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EXAMINING THE TRUE COSTS OF ALCOHOL AND DRUG ABUSE IN NATIVE COMMUNITIES

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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EXAMINING THE TRUE COSTS OF ALCOHOL AND DRUG ABUSE IN NATIVE COMMUNITIES

WEDNESDAY, JULY 29, 2015

U.S. SENATE,
COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m. in room 628, Dirksen Senate Office Building, Hon. John Barrasso, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. JOHN BARRASSO, U.S. SENATOR FROM WYOMING

The CHAIRMAN. Good afternoon. I call this hearing to order.

Before we begin, I want to welcome Ms. Sunny Goggles to the hearing. Ms. Goggles serves her community in many roles. She is a member of the Northern Arapaho Tribe and the Director of the White Buffalo Recovery Center on the Wind River Indian Reservation in Wyoming. She also serves on the Tribal Committee for the National Association of Drug Court Professionals. Welcome.

Tribal leaders from both tribes in the Northern Arapaho and the Eastern Shoshone and the Wind River Indian Reservation have remarked favorably on her leadership, on her strength and on her capabilities. Those character traits were put to the test when a recent terrible, tragic crime affected those very close to her and to the entire community. Our hearts and thoughts go out to you, to your family and to the community. Thank you for serving your community and for being here with us today.

This month, we have examined many difficult topics. Today is no different. We will receive testimony regarding the true costs of alcohol and drug abuse in Native communities. Over the past five years, this Committee has held five hearings related to alcohol and drug abuse. This past March on the Wind River Indian Reservation, in my home State of Wyoming, this Committee held a field hearing on addressing the harmful effects of dangerous drugs. Nearly every single witness testified how the abuse of alcohol and drugs had serious and often tragic effects on Indian communities.

Alcohol is noted to be a contributing factor in a significantly high number of crimes. It is also a contributing factor in too many deaths on the Wind River Reservation. According to the Indian Health Service, the average life span for Indians is 73 years. On the Wind River Reservation, the average age at death has for years hovered around 49 years of age. These premature deaths are due primarily to alcohol and alcohol-related injuries.

I am astonished that both the Substance Abuse and Mental Health Services Administration and the Indian Health Service are not doing more to change that death rate. I am also astonished that the Substance Abuse and Mental Health Services Administration, the agency devoted entirely to substance abuse and mental health, failed to submit its testimony on time. This has been a bipartisan concern for those of us on this Committee. The testimony that was submitted does little more than recite basic information included on the agency's website. The testimony doesn't even explain what the agency is actually doing to address alcohol and drug abuse in Indian Country. Frankly, this reflects a troubling lack of seriousness and commitment to the important issues we are examining here today and it is completely unacceptable.

The many devastating impacts drugs and alcohol have had on Indian communities warrant our heightened attention. As a physician, I am especially troubled by the needless, preventable injuries and the deaths that often result from alcohol and drug abuse. These tragedies can take an immeasurable toll in individuals, families and communities.

So as we focus on the issue before us today, while we must examine the financial burdens associated with alcohol and substance abuse, it is important to remember that the full cost of abuse cannot be measured in dollars and cents. In 2011, the Justice Department estimated that the total cost of alcohol and drug abuse in the United States exceeded $600 billion a year. Again, this is only part of the picture. The other financial, societal, systemic and individual costs of substance abuse are high.

The National Institute on Drug Abuse states that these costs include unemployment, poor educational outcome, domestic violence, child abuse, motor vehicle accidents and death. Substance abuse is also associated with homicide, suicide and family breakdown.

The impact of abuse is even worse in Indian Country, where one in ten deaths is alcohol-related. Compared to the general U.S. population, Native Americans in Indian Country are also twice as likely to live in poverty and experience two and a half times the general rate of violent victimization. This group has a shorter life expectancy and a higher infant mortality rate than the general population.

Research by the National Institute of Drug Abuse suggests that addiction to and abuse of alcohol and drugs is preventable. The testimony from the Committee field hearing on addressing the harmful effects of dangerous drugs suggested that by preventing or reducing alcohol abuse, crime could be reduced as well. If that is the case, we must work together to find realistic solutions that will prevent and treat substance abuse in Indian communities.

I am interested in hearing any solutions that target culturally competent prevention or treatment strategies for alcohol and drug abuse in Native communities. One thing is clear: there are not enough resources to address the high rates of abuse and addiction in Indian Country. These problems need to be mitigated, not intensified.

As we will hear today, Native communities need to understand that if they go down the road of legalizing marijuana, it will come

at a great cost. The resulting health care costs alone would be crushing and have an impact on all of Indian Country.

I want to welcome our witnesses, and I look forward to hearing from each of them. But before we hear from the panel, I want to ask the Vice Chairman, Senator Tester, if he has an opening statement.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Thank you, Mr. Chairman, and thank you for holding this hearing today on the harmful impacts of drugs and alcohol abuse have had and continue to have in Native communities.

While we are focused on the true costs of drug and alcohol abuse, including the devastating economic impacts that these behaviors have in Native communities, I think it is vital that we look beyond the economics of this issue. I know that it is the human cost that most of Indian Country is focused on at this point in time. It is the babies that are born addicted to drugs or that are that are developmental impacted by alcohol, it is the children who are separated from their mothers and fathers because of the pull of drugs and alcohol. It is the youth who begin experimenting with these substances far too early in life and often lose themselves and sacrifice their future.

There are real human costs that are devastating Indian Country. I think everyone on this Committee is well aware of the impacts that drug and alcohol abuse has wreaked in our Native communities, especially on our Native youth. We sit here week in, week out, and hear about how our kids are dropping out of schools, living in unsafe housing and engaging in risky behaviors, largely because, quite frankly, they lack alternatives. Our youth and many others in Native communities are turning to drugs and alcohol to escape from the harsh realities of their life. Addiction becomes a new reality for many of these communities.

Drug and alcohol abuse is a problem, there is no question about it. Yet these are issues that are entirely preventable. They are also issues that impact every Federal agency that plays a role in Indian Country. That is why I am glad to see our friends are here from the Indian Health Service and from SAMHSA to testify on what the Federal Government is doing to prevent substance abuse.

I am also pleased that we will hear from folks in the field and on the ground who are working to prevent the loss of another generation of our children to drugs and alcohol. We all know that it will take the work of those in our Native communities to truly break the cycle of addiction that continues to plague too many families.

But those on the ground cannot do it alone. They need the support and resources to carry out the programs to combat these problems. They must do a better job ensuring that the resources get to the ground in Indian Country.

I look forward to hearing the testimony of the witnesses this afternoon. I want to thank you all for the work you do and I look forward to hearing some of the solutions to the crisis that is robbing Indian Country of current and future generations.

Finally, I would just like to say, all of you have great names. Bob McSwain, Mirtha Beadle, Melanie Benjamin, John Walters. But nobody has a name like Sunny Goggles.

[Laughter.]

Senator TESTER. Thank you all for being here.

Senator FRANKEN. Actually, Melanie Benjamin means Sunny Goggles in Ojibwe.

[Laughter.]

The CHAIRMAN. Would any other members like to make an opening statement? Any opening comments?

Senator FRANKEN. May I follow up?

The CHAIRMAN. You may follow yourself, yes, thank you.

STATEMENT OF HON. AL FRANKEN,
U.S. SENATOR FROM MINNESOTA

Senator FRANKEN. I would like to introduce Melanie, who again, in Ojibwe, her name means Sunny Goggles.

[Laughter.]

Senator FRANKEN. Senator Barrasso, Vice Chairman Tester, thank you for holding today's hearing on substance abuse in Indian Country, a tragic subject. I am proud to introduce Melanie Benjamin, who is Chief Executive of the Mille Lacs Band of Ojibwe, as a witness to this Committee.

Right now, tribes in Minnesota face a public health crisis. Melanie knows the devastating impact that opiate abuse is having on the Mille Lacs Band and on other tribes and bands in Minnesota. The impact on mothers and on children is especially sobering. Melanie is dedicated to addressing this crisis, and she has been working with other tribal leaders in our State to develop a response that incorporates both prevention and treatment.

Last year, tribal leaders in Minnesota convened at the Bois Forte Reservation for a summit on the future of Indian children. This May, the Mille Lacs Band hosted a second summit where these leaders continued to discuss and work toward effective solutions. Tribes in Minnesota are working cooperatively to respond to this major public health problem. Our role in Congress is to make sure we are doing all we can to support their work. I look forward to hearing Melanie's recommendations and learning what tribes need from the Federal Government from all our witnesses today, so we can fully address substance abuse. Melanie's testimony is going to be mainly on opiate abuse, which has become rampant.

Thank you, Mr. Chairman

The CHAIRMAN. Thank you, Senator Franken. Anyone else have an opening statement they would like to make, any comments? Hearing none, we will now hear from our witnesses. The first is the Honorable Robert McSwain, who is the Principal Deputy Director of the Indian Health Service, Department of Health and Human Services.

I want to thank all of you for being here. I want to remind the witnesses that your full written testimony will be made part of the official hearing today. So please try to keep your statements to under five minutes so that we may have time for questions. I look forward to hearing the testimony, beginning with Mr. McSwain. Please proceed.

STATEMENT OF HON. ROBERT G. MCSWAIN, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MCSWAIN. Mr. Chairman, members of the Committee, good afternoon. As noted, I am the Principal Deputy for Indian Health Service. Today I appreciate the opportunity to testify on examining the true costs of alcohol and drug abuse in Native communities.

As you know, the Indian Health Service plays a unique role in the Department of Health and Human Services to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives. Examining the true costs of alcohol, illicit and non-medical prescription drug use for Native communities is challenging, although we know it is substantial. In the absence of studies on the scope and cost of alcohol and drug abuse for Native communities, IHS depends largely on measures of prevalence, morbidity and mortality related to alcohol and drug abuse for American Indians and Alaska Natives.

In the fiscal year 2015 enacted budget for IHS, the alcohol and substance abuse program was slightly more than $190 million. Over 80 percent of that amount is contracted or compacted with tribes. The IHS program approach to addressing alcohol and substance abuse disorders in Native communities is to treat, the important feature is predominantly to treat alcohol and substance abuse disorders and treat individuals struggling with substance abuse disorders, train health care providers to treat substance use disorders in outpatient settings and intervene early before substance use disorder develops and prevent alcohol and drug use before it begins.

Compared with other racial groups, American Indian and Alaska Natives tend to begin using alcohol and drugs at a younger age, use them more often and in higher quantities and experience more negative consequences from them. A 2009 to 2012 study focusing on American Indian youth reveals alarming substance use patterns, including patterns of drug use beginning earlier than is typical for other Americans. For instance, 56.2 percent of American Indian eighth graders and 61.4 percent of American Indian tenth graders had used marijuana, compared to 16.4 percent of eighth graders and 33.4 percent of tenth graders nationally.

American Indian students annually, and we will hear more about that a little bit later, but annual heroin and OxyContin use is about two to three times higher than the national averages in those years. To help with the substance abuse for youth, the Indian Health Service has actually built ten youth regional treatment centers across the Country and is preparing to build two in California, bringing us to a total of 12. They provide a wide range of clinical services to provide treatment services rooted in culturally relevant and holistic models of care, including group, individual and family psychotherapy, life skills development, medication management, after-care relapse prevention and post-follow-up. We can talk more about this as well.

The important thing about the Indian Health Service is that we tend to serve small, rural populations with primary medical care. Then we rely on paying for care, or buying care, in the private sector through our purchase referred care. In FY 2014, IHS spent over

$5.8 million on inpatient admissions related to alcohol and substance abuse diagnoses. During the same period, over $12 million was expended for inpatient visits related to liver disease.

Workforce development is an IHS resource available to Federal and tribal care systems as an essential part, it is by having to build a staff. In addition to that, where we can't reach people, we have been implementing tele-behavioral health into the remote locations. We started this in 2008.

IHS' primary source of prevention funding through methamphetamine is the MSPI program, which some of you asked about the last time. The program funds 130 programs across the Indian Health Service. We have just sent out another invitation for new applications this year.

The Federal coordination, certainly the Tribal Law and Order Act signed into law by President Obama in July 2010 contains provisions that would actually have agencies work together. With the high rates and the academic failures as mentioned earlier by one of the members, the IHS is committed to partnering with the Committee, tribes and other Federal agencies and key stakeholders on further examining and addressing the true costs of alcohol and drug abuse in Native communities.

That ends my statement, Mr. Chairman. I am prepared to answer questions.

[The prepared statement of Mr. McSwain follows:]

PREPARED STATEMENT OF HON. ROBERT G. MCSWAIN, PRINCIPAL DEPUTY DIRECTOR, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman and Members of the Committee:

Good afternoon, I am Robert G. McSwain, Principal Deputy Director of the Indian Health Service. Today, I appreciate the opportunity to testify on "Examining the True Costs of Alcohol and Drug Abuse in Native Communities." As you know, the Indian Health Service (IHS) plays a unique role in the Department of Health and Human Services to meet the Federal trust responsibility to provide health care to American Indians and Alaska Natives. The IHS provides high-quality, comprehensive primary care and public health services through a system of IHS, Tribal, and Urban Indian operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The IHS has the responsibility for the delivery of health services to an estimated 2.2 million American Indians and Alaska Natives who belong to 566 Federally-recognized Tribes. The mission of the agency is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

Two major pieces of legislation are at the core of the Federal Government's responsibility for meeting the health needs of American Indians and Alaska Natives: The Snyder Act of 1921, 25 U.S.C § 13, and the Indian Health Care Improvement Act (IHCIA), 25 U.S.C. § § 1601–1683. The Snyder Act authorized appropriations for "the relief of distress and conservation of health" of American Indians and Alaska Natives. The IHCIA was enacted "to implement the Federal responsibility for the care and education of the Indian people by improving the services and facilities of Federal Indian health programs and encouraging maximum participation of Indians in such programs." Like the Snyder Act, the IHCIA provides the authority for the provision of programs, services, functions, and activities to address the health needs of American Indians and Alaska Natives. The IHCIA also includes authorities for the recruitment and retention of health professionals serving Indian communities, health services for people, and the construction, replacement, and repair of healthcare facilities.

Introduction

The economic costs of alcohol and drug misuse are enormous. The Centers for Disease Control and Prevention estimated the costs of excessive alcohol consumption in 2006 to be $223.5 billion in lost productivity, healthcare, and criminal justice

costs.[1] According to the National Drug Intelligence Center, in 2007 alone, illicit drug use cost our Nation more than $193 billion in lost productivity, healthcare, and criminal justice costs.[2] However, examining the true costs of alcohol and illicit and nonmedical prescription drug use for Native communities is challenging, although we know it is substantial. In the absence of studies on the scope and costs of alcohol and drug misuse for Native communities, IHS depends largely on measures of prevalence, morbidity, and mortality related to alcohol and drug misuse for American Indians and Alaska Natives (AI/AN). In 2007–2009, the AI/AN age-adjusted death rates for the following causes were considerably higher than those for the U. S. all races population in 2008:[3]

- Alcohol related—520 percent greater;
- Chronic liver disease and cirrhosis—368 percent greater;
- Motor Vehicle Crashes—207 percent greater;
- Unintentional injuries—141 percent greater;
- Homicide—86 percent greater;
- Suicide—60 percent greater; and
- Firearm injury—16 percent greater.

While these data are staggering, IHS data have shown improvements in the age-adjusted alcohol-related death rate for AI/AN people in recent years with rates decreasing from 77.5 per 100,000 people between 1979–1981 to 49.6 in 2007–2009 per 100,000 population. However, the age-adjusted drug-related death rate for AI/AN residing in IHS service areas increased from 4.1 deaths per 100,000 in 1979–1981 to 22.7 in 2007–2009. By comparison, the 2007–2009 age-adjusted drug-related death rate is 1.8 times greater than the U.S. all races rate for 2008. These data speak to the need for a public health strategy, informed by Tribes, to address alcohol and drug use. The human cost is too great to ignore this problem.

IHS Alcohol and Substance Abuse Program

As alcohol and substance abuse treatment and prevention have transitioned from IHS direct care services to local community control via Tribal contracting and compacting, IHS' role has transitioned from primarily providing direct services to providing funding, training, and technical assistance to enable communities to plan, develop, and implement culturally-informed programs. The Fiscal Year (FY) 2015 enacted budget for the IHS Alcohol and Substance Abuse Program (ASAP) was slightly more than $190 million. Over 80 percent of the ASAP budget is contracted or compacted by Tribes. The IHS ASAP approach to addressing alcohol and substance use disorders in Native communities is to treat AI/AN individuals struggling with substance use disorders; train healthcare providers to treat substance use disorders in outpatient settings and intervene early before substance use disorder develops; and prevent alcohol and drug use before it begins.

Treat Individuals Struggling with Substance Use Disorders

Compared with other racial/ethnic groups, AI/AN tend to begin using alcohol and drugs at a younger age, use them more often and in higher quantities, and experience more negative consequences from them. A 2009–2012 study focusing on American Indian youth reveals alarming substance use patterns, including patterns of drug use beginning much earlier than is typical for other Americans.[4] For instance, 56.2 percent of American Indian 8th graders and 61.4 percent of American Indian 10th graders had used marijuana, compared to 16.4 percent of 8th graders and 33.4 percent of 10th grade students nationally.[5] American Indian students' annual heroin and OxyContin use was about two to three times higher than the national averages in those years.[6]

To help youth with substance use disorder, IHS funds ten Youth Regional Treatment Centers (YRTCs). The YRTCs provide a range of clinical services to provide

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[1] Available at: *http://www.cdc.gov/features/alcoholconsumption/*

[2] National Drug Intelligence Center. (2010). National threat assessment: the economic impact of illicit drug use on American society. Department of Justice. Washington, D.C.

[3] Indian Health Service. (2015). Trends in Indian Health 2014 Edition. Available at: *https://www.ihs.gov/dps/includes/themes/newihstheme/display_*objects/documents/Trends2014Book508.pdf

[4] Stanley, L., Harness, S., Swaim, R., & Beauvais, F. (2014). Rates of substance use of American Indian students in 8th, 10th, and 12th grades living on or near reservations: update, 2009–2012. *Public Health Report,* Mar-Apr; 129(2): 156–63.

[5] *Ibid.*

[6] Stanley, L., Harness, S., Swaim, R., & Beauvais, F. (2014). Rates of substance use of American Indian students in 8th, 10th, and 12th grades living on or near reservations: update, 2009–2012. *Public Health Report,* Mar-Apr; 129(2): 156–63.

treatment services rooted in culturally relevant, holistic models of care including group, individual, and family psychotherapy, life skills development, medication management, aftercare relapse prevention, and post-treatment follow up. YRTCs also provide education, culture-based prevention activities, and evidence- and practice-based models of treatment to assist youth in overcoming their challenges and to become healthy, strong, and resilient community members.

The IHS and Tribes primarily serve small, rural populations with primary medical care and community-health services, relying on the private sector for much of the secondary and most of the tertiary medical care needs through the Purchased/Referred Care (PRC) program, including treatment for alcohol and substance use. In FY 2013, the total rate of alcohol-related discharge diagnoses for IHS and Tribal direct and contract hospital was 11.6 per 10,000 user population aged 15 years or older. This is 19 percent lower than the Calendar Year (CY) 2013 discharge diagnosis rate of 14.1 for U.S. Short Stay hospitals. In FY 2014, IHS PRC spent over $5.8 million on inpatient admissions related to alcohol and substance use diagnoses. During the same time period, over $12 million was expended for inpatient visits related to liver disease. It is important to note that the PRC dollars spent on inpatient admissions are likely an underrepresentation of the actual costs of treatment for alcohol and substance use disorders as this number represents PRC expenditures from Federal programs only and not tribal programs that are not required to report their expenditures to IHS.

Train Healthcare Providers to Identify Substance Use and Intervene Early

Workforce development is an IHS resource available to Federal and tribal healthcare systems as an essential part of effectively addressing mental health and substance use disorder issues in AI/AN communities. Established in 2008, the IHS Tele-Behavioral Health Center of Excellence (TBHCE), in partnership with the University of New Mexico Center for Rural and Community Behavioral Health, provides workforce training and tele-behavioral health services. The prevention and treatment of alcohol and substance use disorders is reinforced by connecting widely separated and often isolated programs of varying sizes together into a network of support. Whereas small clinics would need to develop separate contracts for addiction services, the TBHCE is able to provide more cost-effective specialty care conveniently located within the clinics where patients utilize services. IHS and Tribal programs are increasingly adopting and using these technologies, with more than 8,000 encounters provided via tele-behavioral health in FY 2014. Specific to addiction psychiatry, the TBHCE provided 868 hours of direct care via tele-behavioral health. In the same timeframe, the TBHCE hosted trainings on substance misuse and prevention related topics for the Indian health system as a means to increase competent health care providers to treat substance use disorder in outpatient settings and intervene early before a substance use disorder develops. Training topics included: opioid use disorder; essential training on proper pain management; using non-opioid pain medication for chronic non-cancer pain; and medication management for pain: opiate analgesics and safe prescribing. These trainings had more than 8,000 participants.

Screening, Brief Intervention, Referral to Treatment (SBIRT) is a comprehensive approach for early intervention and treatment for people with substance use disorders and those at risk of developing these disorders. IHS is broadly implementing SBIRT as an evidence-based practice designed to identify, reduce, and prevent problematic use, substance use disorders, and dependence on alcohol. SBIRT is a payable service under state Medicaid plans, while Medicare pays for medically reasonable and necessary SBIRT services in the physician office setting and outpatient hospitals through the Medicare Physician Fee Schedule or the hospital Outpatient Prospective Payment System. Another activity IHS is developing/promoting is Medication Assisted Treatment (MAT) for opioid use disorder, which uses Food and Drug Administration approved pharmacological treatments, in combination with psychosocial treatments. IHS will continue to provide the necessary MAT training through its TBHCE.

Prevent Alcohol and Drug Use Before It Begins

IHS' primary source of prevention funding is through the Methamphetamine and Suicide Prevention Initiative (MSPI), established in 2009. The MSPI currently funds 130 IHS, Tribal, and Urban Indian Health Programs (UIHPs) in a nationally coordinated six-year demonstration pilot project. The MSPI promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine use and suicide prevention from a community-driven context. The MSPI primarily focuses on treatment for methamphetamine under provision of the appropriations language; how-

ever, during the evaluation of MSPI, data revealed a need for prevention strategies to reduce the use of marijuana, alcohol, prescription drugs, and other substances.

From 2009 to 2014, the MSPI resulted in over 9,400 individuals entering treatment for methamphetamine use; more than 12,000 substance use and mental health encounters via telehealth; over 13,150 professionals and community members trained in suicide crisis response; and more than 528,000 encounters with youth provided as part of evidence-based and practice-based prevention activities.[7] The demonstration pilot project phase ends on August 31, 2015. On July 8, 2015, IHS announced the FY 2015 MSPI funding opportunity, which will be a $13.5 million five-year funding cycle to continue the planning, development, and implementation of the MSPI. In the new funding announcement, eligible applicants will be able to focus on alcohol and drug use and suicide prevention strategies for Native youth.

The high prevalence of alcohol and other substance use rates in Native communities, especially among AI/AN youth, alerts us to the urgency of implementing prevention programs to intervene at an earlier age. The FY 2016 President's Budget includes key investments to support the Generation Indigenous Initiative, which takes a comprehensive, culturally appropriate approach across the Federal Government that will help ensure that Native youth can reach their full potential. The request for the Tribal Behavioral Health Initiative for Native Youth is a total of $50 million in additional funding for IHS and the Substance Abuse and Mental Health Services Administration (SAMHSA). Within IHS, the request includes $25 million to expand the successful MSPI to increase the number of child and adolescent behavioral health professionals who will provide direct services and implement youth-based programming at IHS, tribal, and urban Indian health programs, school-based health centers, or youth-based programs.

Federal Coordination to Address Indian Alcohol and Substance Use Disorders

The Tribal Law and Order Act (TLOA), signed into law by President Obama in July 2010, contains provisions expanding the number of Federal agencies that are required to coordinate efforts on alcohol and substance use issues in Indian Country. Agencies included in coordinated efforts are the IHS, Department of Justice (DOJ), and SAMHSA, along with the Department of Interior (DOI) Bureau of Indian Affairs (BIA) and Bureau of Indian Education (BIE). A key provision of TLOA directs SAMHSA to take the lead role in interagency coordination and collaboration on tribal alcohol and substance use programs through the establishment of an Office of Indian Alcohol and Substance Abuse.

The permanent reauthorization of Indian Health Care Improvement Act (IHCIA) required the review and update of an existing memorandum of agreement (MOA) from 2009 between IHS and the DOI BIA and BIE on Indian Alcohol and Substance Abuse Prevention. This MOA serves as the formal mechanism to advance IHS' partnership with Federal agencies to assist Tribes in addressing behavioral health issues among Indians, specifically mental illness and dysfunctional and self-destructive behavior, including substance misuse, child abuse, and family violence.

Conclusion

A wide variety of healthcare costs are associated with alcohol and substance use disorders, including hospital costs from injuries, illnesses, residential and outpatient treatment costs, pharmaceutical costs, nursing home and long-term facility costs, and the cost of treating Fetal Alcohol Syndrome, HIV/AIDS, and hepatitis B and C. Given the high rates of alcohol and substance use-related problems on reservations, such as academic failure, delinquency, violent criminal behavior, suicidality, and alcohol-related mortality, the costs to Native communities will continue to be far too high, indicating that a comprehensive public health strategy aimed at primary prevention and early intervention of alcohol and drug use in Native communities is essential. This approach must be a coordinated response, guided by Tribes, that has impacts beyond the Indian health system, including research of root causes, poverty, unemployment, unstable housing, education, food insecurity, and community infrastructure. IHS is committed to partnering with the committee, Tribes, other Federal agencies, and key stakeholders on further examining and addressing the true costs of alcohol and drug use in Native communities.

The CHAIRMAN. Thank you very much, Director McSwain.

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[7] U.S. Department of Health and Human Services. Indian Health Service, Division of Behavioral Health. *http://www.ihs.gov/mspi/aboutmspi/*

Next is Mirtha Beadle, who is the Director of the Office of Tribal Affairs and Policy, Substance Abuse and Mental Health Services Administration, Rockville, Maryland. Thank you, welcome and please proceed. ″

STATEMENT OF MIRTHA BEADLE, DIRECTOR, OFFICE OF TRIBAL AFFAIRS AND POLICY, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. BEADLE. Thank you, Chairman Barrasso, Ranking Member Tester and members of the Senate Committee on Indian Affairs. Thank you for inviting me to testify at this very important hearing on substance use and substance use disorders in Native communities.

As the Chairman said, my name is Mirtha Beadle. I am the Director of the Office of Tribal Affairs and Policy within the Substance Abuse and Mental Health Services Administration.

As you are aware, SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA's Office of Tribal Affairs and Policy, or OTAP, as we refer to it, serves as a primary point of contact for tribal governments, tribal organizations, Federal agencies and other entities as well. The Office of Indian Alcohol and Substance Abuse, or OIASA, is an organizational component of OTAP and is charged with improving Federal coordination amongst a number of agencies and carrying out specific requirements of the Tribal Law and Order Act.

In November, 2014, SAMHSA held its very first cross-agency tribal grantee conference. The focus was on empowering Native youth. We were pleased to have Ranking Member Tester participate in that important event. I have to tell you that more than 125 youth participated in that conference. Their top concerns were alcohol and substance use. Nearly 75 percent of American Indians and Alaska Native treatment admissions reported alcohol as a substance of abuse compared to about 56 percent of non-American Indian and Alaska Native admissions.

Through CDC data, we also know that American Indians and Alaska Natives are more likely than other racial-ethnic groups in the U.S. to die from drug-induced deaths.

SAMHSA provides and supports vital technical assistance to tribes to address substance use and substance use disorders. For example, the SAMHSA Tribal Training and Technical Assistance Center supports Native communities with infrastructure development, capacity building, program planning implementation and also training. We also have SAMHSA's Fetal Alcohol Spectrum Disorders Center for Excellence, a Native initiative, which educates and trains policy makers and providers, caregivers and communities, individuals and families, on preventing alcohol-exposed pregnancy and improve the lives of individuals affected by FASD.

SAMHSA helps to support American Indians and Alaska Natives. It is a priority for the agency. In fiscal year 2014, Congress appropriated for the first time $5 million to begin the Tribal Behavioral Health Grant program. Twenty grants were awarded in fiscal year 2014. We had grantees such as Turtle Mountain Band of Chippewa, Pueblo of Nambe, and they are working across tribal

suicide prevention, mental health, substance use prevention and substance use disorder treatment, to build positive behavioral health in their communities.

The President's fiscal year 2016 budget for the Tribal Behavioral Health Grant is $30 million. That will allow the agency to expand support to approximately 103 additional tribes.

The House Appropriations Committee fully funds the Tribal Behavioral Health Program for fiscal year 2016 at the requested level of $30 million. However, the Senate Appropriations Committee level-funds the Tribal Behavioral Health Grant Program for 2016 at just under $5 million.

The Strategic Prevention Framework-State Incentive Grant program supports the development of comprehensive plans for prevention and infrastructure development, system development and is providing funds to a number of important tribal communities, including the Confederated Salish and Kootenai Tribes, the Leech Lake Band of Ojibwe, Nooksack Indian Tribal Council, Northern Arapahoe Tribe, Oklahoma City Inter-Tribal Health Board and several other grantees as well.

The Substance Abuse and Mental Health Services Administration also has a grant program called the Strategic Prevention Framework that has been very vital for tribal communities. That program funds a number of tribes as well, such as Cook Inlet Council, the Montana-Wyoming Tribal Leaders Council and Cherokee Nation.

I have to say that SAMHSA also is involved in a number of important treatment drug court programs. The intent here is to break the cycle of criminal behavior, alcohol and substance use and incarceration, including among Native American populations. In fiscal year 2014, the Juvenile Treatment Drug Courts Program and also through the adult Tribal Healing to Wellness Program, we funded a number of tribes including the Lac Du Flambeau Band of Chippewa, Mescalaro Tribe and also Lower Brule Sioux Tribal Council.

We thank you for the opportunity to discuss SAMHSA's efforts to address the issue of substance use and we are happy to take any questions that you may have. Thank you for the time.

[The prepared statement of Ms. Beadle follows:]

PREPARED STATEMENT OF MIRTHA BEADLE, DIRECTOR, OFFICE OF TRIBAL AFFAIRS AND POLICY, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Barrasso, Ranking Member Tester, and members of the Senate Committee on Indian Affairs, thank you for inviting me to testify at this important hearing on substance use and substance use disorders in Native Communities. My name is Mirtha Beadle, and I am the Director of the Office of Tribal Affairs and Policy within the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (HHS).

We all know that substance use and substance use disorders are some of the most severe public health and safety problems facing American Indian and Alaska Native (AI/AN) individuals, families, and communities and more must be done to diminish the devastating social, economic, physical, and mental consequences.

SAMHSA's work with AI/AN populations is rooted in the belief that tribes know best how to solve their own problems through prevention, treatment, and recovery activities and engaging with and strengthening community partnerships. In addition, SAMHSA's work with tribal communities supports behavioral health and wellness through culturally-tailored programs and initiatives that value tribal beliefs. SAMHSA also offers help in real time to tribes and grantees as they work to

advance substance use prevention, mental health promotion, and behavioral health treatment programs.

In November 2014, SAMHSA held its first cross-agency tribal grantee conference. The focus of the conference was on empowering Native youth through leadership and behavioral health workshops and to engage them in a dialogue about behavioral health. SAMHSA was pleased that Ranking Member Tester was able to speak at this important event at which more than 125 youth participated and shared challenges and opportunities for improving the behavioral health of their peers and communities. At the top of their list were concerns around alcohol and substance use and a range of social and economic problems, including unemployment, poor educational outcomes, poor housing, and insufficient access to behavioral health services. SAMHSA will continue efforts to support positive development of tribal youth through additional training opportunities.

SAMHSA

As you are aware, SAMHSA's mission is to reduce the impact of substance use and mental illness on America's communities. SAMHSA envisions a nation that acts on the knowledge that:

- Behavioral health is essential for health;
- Prevention works;
- Treatment is effective; and
- People recover from mental and substance use disorders.

In order to achieve this mission, SAMHSA has identified six Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. SAMHSA's Strategic Initiatives are: Prevention of Substance Abuse and Mental Illness; Health Care and Health Systems Integration; Trauma and Justice; Recovery Support; Health Information Technology; and Workforce Development.

Office of Tribal Affairs and Policy (OTAP)

SAMHSA's OTAP serves as SAMHSA's primary point of contact for tribal governments, tribal organizations, Federal departments and agencies, and other governments and agencies on behavioral health issues facing AI/AN populations in the United States. OTAP supports SAMHSA's efforts to advance the development and implementation of data-driven policies and innovative practices that promote improved behavioral health for AI/AN communities and populations. The creation of OTAP brought together SAMHSA's tribal affairs, tribal policy, tribal consultation, tribal advisory, and Tribal Law and Order Act (TLOA) responsibilities to improve agency coordination and achieve meaningful progress. OTAP carries out its work in partnership with tribal nations and in collaboration with SAMHSA centers and offices, and other Federal agencies.

The Office of Indian Alcohol and Substance Abuse (OIASA) is an organizational component of OTAP. OIASA is required under TLOA to coordinate federal partners to provide tribes with technical assistance and identify resources to develop and enhance alcohol and substance use prevention and treatment programs.

Prevalence of Behavioral Health Conditions and Treatment

Alcohol and substance use, as well as mental health issues and suicide, continue to be among the most severe health and social problems AI/ANs face. According to SAMHSA's 2013 National Survey on Drug Use and Health (NSDUH), the statistics related to behavioral health conditions and treatment needs among the AI/AN populations are very troubling.

Substance Misuse and Abuse

- Though lower than in 2012, the rate of substance dependence or abuse among people aged 12 and up was still higher among the AI/AN population (14.9 percent) than among other racial/ethnic groups. [1]
- According to data from the 2011 Behavioral Risk Factor Surveillance System (BRFSS), AI/AN individuals have the second highest rate of binge alcohol use (18.2 percent) compared to white, non-Hispanic (21.2 percent), AI/ANs report the highest intensity of drinks per binge (8.4 drinks per binge episode) and the

[1] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings *http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf*

highest frequency of binge drinking episodes (4.5 during the past 30 days) compared with other racial/ethnic groups. [2]

- The rate of tobacco use among the AI/AN population (40.1 percent) is higher than all other racial/ethnic groups. [3]
- American Indians and Alaska Natives are also more likely than other racial/ethnic groups in the United States to die from drug-induced deaths (17.1 per 100,000 people), according to 2010 National Vital Statistics System data reported in a 2013 Centers for Disease Control and Prevention (CDC) report on U.S. health disparities and inequities. [4]

Substance Abuse Treatment [5]

- 76.6 percent (33,401) of AI/AN treatment admissions reported alcohol as a substance of abuse. By comparison, 56.2 percent of non-AI/AN admissions reported alcohol as a substance of abuse.
- Among admissions aged 15 to 24, 68.5 percent (6,885) of AI/AN admissions reported alcohol as a substance of abuse. In the same age group, 45.2 percent of non-AI/AN admissions reported alcohol as a substance of abuse.

Improving Practice

SAMHSA, as the Federal agency that leads public health efforts to advance the behavioral health of the nation, has several roles. I just spoke about the ways in which SAMHSA provides leadership and voice and supports the behavioral health field with critical data from national surveys and surveillance. SAMHSA also has a vital role in collecting best practices and developing expertise around prevention and treatment for people with mental illness and substance use disorders. SAMHSA's staff includes subject matter experts that provide technical assistance and training to individuals, organizations, states, tribes, and others every day.

The SAMHSA Tribal Training and Technical Assistance (TTA) Center uses a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development and capacity building, as well as program planning and implementation. It provides training and technical assistance on mental and/or substance use disorders, suicide prevention, and mental health promotion. It also offers training and technical assistance, ranging from broad to focused, to federally recognized tribes, SAMHSA tribal grantees, and tribal organizations serving Indian country.

SAMHSA funds the National American Indian and Alaska Native Addiction Technology Transfer Center (ATTC), one of four National Focus Area ATTCs. The primary goal of the Center is to serve as a subject matter center of excellence in technology transfer for the AI/AN behavioral health workforce. The Center and the ATTC Network as a whole are charged with providing training and technical assistance to the behavioral health workforce. Building on the Network's experience and evolution over the last 20 years, the Center is working with AI/AN behavioral health providers, peoples, organizations and communities to help develop and deliver effective culturally-relevant professional development and behavioral health services.

The National Native Children's Trauma Center (NNCTC) is funded by SAMHSA under the National Child Traumatic Stress Initiative to provide national expertise on childhood trauma among AI/ANs. NNCTC works in collaboration with Indian Health Service (IHS) providers, tribal leadership, and other representatives in tribal communities to utilize evidence-based, culturally-appropriate, trauma-informed interventions for AI/AN children, youth, and military families who experience disproportionate childhood trauma, violence, grief, poverty, historical and intergenerational trauma. The Center serves as a national resource for consultation for AI/AN youth programming with a particular focus on working with school communities across the United States.

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[2] Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report—United States, 2013. MMWR 2013;62(Suppl 3):[77–80] *http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a13.htm*

[3] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings (*http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf)*

[4] CDC Morbidity and Mortality Weekly Report (MMWR) *http://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a27.htm?s__cid=su6203a27__w#x2014;%20United%20States,%201999–2010)*

[5] Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (2012 data).

SAMHSA's Center for the Application of Prevention Technologies (CAPT) Training and Technical Assistance Services is a national substance abuse prevention training and technical assistance system dedicated to strengthening prevention systems and the nation's behavioral health workforce. Nationwide, SAMHSA's CAPT provides state-of-the-science training and technical assistance to tribes supported under SAMHSA's Strategic Prevention Framework and its Substance Abuse Prevention and Treatment Block Grant programs, as well as to tribal epidemiological workgroups and innovative local programs participating in SAMHSA's Service to Science Initiative. Tribal governments are not required to waive sovereign immunity as a condition of receiving SAMHSA block grant funds or services.

SAMHSA's Fetal Alcohol Spectrum Disorders (FASD) Center for Excellence (CFE) Native Initiative promotes prevention of FASD in Indian country. Native Americans have some of the highest rates of alcohol-related birth defects in the nation. The FASD CFE works across multiple disciplines to educate and train policymakers and providers, caregivers and communities, and individuals and families on how to help prevent alcohol-exposed pregnancy and improve the lives of individuals affected by FASD.

Public Awareness and Support

As part of SAMHSA's highly successful "Talk. They Hear You." underage drinking prevention campaign, a promotion video was recorded with Rod Robinson, the former Director of SAMHSA's Office of Indian Alcohol and Substance Abuse. In the video, Mr. Robinson discusses materials developed to help prevent and reduce underage drinking in American Indian communities, and he responds to questions such as why underage drinking is an important concern for American Indian populations. He also communicates ways in which the "Talk. They Hear You." materials will help parents and adult caregivers address underage drinking within tribal communities. The video is available on SAMHSA's You Tube channel.

Strategic Grant Making

Tribal Behavioral Health Grants

SAMHSA has made helping American Indians and Alaska Natives a priority. For several years, the President's Budget for SAMHSA had requested funding for a new program specifically focused on tribal communities to address the high incidence of substance use and suicide in AI/AN youth and young adult populations. In Fiscal Year (FY) 2014, Congress appropriated for the first time $5 million to begin such a program, Tribal Behavioral Health Grants (TBHG). In FY 2014, SAMHSA awarded 20 Tribal Behavioral Health grants to tribes or tribal organizations with high rates of suicide to develop and implement a plan that addresses suicide and substance use (including alcohol) and is designed to promote mental health among tribal youth. Grantees such as the Selawik Village Council in Alaska, the Turtle Mountain Band of Chippewa Tribe in North Dakota, and the Pueblo of Nambe in New Mexico, indicated in their applications how they will incorporate evidence-based, culture-based, and practice-based strategies for tribal youth. Grantees are required to work across tribal suicide prevention, mental health, substance use prevention, and substance use disorder treatment programs to build positive behavioral health among youth Grantees will create or enhance effective systems of follow up for those identified at risk of suicide and/or substance use or mental health issues that could lead to suicide. With a focus on tribal traditions, interagency collaboration, early identification, community healing, and preventing future deaths by suicide, grantees connect appropriate cultural practices, intervention services, care, and information with families, friends, schools, educational institutions, correctional systems, substance use programs, mental health programs, foster care systems, and other support organizations for tribal youth. Attention to the families and friends of tribal community members who recently died by suicide is encouraged as well. In addition, technical assistance is provided to grantees through SAMHSA's Tribal Technical Assistance Center to support their ability to achieve their goals.

The President's FY 2016 Budget for the TBHG program is $30 million, including $15 million in the Mental Health appropriation and $15 million in the Substance Abuse Prevention appropriation. This request represents an increase over the FY 2015 Enacted Level of $10 million in the Mental Health appropriation and $15 million for a newly established line in the Substance Abuse Prevention appropriation. This funding expands work supporting Generation Indigenous, an initiative focused on removing possible barriers to success for Native youth. This initiative will take a comprehensive, culturally appropriate approach to help improve the lives and opportunities for Native youth. In addition to HHS, multiple agencies including the Departments of Interior, Education, Housing and Urban Development, Agriculture, Labor, and Justice, are working collaboratively with tribes to address issues facing

Native youth. The FY 2016 Budget would allow SAMHSA to expand activities that are critical to preventing substance use and promoting mental health and resiliency among youth in tribal communities. The additional funding would expand these activities to approximately 103 additional tribes and tribal entities. With the expansion of the TBHG program, SAMHSA aims to reduce substance use and the incidence of suicide attempts among tribal youth and to address behavioral health conditions which impact learning in Bureau of Indian Education-funded schools. The TBHG program will support mental health promotion and substance use prevention activities for high-risk tribal youth and their families, enhance early detection of mental and substance use disorders among tribal youth, and increase referral to treatment.

The House Appropriations Committee (House Report 114–195) fully funds the THBG program for FY 2016 at the requested level of $30 million. However, the Senate Appropriations Committee (Senate Report 114–74) level funds the TBHG program for FY 2016 at just under $5 million.

Strategic Prevention Framework-State Incentive Grant (SPF–SIG) Program

The Strategic Prevention Framework-State Incentive Grant (SPF–SIG) program supports activities to help states and tribes build a solid foundation for delivering and sustaining effective substance use prevention services and reducing the consequences of substance use. Following the SPF five-step process, SPF–SIG grantees develop comprehensive plans for prevention infrastructure and systems at the state and tribal levels. Ultimately, SPF–SIG States/Tribes assist and support selected sub-recipient communities to implement effective programs, policies, and practices to reduce substance use and its related consequences. The SPF–SIG program provides the foundation for success of the SPF—Partnerships for Success (PFS) Grant Program. Grantees include: Confederated Salish & Kootenai Tribes (Montana); First Nation Community Healthsource (New Mexico); Leech Lake Band of Ojibwe (Minnesota); Nooksack Indian Tribal Council (Washington); Northern Arapahoe Tribe (Wyoming); Oklahoma City Area Inter-Tribal Health Board; Tanana Chiefs Conference, Inc. (Alaska); and Oglala Sioux Tribe and Lower Brule Sioux Tribe (South Dakota).

Strategic Prevention Framework—Partnerships for Success State and Tribal Initiative (SPF–PFS)

The Strategic Prevention Framework—Partnerships for Success State and Tribal Initiative (SPF–PFS) grant program was initiated in FY 2009 and one of its targeted goals is to help young American Indians and Alaska Natives with reducing substance use-related problems; preventing the onset and reducing the progression of substance use disorders; strengthening prevention capacity and infrastructure at the state and community levels in support of prevention; and leveraging, redirecting, and realigning statewide funding streams for substance use prevention. Since FY 2012, the SPF–PFS program has concentrated on addressing two of the nation's top substance use prevention priorities: (1) underage drinking among persons aged 12 to 20; and (2) nonmedical prescription drug use among persons aged 12 to 25. In 2014, SAMHSA funded all five tribal applicants for the SPF–PFS program. The grantees include: Cook Inlet Tribal Council in Alaska; the Montana Wyoming Tribal Leaders Council; and the Cherokee Nation in Oklahoma.

Criminal Justice and Juvenile Justice

SAMHSA is committed to enhancing substance use treatment services in existing adult tribal healing-to-wellness courts and in all juvenile treatment drug courts. SAMHSA's Treatment Drug Courts grant program aims to break the cycle of criminal behavior, alcohol and/or substance use, and incarceration, including among Native Americans. The purpose of this program is to expand and/or enhance substance use treatment services in existing adult Tribal Healing to Wellness Courts and in any Juvenile Treatment Drug Courts, which use the treatment drug court model in order to provide alcohol and substance use disorder treatment (including recovery support services, screening, assessment, case management, and program coordination) to justice-involved individuals. With respect to the Juvenile Treatment Drug Courts program, in FY 2014, SAMHSA awarded a three-year grant to the Omaha Tribe of Nebraska. In addition, SAMHSA funded all three tribal applicants for the adult Tribal Healing to Wellness Courts in FY 2014. The grantees include: Lac Du Flambeau Band of Chippewa Indians (Wisconsin); Mescalero Apache Tribal Council (New Mexico); and Lower Brule Sioux Tribal Council (South Dakota).

Nonmedical Prescription Drug Use and Opioid Use Disorder Treatment

Nonmedical use of prescription medications takes a devastating toll on public health and safety. In 2013, NSDUH data showed that approximately 6.5 million

Americans aged 12 or older reported current non-medical use of prescription drugs. In 2013, among persons aged 12 or older, the rate of current illicit drug use was 12.3 percent among American Indians and Alaska Natives.[6] In response to this public health crisis, IHS established the Prescription Drug Abuse (PDA) workgroup and developed a multi-disciplinary task force to address six key focus areas: patient care, policy development/implementation, education, monitoring, medication storage/disposal, and law enforcement. SAMHSA and other Federal agencies have been active members of the IHS PDA workgroup in an effort to improve national coordination and collaboration. SAMHSA has national and regional resources that include: strategies for reducing nonmedical use of prescription drugs; prescriber and patient education; publications; prevention and early intervention; technical assistance; and prescription drug monitoring programs. The workgroup developed a PDA Resource Guide to support technical assistance, training and education for providers and communities.

SAMHSA is also leading a number of activities in support of the HHS Secretary's Opioid Initiative that focuses on three specific areas: opioid prescribing practices to reduce opioid use disorders; naloxone development, access, and distribution; and, medication-assisted treatment to reduce opioid use disorders and overdose. SAMHSA will be working with IHS to improve training in the use of medication-assisted treatment, the standard of care for opioid use disorders, by providers in AI/AN communities.

Supporting Successful Recovery

SAMHSA has also funded a number of programs that focus on recovery support in AI/AN communities. The Inter-Tribal Council of Michigan's "Anishnaabek Healing Circle, ATR Network" was funded to improve access to a full array of treatment and recovery supports through network of culturally competent providers. The grant focused on tribal youth aged 12 and older who were enrolled members of the federally recognized tribes in Michigan.

Conclusion

Thank you again for this opportunity to discuss SAMHSA's role in addressing the issue of substance use that is exacting significant health and economic tolls in Native communities. The issue is a major priority for SAMHSA, and recent activities such as the establishment of our OTAP underscore our dedication.

The CHAIRMAN. Thank you very much for your testimony. Now, Melanie Benjamin.

STATEMENT OF HON. MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE

Ms. BENJAMIN. Thank you, Mr. Chairman, Senator Franken and members of this Committee.

Like most tribes, our fight against alcohol addiction has been ongoing for more than a century as a byproduct of colonization. In the 1980s, crack and meth invaded our communities. My focus today is on a terrible family of drugs now hitting our Minnesota tribal communities, claiming our youngest and most precious as victims, our babies, our future.

Minnesota now leads the Nation in babies being born addicted to opiates. It is with profound sadness and concern that I report that my community is among the hardest hit. Babies born addicted to opiates are now the single greatest threat to the future of my band.

The opiate explosion in Minnesota is so new that there is a great deal of information we do not know yet. Here is what we do know. Prescription opiates, including Vicodin, OxyContin, Percoset, morphine and codeine are each a pathway to heroin use. Nearly, 100 percent of heroin addicts repot their addiction began with an opiate

[6] Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings *http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf*

prescription. More than 28 percent of the babies born addicted to opiates in Minnesota are Native Americans, even though we are only about 2 percent of the population.

Seventy-eight percent of opiate-addicted Indian babies are born in rural Minnesota. So this is more of a reservation problem. Indian women are 8.7 times more likely than non-Indians to be diagnosed with opiate dependency or abuse during pregnancy. Fifty-seven percent of these women have a legal opiate prescription for pain given to them by a doctor, even throughout pregnancy, 57 percent, Mr. Chairman.

The Mille Lacs Band is conducting a study that appears to show that our band members may be rapid metabolizers of many addictive drugs. This means that those who are addicted need more of the drug more frequently in order to maintain that effect, which means higher addiction rates. Babies born addicted to opiates go through horrifying withdrawal, struggling with pain, seizures, rapid breathing, sweating, trembling, vomiting, diarrhea, slow weight gain. They are at a high risk of premature birth and sudden infant death syndrome.

The financial costs are high. Last year 262 Indian babies were born with opiate addiction in Minnesota and cost about $8 million in medical care during withdrawal. That is about $30,000 per baby, and this is in the first year. But the social and financial costs continue to mount after their hospital stay. Most of these babies must be placed in foster care until the mother is able to care for them. But when the baby is removed, all the other children in the home are also usually removed as well.

Mr. Chairman, we simply do not have enough Native foster families to take in this high number of children, nor do we have enough resources. Their medical issues are complex and may include high rates of cerebral palsy and other serious complications, the same as with victims of fetal alcohol syndrome. FAS spending can average $2 million over the lifetime of a child.

My written statement goes into more detail about associated costs. But I want to close with providing you with some suggestions of what Congress can do. We need research to study this crisis. We must know more about the long-term impacts of newborn opiate addiction. We need funding for a culturally-based treatment center for pregnant Native women in Minnesota. Currently the only program like this in Minnesota has just 21 beds. At Mille Lacs alone, we had 21 babies born addicted to opiates in 2014.

We need support to mount a massive public education campaign to highlight the risks of opiates. And we need the Federal and State governments to crack down on physicians who are prescribing these dangerous drugs without good reason. In the late 1800s, a genocide nearly occurred after Indian people were given blankets infested with smallpox. Dr. Barrasso, for Indian Country, opiates are a 21st century version of smallpox blankets.

There is no reason for a teenager with depression to be prescribed Vicodin, but it happens every day. We need the medical community and the pharmaceutical companies to step up and police themselves. If they will not, then we ask you to help us police them. As tribal leaders we cannot do this by ourselves.

Thank you, Mr. Chairman.

[The prepared statement of Ms. Benjamin follows:]

PREPARED STATEMENT OF HON. MELANIE BENJAMIN, CHIEF EXECUTIVE, MILLE LACS BAND OF OJIBWE

Mr. Chairman and Members of the Committee, as Chief Executive of the MilleLacs Band of Ojibwe, I thank you for allowing me to testify today about the true cost of addiction in our community. The Mille Lacs Band of Ojibwe is located in east-central Minnesota, with 4,462 enrolled tribal members.

Like most tribes, our fight against alcohol addiction has been on-going for more than a century, as a by-product of colonization. In the 1960s, marijuana came into our communities. In the 1980's, crack and meth entered into the fray.

But I am here today to focus my remarks on a family of drugs that has just recently hit our tribal communities in Minnesota, and is claiming as its victims our youngest and most vulnerable band members: **Our babies.**

Minnesota now leads the Nation in babies being born addicted to opiates. It is with profound sadness and concern that I report that my community, the Mille Lacs Band of Ojibwe, is among the hardest hit in Minnesota. In my January 2015 State of the Band Address, I had the difficult task of informing our tribal members that babies born addicted to opiates is now the single greatest threat to the future of the Mille Lacs Band of Ojibwe.

The State of Minnesota Health Commissioner Lucinda Jesson reports that in Minnesota, treatment admissions for heroin addiction have doubled over the last five years, and this epidemic disproportionately impacts Native Americans in Minnesota. **Minnesota ranks first among all states in deaths due to drug poisoning among American Indians of all ages.** [i]

The focus of this hearing is the cost of addiction. The opiate crisis has exploded in Minnesota, Mr. Chairman, and is so new that there is a great deal of information we do not yet know. I want to clarify that when I refer to "opiates", I am referring to the prescription drugs Vicodin, Oxycontin, Percoset, Morphine and codeine. Each of these is a pathway to the street drug heroin, also an opiate.

I will begin by sharing what little we do know:

- Nearly 100% of heroin addicts report that their addiction began with a legal prescription from a doctor for one of these drugs.
- Of babies born addicted to opiates in Minnesota, **more than 28% are Native American babies,** even though we only comprise about **2% of the state population.**
- Of these opiate-addicted Indian babies, **78% are born in rural Minnesota,** which means this is largely an out-state, reservation problem.
- American Indian women **are 8.7 times more likely than non-Indians** to be diagnosed with opiate dependency or abuse during pregnancy than non-Indians.
- **57% of these women have a legal opiate prescription given to them by a physician for pain, even throughout pregnancy!** [ii]

The Mille Lacs Band has commissioned a study with a national laboratory examining how our tribal members metabolize various substances. The first phase of this research has been completed, and preliminary results appear to show that the majority of Mille Lacs Band Members sampled are very rapid metabolizers of many addictive drugs. What this means is that when these drugs are prescribed for pain management, they may hit the system of a rapid metabolizer must more quickly, causing more intense and immediate physical sensations, but these drugs also run through the body much more quickly. This rapid metabolizing can result in the pain returning much sooner than it would for someone who is not a rapid metabolizer, thereby causing a person to need more of the drug more often in order to control the pain. This, Mr. Chairman, is how the seeds are planted for opiate addiction.

Methadone clinics, which are intended to treat opiate addiction, have also had a devastating impact on Native Americans in northern Minnesota. For several years, Minnesota tribal officials expressed alarm over practices of the Lake Superior Treatment Center, the only methadone clinic operating in northeastern Minnesota. This clinic was well known among opiate users to disperse methadone very liberally and with little patient oversight or follow-up care, largely driven by profits. Much of the methadone dispersed from this clinic was eventually sold illegally in tribal communities.

Finally, in response to alarms raised by tribal officials after methadone-related deaths of 11 American Indian patients and others, the Minnesota Department of Human Services launched an investigation and revoked the clinic's license in September 2012 after finding 50 violations during an inspection that summer. An additional 22 violations were found in 2014; yet this clinic continued to operate while appealing the decision. It is finally scheduled to close this summer. [iii]

While the National Institute of Health and the Centers for Disease Control both describe methadone as the most effective treatment for opiate addiction, we doubt that studies on drug efficacy included Native Americans and certainly did not include Mille Lacs Band Members. Again, our preliminary evidence from our own laboratory study indicates that **methadone is s also metabolized very rapidly by Mille Lacs Band Members,** making it a drug with heightened risk for addiction for our community.

This Committee is particularly interested in costs, and we do know some of the short-term costs. When babies are born addicted to opiates and go through withdrawal, this is called "Neo-Natal Abstinence Syndrome", or "NAS". What these NAS babies go through is horrifying, including pain, seizures, rapid breathing, sweating, trembling, vomiting, diarrhea, slow weight gain and they are at high risk of pre-mature birth and sudden infant death syndrome.

On average, the medical cost of caring for one newborn going through withdrawal averaged $30,000 in 2013 for an average stay of 15 days in neonatal intensive care. Last year, there were approximately 260 Native American NAS babies born in Minnesota, costing approximately $7.8 million dollars in medical care immediately after birth, 77.6% of which was attributed to state Medicaid programs. [iv]

But the costs don't stop there when withdrawal is finally over. Most often, these babies must be placed in foster care until the mother is able to care for her child. But when the baby is removed, **all the other children in the home are removed as well.**

Mr. Chairman, every reservation in Minnesota is facing a crisis of out-of-home placement of Native children. We simply do not have enough Native foster families on or off reservation to take in these high numbers of children, nor do we have enough resources. It is hard for our staff to not wonder, *"What good is the Indian Child Welfare Act when we have no Indian homes left to place these kids in?"*

We also lack critical information about the long-term medical and educational costs for these babies through their lifetime. Anecdotally, we are hearing from providers and early childhood specialists that these children appear to have similar symptoms as children with Fetal Alcohol Syndrome, but their medical issues might be far more complex, including higher rates of cerebral palsy and other serious physical medical complications.

This committee has done many hearings on Fetal Alcohol Syndrome, and has documented that government spending can average $2 million over the lifetime of a child born with FAS. Until we get more data, we must assume that the cost of providing care to these children will be very similar to FAS babies.

Mr. Chairman, we need your help in addressing this crisis. I have some recommendations that I respectfully request you consider.

1. **We need research about this crisis.** We must know more about the long-term impacts of newborn opiate addiction, but we need help. The tribes in Minnesota have joined forces and our providers are working together to share data, but we are in urgent need of research. Either a federal agency needs to study this issue or a federal grant should be provided to a research entity to conduct the study. With our preliminary research I referenced earlier, it is critical that any research done must be specific to Native Americans due to the strong possibility that many Native people beyond the Mille Lacs Band of Ojibwe might also metabolize these drugs differently than the majority population.

2. **Tribes in Minnesota are in urgent need of support for a culturally-based in-patient treatment facility for expectant Native women.** Over the years, this Committee has done an excellent job of documenting that traditional 12-step programs are ineffective for Native people without a very strong cultural component that is specific to American Indian spirituality and identity. Currently, the only program like this in Minnesota has just 21 beds, and is located in Brainerd, MN. At Mille Lacs alone, we had more than 21 babies born with NAS in 2014. The Band is currently in discussions with the State of Minnesota and considering purchasing this facility and expanding it to 56 beds. Even with the expansion, however, this will barely make a dent in the need at Mille Lacs alone; there are 10 other tribes in Minnesota which face the same crisis as we do.

3. **Because there will never be enough beds, we also need support for a culturally-sensitive out-patient treatment program targeted toward expectant Native women.** Project Child is an out-patient program operating in Hennepin County that has shown promising results, and has been discussed with regard to replicating it for Native American women with a Native American focus on culture, identity and spirituality. State officials estimate that offering a similar program targeted toward Native American women might cost $272,000 in the first two years, but they also predict it would generate "at least $1.3 million in savings in the ensuing two years by eliminating prolonged state-funded hospital stays for infants suffering from opiate exposure." [v] In the first nine months of 2013, Project Child served 124 women and "all but one or two gave birth "free of chemicals," found stable housing, completed long-term support programs, and maintained custody of their children", according to its program director, Tom Turner. The Mille Lacs Band Health and Human Services Department [vi]

4. We need the state and federal government to make and enforce severe consequences for those physicians over-prescribing opiates to Native Americans. In the late 1800's, Indian people and children were devastated by small pox after being given blankets infested with the disease. **Mr. Chairman, opiates are our 21st century version of smallpox blankets.** It is inexcusable and even criminal for any physician to prescribe drugs like Vicodin to teenagers with depression, but it happens every day. Opiates are extremely dangerous drugs, yet they are prescribed for such minor ailments as sore ankles and tooth-aches; conditions that could be effectively treated with ibuprofen or acetaminophen.

Mr. Chairman, we need the medical community and the pharmaceutical companies to step up and police themselves, and if they will not, then you must. Physicians also routinely prescribe more medication than is necessary to elderly people; these excess medications are guaranteed to end up in the hands of those with opiate addictions.

At the request of Governor Mark Dayton, the State of Minnesota has included in his 2015 legislative proposal the formation fo a community-based Opiod Prescribing Workgroup (OPWG) to make recommendations regarding educational resources for providers. They are also charged with developing a system for notifying Minnesota Health Care Plan providers whose practices fall outside recommended quality controls, and dis-enrolling providers who practices are "so consistently extreme" that they warrant dis-enrollment. [vii] This will not address non-MHCP providers, however. We need federal standards to address over-prescription of medications to Native American patients and suggest the Indian Health Service be requested to begin working on these standards with tribal providers.

I would be remiss if I did not mention one more systemic issue that directly impacts opiate addiction and over-prescription to Native people in Minnesota. In 2014, the Minnesota Department of Health released a report entitled "Advancing Health Equity: A Report to the Legislature". This report directly identified of Minnesota structural racism as a key factor in health inequities by race in Minnesota, specifically referencing that American Indian babies have twice the mortality rate of white babies. The report states:

> **"Structural Racism -- the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians — is rarely talked about. Revealing where structural racism is operating and where its effects are being felt is essential for figuring out where policies and programs can make the greatest improvements."** [viii]

Mr. Chairman, tackling structural racism as it is embedded throughout our state policies and systems is overwhelming to think about, because often it is invisible to everyone but those whom it impacts. Yet as Native people, we know structural racism exists and see it every day. In Minnesota, state agencies are being encouraged to examine their policies and try to identify where structural racism may exist in invisible ways, but impacting the health outcomes for Native people and communities of color. But that is a problem that will take decades to solve, and frankly, our children don't have the luxury of time to wait.

I want to close with a note about what tribes in Minnesota are doing together to combat the opiate crisis. Last summer, the Minnesota Indian Affairs Council (MIAC) under the leadership of our President Kevin Leecy (Bois Forte) held a statewide Summit on the crisis facing Native children. Our health and human service directors came together with elected tribal leaders to convey the magnitude of this crisis and work together toward solutions. Many county and state officials were also involved, and committed to partnering to face this crisis.

On May 28, the Mille Lacs Band hosted the MIAC's second state-wide summit, where several of the recommendations in my testimony today were developed. We will continue to meet and partner with the State where possible to combat this terrible epidemic.

I also want to note that we are also fighting this issue on the front lines in our communities and our families. I am including as an appendix a report from our Commissioner Samuel Moose, of the Mille Lacs Band Health and Human Services Department, which was prepared as an internal roadmap for doing what we can do address this crisis as a tribe. [ix]

Finally, we are not just looking to government to solve these issues. We know that as community and family members, we must learn how to identify and prevent addiction in our loved ones and help them get the help they need. The Mille Lacs Band held our own two-day conference for Band Members on this topic on April 1, 2015. At this conference, we had community dialogue about strategies for confronting opiate use among our family members, and getting treatment and help for our loved ones whom we fear have become victims of opiate addiction.

The sooner a young woman gets help, the greater her chances are of delivering a healthy baby. We know this is not just a government responsibility, but a personal responsibility each of us has to our family members.

Mr. Chairman, in Anishinaabe culture, we always say that we look ahead seven generations. Right now, we are living in fear about the impact of this problem on the generation that is being born today. I am hoping that, with your help, we can do something about this crisis immediately, before we lose a generation.

Thank you for this opportunity to testify, and I look forward to answering any questions you might have.

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[i] 2016-17 Revised Biennial Budget, Human Services, March 2015. Appendix 1.
[ii] DHS Commissioner Lucinda Jesson letter to Secretary Burwell, April 23, 2015
[iii] http://www.twincities.com/localnews/ci_28416912/methadone-clinic-operating-without-license-close-duluth
[iv] https://www.minnpost.com/mental-health-addiction/2014/02/pregnant-and-addicted-awful-burden-carry
[v] http://www.startribune.com/minnesota-comes-to-the-aid-of-opioid-exposed-babies/295105051/
[vi] https://www.minnpost.com/mental-health-addiction/2014/02/pregnant-and-addicted-awful-burden-carry
[vii] DHS Commissioner Lucinda Jesson letter to Secretary Burwell, April 23, 2015
[viii] Advancing Health Equity in Minnesota: A Report to the Legislature, Feb 1, 2014.
http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf
[ix] Opiate Crisis: A Community Response for Health and Human Services, Commissioner Samuel Moose,

Attachments

OPIATE CRISIS:

A Community Response from Health and Human Services

Abstract

The Mille Lacs Band is facing an epidemic of drug abuse that Chief Executive Melanie Benjamin has called "the single greatest threat to the future of the Mille Lacs Band of Ojibwe." This paper outlines a series of steps coordinated by the Mille Lacs Band of Ojibwe Department of Health and Human Services. The approach will address community needs from a variety of perspectives to address the impact of opiates.

Samuel Moose, Commissioner
Sam.moose@hhs.millelacsband-nsn.gov

Executive Summary

The Mille Lacs Band is facing an epidemic of drug abuse that Chief Executive Melanie Benjamin has called "the single greatest threat to the future of the Mille Lacs Band of Ojibwe." This problem does not just affect the users; innocent newborns are also facing the effects. In recent months the Band has learned that American Indian babies are 8.7 times more likely than white babies to be born with Neonatal Abstinence Syndrome (NAS), and that 28 percent of Minnesota babies born with NAS are born to Indian mothers. The Mille Lacs Band is among the hardest hit communities in the state. The extent of the opiate problem at Mille Lacs is further evidenced by increased drug related arrests, increases in medical calls to tribal police, and increases in out-of-home placements due to opiate-related issues.

This paper outlines a series of steps coordinated by the Mille Lacs Band of Ojibwe Department of Health and Human Services. The approach will address community needs from a variety of perspectives to address the impact of opiates.

Background and History

The Mille Lacs Band has approximately 4,462 members. The Mille Lacs Reservation consists of three districts, the most populous of which is District I. More than 1,400 Band members live in District I. Districts II and IIA are near the cities of McGregor and Isle with a population of 359 members total. District III, near the city of Hinckley, has 555 members. Most of the remaining Band members live throughout Minnesota and the United States. The MLBO service area population is approximately 51% of the total 4,462 Mille Lacs Band membership.

Issues related to health and wellness are common themes for the Mille Lacs Band of Ojibwe communities. Unfortunately, this population leads just about every category of health disparities, including alcohol and drug abuse and addiction and resulting out-of-home placements. Child Welfare services and out=of-home placement have seen an increase in the past year. Many tribal members are raising grandchildren or their siblings' children, in order to keep their family together.

Over the course of several decades, the community has seen a recurring cycle of chemical use and abuse, beginning with alcohol and moving to cocaine, methamphetamines, and opiates. During recent years, Band members who have become addicted to prescription opioid painkillers have turned to heroin because it is cheaper and more readily available. Tribal police data also show that methamphetamine abuse is still common in the area.

The blame for this cycle of addiction falls largely on historical trauma suffered by generations of Mille Lacs Band members who experienced violence, broken treaties, forced relocation, assimilation, racism and discrimination. This trauma has resulted in broken families and suffering individuals who have turned to alcohol and other drugs out of hopelessness and pain.

The Mille Lacs Band already operates behavioral health and maternal-child health programs that address drug and alcohol dependency and strive to increase healthy birth outcomes. The Behavioral Health department of HHS offers mental health and chemical dependency assessments and counseling, as well as prevention and support programs. The Public Health Department offers prenatal and postpartum visits, family planning, childbirth education, tobacco cessation and health promotion. Unfortunately, the prevalence of neonatal abstinence syndrome indicates that these programs have not been adequate to keep women and children safe. More needs to be done to ensure that pregnant women remain chemical free and that Mille Lacs Band children are given the healthiest possible start.

Six Initiatives

While many of the causes of drug and alcohol dependency are known, the solutions are much harder to pinpoint. What is clear, however, is that a multi-dimensional problem requires a multi-pronged solution. After consultation with elders, experts and other tribes, the Mille Lacs Band's Health and Human Services Department has arrived at a six-pronged strategy to address the problem and help the community move in a healthy direction.

The initiatives in the process of implementation are as follows:

- Creation of a Neonatal Drug Use Response Team
- Development of a recovery-oriented care system
- Strengthening of outpatient services
- Exploration of new residential treatment options
- Expansion of women's and children's programs
- Enhancement of existing prevention programs and collaborations

I. Neonatal Drug Use Response Team

A multidisciplinary team of professionals is needed to respond urgently when it is reported that a pregnant woman or newborn infant tests positive for opioids or other drugs. This team will provide a collaborative approach and wraparound services to stop the drug use, treat the symptoms, and prevent relapse through ongoing support.

The team consists of a public health nurse, a chemical dependency counselor, and a social worker to help provide support and intervention.

If the team is informed through county child protective services that a pregnant woman or newborn tests positive for drugs, the team will provide timely assessments for chemical dependency treatment and help mothers access treatment immediately. The team will also assess other types of support they may need to remain clean during pregnancy and afterwards. The team will coordinate prenatal care and follow the mother throughout pregnancy and beyond, providing support both to the mother and to the child. The team will be led by an Licensed Alcohol and Drug Counselor due to the focus being on accessing treatment and recovery based services. Each mother will have a case plan developed that addresses

The team will collaborate closely with our MLBO partners in housing, law enforcement, tribal courts, health services, law enforcement and other departments. Additionally the team will develop strong collaborative relationships with county partners who will coordinate needed services that the MBLO systems are unable to access currently.

II. Recovery-oriented care

People enter the care system from various points, so coordination of care is often lacking. A times, services lose track of those in need of care during transitional periods, like going to or returning home from inpatient treatment. It is critical that mothers and their families have access to a system that helps to keep them engaged as they move through the continuum of services.

A team of case managers is being developed to work with people from their initial assessment through all levels of care. Case managers will maintain contact with those who are going away to treatment and reestablish face-to-face contact when they get home.

A true recovery-oriented system engages peer supports. Until a system of peer support is developed, professionals or paraprofessionals will provide that support.

III. Strengthening outpatient services:

Holes in services need to be filled to strengthen existing programs. Individuals returning from treatment may face homelessness, unsafe environments, lack of peer and family support, and lack of financial resources to maintain sobriety.

Outpatient services in all three districts will be revised or created to provide flexibility and full integration of mental health and chemical health treatment services so care is coordinated and addresses all the individual's needs. Support services will also be individualized to treat each person's specific recovery needs.

IV. Residential treatment options

Residential treatment in Minnesota has been in the process of changing to meet the evolving demands of clients and the ever-changing climate of drug and alcohol use and abuse. Over the past several years Mille Lacs Band of Ojibwe officials, employees and members have discussed the need for an inpatient or residential treatment component that meets the direct needs of community members. Residential treatment options vary and decisions need to be made that identify key community needs for the Mille Lacs Band.

Based on community needs, HHS is pursuing a number of options to develop a facility that provides a residential treatment option for Mille Lacs Band members. The program will be rooted in Anishinaabe culture and utilize our spiritual heritage to provide a foundation for recovery for our community members.

The establishment of this program needs to be fiscally responsible and sustainable for it to be an effective tool for members to access for the long term.

V. A program for women and children

Historically, addiction treatment services have struggled to meet the needs of pregnant and parenting women. Treatment programs have often taken mothers out of the home and moved children to foster care in an attempt to stabilize the mother.

Over the past 10-15 years, a movement has developed to provide addiction treatment services that allow women to live with their children in a supportive residential environment while they begin their recovery journey. This kind of family-centered treatment resonates with the MLBO values of maintaining family relationships and support, and it strives to meet the needs of mothers and their children in treating addiction as a disease that impacts the entire family.

The Mille Lacs Band's Health and Human Services Department is developing a Family Healing Center project that enables women to have access to residential addiction and mental health services and continue to live with their children. The department is working to identify a site that can provide a housing option as well as accommodate the needs for mothers and children to access recovery support, child care services and the professional counseling and therapeutic care necessary to build a solid family-based recovery foundation.

VI. Prevention, harm reduction and community-based intervention efforts.

The Mille Lacs Band Health and Human Services will focus available and appropriate financial and staffing resources toward prevention of the spread of addiction problems and to community-based campaigns that address efforts to minimize the impact of drug use.

a. The MLBO will develop media and marketing campaigns that present messages designed to prevent youth from turning to experimentation, provide clear education about the dangers of drug use, educate women about the dangers of use during pregnancy and appropriate strengths-based messages designed to engage youth in positive activities, values and cultural connections.
b. The MLBO Health and Human Services Department will collaborate with other agencies to establish access to naloxone for families and law enforcement first responders to have ready access to intervene on overdose incidents
c. HHS will coordinate sharing of information with the Community Development department to ensure that drug issues within the housing department are communicated clearly to HHS departments that can help families.
d. HHS will propose a drink tax expansion to include Eddy's and other sites from Corporate Ventures as a source of revenue to support treatment, intervention and prevention services.
e. HHS will collaborate with Tribal Police to communicate and engage individuals in getting help and understanding services available.



Minnesota Department of **Human Services**

April 23, 2015

Sylvia M. Burwell
Secretary of Health and Human Services
Washington, D.C. 20201

Dear Secretary Burwell:

I am writing on behalf of Governor Mark Dayton. Thank you for the opportunity to inform your office of Minnesota's planning efforts to reduce the injury and mortality associated with prescription and illicit opioid use and overdose. The Minnesota Department of Human Services (DHS) in conjunction with the National Governors Association and the Minnesota State Substance Abuse Strategy, which includes the Departments of Health, Education, Public Safety, and Corrections as well as the state judicial branch and the Minnesota Board of Pharmacy, has developed a robust approach to reduce access to prescription opioids, increase access to naloxone and expand medication-assisted treatment.

In 2015, Minnesota is experiencing unique public health tragedies as a result of the over-prescribing of opioid pain relievers and the availability of heroin in our communities:

- Minnesota ranked first among all states in deaths due to drug poisoning among American Indians/Alaska Natives.
- Approximately 3,000 Minnesota Health Care Plan (MHCP) enrollees become chronic opioid users annually.
- Of the new chronic users, over 80 percent have a recent diagnosis of mental illness, substance abuse disorder, or both mental illness and substance abuse disorder, each of which make it more likely that a person will become opioid dependent.
- More than half of pregnant Minnesota women who are known to be opioid dependent are still prescribed opioids for pain during pregnancy.
- The number of fetuses exposed to illegal or prescription drugs disproportionately impacts American Indians in Minnesota. The rate of prescribed opioids for pain during pregnancy is twice as high among American Indians then among other Minnesotans.

Overprescribing Opioid Pain Relievers - In response to inappropriate opioid prescribing, the governor's 2015 legislative proposal recommends the following:

- Formation of a community-based Opioid Prescribing Work Group (OPWG) to recommend protocols that address all phases of the opioid prescribing cycle, such as prescribing for acute and chronic pain

and the period in between. The OPWG will make its recommendations to the commissioners of health and of human services.
- Developing educational resources and messages for providers about communicating with patients about pain and using opioids to treat pain.
- Providers not enrolled in MHCP may voluntarily use the OPWG's recommendations to improve their opioid providing practices.
- DHS will notify MHCP-enrolled providers whose practices fall outside recommended quality improvement thresholds. These providers will be required to submit plans in order to bring their practices into alignment with community-developed standards.
- DHS will dis-enroll MHCP providers whose practices are so consistently extreme that they meet OPWG recommended opioid disenrollment thresholds.

Results:
Within four years of implementing the recommendations, DHS anticipates that our state will see:
- Fewer deaths attributed to prescription opioid overuse.
- A decline in substance abuse disorder related to prescribed opioids.
- A decline in opioid overuse, particularly for treatment of chronic pain, and among populations with disparate rates of opioid overuse.
- A reduction in the incidence of fetuses exposed to prescription drugs.

The State Opioid Oversight Project - At the request of the Office of Governor Mark Dayton, the Chemical and Mental Health Services and Health Care Administrations of DHS along with the MDH, the DHS Office of the Inspector General, the Board of Pharmacy, and the Department of Public Safety are participating in the yearlong National Governors Association prescription drug abuse summit, are working together to provide a state opioid oversight project which will oversee seven multi-agency focus areas addressing the spectrum of challenges from prevention to treatment of opioid abuse. The State Opioid Oversight Project will report to the Minnesota State Substance Abuse Strategy Executive Sponsors to ensure that all parties are able to reduce the impact of opioid dependence among Minnesotans while appropriately managing pain.

The State Opioid Oversight Project is organized to best address the complex issues of opioid use and abuse. SOOP has developed these focus areas to tackle opioid use and abuse from every angle. This project will allow us to reduce the consequences associated with prescription drug abuse and increase the awareness of this important issue within our communities. The approach will address prescription drug abuse with a recovery oriented systems of care (ROSC) philosophy and will incorporate a person centered approach that builds on the strengths of community to improve the quality of life for the individual, family member and communities.

The State Opioid Oversight Project is focusing on seven targeted focus areas:
1) Neonatal Abstinence Syndrome
2) Medication Assisted Treatment
3) Opioid Prescribing
4) Prescription Monitoring Program
5) Increasing Access to Naloxone
6) Prevention/Awareness
7) Increasing Prescription Take Back Opportunities

Neonatal Exposure to Opioid Medications - In response to the burgeoning problem of opioid related neonatal exposure use disorder, the governor's 2015 legislative proposal recommends the following:

- Grant funds to support the provision of targeted integrated services for pregnant mothers who are at high risk of adverse birth outcomes due to either maternal opioid use or prematurity/low birth weight in geographically identified areas of high need.
- Support for planning, system development and integration of medical, substance use disorder and social services for women within target areas.
- Integration of community-based paraprofessionals such as doulas and community health workers, as a routinely available service component.
- Systematized screening, collaborative care planning, referral, and follow up for behavioral and social risks known to be associated with poor birth outcomes.

In addition to the governor's legislative recommendations, the Department of Human Services established the neonatal abstinence policy academy workgroup to address the impact of opioid addiction on Native American women of child-bearing age. The three priorities of the workgroup are to develop education materials for provider and community members on neonatal abstinence syndrome, develop a culturally-based treatment model across the spectrum of prevention, treatment and recovery, and to encourage substance use screening for all pregnant women and subsequent referral for treatment services, if necessary.

The Alcohol and Drug Abuse Division in the Department of Human Services supports specialized women's treatment services with grant funding. These grants provide treatment support and recovery services for pregnant and parenting women who have substance use disorders. With enhanced services, families can access additional recovery supports, meet their basic needs of daily living, address mental and physical health needs and obtain parenting support to increase family stability.

Increasing Access to Naloxone – In 2014, the Minnesota legislature passed a bill that is referred to as "Steve's Law," which increases the availability of naloxone and provides some Good Samaritan protections. The intent is to increase both the availability of overdose reversal medications as well as decrease the fear of contacting law enforcement/first responders in an overdose situation by granting limited immunity to the caller. Wider distribution of emergency use naloxone will reduce mortality among individuals using illicit opioids.

The State Opioid Oversight Project will target its efforts to increase the availability of naloxone for needle-exchange clinics, law enforcement, and emergency responders and for prescribing it with opiate prescriptions until it is available over the counter. The project recognizes that the price of naloxone has continued to double since last year which can cause a financial burden to states trying to expand the availability. The project also recognizes there is much work to be done within law enforcement to reduce the resistance from law enforcement to carry naloxone.

Expanding Medication Assisted Treatment – The State Opioid Oversight Project recognizes that individuals need treatment, but access to treatment has not kept up with the demand. The increase in individuals using and abusing prescription drugs has led to increased need for addiction treatment and recovery resources. Traditionally, the Minnesota model of addiction treatment excludes medication assisted therapies. Nearly 90% of Minnesota treatment programs still use a 12-step, abstinence-based treatment, which is ineffective for some patients with opioid dependence. The availability of medication-assisted treatments is scarce in relation to the demand particularly in rural Minnesota, as

troubled methadone clinics are in danger of closing and the primary care community has not yet engaged to meet the need with offering buprenorphine-based treatments.

As we develop strategies to add medication assisted treatments to specialty addiction programs and in primary care settings, we will also integrate this evidence-based treatment into a comprehensive, modernized model of care. We believe that treatment can be offered in a variety of clinical settings and the opportunity to recover is enhanced with peer support, care coordination and long-term care.

The Minnesota Department of Human Services will continue to support the strategies deployed through your office and welcomes the opportunity to collaborate in order to stop the unnecessary death and suffering associated with opioid use.

Thank you for considering these comments.

Sincerely,



Lucinda E. Jesson
Commissioner

Human Services

FY16-17 Biennial Budget Change Item

Change Item: Opioid Prescribing Improvement and Monitoring Program

Fiscal Impact ($000s)	FY 2015	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	54	(21)	(21)	(21)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	54	(21)	(21)	(21)
FTEs	1.5	1.5	1.5	1.5

Request:
Effective July 1, 2015, the Governor recommends the implementation of a community-based, collaborative approach to reduce inappropriate opioid analgesia prescribing within the Medical Assistance (MA) program. This proposal has a general fund cost of $33,000 in the FY2016-17 biennium and a savings of $42,000 in the 2018-19 biennium.

Rationale/Background:
At any given time, there are approximately 19,000 chronic opioid users in Minnesota's public programs. Based on 2011 data, approximately 3,000 MHCP enrollees become new chronic opioid users each year. Of the new chronic users, over 80% have mental illness; current or a history of substance abuse; or both substance use and mental illness.

Within the data is a marked racial disparity. Preliminary data show a doubling of the rate of neonatal abstinence syndrome over the past five years. The crisis disproportionately impacts newborns from the American Indian nations located in Minnesota. In 2010, Minnesota ranked first among all states when measuring the age-adjusted disparity rate ratio (DRR) of deaths due to drug poisoning among American Indians/Alaska Natives relative to Whites (out of 13 states for which data are available) and of Blacks relative to Whites (out of 36 states for which data are available). The age-adjusted rate of death due to drug poisoning was more than four times greater among American Indians/Alaska Natives relative to Whites and nearly two times greater among African Americans/Blacks relative to Whites.

In 2012 DHS' Health Services Advisory Council (HSAC) formed an ad hoc Emergency Department (ED) utilization work group (ED work group) charged with recommending one or more approaches for improving ED care while also reducing costs. The ED work group chose to focus its efforts on improving opioid-related prescribing practices within the ED. The ED work group comprised representatives

- HSAC
- health plans
- hospitals and health systems
- emergency medical professionals (both rural and metro-based)
- emergency medical responders
- MN Community Measurement
- Institute for Clinical Systems Improvement (ICSI).

The work group developed collaborative recommendations that built on the best of their respective, individual efforts to curtail inappropriate prescribing within EDs. The group's recommended protocols would form the basis for the emergency department setting-specific protocols described in this proposal.

Proposal:
This proposal calls for the following:

1. Endorsement and development of prescribing protocols that address all phases of the opioid prescribing cycle (prescribing for acute pain, prescribing in the time after the immediate acute event, and prescribing for chronic pain). Protocols will be developed in collaboration with the community and under contract with an organization identified through a Request for Proposal process. The protocols will differentiate between opioids prescribed in emergency settings and those prescribed in other outpatient settings.

2. Development of sentinel measures of the quality of opioid prescribing (such the duration and type of opioids prescribed for non-malignant acute or chronic pain for patients).
3. Development of consistent messages and other educational resources for prescribing providers about communicating with patients about pain management and use of opioids to treat pain.
4. Development of a data feedback system to providers that will
    a. annually collect and report to providers their sentinel measures compared to their anonymized peers
    b. attribute individual providers to one or more provider groups with which they are affiliated or employed. DHS will develop mechanisms for attribution in consultation with the provider community.
5. Outlier providers will be identified based on criteria developed by the provider community. Individual, outlier prescribers will be notified, as will any practice group with which the provider is affiliated or employed. Any identifiable information about a provider or practice group will be considered protected for peer-review, quality improvement purposes, unless the provider or practice group's enrollment in MHCP is temporarily or permanently restricted or the provider or practice group is disenrolled.
6. Practice groups together with their outlier provider(s) will submit plans for quality improvement for review and approval by the Commissioner, with the objective of bringing their providing practices into alignment with the community-developed standards described in paragraph 1.
7. If any individual or groups remain outliers for two or more years, whether or not consecutive, the Commissioner may take any or all of the following steps:
    a. Monitoring performance more frequently than annually and/or monitoring more aspects of prescribing practices than the sentinel community measures
    b. Requiring additional quality improvement efforts, including but not limited to mandatory use of the Minnesota Prescription Monitoring Program
    c. Temporarily or permanently restricting the individual provider's enrollment in MHCP.
    d. Temporarily or permanently restricting the provider group's enrollment in MHCP
    e. Disenrollment of the individual provider
    f. Disenrollment of the practice group and of individual providers affiliated with or employed by the practice group

Within one year expected outcomes include better data and understanding of opioid prescribing and use within MHCP and a more coherent set of expectations for improved prescribing practices among providers who provide care to MHCP recipients.

Within four years DHS anticipates

1. Fewer deaths attributed to prescription opioid overuse;
2. A decline in opioid use overall, particularly for treatment of chronic pain and particularly among populations with disparately high rates; and
3. Reduced incidence of neonatal abstinence syndrome, particularly in populations with disperately high rates.

One-time contracting costs total $250,000.The program will also require 1 FTE with significant policy expertise in opioid prescribing and the treatment of pain. It will also require 0.5 FTE for a research scientist to provide data and analytics support.

This proposal will result in cost offsets that will include savings due to reduced spending on prescription opioids, reduced conversion of acute pain patients to chronic opioid users, reduced rates of conversion of prescription opioid use to dependence on prescribed opioids or heroin, and prevention of other medical complications of opioid dependence, including HIV and Hepatitis C.

Results:
This proposal will result in a decrease in the percentage of MHCP recipients receiving opioid prescriptions and a decrease in the overall volume of opioids prescribed as measured by total days supply.

Statutory Change(s):
M.S section 152.126 – Prescription Monitoring Program

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

February 1, 2014

Dear Legislators:

It is a great privilege to present this report on Advancing Health Equity in Minnesota. The growing economic inequities and the persistence of health disparities in our great state are a matter of life and death for many. Communities across the state are being devastated by high rates of infant mortality, diabetes, suicide, and more. Multiple efforts have been made to try to close the significant gaps in health outcomes across populations, but essentially we have been running in place.

This report reveals that:

- Even where health outcomes have improved overall, as in infant mortality rates, the disparities in these outcomes remain unchanged: American Indian and African American babies are still dying at twice the rate of white babies.
- Inequities in social and economic factors are the key contributors to health disparities and ultimately are what need to change if health equity is to be advanced.
- Structural racism — the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians — is rarely talked about. Revealing where structural racism is operating and where its effects are being felt is essential for figuring out where policies and programs can make the greatest improvements.
- Improving the health of those experiencing the greatest inequities will result in improved health for all.

In the process leading to the release of this report, hundreds of critical conversations took place. Relationships were strengthened, new leaders emerged and important tensions, challenges and resistance were uncovered. Individuals and organizations from both the community and the health department made invaluable contributions to this report, sharing evidence of the devastating effects of health inequities throughout the state as well as examples of what can be done to improve health for all. Although we were not able to include every example of the heath inequities or effective strategies shared with us, the passion of many for addressing health disparities and advancing health equity was evident in the process of compiling this work.

It is our hope that this report will provide a much-needed foundation for building on the work to eliminate health disparities and ultimately achieve health equity for all people in Minnesota.

Advancing Health Equity Project Co-Leads:

Melanie Peterson-Hickey, Research Scientist
Minnesota Center for Health Statistics

Jeanne Ayers
Assistant Commissioner

The CHAIRMAN. Thank you, and I especially want to thank you for that list of suggestions. It wasn't just one thing, it was an entire list and a broad list and encompasses a lot of different areas. I think that is going to be one of the most helpful parts of this Committee hearing today. Thank you very much for that.

Next is Mr. John Walters. Mr. Walters, thank you for being with us. Please proceed.

STATEMENT OF HON. JOHN P. WALTERS, CHIEF OPERATING OFFICER, HUDSON INSTITUTE

Mr. WALTERS. Thank you, Mr. Chairman, members of the Committee. I am the former director of the Office of Drug Control Policy from the last Administration and am now the Chief Operating Offi-

cer of the Hudson Institute and Co-Director of the Center on Substance Abuse Policy Research.

I am pleased to be with you and pleased to be with some of the people who are working with Native American and Alaska Native communities as I did back when I was in government.

I will not repeat the detail not only in my testimony, but you have already heard about the disproportionate effect of substance abuse in Indian Country. It is staggering. The estimates of national cost of $200 billion or $600 billion don't capture the real human cost. These are our models, they are imprecise. The data here is embarrassingly bad.

What we should do and what we can do to get national leaders and local leaders better help is begin to look at the problem as if it were as serious to us as it is to the people living in these communities.

First thing I would recommend is that someone direct the Centers for Disease Control to treat this as an epidemic and begin to collect monthly data and precise geographic monthly data on the spread of this disease. If this were a virus, the Centers for Disease Control, I can tell you from my experience, resists this topic. It doesn't like substance abuse, in my experience. I have been out of government a while and maybe attitudes have changed. It also wants to say that it only deals with infectious diseases. That is not acceptable. The cost and the devastation is too high and you need to localize the particular knowledge about the spread of these phenomenon, because they are an epidemiological phenomenon.

And if you are going to tie resources where they are needed, you need to know where the problem is and you need to know how well the resources are reaching the people who need them. That is not happening. And it is unacceptable, in my view.

In addition, I think it is important to recognize that we do not do a very good job of providing the care, as you have heard from previous witnesses. Even if we expand resources under the Affordable Care Act and other programs, the problem is that the geographic isolation, the limits of infrastructure, the limits of referral and support programs after immediate detoxification and other services create a failure of treatment to work in these communities and a failure of prevention to be effective and comprehensive.

We need to be more specific about how we can create targeted, culturally sensitive programs in these areas. Demonstration programs are nice, but demonstration programs are by definition inadequate to meet the real need. There has to be a plan and a consistent effort. I think someone in the Federal Government has to be targeted such that their job is on the line to give you a solution that reaches the real scope and focus of the problem. And given a fixed period of time, not four years and not eight years.

I started working on the drug problem in the Reagan Administration at the Department of Education. The same agencies have been telling you they are going to get a national plan with real estimates and real achievement and real output data for decades. It is not happening.

So until somebody's job in six months or twelve months or eighteen months is to produce such a plan or be fired, it is not going to happen.

In addition, I want to just mention in connection with the overall problem the danger that was referred to, Mr. Chairman, in your opening remarks. There is now a movement to legalize the production of marijuana on Native land. On top of all that you have heard of the consequences of addiction and substance abuse, in all the areas you have heard of those consequences, this is devastating. If there ever was a bad idea that we ought to stop, it is this one. And of course, it doesn't just affect people in Indian Country. But it is a terribly, terribly destructive additional harm that we are inflicting on people who are already suffering.

My testimony goes into detail about the latest research and what the findings are for educational, health, illness, violence, and other problems including family violence associated with marijuana and its connection to other substance abuse. It is worsening with regard to impaired driving, as well as educational performance. Recent research has suggested very strongly in multiple cases that the current high potency marijuana has the ability to not only reduce the educational performance but perhaps permanently reduce i.q. in young people. That is not the kind of additional ingredient we need to add to the mix here.

In terms of the promises of profits, my testimony has some of the research that suggests this is as illusory as it is to say the taxes on alcohol are paying the cost of alcoholism in Indian Country. It is a lie. It is not going to happen and it is never going to happen.

In short, I would say for the purposes of this Committee, we need to have not only a better understanding of the cost but how to drive our resources effectively to scale our resources and to hold people accountable. We can do that at the Federal level. But in addition, we are at a crossroads now with this latest movement. We can not only improve, but we also need to stop something that is going to be devastating to people who live in these communities who have already suffered enough.

With that, I am going to conclude. I will be happy, when it is my turn, to answer any questions.

[The prepared statement of Mr. Walters follows:]

PREPARED STATEMENT OF HON. JOHN P. WALTERS, CHIEF OPERATING OFFICER, HUDSON INSTITUTE

Chairman Barasso, Vice Chairman Tester, and members of the Committee, thank you for this opportunity to address the public health and public safety issues surrounding the costs and consequences of substance abuse on the Native population of the United States.

In this testimony, I will briefly review what is currently known about the consequences of substance abuse on Native American and Alaskan Native communities—specifically focused on costs, expressed both in public health and in dollars. I also wish to draw attention to treatment need and address proposals to expand access to marijuana in these communities.

According to a recent report from the Centers for Disease Control and Prevention (CDC) on minority health populations, there are 566 Federally-recognized tribes plus an unknown number of tribes that are not Federally-recognized, each with its own culture, beliefs, and practices. [1]

As the CDC report notes, according to U.S. Census Bureau in 2013, there were roughly 5.2 million American Indians and Alaska Natives living in the U.S., representing approximately 2 percent of the U.S. total population.

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[1] *http://www.cdc.gov/minorityhealth/populations/REMP/aian.html*

The projected U.S. population of American Indians and Alaska Natives for July 1, 2060 is estimated to reach 11.2 million, constituting approximately 2.7 percent of the U.S. population by that date.

In the 2010 U.S. Census, tribal groupings with 100,000 or more responses were: Cherokee (819,105), Navajo (332,129), Choctaw (195,764), Mexican American Indian (175,494), Chippewa (170,742), Sioux (170,110), Apache (111,810), and Blackfeet (105,304).

In 2013, there were 14 states(with more than 100,000 American Indian and Alaska Native residents: California, Oklahoma, Arizona, Texas, New Mexico, Washington, New York, North Carolina, Florida, Alaska, Michigan, Oregon, Colorado and Minnesota.

In 2013, the(states with the highest percentage of American Indian and Alaska Native population were Alaska (14.3 percent), followed by Oklahoma (7.5 percent), New Mexico (9.1 percent), South Dakota (8.5 percent), and Montana (6.8 percent).

A precise accounting of the true costs of substance abuse on Natives is difficult to establish, owing in large measure to deficiencies in our data sets, which is an on-going and frankly disturbing incapacity affecting all of drug policy. Broadly, for the United States population as a whole, estimates have been provided showing approximately $193 billion per year (measured in 2011 based on 2007 datad the figure has since been updated to $209 billion in 2009 dollars) as the costs to society of illicit drug use. The majority of those costs are attributed to law enforcement activities, lost productivity, and public health/health care impact. [2]

Some proportion of those costs can be allocated to Native communities, but we must acknowledge that the true impact is almost surely far worse than one would find by simply dividing those costs by population share. Native communities are adversely situated with regards to substance abuse impact, in many instances facing vulnerabilities driven by, among other issues, poverty, geographic remoteness, and insufficient health care resources. Even in circumstances where the largest Native populations are found in urban settings, similar vulnerabilities pertain.

In addition to the economic costs, we must acknowledge the personal and social costs measured in both lives and human potential lost, as well as diminished economic opportunity and well-being.

The current human cost is staggering. As measured by the National Survey on Drug Use and Health (NSDUH), in 2013, American Indians and Alaskan Natives had the highest rate of substance abuse or dependence when compared to other racial or ethnic groups. The percentage who needed treatment for an alcohol or illicit drug use problem in the past year was nearly 88 percent higher than the national average for adults.

Such high rates of abuse/dependence are linked with a host of health problems, including premature death. Yet the Substance Abuse and Mental Health Services Administration (SAMHSA) of the Health and Human Services Department (HHS) reports that Native Americans and Alaskan Natives are not well served by the publically-funded health care system. For instance, they are three times more likely than whites to lack health insurance, with approximately 57 percent depending on the Indian Health Service for treatment care.

While the Affordable Care Act allows for enrollment in state exchanges for Natives, a 2004 study in the *American Journal of Public Health* found that less than half of low-income uninsured Native Americans/Native Alaskan had access to Indian Health Service care. [3]

The *American Psychiatric Association Fact Sheet on Mental Health Disparities American Indians and Alaskan Natives* summarized what we know all too well about the struggle of Native communities. Natives are twice as likely to live in poverty than the rest of the US population, have lower life expectancy, higher infant mortality, and two and a half times the rate of violent victimization faced by whites. They face significantly higher rates of death from tuberculosis, diabetes, unintentional injury, while dying from alcohol-related causes at significantly higher rates than the national average.

In 2008, the Centers for Disease Control and Prevention (CDC) released a report finding nearly 12 percent of deaths, between 2001 and 2005, among Native Americans/Alaskan Natives to be alcohol related, compared to 3.3 percent nationally. [4] Finally, suicide is the second leading cause of death for those between ten and thirty-four years of age.

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[2] *http://www.justice.gov/archive/ndic/pubs44/44731/44731p.pdf*

[3] *http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449826/*

[4] *http://www.nbcnews.com/id/26439767/ns/health-addictions/t/native-american-deaths-alcohol-related/#.VbOpcVy76fR*

According to the *White House 2014 Native Youth Report,* more than one in three Native youth live in poverty, while their rate of high school graduation (67 percent) is the lowest of any racial/ethnic group across all schools, falling to 53 percent for Bureau of Indian Education schools, compared to a nationwide rate of 80 percent graduation.

The lessons are painfully clear. In regards to the substance abuse of Native Americans, there is one thing that we must do, and one thing that we must not do.

Finding ways to increase resources for substance abuse treatment is the critical one thing that we need to advance. Targeted, culturally-competent, and tailored specialty treatment drug and alcohol programs, especially for youth, are urgently needed.

Even with expanded potential health care access offered under the Affordable Care Act, substance abuse treatment parity will be difficult to obtain in reality. Regardless of insurance coverage, insufficient access to treatment providers, both physicians and treatment facilities, will hinder the actual delivery of services.

And now the thing that we must not do: either willfully or inadvertently increase the burden in their lives by making things worse. For instance, allowing the cultivation, production, and sale of marijuana on Native lands, either through programs of so-called medical marijuana dispensing or by outright commercial legalization, would be perversely the wrong thing to do, and would actively foster harm.

This preventable harm would begin with increased drug availability, use, and addiction and all the related threats they pose to public health. It will also create greater threats to public safety by increasing the risk of enhanced drug smuggling and black market activities by criminal organizations. Additionally, there is a serious risk of corruption and loss of integrity for banking and governance through the presence of a cash business illegal at the federal level.

These threats would affect Native peoples, as well as neighboring non-Native communities.

Some have argued that Native communities might benefit economically from being allowed to operate commercial operations involving marijuana, the cultivation and sale of which might generate jobs and tax revenue for those on Reservations. It is my judgment that such benefits are illusory, and that whatever economic benefit is promised will be overwhelmed by the accompanying criminal justice and public health costs that will accrue to communities that pursue such paths.

Experience has shown us that in the presence of legalized marijuana markets, price declines, availability increases, prevalence rates rise, and one still finds the operation of a criminal black market. Potential financial savings from legalization and taxation fail to account for the economic and social costs of drug use. As a RAND Corporation study argued, legal marijuana places a dual burden on tribal governments of regulating the new legal market while continuing to pay for the negative effects associated with the underground market, which likely will be enhanced in the legalized environment. [5]

There is a basis for my doubts concerning net benefits found in studies of alcohol markets. Some studies [6] have estimated, for 2009 dollars, that federal and state revenues from alcohol sales total no more than six percent of the $237.8 billion in alcohol-related costs from health care, treatment services, lost productivity and criminal justice imposed by alcohol use.

Similar ratios can be expected for any commercial marijuana market. We have learned already from our experience in Colorado that users will evade regulated taxation schemes, and whatever revenue is attained will be swamped by the accompanying costs associated with drug use. In circumstances where treatment resources are already inadequate, and facing a population already at great risk for negative consequences, the promise of revenue and benefit for these communities is a misguided hope.

Simply put, offering more drugs is a bad bargain, especially for communities already struggling under the weight of history, oppression, marginalization, and impoverishment.

Further, Native communities that might chose to engage in marijuana cultivation and production will face additional negative impact on their already stressed environment. Marijuana cultivation results in chemical contamination, degraded water supplies, elimination of native vegetation, wildlife alteration, toxic wastes and garbage, food chain contamination, and wildfire risks, according to studies by the National Park Service of the Department of the Interior. [7]

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[5] *http://www.rand.org/content/dam/rand/pubs/testimonies/2009/RAND__*CT334.pdf
[6] *http://www.ajpmonline.org/article/S0749-3797(11)00538-1/fulltext*
[7] *https://www.whitehouse.gov/ondcp/frequently-asked-questions-and-facts-about-marijuana*

These negative effects and costs would come in addition to current degradation of Native lands associated with the operations of criminal organizations, which currently traffic marijuana and other drugs through Native territory, often with legal impunity because of jurisdictional complexities.

And now let us turn in greater detail to the specifically human cost, especially to youth. Marijuana is the most widely-used illegal drug in the United States, and the health impairments associated with this drug, especially in newer high potency forms, are well known.

Yet the Department of Justice (DOJ) has issued a determination that Native American reservations may become centers for "legal" marijuana sales and use, notwithstanding that this policy stands in stark violation of the federal Controlled Substances Act.[8]

The Attorney General's subcommittee on Native American issues has proposed to allow growing or selling marijuana on "sovereign" lands, even if encompassing state law, as well as federal law, prohibit the practice. Moreover, DOJ has expressed that there will be no federal law enforcement on their lands if a tribe does express opposition.

This new push for expanding marijuana use is legally suspect on many grounds. Prior DOJ memoranda suspending enforcement of federal law, such as in Colorado, were contingent on the alignment of marijuana sales and use with prevailing state laws or regulatory regimes. But Native reservations are not legally equivalent to statesd rather, they are "dependent domestic sovereigns," broadly subject to federal law. Hence, the proposal appears contradictory on the face of it.

But there is worse in store. The impact on both Native Americans and upon the broader principles of political and economic integrity is deeply damaging.

Native history teaches that they have suffered as much from well intentioned but devastating policies offered by "friends" as they have from the malign attacks from those who sought to destroy their cultures.

In addition to the damage from addiction, there is damage to the wider community. Internationally, "legal" drug markets are known to be accompanied by organized crime,[9] prostitution, theft, violent coercion, neighborhood degradation, and economic loss, as documented by the Netherlands'[10] "cannabis cafes." Meanwhile, Colorado is already experiencing law suits[11] filed by businesses claiming harm from marijuana sales operations, based on racketeering and organized crime statutes.

There is the threat to Native lives from ongoing substance abuse, which shows a history of degradation, violence, and pathology for First Americans. As we have seen, alcohol and marijuana abuse is pronounced, while heroin and methamphetamine are established criminal threats, especially for tribes adjacent to Southwest Border smuggling routes, which exploit the interstitial nature of Reservation boundaries and competing jurisdictions.

Let me conclude with a brief review of recent studies of marijuana use in association with negative health and criminal justice outcomes, associations that are of particular pertinence to Native populations.

As reported by the *Washington Post*,[12] last year Congress approved a law[13] that for the first time will allow Indian tribes to prosecute certain crimes of domestic violence committed by non-Indians in Indian country. The Justice Department announced it had chosen three tribes for a pilot project to assert the new authority.[14]

In 1978, in a case widely know in Indian country as "Oliphant,"[15] the Supreme Court held that Indian tribes had no legal jurisdiction to prosecute non-Indians who committed crimes on reservations. Even a violent crime committed by a non-Indian husband against his Indian wife in their home on the reservation could not be prosecuted by the tribe.

While it is laudable to have domestic violence addressed, there is a striking irony when seen in relation to the proposed marijuana measure. A recent study of factors

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[8] *http://www.latimes.com/business/la-fi-marijuana-indians-20141211-story.html*

[9] *http://www.dutchamsterdam.nl/686-amsterdam-coffeeshops-organized-crime*

[10] h*https://www.washingtonpost.com/world/europe/new-law-threatens-amsterdams-cannabis-culture/2012/05/03/gIQAvQ570T*__story.html

[11] *http://www.washingtonpost.com/blogs/govbeat/wp/2015/02/18/group-opposed-to-legal-marijuana-plans-to-sue-colorado-and-industry-participants/*

[12] *https://www.washingtonpost.com/world/national-security/new-law-offers-a-sliver-of-protection-to-abused-native-american-women/2014/02/08/0466d1ae-8f73-11e3-84e1-27626c5ef5fb*__story.html

[13] *http://www.justice.gov/tribal/violence-against-women-act-vawa-reauthorization-2013-0*

[14] *https://www.washingtonpost.com/world/national-security/3-tribes-authorized-to-prosecute-non-native-american-men-in-domestic-violence-cases/2014/02/06/27bc1044-8f58-11e3-b46a-5a3d0d2130da*__story.html

[15] *https://supreme.justia.com/cases/federal/us/435/191/case.html*

driving domestic violence found that consistent use of marijuana in adolescence was the single most predictive factor examined. [16]

How could it possibly help the tragedy of domestic partner violence to increase access and use of marijuana?

Sadly, very similar questions can be asked regarding the association of marijuana use explicitly with the social and public health threats faced by Native communities. Alcohol and drunk driving are already threats faced on many Reservations. Yet a recent study [17] found that concurrent marijuana use worsened these risks, approximately doubling the odds of drunk driving, social consequences, and harms to self.

Native youth are at particular risk of suicide. Yet perversely, an increase in suicidal ideation is associated with all levels of marijuana use, regardless of duration. [18]

Faced with sexual abuse and unintended pregnancy, tribes should know that in a study of African American girls, use of marijuana at last episode of sex is associated, for youth, with non-use of condoms, acquisition of sexually transmitted diseases (STD), and unintended pregnancy. [19]

And in the context of the unemployment challenges faced by many tribes, according to recent research, chronic use of marijuana increases the risk of unemployment. [20]

These are just a few of the recent findings, supplementing a well-established host of research results showing marijuana use, particularly in adolescence, associated with serious psychological problems, such as schizophrenia, depression, and psychosis, including findings that marijuana use is associated with a greater than 60 percent increase in school drop out risk. [21]

How conceivably could adding increased supply (and acceptability) of an addictive drug associated with psychosis, IQ and learning loss, increased susceptibility to suicide, school failure and greater need for drug treatment, be anything other than a needless disaster? [22]

But there is another threat emerging, one that portends to affect all Americans. Consider that Southern California alone is home to nearly 30 recognized Indian tribes, with a total population of nearly 200,000. Were they to become purveyors of marijuana, by the experience of Colorado, they could quickly become "smuggling centers" for black market marijuana distribution to surrounding communities and states.

Reservation boundaries could turn into "domestic borders" comparable to international borders, where drug operations by criminal organizations thrive in driving illegal cultivation and trafficking.

This also presents an obvious course for fueling corruption in reservation politics, and equally worrying, U.S. financial affairs, for the emerging market in illicit drugs threatens our economic integrity nationwide. Not only has the DOJ set about dismantling, in states that have legalized, basic banking and money-laundering protections against criminal organizations penetrating the financial system, [23] there is further risk from another center of illicit finance and money-laundering: The cash business of casinos.

There are nearly 500 Indian "gaming" operations found in nearly 30 states, [24] and while the revenues are great (estimated at $27 billion annually), many are in serious debt. [25] What would another cash business, dealing in addiction and in violation of federal law, presumably paying no federal taxes, do to tribal integrity? What could this contribute to the power of transnational criminal cartels?

Already, marijuana-related law firms from Colorado are guiding those tribes with casinos in setting up high-potency marijuana operations. [26] The potential for public corruption is high, as is the certainty of increased suffering within America's Native communities.

In conclusion, it is clear that we need an integrated substance abuse strategy for responding to the current health crisis faced by Native Americans, and that response must include greater support for prevention and treatment programs.

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[16] *http://jiv.sagepub.com/content/27/8/1562.abstract*
[17] *http://onlinelibrary.wiley.com/doi/10.1111/acer.12698/abstract*
[18] *http://www.ncbi.nlm.nih.gov/pubmed/25772435*
[19] *http://www.ncbi.nlm.nih.gov/pubmed/25929200)*
[20] *http://www.ncbi.nlm.nih.gov/pubmed/25955962*
[21] *http://www.hudson.org/research/11298-marijuana-and-school-failure*
[22] *http://www.hudson.org/research/10777-why-we-believe-marijuana-is-dangerous*
[23] *http://www.fincen.gov/statutes__*regs/guidance/pdf/FIN–2014–G001.pdf
[24] *http://www.nigc.gov/LinkClick.aspx?fileticket=0J7Yk1QNg-0%3D&tabid=943*
[25] *http://www.huffingtonpost.com/2012/01/22/indian-casinos-debt__*n__1222121.html
[26] *http://www.denverpost.com/business/ci__*27284773/united-cannabis-denver-help-calif-indian-tribes-grow

In addition to the traditional threat of alcohol, Native communities today are at risk from rising heroin and methamphetamine use and the presence of criminal operations within their borders. These are extremely tough challenges. But one thing that is directly in our hands is to refuse to do greater harm.

It should be painfully clear that greater harm is precisely the most likely outcome from increased access and availability of high-potency marijuana in Native communities. It would be irresponsible of us to allow this to happen.

Thank you.

The CHAIRMAN. Thank you very much for your testimony and for your passion. Thank you, Mr. Walters.

Now, Sunny Goggles.

STATEMENT OF SUNNY GOGGLES, DIRECTOR, WHITE BUFFALO RECOVERY PROGRAM, ARAPAHO TRIBE, WIND RIVER RESERVATION

Ms. GOGGLES. Thank you to Chairman Barrasso and Committee members for inviting me to testify on this important subject. I come to you from one of the most beautiful places in the world, The Wind River Reservation in Wyoming. Our community is rich in culture and tradition and we are blessed with our youth shining with promise and potential. And we are struggling.

We suffer high rates of alcohol and drug abuse as well as unemployment and poverty. Our beautiful community has been classified as notorious, deadly and renowned for brutal crime in the media. We directly see and feel the cost of alcohol and drug abuse in our community.

Many times we think of the cost of alcohol and drug abuse and we focus on the financial costs. We consider how much money we are spending on the justice system, including law enforcement, courts and corrections. On Wind River, over 90 percent of the crime is drug and alcohol related. There are also the costs to victims of crime, property destruction and theft.

In 2014, a victim incurred over $500,000 of medical costs from one single incident. Medical costs related to alcohol and drug abuse deplete already limited resources in our community. On Wind River, those high-cost patients that abuse alcohol and tobacco outnumber patients who do not use 16 to 5. High-cost patients are those that incur over $100,000 of expenses in a year.

Employers lose thousands of dollars a year due to high turnover rates in our community. There is an increase in the rate of illness and job abandonment due to alcohol and drugs. If a person is willing to get help, the cost of treatment includes the average stay of inpatient at $450 a day. For a stay of 90 days for one person, it is over $40,000.

In 2014, at the White Buffalo Recovery Program in Arapaho, we served over 100 individuals. The cost is $4 million to accommodate this need. This is not considering the cost of transportation to and from the closest inpatient facility, which is 264 miles away from our community. Families who would like to participate and support an individual must travel these distances also.

Many of these individuals have always lived on the reservation in which they are the majority. We place them in these facilities where they are subject to a minority experience for months. Facilities are limited in knowledge and understanding of Native culture

and tradition and treatment is a difficult process. We expect somebody to change their life in a matter of months.

Alcohol and drug abuse is not limited to the person. Children, parents, grandparents, aunts and uncles suffer the costs of their family members' abuse. It is overwhelming to watch a family member destroy their life with alcohol and drugs. This can lead to family members felling anxiety, fear, anger, concern, embarrassment or guilt and shame.

Due to the correlation with violence, many families are subject to trauma from witnessing violence or being subject to physical or sexual abuse. This adds pressure to the limited resources of mental health services and social services.

One of the most devastating costs is the human cost, the loss of life which can never be included in an additional line item on next year's budget. No amount of funding can replace this cost. On Wind River, 76 percent of unnatural deaths, such as accidents, suicide and homicide, are alcohol and drug related. Alcohol and drug use increases the odds of death 16.9 times and equals 42.3 years of life lost in our community.

Cancer, heart disease, cirrhosis and diabetes are also major causes of death to our tribal population in Wyoming, and are directly related to or contributed to by substance abuse. Individuals that use alcohol are more likely to die at 35 to 39 years of age on Wind River. Based on mortality rates in our close-knit community, we lose a life nearly every week of the year. The loss of life contributes to more trauma on our families and our community. The loss of a tribal member is also a cost to our language, our culture, our traditions and our future.

It is disheartening to think of all these costs to a real life, especially because it is preventable. Thank you.

[The prepared testimony of Ms. Goggles follows:]

PREPARED STATEMENT OF SUNNY GOGGLES, DIRECTOR, WHITE BUFFALO RECOVERY PROGRAM, ARAPAHO TRIBE, WIND RIVER RESERVATION

Tous' Neneeninoo Nii'eihii Honobetouu. Thank you to Chairman Barrasso and committee members for inviting me to testify on this important subject. I come to you from one of the most beautiful places in the world, the Wind River Reservation in Wyoming. My community is rich in culture and tradition. We are blessed as our youth shine with promise and potential.

And we are struggling. We suffer high rates of alcohol and drug abuse as well as unemployment and poverty. Our beautiful community has been classified as "notorious", "deadly" and "renowned for brutal crime" in the media. We directly see and feel the costs of alcohol and drug abuse on our community.

Many times when we think about the costs of alcohol and drug abuse we focus on the financial costs. We consider how much money we are spending on the justice system including law enforcement, courts and corrections. On Wind River over ninety percent 90 percent of the crime is drug and alcohol related. There are also the costs on victims of crime, property destruction and theft. In 2014 a victim incurred over $500,000 dollars of medical costs in one single incident.

Medical costs related to alcohol and drug abuse deplete already limited resources in our community. On Wind River those high cost patients that abuse alcohol and tobacco outnumber patients who do not use, 116 to 5. High cost patients are those who incur more than $100,000 of expenses in a year.

Employers loose thousands of dollars a year due to high turnover rates in our community. There is an increase in the rate of illness and job abandonment due to alcohol and drugs.

If a person is willing to get help, the cost of treatment services include the average stay in inpatient at $450 per day. For a stay of ninety days for one person is over $40,000. In 2014 at the White Buffalo Recovery program in Arapaho, we served

over 100 individuals that were in need of this level of care. The cost is four million dollars to accommodate this need. This is not considering the cost of transportation to and from the closest inpatient facility which is 264 miles from our community. Families that would like to participate and support an individual must travel these distances also. Many of these individuals have always lived on the reservation in which they are a majority. We place them in the facilities where they are subject to a minority experience for months. Facilities are limited in knowledge and understanding of Native culture and tradition. And treatment is a difficult process. We expect someone to change their life in a matter of months.

Alcohol and drug abuse is not limited to the person. Children, parents, grandparents, aunts and uncles suffer the costs of their family member's abuse. It is overwhelming to watch a family member destroy their life with alcohol and drugs. This can lead to family members feeling anxiety, fear, anger, concern, embarrassment and guilt or shame. Due to the correlation with violence many families are subject to trauma from witnessing violence or being subject to physical or sexual abuse. This adds pressure to the limited resources for mental health services and social services.

One of the most devastating costs is the human cost. The loss of life which can never be included in an additional line item on next year's budget. No amount of funding can replace this cost. On Wind River 76 percent of unnatural deaths such as accidents, suicide and homicide are alcohol and drug related. Alcohol and drug use increase the odds of death 16.9 times and equal 42.3 years of life lost in our community.

Cancer, Heart Disease, Cirrhosis and Diabetes are also major causes of death to the tribal population in Wyoming and are directly related to or contributed to by substance abuse. Individuals that use alcohol are more likely to die at 35 to 39 years of age on Wind River. Based on mortality rates in our close knit community we lose a life nearly every week of the year.

The loss of life contributes to more trauma on our families and community. The loss of a tribal member is also a cost of our language and culture, our traditions and our future. It's disheartening to think of all the costs to our way of life, especially because it is preventable.

The CHAIRMAN. I want to thank you for sharing all of that information and for your very thoughtful testimony. We appreciate your comments and we are happy to have everyone here today.

We are going to start with a series of questions. I would like to start with Senator Hoeven.

STATEMENT OF HON. JOHN HOEVEN,
U.S. SENATOR FROM NORTH DAKOTA

Senator HOEVEN. Thank you, Mr. Chairman. I would like to thank all the witnesses for being here with us today.

I would like to start with Mr. McSwain. My question to you is, when dealing with the challenges of drug abuse, particularly in the Native American community, very often we are talking about rural areas. What is IHS doing and what can IHS do to provide services to deal with substance abuse and treatment in these rural areas?

Mr. MCSWAIN. Thank you, Senator. I believe that, well, I actually don't believe, but we are in fact addressing it through a number of programs we have. Certainly the alcohol and substance abuse programs that we have put in the communities to provide services, we actually have in many cases clinics and hospitals and health centers that are in rural America whereby we provide behavioral health services.

We have a number of programs that we have actually addressed. It is a great question from the standpoint of, we are doing a lot of treating. We are a health care delivery system, so we treat a lot of folks who hit our system.

The biggest thing that we are working on now is on the prevention side. That is our meth-suicide prevention initiative program

that is actually providing behavioral and the prevention side of the equation. But to provide care through our health care system.

It is a growing issue for us, because we are doing basically health care, ambulatory and inpatient care. But now the growing need to address behavioral health is a challenge for us, simply because we need to have trained health care professionals to help us in that regard.

Senator HOEVEN. The statistics I have, in 2012, over 20 percent of Native American youth were using alcohol. Twelve percent of Native American youth over the age of 12 were using illegal drugs in 2013. So clearly more needs to be done.

What do we need to do? One, two, maybe three steps, what needs to happen?

Mr. MCSWAIN. I believe that one of the things we need to do is engage the youth. The one thing that we haven't done and we need to do as a system, whether it is IHS or SAMHSA or other Federal agencies, actually need to, and I think that, well, number one, our budget for 2016 has a generation indigenous initiative for actually addressing youth mental health issues. That budget piece for us is $25 million. SAMHSA has $25 million. And between the two of us we are putting those resources toward youth.

Senator HOEVEN. Well, let me come at it this way. I am going ask all of you, what is the number one thing we need to be doing? And is there agreement on it? What can make this better? What is the one thing you would say should be done? I know there are a lot of things, but what is the first thing you would do?

Mr. MCSWAIN. The first thing we need to do is engage the youth.

Senator HOEVEN. And that means?

Mr. MCSWAIN. That means talking to them, because they will tell us what they need.

Senator HOEVEN. I would like to ask each witness to comment on that.

Mr. MCSWAIN. That would be my response, is to engage the youth in a conversation about what help they need as opposed to us simply telling them what we think they need.

Senator HOEVEN. I would ask each of the witnesses to react to that. And fairly briefly, I am limited here on time.

Ms. BEADLE. Thank you, Senator.

I would agree with Mr. McSwain. I think the critical issue is the fact that Native communities are relatively young in age. If we don't engage the youth in identifying the critical things that must be done, we are not going to get anywhere. The funding is limited. We have tried very hard to coordinate with one another. I think we are doing some great things, we are doing a lot of work. But we have to bring the youth in.

We also have to work with tribal leaders differently. They have asked SAMHSA to work with them differently on their programs. As an agency, we have increased the amount of funding that is going to tribal communities.

The question now is how will we bring those resources together to be as effective as possible. I think the chairman talked about the limited resources that there are available. But it is that connection of those resources, because tribes have funds, the Federal govern-

ment has funds, States have funds and other community organizations have funds.

The question that we are grappling with now is how do we improve the coordination and work together differently to maximize and leverage those funds. They are not going to grow. So part of the solution the tribal leaders have come to us about is working together differently.

Senator HOEVEN. Ms. Benjamin?

Ms. BENJAMIN. The Mille Lacs Band of Ojibwe, what I know is when we have young men coming from prison, and if they connect to the spiritual and cultural aspects of the reservation, they seem to really focus on taking the right path. So anything that we have to do has to be culturally specific to our communities, because the way we communicate and the way they can get to the inner spirit has to be through that language and that culture. That has to be the basis for anything that we do, whatever program it is. They have to be able to communicate in a way and educate in a way that they understand.

That is, for the Mille Lacs Band, that you have to think like an Anishinaabe or an Ojibwe, then you can understand and move forward.

Senator HOEVEN. Mr. Walters?

Mr. WALTERS. I'm more practical on some of these specific things. I think we are, given the magnitude of the problem and the use rates you see here, you must try to help do screening in health care system. We have not adequately dealt with the stigma we have in society for substance abuse. We have to understand that it is a disease. We have to understand it is a disease we can treat. We have to understand it is a disease we can screen for in routine medical care, wellness care and routine health care.

We have introduced some of those programs in the past, supported by the Federal Government as models. They ought to be routine in the medical system. The rates of involvement that you see in Indian Country dwarf anything you see in almost any other community in the United States. There ought to be an automatic screening. It would be confidential.

Then you need to also obviously build the infrastructure that is culturally appropriate to refer families and individuals to both early intervention care, which may be before somebody gets heavily involved and addicted, or when they are addicted refer them into care. But you need an intake system that is going to be systematic and comprehensive. The health care system needs to do that and you may want to encourage screening on a wider level to get people into care.

Now, that is going to obviously display the fact that you don't have infrastructure to care for everybody. But right now, you don't have the infrastructure and nobody is screening. Let's create a drive to create the infrastructure to save lives and not watch people die at higher rates.

Look, what you are hearing here and what you already know as the members of this Committee is the system is failing here. It is not close. It is getting worse at a very great rate, especially in some of these communities. It is not uniform, but right now, the status

quo is not sustainable. And it is only because people don't hear these cries that it hasn't become more of an outrage.

Senator HOEVEN. Mr. Chairman, do I have time to finish or shall I relinquish?

The CHAIRMAN. No, no, please, go right ahead. Let me ask Senator Franken if it is okay with him.

Senator FRANKEN. Absolutely.

Ms. GOGGLES. I just wanted to say, our youth are our resource. I have amazing youth back at home and we are utilizing them to be peer mentors for our younger people. Because we are seeing a lot of our youth actually start around nine or ten years old. So we are really focusing on using those teenagers who are sober, who are following their culture. I really believe that we have to integrate that cultural part of it.

But we can work with the youth as much as we can, but if we don't have the parents on board, they are going back home to a really toxic environment. So it has to be a family approach. We have to look at the youth, we have to look at the adults and utilize those resources that we have available. Thank you.

Senator HOEVEN. Thank you. Interesting, the dialogue and screening, interesting that those two come up together. Seems one would generate a lot of the other. So thank you.

The CHAIRMAN. Thank you, Senator Hoeven.

Senator Franken?

Senator FRANKEN. I am struck with how, when we have hearings on youth suicide, when we have this hearing, and you start to get asked what is the first step. Of course, that is a very logical question. And you just realize how big and endless and circular these problems are.

Because when you go to youth, the first thing I would like to do is give youth hope. And that means having economic activity, that means having housing and it means not being witness to other pathologies like abuse and neglect, violence.

So this again, we are faced with this. I want to say this one more time to all of us on this Committee. We need to be ambassadors to the rest of the Senate and tell them the scale of the problems in Indian Country. Because every time we start talking about resources, it is woefully inadequate. The problems are so cyclical.

I went to a rehab, Oshki Manidoo, in Bemidji, that is for White Earth, they are also a band of the Ojibwe. I have been to a number of rehabs in my life. I have never seen, this is for young people, I had never seen a more bummed out group at a rehab. Most people at rehabs are hopeful, they are happy, they have finally, whether they make it or not, at this point there is some hope. Every one of these kids, I asked them, started using with their parents.

So Melanie, thank you for your testimony, all of you, thank you, especially Ms. Goggles, and you too, Mr. Walters. You talked in your testimony about a number of things, a lot about opiates, a lot of kids being born, a lot of babies being born addicted to opiates. You talked about Project Child and HCMC, Hennepin County Medical Center. They seem to be having a lot of success in taking these moms and intervening so that the babies aren't born addicted. Is that right?

That is with the general population and not an Indian population. Because you talk about the culturally, using a cultural element in the treatment. What does that look like? What does it feel like? Obviously AA and any of those kinds of things, it is a spiritual program. So is that part of it? That is what you were saying.

Ms. BENJAMIN. We do look at the Anishinaabe or the Ojibwe. There is a way of how to get to our spirit. Over the centuries that that inner strength, that self-esteem that we have as Anishinaabe has been taken away from us. Through just endless land steals, racism, lack of good housing, things of that sort over the years of living on the reservation. Also, a lot of the religions had to go underground. You couldn't practice your religion out in the open because you were arrested, you were just made to feel terrible for practicing your own religion.

I think that spirituality has been put down and kept down. But if we can bring that back through cultural programs and give that worth back to the people as tribal governments, provide some opportunities for economic development, education, good health care, good housing, that we can start to see success in a lot of these negative social behaviors.

Senator FRANKEN. Let me ask anybody here, is there any data on culturally inclusive treatment? And if there isn't, shouldn't there be? Shouldn't we be collecting data on what works? Does anybody have any knowledge of whether that has been done?

Mr. WALTERS. Senator, yes and no. There has been some particular evaluations on programs. The Administration I served in, we started a program that was referred to in earlier testimony and still exists, screening, brief interventions, referral treatments, so there was a screening program. But there is also a program called Access to Recovery based on the view that it is not just the immediate 28 days or whatever, but part of the recovery process, especially for people who are heavily involved. It becomes a process of re-entry, sometimes job training, sometimes family support and a variety of other things. It needs to be wrapped together.

We did a series of test sites. Two of them were in California and involved Native tribes that ran these programs. There should be evaluation. It was started near the end, but there should be evaluation data on all those.

But all these programs ought to be producing more evaluation. We say that, we don't require it. We are paying in health care now for more and more information about how well providers are providing. It is important to have tailored programs for Native peoples.

But there also are going to be good and bad programs in that mix. So I think what you want to have is established criteria that you can use and you can look at, because then you can also make the case to your fellow members, everybody wants more money for programs. You have a better case for things that are working.

So it doesn't help the recipients if they get bad services for the money you win for them.

Senator FRANKEN. I am out of time. Speaking of research, Ms. Benjamin, you mentioned metabolizing opiates at a different rates. We should be doing research, I assume, on that, in terms of how American Indians metabolize that.

Thank you, Mr. Chairman, for this very important hearing.

The CHAIRMAN. Thank you, Senator Franken.

Senator Lankford?

STATEMENT OF HON. JAMES LANKFORD,
U.S. SENATOR FROM OKLAHOMA

Senator LANKFORD. Thank you, Mr. Chairman. Thank you to all the witnesses for coming today and for the conversations. It is extremely helpful information.

Mr. Walters, you raised something in your testimony that has been discussed widely, and that is about tribes on tribal lands producing and selling marijuana and trying to decriminalize that. You seem to have a fairly strong opinion about that, and I would be interested to be able to hear more about it.

Mr. WALTERS. The Administration has acted, I believe unilaterally, to encourage that option for tribes in the United States. Again, you already heard, and as a member of this Committee, you already know the damage that substance abuse does in Indian Country. The argument about marijuana is very political in this Country and I certainly understand that. You live in that environment.

But the facts about marijuana are something that we have a blind spot about. My testimony includes a great deal of the information about what now current research is showing. It is all going one way. It is worse than we thought. The kind of high potency marijuana that is being created by these almost industrial kinds of productions you see in Colorado, some of those individuals that have started those have now gone into Indian Country, seeking the ability to cultivate there.

It will not only be a much bigger problem among the Native peoples where it is produced but obviously surrounding areas. It does not get rid of the criminal element. The criminal element thrives as the industrial production thrives.

The consequences for health, the consequences for behavior, the consequences for failure in school by young people, the consequences for young people that we see, including as I mentioned earlier, it is in my testimony, research showing permanent i.q. loss by heavy and continued marijuana use in adolescence and onward.

But it is tied directly, we think other drugs are more serious, but it is tied directly to everything from family violence to now obviously impaired driving, but also things like schizophrenia, psychosis and other serious health problems. And it leads directly into poly-drug use, which not only involves alcohol, but obviously it involves meth, heroin and a whole range of substances.

Senator LANKFORD. Can I ask the rest of the panel, do any of you believe that if marijuana was decriminalized on the reservation, or was allowed to be cultivated and sold in the reservation legally, that would help the drug use problem on the reservation or with the tribe? Does anyone think that? I would say let the record reflect everyone shook their head.

This conversation has been amazing to me, the number of people that I have heard say, you know what, this is a bad problem because people have to do it in secret. And because it is done in secret and because it is illegal, it is a really bad issue. If we only de-

criminalized it, if we only made marijuana legal, then this wouldn't be an issue any more, that this would suddenly be okay. Has anyone been able to track marijuana use around reservations around States that have decriminalized marijuana? Has that had an effect on the amount and the flow that is coming into the reservation areas? Yes, ma'am?

Ms. GOGGLES. Being from Wyoming, and having Colorado just down the road, I can comment on that. We have actually seen a dramatic increase in the marijuana use in our community. One State legalized marijuana, Colorado.

But I would also like to add our sixth leading cause of death is COPD. So not only our tobacco use is 50 percent, our commercial tobacco, so you add marijuana in the mix and it is just adding to the COPD cases.

So we have definitely seen the negative effects, being in Wyoming and having Colorado legalize.

Senator LANKFORD. Any other comments about that? This is a big issue Congress has to deal with, obviously. There is an enormous push to say, you know what, let States decide this, it will have no negative effects, they can choose to do what they choose to do on it. But the real practical effects on families and on generations are pretty traumatic. I think it is us turning a blind eye to our responsibility to say, decriminalizing it is no big deal, it is "just marijuana," I am tired of hearing "it is just marijuana" when we see our families falling apart and we see i.q. levels dropping and productivity dropping and saying "it is just marijuana."

So this is a serious issue. I appreciate you all spending your lives trying to invest into some of these.

Ms. Benjamin, I want to ask you about what you are doing. Just recently you had a two-day conference, I understand, trying to deal with some of the drug issues. How do you evaluate the effectiveness for any program, that program in particular, doing a conference and such? I assume there are going to be multiple steps in the process. So how do you track the metrics of that? Is this effective? How do you improve for next year and what else needs to be done?

Ms. BENJAMIN. One of the outcomes from that conference that we did for our own reservation members is that there were a lot of people in the community, a lot of the women that said, I will do whatever I can to help. There have been a lot of support groups that have started from just participants, people understand, we gave a lot of statistics and what happens. We showed a film of babies going through some of the withdrawal, it is pretty devastating. We had religious people there as well to support.

Also, we are looking to do a safe house for pregnant women as well. We want to give them the opportunity to let them know that we want to help, we don't want to put them in jail just because they are using illegal drugs. A lot of them will not come forward and even get prenatal care, because they are afraid of their babies and being taken care of. So we want to send that message out.

We have been working with our elders in our community to take that stronger leadership role in their families, to make sure that whatever assistance they need that we can offer that and provide

that for them as well. So we see a little progress and people are getting engaged and wanting to be part of the solution.

Senator LANKFORD. Thank you. Thanks to all of you as well. I yield back.

The CHAIRMAN. Thanks, Senator Lankford.

Senator Heitkamp?

STATEMENT OF HON. HEIDI HEITKAMP,
U.S. SENATOR FROM NORTH DAKOTA

Senator HEITKAMP. Thank you, Mr. Chairman.

This is a continuation of, I call it the Committee of despair, as we continue to see these issues and feel like generation after generation we fail. And I don't mean to pick on you, Mr. McSwain, and I know you are acting. But I don't think there is one Native American who lives in Indian Country who thinks that Indian Health Service is providing any kind of treatment for behavioral and mental health. Not anyone that I think who lives in North Dakota.

So when your answer to Senator Hoeven was, you provide treatment, I am going to ask you a simple question. Every person who you are responsible for as a constituent and a patient of Indian Health, if they needed behavior and mental health services, would they get it from you?

Mr. MCSWAIN. They could come into the clinic, and whether or not we have the professionals there, we have had a real challenge in hiring behavioral health professionals.

Senator HEITKAMP. So the answer is no.

Mr. MCSWAIN. The answer is——

Senator HEITKAMP. No.

Mr. MCSWAIN.—not exactly no.

Senator HEITKAMP. You can't, it is not even not exactly no, it is no. And that is one of the problems. And I completely appreciate the health care workforce problem that we have, because it is combined with a rural workforce health care worker problem that we have. So it is extraordinarily difficult.

But once again, Indian Health, which should be providing treatment, let's forget about prevention. I am not even going to put that on you. But you should be providing treatment, because we have heard here that without families, Senator Franken just told you that when he visited a center, all these kids said they started using with their parents.

So if we think we can just visit with kids and that is going to solve the problem, kids do what they see, not what they are told. And what they see every day, kids who are in this situation, is they see a culture of abuse, they see a culture of drug abuse. And they feel a lot of despair. So Indian Health has been unrelentingly unable to address health care crises in Indian Country. And this is a huge part of it, behavior and mental health.

So let's not pretend that we are providing services. The worst thing that we can do here is pretend that we are doing the right thing. Mr. Walters, I don't know if you got a page out of my speeches or whatever it is. I think you are trying to speak truth about what is actually going on and where we go from here. But one of the issues that I have a lot of concern about is, generation after generation, and we can talk about generational trauma. This Com-

mittee has held a hearing on trauma, and I think there is some hope in some of the research.

But there is an amazing lack of scanning and looking back at fetal alcohol effects and fetal alcohol syndrome. We know that one of the symptoms of fetal alcohol is really a lack of consequential thinking. So while we say, well, why don't you just get it, that bad things happen that you drink and you should just quit drinking, well, when you are dealing with somebody who already has a genetic impairment, it is very difficult.

So when we are talking about screening, which I thought was an excellent point, maybe too late after the fact, if we get them in Head Start maybe we have a shot. But what about screening for fetal alcohol effect and fetal alcohol syndrome? And what strategies would you deploy in terms of treatment?

Mr. WALTERS. I agree with you. I think this Committee should obviously also include alcohol. What it allows is, it helps people understand that this is a disease, so it gets rid of some of the resistance and shame by having a medical professional say, this is what we are doing, this is why we are doing it, and provide some information at the time of the screening.

But also, you are right, there has to be, when you find a positive, you are going to have to have people who are able to do family intervention and you have to have people who are going to be able to work with people in a way that meets them where they are.

Now, again, we do have problems in the workforce. But part of the reason we can't get the urgency to get the workforce fixed is because we are not presenting people with the number of illnesses. We do that with a whole bunch of other diseases. We say, we need the capacity to treat this disease at these numbers. And in other venues, that is what generates the infrastructure.

Senator HEITKAMP. And when you don't do that, when you don't recognize you have a problem, then you have no solutions to that.

Mr. WALTERS. Right. You are just part of the noise in the budget debate and the debate about what the community needs to do. And there is a lot of stuff to do. You have to get up to the part of the to-do list that gets done.

I don't think you have to be the Committee of despair. This can be done. It just takes some people who are going to be able to lead. And the government has the ability now to show people where this is and to reinforce what these people are doing and saying it is a priority, in a State, in a region and in the government of the United States. You can fix these bureaucracies. It just takes enough pressure.

Senator HEITKAMP. I can't agree with you more. Just a couple more points.

I once went to a high school, it actually was a junior high school. I asked how many kids were drinking. This was not a Native American school. About 30 percent raised their hand, they reported that their friends were drinking, so you can take it from there. I said, why are you drinking? The kids started saying, peer groups and all this. I said, you are drinking to get high.

So it is, we need to recognize that there is some amount of secondary effect here. This is a very complicated problem.

Mr. WALTERS. But also back to your original point, no matter what the demographic, substantial underage drinking, in my experience, cannot exist unless adults enable it.

Senator HEITKAMP. I think that is correct.

Ms. Goggles, your testimony has a huge impact on all of us as we kind of look forward. I want to know what kind of services Indian Health could provide at Wind River that could make a difference to you that would be altering for your tribe.

Ms. GOGGLES. Thank you. I think one of the biggest parts is the MSPI program. We utilize MSPI funding to do a horse culture program. It is a way of getting our youth back to utilizing their traditional values as far as taking care of their horses. They show them how to ride, show them how to take care of them. It is just a really good program. It gives our youth an opportunity to get in touch with their culture.

Now the funding is competitive. So that makes things a little bit more difficult. I don't know what these other tribes are doing.

Senator HEITKAMP. To Senator Franken's point, do you have any long-term studies that show that a program like this would actually result in a 20, 30 year history of sobriety?

Ms. GOGGLES. No, because the program just started this last year.

Senator HEITKAMP. That is the problem.

Ms. GOGGLES. And the funding actually, that is one of the things, though, you fund things for a year, or things are funded for three years. You are not going to get long-term funding.

Senator HEITKAMP. We don't have a strategy, we just have a series of events. Right?

Ms. GOGGLES. Yes.

Senator HEITKAMP. Thank you, Mr. Chairman, for the extra time.

The CHAIRMAN. Thank you, Senator Heitkamp.

Senator Murkowski?

STATEMENT OF HON. LISA MURKOWSKI,
U.S. SENATOR FROM ALASKA

Senator MURKOWSKI. Thank you, Mr. Chairman, for having yet another very important hearing. As I listened to my friend from North Dakota, you just kind of get a here we are again feeling of despair. I appreciate your saying that we don't have to be the Committee of despair. But I do think that these are problems that we recognize we have been struggling with for generations.

Despite efforts, we are not making the progress that we should. There has been some discussion, and I appreciate what you have said about fetal alcohol spectrum and the syndrome. We have actually made some headway in Alaska, when it comes to our Alaska Native women and the number of children who are being born afflicted with FASD. We are seeing a reduction in the number of those afflicted at birth in the Native population. But at the same time we are seeing a drawdown there, we are seeing an increase in our urban population. So go figure.

We are not hitting it right if we are not able to make a difference across the spectrum when it comes to something that is 100 percent preventable. This is where I get so, so really distraught talk-

ing about fetal alcohol syndrome. We talk a lot here in the Congress about the diseases that we deal with and the funding that we have to do for research.

There is no research that we need to fund on how to end FASD. You just don't drink when you are pregnant and you will not have a child that is afflicted with fetal alcohol spectrum disorder. We know how to stop it. Yet we go up and we go down. We are just not there yet.

I think we recognize in Alaska that alcohol is still the substance of choice in my State when it comes to just the things that are leading to incredibly horrific episodes and destructive behavior. So much of our problem is we have our local governments, we have our villages that say, we want to control alcohol that comes into the community. We vote to be a dry community. And you have bootleggers that are coming in, a bottle of liquor that you could get for $10 in town you might get a couple hundred for that same bottle out in a dry village.

We mentioned the issue of marijuana. Alaska just legalized marijuana and we are in the process now of trying to figure out how we as a State regulate it. Well, one of the great issues of discussion was, well, what will happen in a village that is cut off from the rest of the State, no road access, no access except airplane in and out, that is dry when it comes to alcohol? What happens with the issue of marijuana? What do we do there? We are still trying to define the impact.

But to Senator Lankford's question, I don't think that there is anybody who thinks that by making marijuana legal we are going to be helping those with substance issues. It is just not possible.

So I am really very troubled about where we are with our solutions. We have been operating on a triage basis. We have a situation in a southeastern island community where we know the drugs, how they are coming in, they are coming in by the mail, we need to get cooperation between the Post Office, the DEA. We don't have a magistrate or a judge in the community to issue a search warrant. We literally pull together a SWAT team to make a difference in that community.

We go ahead and we crack the case and we seize the drugs. And what happens is we have managed to squeeze balloon over here and the drugs next month end up in the next island community. We just had a big bust in, again, the island community of Kodiak, with a large heroin seizure. It is like a whack-a-mole game, and we are not getting ahead of it.

I met yesterday with the head of the DEA in my office. He reminded me that in many ways, those bad actors, the dealers, they look to build a clientele. If you can capture a whole island community that is remote, that can be your customer base. On a reservation, to be able to go in and basically get people addicted to your drug of choice that you are dealing, knowing that there are no treatment facilities either in that area or near that area, you have them locked. It is just extraordinarily troubling where we are with it.

I don't want to talk without asking questions, and I want to go to what Senator Heitkamp has raised with you, Mr. McSwain, about the trauma issue. There has been a lot of discussion here in

this Committee, which I appreciate. But when you think about what we are dealing with, the levels of abuse, suicide, violence, other trauma that we see, and then the linkage between the high rates of drug and alcohol abuse, this is something that I do hope is being addressed in coordination between the departments. I think we like to think that is going on.

Can you confirm or affirm to me that in fact there is collaboration going on within the agencies? We require that in the 2010 Tribal Law and Order Act. We required coordination efforts on alcohol and substance use issues in Indian Country when we expanded the number of Federal agencies that are involved in it.

So are you working it and how are you working it? Do you have any thoughts that might be helpful as we try to focus further in this area?

Mr. MCSWAIN. Thank you, Senator Murkowski. The answer is yes, we are working closely with SAMHSA, we are arm in arm in many of the communities that we have addressed. Of course, then, across the system, wherever they have a grant program and we are present, there is another notice of coordination. Then we reach out to our other people. Certainly, as you just referenced, the Tribal Law and Order Act, we reach out to our sister agency, the Bureau of Indian Affairs and the Bureau of Indian Education. Those kinds of discussions are ongoing.

We are actually partnering, in many respects. I can go example by example. A recent one, with Pine Ridge, we are hand in hand out there trying to address issues. Now, granted, it is about suicides. But SAMHSA has a program, we have an installation out there, several. So we are working together as to how to make sure we can provide all the services available, not only through the SAMHSA grant programs but through our direct care program.

To the extent that we have also implemented tele-behavioral health, to make it available into the outlying communities, particularly a couple of very remote communities on Pine Ridge, that is just one example. We have other examples where we are actually partnering and working together on substance abuse and mental health in those communities.

We have been doing this for some time. In fact, we meet annually. We have an annual conference, have had annual conferences to compare best practices. So we will continue that collaboration very closely.

Senator MURKOWSKI. Mr. Chair, thank you for the additional time. It is good to hear that the programs are working.

I remain concerned that everybody has their program and they have to defend their program. In order for them to get money for the next funding cycle, they have to be able to establish what they have done. So the sharing, while it is good in theory, call me a skeptic at times, I think it is important that we just keep pressing on this if the ultimate goal is to have healthy families, healthy communities and not you worry about the funding for your program or the funding for your program, but are we getting results at the end of the day.

That is where I think we come back year after year after year. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski.

Ms. Beadle, earlier this month, the White House had a Tribal Youth Summit. The purpose was to hear from the youth. So I guess the question is, what did you learn from them about how to address alcohol and drug abuse?

Ms. BEADLE. Thank you, Mr. Chairman. I have to say that in addition to the White House Tribal Youth Conference, there have been a number of roundtables with youth. I am glad you raised this topic. The youth basically are telling us the same thing wherever we go. What they are saying is, they want to be involved. We had this conversation earlier today. They believe that they know what is right to do in their communities. They believe that other youth are talking to each other. They are not going to listen to adults.

So they want to be part of the solution. And part of the solution means incorporating them into some of the programming that gets done as a leader. What they have asked SAMHSA to do specifically, not just at the White House Tribal Youth Conference, but in our own conferences and roundtables, is they want us to bring youth together on a national scale to start talking about how we establish a nationwide peer support program among youth.

They think that if we continue down the same path that we have been on, which is, we fund programs which are great things and not include them at the local level, at the regional level, and at the national level, the programs are not going to include their thoughts, they are not going to include their solutions.

So what they are asking us to do is to get them involved.

The CHAIRMAN. Can you point to anything specific that you have actually done in addition to that? We bring them all together, and I met with the students and young people who have come in from Wyoming, heard the same thing. So what is the next step from there?

Ms. BEADLE. We have a couple of next steps. We actually are establishing what is called the SAMHSA Tribal Youth Leaders, which is a cluster of youth from across the Country. What they have asked for are specific things. They want leadership training, we are going to provide them leadership training. They want training in behavioral health. We are going to do that. Some want very basic things like very brief intervention type programs. Others want to be able to figure out how to make a longer career out of it. So we are going to try to get them involved and connected. Those are two very concrete things we are going to do over the next year.

The CHAIRMAN. In terms of the connection or the continued support, how does that work so you can keep them engaged and they don't just feel that they are isolated once they go back home?

Ms. BEADLE. One of the things they have asked us to do as well is to help connect them with tribal leaders. I say this very respectfully. The youth were amazing, and what they basically said is, in some communities we are acknowledged and we are included in the dialogue; in other communities, tribal leaders don't see us as leaders as well. So they are asking for Federal agencies, not just SAMHSA, to help bring them to the table more locally so that they can actually have their voices heard.

Longer term, we do have a series of programs to support Native youth that we are going to try to connect them to so that they are

engaged not only in this learning and development progress but also in the actual work that is happening in their communities.

The CHAIRMAN. Ms. Goggles, when we met in Wyoming, there was a young man who came to testify who was, I think, part of this sort of an effort in the community. Could you talk a little bit about that and the successes you have seen there?

Ms. GOGGLES. I am also an advisor for the Wind River Youth Council. The Youth Council was established back in the 1980s when we had a rash of suicides. So it has kind of come and gone over the years. But I think that is one of the best resources, is our youth. We have amazing youth on Wind River, I mean, amazing youth. I actually have one with me. She is sitting a couple of rows behind me. And I have to embarrass her, because I am her mom.

But we utilize those resources. We do a lot of peer mentoring. In my office right now I have two peer mentors that teach prevention. Because they are not going to listen to me. So I have two 20-year olds who are trained in mentoring. They go to the schools. I don't go to the schools. Our staff doesn't go to the schools. It is our youth, because they are going to listen to them a lot better than they are going to listen to us.

The CHAIRMAN. Mr. Walters, are there any data sets that we can put together to see how effective this is? It certainly sounds encouraging.

Mr. WALTERS. They don't exist now, but we certainly could have those. We could have the individual sites or schools or communities do regular either self-repot surveys or if you screened in the health care system you could report what the rates were and you could see the difference over time.

We could measure these effects from a variety of these programs, including the early reference to family court and custody cases, which have been used in a variety of settings to help get people in treatment and try and start breaking the intergenerational cycle here. So all these things could be measured, but you have to measure the underlying phenomenon first.

I place some of my emphasis on CDC and the measuring on the health side. DEA ought to be forced to do the same thing. DEA does not produce national data. It could produce national data. Now, in the example of heroin, it hasn't produced a heroin signature report to tell you where the heroin is coming from in months, if not years. That report should be out on a quarterly basis, at least.

The State Department has not produced, as far as I can tell, the report on heroin production from Mexico. I believe what you are seeing now is largely production that is probably an explosion of production in Mexico. If it isn't, then it is an explosion of importing from Afghanistan where 90 percent of the heroin is. Let them know that.

But the agencies are not producing the data and providing it to you, who have to make decisions, and sharing with the American people, who are suffering, to get some idea of who is not doing their job or how we can get a better situation. So right now, we are acting in a way that is more blind than we need to be because information is not being given directly as it should be, even the stuff that is already in the pipeline.

The CHAIRMAN. Thank you. And Mr. McSwain, Ms. Benjamin gave us a whole list of wonderful ideas of things that we ought to be talking about. Have you taken anything from this that you think can be helpful as you work with your folks?

Mr. MCSWAIN. I do. In fact, the whole business about Ms. Beadle's comments about the youth summit, I happened to sit on a panel with her. It was interesting to hear, at least the youth, that is what caught me earlier, when I said talk to the youth. That was my frame of reference.

Because if you can talk to the youth, and then having said that, a recent experience we had was that the youth on Pine Ridge wanted counselors. They used the term, "but not those old codgers." And that notion was younger people who can relate to them. So that is part of a takeaway, at least for me, is when we start dealing with the youth, American Indian and Alaska Native youth, is to ensure that we have a younger set that actually has the ability to relate to them.

I really, back to Senator Heitkamp, I know that we basically provide care, but we have been providing grants. I know at the last hearing, Senator Murkowski, you were pleased with the progress of the MSPI program. I know that what that does is put the capacity in the communities to have them work from their end. I think that is the basis on which we are going to be successful.

The CHAIRMAN. Ms. Goggles, is there anything you would like to add in terms of what you see that works, or other things we ought to be doing differently, maybe from something you have heard today, or something you would like to share with the Committee?

Ms. GOGGLES. Thank you. I really want to emphasize the work as a family and working on the family as a whole. It is easy to pull youth out, provide them a good day, good leadership camp, then they go home to a very toxic environment, as I said before. We need to work with those parents, those aunties, those grandmas, because our family group is not just mom, dad, brother. It is the grandmas, it is the aunties, it is everybody else, the uncles. We need to include that whole portion in our treatment services, our behavioral health services, even our medical services. They need to be included in all this.

And I really want to emphasize the speaking with youth. They have great ideas. They think about how to get out of the box. They come up with new ideas. So our youth are an amazing resource.

The CHAIRMAN. Thank you.

Senator Heitkamp, any additional questions? Senator Murkowski, anything you would like to add?

Senator MURKOWSKI. Mr. Chairman, the only thing I would add, I noted, Mr. McSwain, your comment about the youth and engagement. But you specifically said, we need to talk to the youth. I think we need to listen to the youth. And I think part of what we are dealing with is, we talk to them all the time. I talk to my kids. And sometimes they choose to listen. But when I listen to them first, that is when we have an exchange that actually makes it work.

I mentioned meeting with the head of the DEA yesterday in my office. I had two interns with me. One is from Ketchikan, Ketchikan has a drug problem down there. One of them is from Un-

alaska, two island communities that are dealing with these issues of drugs. The comment that I got from both of them was, when the head of the DEA and you, Senator Murkowski, asked us as young women who have just graduated from high school, what we think would make a difference in our community, that is empowering. We need to remember to listen to what these young people have to say. They are a heck of a lot smarter than we would ever give them credit for.

I appreciate what everybody is trying to do, and we will keep at it. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I want to thank all of you for being here to testify today. The hearing record will be open for two weeks. I want to thank all of you for your testimony and our time.

Since Senator Murkowski mentioned interns, we have a number of interns from the Committee. This will be the last hearing of the Committee before they head back to college or to their life. I want to thank each and every one of the interns for their hard work over the summer. I know they are going to continue to work hard as we are back in our home districts visiting and listening to what people have to say.

With that, the hearing is adjourned.

[Whereupon, at 3:57 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF LESTER SECATERO, CHAIRPERSON, NATIONAL INDIAN HEALTH BOARD (NIHB)

Chairman Barrasso, Vice Chairman Tester and Members of the Committee, thank you for holding this important hearing on "The True Costs of Drugs and Alcohol in Indian Country". On behalf of the National Indian Health Board (NIHB) and the 567 federally recognized Tribes we serve, I submit this testimony for the record. The federal promise to provide for the health and welfare of Indian people was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation's obligations to the Tribes and the special trust relationship between the United States and Tribes. The United States assumed this responsibility through a series of treaties with Tribes, exchanging compensation and benefits for Tribal land and peace.

Of the challenges facing American Indian and Alaska Native (AI/AN) communities and people, few challenges are greater or more far reaching than the epidemics of alcohol and the abuse of other substances. AI/ANs are consistently over-represented in statistics relating to alcohol and substance abuse disorders, deaths (including suicide and alcohol/substance related homicides), family involvement with social and child protective services, co-occurring mental health disorders, infant morbidity and mortality relating to substance exposure, the diagnosis of Fetal Alcohol Syndrome (FAS) and other Fetal Alcohol Spectrum Disorders (FASD), partner violence, diabetes complications and early onset as a result of alcohol abuse, and other related issues. Current alcohol and substance abuse treatment approaches (offered by both the Indian Health Service (IHS) and Tribal facilities) employ a variety of treatment strategies consistent with evidenced-based approaches to the treatment of substance abuse disorders and addictions (such as outpatient group and individual counseling, peer counseling, and inpatient/residential placements, etc.) as well as traditional healing techniques designed to improve outcomes and align the services provided with valuable cultural practices and individual and community identity. IHS-funded alcohol and substance abuse programs continue to focus on integrating primary care, behavioral health, and alcohol/substance abuse treatment services and programming through the exploration and development of partnerships with stakeholder agencies and by establishing and supporting community alliances. Adult and youth residential facilities and placement contracts with third party agencies are funded through the IHS budget for alcohol and substance abuse treatment; however, as a result of diminishing resources, placement and treatment decisions are often attributed more to funding availability than to clinical findings.

Costs of Drugs and Alcohol in Indian Country

Current research indicates that 64.8 percent of American Indians or Alaska Natives have used illicit drugs in their lifetimes while 27.1 percent have used in the past year. These drastic numbers mean that almost two thirds of the AI/AN population has been exposed to addictive and illicit drugs. According to the California Tribal Behavioral Risk Surveillance System survey, 39 percent of AI/AN respondents reported heavy alcohol consumption within the past 30 days, compared to the national average of 24 percent.

According to a study in 2009,[1] AI/ANs were almost twice as likely to need treatment for alcohol and illicit drugs as non-Native people. The study found that AI/ANs needed treatment at a rate of 17.5 percent compared to the national average of 9.3 percent. Providing this treatment is costly to the community and gaps in funding mean that the treatment is often inconsistent both from year to year and across Indian Country. Because funding is never guaranteed, vulnerable people and communities can slip through the cracks and back into drug habits when grant resources run out. For example, the Fort Peck Tribes of the Assiniboine and Sioux cre-

[1] Abbey, A., Parkhill, M.R., Jacques-Tiura, A.J., Saenz, C. (2009). Alcohol's Role in Men's Use of Coercion to Obtain Unprotected Sex. Substance Use & Misuse Journal, 44(9–10):1329–1348.

ated a drug task force on their remote reservation in northeastern Montana in order to employ a crossjurisdictional strategy for treating and preventing substance abuse. The task force was funded through a state-funded program. NIHB Board Member, Charles Headdress, noted that the program was making progress, but when the funding ran out, the gains the task force made diminished and methamphetamine dealers were able to increase their presence on the reservation. Because exposure to illicit drugs is so common and AI/ANs are more likely to need treatment, it is clear that continued funding for treatment of alcohol and drug use is a top priority for Indian Country. During the hearing, Senator Heitkamp noted that "we don't have a strategy, we just have a series of events" when it comes to health care delivery in Indian Country. There is truth in this statement: Congress must commit considerable, consistent resources in the treatment and prevention of alcohol and substance abuse.

The monetary cost of addiction treatment is just one of the major costs of drugs and alcohol in Indian Country. Intentional and unintentional injuries and hospitalizations related to drugs and alcohol can incur huge costs both to individuals, communities and healthcare facilities. Alcohol was associated with 32.2 percent of all unintentional injury hospitalizations among AI/ANs, yet Tribes are not getting significant funding from the federal government to address this issue. For example, in FY 2016, the unintentional injury program at the Centers for Disease Control and Prevention (CDC) is not receiving any additional funding in either the House or Senate's draft Appropriations bills. This is problematic for Tribes, as unintentional injury is the third leading cause of death among AI/ANs, and many of these are alcohol related. CDC is currently operating efforts in Alaska and the outcomes from these programs are promising—showing real behavior change. But the opportunities to expand these efforts into other parts of Indian Country will be severely limited by the proposed flat funding. Above and beyond funding levels, there are other considerations for how the allocations will be spent. For example, the unintentional injury prevention will be administered by states, not through any of the Tribes. It is critical that Congress provide authority for CDC to create a separate, direct funding stream or block grant directly to Tribes for this program eliminate a state pass-through requirement.

More disconcerting is the cost of intentional self-harm induced by drugs or alcohol. Alcohol was associated with 63.2 percent of all intentional injury hospitalizations nationwide among AI/ANs. In Alaska, three out of five (57.5 percent) suicide and self-harm hospitalizations were alcohol-related among Alaska Natives. Both nationally and locally, when American Indians and Alaska Natives do harm to themselves, alcohol is involved approximately 60 percent of the time. In small reservation communities or Alaskan villages, a suicide or incidence of self-harm can have a ripple effect throughout the community, and increase suicidal ideation among peer groups in the community. Providing effective and timely treatment for one at-risk person can remove the catalyst for a rash of responsive suicides within a community.

During the hearing, most witnesses and Senators agreed that the biggest cost of drugs and alcohol is the loss of human life. NIHB agrees. In the Bureau of Indian Affairs Nashville Area, 9 percent of all AI/AN deaths from 2002–2012 were substance-abuse related. Drugs and alcohol can affect all members of a community. Mr. Headdress stated that "prominent members of our societies are falling by the wayside and into addiction." This problem encompasses all people in a tight knit community and the death that comes from drugs and alcohol reverberates outside of the traditional family, putting even more individuals at risk from suicide, especially when it comes to youth. Drugs and alcohol truly do cost human lives.

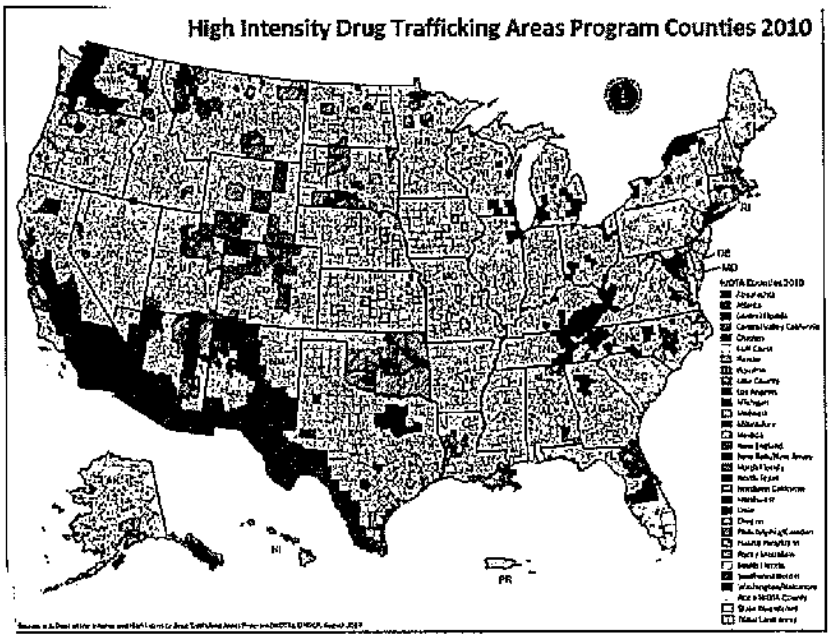
Methamphetamines

Although alcohol has long plagued our communities, specific drugs are coming in great numbers to Indian Country. Methamphetamine and prescription drugs (specifically opiates) are proving to be major destructors of our communities. Because of the accessibility and highly addictive nature of these drugs, healthy communities can quickly fall into despair. One Tribal leader described those addicted to meth and prescription drugs as "skeletal zombies walking around with no teeth."

Meth is a drug that thrives in rural communities, including reservations and Alaska Native villages. Tribal leaders are aware that meth dealers target our communities because of the remote locations and limited law enforcement presence. In fact, many leaders know where the meth houses are in their communities, but do not have the law enforcement resources to move against these entrenched operations. For example, The Fort Peck Tribe in Montana has 23 police officers that cover a two million acre reservation. (For reference, the state of Delaware is 1.594 million acres.) With such a small police presence covering these large tracts of land,

meth manufacturing and distribution can thrive. In addition to bad actors bringing drugs onto the reservations, Native people in the depths of addiction can create the drug themselves with household goods instead of relying on outside dealers. Meth labs have cropped up in Tribal housing and often times the subsequent damage to the homes prohibits the Bureau of Indian Affairs from moving in other families: the houses are uninhabitable. Tribes are finding that they simply do not have the money, resources or man power to tackle a drug like meth. When they bust one house, the drugs move to another place on the reservation.

In the map below, provided by the White House Office of National Drug Control Policy, one can clearly see how close drug trafficking areas (colors) are to reservations (brown hash marks). Tribes in the Southwest are constantly trying to keep drugs that are coming across the Mexican border out of their communities. (orange). The drug trafficking areas in North and South Dakota (light blue) are on or near some of the largest and most populous reservations in the country. Western Washington Tribes combat drugs coming in through their ports from Asia (lavender). The main trafficking area between the US and Canada runs through New York State and Iroquois country (navy blue).



According to The National Institute of Health, "while national trends are showing declines, methamphetamine abuse continues to exhibit regional variability. . .with the strongest effects felt in the West and parts of the Midwest." States in the West and Midwest happen to have the largest numbers of Native populations. In addition, according to The California Tribal Behavioral Risk Surveillance System, 30 percent or AI/AN people have reported using meth, crank or ice.

Tribes in the Northern Plains are noticing an influx of drugs due to the booming economy of the Bakken Oil Field. Again, drug dealers target these reservations, especially in North Dakota, South Dakota and Eastern Montana, because of their understaffed police forces, fluctuation of the labor population and large acreage. Drug cases are flooding Tribal courts in South Dakota especially with the Three Affiliated Tribes of the Mandan, Hidatsa and Arikara (MHA). MHA Nation Chief Judge, Diane Johnson, declared to the Los Angeles Times, before the oil boom "about 30 percent of the cases that came to her court were drug-related and that number is now closer to 90 percent." The effects are overwhelming Tribal administrations and Tribal courts.

The effects of meth addictions are felt by the entire community. Many AI/ANs from across the country have echoed that every family has at least one member with a meth problem. Those addicted to meth have often given up on participating in the

community and begin taking from the community to fuel their habits. Community members cannot leave belongings unattended for fear that they will be stolen and sold for drug money. Lastly, because many of these rural reservations have depressed economies, there is a financial incentive for Tribal members to participate in the illegal drug trade because that is often the only way they can make money.

Opiates and Prescription Drugs

Heroin and prescription drug use go hand in hand. Prescription painkillers like Vicodin or OxyContin are routinely prescribed by doctors for a myriad of medical concerns. However, these highly addictive prescription opioids can open the door to heroin and other opiate drug use. In addition, heroin leads to many public health concerns regarding intravenous drugs use like Hepatitis C and HIV.

Much like meth, prescription drug abuse affects rural communities differently than it does urban and suburban areas. For example, in Montana, IHS doctors have been prescribing opioid painkillers like Vicodin or OxyContin in lieu of surgery because hospitals are often hundreds of miles away, or the IHS is unable to provide funding for referrals. According to the National Institute on Drug Abuse, those who abuse opioid prescription drugs often switch to heroin as a substitute. Exposing AI/AN populations to highly addictive painkillers through the Indian Health Service fuels heroin addiction on reservations. An elected Tribal leader of a Tribe in California recently said that "the worst drug dealer on the reservation is IHS." More must be done to hold physicians and IHS accountable to the damage they are doing by fueling this crisis in Indian Country.

Heroin and prescription drugs are putting American Indian and Alaska Native youth at risk. Nationally, one in twelve high school students reported non-medical use of prescription drugs in the past year and one in twenty reported abusing Oxycontin. However, AI/ANs annual heroin and Oxycontin use was two to three times higher than this national average.

During the hearing, Senator Murkowski noted how difficult it is to raid heroin dens on island communities in Alaska. This is a common theme throughout Indian Country. Local law enforcement often does not have the resources to conduct a raid: one obstacle is obtaining a warrant when judges are often far away. Tribal leaders have voiced similar concerns about policing drug areas. They have also stated that the Tribal Law and Order Act, while beneficial, has also not helped as much as Tribes have needed or expected in terms of coordination between various agencies or in providing additional resources to law enforcement. Drugs are overwhelming Tribal administrations because combating the epidemic requires additional funding and coordination between law enforcement, Tribal health programs, schools, and community members.

Nationally, deaths involving heroin have quadrupled from 2000 to 2013. Most of the increase occurred after 2010 and the greatest increase was seen in the Midwest. These figures correlate with concerns of Tribal Leaders near the Bakken Oil Development that has reached peak development since 2010. The Bakken Oil Development has had a negative effect on the health and wellbeing of Tribes in the region by increasing drugs on the reservations. Remote locations, and small numbers of law enforcement officers make reservations in the area a primary target for drug traffickers. Congress must support targeted interventions in these areas so that the negative effects of this new development are not harming Tribal communities.

Youth Involvement

During the hearing, Senator Franken told a story about visiting a Native teen recovery center in Minnesota. He asked the youth how many of them started using drugs or alcohol with their parents and all students raised their hands "yes." AI/AN youth are initiating alcohol and drug use earlier than their non-native counterparts. Because drugs and alcohol are so prevalent with adult AI/AN populations on many reservations, it is often only a matter of time before the young people of a community begin to use as well. Not only are AI/AN youth starting to use drugs and alcohol at an earlier age, more youth are using drugs and alcohol more often than non-native youth.

According to the California Department of Education's California Healthy Kids Survey, between 2008 and 2010, 30 percent of AI/AN youth ages 12–17 reported drug or alcohol use in the past month. Of those who used alcohol in California in the past month, 39 percent reported heavy alcohol consumption or binge drinking. AI/AN youth have reported much higher percentage of binge drinking (16.7 percent) compared to the National Healthy People Goal (8.6 percent). Nationally, AI/AN students' annual heroin and OxyContin use was two to three times higher than the national average for youth heroin and OxyContin use.

High substance use in American Indian communities contributes to a range of social problems including violence, delinquency, and mortality from suicide or alcohol or other substance abuse. Thus, these findings alert us to the urgency of implementing prevention programs in these communities. Research documents higher rates of use and earlier initiation among AI/AN adolescents compared with other U.S. adolescents, but the extent of disparities found varies across studies. This is why research for drug use and treatment programs is so important. Part of this research should analyze the use of cultural practices.

Policy Recommendations

Clearly, more must be done to restore alcohol and drug-free Tribal communities. Foremost, long-lasting reform should involve a variety of actors including Tribal, federal, state, and local governments; community elders; youth leaders; school leaders; and the community members themselves. However, there are several things that Congress can do in order to help address the true costs of alcoholism and substance abuse in Indian Country:

- *Increase funding for research on the locations and effects of alcohol and substance abuse in Indian Country.* Before we are able to treat the causes, it is critical that we have better data on the incidence, prevalence, effects and locations that experience these problems. CDC should provide designated funding to Tribal Epidemiology Centers in order to have better data on this critical issue. This research should identify specific targeted locations and causes of alcoholism and drug abuse.
- *Provide funding to Tribes and Tribal researchers to establish indicators for evidence-based criteria that are based on traditional healing practices.* Tribal communities have been healing their people for thousands of years, and are highly effective in the communities where they are employed and engaged. Yet, it is often the case that traditional healing practices are not do not meet mainstream criteria for data collection under federal grants, which puts Tribes at a disadvantage when applying for and administering federal programs. It is critical that Congress support these traditional practices by providing funding to establish evidence-based criteria related to traditional healing methods.
- *Increase and sustain funding for alcohol and substance abuse treatment and prevention programming in Tribal communities.* This should include expanding the Methamphetamine and Suicide Prevention Initiative (MSPI) at IHS, which is currently only funding about 100 demonstration projects. It should also include specific training for Tribal members to become counselors and addiction professionals in order to create sustainable change on reservations. Recruitment and retention of medical professionals is a chronic issue at IHS. Alcohol and substance abuse counselors are no different. According to the IHS' Congressional Budget Justification for FY 2016: "IHS, as a rural health care provider, has difficulty recruiting health care professionals. There are over 1,550 vacancies for health care professionals. . .across the IHS system. . ." (CJ–216). Given these challenges, it is critical that training be provided for community members already living in these Tribal communities so that they there can be continued support for these critically-needed services.

  For FY 2017, the Tribes have recommended that Congress increase funding for Alcohol and Substance Abuse at the IHS to $312.3 million (+121.3 million (+63 percent) from FY 2015). However, it is critical that other federal agencies, including the Substance Abuse and Mental Health Services Administration, CDC, Bureau of Indian Affairs and the Department of Justice also provide longterm, designated resources to Tribes to carry out this work. In addition of funding alcohol and substance abuse treatment, these agencies should provide Tribes funding on the effects of alcohol and drug abuse such as unintentional and intentional injury funding. Congress should also provide additional funding to Tribal justice systems so that enforcing the law in terms of alcohol and drug abuse is possible.
- *Provide Congressional oversight and accountability to ensure that various federal, state, and Tribal agencies are coordinating to combat alcohol and substance abuse as referred to by law.* Congress should increase oversight on Section 241 of The Tribal Law and Order Act (P.L. 111- 211). This section of the law requires The Department of Justice, Substance Abuse and Mental Health Services Administration, Bureau of Indian Affairs and the Indian Health Service to coordinate efforts when addressing Indian alcohol and substance abuse prevention and treatment. Additional oversight and accountability provided by Congress on the implementation of this provision will ensure that The Tribal Law and Order Act is fully executed.

- *Empower Tribal governments by providing funding to create and sustain drug taskforces on reservations with high need.* NIHB's conservations with Tribes indicate that funding for programs designed to bring all aspects of the community together (Tribal leaders, elders, youth, teachers, law enforcement, federal officials, etc.) to develop community-wide strategies to tackle these issues in Indian Country.

Sustained, and continuous funding must be a key element to all of this work. A Tribal leader recently told NIHB, that "It's as if funds are awarded when rates spike, but return to complacency with alarming rates when rates fall somewhat. Programs cannot be sustained with uncertainty over funding from year to year." Indian Country must have continued investments in these programs from all agencies involved in order for there to be change. Congress must also direct the Administration to work with Tribes in forming a concrete strategy to overcome these issues so that we stop just moving from crisis to crisis.

Conclusion:

Thank you for holding this important hearing on The True Costs of Alcohol and Substance Abuse in Indian Country. This epidemic has created community-wide destruction on many reservations. The true costs of this disease have not only resulted in lowering the immediate health status of many American Indian and Alaska Native persons, but also leads long-term health costs such as feelings of depression, anxiety and even suicide. Over time, generations of young people grow up in homes ravaged by alcohol and substance abuse and experience feelings of hopelessness, and then turn to these avenues themselves effecting employment opportunities, placing serious burdens on the Tribal justice system, and eroding traditional ways of life in Tribal communities. We must break this cycle.

The National Indian Health Board stands ready to work with the Committee to create and sustain the programs suggested in this testimony.

PREPARED STATEMENT OF HON. JOHN YELLOW BIRD STEELE, PRESIDENT, OGLALA SIOUX TRIBE

Please accept this as our written testimony for the Senate Committee's hearing "Examining the True Costs of Alcohol and Drug Abuse in Indian Country." This is an issue of vital importance to the Pine Ridge Reservation – alcohol and substance abuse is one of the root problems on our Reservation; we can trace many of our other challenges—domestic violence, crime, youth suicide, and unemployment—to drugs and alcohol use and abuse. We are not unique in Indian Country for facing these problems. Chief Executive Benjamin from Mille Lacs and Ms. Goggles from the Wind River Recovery Program explained well the challenges facing our communities—from children beginning drinking at a young age to drug trafficking on our reservations to an increasing problem with drugs like heroin and methamphetamines. These issues affect us all, and without assistance, they remain intractable.

We look to the Congress for assistance with these problems, in line with the United States' commitments in the several treaties between the United States and the Oglala Sioux Tribe or its predecessors. In the 1868 Sioux Treaty, the United States promised to provide certain benefits and annuities to us, and that Treaty continues to this day. By its terms and subsequent congressional ratification, the Treaty cemented into law the United States' obligation to make annual congressional appropriations to the Oglala Sioux Tribe. This fact was so recognized by the Indian Claims Commission: "the [1868] treaty was an attempt by the United States to obtain peace on the best terms possible," and the United States promised to provide "goods and services" to the tribes. These "goods and services" include, but are not limited to, congressional appropriations for such things as medical care, education, economic development, law

enforcement and safe buildings. According to the terms of our Treaties, we ask that you assist us in our efforts to solve the problems of alcohol and drug abuse on our Reservation.

These problems are not new. The issue of alcohol abuse was one introduced to us over a hundred years ago, and has been a pervasive problem for my Tribe ever since. Many of our people turn to drugs and alcohol to escape the harsh realities of life on Pine Ridge. Worse, there are few people we can turn to for help with these problems. Despite promises from the government to provide for our health care, the cycle of addiction continues to this day, generation after generation.

Nor is this problem a discrete one. As I have emphasized in my testimony before this Committee, the problems affecting my Tribe and others are widespread and interconnected. You cannot fix the unemployment problem without fixing the education problems. You cannot fix the education problem without fixing the substance abuse and alcohol problem. You cannot fix that problem without fixing unemployment. These are cyclical problems, and they need comprehensive, multi-pronged and holistic action to address them. There are no easy solutions on Pine Ridge; there never have been easy solutions for my Tribe. But we are committed, and have the drive to do it. What we need is resources.

Alcohol and Substance Abuse in our Community

Our Tribe has been committed to data collection and community outreach to determine the extent of substance use on our Reservation. In 2013, the Tribe commissioned a Community Health and Wellness Survey, a comprehensive, 89-item questionnaire about general health conditions among our citizens. Part of that survey asked about tobacco, alcohol, and drug use, mental health, and social support. Over 600 people were surveyed, and drug and alcohol abuse was the most cited community concern.

The statistics of alcohol use are striking as well. While a smaller proportion of our membership use alcohol at all, problematic drinking such as binge drinking, alcohol use disorder, or alcohol consumption during pregnancy occurs much more among those on Pine Ridge who do consume alcohol. The rate of alcohol-related deaths for the IHS area including Pine Ridge (Aberdeen) was 81.9 per 100,000. The national rate is 6.9 per 100,000. From 2005 to 2007, the latest years statistics are available for injuries, 31% of all severe injuries were related to alcohol.

Incidence and effects of drug use are of similar concern. In 2012, 33.1% of Tribal members on the Reservation had used illicit drugs in the prior year, more than double of the U.S. rate at large (14.6%). The vast majority of drug users were using marijuana (29.8% in a 30-day sample). Other drugs included non-prescription pain relievers, methamphetamine, heroin, and cocaine.

The statistics by themselves are cause enough for alarm, but the prevalence of alcohol and substance abuse touches every aspect of life on Pine Ridge. Most obvious are the immediate health effects of such use, which contribute to the low life expectancy for our citizens. Alcohol and drugs are also linked to violence on our Reservation, on many levels. Domestic violence goes hand in hand with substance abuse or alcohol use in the home. Violence in our schools and

streets is also linked to drinking or drug use. Worst, substance abuse—and drug trafficking and sale—have brought gangs to Pine Ridge, which spawn tremendous problems for our people. Our law enforcement does what it can, but we only have 44 officers for our entire Reservation.

This all takes place on a backdrop of a community that struggles to address historical and intergenerational, repeating trauma. While conducting the Community Health and Wellness Survey, we found that families today are affected by the fallout of the Occupation of Wounded Knee in 1973, which worsened the already tumultuous relationship with the U.S. Government and Pine Ridge's non-Indian neighbors, increased violence, and increased the prevalence of drugs. However, the Occupation was cited as an event that renewed the strength of Lakota culture and practices—something that we have found is the single most productive way to combat social ills such as drug and alcohol abuse.

Those efforts are challenged by the existence of what is effectively an alcohol-trafficking hub right on the border of our Reservation: the town of Whiteclay, Nebraska. The Tribe's attempts to limit the amount of sales in the town—which is little more than four stores selling alcohol—have been rebuffed, including a request for help from the former Governor of Nebraska, who coldly told our former President that Whiteclay was the Tribe's problem, not his. The town of 14 people continues to sell 12,500 cans of beer a day—almost all of which flows into Pine Ridge, where alcohol remains illegal.

I emphasize again, however, than none of this is new to us or to you. We have been describing these problems to this Committee for many years, yet we still struggle to hold the United States Government to the terms of our Treaty and the many promises it has made to us; we still struggle to find the resources and funding we need to serve our people.

What the Oglala Sioux Tribe is doing to Address Alcohol and Substance Abuse

Reducing addiction and substance abuse on Pine Ridge has been one of our top priorities, and we have been vigilant about accessing resources, personnel, and funding from any location we are able to find to help our Tribe treat and prevent addiction among our citizens. There are several ways we are helping our people with this problem.

Anpetu Luta Otipi (ALO) is a comprehensive substance abuse program that administers a wide variety of addiction prevention, treatment, and recovery support services for adolescents and adults experiencing problems with alcohol and drugs. ALO's mission is to deliver the highest quality behavioral health services that are guided by science and anchored in traditional Lakota culture, philosophy, and worldview in order to eliminate alcohol, commercial tobacco, and other drug abuse on the Pine Ridge Reservation. ALO works in collaboration with other Oglala Sioux Tribe programs that have a shared goal of planning, implementing, and evaluating strong evidence-based prevention programming. Some of the partnering programs include Sweet Grass Suicide Prevention Program, *Tawacin Ohoklila* Prevention Program, and OST Health Education.

Traditional concepts of health among many American Indian families within the Pine Ridge Reservation involve the intersection of physical, mental, and spiritual wellbeing, which

are all seen as inextricably linked. ALO and other Oglala Sioux Tribe alcohol and substance abuse stakeholders believe that the most effective approaches to affecting community norms over time carefully and systematically synchronize traditional Lakota values and practices with science-based methods. The abuse of alcohol has placed a heavy burden on all social institutions within Pine Ridge. The most substantially impacted include the family, health care systems, public safety, and social services.

Comprehensive alcohol and substance abuse intervention programs have the ability to make a tremendous impact at both an individual/personal level as well as within the broader community when services are: (1) rooted in behavioral health science; (2) informed by a community's specific epidemiological data; and (3) delivered with fidelity by passionate, qualified professionals. Investing in evidence-based programming not only decreases the social, economic, and health consequences of alcohol, tobacco, and other drugs, but also contributes to the development of healthy communities.

Our *Tawacin Ohokila* program is dedicated to assisting our Tribe to overcome the ravages of cultural trauma and addiction. This program has become one of our most successful treatment programs. It is under the *Tawacin Ohokila* program that the Oglala Sioux Tribe had commissioned the above-mentioned Community Health and Wellness Survey. The results of that Survey were used to produce the 2014-2017 Oglala Sioux Tribe Strategic Prevention Plan to prevent alcohol and drug use, as well as to increase the general health and wellness of our citizens. Under the auspices of *Tawacin Ohokila*, we have formed the Oglala Sioux Tribe Epidemiological Workgroup (OSTEW) to work across Tribal agencies (Schools & Colleges, Public Safety, Behavioral Health, Elected Officials, and Tribal Health & Indian Health Service) to provide leadership for the coordination, management, and dissemination of the Tribe's epidemiological data to ensure data collection for the effective execution of our prevention plan.

In implementing our Strategic Prevention Plan, we have focused on the following goals:

- Monitor alcohol, commercial tobacco, and other drug use within the Pine Ridge Reservation.
- Prevent the initiation and progress of alcohol, commercial tobacco, and other drug use.
- Increase the capacity of Tribal systems to plan and implement best and promising practices that aim to reduce the abuse of alcohol, commercial tobacco, other drugs, and suicide.
- Promote systems and environmental changes that decrease access to alcohol, commercial tobacco, and other drugs.

These goals will be met through planning and policy advocacy, but most importantly with outreach and direct service to our citizens. The Oglala Sioux Tribe realizes that these goals are only reached if efforts are made in a wide-ranging and comprehensive way, so our services range from reading promotion and education among our very young, to social media outreach to engage our adolescent and young adult populations, to workforce development and training for our working age population, to enlisting the help of our traditional leaders and elders to revitalize and maintain cultural ties that help the lessons of preventing addiction "stick" with our people.

Still other programs reach our members to assist them with problems that stem from substance abuse. Our suicide prevention efforts are chief among these, and the Tribe takes a similarly comprehensive path towards intervention. In order to address this problem, we are targeting economic growth and infrastructure development, education and youth engagement, housing conditions and availability, physical and mental health, and law enforcement.

Unfortunately, the Indian Health Service and the Substance Abuse and Mental Health Services Administration are not living up to their trust and treaty responsibilities in providing health care for our people. While the Community Health and Wellness Survey and drafting of our Strategic Prevention Plan was assisted by a grant from SAMHSA, continuing funded is needed to maintain our assessment and screening activities, to engage in prevention, and to provide treatment.

Steps to Assist our Tribe Heal our People

As I have emphasized, the only way to address the challenges on Pine Ridge is comprehensively, to approach them from all sides and with all resources, agencies, and programs working together. We need to address the large concerns at our community: rampant unemployment, crime and violence, addiction, and the resulting feelings of despair and hopelessness. While alcohol and drug abuse is a factor in all of these problems, the problems are likewise a factor in the high rates of alcoholism and addiction.

We also hear—many times from the Committee itself—that there is "not enough funding to go around." This refrain has become so commonplace in Washington that we here in Indian Country think you are starting to believe it. We contest that notion completely. There are enough resources to address the problems in Indian Country; it is only a matter of *priorities* that results in our funding shortfalls, limited demonstration programs, and the unmet needs in our physical and mental health care facilities. We know that the Committee is doing its best to convince your colleagues in Congress that our issues deserve attention; we ask that you keep doing so.

The following are recommendations we have to address needs in all areas that will assist in lessening the negative effects of alcohol and substance abuse on Pine Ridge:

- Funding for substance abuse treatment, behavioral and mental health, and prevention efforts in the Indian Health Service must be increased to address the need of all in Indian Country. For a problem of epidemic proportions, it is unconscionable that the Indian Health Service does not have enough physicians and psychologists or counselors to treat Native people directly (without the use of Purchased and Referred Care, which can present barriers to healthcare access). To begin, the Senate can vote to fully fund the Tribal Health Initiative in SAMHSA at its full authorization of $50 million, and provide $25 million for the Methamphetamine and Suicide Prevention Initiative at the IHS.

- We support the idea that alcohol and substance abuse screening in schools and health care facilities will help us intervene earlier in the cycle of alcoholism or addiction. Increasing

the number of counselors in the schools, their training, and the training of healthcare professionals to screen for these issues would be advantageous to our Tribe.

- We need more resources for public safety and courts to help interdict drug and alcohol trafficking on our Reservation, and to combat the violent crime that accompanies that activity. Funding for 60 additional tribal law enforcement officers is paramount, as is increased justice funding for tribal court systems and detention facilities (which can also include substance treatment programs). Further, Congress must restore tribal jurisdiction so we may prosecute all crimes in Indian Country, regardless of who commits them; state and federal courts have proven unable to handle these problems.

- Given that we have a high proportion of young people in our Tribe, we support efforts behind the President's "Generations Indigenous" effort to promote the health, education, and achievement of the Nation's Native youth. We ask that Congress make permanent the programs the Administration has undertaken to support these efforts, such as the Native Youth Community Projects program at the Education Department, Native Languages programs, and job training programs.

- As we testified to the Committee earlier this year, preventing Youth Suicide is our first priority on the Pine Ridge Reservation. The main goal of our effort is to reduce the sense of despair and hopelessness among our youth, which requires a comprehensive approach to reduce unemployment, increase education outcomes, improve health and treatment services, and increase the availability of high-quality housing to prevent overcrowding. This also entails improving the infrastructure on Pine Ridge; our roads, water & sewer facilities, and school buildings are in disrepair. We need funding to revamp our infrastructure, then sufficient resources to maintain these physical resources.

- The IHS and other agencies must be able to easily integrate traditional health and treatment methods in their substance abuse treatment and prevention activities. These efforts are, by-definition, community based, and serve to strengthen social ties among our people. Increased federal funding for these services could do more than any other program to address the substance and alcohol abuse problems in Indian Country.

Thank you for considering our testimony. The Oglala Sioux Tribe is dedicated to battling the problems of substance abuse and alcoholism, and we respectfully seek the support of this Committee and Congress in our efforts. Please feel free to contact me if you have any questions.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO HON. ROBERT G. MCSWAIN

Question. Mothers with opioid addiction often begin with legal prescriptions. Poor prescribing practices can have tragic consequences so it's very troubling when individuals receive addictive drugs for minor conditions or receive more medication than is necessary.

Many American Indians receive health care through the Indian Health Service (IHS). What specific steps has the IHS taken to improve prescribing standards and address over-prescription?

Answer. IHS works with partners within and outside the Department of Health and Human Services, including the Behavioral Health Coordinating Council's Prescription Drug Abuse Working Group on this issue. IHS has provided mandatory training for its providers on safe and appropriate prescribing practices. The first five-hour training course was held in February 2015. The training is held on a regular basis. By April 2017, all IHS health care professionals who prescribe as part

of their duties will have received the training at least once, with refresher courses at least every 3 years thereafter. [1, 2]

IHS has established a national IHS chronic non-cancer pain management policy to provide direction to its federal hospitals and clinics on appropriate opioid prescribing. This will be updated once the Centers for Disease Control and Prevention (CDC) publishes final guidelines for primary care providers on safer, more effective care for patients with chronic pain. To assist providers with resources, IHS developed its pain management website *http://www.ihs.gov/painmanagement/).*

In addition to the steps above, many IHS providers participate in State Prescription Drug Monitoring Programs (PDMPs), and IHS is working to decrease barriers to PDMP use. An IHS circular has been drafted on participation in PDMPs and is under Agency review. In 2012, IHS convened a multi-disciplinary workgroup to focus on Prescription Drug Abuse in Indian Country. As part of the workgroup's recommendations, IHS has worked with ONDCP, the Bureau of Justice Assistance, and numerous state PDMPs to expand participation with existing state PDMPs, to develop best practice recommendations, and to report controlled substance dispensing data to state PDMPs. IHS has developed software compatible with five American Society for Automation in Pharmacy formats, deployed reporting capacity in 21 states, and assisted tribal programs with PDMP program deployment. As these systems continue to mature, PDMPs can enable health care providers and law enforcement agencies to prevent the non-medical use and diversion of prescription opioids.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. AL FRANKEN TO MIRTHA BEADLE

Tribes in Minnesota have noted that there is limited research on opioid abuse and treatment that is specific to Indian Country.

Question. How can the Substance Abuse and Mental Health Services Administration and other federal agencies support research on the contributors to opioid abuse among Native Americans as well as what treatment approaches are most effective for this population?

Answer. The Substance Abuse and Mental Health Services Administration's Center for Behavioral Health Statistics and Quality (CBHSQ) currently conducts research on the epidemiology of and factors contributing to opioid use and misuse among American Indians and Alaska Natives. CBHSQ collects data through the National Survey on Drug Use and Health (NSDUH) on substance use and mental health, including opioid use and misuse, as well as associated demographic and risk and protective factors. Data are also collected through the Treatment Episode Dataset (TEDS) on treatment admissions and discharges, as well as associated demographic factors. CBHSQ frequently reports on analyses by demographic characteristics, including for the American Indian and Alaska Native population. CBHSQ is developing a Public Health Research and Surveillance Agenda for the American Indian and Alaska Native (AI/AN) population that will include a description of what is known and questions that remain regarding the behavioral health epidemiology of the AI/AN population. Recent CBHSQ publications include:

- 2014 National Survey on Drug Use and Health: Detailed Tables (2015)
- The NSDUH Report: Need for and Receipt of Substance Use Treatment among American Indians or Alaska Natives (November 2014)
- The TEDS Report: American Indian and Alaska Native Substance Abuse Treatment Admissions Are More Likely Than Other Admissions to Report Alcohol Abuse (November 2014)
- Treatment Episode Data Set (TEDS): 2002–2013. National Admissions to Substance Abuse Treatment Services (2015)
- Data Spotlight: Almost Half of American Indian and Alaska Native Adult Substance Abuse Treatment Admissions Are Referred through the Criminal Justice System (November 2012)

To support effective treatment, SAMHSA's Treatment Improvement Protocol 51: Substance Abuse Treatment Addressing the Specific Needs of Women provides substance use disorder treatment advice to clinicians and administrators for Native-American Women, which includes clinical, program development, and staff training

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[1] *https://www.whitehouse.gov/the-press-office/2015/10/21/fact-sheet-obama-administration-announces-public-and-private-sector*

[2] *https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin*

components. Among these components, specific advice includes exploring women's beliefs regarding healing and knowledge of cultural practices; combining contemporary approaches with traditional/spiritual practices; and training staff to address biases and myths associated with Native American Clients.

The National Institute on Drug Abuse (NIDA), within the National Institutes of Health, also funds research on opioid misuse. Since 1975, NIDA has funded the Monitoring The Future (MTF) survey, which measures drug, alcohol, and cigarette use and related attitudes among adolescent students nationwide. Survey participants report their drug use behaviors (including prescription opioid misuse) across three time periods: lifetime, past year, and past month. Overall, 44,892 students from 382 public and private schools participated in this year's MTF survey. NIDA has also funded research comparing MTF survey results with survey data specific to the AI/AN population.

