Testimony of Governor Michael Chavarria
Pueblo of Santa Clara, New Mexico

"Legislative Hearing on S. 3126 and S. 3264"
Senate Committee on Indian Affairs
September 23, 2020

Introduction. Thank you Chairman Hoeven, Ranking Member Udall, and Members of the Committee for inviting to testify on S. 3126, the "Native Behavioral Health Access Improvement Act of 2019" and S. 3264, the "Bridging the Tribal Digital Divide Act of 2020." Behavioral health and broadband access represent two areas of increasingly dire need in Pueblo Country. S. 3126 and S. 3264 would make critical strides in addressing these two areas of unmet need.

My name is J. Michael Chavarria and I am the Governor of Santa Clara Pueblo, also serving in the capacity of the Chairman of the All Pueblo Council of Governors (APCG), which is comprised of the leaders of the nineteen Pueblos of New Mexico and Ysleta del Sur Pueblo in Texas. Together and individually, our communities are dedicated to improving the health and welfare of our Pueblo citizens. I testify today on behalf of the Pueblo of Santa Clara to share our experience in the hope that it will assist you and your staff in considering these vitally important bills.

Santa Clara Pueblo and the Ubiquitous Need for Behavioral Health Services. Our Pueblo has felt and continues to feel the direct impacts of inadequate access to behavioral health services. It affects our students at the Kha'p'o Community School, our adults in social support programs, and our teenagers and youth throughout the community. Because the needs in this area are so great and diverse, it would be possible to spend the entirety of my testimony on this topic alone. However, for the purposes of manageability, I will focus on the connection between substance abuse disorders (SUDs) and behavioral health.

Northern New Mexico and the Española Valley, where Santa Clara Pueblo is located, have the lamentable distinction of having among the highest national rates opioid abuse and overdose. Our home county of Rio Arriba reported an annual average of 89 drug-related fatalities per 100,000 residents between 2012 and 2016. For comparison, New Mexico as a whole averaged 24 drug-related fatalities annually for the same period. Our Pueblo has not been spared. Tribal Court cases involving opioid use are on the rise with at least 30 such cases coming before our Tribal Judge since 2014. Many of these cases involved individuals subject to a dual diagnosis of an opioid SUD and a mental health disorder that must be treated together. Unfortunately most facilities and programs treat addiction and mental health separately and that is one of the reasons for high rates of recidivism.

In the last six years, our Tribal Court has played an essential role in reducing crime by over 50% and reducing the incarceration budget by 66%. To continue this success, there must be more beds and facilities for those needing integrated dual diagnosis treatment. In general, the most effective treatment for a dual diagnosis individual is treatment at a long-term or residential care facility followed by targeted support upon discharge.

Tragically, we do not have the behavioral and mental health resources to assist our Pueblo members in breaking cycles of addiction and staying on the path of sobriety. The effects of decades of understaffing, insufficient resourcing (including funding), and inadequate facilities are now painfully evident. The IHS, for example, has only *twelve* behavioral health specialists to serve the entire Albuquerque Area, an area that covers three states and twenty-seven tribal nations. Our members must often wait extended periods for an appointment with a behavioral health specialist. In the interim, our people must suffer through behavioral or mental health crises without formal support – placing both themselves and the greater community at risk.

Extenuating Circumstances Caused by the COVID-19 Pandemic. As Ranking Member Udall is well aware, the current public health emergency has disproportionately impacted Pueblo and tribal communities in New Mexico. At one point, AI/ANs accounted for nearly 60% of all COVID-19 positive cases in the State. Today, the AI/AN positivity rate stands at 30%, meaning that 1 in 3 cases in New Mexico is an AI/AN individual – a terrible feat given that we make up only 11% of the State's overall population.

The disparate impacts are attributable, in significant and substantial part, to the direct connection between a chronically underfunded Indian Health Service and our members' physical welfare. Pueblo people suffer from high rates of chronic and acute health conditions like diabetes and heart disease that contribute to severe COVID-19 cases and increased rates of patient mortality. The Special Diabetes Program for Indians and other federally-funded health programs are key to managing contributing health factors and symptoms.

Like other tribal nations, the Pueblo of Santa Clara has closed tribal businesses, offices, and borders in an attempt to stem the incursion of COVID-19 onto our lands. Our members have been instructed to shelter in place and to only leave home for essential services and emergencies. The prolonged social isolation is a deep hardship for many members. Our Pueblos are communal in nature with life taking place through community interactions and the gatherings of our extended, intergenerational families. The pandemic has prevented us from expressing these essential aspects of our Pueblo identities – unmooring us from our communal, ceremonial, and traditional lifestyle. The result is an across-the-board increase in depression, anxiety, and loneliness, along with a dangerous increase in SUDs and suicide risk among our vulnerable members.

Broadband and Telehealth Limitations at this Time. Pueblo members struggle to manage the many economic, social, familial, personal, emotional, and physical stressors being placed upon them with limited to no formal support. Members who struggled with SUDs before the pandemic also have to deal with the unfortunate additional stressor of being abruptly cut off from individual and group therapies, treatment services (including Medication Assisted Therapy or MAT), and immersive SUD programs like residential and long-term treatment centers.

Our members have been directed to use telehealth services to meet their behavioral health support and case management needs during the pandemic. The direction, however, assumes that (a) individuals have access to Internet at home through a smartphone or other device; and (b) communities have the requisite infrastructure to support high-speed connections across tribal lands. Both of these assumptions are false when talking about Pueblo Country. Individuals and families lack sufficient data plans to access services via cell phone and many homes are not

connected to any kind of wireless or broadband service. Where connections are possible, the bandwidth is often overstretched due to the high demand for services as everyone in the household is logged on simultaneously for work, school, grocery shopping, family calls, and appointments. Further, overcrowding and potential unsafe housing conditions may make it difficult, if not impossible, for individuals to access services with any privacy.

We are establishing hot spots across Pueblo lands to facilitate community access to the Internet. Students, families, workers, behavioral health patients, and others endure scorching temperatures and discomfort to use these hot spots for everything from classroom instruction to bill payments to medical and therapy appointments. How can we expect community members to continue this type of behavior as the pandemic stretches into the winter months? Telehealth and tele-service programs are only as effective as the systems that support them. We simply must find a way to provide high-speed Internet at reduced or no cost to our Pueblo members. Without it, it is as if our most vulnerable Pueblo members have been given a boat filled with holes and told to make it to shore with just a single plug … and no oars. Is it any wonder that the behavioral and mental health needs of our members are at an unprecedented high?

Opportunities for Positive Change Presented by S. 3126. The Native Behavioral Health Access Improvement Act would provide Pueblo members with the tools they need to plug into urgently needed behavioral and mental services and stay afloat. The central tool for this effort is the creation of a Special Behavioral Health Program for Indians (SBHPI) modeled after the Special Diabetes Program for Indians (SDPI). SDPI has been broadly successful in reducing incidences of diabetes and diabetes-related conditions in Indian Country through the successful integration of cultural derived and evidence-based health prevention, management and treatment practices. SDPI also provides tribal nations with funding flexibility to tailor their programs to meet local needs. We think that taking the best practices learned from SDPI to create a targeted SBHPI could be effective in addressing unmet behavioral and mental health needs.

It is vital that covered services for a SBHPI grant include workforce development. As mentioned earlier, there is a severe shortage of behavioral and mental specialists in the IHS Albuquerque Area. We firmly believe that a greater investment in home-grown healthcare providers is needed to help address this workforce deficit and connect our people to culturally competent care. Flexible SBHPI grants could go a long way in facilitating targeted workforce development and training programs to increase access to behavioral health and mental health services in Pueblo Country.

We fully support the requirement in S. 3126 that grant reporting requirements for the SBHPI be developed in consultation with tribal nations. Our Pueblo and other tribal nations have expressed frustration with grant reporting requirements that are overly burdensome, rigid, and unresponsive to the diverse governing structures and internal capacities of our country's 574 federally recognized tribal governments. Incorporating tribal voices into the development process of this new program would help to preemptively address these concerns.

It has been the general experience of Santa Clara Pueblo and Pueblo Country overall that where there are behavioral health programs available through the IHS or tribal health programs, those programs are severely underfunded and cannot meet the existing and growing need for specialized services in our communities. Additional information on how Congress intends to fund the $150

million annual appropriation for the SBHPI. We would not want to see the establishment of the new program come at the direct cost of a line item that is serving Indian Country in the IHS, Substance Abuse and Mental Health Services Administration, or other federal agency budget.

Opportunity to Connect Pueblo and Indian Country to Essential Broadband under S. 3264. The Bridging the Tribal Digital Divide Act contains numerous provisions that would help facilitate advancements in high-speed broadband deployment and access in tribal communities like ours. We appreciate the multi-faceted approach of the bill. As you well know, the limited access to broadband and healthcare services that we experience daily in Indian Country cannot be fixed in isolation. They require a holistic response. One that looks at the challenge of rural geography in running fiber optic cables; the density of adobe walls in impairing signal strength; the need for AI/AN workforce development in sustainable programming; and the reality of low-income households that must too often choose between groceries and car payments or Internet bills and SUD treatments.

S. 3264 does not address all of these matters at once, but it provides avenues for tribal nations to help their communities connect to essential broadband services through long-term infrastructure investments, tribal aside funding within key USDA and FCC telecommunications programs, a Tribal Broadband Right-of-Way Pilot Program, and the provision of technical assistance to underserved tribal nations to develop appropriately tailored plan for meeting deployment benchmarks, including spectrum purchases and internal tribal capacity building. We support these proactive measures to advance the sustainable deployment of affordable broadband on tribal lands.

We are also very pleased by how S. 3264 would create both a Tribal Broadband Interagency Working Group and a Tribal Broadband Deployment Advisory Committee. The former would improve coordination across federal broadband programs that are available to tribal nations by breaking down the communication silos that exist across the federal government. The latter would ensure that tribal leaders have an active voice in assessing telecommunications regulations and identifying innovative means of meeting the broadband needs of tribal communities. Both of these types of bodies are key to raising our Pueblo and others out of electronic isolation.

Conclusion. Kuunda, thank you, for the opportunity to testify on behalf of these two compelling legislative proposals. We turn to Congress and our federal partners to ask for your sustained assistance in addressing the healthcare and broadband access needs of our Pueblo and of other tribal communities across the United States. Passage of S. 3126 and S. 3264 would mark two critical steps in the right direction.