# 2023 NATIONAL TRIBAL OPIOID SUMMIT (NTOS)

## FEDERAL POLICY RECOMMENDATIONS

December 2023

# PRIORITIES FOR THE EXECUTIVE BRANCH

## Multi-Agency

### *Declare a National Emergency on Opioid Epidemic*

Tribal communities are currently experiencing poor mental health and substance use outcomes as a result of isolation from familial, social and cultural activities, anxiety and depression, significant deaths, economic instability, and barriers to accessing mental health services and substance use treatment during the pandemic. As a result, AI/AN people are facing a devastating opioid and fentanyl epidemic with increased overdoses and deaths. AI/AN people are nearly twice as likely to use illicit drugs compared to other racial groups in the U.S., and experience the highest rate of misuse for opioids, prescription pain relievers, and other prescription misuse. Since 2018, the rate of AI/AN opioid overdose deaths nationally has increased 174%.

The increase in opioid and fentanyl related overdoses is impacting Tribal programs and services, including health care, public safety and Tribal justice systems, child welfare, housing, social services, and elder care programs, which are all under-resourced and understaffed. Tribal resources are exhausted and Tribally-based treatment services with wraparound services are extremely limited and/or existing Tribal treatment programs are unable to provide the wrap-around services that those in treatment need to heal and remain in recovery.

We therefore call on the President of the United States to unilaterally declare a national emergency for the opioid epidemic devastating Tribal communities under the National Emergencies Act, 50 U.S.C. § 1601 et. seq., the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121 et. seq., and Public Health Service Act, 42 U.S.C. § 247d to open additional resources and authorities to address this crisis.

### *Ensure Tribal practices, including traditional medicine, are reimbursable by third-party payers.*

- *Including approving state 1115 Medicaid waivers that would allow for traditional healing reimbursement*

Recognizing Tribal sovereignty means recognizing the sovereign right of Tribal nations to utilize traditional practices to provide for the health of their people. Traditional medicine is central to many Tribal cultures and effectively treats many

chronic health issues faced by American Indian and Alaska Native (AI/AN) people. Many Tribal nations are utilizing traditional healing to treat and promote recovery from substance use disorder (SUD), and behavioral health, more broadly. By focusing on holistic care, traditional healing practices, and Indigenous ways of knowing, we have seen remarkable results in Tribal communities for treatment of opioid use.

Despite its effectiveness and existence from time immemorial, traditional practices are still blocked from inclusion in contemporary health care delivery and from reimbursement from 3rd party payers such as Medicaid. Tribal nations support funding of traditional health practices, including reimbursement through programs at the Centers for Medicare and Medicaid Services (CMS) and private insurance.

### *Provide additional and proactive technical assistance to Tribal nations to access and apply for available funding to treat and prevent Substance Use Disorders.*

- *Simplify grant application processes and reporting requirements*
- *Ensure grant applications are strengths based and not deficit based.*
- *Emphasize culturally competent care, not only evidence-based practices, for federal grants*
- *Allow innovative approaches through federal grant funding, such as developing a Tribal prevention model based on the Icelandic Model*
- *Extend grant cycles to better allow for prevention and treatment planning to over 5 years.*

While the federal government does make specific opioid funding available to Tribal nations, competitive grants do not honor the federal trust responsibility. Instead, those with significant resources are the areas that are funded, and not necessarily where the need is the greatest. The existing framework forces Tribes to compete for these funds, pitting them against states and local governments with greater grant-writing capacity. As a result, Tribes regularly lose out on funding. Funding opportunities should be formula-based, and not tied to onerous reporting requirements. Funding should not pass through state or local governments. Direct funding eliminates the administrative burden imposed by the grant process for both agencies and Tribes. Additionally, any new funding must be made available to be received through compacts and contracts under the Indian Self-Determination and Education Assistance Act (ISDEAA) (P.L. 93-638).

### *The Indian Health Service and Bureau of Indian Affairs should provide technical assistance and outreach to Tribal nations for available uses of 105(l) leases, including housing and other services.*

- *Include all options available in current law.*

ISDEAA authorizes IHS to enter a lease for a facility upon the request of a Tribal nation or Tribal organization for the administration or delivery of programs, services, and other activities under the Act. The available uses for these funds could help Tribal nations with unique needs when it comes to facilities for SUD, for example, SUD treatment housing. With many Tribal nations increasingly turning to 105(l) leases in response to the chronic underfunding of IHS and BIA facilities, the agencies need to provide more outreach to Tribal nations on unique and innovative options for this funding stream.

### *Increase behavioral health providers in Indian Country by:*

- *Increasing available scholarships and loan repayment options;*
- *Authorizing and expanding additional provider types (e.g. behavioral health aides);*
- *Providing adequate housing for providers living in Tribal communities; and*
- *Ensuring that all provider types are able to bill for third party revenue.*

The IHS and Tribal health care providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country, and this is especially true of behavioral health providers. On the federal side, IHS Director Roselyn Tso testified in May of 2023 before the House Natural Resources Committee that the agency has a 28% provider vacancy rate and a 40% mental health professional vacancy rate.

To strengthen the health care workforce, IHS and Tribal programs need investment from the federal government to educate, recruit, and expand the pool of qualified medical professionals and support for new levels of practitioners. IHS currently provides scholarship opportunities to AI/AN students to enter the health professions. IHS also provides loan repayment opportunities for those who work in the Indian health system. However, both of these programs are severely underfunded. Congress should increase appropriations for both IHS scholarship and loan repayment consistent with the request from the IHS Tribal Budget Formulation Workgroup. IHS Scholarship and Loan Repayment programs should also be made tax exempt.

### *Improve Federal Standards for Data Collection and Reporting to Improve AI/AN Visibility and Better Measure Health Inequities including for opioid and fentanyl use.*

High-quality, meaningful AI/AN health, justice and vital statistics data is essential for identifying disparities, setting priorities, designing strategies, and highlighting successes related to health equity. However, racial misclassification, missing data, and other quality issues impede the representation of AI/ANs in many data sets. With AI/AN people and communities so often missing from the data, this becomes one more form of erasure of American Indians and Alaska Natives – our experiences are not represented, our needs are not heard, and our very existence becomes invisible. In addition, the way federal data is reported often excludes the many AI/ANs who identify as Hispanic or with multiple racial identities. Reframing the data away from focusing on race and instead focusing on "AI/AN" as a political status is a more effective, empowering, strengths-based approach supporting Tribal self-determination. We support improved data access for Tribal nations and Tribal Epidemiology Centers as a crucial step to undo the centuries of AI/AN erasure contributing to the ongoing health inequities in Tribal communities.

## Indian Health Service (IHS)

### *End competitive grants for behavioral health/ substance use programs, and distribute on a formula basis through ISDEAA Contracts and Compacts*

- *If funding is unavailable, IHS should prioritize this in their annual budget request to Congress.*

The Indian Health Service operates several grant programs related to substance use and behavioral health. However, despite the wishes of Tribal nations, those funds have been distributed on a competitive basis and not through self-governance agreements. This means that funds are not widely available and Tribal nations face significant administrative hurdles which detract from the purpose of the funding.

### *Utilize existing Community Health Aide Program authorities to expand available behavioral health providers*

- *Approve Behavioral Health Aide (BHA) certification for the lower 48 immediately;*
- *Prioritize BHA funding in CHAP expansion annual budget formulation process;*

- ***Allow area certification boards to certify their own community health aide providers, including BHAs***

Since the 1960s, the Community Health Aide Program (CHAP) has empowered frontline medical, behavioral, and dental providers. The IHS and Tribal health care providers continue to struggle to find qualified medical professionals to work in facilities serving Indian Country. To strengthen the health care workforce, IHS and Tribal programs need investment from the federal government to educate, recruit, and to serve Alaska Native communities, successfully expanding access in these communities to urgently needed health and dental services. CHAP is now a crucial pathway for AI/AN peoples to become health care providers. The IHCIA authorized the IHS to expand the CHAP to Tribes outside Alaska. Based on the IHCIA and the CHAP's success in Alaska, IHS developed CHAP expansion policies from 2016 to 2020. Yet, in 2023, IHS has still not provided a national standard for CHAP certification or allowed the creation of regional CHAP certification boards outside of Alaska. IHS must immediately implement CHAP to improve the pool of behavioral health providers in Indian Country.

## *Ensure that Tribes have access to their own behavioral health data stored in the IHS National Data Warehouse*

Access to Behavioral Health data in the National Data Warehouse for the Indian Health Service is partitioned and inaccessible to Tribes and to staff of the Indian Health Service. This data must be made accessible to the Tribal entities providing the data to allow for adequate program planning, development, and assessment. Without access to such data, in aggregate, it is difficult to assess the impact of programs and progress being made to address the opioid epidemic. A data portal with Tribal clinic-specific data available to the Tribe providing the services would be a valuable resource to evaluate the impact of interventions on the health of the community.

## *Ensure that Tribal Epidemiology Centers have access to behavioral health data through the Epi Data Mart if Tribes in their area support access*

Access to Behavioral Health data in the Epi Data Mart is partitioned and inaccessible to Tribal Epidemiology Centers. The revised rule does not alter the basic framework for confidentiality protection of substance use disorder (SUD) patient records created by federally assisted SUD treatment programs. 42 CFR Part

2 restricts the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a medical emergency or for scientific research, audit, or program evaluation. 42 CFR Part 2 interpretation needs to be examined to allow Tribes and Tribal Epidemiology Centers to access data for public health purposes without classifying that activity as research.

### *Expand Medication Assisted treatment (MAT) Access at IHS, Tribal and Urban health facilities*

Tribal, IHS and Urban health programs have limited resources and this hinders the capacity to provide MAT services. Patients have limited ability to travel great distances to receive MAT services. Other logistical barriers – such as lack of electronic prescribing – further limit a local IHS clinic to use MAT. We encourage IHS to work with Tribes to find solutions, for example, technical assistance for establishing MAT services, so that patients can access MAT closer to home.

## Centers for Medicare and Medicaid Services (CMS)

### *Require states to recognize Tribal health provider placement assessments for inpatient treatment under Medicaid*

Currently, patients of Tribal health programs are subject to state requirements for inpatient treatment, which may require double assessments – first from the referring Tribal health provider, and then again from a state or managed care plan provider. This double assessment is an inefficient use of resources, but more critical is the time lag it creates between when the patient is ready to start treatment to when they can enter treatment. Requiring states to recognize Tribal health provider placement assessments for inpatient treatment covered by Medicaid will allow for quicker, more efficient access to substance use disorder treatment.

### *Expand Medicare and Medicaid benefits to include alternative pain treatments such as traditional healing, naturopathic, acupuncture and chiropractic services*

The Indian health system relies on reimbursements through Medicaid to support the inadequate federal appropriations received by the IHS each year. However, promising and innovative practices to assist with pain management and SUD

treatment and recovery are often not covered by Medicaid. CMS should authorize alternative pain treatment reimbursement to move patients off opioid-type pain relief.

## Substance Abuse and Mental Health Services Administration (SAMHSA)

### *Conduct Tribal consultation with Tribes on the burdens of 42 CFR Part 2 on IHS and Tribal facilities and ensure Tribal input on any changes to Part 2*

The current opioid crisis has revealed that some of the strict confidentiality requirements of the rule hinder the ability of Tribes and IHS to provide care. As was previously noted, "aligning 42 CFR Part 2 with HIPAA would allow clinicians to provide the best and safest care for AI/ANs, improve care coordination, ensure patient safety, and facilitate integration of services while maintaining the protections for patient privacy." and "Given the … impact on care coordination within the Indian health system and the lives of AI/ANs with substance use disorders, we urge SAMSHA to provide opportunities for Tribal consultation. Every Tribe is different, and the Indian health system complex, so it is important to get as much input from Tribes on this proposed rule to ensure that Tribal concerns are addressed."

### *Eliminate duplicative Government Performance and Results Act (GPRA) standards and streamline grant reporting process.*

SAMHSA requires reporting on many of the same measures that are already reported to IHS but with slightly different parameters. This creates an unnecessary burden on program staff and detracts from program implementation Furthermore, many of the questions SAMHSA requires Tribes ask patients are traumatizing and triggering for many patients. SAMHSA should align reporting requirements with IHS GPRA requirements and work with Tribes to reform reporting requirements to ensure that it is culturally appropriate with minimal reporting burden on grantees.

# Department of Justice (DOJ)

## *Coordinate with Tribal, federal, state, local law enforcement agencies on arrest, including:*

- *Cross-departmental cooperative agreements*
- *Jurisdictional issues, Tribal warrant reciprocity*
- *Cross deputization agreements*

The severity of the opioid / fentanyl epidemic in Tribal communities is directly related to the lack of resources and support for law enforcement and jurisdictional challenges. Lack of Tribal law enforcement resources, and lack of support by state and local police, can mean that illicit drugs easily evade law enforcement in many Tribal communities. We support policies to encourage Tribal, local and state law enforcement to work collaboratively and address common jurisdictional issues that are specific to each Tribal nation and local community.

## *Provide law enforcement training-focused on mental health (Tribal Law and Policy Group provides training), compassion, screening procedures*

Tribal, federal, state, and local law enforcement should have additional training on how to respond to individuals suffering from SUD. This should include culturally appropriate training for law enforcement working on and near Tribal communities. This training should be designed to get individuals away from jail, and into appropriate treatment.

## *Expand culturally appropriate drug courts*

Tribal Healing to Wellness Courts use culturally informed approaches that promote accountability, healing, and Tribal identity for Native-American youth younger than age 21. The Department of Justice should provide increased support for these programs across Indian Country.

# PRIORITIES FOR CONGRESS

## *Provide increased support and funding for housing-- expanding funding for "Housing First" in Tribal communities and other social determinants of health*

- *Ensure that Medicaid can reimburse all social determinants of health nationwide*

Social determinants of health such as housing, education, employment, food access, transportation, and income level can play a major role in the ability of individuals to recover from SUD or opioid use disorder (OUD).It can be impossible for a patient to be successful in recovery if they have nowhere to live, and often, federally funded housing programs require tenants to be free of all substances. This creates barriers for those who are trying to heal. Instead, federal resources should support "housing first" which focuses on providing housing support so that individuals can attend to other needs such as employment or attending treatment for SUD.

Additionally, Health equity for AI/ANs will advance with a Tribally created an Indigenous model of social and structural determinants of health that will identify root causes of inequities and priorities for intervention.

## *Enact legislation that offers educational and workforce development opportunities for people with opioid use disorder, independent of past criminal activity*

Some of the most effective providers for OUD and SUD are those who have been patients before. Legislation should be enacted specifically targeting those who are in recovery. Past criminal activity should not bar an individual from participating in this program.

## *Increase funding for prevention services at the Indian Health Service (IHS) including harm reduction programs, peer support, syringe service programs*

IHS and Tribally operated programs support an integrated behavioral health approach to collaboratively reduce the incidence of alcohol use disorders and other substance use disorders in AI/AN communities. IHS alcohol and substance use

funding is used to provide a comprehensive array of preventive, educational, and treatment services that are community-driven and culturally competent. These collaborative activities strive to integrate substance use treatment into primary care. Additional funding focusing on harm reduction and peer support is desperately needed. IHS should provide best practices around these models for federally operated and Tribal facilities to implement.

The IHS Tribal Budget Formulation workgroup recommends $4.86 billion in FY 2025 for this Alcohol and Substance Abuse.

### *Increase facilities funding, including for medical facility construction, dual-diagnosis facilities, and medically supervised withdrawal / detoxification for adults and youth.*

The need for new healthcare facility construction at IHS was estimated to be $23 billion in 2021 (up 59% from 2016). There is an additional $1.5 billion backlog in maintenance to existing IHS facilities. The IHS hospitals now average 39 years of age, over three times older than the average age of U.S. not-for-profit hospitals (11.5 years).These facilities are often not appropriate or available for the current needs of the patient population when it comes to OUD and SUD. Congress should prioritize investment in IHS facilities and especially those targeted at treatment for OUD such as detox facilities.

The IHS Tribal Budget Formulation workgroup recommends $2.5 billion for Health Care Facilities Construction in FY 2025.

### *Increase funding for Tribal data analytics at Tribes and of TECs*

Many Tribes do not have sufficient funding to employ health data analysts, biostatisticians, or epidemiologists. The priority is the provision of clinical services rather than data analysis. More funding is needed for Tribes to hire analysts to evaluate data and drive community-based recommendations using Tribal specific data. In addition to funding staff at Tribes to do this work, each Tribal Epidemiology center would benefit from stable ongoing funding to support substance use disorder and behavioral health analytics.

### *Enact a Special Behavioral Health program for Indians, similar to the Special Diabetes Program for Indians*

One of the most successful models for addressing chronic health issues is the Special Diabetes Program for Indians. This program provides funding to over 300 grantees to treat and prevent type 2 diabetes through approaches that are culturally driven and tailored to local community needs. Data shows the program being remarkably successful with type 2 diabetes onset and complications for AI/ANs decreasing year after year. Congress should enact a similar program for behavioral health challenges that would focus on local needs and cultural practices.

## The Administration for Children and Families (ACF)

### *Fund revitalization of Indigenous cultural practices and language, such as reconnection programs*

Increasing the use of Native languages helps patients stay closer to their culture and promotes healing. Colonization stripped Indigenous people of their native language, culture and customs and the impact of that is still being seen today. This historical trauma often can manifest itself through medication through abuse of opioids and other illicit drugs. By providing funding to revitalize native languages, more people will be closer to their own culture, and have a better chance at overall healing and recovery.

### *Allow all ACF programs to be administered through self-governance contracts and compacts*

Outside of the IHS, ACF is the biggest funder for Tribal nations at the Department of Health and Human Services. Programs such as Temporary Assistance for Needy Families, Child Care Block Grant, Head Start, Child welfare services programs under part B of title IV of the Social Security Act, the promoting safe and stable families program under part B of title IV of the Social Security Act, and the Community Services Block Grant (among others).But administration of these programs is often impeded by grant requirements and reporting that does not honor Tribal sovereignty and takes away critical resources from program implementation. Instead, Congress should authorize ACF programs (and other programs at HHS) to disburse funding through ISDEAA contracts and compacts to promote Tribal efficacy and self-determination.

## Centers for Medicare and Medicaid Services (CMS)

### *End the "IMD Exclusion" under Medicaid which prohibits states from authorizing Medicaid at psychiatric hospitals or other residential treatment facilities that have more than 16 beds*

Since 1965, federal law has prohibited Medicaid from paying for care provided in "institutions for mental disease" (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. With the high demand in Indian Country, and a lack of culturally appropriate facilities, it is critical that this exclusion be lifted to increase treatment options for those suffering from OUD and other behavioral health challenges.

### *Provide universal Medicaid/Medicare reimbursement for prevention services including:*

- *Harm reduction programs*
- *Peer support,*
- *Syringe service programs*

### *Amend the Medicaid statute's definition of "clinic services" to ensure that services furnished by Indian Health Service and Tribal clinic services will be reimbursable wherever the services are delivered.*

CMS should universally cover programs that are known to reduce OUD and SUD risk. It is critical to be able to provide services to patients not just within the four physical walls of a health clinic, but out in the community and the homes where patients reside. In many Tribal communities, American Indian and Alaska Native healers traditionally provided (and continue to provide) care wherever the patient was located, not just if the patient was present within a dedicated healing structure. This is especially true of the programs serving OUD and SUD. Access to care is improved when services are furnished in non-traditional settings, such as schools, community centers, and patients' homes. Yet, CMS believes these services cannot be billed as clinic services under the statutory definition of clinic services. CMS has not yet enforced this requirement due to the dramatic impact it will have on IHS and Tribal providers, and issued a series of grace periods in order to give the agency time to address the issue. Congress should amend the "clinic services" definition to ensure that reimbursements for services furnished by IHS and Tribal clinic services providers will be available wherever the service is delivered.

### *Allow for Medicaid reimbursement to individuals who are incarcerated and cover treatments that are inclusive of culturally competent care*

Medicaid has an exclusion for outpatient health services for inmates based on the rationale that Congress already directly appropriates funds to pay for the healthcare costs of federal prisoners and that state and local jurisdictions do the same; but the Indian Health Service has no correctional health care budget; and Medicaid's "inmate exclusion" combined with the lack of funding for correctional health care at either BIA or IHS jeopardizes the financial sustainability of Tribal healthcare facilities, forcing IHS and 638 Tribal healthcare facilities to absorb, on average, $1.5 million in annual uncompensated cost when a new Tribal jail opens in their service area. The 2017 NCAI Resolution, #MOH-17-013, Funding for Correctional Health Care in Tribal and BIA Facilities includes recommendations that should be supported in full.

### *Provide Indian health care providers equal access to Medicaid services no matter what State they are located in by authorizing them to bill Medicaid for a new set of Qualified Indian Provider Services*

In 1976, Congress provided equal access to the Medicaid program to all Indian health care providers, but they do not have access to the same Medicaid services. States have the option of selecting some or none of the optional Medicaid services, so the amount and type of services that can be billed to Medicaid varies greatly state by state. As a result, different Tribes in different states have access to different Medicaid services. This significantly impacts availability of a variety of services around prevention and treatment around OUD. This includes harm reduction services, traditional healing, and other peer support services. Qualified Indian Health Care Provider Services would include all mandatory and optional services described as "medical assistance" under Medicaid and specified services authorized under the IHCIA when delivered to Medicaid-eligible AI/ANs. This would allow all Indian health care providers to bill Medicaid for the same set of services regardless of the state they are located in. States could continue to claim 100 percent FMAP for those services so there would be no increased costs for the states for services received through IHS and Tribal providers.

## Substance Abuse and Mental Health Services Administration (SAMHSA)

### *Provide Tribal access and dedicated funding to the Alcohol and Substance Abuse Block grant; allow it to be received under 638 contracts and compacts.*

The Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG), administered by SAMHSA, is available to states and territories, but Tribal nations are largely left out of this funding stream. The funding supports activities to prevent and treat substance use, and these resources continue to be critically needed in Tribal communities. By leaving Tribal nations out of this funding stream, it contributes to resource challenges that our communities face.

### *Increase funding for Tribal Opioid Response grants and allow these grants to be received through self-governance contracts and compacts.*

In FY 2023, Congress provided $55 million for Tribal opioid response grants. Yet, this funding is still subject to grant requirements that make programs more difficult to implement. The recent pandemic has demonstrated the need for more coordinated funding, better communication and coordination between all Departments and agencies at the Federal level, and more equitable funding for all Tribes. This is especially true of funding for programs to treat and prevent OUD, and the impacts of which are multi-faceted and reach across many areas. Under Self-Governance, programs and services would be better designed and operated with better results, better health, and better social outcomes for Tribal citizens, their families, and communities. Tribal health programs would reduce administrative costs and eliminate onerous and duplicative reporting requirements.

### *Fund the Behavioral Health and Substance Use Disorder Resources for Native Americans program at the full authorized amount*

At the end of 2022, Congress authorized a new program called the Behavioral Health and Substance Use Disorder Resources for Native Americans but did not provide funding. We request that Congress provide funding for this program at the full authorized amount.

## Bureau of Indian Affairs (BIA)

### *Enact the Parity for Tribal Law Enforcement Act (amends the Indian Law Reform Act)*

This legislation would authorize Tribal officers acting under an ISDEAA contract or compact to be considered federal law enforcement officers and enforce federal law, provided they meet certain qualifications, including having completed certain training and background investigation requirements that are comparable to BIA law enforcement officers. This action would eliminate the need for Indian Tribes to enter into Special Law Enforcement Commission (SLEC) agreements, which are currently required under existing for Tribal officers to enforce federal law and have proven administratively burdensome for Tribes to obtain. It would also treat Tribal law enforcement officers acting under a 638 contract or compact as federal law enforcement officers for purposes of other federal laws, including for benefits applicable to federal law enforcement officers for injury and death, retirement, and pension benefits.

### *Provide additional funding for law enforcement in Indian Country; including focusing on healing*

## Department of Justice (DOJ)

### *Enact legislation to recognize Indian Tribal government authority to prosecute Drug Trafficking and Drug-related Offenses occurring in Indian Country*

Tribal nations face unique challenges in addressing the opioid and fentanyl crisis due to jurisdictional limitations imposed by federal law, which currently does not allow for the prosecution of non-Indians by Tribal courts for drug offenses committed within Indian Country.

Drug traffickers, recognizing jurisdictional loopholes, have historically targeted Tribal nations. For example, in the 1990s, non-Indian methamphetamine producers often set up clandestine labs on Tribal lands, exploiting the fact that the Tribes lacked the authority to prosecute them, thereby creating illicit havens that undermined community safety and sovereignty.

### *Enact a Special Jurisdiction:*

- ***Enact legislation that extends special criminal jurisdiction to Tribal governments, akin to the provisions in the Violence Against Women Reauthorization Act of 2022 for domestic violence, to include drug offenses by non-Indians.***
- ***Provide for the necessary resources and support to Tribal justice systems to ensure they have the capacity to enforce these laws effectively.***
- ***Establish intergovernmental collaboration mechanisms to facilitate cooperation between Tribal, state, and federal law enforcement agencies in combating drug trafficking.***

The Lummi Nation has a draft bill to address these jurisdictional challenges.