely to use MOUD for ongoing treatment.[12] This could be due to limited resources of tribe and Indian Health Service addiction services, lack of providers near reservations, and the lack of integration of MOUD into indigenous healing practices exacerbate lack of MOUD access.

LIMITED ACCESS TO OVERDOSE PREVENTION AND HARM REDUCTION EDUCATION, TOOLS, AND SUPPLIES – PARTICULARLY ON TRIBAL LAND.

Many harm reduction programs target people who inject drugs and use opioids. This may mean that Native American people who smoke methamphetamine. may not seek services at traditional syringe service programs. In many states, it is not legal for harm reduction programs to distribute smoking equipment or fentanyl test strips. In fact, there are still states with no legal syringe distribution either. With limited access to harm reduction programs on tribal land and in states, Native American people who use drugs may not get free naloxone, supplies, and harm reduction education to stay safer.

NATIVE AMERICANS ARE DISPROPORTIONATELY CRIMINALIZED DUE TO RACIST DRUG ENFORCEMENT.

Due to targeted and racist enforcement, Native American people are incarcerated in jails and prisons at a rate only second to Black people in the United States.[13] Alcohol and drug overdose deaths are high in jails and prisons because MOUD and other treatment is often unavailable. It is estimated that MOUD is unavailable in over half of all jails and in 90% of state prisons.[14] Overdose risk is also highest in the first two weeks of release from incarceration.[15] This is because drug tolerance goes down after abstinence or without treatment. It is also challenging to find treatment after release, especially for those without insurance. (In fact, Native people have the highest uninsurance rates compared to all other groups.[16]) For those on probation, parole, and in drug courts, access to MOUD can be limited. Research shows that Native Americans who are referred to treatment by the criminal legal system are less likely to access MOUD due to the fact that many referrals are to programs that do not provide MOUD.[17]

In addition, having a criminal record can create barriers and obstacles in people's lives. It can affect one's health by limiting job options, housing options, and other social determinants of health.

Social determinants of health refer to the non-medical factors that impact health outcomes (i.e. job opportunities, immigration status, housing, food security etc.)

MISTREATMENT AND STIGMA IN HEALTHCARE SETTINGS DUE TO RACISM AND NEGATIVE ATTITUDES TOWARDS PEOPLE WHO USE DRUGS.

Many Native American people face discrimination in medical settings, especially those who use drugs. They are less likely to have high-coverage health insurance and less access to quality services from providers and local healthcare facilities.[18] This can mean they do not seek or finish treatment for mental health, addiction, or other medical issues. When people have untreated medical needs, they are more vulnerable to experiencing drug harms.

WHAT WE NEED TO DO TO SAVE LIVES

Decriminalize drug possession, overdose prevention and harm reduction tools. Drug use is a health issue and should not be treated as a criminal issue. If drugs were no longer criminalized, people who use drugs would not face arrest and incarceration for personal possession. People who use drugs would not get a criminal record that would create future obstacles in life. It is important to decriminalize syringes, smoking equipment, and drug checking tools in all states. When supplies are decriminalized, harm reduction programs can distribute them in the community.

Improve access to medications for opioid use disorder (MOUD). In other countries, people can access methadone in pharmacies. We must explore options beyond the Opioid Treatment Program (OTP) model to make methadone easier to access for people with OUD. We must provide access to methadone and buprenorphine in jails and prisons. We must also make it easier to start patients on MOUD while in the emergency room and in other medical settings. Treatment should be available with few requirements and restrictions.

Expand and fund more harm reduction and overdose prevention services. Harm reduction services must be available in all communities, especially on tribal lands. This can include brick-and-mortar programs, but also mail-order and mobile outreach programs.[19] Drug checking, including fentanyl test strips and more advanced methods, is an important tool to save lives. Overdose prevention centers are needed in communities across the nation. They provide life-saving services and help connect people to other services too.

Increase culturally sensitive and gender-specific services. Native American people who use drugs need services that are culturally sensitive to their needs and acknowledge their histories of mistreatment. Since Native American women are disproportionately impacted by overdose, they must also receive gender-specific harm reduction and treatment to stay safe. We also need more Native American harm reduction, treatment, and medical providers in communities.

Invest in more data collection and research. Unfortunately, overdose deaths among Native Americans do not receive enough public attention due to what researchers call "indigenous data genocide."[20] Since Native American people are a small portion of the general population and they are often racially misidentified in death certificate data, the quality of data about Native American overdose deaths is poor. This led many researchers in the early waves of the overdose crisis to downplay the impact of the crisis on Native communities compared to white communities. We need more accurate research on the efficacy of various harm reduction and treatment approaches with Native communities, with a focus on culturally sensitive approaches.

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