

**OPIOIDS IN INDIAN COUNTRY: BEYOND THE
CRISIS TO HEALING THE COMMUNITY**

HEARING

BEFORE THE

COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

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MARCH 14, 2018
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OPIOIDS IN INDIAN COUNTRY: BEYOND THE CRISIS TO HEALING THE COMMUNITY

WEDNESDAY, MARCH 14, 2018

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 Hoeven, Chairman of the Committee, presiding.

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

The CHAIRMAN. I call this oversight hearing to order.

Today we will examine the opioid abuse crisis and its effect on Indian Country.

On November 9, 2017, this Committee held a roundtable on the opioid abuse epidemic in Indian Country. The roundtable highlighted how the opioid abuse epidemic is particularly complex in tribal communities given the lack of access to medical care, shortage of law enforcement and insufficient data on substance abuse. This hearing will build on that discussion and examine how Congress, the Administration, tribes and tribal organizations can work together to combat the crisis and heal Indian communities.

The facts of the opioid abuse epidemic are tragic. Our Country has witnessed an 18-year increase in deaths from prescription opioid overdoses and a recent surge in illicit opioid overdoses. According to the U.S. Centers for Disease Control and Prevention, CDC, drugs now kill more Americans, nearly 40 percent more, than car accidents.

Native American communities have been among those hit hardest by the opioid abuse crisis. The Substance Abuse and Mental Health Services Administration reports that the rates of opioid abuse are consistently the highest among Caucasian and Native peoples.

According to the CDC, in 2016, 4.1 percent of American Indian and Alaska Natives age 12 and older reported opioid misuse in the past year, similar to whites at 4.4 percent. These statistics are serious, but they may not represent the magnitude of the crisis in Indian Country, as the epidemic may be underreported.

Many witnesses at the roundtable highlighted that Native Americans are sometimes incorrectly classified as another race. Without accurate data, Congress, the Administration and tribes are limited in their ability to allocate resources to the area of greatest need.

The Committee is dedicated to engaging with tribes and finding ways to advance the Federal Government's role in combating the dangers that opioids and other substances present to tribal communities.

The Indian Health Service has established the National Committee on Heroin, Opioids, and Pain Efforts, the HOPE Committee. The HOPE Committee has been tasked with promoting appropriate and effective pain management, reducing overdose deaths from heroin and prescription opioids and improving access to culturally appropriate treatment. The IHS also now requires all IHS Federal prescribers, contractors, clinical residents and trainees to complete a course on treating pain and addiction.

On March 29, 2017, President Trump signed an Executive Order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. On October 26, 2017, the President declared the opioid abuse crisis a national public health emergency and one week later, the President's Commission released its comprehensive final report.

The final report contains more than 50 recommendations to agencies and to Congress. The Commission recommended that the IHS remove reimbursement and policy barriers to substance abuse treatment. Removing these barriers would help Native American communities access much needed treatment. It is important to begin implementing these recommendations. I look forward to hearing from our witnesses on these and other efforts to find a path toward healing for Indian communities.

Finally, I am also mindful that when Congress does appropriate funding to combat this epidemic, it is important that Indian Country receives an adequate share of the funding and receives this funding in a manner that will ensure maximized impact to their communities.

With that, I would like to welcome our witnesses. Thank you for testifying today. I will now turn to our Vice Chairman, Senator Udall, for his opening comments.

**STATEMENT OF HON. TOM UDALL,
U.S. SENATOR FROM NEW MEXICO**

Senator UDALL. Thank you, Chairman Hoeven, for calling this oversight hearing and continuing this Committee's work to address the opioid crisis in Indian Country.

Before I begin my formal remarks, I would like to welcome New Mexico's newest U.S. Attorney, John Anderson. Thank you, John, for your testimony and hard work on behalf of DOJ and New Mexicans. I look forward to working with you on some of these important Indian Country issues.

Last November, we held a roundtable on this very same issue. Tribal leaders and Native organizations joined us to engage in a dialogue with agency officials from the Indian Health Service, Department of the Interior, Department of Justice, and the White House.

These participants brought with them a lot of good information on the need for more treatment and prevention resources, especially culturally-based services. We were reminded that Congress must build in flexibility when making these resources available.

Native communities require and deserve the right to design behavioral health programs that suit local needs. Any successful response to the opioid and substance abuse crisis in Indian Country must be driven by the tribes. Congress must support tribal efforts by holding Federal agencies accountable and providing sufficient resources.

We are also working with our colleagues over at the Health Education Labor and Pensions Committee. Just last week, at the HELP hearing on State responses to the opioid crisis, three Senators, Ranking Member Murray, Senator Warren and Senator Smith, spoke about tribal opioid challenges and the need for better State-tribal coordination.

As members of the Indian Affairs Committee, we are obligated to educate our Senate colleagues about what is happening on this Committee so that Indian Country's priorities and the voices of tribal leaders are heard beyond these four walls. When members work across committees to amplify tribal needs, good things happen. The ideas we heard on addressing Native substance abuse disorders at the roundtable resulted in the introduction of S. 2437, the Opioid Response Enhancement Act, a bill led by Senator Baldwin and joined by 15 Senate colleagues, including myself and three other Indian Affairs Committee members.

The legislation refines the 21st Century Cures Grant Program to make tribes eligible to receive funds, provide tribes with programmatic flexibility and includes a 10 percent tribal setaside to further ensure that these funds actually make it out to Indian Country. Last week, I joined a group of ten Senators, led by Senator Heitkamp, on a letter to the Appropriations Committee leadership outlining the dire need for tribal-specific funding streams within the \$6 billion in opioid funding put in place as part of the recent budget cap agreement.

Finally, just this morning, I joined Senator Smith and four other colleagues to introduce the Native Behavioral Health Access Improvement Act. Modeled after the Special Diabetes Program for Indians, this legislation would create a special behavioral health program for Indians, a mandatory program funded at \$150 million annually.

I am heartened by this robust response to Indian Country's call for action but as we will learn from our witnesses today, there is much left to do. The substance abuse crisis has sent ripple effects through Native communities, straining already overtaxed tribal systems. Tribal schools, housing departments, social services, law enforcement and the courts are all being asked to address the broader community disruptions caused by this public health emergency.

I look forward to hearing from all of our witnesses today about how Congress can work to address the full impact of the opioid crisis in Indian Country. I look forward to continuing those efforts at next week's oversight hearing on the President's fiscal year 2019 budget proposal.

Thank you again, Mr. Chairman, for getting this here today.
The CHAIRMAN. Senator Barrasso.

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

Senator BARRASSO. Thank you very much, Mr. Chairman.

I just want to take a moment to thank you personally, Mr. Chairman, for holding this important hearing today. As a doctor, I have given a great deal of attention during my time as a member of this Committee to the delivery of health care in Indian Country, especially in rural areas.

I have long been concerned about the serious drug addiction crisis facing our Nation. Nowhere is the challenge more apparent than it is in tribal communities. I have been working hard with my colleagues on this Committee to finalize my bill to restore accountability in the Indian Health Service, which I believe is a step in the right direction but specific action for opioid addiction is critical.

Just yesterday before the Senate Energy and Natural Resources, we are joined now by the Chairman of that committee, Secretary Zinke shared his concerns and his commitment to addressing the opioid crisis. Successful implementation of programs requires cooperation and coordination from all sides, Interior, Justice, Health and Human Services and the tribes themselves.

Last year, the Northern Arapaho and Eastern Shoshone Tribes joined several Montana tribes to hold the Wind River War Staff Symposium in an effort combat drug and alcohol abuse. The symposium was held in conjunction with their youth winter retreat. While symposiums are not specific to opioid addiction, it is the prime example of the need to educate and engage youth if we are going to be successful in the fight to end opioid addiction.

I thank you, Mr. Chairman, for your continued leadership.

The CHAIRMAN. Are there other Committee members who would like to make an opening statement? Senator Murkowski.

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

Senator MURKOWSKI. Thank you, Mr. Chairman. I too appreciate that you have brought this very important issue before the Committee and thank you to the Ranking Member.

In the State of Alaska, we joined six other States in the Country in declaring a public health crisis in response to the opioid epidemic. We have joined Arizona, Florida, Virginia, Maryland, Massachusetts and now Alaska has issued a State disaster declaration.

As many in this Committee know and have heard from me, our very rural communities are predominantly Alaska Native communities that are being devastated by substance abuse and now opioids. The rate of overdose deaths attributed to opioids has increased and, in many cases, has greatly exceeded the national average.

In 2012, our prescription opioid pain reliever overdose death was more than double the national average. Our heroin-associated overdose deaths were over 50 percent higher than the national rate. The overdose death rate by race was the highest amongst Alaska Native people. Our statistics are troubling to the core.

There is a much reported story of four people who overdosed in the Native Village of Quinhagak a couple years ago. Quinhagak has a population of 700. One of these individuals did die as a con-

sequence of that overdose. It was determined that it was Fentanyl, more Fentanyl than heroin. We are seeing this in a remote, tiny, tiny community.

We clearly have an opioid epidemic, Mr. Chairman. We must deal with it but I must say that we must not lose sight of the other killer we are facing in our Native communities, not only in Alaska but around the Country. That killer is alcohol and how alcohol has wrought devastation.

The Napaskiak Tribal Council passed a resolution on March 5 asking that the governor declare a disaster of emergency to close the liquor store in Bethel due to high rates of alcohol-related deaths, accidents and injuries in the surrounding area. It is one more reminder to me that when we think about those we serve and their cries for help, we have so very much to do.

I thank you for bringing opioids to the attention of the Committee this afternoon. Whether it is opioids, alcohol or anything in between, know that I am committed to working with you.

I do ask that my full statement be included as part of the record. Thank you, Mr. Chairman.

[The prepared statement of Senator Murkowski follows:]

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

Chairman Hoeven, Vice Chairman Udall, I appreciate this oversight hearing to discuss the impacts of the opioid epidemic in Native American and Alaska Native communities. Alaska may be a very rural state, but we are not shielded from this epidemic and in fact opioid abuse in Alaska has rapidly become one of our most pressing issues.

Last year, Alaska Governor Bill Walker issued a State Disaster Declaration to address the growing opioid epidemic in Alaska. This meant that Alaska became one of the six states in the Nation to declare a public health crisis in response to the opioid epidemic. (Others: Arizona, Florida, Virginia, Maryland, Massachusetts)

Many of our communities, including our very rural ones who are predominantly Alaska Native, are being devastated by opioids. The rate of overdose deaths attributed to opioids have steadily increased in Alaska, and in many cases has greatly exceeded the national average. For example, in 2012, Alaska's prescription opioid pain reliever overdose death rate was more than double the national average (10.5 vs. 5.1 per 100,000 persons, respectively), and Alaska's heroin-associated overdose death rate was over 50 percent higher than the national rate (3.0 vs. 1.9 per 100,000 persons, respectively). Furthermore, the overdose death rate by race was the highest among the Alaska Native people (20.2 per 100,000).

The opioid epidemic has been increasingly more prevalent in the Alaska Native communities. For instance, the Native Village of Quinhagak, with a population of about 700, saw four people overdose (one fatally) in the span of one week in August 2016. The heroin used in Quinhagak was tested at the Alaska State Crime Lab and it was discovered that the heroin used in Quinhagak contained more fentanyl than heroin. That was only the second time in Alaska's history that a drug submitted to the state crime lab had been confirmed as mixture of heroin and fentanyl and it wasn't heroin from the streets of Anchorage or Fairbanks. But in a rural village in remote Southwest Alaska.

Alaska certainly has an opioid epidemic. But, I think this is indicative of a much larger substance abuse problem in Alaska and other areas across the country. According to the Alaska State Troopers 2016 Annual Drug Report, the single most abused substance in Alaska is alcohol. Not heroin, not cocaine, but alcohol. To date, there are 109 villages in rural Alaska that have prohibited the sale, importation, and possession of alcoholic beverages. I do understand wholeheartedly the seriousness of the growing issue of opioids, but I do not want to lose focus of some of the other issues we have that have gut-wrenching statistics as well. I have said this before, but we must have an all hands on deck, and an all-of-the-above strategy for solutions to make it through these complex substance abuse issues.

Just recently, the Native Village of Napaskiak voted on and passed a resolution that formally asked the Governor to declare a disaster of emergency to close down a liquor store in Bethel, Alaska. One of the many reasons that Napaskiak voted on

this resolution was because they saw an increase in the number of preventable deaths in their community related to alcohol abuse. In addition to that, the tribe saw an increase in the number of cases brought before their ICWA program, a decrease in the attendance rate at the local school because kids weren't getting enough sleep due to alcohol disturbances, and an increased caseload for law enforcement officials in the region.

The Tribal Council specifically asked to close the liquor in Bethel, Alaska, because that was the primary means for their members to obtain alcohol. Napaskiak is one of the 109 villages that has banned alcohol and there was still alcohol in the village because the alcohol was imported illegally from the liquor store in Bethel.

Despite the prevalence of opioids in rural Alaska, bootlegging alcohol continues to be the most lucrative and profitable criminal enterprise in Alaska. In 2016 alone, the Alaska State Troopers arrested 225 people for the possession or sale of alcohol in dry villages. This was more than any other drugs, including cocaine, heroin, and prescription medication.

Alaska Native communities don't just have an opioid epidemic, many have a substance abuse epidemic. There are tribes who are standing up against this. There are community members who are going out on a limb in their own communities to be the one to stand up against it. We must stand with them. I look forward to working with my colleagues in this committee to find a solution to this epidemic and thank you to all of the witnesses that came here today to address this issue.

The CHAIRMAN. Without objection.

Are there other opening statements?

[No audible response.]

The CHAIRMAN. Hearing none, our witnesses today are: The Honorable John C. Anderson, United States Attorney for the District of New Mexico, U.S. Department of Justice, Albuquerque, New Mexico; Captain Christopher Jones, Director, National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Rockville, MD; and Rear Admiral Michael Toedt, MD, Chief Medical Officer, Indian Health Service, U.S. Department of Health and Human Services, Rockville, MD.

I want to remind the witnesses that your full written testimony will be made a part of the official record and to please keep your statements to five minutes.

With that, we will begin with you, Mr. Anderson.

**STATEMENT OF HON. JOHN C. ANDERSON, U.S. ATTORNEY,
DISTRICT OF NEW MEXICO, U.S. DEPARTMENT OF JUSTICE**

Mr. ANDERSON. Chairman Hoeven, Vice Chairman Udall and members of the Committee, thank you for inviting us today to discuss this critical issue and the Department of Justice's efforts to support Native communities dealing with the devastating aftermath of the opioid epidemic.

The Department has been uncompromising in our commitment to combating drug abuse and drug crimes, particularly opioids, in Indian Country and across the Nation. In my district, New Mexico, the opioid crisis in Indian Country is particularly acute.

Despite its staggering natural beauty, northern New Mexico and Espanola, New Mexico in particular, has one of the highest opioid death rates in the Country. For decades, Espanola has had a severe heroin problem. As you may know, Espanola is surrounded by Indian reservations. Many New Mexico Indian pueblos, including the pueblos of Santa Clara, Okawingay, San Ildefonso, Pecurist, Owakay, Nambé, and Tuzukay are all within a short distance of the Espanola area.

The opioid epidemic knows no boundaries, so our Pueblos are equally affected by heroin and prescription opioids. Individuals and communities alike continue to be plagued by the opioid scourge and its secondary effects.

At a recent consultation in New Mexico, one Pueblo governor shared photographs of the parking lot of their casino. The photos were of the discarded needles, syringes and other drug paraphernalia scattered about the parking lot.

At the same consultation, a Pueblo chief of police emotionally described losing a brother to a heroin overdose and a sister to a prescription opioid overdose. The chief of police explained that the drug epidemic is dire in northern New Mexico and that something needs to be done to address the problem.

The catastrophic impact opioid abuse can have at every level of a community, from family units to infrastructure and economic stability, demands our best efforts to offer effective and sustainable support to communities in crisis. The Department has developed a multifaceted approach to addressing the threat and the impact of opioid abuse. Our approach in Indian Country is based on the belief that the tribes are in the best position to identify solutions to the problems in their communities.

An important element of the Department's support is in providing opportunities for funding. In fiscal year 2017, the Department awarded nearly \$59 million to strengthen drug programs and combat the opioid epidemic.

The Office of Justice Programs administers the Department's Comprehensive Opioid Abuse Program. The goals of the Comprehensive Opioid Abuse Program are twofold. First is to reduce opioid misuse and the number of overdose fatalities. Second is to support the implementation of prescription drug monitoring programs to prevent the diversion of controlled substances.

The Department understands that effective coordination among Federal agencies is crucial to ensuring the success of our efforts. We have participated in the High Intensity Drug Trafficking Areas Program, the HIDTA Program, which increases collaboration and information sharing between tribal law enforcement and Federal, State and local agencies to improve investigation and interdiction in Indian Country.

The Indian Country Law Enforcement Coordination Working Group, co-chaired by the Department of Justice and the Bureau of Indian Affairs, includes representatives from 13 Federal law enforcement agencies. This group is an important tool for enhancing interagency Federal law enforcement coordination in tribal communities.

We recognize that the crisis requires more than a law enforcement response. The Department is working closely with Indian Health Service to ensure that other Federal agencies are aware of the updated prescription drug monitoring protocols in IHS facilities.

We have also developed a number of training opportunities to better equip law enforcement and secondary providers working in Indian Country in addressing drug crimes and the secondary effects of opioid abuse.

The DEA has conducted a prolonged community outreach in Indian Country to educate tribal leaders and citizens on opioids and other drugs. On October 28, 2017, the Department and the BIA collaborated on the most recent prescription drug takeback day.

This initiative provided a safe and convenient means of disposing of prescription drugs while also educating Native communities on the potential for opioid abuse. Over 115 tribal communities participated and we intend to repeat this initiative in the near future.

Our goal is clear. We must continue working in partnership with tribal, Federal, State and local partners to respond to the opioid epidemic and to support communities affected by the crisis. We appreciate this Committee's focus on the issue and look forward to working with you in combating this threat to the health and well-being of our Native communities.

Thank you again for the opportunity to participate today.
[The prepared statement of Mr. Anderson follows:]

PREPARED STATEMENT OF HON. JOHN C. ANDERSON, U.S. ATTORNEY, DISTRICT OF
NEW MEXICO, U.S. DEPARTMENT OF JUSTICE

Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee:

Thank you for inviting us today to discuss this critical issue and the Department of Justice's (the Department) efforts to support Native communities dealing with the devastating aftermath of the opioid epidemic. The Department has been uncompromising in our commitment to combatting drug abuse and drug crimes, particularly opioids, in Indian country and across the nation.

In my district, New Mexico, the opioid crisis in Indian Country is particularly acute. Despite its staggering natural beauty, northern New Mexico, and Espanola, New Mexico in particular, has one of the highest opioid overdose death rates in the country. For decades, Espanola has had a severe heroin problem. And as you may know, Espanola is surrounded by Indian reservations. Many New Mexico Indian Pueblos, including the Pueblos of Santa Clara, Ohkay Owingeh, San Ildefonso, Picuris, Pojoaque, Nambe and Tesuque are all within a short distance of the Espanola area. The opioid epidemic knows no boundaries, and so our Pueblos are equally affected by heroin and prescription opioids; individuals and communities alike continue to be plagued by the opioid scourge and its secondary effects.

At a recent consultation in New Mexico, one Pueblo Governor shared photographs of the parking lot of their casino. The photos revealed discarded needles, syringes and other drug paraphernalia scattered about the casino parking lot.

At the same consultation, a Pueblo Chief of Police emotionally described losing a brother to a heroin overdose and a sister to a prescription opioid overdose. The Chief of Police explained that the drug epidemic is dire in Northern New Mexico and that something needs to be done to address the problem.

The catastrophic impact that opioid abuse can have at every level of a community, from family units to infrastructure and economic stability, demands our best efforts to put forth effective and sustainable support to communities in crisis. The Department has developed a multi-faceted response to addressing the threat and the impact of opioid abuse. Our approach in Indian country is based on the belief that the Tribes are in the best position to identify solutions to problems in their communities. We have sought to develop resources and initiatives that rely on partnership with the Tribes and are continually interested in hearing from our Tribal and federal partners as we adjust our efforts to better meet the needs of Native communities.

An important element of the Department's support is in providing opportunities for funding. In fiscal year 2017, the Department awarded nearly \$59 million to strengthen drug court programs and combat the opioid epidemic. The Office of Justice Programs (OJP) administers the Department's "Comprehensive Opioid Abuse Program." The goals of the Comprehensive Opioid Abuse Program are twofold: First, the program aims to reduce opioid misuse and the number of overdose fatalities. Second, the program supports the implementation, enhancement, and proactive use of prescription drug monitoring programs (PDMPs) to support clinical decision-making and prevent the misuse and diversion of controlled substances. Tribes are eligible to apply for a variety of funding opportunities under this program. As an example of recent awards under this program, in Fiscal Year 2017, the Seneca Na-

tion Peacemakers Court was awarded funds to create a community-driven, culturally competent diversion project aimed at helping Native American opioid users. The Port Gamble S'Klallam Tribe was awarded funds in Fiscal Year 2017 to support drug courts and programs that support veterans. The Department will continue to offer these opportunities to Tribes going forward.

The Department understands that effective coordination among federal agencies is crucial to ensuring our efforts are successful. We have participated in the High-Intensity Drug Trafficking Areas (HIDTA) program, funded through the Office of National Drug Control Policy, for many years now. The HIDTA program increases collaboration and information sharing between Tribal law enforcement and federal, state, and local agencies to improve investigation and interdiction in Indian country. As the Department continues to participate in the HIDTA program, our law enforcement agencies, particularly the Drug Enforcement Administration (DEA), have been working to build stronger relationships with other law enforcement agencies and service providers active in Indian country so that we are able to adjust our Task Force presence in Indian country most effectively.

The Indian Country Law Enforcement Coordination Working Group, cochaired by the Department of Justice and the Bureau of Indian Affairs (BIA) at the Department of the Interior, has become important to enhancing inter-agency federal law enforcement coordination in tribal communities. The group includes representatives from 13 federal law enforcement agencies and has focused heavily on several aspects of the opioid epidemic including proliferation, identifying top challenges to law enforcement, and coordinating responses. We will continue to use this working group to strengthen our coordinated efforts. For example, trafficking through the mail is a significant concern and we intend to use this working group as a forum to develop better ways to stop the movement of opioids through the postal service.

We recognize that the crisis requires more than a law enforcement response, so our efforts to coordinate go beyond law enforcement. For example, the Department is working closely with the Indian Health Service (IHS) of the Department of Health and Human Services to ensure that other federal agencies are aware of updated Prescription Drug Monitoring Program (PDMP) protocols in IHS facilities. The updated protocols have an impact on how some drug crimes are investigated and prosecuted, and on efforts to introduce safeguards against opioid abuse. Additionally, we have developed a number of training opportunities to better equip law enforcement and service providers working in Indian country to address the drug crimes and the familial and community impacts of opioid abuse. The Department has presented recent trainings, often in coordination with BIA, on opioid trends, investigative techniques, drug handling precautions regarding opioids, naloxone use, and indicators that opioids are present in a community. Other training is available on violent crime associated with opioids, prescription drug diversion, and investigating and prosecuting medical professionals and others involved in distributing prescription medications outside the scope of legitimate medical practice. These training opportunities are available to Tribal law enforcement and, in some cases, entirely geared for a Tribal audience. The Department is currently working with BIA on a new opportunity tentatively slated for this summer that will bring Tribal law enforcement representatives together with a number of federal law enforcement agencies to train on a wide range of drug-related topics.

Community outreach is another important aspect of our approach to this issue. The DEA has conducted a prolonged community outreach effort in Indian country to educate Tribal leaders and citizens on opioids and other drugs. Additionally, on October 28, 2017, the Department and BIA collaborated on the most recent Prescription Drug Take Back Day, which is a nationwide program that has also allowed the successful collaboration between BIA and DEA. This initiative provided a safe, convenient, and responsible means of disposing prescription drugs, while also educating Native communities on the potential for opioid abuse. Over 115 Tribal communities participated; we intend to repeat this initiative and expand participation in the future.

Improved information sharing plays a crucial role in any law enforcement effort, even more so in the context of opioids as we all work to get ahead of this terrible epidemic. The Tribal Access Program for National Crime Information (TAP) is an effective tool for participating Tribes to track and contribute data on opioid-related crimes and to perform required background checks. TAP assists Tribes by providing a means of access to national crime databases maintained by the FBI Criminal Justice Information Services (CJIS) Division for both criminal justice and civil background check purposes. This has been an especially important tool for performing checks on those who have regular contact with children in Indian country, including schools and foster care. Service providers in Indian country carry much of the burden of healing communities in the wake of opioid abuse, so we believe TAP plays

an equally necessary role in ensuring safe providers as it does in sharing important law enforcement information.

The use of data analytics to combat the opioid crisis is among the new tactics that are under development Department-wide. Attorney General Sessions formed the Opioid Fraud and Abuse Detection Unit to utilize data analytics, such as distribution and inventory figures, to identify patterns, trends, and statistical outliers that can be developed into targeted law enforcement operations. As we better understand the data across the country we will be able to better understand patterns and trends in Indian country.

Our goal is clear: we must continue working in partnership with Tribal, federal, state, and local partners to respond to the opioid epidemic and to support communities that are affected by the crisis. We are committed to putting forth our best efforts in this joint undertaking. We appreciate this committee's focus on this issue and look forward to working with you going forward. Thank you again for the opportunity to participate today.

The CHAIRMAN. Thank you.
Captain Jones.

**STATEMENT OF CAPTAIN CHRISTOPHER JONES, PHARM.D.,
M.P.H., DIRECTOR, NATIONAL MENTAL HEALTH AND
SUBSTANCE USE POLICY LABORATORY, SUBSTANCE ABUSE
AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S.
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

Dr. JONES. Thank you, Chairman Hoeven, Vice Chairman Udall and members of the Committee. Thank you for the opportunity to testify at this important hearing focusing on tribes and tribal entities.

From the start of his Administration, President Trump has been addressing the opioid epidemic as a top priority. At SAMHSA, we share the President's commitment to ending the crisis in the U.S.

The American Indian and Alaskan Native population has been significantly impacted by the opioid epidemic. Among this population, 4 percent of people 12 and older reported prescription opioid misuse in 2016. More than 1 percent had an opioid use disorder.

Most concerning are the continued increases in overdose deaths. In 2016, American Indians and Alaska Natives had the second highest overdose death rate in the United States, 13.9 deaths per 100,000 people, which represents a 400 percent increase since 2000.

To combat the opioid crisis, HHS launched a five-point opioid strategy in April 2017. The strategy aims to improve access to prevention, treatment and recovery support services; target the availability and distribution of overdose-reversing drugs; strengthen public health data reporting and collection; support cutting-edge research that advances our understanding of pain and addiction; and advance the practice of pain management.

As the Department's lead agency for behavioral health, SAMHSA has been at the forefront of the HHS response to the opioid crisis. Today, I want to focus on how SAMHSA is working with tribal communities under the HHS opioid strategy.

Since joining SAMHSA, Assistant Secretary McCance-Katz has prioritized efforts to support the behavioral health needs of the American Indian and Alaska Native population. She has charged SAMHSA leadership with identifying every possible opportunity for tribal entities to engage with SAMHSA. This includes making tribal entities eligible for discretionary grant programs wherever pos-

sible; ensuring flexibility in how tribal entities incorporate cultural practices into their programs; and providing assistance to ensure that tribal entities are set up for success.

Under the HHS strategy, SAMHSA focuses its work in three areas: building prevention, treatment and recovery capacity through funding; providing technical assistance and training; and leveraging key stakeholders to support incorporation of tribes and tribal populations into the opioid response.

In the area of funding, SAMHSA administers the State Targeted Response to the Opioid Crisis Grants, a two-year program authorized under the 21st Century Cures Act. Although tribal entities were not eligible for funding under the statutory structure of the STR Program, SAMHSA has taken a number of steps to support inclusion engagement of tribes in State plans.

Specifically, we required States to assess the needs of tribal communities and include them in their strategic plans and reviewed each State plan for tribal engagement. We held a webinar with States to clarify our expectation that American Indians and Alaska Natives be incorporated as a population of focus and provided examples of how States are working with tribes on the STR Program.

Most recently, Dr. McCance-Katz sent a letter to governors calling on them to work with tribes and allocate funds directly to them so they can offer the essential and life-saving services their communities need to respond to the opioid crisis. Our assessment of the State STR plans indicates that of the 35 States with federally-recognized tribes within their borders, at least 12 have specifically identified tribes as a population of focus or specified actions that are working to combat opioids in tribal communities.

Tribes have also received funding from a number of SAMHSA's other discretionary programs. Under the Strategic Prevention Framework Partnerships for Success Program, First Nations Community Healthsource of New Mexico is using funding to develop prevention strategies for tribal communities.

Under the Strategic Prevention Framework for Prescription Drugs Program, four tribes are working with their States to incorporate tribal data into State prescription drug monitoring programs to better target prevention efforts and reduce prescription drug misuse. Last September, SAMHSA awarded funding to four tribes under our First Responders Naloxone Grant Program. We also recently released a funding announcement for Treatment and Recovery Services for Adolescents, Transitional Aged Youth and Their Families that actually, for the first time, includes a \$5 million set-aside for tribal entities.

In the area of technical assistance, Assistant Secretary McCance-Katz recently reinstated SAMHSA's American Indian and Alaska Native Support Center which is part of our Addiction Technology Transfer Center Network. This center provides critical support to develop and strengthen the specialized behavioral and primary healthcare workforce that provides treatment and recovery services to tribal communities.

We also fund a Tribal Training and Technical Assistance Center which actively engages and serves tribes across the Country. In fact, today, this center is conducting the first of two webinars on opioids in Indian Country.

Finally, SAMHSA is committed to leveraging a broad range of stakeholders to ensure that the behavioral health needs of tribal populations are a part of our Nation's response to the opioid crisis. To support this commitment, SAMHSA is currently planning a tribal-State Policy Academy for August 2018 that will bring States and tribes together to develop specific, actionable plans for how they can collaborate to address the opioid crisis and substance use issues in their community.

Thank you for inviting me to testify. I look forward to your questions.

[The prepared statement of Dr. Jones follows:]

PREPARED STATEMENT OF CAPTAIN CHRISTOPHER JONES, PHARM.D., M.P.H.,
DIRECTOR, NATIONAL MENTAL HEALTH AND SUBSTANCE USE POLICY LABORATORY,
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S.
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hoeven, Vice Chairman Udall, and members of the Senate Committee on Indian Affairs, thank you for inviting me to testify at this important hearing. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been actively engaged in the Administration's effort to combat the opioid epidemic. SAMHSA works with our colleagues at the Department of Health and Human Services (HHS), state and local governments, tribal entities, and other key stakeholders.

Thank you for the opportunity to discuss the opioid crisis in the United States and the Federal response, particularly in relation to tribes and tribal entities. From the start of his Administration, President Trump has made addressing the opioid epidemic a top priority, and at SAMHSA we share the President's commitment to bringing an end to this crisis, which is exacting a toll on individuals, families, and communities across the country. The Department, including SAMHSA, has made the crisis a top priority and is committed to using our full expertise and resources to combat the epidemic.

Over the past 15 years, communities across our Nation have been devastated by increasing prescription and illicit opioid abuse, addiction, and overdose. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), in 2016, over 11 million Americans misused prescription opioids, nearly 1 million used heroin, and 2.1 million had an opioid use disorder due to prescription opioids or heroin. The American Indian/Alaska Native (AI/AN) population is likewise affected by the opioid crisis. According to NSDUH, 5.2 percent (72,000) of AI/AN aged 18 and older reported misusing a prescription drug in the past year and 4.0 percent (56,000) of AI/ANs aged 18 and older reported misusing a prescription pain reliever in the past year. Over the past decade, the United States has experienced significant increases in rates of neonatal abstinence syndrome (NAS), hepatitis C infections, and opioid-related emergency department visits and hospitalizations. Most alarming are the continued increases in overdose deaths, especially the rapid increase since 2013 in deaths involving illicit fentanyl and other highly potent synthetic opioids. Since 2000, more than 300,000 Americans have died of an opioid overdose. Opioids were involved in 42,249 deaths in 2016, and opioid overdose deaths were five times higher in 2016 than 1999.

The opioid epidemic in the United States can be attributed to a variety of factors. For example, there was a significant rise in opioid analgesic prescriptions that began in the mid-to-late 1990s. Not only did the volume of opioids prescribed increase, but also well-intentioned healthcare providers began to prescribe opioids to treat pain in ways that we now know are high-risk and have been associated with opioid abuse, addiction, and overdose, such as prescribing at high doses and for longer durations. One additional factor is a lack of health system and healthcare provider capacity to identify and engage individuals, and provide them with high-quality, evidence-based opioid addiction treatment, in particular the full spectrum of medication-assisted treatment (MAT). It is well-documented that the majority of people with opioid addiction in the United States do not receive treatment, and even among those who do, many do not receive evidence-based care. Accounting for these factors is paramount to the development of a successful strategy to combat the opioid crisis. Further, there is a need for more rigorous research to better understand how existing programs or policies might be contributing to or mitigating the opioid epidemic.

HHS Five Point Strategy

In April 2017, HHS outlined its five-point Opioid Strategy, which provides the overarching framework to leverage the expertise and resources of HHS agencies in a strategic and coordinated manner. The comprehensive, evidence-based Opioid Strategy aims to:

- Improve access to prevention, treatment, and recovery support services to prevent the health, social, and economic consequences associated with opioid addiction and to enable individuals to achieve long-term recovery;
- Target the availability and distribution of overdose-reversing drugs to ensure the broad provision of these drugs to people likely to experience or respond to an overdose, with a particular focus on targeting high-risk populations;
- Strengthen public health data reporting and collection to improve the timeliness and specificity of data and to inform a real-time public health response as the epidemic evolves;
- Support cutting-edge research that advances our understanding of pain and addiction, leads to the development of new treatments, and identifies effective public health interventions to reduce opioid-related public harms; and
- Advance the practice of pain management to enable access to high-quality, evidence-based pain care that reduces the burden of pain for individuals, families, and society while also reducing the inappropriate use of opioids and opioid-related harms.

As HHS lead agency for behavioral health, SAMHSA's core mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA supports a portfolio of activities that address the HHS Opioid Strategy.

Today, I will address how SAMHSA is working with tribes and tribal organizations as that work relates to this strategy.

Improving Access to Prevention, Treatment, and Recovery Support Services

SAMHSA administers the State Targeted Response to the Opioid Crisis Grants, a two-year program authorized by the 21st Century Cures Act (P.L. 114-255). By providing \$485 million to states and U.S. territories in Fiscal Year (FY) 2017, this program allows states to focus on areas of greatest need, including increasing access to treatment, and reducing opioid overdose related deaths through the provision of the full range of prevention, treatment, and recovery services for opioid use disorder. Specific areas in which states and tribes collaborate on prevention activities include: Prescription Drug Monitoring Program (PDMP) data-sharing; State Epidemiological Outcome Workgroups; overdose education on naloxone distribution; and media campaigns. In Minnesota, the state is supporting five Native American communities to service high-risk pregnant women with opioid use disorder (OUD) in order to strengthen and enhance peer recovery support services. In Montana, the state is working with the Rocky Mountain Tribal Leaders Council to develop culturally tailored versions of the current peer monitoring trainings and peer supervisor trainings.

Tribes receive SAMHSA prevention grant funds to address opioid misuse and abuse. Prevention programs include a focus on change at the community level that will, over time, lead to measurable changes at the state and tribal levels. Under the Strategic Prevention Framework-Partnerships for Success (SPF-PFS) grant program, First Nations Community HealthSource in New Mexico serves four tribes: Pueblo de Cochiti; Pueblo of Laguna; Native American Community Academy; and Zuni Pueblo. First Nations Community HealthSource has developed prevention strategies based on research and tribal traditions, culture, language, and values that reduce prescription drug abuse and misuse; improve the capacity of tribal leadership to understand and support prevention strategies designed to decrease prescription drug abuse and misuse; and develops a tribal strengths based method to decrease prescription drug abuse and misuse.

Other tribes are developing capacity and expertise in the use of data from state-run PDMPs. Under the Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant program, four tribes (Cherokee Nation, Southern Plains inter-tribal, Nooksack, and Little Traverse Bay Band of Odawa Indians) currently work with their states to bring tribal data into the system and decrease prescription drug misuse in their communities. For example, in Oklahoma, the Cherokee Nation has used the PDMP data to develop a tribal-wide media campaign, "Think SMART," that is educating community members on the responsible use of opioids and the risks associated with overprescribing.

Since coming to SAMHSA, the Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance-Katz, has reviewed all of our discretionary funding

announcements and has looked for opportunities to improve tribal access to SAMHSA's discretionary grant funds. For example, tribal leaders informed her they have a great concern about the vulnerability of tribal youth to developing mental and substance use disorders. With clarity that tribal youth are a priority, Assistant Secretary McCance-Katz was able to ensure that a funding opportunity announcement (FOA) that SAMHSA recently released entitled "Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families" included at least a \$5 million set-aside for tribes, tribal organizations, urban Indian health programs, and consortia of tribes or tribal organizations. This amount is approximately 34 percent of the total anticipated \$14.6 million available for this program.

Targeting Overdose-Reversing Drugs SAMHSA has been a leader in efforts to reduce overdose deaths by increasing, through funding and technical assistance, the availability and use of naloxone to reverse overdose. SAMHSA's "Opioid Overdose Prevention Toolkit," first released in 2013, is one of SAMHSA's most downloaded resources. The Toolkit provides information on risks for opioid overdose, recognition of overdose, and how to provide emergency care in an overdose situation. The Toolkit is intended for community members, first responders, prescribers, people who have recovered from an opioid overdose, and family members, as well as communities and local governments.

SAMHSA provides a number of funding streams that can be used to expand access to naloxone. In September 2017, SAMHSA awarded funding for the First Responders-Comprehensive Addiction and Recovery Act (FR-CARA) grant program, which includes grants to four tribes: White Earth Band of Chippewa Indians; Cherokee Nation; Choctaw Nation of Oklahoma; and Lac Du Flambeau Band of Lake Superior Chippewa Indians. The First Responders grant program provides resources to first responders and treatment providers who work directly with the populations at highest risk for opioid overdose. For the White Earth Band of Chippewa Indians in Minnesota, prescription opiate and heroin admissions for American Indians on the Reservation totaled almost 30 percent of the treatment admissions. SAMHSA's grant helps support the tribe's collaborative approach to addressing the crisis throughout its community, including partnerships with public health, law enforcement, behavioral health, first responders, public relations, and cultural representatives.

Strengthening Public Health Data and Reporting

NSDUH provides key national and state level data on a variety of substance use and mental health topics, including opioid misuse. NSDUH is a vital part of the surveillance effort related to opioids, and the data from NSDUH has been used to track historical and emerging trends in opioid misuse, including geographic and demographic variability.

According to the 2016 NSDUH, 5.2 percent (72,000) of AI/AN aged 18 and older reported misusing a prescription drug in the past year and 4.0 percent (56,000) of AI/ANs aged 18 and older reported misusing a prescription pain reliever in the past year, compared to national averages of 7.1 percent and 4.3 percent respectively. The 2016 NSDUH also found that 4.1 percent (63,000) of AI/ANs aged 12 and older reported opioid misuse in the past year, in line with the national average of 4.4 percent. The 2016 NSDUH found that 1.1 percent (16,000) of AI/ANs aged 12 and older reported having an opioid use disorder in the past year.

Working with Tribes and Tribal Organizations to Reduce Opioid Misuse and Abuse

Assistant Secretary McCance-Katz reinstated SAMHSA's Addiction Technology Transfer Center (ATTC): American Indian and Alaska Native Support Center Cooperative Agreement (AI/AN ATTC). The purpose of this program is to provide support for the ATTC Network, AI/AN, tribal organizations, urban Indian programs, state and local governments, and other organizations to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides substance use disorder (SUD) treatment and recovery support services to tribal communities. The University of Iowa, the grantee, works directly with SAMHSA and in collaboration with the FY 2017 ATTC National Coordinating Center and the 10 Regional ATTC Centers. The Centers focus on activities aimed at improving the quality and effectiveness of treatment and recovery, as well as working directly with providers of clinical and recovery support services, and others that influence the delivery of services, to improve the quality of workforce training and service delivery to tribal communities.

SAMHSA also funds the Tribal Training and Technical Assistance Center, which actively engages and serves tribes across the Nation. Through onsite and virtual

training, targeted resources, learning communities, assistance with Tribal Action Plans, and intensive community engagement, our technical assistance guides tribal communities and organizations in using cultural knowledge and strengths to support wellness, including addressing the opioid crisis. For example, today, this Center is conducting the first of two webinars targeting opioids in Indian Country. SAMHSA is in the process of assessing the technical assistance provided to assure that the funding is appropriate to the need and that the tribal entities get the support they need while maximizing grant funds to communities.

SAMHSA received input from our Tribal Technical Advisory Committee (TTAC) and shared TTAC's recommendations with the Secretary's Tribal Advisory Committee. Based on input from these tribal leaders, SAMHSA is partnering with the Centers for Disease Control and Prevention, Indian Health Service, Centers for Medicare & Medicaid Services, and National Institutes of Health to host a Joint Tribal Advisory Committee (JTAC) meeting. The JTAC will bring together tribal leaders from the tribal advisory committees for these operating divisions to discuss related priorities. Our plan is to host the joint meeting immediately preceding the National American Indian and Alaska Native Behavioral Health Conference this summer.

We have heard from tribal leaders that SAMHSA also has a responsibility to improve tribal-state relationships. In response, the Agency is hosting a Tribal-State Policy Academy (TSPA) to advance tribal behavioral health planning. The TSPA will have a particular emphasis on improving current efforts to address the impact of the opioid epidemic in Indian Country but will also include an opportunity for tribes and states to work together on other primary substances of abuse affecting local tribal communities. Beyond supporting improved working relationships and planning, proposed outcomes include joint tribal-state plans for combating drug use in tribal communities and collaborative models that may be replicated by other states and tribes. Up to ten tribal-state teams will be able to participate in the Academy that is targeted for this summer. Additionally, Assistant Secretary McCance-Katz recently sent a letter to governors urging them to assess the behavioral health needs of AI/ANs in their states and to equitably distribute federal funds directed to states to address the opioid crisis and mental health needs.

Finally, SAMHSA has had discussions with tribal leaders about the importance of recognizing and elevating tribal behavioral health as a critical step toward collaborative improvements. SAMHSA is in the process of engaging Federal and tribal organization partners to host a national town hall on combatting substance use in tribal communities. The town hall will bring together senior government officials and tribal leaders to explicitly address opportunities, and identify a clearer path forward, for combatting substance use in AI/AN communities.

Thank you again for inviting me to testify today. I look forward to answering your questions.

The CHAIRMAN. Rear Admiral Toedt.

STATEMENT OF REAR ADMIRAL MICHAEL TOEDT, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. TOEDT. Good afternoon, Chairman Hoeven, Vice Chairman Udall, and members of the Committee.

I am Dr. Michael Toedt, Chief Medical Officer for the Indian Health Service. Today, I appreciate the opportunity to provide information on the work that IHS has been doing to address the opioid crisis, which is a top priority for the agency and the Department of Health and Human Services.

The impact of the opioid crisis on American Indians and Alaska Natives is immense. American Indians and Alaska Natives have had the highest drug overdose death rates in 2015 according to the CDC, and the largest percentage increase in the number of deaths over time from 1999 to 2015 compared to other racial and ethnic groups.

During that time, deaths rose more than 500 percent among American Indians and Alaska Natives. Collaborating and con-

sulting with tribes to address the opioid crisis in Indian Country is important. We work with our tribal advisory committees to gather input on critical next steps. The opioid crisis has been and will continue to be a priority for the advisory committees.

IHS strengthened and prioritized efforts to address the opioid crisis in 2012 and developed a number of recommendations focused on six areas: patient care; policy development and implementation; education; monitoring; medication storage and disposal; and law enforcement.

To address these areas, in March 2016, IHS chartered the National Committee on Heroin, Opioids and Pain Efforts referred to as the HOPE Committee. The Committee works to advance the Department's multifaceted plan to combat opioid abuse including: better prevention; treatment, and recovery services; better targeting of overdose reversing drugs; better data on the epidemic; better pain management; and better research.

Our Prescription Drug Monitoring Program policy strengthens the monitoring and deterrence of prescription misuse and diversion. It requires IHS providers to check State PDMP databases prior to prescribing opioids for longer than seven days. IHS has partnered with all States where IHS Federal facilities are located and successfully connected so far with 17 out of 18 State PDMP databases. As a result, 99 percent of IHS facilities offering pharmaceutical services have access. IHS pharmacies must report opioid-prescribing data to State PDMPs, a proactive requirement not currently required by law.

We are not working alone. IHS partners with SAMHSA to train nearly 70 physicians to treat opioid use disorders, increasing access to treatment services in tribal communities. In 2008, IHS established a Telebehavioral Health Center of Excellence to provide clinical services, provider education and technical assistance through the Indian Health system. This center supports remote, isolated Native communities with limited access to behavioral health services.

We partner with the Bureau of Indian Affairs to train and equip law enforcement officers to recognize symptoms of overdose and intervene when necessary. As of December 2017, we have trained and provided naloxone at no cost to BIA for more than 300 law enforcement officers. We also certified 47 BIA law enforcement officers as naloxone trainers.

Addiction is complex but treatable. There is no single treatment that is right for everyone. The IHS Alcohol and Substance Abuse Program provides funding, training and technical assistance to IHS tribal and urban Indian programs. This ensures a variety of treatment options exist. Approximately 90 percent of the fiscal year 2017 Alcohol and Substance Abuse Program budget of \$205 million is administered by tribes.

IHS also supports prevention efforts through the Substance Abuse and Suicide Prevention Program. As of fiscal year 2017, program funds are approximately \$30 million for 175 IHS tribal and urban Indian Health organizations. The funds are used to develop and implement culturally-appropriate, evidence-based and community-driven models. We fund 19 projects that focus specifically on

methamphetamine and substance abuse prevention treatment and recovery programming.

The majority of substance abuse and suicide prevention projects focus on reducing risk factors for suicidal behavior and substance use among Native youth. Furthermore, we work with tribes to develop and implement models of care that are sustainable to combat the opioid crisis. We focus on treatments that are evidence-based and culturally-appropriate that will have significant impacts on the prevention, treatment and recovery efforts.

IHS collaborates with key stakeholders to develop viable reimbursement models for services provided. This comprehensive strategy will allow for a more unified approach with tribal communities.

We will continue to work with tribes to develop coordinated responses using every available resource possible to battle the opioid crisis in tribal communities. Thank you for your commitment to improving healthcare for American Indians and Alaska Natives by addressing the opioid crisis as a top priority.

I will be happy to answer any questions the Committee may have.

[The prepared statement of Admiral Toedt follows:]

PREPARED STATEMENT OF REAR ADMIRAL MICHAEL TOEDT, M.D., CHIEF MEDICAL OFFICER, INDIAN HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am Dr. Michael Toedt, Chief Medical Officer, Indian Health Service (IHS). I earned my Doctorate of Medicine from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. I am board certified in family medicine and I am a fellow of the American Academy of Family Physicians. I have served as a Commissioned Officer for 26 years in both the National Health Service Corps and the Indian Health Service. Today, I appreciate the opportunity to provide information on the work that IHS has been doing to address the opioid crisis, which is a top priority for the Department of Health and Human Services (HHS).

IHS is a distinct agency in HHS, established to carry out the responsibilities, authorities, and functions of the United States to provide health care services to American Indians and Alaska Natives. It is the only HHS agency whose primary function is direct delivery of health care. The mission of IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS system consists of 12 Area offices, which oversee 170 Service Units that provide care at the local level. Health services are provided through facilities managed by the IHS, by Tribes and tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act (ISDEAA), and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

The impact of the opioid crisis on American Indians and Alaska Natives is immense. The Centers for Disease Control and Prevention (CDC) reported that American Indians and Alaska Natives had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999–2015 compared to other racial and ethnic groups.¹ During that time, deaths rose more than 500 percent among American Indians and Alaska Natives. In addition, because of misclassification of race and ethnicity on death certificates, the actual number of deaths for American Indians and Alaska Natives may be underestimated by up to 35 percent.¹

Addressing the Opioid Crisis in Indian Country

IHS recognizes the importance of collaborating and consulting with tribes to develop a comprehensive plan for addressing the opioid crisis in Indian country. IHS partners with its tribal advisory committees, including the Tribal Self-Governance

¹<https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf>

Advisory Committee, the Direct Service Tribes Advisory Committee, and the National Tribal Advisory Committee on Behavioral Health to gather input on critical next steps to address the opioid crisis. The opioid crisis has been a priority on recent meeting agendas for the advisory committees and will be a topic for future meetings as well.

IHS strengthened and prioritized efforts to address the opioid crisis in 2012 and developed a number of recommendations focused on six areas: patient care, policy development/implementation, education, monitoring, medication storage/disposal, and law enforcement. In March 2017, IHS chartered the National Committee on Heroin, Opioids and Pain Efforts (HOPE). The HOPE committee, which consists of multidisciplinary health care professionals across IHS, works to advance the Department's multifaceted plan to combat opioid abuse: (1) better prevention, treatment, and recovery services; (2) better targeting of overdose reversing drugs; (3) better data on the epidemic; (4) better pain management; and (5) better research. To address better research, IHS partners with the National Institutes of Health on research addressing health disparities and health priorities within Indian communities.

The HOPE committee is reviewing and updating IHS policies to ensure they are aligned with the most current national guidelines and addressing the most urgent needs. For example, the IHS "Chronic Non-Cancer Pain Management" policy, originally published in 2014, was re-released earlier this year to align with the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain. This policy also requires mandatory opioid training for all Federal controlled substance prescribers with required refresher training every three years.

The IHS Prescription Drug Monitoring Programs (PDMP) policy strengthens the monitoring and deterrence of prescription misuse and diversion by requiring IHS providers to check state PDMP databases prior to prescribing opioids for longer than seven days. IHS has partnered with all states where IHS federal facilities are located and has successfully connected with 17 out of the 18 state PDMP databases, allowing access for 82 of the 83 IHS facilities offering pharmaceutical services. The IHS PDMP policy also requires IHS practitioners to conduct peer reviews of prescriber activity. Additionally, under the IHS policy, pharmacies must report opioid prescribing data to state PDMPs—a proactive requirement not currently required by law. IHS is also working to establish two additional policies to expand access to medication assisted treatment (MAT), and to standardize how first responders in American Indian and Alaska Native communities are provided naloxone, a medication for reversing opioid overdoses.

To address the shortage of specialists who can provide MAT in rural tribal communities, IHS is training its current workforce to provide these specialty services. Over the last two years, IHS partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to train nearly 70 physicians to obtain their Drug Addiction Treatment Act waivers to treat opioid use disorders, which increases access to treatment services in American Indian and Alaska Native communities. In 2008, IHS established the Telebehavioral Health Center of Excellence (TBHCE) which provides, clinical services, provider education and technical assistance throughout the Indian health system. The TBHCE was developed to support remote and isolated American Indian and Alaska Native communities and areas with limited access to behavioral health services. These services directly equip IHS staff to reduce morbidity and mortality surrounding the opioid epidemic. Currently, the TBHCE is providing training on MAT for opioid use disorder, which uses Food and Drug Administration approved pharmacological treatments, in combination with psychosocial treatments and social supports.

Additionally, IHS offers weekly continuing education on pain and addiction as well as consultation on complex cases to further train primary care clinicians to provide these specialty MAT services. Consultation is offered through virtual clinics hosted by the University of New Mexico to connect primary care clinicians with expert teams to share knowledge and elevate the level of specialty care available to patients. There are some promising signs of the positive outcomes as a result of these efforts. For example, a preliminary analysis of available IHS data indicates a 13 percent decrease in the average number of opioid prescriptions per 100 of all IHS users from FY 2013–2016.²

The Tribal Law and Order Act requires HHS, the Department of Justice, and the Department of Interior to coordinate efforts on alcohol and substance use issues in Indian country. IHS is actively involved in interagency coordination and collaboration on tribal alcohol and substance use programs. As part of this effort, tribes are encouraged to develop Tribal Action Plans (TAP) to address substance use and

² IHS—National Data Warehouse

opioid use in their communities. IHS is an integral part of the TAP workgroup that works with tribes to help them gain access to government resources and coordinate efforts in order to achieve our shared goals of preventing and treating substance use disorders.

IHS partners with the Bureau of Indian Affairs (BIA) to train and equip law enforcement officers (LEOs) to recognize signs and symptoms of overdoses and intervene when the overdose is occurring. As of December 2017, the IHS trained and provided naloxone at no cost to BIA for more than 300 LEOs and certified 47 BIA LEOs as naloxone trainers. In direct care facilities, IHS has also been providing naloxone supplies, training and tool kits to tribal law enforcement. IHS encourages its pharmacists to co-prescribe naloxone to patients who are at higher risk for opioid overdose based on criteria developed with primary care clinicians, and as a result the number of naloxone prescriptions has increased by 518 percent from FY 2013 to FY 2017.

IHS has developed a data reporting system that will provide prescribing data on national, regional, and local levels. We will track data focusing on the overall improvements and monitoring of prescribing practices and procurement. Regional data will be used for comparison with state-level data from the CDC and among other facilities in their region, as well as nationally. We will use the information to identify areas of improvement, monitor trends, intervene early and effectively, and enhance efforts to train medical providers.

IHS Behavioral Health and the Alcohol and Substance Abuse Program

Addiction is complex, but treatable. Unfortunately, there is no single treatment that is right for everyone. The IHS Alcohol and Substance Abuse Program (ASAP) provides funding, policy, training, and technical assistance to local IHS, tribal, and urban Indian programs to ensure a variety of treatment options exist. Approximately 90 percent of the FY 2017 ASAP budget of \$205 million is contracted or compacted by Tribes enabling those programs to deliver treatment services tailored to meet their local needs. These programs provide services at all stages of recovery from detoxification, behavioral counseling, outpatient and residential treatment, and long-term follow up to prevent relapse.

IHS also targets suicide and substance use and misuse prevention through the Substance Abuse and Suicide Prevention (SASP) program. As of FY 2017, SASP funds approximately \$30 million to 175 IHS, Tribal, and Urban Indian Health organizations to develop and implement culturally appropriate, evidence-based and/or practice-based, community driven models. We fund 19 projects that focus specifically on methamphetamine and substance abuse prevention, treatment, and recovery programming. The majority of the SASP projects focus on prevention and early intervention strategies to reduce risk factors for suicidal behavior and substance use among American Indian and Alaska Native youth. A total of 108 funded projects work with Native youth to increase resiliency, teach coping skills, promote family engagement, and hire behavioral health providers who specialize in treating children, youth, and families. The SASP program is currently in its third year and IHS will evaluate SASP data to better understand the full impact of the program, what is working in tribal communities, disseminate best practices, and share lessons learned.

IHS is addressing the need to assist youth with substance use disorders including opioid dependency through twelve Youth Regional Treatment Centers (YRTC's). The YRTC's provide a range of clinical services to provide treatment rooted in culturally relevant, holistic models of care.

IHS actively solicits feedback and works with the tribes to develop and implement models of care that are sustainable to combat the opioid crisis. We focus on treatments that are evidence-based and culturally effective that will have a significant impact on the prevention, treatment and recovery efforts. To sustain this strategy, IHS is collaborating with key stakeholders to develop viable reimbursement models for services provided, while advocating for reimbursement for traditional and culturally based practices, a critical approach to opioid recovery in tribal communities. This comprehensive strategy will allow for a more unified approach with tribal communities and also afford IHS the time to evaluate the impact of these interventions. IHS will continue to work with Tribes to develop coordinated responses using every available resource possible to battle the opioid crisis in tribal communities.

Thank you for your commitment to improving health care for American Indians and Alaska Natives by addressing the opioid crisis as a top priority. I will be happy to answer any questions the Committee may have.

The CHAIRMAN. Thank you.

We will now start five minute rounds of questioning.

Captain Jones, your written testimony outlined the Department of Health and Human Services' five point strategy which establishes a framework for substance abuse and mental health services and SAMHSA's efforts to combat the opioid addiction epidemic.

I would like to hear about benchmarks for success and how you gauge the effectiveness of these kinds of programs? What are your metrics?

Dr. JONES. Thank you for the question.

Through the Department, we are currently working through a process to finalize what are the exact measures we want to have over time, looking at shorter term behavioral changes, such as changes in opioid prescribing, increases in the number of people who are receiving addiction treatment, morbidity and mortality measures and reductions in emergency department visits and overdose deaths. Through that process of the five point strategy, we are working to do that.

We have not specified exactly what our points of success are but we have learned from prior experience that oftentimes, as in the case of naloxone, we previously had a goal of increasing by 25 percent the prescriptions dispensed for naloxone. We actually found that there was such a tremendous movement at the State level on standing orders and other things for naloxone that we saw about a 1,000 percent increase. We want to make sure we are calibrating this with the facts happening on the ground. It is a process we are working through and have not finalized yet.

The CHAIRMAN. You are setting metrics but are working through a process?

Dr. JONES. Yes.

The CHAIRMAN. Rear Admiral Toedt, the same question?

Dr. TOEDT. Thank you, Mr. Chairman.

IHS has committed to addressing the opioid crisis in American Indians and Alaska Native communities. The key to this approach is partnering with tribal communities, listening to them and being responsive to their concerns.

Some of the examples IHS is looking at for metrics and is measuring at the national level include pain management and opioid-related policy implementation. This is evidenced on our National Accountability Dashboard which is on our website.

We are looking at opioid prescribing trends, access to medication-assisted treatment, use of telebehavioral health and naloxone. There will be many more metrics that we need to develop. We want to partner with tribes to do that.

The CHAIRMAN. Mr. Anderson, could you talk a bit more about the HOPE Initiative? Also, could you touch on why right now the High Intensity Drug Trafficking Program is under the control of the Office of the National Drug Control Policy and why the Administration wants to move that?

Mr. ANDERSON. Chairman Hoeven, the HOPE Initiative, as it has been coordinated and implemented in my District of New Mexico, is a partnership between the U.S. Attorney's Office in New Mexico and the University of New Mexico Health Sciences Center. It has a number of prongs including prevention, education, public outreach, law enforcement, as well as rehabilitation and reentry components to it.

The principal efforts of the HOPE Initiative at this point have been public outreach to educate the public, in particular, the youth, on the dangers of opioid abuse. In connection with the U.S. Attorney's Office, the HOPE Initiative has developed an educational program called Roll the Dice that is directed at educating youth on the dangers of opioid misuse. That program is culturally tailored for presentation in our Native communities.

The other aspect of this is the Naloxone Initiative. We have been at the forefront of educating first responders about the benefits of naloxone and educating them about how to properly use that in the hope that it is more widely deployed for its live-saving potential.

The CHAIRMAN. Thank you.

Rear Admiral Toedt, could you talk a bit about how IHS is doing in terms of partnering with State-based prescription drug monitoring programs?

Dr. TOEDT. Yes, Mr. Chairman.

Our partnership includes linking the ability for the electronic medical record to upload that prescription data to the prescription drug monitoring programs. In sites where the Indian Health Service Federal pharmacies exist, we have been able to successfully partner with 17 out of the 18 States so far. We are working with the final State to connect the prescription drug monitoring programs to the electronic medical record.

We also work with tribes in their States as well at their request if they are using the IHS electronic medical record to link to the prescription drug monitoring programs.

The CHAIRMAN. Are you seeing that making a real difference?

Dr. TOEDT. Absolutely. Prescribers are able to see which of their patients are getting prescriptions perhaps from other providers. One of the things patients will do is sometimes they will have to seek medications from different providers both inside and outside our system. Using the State Prescription Drug Monitoring Database ensures we get the broadest input as to where they may be getting prescriptions.

The CHAIRMAN. Vice Chairman Udall.

Senator UDALL. Thank you, Mr. Chairman.

Mr. Anderson, as the new U.S. Attorney for New Mexico, you will be directly responsible for upholding the Federal government-to-government relationship with each of the 23 tribes in New Mexico, several of whom you mentioned in your testimony.

What are your plans to engage with tribes in New Mexico to address public safety issues like the opioid epidemic in Indian Country?

Mr. ANDERSON. Senator, the United States Attorney's Office in New Mexico has an active outreach program, some of which is mandated by statute through the Tribal Law and Order Act. We do an annual consultation with all the tribes to address matters of concern.

We also host regular educational outreach and communication opportunities. Just last week, prosecutors from my office were presenting to both the Navajo Nation and in the Espanola area on this very topic, heroin and opioid awareness. The thrust of that presentation was to educate in particular tribal law enforcement on this opioid crisis we are discussing today.

In addition, my office has a dedicated tribal liaison tasked with ensuring open and prompt communication between the U.S. Attorney's Office and the tribes and ensuring that any issues they raise in the course of those communications are properly addressed.

On a more basic level, line prosecutors in my office routinely communicate with their tribal counterparts in tribal law enforcement, in particular, on a case basis. In that context, they address any concerns the tribes may have.

Senator UDALL. Thank you. Can I get your commitment that you will meet regularly with New Mexico's tribal leaders to develop your office's Indian Country public safety priorities?

Mr. ANDERSON. That is certainly something we are committed to doing, Senator. Again, I believe we have an active and robust communication process and will maintain that in the U.S. Attorney's Office.

Senator UDALL. Just last December, DOJ's OIG released a report confirming what tribes have told us. According to this report, nationally, Indian Country case declinations increased by 20 percent between 2013 and 2015. Even more of a concern, the report showed the number of referrals from DEA for crimes in Indian Country decreased by 81 percent.

Based on this OIG report, Mr. Anderson, should DOJ law enforcement and the U.S. Attorney's Office be doing more to investigate and prosecute drug crimes in Indian Country?

Mr. ANDERSON. Senator, the U.S. Attorney's Office and the Department, in general, are committed to robust enforcement of drug laws in Indian Country. The DEA is actively involved in that in coordination with the BIA and the Department of Justice and my office will continue to focus on robust enforcement of those laws in our tribal communities.

Senator UDALL. Do you know how many current Indian Country cases are pending before your office and how many of those cases are drug-related?

Mr. ANDERSON. Senator, in preparation for today's remarks, I looked into that. I can tell you in fiscal year 2017, we prosecuted 49 violent crimes in Indian Country cases. That is a subset of the total number of cases we addressed in Indian Country. It does not include drug crimes, assaults on law enforcement officers or sexual assaults in Indian Country which would vastly increase that number.

We do not track at this point for drug cases, which ones arise in Indian Country and which ones do not because it is a statute of general applicability but again, I can tell you that in New Mexico, enforcement is robust.

Just last year, we recently did the first Title III wiretap case in Indian Country. We also had a substantial seizure of methamphetamine on a case developed and worked on the Navajo Nation. Those efforts are ongoing and are certainly a priority for us in the Department.

Senator UDALL. Can I get your commitment that you will speak to your Federal law enforcement counterparts about increasing their investigation efforts in Indian Country?

Mr. ANDERSON. Certainly, Senator. We will continue to promote those communications. Again, Federal law enforcement is quite ac-

tive in Indian Country in partnership with the BIA and our tribal law enforcement.

Senator UDALL. Will you also commit to reviewing your office's Indian Country declination rates and working with tribal leaders to identify and resolve any barriers to prosecution?

Mr. ANDERSON. We will certainly do that, Senator. We constantly reevaluate the process by which we decline cases. We carefully scrutinize those brought to us. We do our very best in that area, Senator, and will continue to make that a priority.

Senator UDALL. Great. Thank you very much. I appreciate it.

The CHAIRMAN. Senator Lankford.

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

Senator LANKFORD. Gentlemen, thank you for being here and for the conversation. You all know this is exceptionally important, not only to the Nation, but obviously to Indian Country and all of us as well. This is a big issue and affects a lot of families and our communities.

Let me start where I typically like to start. We have not had an opportunity to talk about it. In Indian Country, can you tell me a good example in a tribal area either in interdiction, recovery or prevention, any of those three, that you would say this particular tribe or this particular location or State is doing an exceptional job in one of those three that you can pull out and say what they are doing is working? Mr. Anderson.

Mr. ANDERSON. Thank you, Senator.

There is always room for improvement in our efforts to combat the opioid epidemic. I think we have had successes along the way in both the prevention and enforcement areas, recognizing there is continued room for improvement in terms of our collaborative efforts with State, local and tribal authorities.

In New Mexico, we have had some successes to include a prosecution that centered on the Navajo Nation that happened to be a methamphetamine case. My office viewed it as a substantial victory on the enforcement front against trafficking in Native communities.

Again, we are tribal partners and are working to improve, recognizing that certainly given the state of affairs, there is room for improvement.

Senator LANKFORD. Can you give me a good example of any one location that really stands out to you more than others at this point?

Mr. ANDERSON. Senator, the case we had on the Navajo Nation, I think, was a real victory.

Senator LANKFORD. I will take that. Any others?

Dr. TOEDT. Thank you, Senator Lankford. I appreciate the opportunity to highlight a program.

The Indian Health Service has 12 Federal and tribal youth regional treatment centers. One of those youth regional treatment centers, Desert Visions Youth Wellness Center, has made tremendous efforts on incorporating traditional practice into the evidence-based care. It was highlighted in the Surgeon General's report, Facing Addiction in America, as a best practice. Desert Visions used dialectical behavior therapy, an evidence-based approach for

the treatment of substances, while incorporating sweat lodge ceremonies, talking circles and smudging ceremonies.

Senator LANKFORD. Thank you.

Captain Jones.

Dr. JONES. I will just identify Project HOPE which is in Alaska. It is not tribal specific but has had a large tribal component that uses SAMHSA's funding for naloxone training. When you look at some of the metrics, there were 1,300 people trained, 8,900 naloxone kits distributed, and 45 overdose reversals.

In particular, in a very disparate, rural State like Alaska, I think this is an example, in particular, of where tribes can engage with States. I would highlight that as an example.

Senator LANKFORD. Captain Jones, we have been able to identify exactly the makeup of what is the typical overdose and that individual in Indian Country, male, female, a certain age, and marital status. What is the normal on that?

Again, I know it will be all over the map. Opioid addiction is no respecter of persons, but is there something we have identified to say is more typical?

Dr. JONES. I would say the typical makeup of an overdose case is not necessarily different among American Indians and Alaska Natives than it is for say, non-Hispanic Whites, which the group that looks most similar as far as overdose death rates. You tend to see higher overdose death rates among males and more than one drug involved. Although we often label them as opioid overdose deaths, they often involve alcohol or benzodiazepines, and other substances of abuse.

When you look at age groups, it is very interesting because of the rise in heroin use and the proliferation of illicit fentanyl and fentanyl analogs. We actually now see two age groups that are most impacted.

The highest overdose death rates for fentanyl, synthetic opioids and heroin are among 25 to 34 year-olds. For prescription opioids, it is 45 to 54 year-olds. For many years, we just sort of saw the top point at 45 to 54 but now we see the distribution that is quite different depending on the drug. We know those things about individuals. We tend to see variations for more heroin or synthetic opioids in more urban areas and rural areas still tend to be heavily influenced by prescription opioids.

Senator LANKFORD. Tell me about the cooperation with the Office of National Drug Control Policy and how that is working specifically in coordination with Indian Country because when I see the total budget, I have gone through it, for the Bureau of Indian Affairs and drug control funding, it is about \$9.7 million.

Obviously, brings out other areas. What is the cooperation like? Obviously that is not going to be enough to be able to cover it.

Dr. JONES. I will speak from my perspective at SAMHSA. We work very closely with ONDCP and other components at the White House to plan out the national drug control strategy and the broader framework for addressing substance abuse issues in the U.S.

From the SAMHSA perspective, in fiscal year 2017, we issued \$36 million in substance use funding to tribes. There is about \$83 million currently eligible for tribes in fiscal year 2018 as part of the larger pot of grant funding that is available.

I cannot comment specifically on BIA but we do work closely.

Senator LANKFORD. You have funding that is separate, BIA has funding, and others have funding. I am trying to figure out how the coordination between all of those is going as far as planning out how it is going to go and where it is going?

Dr. JONES. ONDCP has responsibility for the drug control budget. They issue letters to departments each year as the budget process is in the works. We respond to those requests from the Department's perspective.

We say what is ONDCP asking of SAMHSA in their coordination role, we would respond that these are the President's priorities, here is where we think our budget lines up with this or we can add money here or there in the budget's request and then ONDCP, OMB and others work out those things.

Senator LANKFORD. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Smith.

**STATEMENT OF HON. TINA SMITH,
U.S. SENATOR FROM MINNESOTA**

Senator SMITH. Thank you very much, Chairman Hoeven and Ranking Member Udall. Thank you very much to all of you gentlemen for being here today.

I would like to talk with you a little bit and get your thoughts on the question of culturally-based treatment and dive into that a little more.

We often talk a lot about the immediate impacts of the opioid addiction on people but also we know we need to think about this in terms of two generations or multiple generations. Children of mothers who are addicted to opioids are at risk of being born of course with Neonatal Abstinence Syndrome which is a particularly terrible problem.

The Leech Lake Band in Minnesota has actually declared a public health emergency related to the opioid epidemic in maternal and child health because so many babies are being born with Neonatal Abstinence Syndrome.

I would like to hear from Captain Jones or Rear Admiral Toedt if you could tell us a little bit about what you are doing to expand access to treatment for pregnant women?

Dr. JONES. Thank you for the question.

I think this is an important area and certainly an area that has received increased attention over the last several years. Our perspective at SAMHSA is that we need to look at this comprehensively, not neonates who are born physically dependent and siloed from the mother who was addicted during the pregnancy.

A couple of programs we have in place are trying to build a comprehensive suite of services to address the needs of mother and baby and even family, and include our pregnant and postpartum women grant programs.

We have two different programs. One is a residential-based program. We funded 19 grantees last year. Under CARA legislation, we have a new pilot program at the State level for essentially outpatients, trying to move that comprehensive suite of services to the outpatient setting.

We know sometimes going in-patient is very much needed for post-partum women or someone who is pregnant. Also that brings its own constraints of, how do you manage your responsibilities as a parent if you have older kids and trying to make sure those systems are in place to support residential care when needed. Also looking at, if we provide high quality evidence-based treatment in the outpatient setting, how does that help connect them to the regular part of their day, to other kids or other family responsibilities? We are looking at both of those.

We also have family treatment drug courts which use the drug court model but try to address the family aspect of this issue. I think across all three of those programs, it is very important that it is not just about providing the medication or addiction treatment, it is what are the recovery supports, the housing, employment and what are the other supports that really set a family as well as the individual who is addicted up for success as they are leaving?

We have also issued a variety of different guidance documents and communications around how to do this in practice. If you are not one of our grantees, how do you go about doing it because many communities are affected by this?

Most recently, we issued a clinical guidance for treating pregnant and parenting women who have opioid use disorder and treating of the infants. It is really the playbook of how the clinicians go about doing this in a comprehensive manner. We are trying to address both through our funding streams as well as training and technical assistance that system that needs to be built to address the needs of those individuals.

Senator SMITH. Thank you very much. I think what you said is very important because the old way of thinking about this is to separate moms from their babies. Oftentimes, that is exactly the wrong thing to do if you want everyone to recover.

Dr. JONES. We know people often do much better if they are there. Certainly, if you are a mom and preoccupied with thinking about what is going on with your kids, it is really hard to pay attention to treatment and address the things right in front of you.

Senator SMITH. Thank you very much.

Admiral Toedt, would you like to add anything?

Dr. TOEDT. Yes, Senator Smith. Thank you.

I agree entirely with your comment about the importance of bonding between mothers and infants. All of our hospitals in the Indian Health Service which deliver babies are baby friendly hospitals in support of the mother-baby dyad of keeping them together.

The Indian Health Service is partnering with professional organizations such as the American College of OB-GYN and the American Academy of Pediatrics to create culturally appropriate guidelines for care such as the Neonatal Withdrawal Syndrome guideline.

We also are increasing screening to mothers identified as at risk who may benefit from early referral to medication-assisted treatment programs. We are increasing the number of treating providers by training nurse practitioners and midwives through in-

creased authority through the Comprehensive Addiction and Recovery Act.

Senator SMITH. Thank you very much.

Mr. Chairman, I see I am almost out of time but I want to thank Senator Lankford for his question about giving us examples of what works.

The CHAIRMAN. I am sorry, Senator Smith. We do not have time for thanking Senators.

Senator SMITH. I am still learning all the rules, Chairman Hoeven.

The CHAIRMAN. Please go ahead.

Senator SMITH. I appreciated that question. I wanted to mention that on the White Earth Reservation in Minnesota, we have a program called the MOMS Program which specifically focuses on what we have just discussed, how to help support pregnant women and then moms and babies. I think it is a good example of something that could be applied in lots of different places.

Thank you.

The CHAIRMAN. Thank you, Senator.
Senator Cortez Masto.

**STATEMENT OF HON. CATHERINE CORTEZ MASTO,
U.S. SENATOR FROM NEVADA**

Senator CORTEZ MASTO. Thank you.

Thank you, gentlemen, for being here today. Let me start with Captain Jones and Rear Admiral Toedt.

After talking with our Washoe Tribes of Nevada and California, what I am hearing from many of our tribes is that tribal-specific funding streams to address the opioid epidemic in our tribal communities was not included in the 2017 State-targeted response to the opioid epidemic grants. Is that true?

Dr. JONES. Correct. The statute basically limits eligibility to States.

Senator CORTEZ MASTO. Don't you think there should be targeted grant funding to address these issues in tribal communities?

Dr. JONES. We certainly would be willing to carry forward however Congress appropriates or authorizes those dollars.

Senator CORTEZ MASTO. Are they needed?

Dr. JONES. I think we have described today that there is a substantial problem in Indian Country. We have taken as many flexibilities as we can.

Senator CORTEZ MASTO. I will take that as a yes.

My colleague talked to you about culturally-appropriate treatment. I believe in it. I think not only do we need culturally-appropriate but we need trauma-informed treatment as well. Can both of you talk a bit about that? Do you provide trauma-informed treatment as well when we talk about substance abuse needs and treatment in the tribal communities?

Dr. TOEDT. Yes, ma'am.

We entirely support trauma-informed care. It is very important to get to the root of the problem. So many patients that are seeking relief from opioids may actually be suffering from untreated mental illness. They may also be suffering from economic disparity, histor-

ical trauma, or a lot of issues that came up through childhood as well.

Having an understanding of a person's background and culture, where a person is coming from, is very important to being able to effectively bond with them, make a connection and deliver effective treatment.

Senator CORTEZ MASTO. Thank you.

Dr. JONES. I think trauma-informed care and the importance of addressing co-occurring substance use and mental disorders are infused throughout our grant programs.

Senator CORTEZ MASTO. Fantastic.

Rear Admiral, do you have the resources you need to provide that level of care?

Dr. TOEDT. I appreciate the question.

The IHS wants to be responsive to tribal concerns. I have heard from tribes that there are not enough resources out there. Certainly any funding that Congress can provide will definitely be appreciated.

Senator CORTEZ MASTO. I also hear from our tribes that it is difficult to get that treatment. I have heard a lot of conversation about working with our States but the States already have tapped out trying to find the treatment they need for substance abuse within their States.

Requiring our tribes to work with the States to fight for that money is difficult and makes it much harder to get the resources to our tribal communities. Wouldn't you agree with that?

Dr. JONES. I think building the capacity is really the importance of the STR funding and other training and technical assistance we are applying broadly across the U.S., even specific to tribes around training and technical assistance.

We could have multiple billions of dollars that could be spent on treatment but if we do not have providers who can provide that care, whether you are in Indian Country or not, you are not going to be able to get access to evidence-based care. Really a core part of the work we are doing is to build that foundational capacity.

Senator CORTEZ MASTO. Would you agree that a special behavioral health program for Indians that parallels the structure of the existing Special Diabetes Program for Indians to provide substance abuse prevention, intervention and other needed behavioral health services might be an answer to addressing these substance abuse needs in tribal communities?

Do you think the Diabetes Program is a good model to emulate?

Dr. TOEDT. Thank you, Senator.

We absolutely think that the Diabetes Program has been an excellent model. Emulation of that funding model is something we have heard from tribes. Yes, it is an excellent idea.

Senator CORTEZ MASTO. Thank you.

I have one final question for Mr. Anderson. Thank you for everything you do.

First of all, I do know U.S. Attorneys and AUSAs across the Country are working very hard in our tribal communities. You are tapped for resources. I know that. I will say that as somebody who worked in my State in law enforcement.

Chairman Hoeven asked you about the impact of moving HIDTA out of the Office of National Drug Control Policy. Can you talk a bit about HIDTA and how important those grants are and how effective HIDTA is in our communities?

Mr. ANDERSON. Senator, HIDTA certainly is an important part of what we do with the Federal partnership focusing on those high intensity drug corridors throughout the Country.

In terms of the structure of HIDTA or its funding, that is not something I can discuss today but I can tell you that they are, from the Federal law enforcement perspective, a critical aspect of our efforts to interdict the flow of illegal drugs, including opioids, heading to and that end up in our tribal communities.

Senator CORTEZ MASTO. Thank you. Critical and effective, right?

Mr. ANDERSON. Yes.

Senator CORTEZ MASTO. Let me just say this. We are combating opioids now and it is a crisis across the Country. Ten years ago, it was methamphetamines. It is black tar heroin. I can promise you that unless we address this through treatment, dollars and fighting, not just assuming law enforcement will do it all, we are going to constantly see this shifting from methamphetamines to black tar heroin to the opioids in our communities.

It is a scourge that we need to address. We have to come together on the treatment and law enforcement sides and adequately fund in all of our communities, including our tribal communities to really combat the crisis we have across this Country.

Thank you.

The CHAIRMAN. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

Gentlemen, thank you all for what you do respectively. I apologize that I was not able to hear some of the colleagues' questions. Again, these are issues that are so key and important.

Captain Jones, I appreciate you mentioning the Project HOPE Program and how it is working or helping in Alaska.

I mentioned in my opening not just the opioids and how that has ravaged us but also alcohol. I will just cite our annual drug report which acknowledges the multifaceted drug abuse problem in the State. Drug abusers in Alaska tend to abuse more than one substance, oftentimes multiple substances. The drug of choice is alcohol, heroin, meth, cocaine, prescriptions and marijuana. They emphasize that alcohol was the single-most abused substance.

As we have been focusing our efforts here in Congress on opioid, opioid, I don't want us to lose sight of the fact that underlying so much of this is alcohol and fail to provide the support for programs and grants in that alcohol space as well. When we talk about substance and substance abuse, we need to make sure that it is alcohol and substance programs. Everyone is shaking their heads like you agree with me. We do not need to bifurcate these. These are all one big, ugly, horrible problem with which we are dealing.

Let me ask about what I will call a workforce issue. Our reality is that we have identified the problem and some of the solutions. However, we know so much of this comes back to making sure we have mental professionals able to be there, to be that support.

I have been working with my colleague from Indiana, Senator Donnelly, on an effort that would incentivize those to go into substance use disorder treatment work. Basically, it is a loan forgiveness program we think will be helpful in incentivizing more.

I have to assume part of the challenge we are facing is we simply do not have enough mental professionals to help us. Is that so? I am getting head nods. We need to work on that as well.

Here is my question to you. This is intended to help at least three individuals in the audience. I met with the Mayor of Utqiagvik who is with us today and two others who are part of her council. They mentioned that in Utqiagvik, formerly Barrow, the issue relating to opioids and drugs, again the intensity we cannot single out enough.

From an enforcement perspective, I will look to you, Mr. Anderson. They say they do not have a district attorney there and that prosecution for these drug offenses is not moving forward.

The drugs come in by mail and plane. We know how they get in but we cannot get attention on anything unless it is at the full felony level. People know that they can sell, deal, and use. There is no follow up, consequence and no enforcement.

What would you tell the Mayor of Utqiagvik?

Mr. ANDERSON. Senator, I would urge the Mayor to work to seek Federal grants to develop that type of thing. There are Federal grants available through the Department of Justice's Comprehensive Opioid Abuse Program. I would hope those could be used to develop that type of legal infrastructure described in your question in posing that issue.

Certainly it is an important component of addressing this crisis, that we have that law enforcement infrastructure in place. I understand that in your State and many of our tribal communities, there is a shortage of access to courts and related resources.

I would urge those communities to apply to the Department's grant program to be able to fund that type of infrastructure. I think that is critical to proper enforcement in combating the opioid epidemic.

Senator MURKOWSKI. I appreciate that.

Mr. Chairman, I also recognize we hear from a lot of our constituents that we are basically setting tribes up to compete with other tribes when they all have significant need. You have some tribes that perhaps might not have the bandwidth to submit. I think a community like Utqiagvik is probably positioned a bit differently.

It is something I recognize. We have some gaps. We have been talking about tribal courts and the opportunities they may present to help address some of these issues on the enforcement side. We know we have a lot of work to do.

I am over my time. I could spend all afternoon with you. Thank you again and thank you for your work.

The CHAIRMAN. Senator Tester.

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

Senator TESTER. Thank you, Mr. Chairman.

I want to thank you all for being here. I want to follow up a bit on the Ranking Member's line of questioning on declinations.

Ten years ago, if my memory serves me correctly, when Byron Dorgan was chairman of this Committee, we talked about how declinations were way, way too high in Indian Country. From 2013 to 2015, the U.S. Attorney's Office declinations increased by another 20 percent, according to the Ranking Member's information.

In this case, increase is not a good thing. Declinations increased by 20 percent. Can you tell me why?

Mr. ANDERSON. Senator Tester, we are committed, obviously, to constantly look at why the declination rate in Indian Country moves the way it does. It is an important figure for us to follow and to work to reduce that declination figure.

Senator TESTER. I got you. But that does not answer my question. It does not make any sense to me. Is it that we do not have enough FBI agents or you do not have enough people on your staff? What is going on?

As I said, it has been fully 10 years, probably 11, and was probably a problem 10 years before that. I am not blaming you. I just need to know why because it is unacceptable. What can this Committee do to make it work so there aren't these kinds of declinations in Indian Country? In Montana, that is what the highest crime rate is.

Mr. ANDERSON. Senator, I am not sure I can give you an answer for why over a period that long, for example, 10 years, the declination rate has gone the way it did. I can hypothesize and am hopeful that it may be an increasing number of reported crimes. Obviously, every case that is opened by my office in New Mexico is carefully examined by an Assistant U.S. Attorney and worked by an FBI agent.

Senator TESTER. I will use the Ranking Member's numbers again. Between 2011 and 2014, the numbers referred to the U.S. Attorney's Office decreased by 81 percent.

Here is the problem and what I would love to have you do. I know you are fairly new to this position. Could you take it back to your group and tell us why? That is all I want. Is it because of the sovereignty issue and there is no cross work being done as far as law enforcement or is it because the FBI has not put enough people in this Country? As I said, is it your staff?

We are not getting it done. I think it is a big issue in Indian Country because of violence against women, which could have to do with drugs, poverty or something else but it is crimes and is serious stuff.

I think it is something we have always talked about. People have come before committees like this and answered and it continues to get worse. This position is not forever for you but maybe it is. Udall says you are a good guy, by the way.

The truth is, in fact, if you can do something about this and give us some instruction, put it back on us. Say, Indian Affairs Committee, here is what you need to do and we can get this fixed. We would be more than happy to work with you.

I want to talk to you, Captain Jones. You discussed the budget request for fiscal year 2019 being \$10 billion in new resources across the Department of Health and Human Services. This follows a question maybe Senator Smith asked.

Would you be opposed, when the Appropriations Committee gets done with massaging these numbers, if they carve out a certain percentage of that \$10 billion for Indian Country?

Dr. JONES. Again, we are absolutely ready to carry forward what direction we get from Congress.

Senator TESTER. The question is if you oppose it, we will never get it done. If you do not oppose it, then we would probably do it and get it done.

Dr. JONES. I will say our posture has been where we have been able to be flexible in putting setasides in place, when there is not a statutory prohibition that funds can go to different groups, we have tried to include tribe in setasides or other means.

Senator TESTER. I will try, and I think Senator Murkowski would probably maybe do the same thing, to peel some of this money off and dedicate it to Indian Country. I would hope you would not oppose that when it comes through, okay? That is just a little heads up.

I will make the last thing quick because I know Heidi has some important questions to ask you guys. Can the money only be used for opioids? Can it be used for meth also?

Dr. JONES. The STR dollars are an opioid-specific grant but certainly we recognize that individuals have co-occurring disorders using other substances.

Senator TESTER. Are the STR dollars the \$10 billion in resources? Is STR what that is called?

Dr. JONES. The STR Program is the program created under the 21st Century Cures Act in the 2019 budget.

Senator TESTER. That is fine, that is different. I am talking about the \$10 billion of new resources across the Department of Health and Human Services. Can that be used for opioids, meth and heroin, as far as that goes?

Dr. JONES. STR would be a component of that. Under the 2019 budget, that is an increase of \$1 billion for the STR Program, which is specific to prescriptions or illicit opioid. Heroin would be in that group. The specifics of the remainder of the dollars are still being worked out.

Senator TESTER. Would meth be a part of it?

Dr. JONES. Again, to the extent they are co-occurring and co-use of other substances.

Senator TESTER. But it would not be in and of itself. That is good. I would just ask you go back to your people.

Dr. JONES. I just want to say in the budget, we also have requested \$30 million for the Tribal Behavioral Health Grant which is much broader.

Senator TESTER. Did you say \$30 million?

Dr. JONES. Yes, \$30 million. Again, we try to be very flexible.

Senator TESTER. I am way, way over. I would just say we need your help on this stuff. This is your budget and not mine. I need to know what you had in mind when you crafted your budget for this.

With that, I appreciate you being here.
 Thank you, Mr. Chairman.
 The CHAIRMAN. Senator Heitkamp.

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

Senator HEITKAMP. Mr. Anderson, I want you to know that I have asked all these questions of FBI Director Wray as well, so I am not just picking on you. Do you think we need more FBI and DEA agents in Indian Country, yes or no?

Mr. ANDERSON. Senator, I would have to figure it out. I think it depends on each specific reservation.

Senator HEITKAMP. No. I will tell you this. We need more DEA and FBI agents in Indian Country. It does not depend on anything.

The reason why you have declinations is you do not have quality investigations. I will tell you that. The other reason why you have declinations is because your limit in FBI and DOJ is too high. It is too high because you guys treat it the way you would if you worked in Indian Country.

You are the only jurisdiction in Indian Country. When you do not show up, we do not have law enforcement. When there is no law enforcement, we have mayhem and give out jail free zones for drug dealers.

We have to have protection for people in Indian Country. I can tell you it frustrates me to no end to hear a discussion, Captain Jones, about well, you know, if you use opioids but maybe you have a co-utilization. That is nonsense. Our problem in North Dakota is not opioids. It is methamphetamine. It is methamphetamine. It is killing whole generations of people in my State. It has to end.

It has to end first from a law enforcement standpoint. We can do all the treatment in the world but if these drugs flow freely into Indian Country with no opportunity for change, we will not change anything. We have to get law enforcement.

Mr. Anderson, you are just the brunt of my frustration today. I have had this conversation with Directory Wray, the then-nominee for the Attorney General and with DOJ officials who deal with Indian Country, on drugs and trafficking in Indian Country. We are screaming for help. We are screaming for help. There is no one who lives in Indian Country who does not recognize this. I just want to read the comments from Vice Chairman Headdress from the Ft. Peck Assiniboine and Sioux Tribes who attended our roundtable on this issue.

He asked "Why service units or tribes cannot funnel some of their purchase and referred care dollars for prevention and treatment of opioid misuse?" I will tell you in our neck of the woods, there does not seem to be a coordinated response to this problem in Indian Country. I mean across the board. You see it right there.

I am telling you we are an endangered species in many tribal organizations. It is because we are losing generations to addiction whether it is alcohol, opioids or methamphetamines. I cannot state it more clearly.

We need to do better. Hearings like this give us a chance to vent but I hope a unified plan comes out of this. We are all going to sup-

port setasides. I do not think there is any doubt about it. Maria has been working on setasides for tribal organizations.

To give you just a little example, in my State, the first grants that went out, the opioid grants, there were I think seven or eight applications. Two were denied; both were in Indian Country. We eventually complained and the Governor found some additional money to send to Indian Country.

It has to be culturally significant in the way Senators Cortez Masto and Smith discussed. We need a plan. It cannot just be about treating the addiction. It has to be a plan about getting law enforcement on the ground. I hope you guys will take from this an opportunity to sit down and actually come up with a plan in consultation with the tribes because they are screaming for help.

I ask to tell one story. A friend of mine, Paul Iron Cloud, who was Chairman and head of housing for Pine Ridge, came to me in one of his last visits. Unfortunately, he died of cancer after his visit with me.

He was very frustrated. He said, "Senator Heitkamp, we need help. We need law enforcement. We need the FBI. We need people to come help us." I said, "Paul, where are the tribal elders and where are the tribal communities?" He looked at me incredulously and said, "We are afraid. All the good people are hiding. They are afraid of what is happening in their homes."

This cannot continue, not in the United States of America. We have murder rates that are unsurpassed in any other part of the Country. This is driven by drugs and addiction and we need to get to the bottom of this.

I am pleading with you, on behalf of all the people that I represent who are pleading with me, please, please, please, make this a top priority. If you care about law and order, this has to be a top priority. If you care about Indian healthcare, this has to be a top priority. If you care about changing the dynamic for children in the future, this has to be a priority or we will be nowhere.

I want to thank the Chairman for having the hearing. I want to thank this Committee for being so engaged and involved. And I want to pledge to you, as Senator Tester did, tell us what you need and what will change the outcome. We will work with you to make it happen. Tell Director Wray I had some strong words.

The CHAIRMAN. I would like to thank our witnesses. Members may also submit follow-up questions for the record. The record will be open for two weeks. I want to thank the witnesses for being here and for your testimony today. Panel One is adjourned.

We will now set up our second panel. We will now hear from our second panel. Our witnesses today are: Ms. Jolene George, Behavioral Health Director, Port Gamble S'Klallam Tribe of Kingston, Washington and Mr. Samuel Moose, Treasurer and Bemidji Area Representative, National Indian Health Board, Bemidji, Minnesota.

Ms. GEORGE.

Ms. GEORGE. Thank you, members of the Committee, on behalf of the Port Gamble S'Klallam Tribe.

The CHAIRMAN. Ms. George, I am sorry to interrupt. I understand Senator Cantwell wanted to give you a glowing introduction and I do not want to get in the way of that. I apologize.

Senator Cantwell.

**STATEMENT OF HON. MARIA CANTWELL,
U.S. SENATOR FROM WASHINGTON**

Senator CANTWELL. Thank you, Mr. Chairman. I know we are tight on time because there is a vote.

I did want to point out that Ms. George is Behavioral Health Director for the Port Gamble S'Klallam Tribe in Kingston. S'Klallam means "strong people," by the way.

I am really happy she is here because she has been on the front lines of the opioid crisis with her tribe and the surrounding community. They have had numerous overdoses and deaths stem from the opioid epidemic. Many of these deaths stem from the fact that the drugs were prescribed by medical professionals.

I believe Ms. George will talk about this crisis, how it has impacted families and put a strain on law enforcement and tribal services. She is also going to talk about the collaborative approach that the Port Gamble S'Klallam Tribe has used to address this abuse.

I think the Federal Government can learn something from her and the Port Gamble S'Klallam Tribe in tackling this epidemic. Thank you for being here today and thank you for the good work in this area.

**STATEMENT OF JOLENE GEORGE, BEHAVIORAL HEALTH
DIRECTOR, PORT GAMBLE S'KLALLAM TRIBE**

Ms. GEORGE. Thank you again, members of the Committee, on behalf of the Port Gamble S'Klallam Tribe, for this opportunity to present the impacts of the opioid epidemic on our tribe and what we need from Congress to effectively confront this issue.

I ask that my written statement also be included in the record.

My name is Jolene George. I am a tribal member and the Behavioral Health Director. We are a federally-recognized, self-governing tribe, owning 100 percent of our reservation lands with over 1,200 enrolled members.

As this Committee knows, we are disproportionately impacted by opioids. The statistics you hear reflect our heartbreaking reality as we struggle to confront the drug epidemic caused by opioids flooding our community. Every family on our reservation has been impacted by this epidemic. Many are grieving the loss of loved ones because of it.

At a government level, these impacts cut across all departments, complicating funding priorities and creating competition for already scarce resources. I shared statistics from our department to highlight the strain on staff and resources.

At least 75 percent of our substance abuse patients are opioid-dependent. These complex patients often utilize behavioral health resources at a higher rate than other patients. In our health clinic, pain management patients overwhelm the schedule. Our family medicine physician has become a pain management specialist.

In social services, 98 percent of our dependency cases are due to drug use. In one year, 100 percent of our housing program evictions were drug-related. Creating homeless drug addicts does nothing but perpetuate the vicious cycle.

Opioids have increased crime and police focus on drug interdiction means less time for other police priorities. Our court system

has had a 90 percent increase in drug and alcohol-related cases over the past four years. Again, the impacts of the opioid crisis cut across all aspects of our community and our government.

The opioid epidemic is a complex issue and there is no quick and easy fix for resolving it. We need a multi-faceted, comprehensive approach with tactics that work.

We took note of the November 2016 Surgeon General's report on Alcohol, Drugs and Health, which identified prevention as key to the fight against abuse and addiction. Our tribe has been working to implement just such an approach but we need your help.

We have shown leadership and are aggressive in our comprehensive response to the opioid epidemic with the following. We have developed THOR which stands for Tribal Healing Opioid Response. Unique about THOR is the coordination among all departments, community engagement and the custom strategies. THOR has three main goals: preventing opioid misuse and abuse; expanding access to opioid use and disorder treatment; and preventing deaths from overdose. We have self-funded the opioid response.

While we have made a thoughtful and deliberate attempt to combat this epidemic, we still experience many barriers. Adequate and direct funding is necessary to continue our coordinate efforts.

We support Senator Daines' bill which reflects the government-to-government relationship and would make the tribes eligible for direct funding. Our tribe participated in the Indian Health Service Tribal Budget Formulation Work Group and we support that request, including full funding of contract support costs.

Forty-two CFR Part 2 is our biggest regulatory hurdle towards behavioral health integration. Segmented care does not work. Health care providers need to see a patient's complete health record, including CD records to provide whole person care. Congress can eliminate this hurdle by aligning the status of chemical dependency records with medical and mental health records under HIPPA.

The lack of co-location of primary care and behavioral health services on our reservation only adds to our struggle. We look to Congress for innovative ideas, perhaps through its infrastructure package, for facilitating construction of co-located health care facilities on tribal lands.

We support Senator Cantwell's bill, the CARES Act. This is a good bill that would increase opioid prevention and treatment funding, limit opioid prescriptions and enhance prescription drug monitoring programs. We appreciate her work on behalf of Indian Country and her early consultation with us on the bill.

As our chairman said, "Our tribe has been devastated by this epidemic. Opioids keep taking from our community. They have torn apart our families and taken away loved ones." It is my hope that, with your help and the agencies here, we can put an end to the opioid crisis. The Port Gamble S'Klallam Tribe is happy to share any of the resources we have developed with other tribes. We formally invite the Committee members to visit our tribe to learn more about our ongoing work and continue this discussion.

I am going to leave with you a postcard with our THOR logo designed by our tribal member and comic book artist, Jeffrey Veregge, with our three main goals on the back.

I thank you for this opportunity to testify and I am happy to answer any questions.

[The prepared statement of Ms. George follows:]

PREPARED STATEMENT OF JOLENE GEORGE, BEHAVIORAL HEALTH DIRECTOR, PORT GAMBLE S'KLALLAM TRIBE

Thank you, members of the Committee, on behalf of the Port Gamble S'Klallam Tribe, for the opportunity to present the impacts of the opioid epidemic on our Tribe, our response, and what we need from Congress in order to effectively confront this issue.

I. About the Tribe, our Health Care System and Relevant Programs

The Port Gamble S'Klallam Tribe is a federally recognized, self-governing tribe owning 100 percent of its reservation lands. We are located on the northern tip of the Kitsap Peninsula in Kitsap County Washington. The Tribe's Reservation is home to about two-thirds of the Tribe's 1,200 enrolled members. The Tribe is the only Indian health care provider of both primary and behavioral health services in Kitsap County, and proudly provides culturally appropriate health care to our members and approximately 800 other American Indians and Alaska Natives (AI/AN) and community members living on our Reservation.

The Tribe joined the Tribal Self-Governance Project, a consortium of self-governing Indian Tribes, in 1990 and has directly provided health services to its members for over 20 years. We fund our health services through a compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act, and operate and manage our entire health system on our Reservation.

Our health system includes primary care, dental, mental health and substance abuse services. We provide our primary care services out of our outpatient primary care health clinic, which is staffed with 2 physicians, a physician assistant, and 4 registered nurses. Our dental building is next door and includes 2 dentists, 1 dental health aide therapist, and a dental hygienist. Our behavioral health clinic is approximately two miles away. It includes 1 physician, 1 Advanced Registered Nurse Practitioner (ARNP), 4 substance abuse counselors, 5 mental health counselors and 2 prevention specialists. It provides outpatient substance abuse treatment, relapse prevention, group, individual and family mental health counseling, psychiatric evaluation and medication management, and Medication Assisted Treatment (MAT). Over 98 percent of our behavioral health clients are also served by our primary care clinic. Community Health Representatives and transporters fill an essential role for both clinics, providing clinical linkages to the community and transportation services.

In addition, relevant to the opioid issue, our Tribe operates a police department, which consists of nine officers and places a strong emphasis on community-oriented policing for all residents and visitors. We also operate a Tribal Court with jurisdiction over criminal, civil and juvenile matters. Appeals are heard by our three-judge Court of Appeals.

Our Children & Family Services Department includes our Behavioral Health Division and the Community Services Division and works to enhance the quality of life of our Tribal members and their families through a culturally sensitive approach that encourages living a healthy lifestyle and promotes self-sufficiency. The Port Gamble S'Klallam Tribe operates all eligible programs under Title IV of the Social Security Act; Temporary Assistance to Needy Families (TANF) Part A, Child and Family Services (Part B), Child Support (Part D), and lastly, Foster Care and Adoption Assistance (Part E).

II. Impacts of the Opioid Crisis on the Tribe

In Washington State, the Native American overdose rate is more than twice as high as that of white Washingtonians.¹ The data shows that AI/AN in Washington State die of drug overdoses at a rate of 34.4 per 100,000 people, more than twice the rate of the next highest group (15.1 for Pacific Islanders), and almost three times that of whites at 12.4 and African Americans at 12.3. Other rates are 1.1 per 100,000 for Latinos, and 1.2 for Asian Americans.² For every opioid overdose death,

¹Austin Jenkins, Inslee Wants Washington State to Declare Opioid "Public Health Crisis," KUOW.org (Jan 12, 2018), available at <http://kuow.org/post/inslee-wants-washington-state-declare-opioid-public-health-crisis>.

²Washington Department of Health Death Certificate Data.

there are 10 treatment admissions for abuse, 32 emergency room visits, 130 people who are addicted to opioids, and 825 nonmedical users of opioids.³

Misuse of prescribed opioids frequently leads to other drugs such as heroin. According to the National Institute of Drug Abuse, 21 to 29 percent of patients prescribed opioids for chronic pain misuse them, and 4 to 6 percent who misuse prescription opioids transition to heroin. About 80 percent of people who use heroin first misused prescription opioids. The death rate for heroin overdoses among Native Americans has also skyrocketed, rising 236 percent from 2010 to 2014.⁴

The CDC reports that American Indians/Alaska Natives had the highest national drug overdose death rates of any race in 2015, and a 519 percent increase in the number of non-metropolitan overdose deaths from 1999–2015.⁵ Alarming, approximately 1 in 10 American Indian youths ages 12 or older used prescription opioids for nonmedical purposes in 2012, double the rate for white youth.⁶

These statistics reflect the heartbreaking reality on the Port Gamble S'Klallam Reservation as we struggle to confront the drug epidemic caused by opioids flooding our community. We have had numerous overdoses and deaths in our community as a result of the opioid crisis, and not only from the vast supply of drugs available on the black market. It has been estimated that approximately 60 percent of the opioids that are abused come, directly or indirectly, through doctors' prescriptions.

On our Reservation, the deaths include members who were prescribed opioids as pain medication and accidentally overdosed. In the recent past, the Tribe experienced an overdose by a young mother and the death of a toddler, just two years old, who got into his parents' opioid medication. We have grieving children, parents, grandparents, and great-grandparents who have lost family due to this scourge. Every family on our Reservation has been impacted by this epidemic.

At a government level, these impacts cut across all departments, complicating funding priorities and creating competition for scarce resources. Our Health, Behavioral Health, Children & Family Services, and Housing Departments, as well as our courts, law enforcement, and administration, all have a role to play in responding to this crisis.

Our Children & Family Services Department feels the effects of the opioid crisis acutely. One of its roles is to keep children with their families. When children are removed, we have both relative placements and 20 Tribal licensed foster homes, but the increased number of dependency cases due to opioid abuse or overdose has challenged our capacity. Opioid abuse impacts the whole family. Our Tribal member grandparents are often raising their grandchildren. In addition to this role, they often struggle to help their own child who is suffering from addiction.

One specific example of the impacts we face involves dependency cases that the Tribe files to ensure a child's safety and well-being. Ninety-eight percent of all dependency cases are due to drug use. In the first eight weeks of 2018, the Tribe filed four new dependency cases, three of which were related to parent(s) opioid abuse. This already surpasses the total new cases filed in 2017. These new cases are in addition to the open dependency cases that the Tribe has already filed.

The increased number of dependency proceedings burden existing child welfare services staff and resources, and require additional hires. Every child who comes into the Tribe's care and custody needs an array of intervention and services, including mental health counseling, medical services, substitute care, and housing. The parents who survive need treatment and counseling as well. Children who are exposed to opioids *in utero* suffer from opioid withdrawal and Neonatal Abstinence Syndrome, and often bear scars that will last a lifetime. These infants are immediately transferred to a neonatal intensive care unit for a period of days, weeks, or even months, frequently requiring emergency evacuation for care to save the infant's life. Such emergency transportation costs the Tribe thousands of dollars for each occurrence.

The crisis has forced the Tribe to staff new positions at great expense, including additional substance abuse counselors to deal with the substantial increase in opioid addiction, a nurse specializing in substance abuse disorders for case management

³National Institute on Drug Abuse. Opioid Abuse Crisis. Available at <https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis> (last accessed March 8, 2018).

⁴Dan Nolan and Chris Amico, How Bad is the Opioid Epidemic?, PBS.org (Feb. 23, 2016), available at <https://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/> (last accessed Feb. 27, 2018).

⁵CDC Morbidity and Mortality Weekly Report (MMWR), available at https://www.cdc.gov/mmwr/volumes/66/ss/ss6619a1.htm?cid=ss6619a1_w (last accessed March 8, 2018).

⁶National Congress of American Indians, Reflecting on a Crisis Curbing Opioid Abuse in Communities (Oct. 2016), available at http://www.ncai.org/policy-research-center/research-data/pre-publications/Opioid_Brief.pdf (last accessed Feb. 27, 2018).

related to the opioid epidemic, and physicians to provide Medication Assisted Treatment with drugs such as naltrexone for opioid addiction and abuse.

The Tribe has provided naloxone HCl, also known as “Narcan”, a nasally administered overdose reversal drug, and the training to use it, to all law enforcement personnel and natural resource officers. Due to their work in the field in our Tribal community, those officers and personnel regularly encounter individuals suffering from opioid overdose symptoms who can only be assisted and saved from death by timely administration of Narcan. The Tribe provides Narcan and training in its use to other members of our community, because the need for such emergency treatment is severe. Approximately 120 Tribal members have been provided with Narcan and trained on how to administer the drug. These steps are necessary, but they also cost money, which affects our Tribe’s budget and priorities for budget spending.

In terms of housing, the Tribe receives federal funding under the Native American Housing Assistance and Self-Determination Act (NAHASDA) to develop and operate affordable housing for low-income Indian families. Due to the substantial increase in opioid abuse, the Tribe has seen a parallel increase in evictions of Tribal members and other Indian families (since NAHASDA requires all leases to have language authorizing eviction for “drug-related criminal activity”). When those families are evicted from the Tribe’s housing they generally become homeless, and as a result they are then in even greater need of social, medical, and child welfare services from the Tribe.

The opioid crisis is overwhelming to our law enforcement and social services programs as they are not presently resourced sufficiently to meet the needs arising from the opioid epidemic. We are working as hard and as efficiently as we can with the resources we have, but additional resources in terms of funding, personnel and authorities are needed to combat the myriad problems the opioid crisis causes.

This epidemic is a complex issue, and there is no quick and easy fix for resolving the problem. Rather, we need a multifaceted, comprehensive approach with tactics that work. Our Tribe has been working to implement just such an approach, but we need your help.

III. What Port Gamble S’Klallam Tribe is Doing to Combat the Crisis

The Tribe has shown leadership in its aggressive and comprehensive response to the opioid epidemic through our cross-governmental Tribal Healing Opioid Response (THOR) program, collaboration with Washington State, through participation in the Three County Coordinated Opioid Response Project (3CCORPS), and, most recently, like many other state and tribal governments, by seeking to cut the flow of opioids into our community by filing a lawsuit against the manufacturers and distributors of these drugs.

A. THOR—Tribal Healing Opioid Response

The Tribe convened two Tribal town hall meetings last year to share the local impacts of the opioid crisis and determine a path forward. The extraordinary attendance at these community events demonstrated the intense and widespread impact of the crisis. Our Tribal Council then met with Kitsap County officials to discuss a response to the opioid crisis. The Tribe recognized that the crisis affects all our members and Tribal agencies and requires a cross-government response. These efforts led to the creation of our Tribal Healing Opioid Response, a project led by the Tribe’s Behavioral Health and Health Services Departments. THOR is now the heart of our opioid response on our Reservation.

THOR has three main goals, and Departments across the Tribe—not just health-related entities—are responsible for achieving them. These three main goals and the associated strategies are:

- (1) preventing opioid misuse and abuse by changing prescription practices, raising awareness of the danger of overdose, youth prevention programs, safe storage and disposal education, and drug supply reduction;
- (2) expanding access to opioid use disorder treatment by training health providers to recognize disorder symptoms, increasing access to treatment, applying treatment practices in the criminal justice system, implementing syringe exchange and overdose prevention/treatment training, and reducing instances of opioid withdrawal in newborns; and
- (3) preventing deaths from overdose by educating the Tribal community in how to recognize and respond to an overdose, and expanding access to overdose reversal medication.

Since January 2017, the Tribe has convened monthly THOR workgroup meetings composed of Tribal Council Members, Department Directors, staff, and other community members to implement the THOR goals. The workgroup is responsible for

developing, reviewing and updating the Tribe's local response plan. It reviews the statewide opioid response plan and other best practices, identifies appropriate strategies, and assigns tasks and responsibilities to workgroup members.

Significantly, our Tribe took note of the November 2016 Surgeon General's Report on Alcohol, Drugs and Health which identified prevention as key to the fight against abuse and addiction. We pulled strategies from this report and put them into practice in our effort to get ahead of potential addictions by creating a Prevention Team. Our Prevention Team is responsible for numerous programs that focus on youth and using evidenced-based approaches to keep youth active in the community. The youth services program offers extended hours, a safe space, and education about substance abuse and suicide prevention 6 days a week. Through our Chi-e-chee Tribal Coalition, we collaborate with adults in the community and provide substance abuse education and prevention activities to adults and families. Chi-e-chee can be translated to "the workers or the do-ers." The coalition has been active for over 20 years and is identifying and implementing events and activities around issues that are significant to our community.

The Tribe provides education to the community, focusing on pain treatment with exercise, mental health and non-opioid medications. Our ultimate goal through this effort is to significantly reduce the number of opioid prescriptions. Town hall meetings are held quarterly to help educate the community on current issues/topics that are significant to the community and are well attended.

THOR assigns specific responsibilities to each of the Tribe's departments to reach the THOR goals.⁷ For prevention, the Health Department is responsible for promoting best practices in prescribing and promoting safe storage and disposal of prescriptions; the Behavioral Health Department is responsible for awareness programs; Chi-e-chee is responsible for preventing misuse in youth; and the Police Department is responsible for attempting to interdict and decrease the supply of illegal opioids. For treatment, the Health and Behavioral Health Departments, along with the Police Department, train providers to recognize abuse, and the Behavioral Health Department, Health Department and Re-Entry Program work together to increase access to treatment and offer syringe and needle exchange. To prevent overdose deaths, Chi-e-chee, Human Resources, Behavioral Health and Health work together to educate the entire community to recognize and respond to overdoses, including through the administration of naloxone.

As a tribal government, we are focused on providing culturally appropriate treatment to our members suffering from opioid addiction and the host of health and mental health issues that come with it. These include programs such as our wellness activities, talking circles, and group therapy. The Healing of the Canoe Project is a collaborative project among the Port Gamble S'Klallam Tribe, the Suquamish Tribe, and the Alcohol and Drug Abuse Institute at the University of Washington. Its central mission is to develop a life skills curriculum for tribal youth that includes drug abuse materials. The Project has made its curriculum available and has trained a total of 350 attendees from 46 Tribes and 14 tribal organizations in how to adapt and implement the curriculum.

One of central reasons why our THOR program is so effective is because the Tribe is not only a health care provider for our community, we are also a government with the ability to coordinate with State, County, and regional groups. Our clinics, Police Department and social services departments have the ability to quickly work through bureaucracy for cross departmental collaboration, providing better services to both Tribal members and the community as a whole.

B. Collaboration with Washington State and Accountable Communities of Health (ACH)

Washington State has a Section 1115 waiver under the Social Security Act which funds experimental, pilot, or demonstration projects that are found by the United States Secretary of Health and Human Services to be likely to assist in promoting the objectives of the Medicaid program. These demonstration projects provide states additional flexibility to design and improve their programs with an eye toward evaluating state-specific policy approaches to better serve Medicaid populations. Through its Section 1115 waiver authority, Washington State has created Accountable Communities of Health, which bring together leaders from multiple health sectors around the state with a common interest in improving health and health equity. ACHs seek to align resources and activities to support wellness and a system that delivers care for the whole person. ACHs are also working to shift health care

⁷Tribal Healing Opioid Response Program, <https://www.nihb.org/docs/12032017/Tuesday%20Sessions/THOR%20Presentation.pdf> (last accessed March 11, 2018).

reimbursement strategies away from a system that pays for volume of service to one that rewards quality and outcomes.

Through the Section 1115 waiver and the creation of these ACHs, the Tribe has been able to form partnerships that were not otherwise easily accessible or workable. Now, on the opioid issue, specifically, the Tribe has multiple partners at different levels with whom it can and has been coordinating to develop and implement a variety of tactics to address the many issues arising from the epidemic. The Tribe collaborates with Washington State on the Washington State Opioid Response Plan and, on the regional level, the Olympic Community of Health (OCH) which is implementing the Three County Coordinated Opioid Response Project (3CCORPS).

C. Olympic Community of Health and 3CCORPS

OCH is an Accountable Community of Health whose objectives are to improve patient care, reduce the cost of health care and improve the health of the population in Clallam, Jefferson and Kitsap Counties. Each of the seven Tribal Nations within the three county region, including our Tribe, is represented on the OCH Board of Directors.

3CCORPS, OCH's specific opioid response, was launched in September of 2016 and convened an opioid summit in January 2017. It was not long before this summit that one of our Tribal members died due to missing a dose of naltrexone. This tragedy spurred momentum for our Tribe's active opioid response.

3CCORPS is currently in the implementation phase of its opioid response plan. Addressing the opioid epidemic is a required project in the Medicaid Transformation Project (MTP) of the OCH. 3CCORPS' foundations are the same 3 goals and strategies that the Tribe has adopted and adapted as our own opioid response plan. They also align with the statewide plan. The alignment of goals and strategies allows for quick duplication of evidence-based strategies and the ability to coordinate within the broader regional and state level, and also facilitates evaluation and data collection efforts.

3CCORPS is our work on the regional level with the OCH. Other groups that participate in 3CCORPS are independent clinics, police departments, and social service agencies that serve many different communities.

D. Litigation to Curtail Oversupply of Opioids

On March 5, 2018, the Port Gamble S'Klallam Tribe, along with the Suquamish Tribe and the Jamestown S'Klallam Tribe, filed a complaint in federal district court naming various opioid manufacturers and distributors, including Purdue Pharma LP, McKesson Corp., Cardinal Health Inc., AmerisourceBergen Corp. and others. Our complaint alleges that these companies spread false and misleading information about the safety of opioids, negligently created an illicit market for opioids, and failed to control the flow of opioids to our Tribal members. The complaint details the same devastating impacts that we report to you today, and asks the court to find that the defendants broke the law through fraud, negligence, public nuisance, violation of Washington State consumer protection laws, other laws, and racketeering. Through the lawsuit, we seek compensation for the cost of responding to and treating opioid-related addiction and punitive damages. In filing this lawsuit, we join over 400 other plaintiffs across the country,⁸ including state and tribal governments, in seeking to hold these companies accountable for the destruction caused by the opioid crisis.

IV. Lessons Learned and Strategies All Tribes Can Choose to Put in Place

A. Cross-Government Coordination

Through THOR and our 3CCORPS program with the OCH, we have learned many lessons in the fight against opioid addiction and efforts to treat those affected. At the forefront, we learned that coordination and communication across our government is key as well as ensuring that all of our Departments pitch in to the effort however they can. As the opioid epidemic affects all facets of our community, we have taken an "all-hands-on-deck" approach as a government. As explained above, we draw on any and all of our Departments that can help so that we can attack the crisis from many angles. Our monthly THOR workgroup meetings have been key to synchronizing our programs and generating action items to address the opioid problems in our community.

⁸"Can This Judge Solve the Opioid Crisis?" *New York Times*, March 5, 2018, available online at <https://www.nytimes.com/2018/03/05/health/opioid-crisis-judge-lawsuits.html>, (last accessed March 8, 2018).

B. Culturally Appropriate Care

Recognizing that traditional healing practices, cultural beliefs regarding approaches to treatment, and differences in interpersonal communication contribute to significant variances in effectively meeting the healthcare needs of AI/AN, cultural competency is an inherent part of who we are, who we serve and what we do.

C. Abuse Prevention

Prevention is the cornerstone for any opioid response, as the Surgeon General's Report on Alcohol, Drugs and Health (November 2016) states. We realize that availability of resources is different in different parts of Indian Country. Yet, there are strategies that any Tribe can put into place in its fight against the opioid epidemic. Our Tribe has a "toolkit" which we share with other Tribes in their opioid fight. We are happy to share our "toolkit" with any Tribe who would like access to it. Our "toolkit" includes:

- (1) Our Pain Agreement—used in the clinic for clients with opioid prescriptions for chronic pain;
- (2) Our Narcan Standing Orders & Policy—provides Narcan to any Tribal member or household that requests it, and to any patient with an active opioid prescription; and
- (3) Our Good Samaritan Tribal Code—provides liability protection for those who act in good faith and seek medical assistance for any person who is experiencing a drug-related overdose.

Collaborating with federal agencies has been very helpful in our Tribe's fight against the epidemic. We suggest that Tribes regularly call upon their regional federal agency officials from IHS, SAMHSA, HRSA, BIA, DOJ, and others. These agencies have resources, technical assistance and connections that they can share. Further, Tribes may find that partnering with their neighboring governments on this particular issue yields a variety of benefits. Accessing additional resources is always a benefit, whether they are financial resources or non-financial resources such as experience, expertise and technical assistance. Brainstorming and sharing ideas with federal agencies and neighboring governments with mutual interest in stemming the opioid crisis can lead to innovation and cooperation.

The Tribe has benefited from having close collaboration with federal agencies at the regional level. The Acting Regional Director of the Department of Health and Human Services (HHS), and the Regional Director of the Substance Abuse and Mental Health Services Administration (SAMHSA), have both visited the Tribe recently, participating in robust discussions on opioid prevention. As a specific example, our SAMHSA discussion helped clarify 42 CFR Part 2 updates and requirements.

V. Barriers and Needs to More Effectively Fight the Opioid Crisis

A. Funding Needs

There are several barriers that Tribes face in their efforts to overcome the opioid epidemic. We have run into several.

1. Adequate Funding and Direct Funding

Adequate funding to combat this behemoth opioid crisis is, of course, a major barrier. Getting funding out to Tribes for their on-the-ground work is an issue not only in the amounts, but also in the manner in which such monies flow to Tribes. We strongly encourage Congress to not only work on increasing available funding, but to also provide direct funding to Tribes and ensure that any additional funds for opioid crisis response do not decrease services in other areas.

We truly appreciate Congress's inclusion of authorization for \$6 billion over 2 years for opioid efforts in the recently passed Bipartisan Budget Act of 2018. We ask the Committee to advocate for full funding of the authorization and ensure that these funds go directly to tribal governments for them to spend in their own communities. Such funds should not be passed through the States. Direct funding of tribal programs is important as it ensures that funds are available to tribal governments like ours that have culturally appropriate programs and mechanisms in place for fighting the opioid epidemic.

An important bill that includes the requested direct funding mechanism is S. 2270, the Mitigating the Methamphetamine Epidemic and Promoting Tribal Health Act. This bill, introduced by Senator Daines, a member of this Committee, would make Tribes and tribal organizations eligible for direct funding under the 21st Century Cures Act, which provides an allocation to states for opioid prevention and response. S. 2270 would allow such allocation to also be used for prevention and re-

sponse for other substances, such as methamphetamines, if they are having a substantial impact on the state or Tribe.

2. Full Funding of IHS Budget

Additionally, we ask you to work toward providing sufficient funding to the Indian Health Service (IHS) for opioid treatment and prevention. The FY2019 Budget Request provides \$10 billion in new resources across HHS to combat the opioid epidemic and address serious mental illness. As part of this effort, the Budget Request includes an initial allocation of \$150 million to IHS to provide multi-year competitive grants based on need for opioid abuse prevention, treatment, and recovery support in Indian Country.⁹

The Public Health Service Commissioned Corps plays a vital role in providing direct patient care throughout the Indian Health Service, and also has a direct role in the work of Tribes combating the opioid crisis. Any restructuring of the Corps should be done in close collaboration and consultation with Tribes.

The FY 2019 Budget Request eliminated both Community Health Representatives and Health Education from the IHS budget. These two line items support the front line work of Tribes and the IHS on both the opioid crisis and daily operations and patient care.

They need to be restored.

3. Full Funding of Contract Support Costs

The FY 2019 Budget Request fully funds Contract Support Costs at an estimated \$822 million and continues the use of an indefinite appropriation, which allows IHS to guarantee full funding of this program. Funding for Contract Support Costs supports the costs incurred by Tribes for activities that are necessary for administering health care service programs under self-determination contracts and self-governance compacts.¹⁰ This is an important funding mechanism for self-governing Tribes like ours to administer our opioid prevention and treatment programs.

B. Barriers Beyond Funding

1. Regulatory Hurdles

There are several barriers in the fight against the opioid crisis that are beyond funding. One such barrier relates to funding, but is an administrative limit on accessing already available funding. The Health Resources and Services Administration (HRSA) has behavioral health integration funding available, but it is restricted to rural locations. Kitsap County does not qualify as “rural” and so the Tribe is ineligible for these grants. We recently raised this issue to HRSA, and received assurances that this issue would be addressed. However, it would be helpful for members of Congress to encourage HRSA to reconsider the rural restriction and develop a mechanism for channeling such monies to Tribes. This could be through revising the definition of “rural” to include Tribes regardless of location or “geographic trait” of its reservation.

2. Barriers to Medication Assisted Treatment

We also want to point out certain other barriers to our efforts to combat the opioid crisis. Current regulations impose onerous training and waiver requirements for providers of Medication Assisted Treatment (MAT) prescribing drugs such as buprenorphine, even though no such limitation exists on providers prescribing opioids. This creates barriers to accessing MAT. Medicaid dollars used to fund transportation to opioid services could be reduced significantly if buprenorphine, an opioid addiction treatment drug also known as Suboxone, was easier to access at primary care facilities. Those saved funds could be used for prevention or treatment. In addition, nurse care management as an adjunct to MAT has been shown to be successful and is an evidence-based practice in treating opioid addiction. We need to expand Tribes’ access to this treatment.

3. Physician Access to Medical Records

Federal regulations at 42 CFR Part 2, related to the privacy of substance abuse treatment records, currently prevent the Tribe’s primary care and mental health providers from accessing patient records from dependency providers so the whole person can be treated.

This lack of access is a barrier to coordinated, safe, and high-quality medical care and can cause significant harm. Part 2 regulations may lead to a doctor treating

⁹ 2019 Budget in Brief <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>. As of the preparation of this testimony, HHS has not released its detailed FY 2019 Budget Justification, including for IHS.

¹⁰ *Id.*

a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has a substance use disorder.

In August 2017, Congressmen Tim Murphy and Earl Blumenauer introduced bipartisan legislation that would help align 42 CFR Part 2 with HIPAA rules, ensuring that substance use disorder patients can receive proper care while their data remains secure. The Overdose Prevention and Patient Safety (OPPS) Act (HR 3545) allows access by doctors to patients' full medical records with all the safeguards of HIPAA, but also makes use of such information in criminal investigations unlawful. The Tribe joins others such as the Partnership to Amend 42 CFR Part 2, a coalition of over 20 healthcare stakeholders including the American Hospital Association, in support of HR 3545.

4. The Lack of Co-location of Health Services on Our Reservation

The Tribe is actively working to align substance use disorder treatment with primary care to address a person's overall health, rather than treating it as a substance misuse or a physical health condition alone or in isolation. As stated, our Health Facility and Dental Facility are nearby each other, but our Mental Health Facility and Rehabilitation Facility are some distance away. This causes extra administrative burden and expense of resources. Co-locating these services would improve behavioral health integration, but a new integrated facility for all health services would cost over \$8 million dollars. We suspect other Tribes face similar problems with respect to the lack of co-location of services. We look to Congress for innovative ideas, perhaps through its infrastructure package, for facilitating the construction of co-located health care facilities on tribal lands.

5. The Need to Modernize the IHS's Health Information System

This issue impacts the ability of Tribes to confront the opioid epidemic. Barriers to integration within the health information system are being addressed at significant cost to the Tribe as we left the Indian Health Service RPMS system for direct patient care documentation years ago, although we continued to utilize that system for Purchased & Referred Care (PRC). The system we use, NextGen, is adequate for primary care, but has limitations for mental health and substance abuse. This has impacted our behavioral health integration work.

The Veteran's Administration announcement that it will pursue a contract with Cerner as a replacement for the RPMS Parent system may provide an opportunity for both IHS and Tribes. IHS needs to ensure that the replacement of RPMS will include options for non-RPMS tribes and pathways for cost saving programs such as the VA Consolidated Mail Outpatient Pharmacy Service (CMOPS).

6. The Need for Pilot Projects for Residential Post-Treatment Facilities on Tribal Lands

Our Tribe is particularly interested in initiating a pilot program for residential post-treatment facilities. The Tribe would like to provide treatment and support past the prevailing 28-day model, utilizing evidenced-based practices with a robust evaluation component. The Tribe has partnerships with Oxford House and Habitat for Humanity to construct and operate such facilities, and is well positioned to start such a pilot program. We ask Congress to support the establishment of a pilot program by an agency such as SAMHSA, HUD, or IHS to fund residential post-treatment facilities on reservations to be operated by Tribes for their members and families.

7. Lack of Easy Access to Methadone Clinics

Our Tribal Members must travel to Tacoma or the greater Seattle area to a methadone facility to receive such treatment. We are working with OCH to obtain a methadone facility in Kitsap County to save our Members the burden and cost of traveling so far for that treatment. We ask Congress to consider ways it can facilitate the construction and operation of these facilities in locations accessible to tribal and rural communities like ours. Kitsap County, where we are located, has a restriction limiting service to one methadone clinic in the county. This limitation hampers our ability to provide expanded services in the future.

C. Beneficial Legislation: Senator Cantwell's Bill, S. 2440

In addition to S.2270 (Senator Daines' bill), we ask this Committee to support S.2440, introduced by our Senator and Committee Member, Senator Cantwell. We appreciate Senator Cantwell's work on behalf of Indian Country and, specifically, on the opioid issue. We also note that the Senator's consultation with our Tribe for receiving early input about this bill could serve as a model for tribal consultation when developing legislation. Our Tribe supports S. 2440.

S. 2440, known as the Comprehensive Addiction, Recovery, Education and Safety (CARES) Act, would, among other things, hold opioid manufacturers accountable for failure to report suspicious drug orders. The intent of the CARES Act is to increase opioid prevention and treatment funding, limit opioid prescriptions and enhance prescription drug monitoring programs. The Act would increase civil and criminal penalties on companies that fail to reasonably curtail their drugs from entering the illicit drug market. The legislation increases civil penalties from \$10,000 to \$100,000 per violation for negligence in reporting suspicious transaction activity, and doubles the maximum criminal penalty from \$250,000 to \$500,000 for willful violations. The Act increases funding for the DEA's Tactical Diversion Squad which investigates drug manufacturers that fail to prevent their drugs from entering the illicit drug market. The legislation also authorizes \$50 million for the DEA's heroin enforcement groups.

This important bill aligns with the Tribe's goals in our federal lawsuit to hold drug companies responsible for failing to track orders and for creating an illicit market for their drugs, and will be an enormous boost in the fight against opioid addiction. We applaud Senator Cantwell and ask all on this Committee to cosponsor and support this bill. Increased response funding and manufacturer accountability could drastically curtail shipments of the prescription pills that result in crippling addiction for our Tribal members.

VI. Conclusion

The crisis has ripped the fabric of our community. The loss (through death or addiction) of parents, children, brothers and sisters, uncles and aunts, nieces and nephews, and cousins to this crisis has been devastating, and will impact the Port Gamble S'Klallam Tribe for generations. We are doing what we can to fight it, and we want to work with you to eradicate this crisis once and for all.

Thank you for the opportunity to provide this testimony. We invite you to visit our Tribe to learn more about our ongoing work.

The CHAIRMAN. Senator Smith, I believe you wanted to give an introduction of Mr. Moose.

Senator SMITH. Very briefly, Mr. Chair, because I know we are rushed for time.

I want to welcome you to this Committee. It is wonderful to see you.

Mr. Moose is a member of the Mille Lacs Band of Ojibwe from Minnesota and is an important leader on Native health issues broadly, not just issues related to the opioid epidemic. As Chairman Hoeven said, he serves as Treasurer and the Beidji Area representative to the National Indian Health Board. Thank you so much for being here.

I am going to have to run to go vote but I have read your testimony and look forward to hurrying back so that I can ask you a question or two.

Senator CANTWELL. [Presiding] I thank the witnesses for their testimony. Did you want to ask a question at this moment? If you want, go ahead, Senator Smith.

Senator SMITH. I will do that. That way I don't have to run back. Thank you.

Mr. Moose, I am very interested in talking to you about the opportunities we have with the special behavioral health program modeled on the Diabetes Program. Earlier today, I was able to introduce legislation that several Committee members, including Senators Udall, Tester, Cortez Masto and Heitkamp, also introduced.

This bill would provide Native communities with flexible funding, as we have discussed so much today, to create programs that can really build on the work you are already doing. Could you talk a bit from your perspective on what we could do at the Federal level

to make sure we are not just reacting to current events but are really giving tribes the flexibility they need to take action?

Mr. MOOSE. One of the things that is really good about the bill you are looking at introducing is the fact that it does look at long range infrastructure funding for Indian Country. One area we often struggle with is grants, from time to time, are kind of dropped into Indian Country and then go away.

One of the issues we have in Indian Country is infrastructure development, ongoing support and flexibility to utilize funding that meets our specific needs. Unfortunately, at times, States, under good pretenses, provide funding large areas of tribes within their State systems.

Oftentimes that funding gets so specific that it does not meet the needs of every tribe within the State. Some States may need that specific direct funding, whether it is recovery, case manager support or other specific support. However, other tribes may have moved on from that funding and have a hard time utilizing that funding or using that funding to leverage other funding. I think it is really good to see that the bill supports ongoing funding for Indian Country, specifically what we have seen with the Special Diabetes for Indians.

Senator SMITH. Thank very much. I will leave it at that but I thank you and look forward to working with you on the bill. Also, thank you very much, Ms. George, for being with us.

Senator CANTWELL. Thank you, Senator Smith.

Ms. George, you mentioned the CARES Act, which we have introduced. One key focus of that legislation is putting stiffer penalties on manufacturers who fail to meet the standard DEA has set up for some drugs as addictive as opioids.

The DEA really wants to follow the distribution of that product and make sure the failure to report distribution of something as highly addictive as opioids is penalized if manufacturers fail to do that. That is what I and Senator Harris of California have introduced.

In our State, we have had over 10,000 fatal overdoses in basically a 17-year period of time. I know the rate in Indian Country is more than twice as high as the rest of the population. What do you think this kind of partnership with law enforcement in tracking and distribution of drugs would do to help the problem in Indian Country?

Ms. GEORGE. I really believe that collaboration between law enforcement and all sectors needs to be represented in this process to really combat this crisis as a whole. Law enforcement is definitely key.

In our community, although we are a small community, our law enforcement sometimes is the only people that have interactions with some of our folks having overdose incidents. Not only are they able to keep them alive in that instance they experience, but also bring them directly to our programs that service them. They play a very integral part in fighting this. At least in our community, I think our law enforcement recognizes that and is willing to take the steps necessary to move forward.

Senator CANTWELL. Thank you for that answer.

Unfortunately, we are going to have to take a short recess and will resume shortly. The Committee will be in recess.

[Recess.]

Senator UDALL. [Presiding.] The Committee is reconvened.

We apologize for the inconvenience. These votes are an occupational hazard and if we do not vote, we get in a lot of trouble. Thank you for your patience.

I believe we were at the point in the proceeding where next to testify was Mr. Samuel Moose, the Treasurer and Bemidji Area Representative of the National Indian Health Board.

Before you start, Sam, both of you obviously have real admirers in Senators Cantwell and Smith who really appreciate all the good work you are doing.

Thank you.

STATEMENT OF SAMUEL MOOSE, TREASURER AND BEMIDJI AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Mr. MOOSE. Chairman Hoeven, Vice Chairman Udall and members of the Committee, on behalf of the National Indian Health Board and the 573 tribal Nations we serve, I thank you for holding this important hearing.

My name is Samuel Moose. I am the Human Services Director for the Fond du Lac Band of Lake Superior Chippewa and an enrolled member of the Mille Lacs Band of Ojibwe.

The current opioid epidemic represents one of the most pressing public health crises affecting tribal communities. While this epidemic is affecting many communities throughout America, it has disproportionately impacted tribes and has strained the limited public health and health care resources available to tribes.

American Indians and Alaska Natives have had the highest rate of drug overdose deaths every year since 2008 to 2015. In my home State of Minnesota, the age adjusted death rate due to drug poisoning is five times higher among the American Indian population compared to Whites.

American Indians accounted for 15.8 percent of those who entered drug treatment for opioid use despite only being 1.1 percent of tribal or the State population. These statistics demonstrate the critical need for more comprehensive intervention in tribal communities to improve prevention and treatment services.

This epidemic is so bad that several tribes throughout the Country, including three within Minnesota, declared a state of emergency to tackle this crisis. Historic and intergenerational trauma along with current trauma that spans a lifetime for American Indians, a lack of funding for IHS, and the failure to include tribes in State level prevention and public health programs all contribute to the current crisis in tribal communities.

In Minnesota, pregnant American Indian women were 8.7 times more likely to be diagnosed with maternal opioid dependence. American Indian infants were 7.4 times more likely to be born with Neonatal Abstinence Syndrome, meaning that the repercussions and trauma of this crisis are intergenerational.

The deferral of healthcare in the Indian health care system due to funding and workforce shortages has created greater dependency on opiates. Limited funding resulted in nearly 80,000 Purchased/

Referred Care service denials in fiscal year 2016 alone. Instead of being referred for surgeries and support treatment, patients are simply placed on prescription opiate medication as they wait for access to additional care. This endless cycle of deferral and opiate dependency is a direct result of underfunding in the IHS system contributes to the issue.

Solutions should focus on allowing tribes to access long term, sustainable resources, improve data and disease surveillance and enhance tribal practice of traditional healing and culturally-based treatment. Congress should allow tribes access to the State Targeted Response to Opiate Epidemic Grants. NIHB supports the provisions in S. 2270, the Mitigating METH Act, and S. 2437, the Opioid Response Enhancement Act.

Congress should: establish tribally-specific funding streams such as a Special Behavioral Health Program for Indians, modeled after the very successful Special Diabetes Program for Indians; ensure parity between States and Tribes in any new opioid-related legislation advanced in Congress, not only including tribes as eligible entities, but also requiring tribal consultation, information and data sharing, and funding set asides; establish trauma-informed interventions in coordination with tribes to reduce the burden of substance use disorders including those involving opioids; and include set asides for tribes within the \$6 billion in opioid program funding for fiscal years 2018 and 2019.

In addition, health IT and data issues represent a serious challenge when it comes to the opiate crisis. IHS' current Electronic Health Record system has difficulty tracking data across various systems, including those tribes who operate different EHRs. RPMS is often not compatible with State-based prescription drug monitoring programs which makes tracking access to opiates a severe challenge.

Congress should make investments in the health IT resources at IHS, especially as the VA system begins to transition from Vista. It should require that States consult with tribes on use of prescription drug monitoring programs and incentivize providers to adopt E-Prescribe as a way of reducing the needless and harmful spread of opiates.

I would also like to highlight the importance of integrating traditional healing practices with conventional strategies in Indian Country and tribal communities that have been healing their people for thousands of years. Although Federal grants and Medicare do not reimburse for traditional healing services, it is critical that Congress support these traditional practices by providing funding and including them in the Medicaid reimbursement.

Again, thank you for allowing this time for me to be here with you today and holding this hearing.

[The prepared statement of Mr. Moose follows:]

PREPARED STATEMENT OF SAMUEL MOOSE, TREASURER AND BEMIDJI AREA REPRESENTATIVE, NATIONAL INDIAN HEALTH BOARD

Introduction

Chairman Hoeven, Vice Chairman Udall, and Members of the Committee, the National Indian Health Board (NIHB) thanks you for holding the hearing, "Opioids in Indian Country: Beyond the Crisis to Healing the Community." On behalf of NIHB

and the 573 federally-recognized Tribes we serve, I, Sam Moose, Director of Human Services at Fond du Lac Band of Lake Superior Chippewa submit this testimony.

NIHB is a 501(c)3, not for profit, national Tribal organization founded by the Tribes in 1972 to serve as the unified, national voice for American Indian and Alaska Native (AI/AN) health in the policy-making arena. Our Board of Directors is comprised of distinguished and highly respected Tribal leaders in AI/AN health. They are elected by the Tribes in each region to be the voice of all 573 Tribes at the national level.

Since 1972, NIHB has advised the U.S. Congress, Indian Health Service (IHS), and other federal agencies about health disparities and service issues experienced in Indian Country. The current opioid epidemic represents one of the most pressing public health crises affecting Tribal communities. While this epidemic is affecting many communities throughout America, it has disproportionately impacted Tribes and has further strained the limited public health and healthcare resources available to Tribes. The Federal Government must take concrete action to ensure Indian Country has the tools it needs to address opioid abuse and heal Tribal communities.

Trust Responsibility

The federal promise to provide Indian health services 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 unique trust relationship between the United States and Tribes.

The Indian Health Service is the primary agency by which the Federal Government meets the trust responsibility for direct health services. IHS provides services in a variety of ways: directly, through agency-operated programs and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations. Tribes may choose to receive services directly from IHS, run their own programs through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. To ensure accountability and provide greater access for Tribal input, IHS is divided into 12 geographic Service Areas, each serving the Tribes within the Area. It is important to note that Congress has funded IHS at a level far below patient need since the agency's creation in 1955. In FY 2017, national health spending was \$9,207 per capita while IHS spending was only \$3,332 per patient.

Overview of the Opioid Epidemic in Indian Country

The national opioid epidemic represents one of the great public health challenges of the modern era. The Centers for Disease Control and Prevention (CDC) noted over 64,000 drug overdose deaths in 2016 alone, largely driven by prescription and illicit opioids.¹ Among AI/ANs, the rate of drug overdose deaths is twice that of the general population, according to the IHS. Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs.² The CDC reported that AI/ANs consistently had the highest drug overdose death rate by race every year from 2008–2015, and the highest percentage increase in drug overdose deaths from 1999–2015 at 519 percent.³ Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs, with an opioid overdose death rate of 9.6 per 100,000 in 2015—second only to whites.

Regional data trends further demonstrate the high burden of the opioid epidemic within Tribal communities. According to the State of Alaska Epidemiology Center, AI/ANs had the highest overdose death rate by race from 2009–2014 at 20.2 deaths per 100,000 population. Similarly, the Washington State Department of Health reported that from 2011–2015, the opioid overdose death rate was highest among AI/

¹ National Institute on Drug Abuse. 2017. Overdose Death Rates. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

² Indian Health Service. New effort targets drug overdoses in Indian Country. Retrieved from <https://www.ihs.gov/newsroom/pressreleases/2015pressreleases/new-effort-targets-drug-overdoses-in-indian-country/>

³ Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas—United States. *MMWR Surveill Summ* 2017;66(No. SS-19):1–12. DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

ANs at a rate of 29 deaths per 100,000 compared to 12 deaths per 100,000 for Whites.

In my home state of Minnesota, the Department of Human Services reported that the age-adjusted death rate due to drug poisoning is four times higher among AI/ANs compared to whites. Further, despite representing roughly 1.1 percent of the population for the state, AI/ANs accounted for 15.8 percent of those who entered treatment for opioid use disorder. These statistics illuminate the critical need for more comprehensive interventions in Tribal communities to improve prevention and treatment measures.

The Indian Health system is chronically underfunded, understaffed and over-extended. Limited Tribal and IHS public health and healthcare resources have been further inundated by this highly deadly and superbly costly epidemic. While the treatment and recovery costs are certainly great, the human toll of the epidemic on our Tribal communities is even greater. The state of Minnesota reported that pregnant AI/AN women were 8.7 times more likely to be diagnosed with maternal opioid dependency, and that AI/AN infants were 7.4 times more likely to be born with neonatal abstinence syndrome (NAS)—meaning that the repercussions and trauma of this crisis are intergenerational. Other secondary impacts include the undue burdens imposed on many AI/AN families struggling with opioid and substance use disorders, the children forced into foster care, and the kinship care networks that are strained beyond their ability.

While Tribal communities are certainly in need of expanded treatment resources, public health prevention must not be forgotten. This includes upstream prevention activities such as comprehensive substance use education in youth, expanded substance and alcohol use education and training for our providers, prevention of adverse childhood experiences, healing from historical and intergenerational trauma, and investment in culturally appropriate and Tribally-driven programming.

Bolstering Tribal public health surveillance infrastructure is also a major need. The CDC noted in 2017 that the actual drug overdose death count among AI/ANs may be underestimated by as much as 35 percent due to racial misclassification on death certificate data. That is truly unacceptable. Data is the backbone of any public health system, and without it the Tribes and IHS are unable to maintain accurate records of vital statistics, to quantify disparities in health outcomes between AI/ANs and other populations, and to ultimately make true assessments of need. More importantly, Tribal leaders must have this information to make informed policy decisions and implement targeted programs.

Tribes also remain behind many other communities in their public health infrastructure, capacity, and workforce capabilities as a result of being largely left behind when the United States was modernizing its public health infrastructure. These obstacles have made it particularly difficult for Tribal communities to assemble a coordinated and comprehensive defense against major health emergencies, including the opioid epidemic.

At IHS, and indeed even at many Tribal facilities, deferral of care due to funding and workforce shortages has pushed more and more Tribal members towards prescription opioids to treat health conditions that would otherwise successfully be treated with non-opioid therapies. For instance, limited funding resulted in nearly 80,000 Purchased/Referred Care (PRC) services (an estimated total of \$371 million) being denied in FY 2016 alone. This endless cycle of deferral and opioid dependency is a direct result of the underfunding of the IHS system, and must be stopped.

The CDC Guideline for Prescribing Opioids for Chronic Pain describes how opioid therapy should not be the first line of treatment for acute or chronic non-cancer related pain management, and should rarely, if ever, be prescribed with other medications such as benzodiazepines. Nevertheless, many Tribal members still report that opioids are some of the only options available to them to address their pain symptoms. Lack of reimbursement and access to non-opioid therapies, traditional medicine and other alternatives leaves both providers and patients in a catch-22 that ultimately leads to more harm.

Tribes throughout the country are finding that the systemic problems with the current Indian health system are impacting their ability to confront the opioid crisis. Bay Mills, a Tribe located on the Upper Peninsula in Michigan, has capacity issues so severe that, even if that Tribe received federal funds to operate an opioids treatment outpatient program, the Tribe reports that their facilities are too small and outdated to be able to operate such a program on-site. NIHB has noted in previous testimony to Congress that IHS's facilities construction budget is so underfunded that a facility built today would not be able to be replaced for 400 years. These chronic funding issues have limited the ability of Tribes to confront the opioid crisis without additional, sustained Congressional support.

The Red Cliff Tribe of Chippewa Indians in Wisconsin lacks resources to keep up with the latest training practices available to healthcare providers. While the Tribe has started a Harm Reduction Program to provide access to Naloxone, lack of substance abuse and addiction training among Tribal providers limits the program's reach and uptake in the community. The Red Cliff Police Department reported 346 investigations on drug use in 2016, an increase of almost 100 from the year prior. The total population of the reservation is under 1,000.

Tribal Response to Opioids

Despite these challenges and setbacks, Tribes across Indian Country have engaged in multifaceted response efforts that traverse the prevention, treatment and interdiction landscape. For instance, after declaring a state of emergency on the opioid epidemic in March 2016, the Mashpee Wampanoag Tribe in Massachusetts partnered with the IHS to assemble more resources to address the growing number of overdose deaths in their community. The Tribe worked towards establishing an integrated community intervention model, implementing the CDC Guideline for Prescribing Opioids for Chronic Pain, and developing an opioid response grounded in the social determinants of health. The Tribe worked with Tribal Police and Homeland Security to create prescription drug drop boxes, developed a 24-hour call line for crisis intervention, and established a Tribal Coordinating Committee to create a 5 year Tribal Action Plan to address alcoholism and substance abuse issues.

In Washington State, the Muckleshoot Tribe has been operating a successful behavioral health program for the past few years. The initiative includes a medication-assisted treatment program where Tribal members are able to receive Suboxone or Vivitrol for treatment of opioid use disorder. The program has proven successful, as compliance with the program reached 94 percent in July, 2017. Muckleshoot has distributed close to 4,000 kits of Naloxone as of August 2017, and also operates a syringe service program to help reduce the risk of co-occurring health conditions such as HIV and Hepatitis C.

In Oklahoma, the Chickasaw Nation launched the "Define Your Direction" campaign, which is an education initiative encouraging Tribal youth to make healthy choices and be positive role models when it comes to resisting prescription drug misuse and underage drinking in their communities. Some outcomes of the program thus far include equipping all Chickasaw Nation Lighthouse officers with Naloxone; distributing more than 400 medication lockboxes to Elders; recording significant reductions in prescription drug misuse within the past 30 days among 6th, 8th, 10th and 12th graders; and reductions in risk factors such as early drug use initiation and low neighborhood attachment among Tribal youth.

NIHB encourages the Committee Members to connect with the Tribes in your home states to learn more about current initiatives and gain further insight into technical assistance and funding needs, so that programs such as these are replicated in more and more Tribal communities.

Policy Solutions

A) Access to Federal Opioid Resources

Addressing the opioid epidemic is a nationwide priority; however, access to critical opioid prevention and treatment dollars are not reaching many of the Tribal communities that are in serious need of these funds. As sovereigns, Tribes are not systematically included within statewide public health initiatives such as the recent prevention and intervention efforts created through the new opioid crisis grants found in the 21st Century CURES Act, passed by Congress in 2016.

The CURES Act provided \$1 billion in funding over a two-year period to states and territories to combat the opioid crisis. Tribes were not eligible entities for this critically important funding. Although a small number of states subsequently allocated CURES funds to Tribes, access was not at the level of need, nor was it equitably distributed. Furthermore, as the trust responsibility is exclusive to Tribal Nations and the Federal Government, Congress must not circumvent this sacred duty by forcing Tribes to go through state agencies for these funds. In addition, many Tribes have historically had complicated relationships with state governments as a result of having to compete for limited dollars. Providing direct funding to Tribes would solve this issue.

An example of this can be seen in Ho-Chunk Nation in Wisconsin. Like many Tribes, Ho-Chunk has seen an increased number of infants born with substance addiction and NAS, as well as an increase in opioid-related overdose deaths in the community. The Tribal government declared a State of Emergency regarding the opioid crisis and is in the process of developing a Tribal Action Plan within their departments. A major problem for the Tribe is that the grant money the state re-

ceives and distributes to the Tribes is not sufficient to meet the added burden the Tribe's behavioral health facility is experiencing.

To correct this dynamic and ensure that needed opioids funding is reaching the Tribes, Congress should:

- Amend the CURES Act, specifically the State Targeted Response to Opioid Epidemic grants, to ensure Tribes can receive funding directly from the Federal Government to address the opioids crisis. NIHB supports the provisions in S. 2270, the Mitigating METH Act, and S. 2437, the Opioid Response Enhancement Act, that address this.
- Establish Tribally-specific funding streams such as a Special Behavioral Health Program for Indians, modeled off the very successful Special Diabetes Program for Indians, so that Tribes can develop their own programs to address substance misuse and dependence in their communities. NIHB supports House legislation that has been introduced for this purpose, H.R. 3704 the Native Health Access Improvement Act.
- Ensure parity between states and Tribes in any new opioid-related legislation advanced in Congress. This means not only including Tribes as eligible entities, but also requiring Tribal consultation, information and data sharing, and funding set asides, where applicable. For example, the newly introduced "Comprehensive Addiction and Recovery Act (CARA) 2.0" (S. 2456) legislation should include Tribes and Tribal organizations in several sections of the bill. This includes Section 6 which establishes funding for regional technical assistance centers to focus on addiction recovery and naloxone training/dissemination; Section 7 which allows states to increase the 3-day limit on first time opioid prescriptions found in Section 3 if the state passes a law or implements a statewide regulation should include Tribal law as well; and Section 10 which provides funding to states for addiction treatment programs targeted toward pregnant and post-partum women. Finally, we recommend adding language to Section 13 that would require states to consult with Tribes on the implementation of prescription drug monitoring programs.
- Establish trauma-informed interventions in coordination with Tribes to reduce the burden of substance use disorders including those involving opioids.
- Include set asides for Tribes within the \$6 billion in opioid program funding for Fiscal Years 2018 and 2019 appropriated in the February 2018 Continuing Resolution.

FY 2019 Budget Proposal

NIHB and Tribes were glad to see that the FY 2019 President's budget request proposed \$150 million in funding to "provide multi-year competitive grants based on need for opioid abuse prevention, treatment, and recovery support in Indian Country."⁴ Tribes are supportive of this additional funding, but many Tribes have expressed concerns that competitive grant programs are not the solution to long-term, broad-based funding. Competitive grants erode Tribal sovereignty and do not honor the federal trust responsibility. Furthermore, when Tribes are forced to apply for grants it takes away scarce staff and resources from other program-oriented work leading to diminished program effectiveness across the board. We look forward to working with you as this policy is developed to ensure that the proposed funds truly reach the areas with greatest need and fully honor the promises made to our ancestors. In addition, we note that other federal agencies—such as the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention—should have funding made directly available to Tribes.

B) Health Information Technology (IT) within the Indian Health System

The Federal Government has not met its trust responsibility as it relates to updating and modernizing the physical and technological infrastructure within IHS and Tribal health facilities and health IT systems. The current primary Electronic Health Record (EHR) system IHS uses is the Resource and Patient Management System (RPMS), an integrated public health information system based on the U.S. Department of Veteran's Affairs (VA) VistA system. It is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing. RPMS is comprised of over 80 software applications and is designed to track patient and population based clin-

⁴U.S. Department of Health and Human Services. "FY 2019 Budget in Brief." February 12, 2018. Pg. 28.

ical and practice management applications. However, various concerns and challenges have been cited regarding RPMS. Some notable issues are:

- Many Tribes utilize different EHR systems instead of RPMS;
- Smaller Tribal health facilities do not have the bandwidth to fully operationalize RPMS, and would benefit from the ability to share new components such as files that contain all available drugs instead of just some;
- Some smaller Tribal health clinics are in need of greater training and technical assistance on how to utilize the system most efficiently;
- There is a need to further streamline the system and align it with other EHRs utilized by Tribes;
- Robust and timely IT support is not routinely available;
- Interoperability is incomplete, meaning that if a patient is referred to another clinic that utilizes a different system, the patient records are more than likely not cross-referenced which leads to inconsistencies in patient records.

Issues also exist in terms of RPMS interactions with Prescription Drug Monitoring Programs (PDMPs). PDMPs are state-run electronic databases that track controlled substance prescriptions. Across the board, utilization of PDMPs is inadequate. A national survey of primary care physicians found that 86 percent of the time, physicians did not check their statewide PDMP prior to prescribing an opioid, despite the fact that 72 percent of primary care physicians are aware of their state's PDMP.⁵

It is important to note the limitations of the PDMP system, both generally and in its usefulness for IHS and Tribal providers, pharmacists and public health practitioners. One, PDMP laws and regulations differ by state. In other words, whereas one state may require providers to update the system within a 24 hour period, other states only require updating the system every few days, or even over a longer period of time. Further, interstate sharing of PDMP data is not streamlined, which creates gaps in monitoring especially for individuals living in border towns, or for reservations that traverse multiple state boundaries. Additionally, to NIHB's knowledge, only the state of Alaska decreed a special consideration for IHS providers to access the PDMP system, which may explain why IHS established memorandums of understanding (MOU) with state agencies to permit IHS access and reporting. Also, there is currently no Tribally-specific PDMP system. The FY2017 House Appropriations Bill authorized \$1 million to IHS to establish such a system; however, to NIHB's knowledge, this system has not yet been implemented.

Finally, no PDMP system collects racial demographics, limiting its value as a tool for public health monitoring for Tribes and Tribal Epidemiology Centers.

Due to budgetary constraints, IHS has not been able to support operations and maintenance for the certified RPMS site. Other federal agencies, like the Veterans' Administration, are in the process of moving away from RPMS-like systems toward more integrated software platforms, where EHRs and PDMPs can communicate under an interoperable platform. Unless Congress intervenes, this will create a disconnect between IHS and other agencies.

NIHB supports E-prescribing, especially given its potential to reduce the spread of prescription opioid abuse, and encourages IHS to utilize it where practicable. However, most IHS and Tribally run health facilities are in rural areas where limited broadband make widespread adoption of E-prescribing unrealistic without Congressional intervention. To ensure that E-prescribing is a viable tool in the Indian health system, Congress must first continue, and expand, its investment in rural broadband to incorporate rural Tribal communities.

Telehealth is a much-needed and successful innovation in rural areas. For example, the Eastern Aleutian Tribes, a healthcare provision organization serving 8 Alaska Native communities, has begun using telemedicine to diagnose conditions, prescribe treatment, and conduct follow up examinations. Many Tribes in remote Alaska communities, often disconnected by the road system and only accessible by plane or boat, do not have access to medical providers regularly and have come to rely on telemedicine to fill a gap in healthcare provision. However, this was only accomplished through sustained investment in rural broadband.

Greater network bandwidth and broadband access is a critical need, demonstrated by a 2018 FCC report that found as many as 35 percent of individuals living in Tribal lands lack broadband access, while in some Tribal communities as much as 80 percent lack broadband access.

⁵ Office of Management and Budget. Circular A-130. Appendix III. *Security of Federal Automated Information Resources*.

To ensure Tribes are able to utilize Health IT to the greatest extent possible in confronting Indian Country's opioid epidemic, Congress should:

- Provide adequate support, funding, and oversight as IHS moves away from the RPMS system toward a more integrated platform that can better interact with E-prescriptions and EHRs.
- Provide oversight to IHS to implement a Tribally-specific PDMP system than can interact with state PDMPs.
- Review and support IHS's list of Tribal broadband projects, and also include direct funding to Tribes to improve their broadband and telehealth infrastructure.
- Mandate State-Tribal consultation on changes to state PDMPs.
- Incentivize providers to adopt E-prescription as a way to reduce the needless and harmful spread of opioids. Should Congress provide a grant program to that end, a set aside of 3–5 percent would be appropriate to ensure Tribes are not at a disadvantage in tapping into those funds.
- Eliminate the requirement for Tribal providers to obtain the Secretary's authorization to be designated as an Internet Eligible Controlled Substances Provider, as it imposes an undue burden that delays the delivery of much-needed treatment resources, especially given that no other providers are subject to this requirement.⁶

Conclusion

Again, NIHB would like to thank the Committee for holding this hearing and soliciting input from a variety of stakeholders. Indian Country has seen over the past several years that opioids do not face barriers in entering Tribal communities. To truly address this problem, Congress must ensure that Tribes receive direct funding, and are included any type of national-level opioid legislation moving forward.

SUPPLEMENTAL TESTIMONY OF THE NIHB

Chairman Hoenes, Vice Chairman Udall, on behalf of the National Indian Health Board (NIHB) and the 573 American Indian and Alaska Native (AI/AN) Tribes we serve, I would like to thank you for holding the hearing, "Opioids in Indian Country: Beyond the Crisis to Healing the Community," and for NIHB to offer testimony at the hearing.

NIHB is a 501(c)3, not for profit, national Tribal organization founded by the Tribes in 1972 to serve as the unified, national voice for American Indian and Alaska Native health in the policy-making arena. Since 1972, NIHB has advised the U.S. Congress, Indian Health Service (IHS), and other federal agencies about health disparities and service issues experienced in Indian Country.

The current opioid epidemic represents one of the most pressing public health crises affecting Tribal communities. While this epidemic is affecting many communities throughout America, it has disproportionately impacted Tribes and has further strained the limited public health and healthcare resources available to Tribes. The Federal Government must take concrete action to ensure Indian Country has the tools it needs to address opioid abuse and heal Tribal communities.

While each witness brought a wealth of knowledge and experience to the committee, NIHB wishes to ensure the Senators on the committee have all of the information they need to make informed decisions on how best to support Tribes and Tribal health programs in confronting the opioid crisis.

The 21st Century CURES Act included two years of funding to states to develop State Targeted Responses. As CAPT Jones from the Substance Abuse and Mental Health Services Administration (SAMHSA) mentioned in his testimony, of the 36 states with Tribes, only 12 have incorporated Tribes into their State Targeted Responses or identified American Indians/Alaska Natives (AI/ANs) as a specific population under the state plan. The funding is not reaching Tribal communities. NIHB is supportive of the provisions in S. 2270, the Mitigating METH Act, and S. 2437, the Opioid Response and Enhancement Act, which would open CURES Act funding to Tribes directly. These needed revenue streams would allow all Tribes to replicate success seen in several Tribal programs across America. In her questioning at the hearing, Senator Cortez Masto asked witnesses from federal agencies if direct Tribal-specific funding streams were needed to combat the opioids crisis. Had that question been asked of the Tribal witnesses, the committee would have heard an unambiguous "Yes."

⁶(21. U.S.C. 829) Section 311(g)(2)

There is an inherent structural problem with the system of Tribes through states to access federal funding. There is no established legal relationship between the states Tribes. States are not compelled to have consultation with the Tribes, or even listen to their needs. There is no treaty, constitutional relationship or law that sets forth Tribal-state collaboration. Using this type of construct essentially just cuts Tribes out of the system all together. Forcing Tribes to go to states diminishes the federal trust Tribes are not subservient to the state governments, but are recognized as sovereign nations within the federal system. In practice, this means, that few tribes actually see this funding, and if they do it is usually insufficient to meet need.

Senator Tester similarly asked federal agency witnesses if some of the \$10 billion for opioids included in the President's Fiscal Year 2019 Budget Request should be set aside for Tribes. Again, the answer from Tribal witnesses would have been, "Yes."

We were also pleased to see that the Consolidated Appropriations Act of 2018 contained a \$50 million set-aside for Tribes in the State Targeted Response (STR) to opioid grants as well as a \$5 million set aside for medication assisted treatment for Tribal communities. This funding is a critical first step in ensuring that Indian Country has access to the resources it needs to combat this deadly epidemic. Thank you for the advocacy that you and other committee members undertook to make this possible. We look forward to working with you to build on these gains in the coming year so that there is long-term sustained funding going to fight substance abuse among Tribal Nations.

Senator Smith asked CAPT Jones how SAMHSA and other agencies were looking at intergenerational addiction, especially as relates to addicted mothers and newborns. He answered correctly that the agency is looking at the issue holistically and trying to break down siloes. However, it is crucial to note that neither program he cited, the residential program with 19 grantees, nor the outpatient program authorized by the Comprehensive Addiction and Recovery Act (P.L. 114-198), are open to Tribes. Because Congress did not list Tribes, Tribal organizations, and Urban Indian Health Centers as eligible entities, the funding for the grant programs does not reach Tribal communities and should not be cited as a success story in Indian Country.

Furthermore, even if Congress authorized funding from those programs to go directly to Tribes, the competitive grant program is unfair to smaller Tribes which may lack capacity but which do not lack need. As Senator Murkowski said, the current competitive grant program "sets Tribes up to compete with other Tribes." We could not agree more. Instead, Congress should work to empower IHS and Tribal health programs to implement successful, community-based, culturally competent care geared toward helping Tribal communities confront and heal from the opioid epidemic.

While evidence-based care has many advantages in opioids treatment, Congress dictating a one-size-fits-all approach to this challenge will not work in Indian Country. Tribes often utilize traditional, culturally-based and promising practices as well as evidence-based practices. Culturally-based programming helps Tribes tailor initiatives to the specific needs of their community, while also honoring Tribal sovereignty and the right to self-determination. Evidence-based practices that do not integrate traditional Tribal practices are not always as effective at improving health outcomes as programs that do. Many Tribal public health programs—including the well-known and highly successful Special Diabetes Program for Indians (SDPI)—combine Tribal best practices with evidence-based practices. This model has worked and should be replicated to confront opioid addiction, with support and oversight from Congress.

We hope this information clarifies some of the questions raised at the hearing. NIHB thanks you and the Senate Committee on Indian Affairs for holding the hearing and using Congress's authority to support Indian Country as our communities confront and heal from the opioid epidemic.

Senator UDALL. Thank you, Mr. Moose. Thank you, Ms. George for your testimony. Please be assured there will be a lot of questions. The staffs of all the Senators who are here and will be following very closely your testimony. We are really happy to have you here.

Senator Daines, we are happy to see you back. Please proceed with your questions.

**STATEMENT OF HON. STEVE DAINES,
U.S. SENATOR FROM MONTANA**

Senator DAINES. Thank you, Ranking Member Udall. We have votes going on right now, as you understand. There is a lot of interest and they will be coming back from the Floor soon.

I hail from the State of Montana. Opioid abuse is an issue in my home State. Meth use is increasingly a crisis. We know it is even more concentrated among Montana's Indian tribes. That is why I have introduced the Mitigating METH Epidemic and Promoting Tribal Health Act also known as the Mitigating METH Act.

As a matter of this government-to-government relationship between the United States and tribes, this legislation would make tribes, like States, directly eligible for funding that is authorized in the 21st Century CURES Act to combat the opioid crisis. Additionally, it would give States and tribes the flexibility to address the substance abuse and disorders most prevalent among their constituencies, which in Montana, would include meth. This legislation enjoys the support of eight co-sponsors from both sides of the aisle, including members of this Committee and is the only bipartisan legislation in the U.S. Senate that makes tribes directly eligible for this funding.

Mr. Moose, I know you and Ms. George both discussed the benefits of my bill in your testimony. Could you expand on why you see it as important that the bill make tribes directly eligible for Federal funds to combat substance abuse?

Mr. MOOSE. Thank you for the question.

I think probably the most important thing we talk about among tribal program administrators and tribal providers is getting direct funding. Tribal leaders throughout Minnesota, Wisconsin and Michigan are always looking at direct funding for their tribal programs. It helps us enhance the things we currently do well and helps us target the things we need funding to expand or create access for. Anything that will provide sustainable funding for our tribal programs, something we can change or redirect based on how we see the need in our communities is critical to our addressing this issue.

Senator DAINES. Thank you, Mr. Moose.

Ms. George, I have the same question to you. Why do you see my bill, the Mitigating METH Act, as so important and beneficial?

Ms. GEORGE. I think there are a couple areas where we saw significant support for us. Really, it reflects the government-to-government relationship with the tribe, allowing direct access and also recognizing grant funding limits creates competition for resources not just between tribes but even other local agencies we work with.

We are often forced to choose between two or more very important issues. We sometimes do not get where we need to get.

Senator DAINES. I think one of the underlying foundational principles is really tribal sovereignty and this government-to-government relationship and how the U.S. Government should be viewing the direct access for these funds to address the crisis we are seeing right now with meth and opioid abuse.

I agree with both of you and I appreciate your support. These are the very reasons why I have authored this crucial, I think very timely, piece of legislation.

I would like to turn to a discussion of CARA 2.0. I applaud Senator Portman for continuing to lead the charge on this legislation to combat the drug overdose crisis and would like to explore ways to ensure tribes are appropriately included in this effort.

Mr. Moose, what change would you like to see in CARA 2.0 to help address the drug abuse crisis in your community? I would be especially interested in your perspective on needed changes to the section which provides funding to States for addiction treatment targeted toward pregnant and post partum moms.

Mr. MOOSE. We recommend allowing tribes to access the program outlined in Section 6 which establishes funding for regional technical assistance centers to focus on addiction recovery and naloxone training and dissemination. We recommend in Section 7 allowing States to increase the three-day limit on first-time opiate prescriptions found in Section 3 of the bill, if the State passes a law or implements statewide regulations, tribal law should have the same authority.

Tribes should also have access to Section 10 which provides funding to States for addiction treatment programs targeted towards pregnant or postpartum women. Finally, we recommend adding language to Section 13 that would require States to consult with tribes on implementation of their prescription drug monitoring program.

Senator DAINES. Thank you. That input will be relayed to Senator Portman who is a great colleague and leader here in the Senate. I appreciate that testimony.

I want to thank you for the input. I want to continue to work with you, the NIHB and my colleagues to see how we might be able to work some of these changes into that legislation. Indian tribes cannot afford to be left out. They cannot be left out of these discussions. I remain committed to seeing that their needs are addressed.

Thank you.

Senator UDALL. Thank you so much, Senator Daines. I really appreciate your questions.

Early on, I think this is mentioned in your testimony, there were issues about the cuts that were going to take place. I think you all are familiar with those. These are program areas, many of them when you talk about programs and needing services, these are the same program areas where President Trump has Indian line items where he has proposed cutting in the 2019 budget request.

I want to ask you both what impact would cuts to Federal funding for tribal housing, human services and public safety programs have on your tribe's ability to continue its efforts to combat the opioid crisis?

Mr. MOOSE. Thank you for the question, Senator.

Funding for social safety net programs is very much linked with healthcare programs. When individuals do not have access to social safety net services, the effect of substance abuse disorder will be exacerbated because patients will not have the comprehensive services to support them in recovery. This includes protections of SNAP, Medicaid, TANF, and the Indian Housing Block Grant.

For instance, if the proposed cuts to the Medicaid Program were to be enacted, it would place additional burden because there would be less resources available for medical treatment. Further,

many of these programs are effective in preventing substance use altogether.

Research has shown access to healthy and traditional foods, stable housing and other social programs reduces substance use later in life. This is a very important aspect of the public health approach. Comprehensive care, the kind that promotes the whole health of a person, is the most effective in improving the health outcomes related to substance use and opioid abuse disorder.

Senator UDALL. Ms. George?

Ms. GEORGE. I fully support the comments Mr. Moose just made. In addition to that, any cuts to tribal programs hamper the tribe's ability to sufficiently provide services to its members, run our governmental programs and initiate new projects.

Senator UDALL. Aside from more direct tribal funding for behavioral health programs at HHS, for what other departments should we request more dedicated resources for tribal opioid and substance abuse efforts?

Mr. MOOSE. Would you repeat the question?

Senator UDALL. Aside from more direct tribal funding for behavioral health programs at HHS, for what other departments should we, the Committee looking into this, request more dedicated resources for tribal opioid and substance abuse efforts?

Mr. MOOSE. One of the areas we have talked about within our system of care at Fond du Lac is prevention funding such as public health, infrastructure support and support for youth programs and youth prevention programs. One of the initiatives we are looking at starting is a children's initiative. Having support with regard to these types of prevention programs is critical in our heading off the issue of opioid and substance abuse and healthcare disparities in general. I think anything that would fund prevention, public health infrastructure, surveillance and those types of issues would be important for us.

Senator UDALL. Ms. George, do you want to add to that?

Ms. GEORGE. For us, increased funding for tribal courts and law enforcement is important. Our tribal court also operates a reentry program because once we get help for these people, they also need to be reentered to their community, gain skills to maintain employment and be successful, thriving members again in our community. Those are areas I think we would identify as well.

Senator UDALL. Thank you very much.

One issue I have focused on throughout my entire time in Congress is Federal information technology reform. Just last year, I worked with another member of this Committee, Senator Moran, to get our bill, the Modernizing Government Technology Act, passed as part of another bill. The opioid crisis is just one more example of how outdated information technology can slowdown efforts to gather real-time data, in this case, prescription monitoring, people getting prescriptions from multiple areas.

You both testified about the inadequacy of RPMS and PDMP systems coordination putting limitations on tribes' trying to look at opioid prescription patterns. Do you believe that information technology challenges at the Indian Health Service led to shortcomings in implementation of a robust PDMP system?

Mr. MOOSE. Yes, I do. I was the Commissioner of Health and Human Services for the Mille Lacs Band. We utilized the RPMS system. Unfortunately, the RPMS system had challenges with regards to its being robust. I know that within our behavioral health program, in 2014, we started looking at implementing the Behavioral Health Electronic Health Record. That was in 2014, mind you.

We have many programs concerning the program that I am at right now. The Fond du Lac Band of Lake Superior Chippewa purchased an off-the-shelf electronic health record system. We were far more advanced than we are at Mille Lacs. I definitely would support that.

Senator UDALL. Thank you, Mr. Moose.

Ms. George, did you have anything else to add? I have another question focusing on you, but go ahead, please.

Ms. GEORGE. I just wanted to add that our tribe has had to spend an enormous amount of money creating custom templates for our information system. It is still not as adequate as we would like. That was a big burden to us.

Senator UDALL. Ms. George, has the IHS, or any other Federal agency, offered support to help your tribe, or any other tribe that operates its own health facilities, coordinate with State-run PDMPs?

Ms. GEORGE. No, they have not.

Senator UDALL. Ms. George and Mr. Moose, what advice would you give the Administration and this Committee when evaluating replacements for RPMS systems, especially in light of the need to improve opioid prescription monitoring?

Mr. MOOSE. We would suggest tribal consultation, working with tribes to identify the systems, creating a work group that looks and combs the landscape for what is best for Indian Country, along with hearing that input from specific Indian Country practitioners, tribes and tribal units for health service systems.

Senator UDALL. Do you have anything else to add to that?

Ms. GEORGE. I would just like to add that interoperability, reporting and population health are also important aspects.

Senator UDALL. Thank you very much.

Ms. George, I am impressed by your testimony describing Port Gamble's experience combating the opioid crisis through State and local partnerships. These partnerships seem to be working and could be a model for other tribes across the Country.

What advice would you give to other tribes considering partnering with their State and local counterparts? Do you have any advice for those whose State or local governments are not as willing as that of Washington to engage in similar partnerships?

Ms. GEORGE. I am not sure that I have any advice to other. I would like to add that I do not believe there is a community, county or State that this epidemic is not touching right now. I think tribes would be surprised how quickly our local and State governments come to the table because none of us know how to handle this epidemic.

Senator UDALL. Mr. Moose, based on your experience in developing cross-governmental partnerships, could Congress help encourage more fruitful partnerships by providing tribes with their

own direct funding to leverage and bring to the table these other partners?

Mr. MOOSE. Yes, Senator. I believe it would be important to have tribes. One thing I keep thinking about is the discussion in our region with regards to some of the State-targeted response funding that a few of us put together specifically to address the opioid issue.

We were trying to change our services to fit those grants. When I say services, I look at our traditional and cultural practices. Oftentimes when we have to go with that approach, it really takes us away from some of the internal infrastructure or development we have to deal with in some of our cultural practices or traditional approaches. Oftentimes, it takes up time and space when we should be concentrating on those issues, trying to fit our programs to the grant funding or other funding that is competitive, along with administrative time of managing those grants.

Senator UDALL. I know I have asked a number of questions and you also heard from a number of Committee members with questions. Is there anything off the top of your head right now that you wanted to say in conclusion?

Mr. MOOSE. One of the areas we were looking at as part of the information I just provided is we have a young practitioner in our tribal clinic. She is looking at doing her dissertation. In that dissertation, she came across something that was really interesting to her as a non-Indian practitioner.

Several months ago, we started traditional healing services within our clinic. We gave access to a traditional healer we had hired within our clinic system to patients. This mental health practitioner was able to send her clients to this traditional healer. She looked at the clients going through our Core 12 program, our comprehensive opioid response program that utilizes suboxone as part of its treatment modality along with traditional healer services.

One of the things she recognized, which became part of a passion that she wanted to do her dissertation on, was the impact those traditional healer services had on those clients. She saw incredible improvement in their depression rates, their anxiety and the overall treatment outcome for these clients which were incredibly important to us.

Our course our tribe is definitely supporting her in identifying this as a piece within her research and her dissertation. I think it really came to us, and my comments before, that these are the services tribes in Indian Country need to reinvest in, our traditional and cultural practices as part of our treatment modalities.

When we are trying to fit our services into a square peg, oftentimes we lose the ability to make that type of impact. If we could concentrate on those things within our communities that really enhance treatment services or gets a patient to accept that type of modality, I think it is really good for Indian Country.

Senator UDALL. Thank you.

Ms. GEORGE. I would just like to again extend the invitation to the Committee members and the agency directors to come and visit the tribes, see what we are doing and see what is working for us to get a better understanding of where our needs really lie.

Senator UDALL. Thank you for that invitation. You have the Rear Admiral in the audience, so he certainly heard that. I will convey that information to all the members of the Committee. I would love to visit you both in your respective States.

Today, you have given very enlightening testimony and answers for the Committee. We really look forward to digesting all of this and trying to work on getting the legislation just right so we can get resources into Indian Country. As I mentioned earlier, you may get additional questions from Committee members that will be submitted to you in writing after today's hearing.

If there are no more questions today, which looking around, I do not think there are, members may also submit follow-up written questions for the record. The hearing record will be open for two weeks.

Once again, I want to thank these witnesses for their testimony here today.

The hearing is adjourned.

[Whereupon, at 4:55 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF ESTHER LUCERO, CEO, SEATTLE INDIAN HEALTH BOARD

Dear Chairman Hoeven:

The Seattle Indian Health Board (SIHB) thanks you and the Senate Committee on Indian Affairs for holding this hearing, "Opioids in Indian Country: Beyond the Crisis to Healing the Community." We appreciate the opportunity to provide testimony to the committee, and we are glad to provide committee members with the information necessary to best address this ongoing health crisis.

The Seattle Indian Health Board is an IHS-funded Urban Indian Health Program. Urban Indian Health Programs are a component of the IHS' I/T/U system of care, and we provide culturally-attuned health care to American Indians and Alaska Natives (AI/AN) living in urban areas by centering all of our services and supports around traditional Indian medicine. Our patients are roughly 70% AI/AN, and last year we served patients who represent over 250 federally-recognized Tribes.

SIHB also operates the Thunderbird Treatment Center, a 65-bed substance abuse residential treatment facility. Through a state-funded fee for service initiative to pay for American Indians and Alaska Natives who need residential Substance Use Disorder (SUD) treatment, and a county Behavioral Health Organization (BHO) payment model for our non-Native clients, our facility provides a culturally-attuned approach to substance abuse treatment designed to better serve our AI/AN community. At Thunderbird, we provide intake and a full complement of wraparound services, including case management, peer support, traditional medicine (talking circles, smudging, sweat lodges, drumming, and storytelling), and access to both primary care and behavioral health services.

We currently do not receive Medicaid reimbursement for our clients at Thunderbird because the Institute for Mental Diseases (IMD) rule – located at Section 1905(a)(B) of the Social Security Act – precludes us from billing for Medicaid for entities that have over 16 beds. For services that are covered by Medicaid (primary care, SUD, MH, pharmacy, etc.) – unlike IHS and Tribal health care facilities – Urban Indian Health Programs are the only component of the I/T/U system of care for which Medicaid reimbursement is not provided at a 100% federal match. Instead, Urban Indian Health Programs are unique in receiving a combination of federal and state dollars for Medicaid reimbursement for SUD inpatient. The provision regarding a lack of FMAP parity for Urban Indian Health Programs is located at Section 1905(b) of the Social Security Act. This lack of Medicaid access for SUD inpatient and the lack of 100% FMAP parity creates several barriers to care for Medicaid patients receiving care for SUDs at Urban Indian Health Programs, and this makes it difficult to maintain the integrity of the I/T/U system of care.

The lack of a 100% federal Medicaid match divides the IHS' I/T/U system of care, interrupting the coordination of care between IHS, tribal, and Urban Indian Health Programs. Our AI/AN Medicaid eligible clients are highly mobile and low income, they receive care when and where they can. They may start a course of care at SIHB, and because they have to follow work, family, or tribal obligations, a continuity of care is not established. Because IHS and tribal programs receive 100% federal Medicaid dollars, they can coordinate with the Centers for Medicare and Medicaid Services to provide unique models of health care services for Native people. Urban Indian Health Programs, which receive a blend of state and federal Medicaid dollars including our IHS contract dollars, are mostly ineligible for these initiatives, interrupting the continuum of care that the I/T/U system was intended to provide. Furthermore, the Washington State Behavioral Health Organizations has designed an inpatient substance abuse services around a 15-day model. However, our current Indigenous Psychology model is based on a 45-day course of treatment – rendering the reimbursement for our treatment model burdensome having to provide up to four times medical necessity for our clients. Thus, the continuum is interrupted, disrupting culturally-tuned care which is absolutely critical when providing care to help Native people overcome addiction to opioids. Were we able to better coordinate care with the full backing of Medicaid billing, we would be able to work with our partner tribes and community entities to better the health outcomes of our AI/AN community. Washington State has 29 federally recognized tribes and 2 Urban Indian Health Programs, and a continuum of care would require patients to move seamlessly between IHS, tribal, and urban programs to support data consistency and continuity of care. 100% FMAP for Urban Indian Health Programs incentivizes the state to keep the I/T/U system of care intact.

Without 100% FMAP for Urban Indian Health Programs, our Native patients are vulnerable to state budgetary concerns and limits to curtail state Medicaid expenditures. States have limited funding for Medicaid services and the federal match in Washington and many other states is as low as 50%. This creates an incentive for states to find new ways to limit Medicaid expenditures, with states such as Arkansas and Wisconsin imposing work requirements on Medicaid beneficiaries. These and other requirements would be devastating to those AI/AN who need an uninterrupted course of treatment for addiction to opioids and other substances. The fact that state dollars are implicated in the provision of Medicaid services to AI/AN is a violation of the federal Trust Responsibility to provide health care to Native people. The Supreme Court held in the 1974 case of *Morton v. Ruiz* that the federal responsibility to provide assistance to American Indians and Alaska Natives is not limited to those living on a reservation. In 1976, in recognition of the deplorable health status of AI/AN people living in American cities, Congress enacted the Indian Health Care Improvement Act to ensure that health care services made available in fulfillment of the Trust Responsibility reached all AI/AN people – not just those living on reservations. In 2010, Congress permanently reauthorized the Indian Health Care Improvement Act and declared that "It is the policy of the United States in fulfillment of its special trust responsibilities and legal obligations to Indians, to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." It is a contravention of this policy to fracture the I/T/U system of care and leave AI/AN people subject to state efforts to reduce Medicaid spending on the general population.

AI/AN people are more likely than any other racial or ethnic group to suffer from opioid addiction. SIHB is leveraging all available resources to limit the impact of this epidemic on the Native community of Seattle and to save lives. The inclusion of Urban Indian Health Programs such as SIHB within the protections of 100% FMAP will immediately allow for states to realize increased savings to their Medicaid dollars by not having to pay for AI/AN Medicaid encounters. The state then has the opportunity to leverage those savings into reinvestment into our I/T/U system of care to better meet the health service needs of our AI/AN community. It will also create consistency within the I/T/U system of care, ensure continuity of health care coverage for Native people suffering from opioid addiction, protect AI/AN from state efforts to scale back Medicaid coverage, and reaffirm the federal role in providing health care to Native people, wherever they reside.

PREPARED STATEMENT OF THE NATIONAL CONGRESS OF AMERICAN INDIANS (NCAI)

On behalf of the National Congress of American Indians (NCAI), the oldest, largest, and most representative American Indian and Alaska Native organization serving the broad interests of tribal governments and communities, we hereby submit

the following testimony for the record of the Senate Committee on Indian Affairs Oversight Hearing on “Opioids in Indian Country: Beyond the Crisis to Healing the Community.”

Impact of Opioid Epidemic on Indian Country

While the opioid crisis is plaguing communities across the country, studies indicate that American Indians and Alaska Natives (AI/ANs) are impacted at a higher rate than other groups. According to the Centers for Disease Control and Prevention (CDC), AI/ANs had the highest drug overdose death rates compared to all other races in 2015. Further, the same CDC study found that the drug overdose death rates for AI/ANs in nonmetropolitan areas increased by more than 500 percent between 1999 and 2015. Additional studies indicated that pregnant AI/AN women are nearly 9 times more likely than others to be diagnosed with opioid dependency or abuse, and one in 10 AI/AN youths age 12 or older used prescription opioids for non-medical purposes, which is double the rate for Caucasian youth. These statistics illuminate the critical need for a comprehensive strategy to curb the opioid epidemic in tribal communities.

NCAI’s Efforts and Recommendations

NCAI has been addressing this crisis in various ways, by utilizing NCAI’s Policy Research Center to conduct related research, convening meetings of NCAI’s Substance Abuse Prevention Task Force, developing policy objectives during its resolution process, collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA) on developing the Tribal Behavioral Health Agenda, holding a roundtable during Executive Council Winter Session, hosting a webinar series on the crisis, and congressional advocacy. Based on the findings and feedback from these undertakings, NCAI would like to provide the Senate Committee on Indian Affairs with the following recommendations:

Direct Funding to Indian Country

Tribal governments need parity with state and local governments. When Indian Tribes have to go through states in order to access federal funding, the result is often unfavorable. Instead, direct federal funding to address the opioid crisis should be made available to Indian tribes. Currently, tribes are forced to petition states for access to opioid-related grants stemming from the 21st Century Cures Act (Cures Act).

Several pending bills would amend the Cures Act to include Indian tribes and tribal organizations alongside states as eligible entities. These include S. 2270, the Mitigating METH Act (Daines, MT); H.R. 5140, the Tribal Addiction and Recovery Act (Mullin, OK); and S. 2437, the Opioid Response Enhancement Act (Baldwin, WI). NCAI strongly supports the goals of these bills.

Tribal Representation on Federal Task Forces

Tribal representatives need a seat at the table in order to ensure the unique challenges facing Indian tribes are considered. While Indian Country was disappointed about the lack of tribal representation on the President’s Commission on Combating Drug Addiction and the Opioid Crisis, going forward it is crucial that tribal representatives have the opportunity to serve on federal task forces or commissions that are seeking to address the opioid epidemic.

In September 2017, NCAI, along with the National Indian Health Board, sent a letter to former Secretary Tom Price asking him to include a tribal representative on the Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force (Task Force). NCAI remains hopeful that a tribal representative will be selected to serve on the Task Force.

In addition, NCAI recommends that the Indian Health Service’s National Committee on Heroin, Opioid, and Pain Efforts (HOPE) include tribal representation. While the committee is comprised of IHS subject matter experts, it is important to collaborate with tribal leaders in order to fulfill the HOPE Committee’s purpose—promoting appropriate and effective pain management, reducing overdose deaths from heroin and prescription opioid misuse, and improving access to culturally appropriate treatment.

Collaboration and Coordination among Agencies and Tribes

In 2016, NCAI passed Resolution #PHX-16-027, which calls upon all federal agencies to increase resources in order to advance education, prevention, treatment services, and public safety programs designed to address heroin and opioid abuse and addiction within Indian Country. As Congress makes more resources available, effective collaboration and coordination among federal agencies is needed in order to pool together the resources that are available to tribal communities. Further, In-

dian tribes needs flexibility in using various funding sources to develop culturally appropriate programs to address the crisis.

NCAI agrees with Senator Barrasso's statement at the hearing: "Successful implementation of programs requires cooperation and coordination from all sides—Interior, Justice, Health and Human Services, and the tribes themselves." A memorandum of understanding between these agencies may be a valuable tool to help achieve this objective. NCAI is equipped to help ensure that Indian Country is made aware of the resources available throughout the Federal Government, and able to bring agencies together at various NCAI forums.

There are two other important aspects to federal agency cooperation with tribes. First, tribal governments have increasing law enforcement and public safety needs as they work to address the crisis with opioids and other forms of substance abuse. Interagency Task Forces are a proven method of leveraging available resources by increasing cooperation among tribal, federal and state law enforcement, and we urge further consultation on using the Task Force model to address the substance abuse crisis. In addition, tribal courts and correctional systems need additional resources for treatment that can serve as alternatives to incarceration.

Second, the conduct of large pharmaceutical companies has been a focal point in opioid-related litigation. Numerous state, local and tribal governments have filed lawsuits against opioid manufacturers and distributors in various state and federal courts, alleging that they helped create the crisis by improperly marketing the drugs. Tribes are seeking medical costs, social services costs, child welfare costs, and public safety costs. More importantly, tribes are seeking injunctive relief to reduce the flow of unregulated opioids. U.S. District Judge Dan Polster of the Northern District of Ohio is overseeing more than 200 of the opioid cases filed in federal court, in multidistrict litigation under 28 U.S.C. 1407. The Department of Justice has filed a statement of interest on behalf of the Federal Government. There is an opportunity for the Committee to urge the Department to coordinate and consult with tribal governments, and ensure that tribal interests are properly considered in the nationwide multi-district litigation.

Culturally Based Solutions

For Indian Country, factors related to historical and intergenerational trauma will have to be taken into account when addressing this crisis. The high rates of depression, suicide, and substance abuse in Indian Country are often deeply rooted underlying issues. The National Tribal Behavioral Health Agenda (TBHA), which is the result of a collaborative effort between Indian Country and its federal partners, serves as a valuable guide in the efforts to address the opioid crisis in Indian Country. A major tenant of the TBHA is the recognition and support of "tribal efforts to incorporate their respective culture wisdom and traditional practices [sic] in programs and services that contribute to improved well-being."

Legislation such as the Native Health Access Improvement Act (H.R. 3704 (Pallone, NJ) and S. 2545 (Smith, MN)) is a step in the right direction. These bills would establish a Special Behavioral Health Program for Indians (SBHPI) grant program for the prevention and treatment of mental health and substance abuse disorders. The proposed SBHPI program is modeled after the Special Diabetes Program for Indians (SDPI), which has been highly successful, in part, due to its allowance for the incorporation of culture and flexibility in utilizing the funding.

Data Collection

In March 2018, NCAI's Policy Research Center (PRC) published a brief titled, "The Opioid Epidemic: Definitions, Data, Solutions." The PRC brief highlights the need for more reliable data related to the opioid epidemic. It finds that the data on death rates are often underestimated in AI/ANs due to misidentification on death certificates and that national data does not reveal potential regional/local differences in impact. While some tribes indicate that opioids are a huge problem in their communities, others point to greater problems with other abused substances. This underscores the need to understand local and regional trends to inform action. As Chairman Hoeven indicated at the hearing, "[w]ithout accurate data, Congress, the Administration and tribes are limited in their ability to allocate resources to the area of greatest need." In addition, it is important for agencies to establish benchmarks for success.

Conclusion

NCAI applauds the Committee for holding the hearing on this urgent matter and appreciates the opportunity to submit this testimony for the hearing record. Addressing this epidemic will require a multifaceted, collaborative approach across all levels of government.

PREPARED STATEMENT OF HON. JEREMY SULLIVAN, CHAIRMAN, PORT GAMBLE
S'KLALLAM TRIBE

Dear Chairman Hoeven:

On behalf of the Port Gamble S'Klallam Tribe (the "PGST"), thank you for inviting us to testify on March 14, 2018 at the Senate Committee on Indian Affairs (the "Committee") hearing titled "Opioids in Indian Country: Beyond the Crisis to Healing the Community." We would also like to thank Senator Cantwell for her very kind introduction of our witness, Jolene George, a member of the PGST and our Behavioral Health Director.

We were pleased to share our experiences with the Committee and are proud of the steps we have taken towards formulating and implementing a multi-faceted, comprehensive approach to respond to the opioid epidemic in our community. It is encouraging to hear the Committee member's commitment to bipartisan and cross-committee efforts. We are hopeful that this dedication will result in the adoption of legislation specifically targeting the opioid crisis devastating Indian Country. As the Committee continues its endeavors, the PGST is delighted to continue assisting it in whatever way we can.

One lesson that we have learned is that incorporation of traditional healing practices, cultural beliefs regarding approaches to treatment, and differences in interpersonal communication contributes significantly to the quality of care Native people need. It is also key for helping our members escape the destructive cycle of substance abuse. For over 20 years, the PGST has been actively involved in directly providing culturally appropriate health care services to our tribal members and Native community members living on the Port Gamble S'Klallam Reservation. Since joining the Tribal Self-Governance Project, a consortium of self-governing tribes, in 1990, we have funded our health care services through a compact with the Indian Health Service under the Indian Self-Determination and Education Assistance Act. We operate and manage our entire health system on our Reservation, which includes primary care, dental, mental health, and substance abuse services.

As Ms. George testified, the heart of our opioid response is THOR: Tribal Healing Opioid Response. The Tribe convened THOR out of necessity to address the intense and widespread impact of the crisis on our community. The main goals of THOR are: (1) preventing opioid misuse and abuse; (2) expanding access to opioid use disorder treatment; and (3) preventing deaths from overdose. Every department across the PGST is responsible for implementing strategies to achieve these goals.¹ Additionally, we coordinate with the State of Washington, Jefferson and Kitsap Counties, and other nearby tribes to fight opioid addiction and treat those affected.

Support for Specific Legislation

We have shown leadership by implementing an aggressive and comprehensive approach for responding to the opioid epidemic in our community. However, as testified, we still need the help of this Committee, Congress, and Federal agencies to continue our effective efforts to respond to the opioid crisis. We support several pieces of legislation introduced in the Senate with the hope that Congress will enact them soon and aid our efforts in combating the crisis.

S. 2440, the Comprehensive Addiction, Recovery, Education and Safety (CARES) Act. This bill introduced by Committee Member Senator Cantwell—our Senator—would provide law enforcement with more tools to hold drug companies accountable for ensuring that their drugs do not enter the illicit drug market. Specifically, the bill increases civil and criminal penalties on companies that fail to keep proper records or report suspicious opioid distribution practices. Additionally, the bill authorizes funding for the Drug Enforcement Agency (DEA) to investigate suspect drug companies and drug trafficking organizations. The PGST supports S. 2440 because it aligns with our goals in our federal lawsuit to hold drug companies accountable for the destruction caused by the opioid crisis that stems from their failure to track orders and for creating an illicit market for their drugs.

S. 2270, the Mitigating the Methamphetamine Epidemic and Promoting Tribal Health Act (the "Mitigating METH Act"). This bill, introduced by Committee Member Senator Daines, would make tribes and tribal organizations eligible for direct funding (no set-aside) under the 21st Century Cures Act, which provides funding for prevention and response to opioids, or other substances—such as methamphetamines—if they are having a substantial impact on the state or tribe. The bill would increase the allocation of \$500 million to \$525 million. The PGST

¹Through THOR, each of the Tribe's departments have specific responsibilities for reaching the THOR goals. See Tribal Healing Opioid Response Program, <https://www.nihb.org/docs/12032017/Tuesday%20Sessions/THOR%20Presentation.pdf> (last accessed March 15, 2018).

supports S. 2270 because it gives us access to direct funding and important resources for combatting the crisis, in recognition of the government-to-government relationship we have with the Federal Government.

S. 2437, the Opioid Response Enhancement Act. This bill, introduced by Senator Baldwin, would also make tribes and tribal organizations eligible for funding under the 21st Century Cures Act but through a 10 percent tribal set-aside. Like S. 2270, tribes and states could use this funding for prevention and response to other substances threatening public health—such as methamphetamines. Additionally, the bill requires the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide technical assistance to both states and tribes for grant applications, formulating outreach and support efforts, and collecting data. The PGST supports S. 2437 because it has targeted funding for Indian Country, where Native families and communities feel the disparate impacts of the crisis hardest.

S. 2545, the Native Behavioral Health Access Improvement Act of 2018. Recently introduced by Committee Member Senator Smith, this bill aims to help combat the opioid epidemic by creating the Special Behavioral Health Program for Indians (SBHPI): a grant program modeled after the Special Diabetes Program for Indians (SDPI) and administered by the Indian Health Service (IHS), in coordination with SAMHSA. The SBHPI would provide IHS, tribes and tribal organizations, and urban Indian health programs with access to much-needed resources for addressing mental health needs and substance use disorders, specifically providing \$150 million in annual mandatory funding from FY 2018 to FY 2022. The grants would give tribes needed flexibility to provide tribally driven, culturally appropriate behavioral health care to meet the specific needs of their communities. The bill also provides that IHS, in coordination with SAMHSA, would create a technical assistance center responsible for developing grant-reporting standards in consultation with tribal grantees.

The PGST has operated a robust SDPI program for many years and is confident that its use as a model for the SBHPI will be a success. However, we caution against providing tribes resources through another program funded in the form of grants because competitive funding pits struggling tribes and local governments against each other for access to limited resources when we should be working together. One of the reasons why our THOR program is so effective is that the PGST has good relationships with State, County, and regional groups to coordinate on response strategies. The PGST does support S. 2545, but suggests, as an alternative to grant funding, that self-governance tribes—such as the PGST—be able to receive funding through their self-governance compacts.

Additional Information in Response to Committee Member Questions

During the Committee's March 14 Opioid Hearing, Committee Members were actively engaged in questioning the witnesses and we wanted to follow-up on several of those questions to make sure the Committee has ample information about our specific needs and those of Indian Country.

In response to Vice-Chairman Udall's questions about the impacts of funding cuts on the PGST's ability to respond to the opioid crisis and what departments—other than behavioral health—should have direct funding, we would answer that any reduction in funding harms our ability to respond and every department that the PGST operates needs direct funding for its programs and services. At a government level, our Health, Behavioral Health, Children & Family Services, and Housing Departments, as well as our courts, law enforcement, and administration, all have a role to play in responding to this crisis. It affects all of our members and Tribal agencies. Adequate direct funding means reliable resources and flexibility for the PGST to continue implementing our culturally appropriate, multi-faceted, comprehensive approach to abating the opioid epidemic sweeping the community. Additionally, adequate direct funding allows us to plan long term for infrastructure development, program enrichment, and service enhancements necessary for the well-being of our members and local community.

Thank you for the opportunity to speak on behalf of the PGST regarding the opioid epidemic. We look forward to further opportunities for discussion and to actively working with the Committee to tackle the opioid epidemic.

We hope that you and the entire Committee will accept our invitation to come visit the Port Gamble SiKlallam Reservation to see our work—and significant needs—to respond to the opioid crisis.

PREPARED STATEMENT OF THE SOUTHCENTRAL FOUNDATION (SCF)

Southcentral Foundation (SCF) submits written testimony to the Senate Committee on Indian Affairs to supplement its March 14, 2018 hearing entitled: “Opioids in Indian Country: Beyond the Crisis to Healing the Community.” SCF is the Alaska Native tribal health organization designated by Cook Inlet Region, Inc. (CIRI) and eleven Federally-Recognized Tribes—the Aleut Community of St. Paul Island, Igiugig, Iliamna, Kokhanok, McGrath, Newhalen, Nikolai, Nondalton, Pedro Bay, Telida, and Takotna—to provide healthcare services to beneficiaries of the Indian Health Service (IHS) pursuant to a contract with United States government under the authority of the Indian Self Determination and Education Assistance Act (ISDEAA) P.L. 93–638.

SCF provides a variety of medical services, including dental, optometry, behavioral health and substance abuse treatment to over 65,000 Alaska Native and American Indian people. This includes 52,000 people living in the Municipality of Anchorage, the Matanuska-Susitna Borough to the north, and 13,000 residents of 55 rural Alaska villages. Our services cover an area exceeding 100,000 square miles. SCF employs more than 2,300 people to administer and deliver these critical healthcare services.

We appreciate Committee Chairman Hoeven calling the hearing and hosting a roundtable discussion last November concerning opioid misuse. At the March 14th oversight hearing, Senator Hoeven remarked: “The roundtable highlighted how the opioid abuse epidemic is particularly complex in tribal communities given the lack of access to medical care, shortage of law enforcement and insufficient data on substance abuse.”

We applaud the efforts by Committee Vice Chairman Udall, and other members of the Committee, who wrote to Senate Appropriations Committee leaders earlier this month to urge them to provide “robust direct funding to tribal communities” in the FY 2018 omnibus measure for federal programs that will aid in the prevention, treatment and recovery from opioid misuse “to address the disparate impacts of the opioid crisis in Indian Country”.

We also appreciate the day-to-day work that Committee members perform to educate your Senate colleagues about the challenges tribes and tribal organizations like SCF face to prevent drug abuse, successfully treat individuals with addiction disorders, and save the lives of high-risk individuals who would otherwise overdose.

If Alaska Native healthcare providers are to stop the misuse of prescription opioids and illegal drugs like heroin and fentanyl, and begin to heal our Alaska Native customer-owners, we, together with the Federal Government, must attack the root causes that drive demand for such drugs: lack of access to appropriate care for medical conditions requiring pain management, trauma (domestic abuse, child abuse, historic trauma, etc.), mental health disorders, poverty, unemployment, overcrowded housing, and lack of access to prevention, treatment, and recovery services.

We urge the Committee and the Congress to ensure that Alaska Native communities receive an appropriate share of federal funds to stop the illegal distribution of opioids, reduce overdoses, support educational awareness programs, and provide the facilities and medication-assisted treatment (MAT) programs that Alaska Native communities require to combat the opioid epidemic. It is crucial in the battle against opioid misuse that Indian tribes and tribal organizations, like SCF, are *direct recipients* of federally appropriated funds to fight the opioid crisis, consistent with the government-to-government relationship.

We therefore strongly support legislation such as Senator Daines’ “Mitigating METH Act,” S. 2270, and Senator Baldwin’s “Opioid Response Enhancement Act,” S. 2437. These measures would amend the 21st Century Cures Act to include “Indian tribes and tribal organizations” and “Tribal entities” as direct recipients of federal appropriations to fight the opioid epidemic; provide tribes greater flexibility to prevent and treat other substances, such as methamphetamines; establish set-asides for tribes; and increase overall federal appropriations. We recommend that federal appropriations for tribes and tribal organizations be distributed in a manner similar to the Special Diabetes Program for Indians (SDPI) to ensure that every tribe receives funds based on well documented need.

The opioid epidemic did not occur overnight. In April 2017, the State of Alaska Epidemiology noted that overdose deaths steadily increased in Alaska and throughout the country due to three sequential epidemiological phenomena:

The first episode began in the mid-1990s with changes in standards for pain management, approval of new, extended release prescription opioid pain relievers, and aggressive pharmaceutical marketing to encourage the use of prescription opioids. A four-fold increase in prescribing led to a roughly four-fold increase in prescription opioid deaths and created a widespread increase in opioid

dependency and addiction. The second wave emerged over the last 10–15 years as heroin prices decreased, and the purity increased, offering an alternative to prescription opioids for persons who were addicted to or dependent on opioids. The third wave developed over the past 3 years as illicit fentanyl began to enter the opioid black market.¹

According to the Centers for Disease Control and Prevention (CDC), and confirmed by Rear Admiral Michael E. Toedt, Chief Medical Officer, IHS, in his appearance before the Committee on March 14, 2018, Alaska Natives and American Indians (AN/AIs) “had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999–2015 compared to other racial and ethnic groups.”² During that time, deaths rose more than 500 percent among AN/AIs.³ According to IHS, among AN/AIs, the rate of drug overdose deaths is twice that of the general population. Rear Admiral Toedt cautioned that due to misclassification of race and ethnicity on death certificates, the actual number of deaths for AN/AIs may be underestimated by up to 35 percent.

According to the State of Alaska Epidemiology, from 2009–2015, there were 774 drug overdose deaths in the State and AN/AIs had the highest overdose death rate by race from 2009–2014, at 20.2 deaths per 100,000.⁴ In February 2017, Alaska Governor Bill Walker declared the opioid epidemic a public health disaster. According to the CDC, in 2016, there were 64,000 drug overdose deaths in the United States, largely driven by prescription and illicit opioids. In a March 2017 study prepared for the Alaska Mental Health Trust Authority, the McDowell Group estimated the economic cost of the opioid crisis in Alaska alone was \$1.2 billion in 2015 when measured in terms of lost productivity, motor vehicle crashes, health care, criminal justice and protective services and public assistance.⁵

Senator Lisa Murkowski has remarked: “Alaska may be a rural state, but we are not shielded from this epidemic. . . . Opioid abuse in Alaska is devastating our communities throughout the state and has rapidly become one of our most pressing issues.” Senator Dan Sullivan also knows the great harm that the epidemic is causing to Alaska families. In August 2016, he convened a summit in Palmer, Alaska. He recognized that the communities hit hardest by opioid misuse are often those in economic distress. The opioid epidemic places a tremendous strain on Native communities already stretched too thin. SCF and other tribal healthcare providers need more federal resources if we are to stop the epidemic and reverse its harmful effects on Alaska Native families and our State. At that summit, SCF President and CEO, Katherine Gottlieb stated that SCF wants to expand our capacity to provide treatment for individuals struggling with addiction disorders but recurring federal resources to sustain and expand such programs remains our greatest obstacle.

President Trump declared a nationwide public health emergency concerning the opioid crisis on October 26, 2017. In February 2018, Congress passed the “Bipartisan Budget Act of 2018,” Pub. L. 115–123, which includes \$6 billion over two years (FY 2018 and FY 2019) to supplement federal appropriations for opioid addiction by funding grants, prevention programs, and law enforcement services. That legislation, however, did not make tribes and tribal organizations direct recipients of federal funding. As noted above, dedicating funding for Alaska Natives and American Indians is the best means to ensure that federal funds reach Indian Country and the tribal organizations that can make a difference in fighting the opioid epidemic. Give us the resources and we will expand our demonstrated ability to successfully treat patients with opioid addiction by using evidence-based treatment protocols performed in culturally appropriate and familiar settings.

Sam Moose, the Treasurer of the National Indian Health Board (NIHB), testified at the March 14 hearing that the opioid epidemic is “one of the most pressing public health crises affecting tribal communities,” and has “further strained the limited public health and healthcare resources available to tribes.” NIHB noted that Congress has historically funded IHS at a level below patient need. In FY 2017, Moose testified that national health spending was \$9,207 per capita while IHS spending was only \$3,332 per patient, nearly one-third less for Alaska Native/American Indian individuals.

¹State of Alaska Epidemiology, Bulletin No. 11, April 20, 2017, <http://www.epi.alaska.gov/bulletins/docs/b201711.pdf>

²Testimony of RADM Michael E. Toedt, MD, FAAFP, Chief Medical Officer, IHS, March 14, 2018.

³*Id.*, p. 3.

⁴State of Alaska Epidemiology Bulletin, No. 6, March 24, 2016, http://www.epi.alaska.gov/bulletins/docs/b2016_06.pdf.

⁵See <https://www.mcdowellgroup.net/wp-content/uploads/2017/03/mcdowell-group-economicimpacts-of-drug-abuse-final-3.10.17.pdf>.

In April 2017, the U.S. Department of Health and Human Services (DHHS) outlined a five-point, evidence-based Opioid strategy:

1. Improve access to prevention, treatment, and recovery support services to prevent the health, social, and economic consequences associated with opioid addiction and to enable individuals to achieve long-term recovery;
2. Target the availability and distribution of overdose-reversing drugs to ensure the broad provision of these drugs to people likely to experience or respond to an overdose, with a particular focus on targeting high-risk populations;
3. Strengthen public health data reporting and collection to improve the timeliness and specificity of data and to inform a real-time public health response as the epidemic evolves;
4. Support cutting-edge research that advances our understanding of pain and addiction, leads to the development of new treatments, and identifies effective public health interventions to reduce opioid-related health harms; and
5. Advance the practice of pain management to enable access to high-quality, evidence-based pain care that reduces the burden of pain for individuals, families, and society while also reducing the inappropriate use of opioids and opioid-related harms.

Last year, IHS chartered the National Committee on Heroin, Opioids and Pain Efforts (HOPE) to help implement the Department's five-part strategy to combat the opioid epidemic. Alaska Governor Walker also established a similar Program HOPE (Harm reduction, Overdose Prevention, and Education) which is providing overdose reversal kits with naloxone and launching a public information campaign. We wholeheartedly agree with these approaches.

Last December, the heads of three federal agencies; the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH), presented joint testimony to Congress concerning the opioid epidemic. The agency officials confirmed the first cause of the epidemic noted by the State of Alaska Epidemiology; the significant rise in the prescription of highly addictive opioid drugs. In addition, the agency officials stated that delays by the U.S. healthcare system in providing effective treatment programs, especially medication-assisted treatment (MAT) programs, exacerbated the problem of opioid addiction brought about by the over-prescription of highly addictive opioids. They noted that:

It is well-documented that the majority of people with opioid addiction in the U.S. do not receive treatment, and even among those who do, many do not receive evidence-based care. Accounting for these factors is paramount to the development of a successful strategy to combat the opioid crisis.⁶

Each year, SCF and other tribal organizations have urged IHS to request, and Congress to appropriate, increased funding for behavioral health, including funding for the Substance Abuse and Suicide Prevention (SASP) programs as well as increased funding for the Purchased Referred Care (PRC) program to address substance abuse, treatment and recovery programs.

In FY 2017, IHS allocated \$30 million in Substance Abuse and Suicide Prevention (SASP) funds to 175 IHS, tribal and urban Indian health organizations to develop and implement culturally appropriate, evidence-based, community driven programs. The average funding level was only \$171,000 for the service providers. The Federal Government must do better and appropriate greater resources for this important work so that many more at-risk Alaska Natives and American Indians can recover from opioid addiction and lead a productive life.

With available federal funding, SCF established The Pathway Home, a voluntary, comprehensive, and individualized mental health program for adolescents from 13 to 18 years old. The Pathway Home teaches invaluable life skills to Alaska Native

⁶Testimony of Elinore McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, Substance Abuse and Mental Health Services Administration (SAMHSA), Debra Houry, M.D., M.P.H., Director, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), and Francis Collins, M.D., Ph.D., Director, National Institutes of Health (NIH), on "Addressing the Opioid Crisis in America: Prevention, Treatment, and Recovery," December 5, 2017, before the Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies; <https://www.nih.gov/aboutnih/who-we-are/nih-director/testimony-addressing-opioid-crisis-america-prevention-treatment-recovery-before-senate-subcommittee>. Emphasis added.

youth so that they turn away from harmful behaviors. Many of these youth have already experienced trauma or have seen family members struggle with drug and alcohol dependencies, which puts them at greater risk of turning to drugs and alcohol later. The mission of the Pathway Home is to create a loving and supportive community environment where Alaska Native children can develop into independent, serviceminded and productive leaders. Increased funding to address root causes of substance abuse is crucial to combating the opioid crisis.

SCF also operates Dena A Coy (DAC), a residential treatment program that serves pregnant, parenting and non-parenting women who are experiencing problems related to alcohol and other drugs and experiencing emotional and psychological issues. This program is open to all women in Alaska, regardless of ethnicity, and allows some women to participate in the program with their children under the age of 3. Our overall philosophy is to treat the person as a whole, let our customer-owners drive their healthcare decisions, and give them the tools and skills to make healthy decisions. DAC matches national standards for successful program completion. The success rate of this program shows that our approach is working, and with more resources we could expand this program and treat more people who need these services.

If tribal organizations such as SCF are to stop the misuse of opioids, alcohol and other harmful substances and begin the process of helping individuals and families recover, we must have more resources, personnel and, equally important, the facilities to house these programs. With a service population of 65,000 our resources are wholly insufficient in comparison to the crisis. Timely treatment for opioid addiction can mean the difference between recovery or death.

Prevention, education and timely medication-assisted treatment programs remain our most potent tools to raise a new generation of Alaska Native people who practice positive, life-affirming behavioral traits and who will, in turn, pass on these life lessons to their children and grandchildren. Only then will the cycle of trauma and opioid addiction be broken.

Thank you for convening the March 14, 2018 hearing and for allowing us the opportunity to provide testimony.

PREPARED STATEMENT OF THE TANANA CHIEFS CONFERENCE (TCC)

Tanana Chiefs Conference (TCC) submits written testimony to the Senate Committee on Indian Affairs to supplement its March 14, 2018 hearing entitled: *"Opioids in Indian Country: Beyond the Crisis to Healing the Community."* TCC is a non-profit intertribal consortium of 37 Federally-recognized Indian tribes and 41 Alaska Native communities located across Interior Alaska. TCC serves 18,000 Alaska Natives living in Fairbanks and in the rural villages located along the 1,400 mile Yukon River and its tributaries. TCC's service area encompasses 235,000 square miles, about the size of Texas.

To help remote, Interior Alaska Native villages combat the opioid epidemic, Congress must make federal appropriations directly available to tribes and tribal organizations, and give us the flexibility we require to use such funds to prevent, treat and help individuals recover who are already addicted to prescription and illicit opioids and other illegal drugs.

We applaud the efforts that Committee Chairman Hoeven has taken to highlight the destructive effect that the opioid epidemic is causing to American Indian and Alaska Native communities. The March 14, 2018 hearing followed a roundtable discussion Chairman Hoeven convened last November concerning the opioid misuse in Indian Country. Senator Hoeven remarked: "The roundtable highlighted how the opioid abuse epidemic is particularly complex in tribal communities given the lack of access to medical care, shortage of law enforcement and insufficient data on substance abuse." At the March 14 hearing, Chairman Hoeven stated that: "I am also mindful that when Congress does appropriate funding to combat this epidemic, it is important that Indian Country receives an adequate share of the funding and receives this funding in a manner that will ensure maximized impact to their communities."

TCC fully supports the Chairman's remarks. If tribes are to stop the misuse of prescription opioids and illegal drugs, Congress must help tribes and tribal organizations attack the root causes: deferred medical treatment of conditions that require pain management, domestic and child abuse, homelessness, poverty, unemployment, and lack of prevention, substance abuse treatment, recovery services, and adequate law enforcement.

In addition to ensuring that tribes and tribal organizations have access to federal appropriations to educate, prevent, and treat opioid addiction, Congress must also

recognize the challenges tribes and tribal organizations face to adequately finance essential government services such as healthcare, education and job training, public safety, and the facilities to house these programs. This is especially true in remote, rural areas, such as Interior Alaska where TCC operates. Too often, federal appropriations make the difference between the success and failure of tribal initiatives, which in turn, determine whether economic and social conditions in Alaska Native communities improve or deteriorate. Promoting and funding Federal programs that keep Alaska Native families together, and help them prosper, is one of the best means of combating the opioid epidemic in tribal communities.

To better inform Congress of the magnitude of the problem remote Alaska Native communities face to fight the opioid epidemic that threatens our way of life, Congress must better appreciate the degree of isolation that exists in rural Alaska. We share below excerpts from the Indian Law & Order Commission's 2013 report: "A Roadmap for Making Native America Safer," relevant to Alaska:

Forty percent (229 of 566) of the federally recognized Tribes in the United States are in Alaska, and Alaska Natives represent one-fifth of the total State population. Yet, these simple statements cannot capture the vastness or the Nativeness of Alaska. The State covers 586,412 square miles, an area greater than the next three largest states combined (Texas, California, and Montana). There are only 1.26 inhabitants per square mile-as compared to 5.85 for Wyoming, which is the next least populous state.

Many of the 229 federally recognized tribes are villages located off the road system and "more closely resemble villages in developing countries" than small towns in the lower 48. Frequently, Native villages are accessible only by plane, or during the winter when rivers are frozen, by snow-machine. Food, gasoline, and other necessities are expensive and often in short supply. . . . While Alaska Natives constitute a majority of the rural population, each community is nonetheless quite small; typical populations are in the range of 250-300 residents, many of whom share family or clan affiliations. Villages are politically independent from one another. . . .

Problems with safety in Tribal communities are severe across the United States-but they are systematically the worst in Alaska. This is evident in an array of data concerning the available services, crime, and community distress.

Most Alaska Native communities lack regular access to police, courts, and related services:

- Alaska Department of Public Safety (ADPS) officers have primary responsibility for law enforcement in rural Alaska, but ADPS provides for only 1.0-1.4 field officers per million acres. . . . According to ADPS, troopers' efforts "are often hampered by delayed notification, long response distance[s], and the uncertainties of weather and transportation.

Social distress, which can be a cause of crime or other threats to public safety, is also high among Alaska Natives and in Alaska's Tribal communities:

- The suicide rate among Alaska Natives is almost four times the U.S. general population rate, and is at least six times the national average in some parts of the State.
- In 2011, over 50 percent of the 4,499 reports of maltreatment substantiated by Alaska's child protective services and over 60 percent of the 769 children removed from their homes were Alaska Native children.¹

The opioid crisis came as Alaska Native communities were already confronting daunting public safety and public health challenges. Public safety services remain one of the biggest challenges for our Alaska Native communities. Alaska is one of six P.L. 280 States in which jurisdiction over crimes in tribal communities rests mainly with the States. The Bureau of Indian Affairs (BIA) simply does not have sufficient funding for law enforcement services, so it prioritizes its public safety efforts in non-P.L. 280 States on the false assumption that P.L. 280 States like Alaska are investing sufficiently in public safety and law enforcement services in tribal communities. This is not the case. Without basic law enforcement services for our tribal governments, and without sufficient funds for tribal governments to fight opioid addiction, our communities are at much greater risk. The statistics bear this

¹ Indian Law & Order Commission, November 2013, A Roadmap for Making Native America Safer, Report to the President & Congress of the United States, Chapter Two, Reforming Justice for Alaska Natives: The Time is Now, pp. 35-43. See https://www.aisc.ucla.edu/iloc/report/files/Chapter_2_Alaska.pdf.

out. TCC has been using what little resources it has to build partnerships with State and local law enforcement to curb the influx of drugs in to our off-road communities. A tribally led, grassroots effort raised several thousands of dollars to hire and train a canine unit for the Alaska State Troopers in our hub community. TCC supports this type of ownership of issues at a local level, but is all too aware of the limitations of these efforts without continued and dedicated funding.

According to the Centers for Disease Control and Prevention (CDC), American Indians and Alaska Natives “had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999–2015 compared to other racial and ethnic groups.”² During that time, deaths rose more than 500 percent among AIANs.³

The Indian Health Service (IHS) notes that among American Indians and Alaska Natives, the rate of drug overdose deaths is twice that of the general population. The actual number of deaths for AIANs may be underestimated by up to 35 percent.⁴

According to the State of Alaska Epidemiology, from 2009–2015, there were 774 drug overdose deaths in the State and AIANs had the highest overdose death rate by race from 2009–2014, at 20.2 deaths per 100,000.⁵ In February 2017, Alaska Governor Bill Walker declared the opioid epidemic a public health disaster. According to the CDC, in 2016, there were 64,000 drug overdose deaths in the United States, largely driven by prescription and illicit opioids.

The Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (NSDUH) found that in 2016, 5.2 percent or 72,000 American Indian and Alaska Native persons aged 18 and older reported misusing a prescription drug in the past year and 4.0 percent of AIANs, or 56,000 individuals aged 18 and older, reported misusing a prescription pain reliever in the past year. SAMHSA Director Jones also noted that over the last decade, the U.S. has experienced a significant increase in the rates of neonatal abstinence syndrome (NAS), hepatitis C infections, and opioid-related emergency department visits and hospitalizations.⁶

Alaska Governor Walker declared the opioid epidemic in Alaska a public health disaster in February 2017 and created project HOPE (Harm Reduction, Overdose Prevention and Education). Later that year, President Trump declared a nationwide public health emergency concerning the opioid crisis. In February 2018, Congress passed the “Bipartisan Budget Act of 2018,” Pub. L. 115–123, which includes \$6 billion over two years (FY 2018 and FY 2019) to supplement federal appropriations for opioid addiction by funding grants, prevention programs, and law enforcement services. Congress has included billions of additional funding in the Consolidated Appropriations Act, 2018 omnibus measure, making final appropriations for FY 2018, to combat the opioid epidemic.

Federal legislation, however, has not made tribes and tribal organizations direct recipients of funding to address the opioid crisis. Direct appropriations and set-asides in federal legislation for Alaska Native and American Indian tribes and tribal organizations is the best means to ensure that federal funds reach Indian Country and the tribal organizations that can make a difference in fighting the opioid epidemic.

We therefore respectfully urge Congress and the Administration to ensure that Alaska Native communities receive an appropriate share of federal funds to stop the illegal distribution of opioids, reduce overdoses, support educational awareness programs, and provide the facilities and medication-assisted treatment (MAT) programs that Alaska Native communities require to combat the opioid epidemic. Direct funding for tribes and tribal organizations honors the Federal Government’s trust obligation to tribal nations and the special government-to-government relationship between the Federal Government and Indian tribes and Alaska Native Villages.

²Testimony of RADM Michael E. Toedt, MD, FAAFP, Chief Medical Officer, Indian Health Service (IHS), U.S. Department of Health and Human Services, before the Senate Committee on Indian Affairs, Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community, March 14, 2018.

³*Id.*, p. 3.

⁴*Id.*

⁵State of Alaska Epidemiology Bulletin, No. 6, March 24, 2016, http://www.epi.alaska.gov/bulletins/docs/b2016_06.pdf.

⁶Testimony of Christopher M. Jones, PharmD., M.P.H., Director, National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services before the Senate Committee on Indian Affairs, Hearing on Opioids in Indian Country: Beyond the Crisis to Healing the Community, March 14, 2018.

We strongly support Senator Daines' "Mitigating METH Act," S. 2270, and Senator Baldwin's "Opioid Response Enhancement Act," S. 2437. These measures would amend the 21st Century Cures Act to include "Indian tribes and tribal organizations" and "Tribal entities" as direct recipients of federal appropriations to fight the opioid epidemic, provide tribes greater flexibility to prevent and treat other substances, such as methamphetamines, establish set-asides for tribes, and increase overall federal appropriations. We recommend that federal appropriations for tribes and tribal organizations be distributed in a manner similar to the Special Diabetes Program for Indians (SDPI) so that every tribe receives funding.

At TCC we use our available funding to promote substance abuse recovery, but our resources are limited. We operate the Old Minto Family Recovery Camp, an Athabascan alternative to substance abuse treatment where healing is provided in a traditional setting. It is our belief that for Alaska Native people today, alcohol and drug use/abuse became a toxic way of coping with a loss of traditional Native values, cultural patterns identities, relationships, and unresolved trauma. Using Native cultural and traditional values as a foundation, our goal is to help people help themselves as they heal from trauma, choose healthy lifestyles and overcome substance use.

TCC has been working with other stakeholders in the Fairbanks, Alaska area to address the homeless situation among individuals suffering from alcohol and opioid addictions. TCC also held a three-day training session in January on methamphetamine and its impact on brain and behavior. The program was facilitated by faculty from the University of California Los Angeles (UCLA), and provided a skill-building workshop for behavioral health staff and treatment providers to address the unique challenges meth users bring to health service providers. We have advocated tirelessly, and will continue to do so, for equal access to law enforcement and improvement of public safety services that partially due to extremely limited state funding are scarce. We can do so much more to reduce harmful and destructive behavior such as opioid prescription misuse if Congress would only appropriate more funds for tribes and tribal organizations. If we are to stop the misuse of opioids and other harmful substances and begin healing in tribal communities, we must have adequate and recurring federal resources to attract and retain qualified health professionals to come to our remote communities and fight this epidemic. We also require the facilities to house substance abuse programs and services.

TCC and other tribal organizations have successfully demonstrated what we can accomplish in remote Alaska Native communities when given the resources. We cannot afford to lose a generation of Alaskans to the opioid epidemic.

Thank you for allowing us the opportunity to provide testimony.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND (USET SPF)

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we are pleased to provide the Senate Committee on Indian Affairs with the following testimony for the record of the Committee's oversight hearing, "Opioids in Indian Country: Beyond the Crisis to Healing the Community," held on March 14, 2018.

USET SPF is a non-profit, inter-tribal organization representing 27 federally recognized Tribal Nations from Texas across to Florida and up to Maine.¹ Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service (IHS), which contains 36 IHS and Tribal health care facilities. Our citizens receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under con-

¹USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

tracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638.

The opioid epidemic has had a devastating effect on USET SPF Tribal Nations and Tribal Nations across the country, who continue to experience the destructive effects of opioid addiction—often at higher rates than non-Indian communities. According to data from IHS, American Indians and Alaska Natives (AI/ANs) are more likely than any other race/ethnicity to have an illicit drug use disorder in the past year. In addition, according to the Centers for Disease Control and Prevention (CDC), AI/ANs are at the greatest risk for prescription opioid overdose, confronting an opioid overdose rate of 8.4 per 100,000. Though USET SPF is encouraged to see Congress move in an expeditious manner to identify solutions to the opioid epidemic nationwide, USET SPF is concerned that Tribal Nations are frequently left out of the conversation, despite the disproportionate impact the opioid epidemic has had within Tribal communities. USET SPF reminds the Committee of the unique federal trust responsibility to Tribal Nations, and urges the Committee to use its authority to ensure Tribal Nations are fully included in any subsequent legislation or other Congressional efforts to address the opioid crisis.

Direct Opioid Funding for Tribal Nations

The Federal Government has a trust responsibility to ensure Tribal Nations have access to resources, financial and otherwise, to combat the opioid epidemic. Among these vital resources is access to direct federal funding for Tribal Nations. While USET SPF is appreciative of the recent \$50 million Tribal set-aside for this purpose within the Fiscal Year (FY) 2018 Omnibus, more resources are required to fully address the opioid crisis at the Tribal level. Though our data on this issue is incomplete, that which is available shows Indian Country, including USET SPF Tribal Nations, is among the communities affected most by this crisis. Yet, no direct funding stream currently exists to combat this epidemic in Tribal communities. Currently, Tribal Nations are ineligible for a majority of funding available under the 21st Century Cures Act. Where Tribal Nations are eligible for funding, they are forced to compete with state and other entities for limited dollars. Tribal Nations should not have to compete to provide their citizens with the treatment they critically need. This is contrary to the federal trust responsibility to provide healthcare to Tribal Nations, and results in few resources delivered to Tribal citizens. In addition, the Indian Health System remains chronically underfunded, leaving many Tribal communities without the critical resources and funding to address opioid addiction and treatment. During the hearing, Tribal witnesses testified on the need for direct funding to Tribal Nations for Tribal opioid treatment and prevention programs due to the increasing levels of opioid abuse, deaths, and trafficking within Tribal communities. USET SPF echoes these concerns and urges the Committee to prioritize addressing this shortfall by working to ensure Tribal governments have access to direct funding.

Despite the government-to-government relationship between Tribal Nations and the United States, many federal grant programs, including those available as part of the 21st Century Cures Act, require funding to pass through the states before it can be delivered to Tribal governments. Because of this, a majority of Tribal communities have difficulty accessing federal funds, with many completely unable to access them in this manner. Further, when applying for these grants, states will often include Tribal population numbers in the overall state population used to determine each state's award. Yet, Tribal Nations are not provided with outreach for these programs and are left with minimal resources to address the opioid crisis in their communities. In order to ensure Tribal Nations are fully accessing these federal funds in the future, USET SPF recommends the Committee and Congress:

1. Consider implementing a funding model utilized by the CDC's Good Health and Wellness in Indian Country initiative, which allows for a direct, separate funding mechanism specifically for both Tribal Nations and TECs. This model has proven to be successful.
2. Expand language within grant funding programs to specifically include Tribal Nations as direct grantees so that states cannot exclude them in grant funding disbursements.
3. Recognize that competitive grants are not reflective of the federal trust responsibility and work to provide more funding to Tribal Nations via formula-based distribution methodologies.
4. Explore opportunities to deliver opioid funding to Tribal Nations via self-governance contracting and compacting in recognition of Tribal sovereignty and self-determination.

With these priorities in mind, USET SPF urges the Committee and Congress to fully consider the following legislation, as it would provide critical opioid response resources to Tribal Nations, including direct funding.

Mitigating METH Act

As discussed above, despite Tribal advocacy, Tribal Nations are ineligible for a majority of funding delivered to state and local governments under the 21st Century Cures Act. Where Tribal Nations are eligible for funding, they are forced to compete with state and other entities for limited dollars. On December 21, 2017, Senator Steve Daines introduced S. 2270, the Mitigating the Methamphetamine Epidemic and Promoting Tribal Health Act, or the Mitigating METH Act. The Mitigating METH Act would make Tribal Nations eligible to be direct grantees of federal opioid funding under the 21st Century Cures Act to combat opioid abuse in our communities. In addition, S. 2270 would provide an increase in grant funding of \$25 million to states and Tribal Nations under the State Targeted Response (STR) grants within the 21st Century Cures Act. USET SPF supports this legislation² that would bring critical direct funding to Tribal communities for the treatment and prevention of opioid addiction.

Native Health Access Improvement Act

In addition to the Mitigating METH Act, USET SPF would like to convey our support for S. 2545, the Native Health Access Improvement Act of 2018, which was introduced by Senator Tina Smith on March 14, 2018. This legislation would provide critical behavioral health resources to Tribal communities by creating a Special Behavioral Health Program for Indians (SBHPI). The SBHPI is modeled after the Special Diabetes Program for Indians (SDPI), a successful Tribal health program that has had a significant impact on diabetes within Tribal communities. Like SDPI, SBHPI responds to a public health crisis by providing dedicated, formula-based funding to Tribal Nations to address behavioral health and substance use disorders, including opioid abuse and addiction. In addition, it would support cultural competency by promoting the incorporation of both modern and traditional practices into Tribal behavioral health programs. Further, this legislation would require that funding standards and distribution methodology be developed in consultation with Tribal Nations and would provide the technical assistance necessary to develop robust programs. USET SPF requests that the Senate Committee on Indian Affairs ensure this legislation receive an immediate hearing.

Opioid Response Enhancement Act

USET SPF also conveys our support for the Opioid Response Enhancement Act, legislation introduced by Senator Tammy Baldwin, which would make significant investments in Indian Country to fight the opioid epidemic. The legislation would provide an additional funding of \$10 billion to states and Tribal Nations over five years for the State Targeted Opioid Response (STR) Grant, including \$2 billion for a new Enhancement Grant for Tribal Nations and states with high morbidity rates. The Opioid Response Enhancement Act would also include Tribal Nations as eligible entities for STR Grants, funded by a 10 percent set aside, which USET SPF feels reflects a commitment to ensuring this crisis is addressed in Indian Country. Other components of the legislation include:

- Technical assistance delivered from SAMHSA to Tribal Nations through the Tribal Training and Technical Assistance Center; and
- Flexibility to allow Tribal Nations and states to use funding to help address other substance abuse issues in addition to opioid prevention and treatment;

Funding for Comprehensive Opioid Data Collection within the Indian Health System

As noted by Tribal witnesses during the hearing, the available data on opioid abuse and mortality within the Indian Health System is inadequate and fails to fully illustrate the impacts opioids are having in Tribal communities. . As the Committee moves forward with recommendations on how to effectively treat and prevent opioid addiction, the Committee must promote the provision of adequate resources, including direct funding, to the IHS, Tribal Nations, and Tribal Epidemiology Centers in order improve opioid data collection. Expanding data collection and analysis would improve the treatment and prevention of substance abuse within Indian Country. Though our data on opioid abuse is incomplete, data that is available shows Indian Country, including USET SPF Tribal Nations, is among the commu-

²USET SPF Board of Directors supporting resolution.

nities most impacted by this crisis. Without access to critical data, Tribal Nations will continue to feel the impacts of the opioid epidemic for generations. USET SPF urges the Committee to prioritize addressing this shortfall by working to ensure Tribal Nations have access to resources to improve opioid data and provide for the treatment and prevention of substance abuse.

Tribal Prescription Drug Monitoring Programs

During the hearing, witnesses testified on the importance of partnering with state Prescription Drug Monitoring Programs (PDMP). IHS stated that the agency has been partnering with certain states to connect IHS with state PDMP data. USET SPF supports these partnerships and recommends the Committee and Congress ensure IHS has the necessary resources to expand and update the Indian Health Service's Resource and Patient Management System (RPMS) Electronic Health Record (EHR) to fully include and collaborate with state PDMPs on a multi-state basis. Integrating PDMP functionality into the RPMS EHR will connect Tribal Nations to crucial data within state PDMPs and will ensure an efficient and unified platform for Indian health providers to allow providers to quickly and easily make accurate and appropriate diagnoses (addiction, dependence, drug-seeking behavior, etc.) and document those in the RPMS EHR.

Culturally Competent Treatment

The incorporation of traditional healing practices and a holistic approach to health care are fundamental to successful opioid treatment and aftercare programs in Indian Country. Culturally appropriate care has had positive, measurable success within Tribal communities, and the incorporation of traditional healing practices and holistic approaches to healthcare has become central to many Tribal treatment programs. Tribal communities have unique treatment needs when it comes to substance abuse disorders, as AI/ANs experience high levels of substance abuse disorders, with a strong link to historical trauma. Opioid addiction treatment in Indian Country, then, must be cognizant of this trauma, respectful of community factors, and utilize traditional health care practices. Additionally, opioid addiction treatment within Tribal communities must include adequate culturally appropriate aftercare programs to help prevent substance abuse relapse. These services must be accessible through the Indian Health Care Delivery System.

Even though culturally competent care has had success across Indian Country, treatment options that incorporate cultural healing aspects are oftentimes not available within or near Tribal communities due to a lack of resources. However, some USET SPF member Tribal Nations are engaging in innovative practices that have the potential to be replicated across Indian Country. For example, one Tribal Nation's treatment program incorporates a culturally-based recovery model that has had great success, including in preventing early relapse following treatment. Other best practices within USET SPF Tribal Nations include:

- Extended, culturally-based recovery support in a sober living environment; and
- Trauma informed care training for health and behavioral health staff.

Other notable best practices and culturally healing modalities not currently being employed by USET SPF Tribal Nations include:

- Rapid entry into an acute care facility (detox/inpatient care); and
- Prevention and control interventions developed utilizing the Community Based Participatory Action model.

With additional funding and guidance, these best practices have the potential provide higher rates of recovery for our people. USET SPF encourages the Committee to explore how it might expand and promote these models through legislative action.

Tribal Healing to Wellness Courts

In addition to traditional healing practices, USET SPF urges this Committee and Congress to support innovative, culturally-appropriate Tribal restorative justice models through sustained funding. USET SPF is encouraged that the success of family drug courts, or Healing to Wellness Courts (HTWC), was discussed during the hearing. Established as alternatives to conventional sentencing for non-violent individual offenders, Tribal HTWCs promote long-term recovery through treatment, community healing resources, and the Tribal justice process by using a multi-disciplinary approach to achieve the physical and spiritual healing of participants.

For example, USET SPF member, the Penobscot Nation, has operated an HTWC since 2011. Any individual Penobscot Nation citizen who is charged with a non-violent crime can petition to participate in the HTWC program. Once accepted into the program, the individual must agree to enter a guilty plea for the crime charged

against him/her, but his/her sentence is “deferred” to allow the individual to go through the program. Then, a comprehensive, holistic plan is developed in collaboration between 10 Tribal government departments to address the individual’s treatment needs in four phases:

- Phase I: Introduction/Education. This phase is focused on detoxification and beginning treatment and generally lasts 180 days.
- Phase II: Personal Responsibility. This phase is focused on stabilization and treatment and generally lasts 120 days.
- Phase III: Cooperation/Accountability. This phase is focused on maintenance and treatment and generally lasts 120 days. ?
- Phase IV: Completion/Continuing Wellness. This phase is focused on graduation and aftercare and generally lasts 120 days.

Successful completion of the program results in a dismissal of the participant’s guilty plea. Over two dozen individuals have gone into the program since 2011. Recidivism is extremely low. Regrettably, the biggest challenge that the Penobscot Nation has encountered is that they do not have sufficient resources to accommodate all the individuals who are interested in participating in the program. While, the program is funded mainly through the Bureau of Indian Affairs, with supplemental funding from IHS, the Department of Justice, and the Department of Housing and Urban Development, this is administratively burdensome and unlikely to result in additional resources for the Court. Similarly, while some grants offered by the Substance Abuse and Mental Health Services Administration (SAMHSA) could possibly be used for this purpose, SAMHSA’s application requirements and standards often serve to preclude smaller, less resourced Tribal Nations from applying. The recovery model offered by Tribal HTWCs should be supported by this Congress, as it seeks to incentivize long-term sobriety and reduce criminal recidivism among drug offenders. In order to accomplish this, USET SPF urges this Committee to consider dedicated, sustained funding for this infrastructure in Indian Country.

Tribal Engagement at all Levels of Government

USET SPF reminds the Committee that Tribal Nations are sovereign governments to which each member of Congress has a trust responsibility. This trust responsibility is carried out not just through funding, but through meaningful government-to-government consultation and coordination to ensure Tribal Nations are included as full partners. When it comes to addressing the gaps in comprehensive Tribal programs to prevent, treat, and measure opioid addiction, this effort must include collaboration between federal, state, and Tribal governments. During the hearing, Tribal witnesses underscored the crucial need for collaboration on between Tribal Nations and all levels of government, including federal, state and local, in addressing the opioid epidemic. However, Tribal Nations are frequently excluded from these types of collaborative efforts as other units of government work together to ensure a coordinated response.

As the trustee to Tribal Nations, the Committee and Congress must acknowledge the substantial challenges within Indian Country must fulfill the trust responsibility by facilitating and requiring collaboration between Tribal governments and state and local governments in the fight to end the opioid epidemic. Failure to include Tribal Nations, including when seeking solutions to the opioid epidemic will result in major gaps in the ability of the United States to eradicate opioid addiction in this country. These gaps in coordination are detrimental not just from a healthcare and treatment perspective, but from a law enforcement perspective, as well. Outreach from the Committee, as well as future legislation, should promote and require this necessary intergovernmental collaboration.

Access to Law Enforcement Resources

In addition to opioid addiction and treatment resources, USET SPF member Tribal Nations report a lack of adequate law enforcement infrastructure to combat the opioid epidemic within our region. Currently, there are only seven drug enforcement agents assigned to serve over one hundred Tribal Nations within our BIA Drug Enforcement Region (from ME to FL to NM to the central US). This limited number of law enforcement agents is unacceptable considering the persistent and growing problem of opioid trafficking within Indian Country, particularly the USET SPF region. As mentioned during the hearing, law enforcement within Indian Country needs additional resources to in order to sufficiently address the growing opioid abuse and trafficking within our Tribal Nations, including human capital.

Though our Tribal patrol officers perform a vital role in addressing drug issues within a community, our law enforcement agencies face underfunding, understaffing, and other failures due to inadequate appropriations. Though USET SPF is

pleased that \$7.5 million was recently appropriated in the FY 2018 Omnibus bill providing funding to the Bureau of Indian Affairs law enforcement, additional resources and continued investments must be made available to Tribal Nations when it comes to critical drug enforcement investigations. These services are conducted primarily by specialized units or task forces on departmental, statewide and federal levels and involve enhanced intelligence gathering, information sharing, controlled buys, surveillances and other factors. As the Committee approaches this crisis, it must not forget the importance of stopping the supply of opioids on Tribal lands through well-equipped law enforcement.

Conclusion

USET SPF appreciates the Committee's continued attention to the opioid epidemic and the destructive effects that it has had within Indian Country. We call upon the Committee to take action to ensure vital resources are directed to Tribal communities. Failure to include Tribal Nations in future legislation is a failure to recognize the trust responsibility and will result in an incomplete response to this crisis. USET SPF urges the Committee to use the crucial information gathered during these events to educate Senate colleagues on the impact of the opioid epidemic within Indian Country, and to continue to voice these priorities beyond the Committee during the legislative process.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
JOLENE GEORGE

Federal Funding Access for Tribes and Native Communities

Question 1. Legislative proposals that would give tribes access to direct access to dedicated funding to address opioid addition and other behavioral health challenges. Do you support the correction to the State Targeted Response program's state pass-through funding model proposed by S. 2270 and S. 2437?

Answer. Yes, we support direct funding to tribes as authorized in both S. 2270 and S. 2437. Adequate direct funding means reliable resources and flexibility for the PGST to continue implementing our culturally appropriate, multi-faceted, comprehensive approach to abating the opioid epidemic sweeping our community. Additionally, adequate direct funding allows us to plan long-term for infrastructure development, program enrichment, and service enhancements necessary for the well-being of our members and local community. We support both bills and are encouraged by the Sponsors' recognition of the importance of direct tribal funding. However, we note that S. 2437 provides significant increases in funding for a longer period of time, and we prefer that approach. The opioid crisis has been a long time in building, and its impacts are going to be long term. The additional funding is needed and could be put to use by Indian Country to carry out important opioid response activities in light of the magnitude and duration of the crisis.

Further, while the PGST supports both S. 2270 and S. 2437, we would recommend, as an alternative to the grant funding contemplated in both bills, that Congress use the self-governance model for this funding for tribes like ours that already carry out programs and functions through self-governance compacts. Since joining the Tribal Self-Governance Project, a consortium of self-governing tribes, in 1990, we have funded our health care services through a compact with the Indian Health Service (IHS) under the Indian Self-Determination and Education Assistance Act. We operate and manage our entire health system on our Reservation, which includes primary care, dental, mental health, and substance abuse services along with prevention and community health.

We would much prefer receiving these monies through our self-governance compact if possible rather than through grants. Administering programs by competitive grant funding is inappropriate for meeting the critical needs of Indian Country, as it pits tribe against tribe to compete for limited funds and fosters uncertainty since funding cannot be relied on year-to-year. Moreover, having our Program Directors spend time pursuing grants or reporting for grants takes their energy away from carrying out the critical program duties. Finally, if we are competing with the states that will undermine our working together which is what we should be doing to combat the opioid epidemic. One of the reasons why our Tribal Healing Opioid Response (THOR) program is so effective is that we are working with the State, the County, and regional groups to coordinate response strategies.

Question 1a. Would the authorization of a "Special Behavioral Health Program for Indians" as proposed by S. 2545 help your Tribe in its opioid response efforts?

Answer. Yes, we support the creation of a Special Behavioral Health Program for Indians (SBHPI) under this legislation, as it would provide the Indian Health Serv-

ice (IHS), Tribes, Tribal organizations, and urban Indian health programs with access to \$150 million in annual mandatory grant-based funding from FY 2018 to FY 2022. As mentioned above, we operate and manage our entire health system on our Reservation, and we have operated a robust Special Diabetes Program for Indians (SDPI) program for many years. We are confident that using the SDPI program as a model for the SBHPI will be a success.

The PGST supports S. 2545. However, as with S. 2270 and S. 2437, we recommend that self-governance tribes—such as the PGST—be able to receive such funding through their self-governance compacts rather than through grant funding. As we know from our SDPI experience, grant reporting requirements take away from clinical time, and the self-governance model would allow for more administrative efficiency.

Federal, State, Tribal Intergovernmental Coordination

Question 2. What else could Congress do to help encourage states and local governments to coordinate with tribes on their opioid response efforts?

Answer. The following are some ideas that Congress could encourage state and local governments to work with Tribes:

- Establish and set aside funding for demonstration/pilot programs for opioid response activities to show how cooperation leads to results.

—Congress could base such a program on the PGST’s efforts with the Olympic Community of Health, implementing the Three County Coordinated Opioid Response Project. A demonstration/pilot program would provide the framework for bringing tribes and neighboring governments together in areas where states and local governments are reticent to work with tribes. The program could show the successes that are achievable when state, local, and tribal governments work together.

- Create an opioid task force with representatives of state, local, and tribal governments, and include other relevant sectors, e.g. housing, schools, law enforcement, corrections, etc. Doing so would incentivize the governments to come together with each other and the people who are doing the work on the ground to develop coordinated and creative approaches to dealing with the crisis on an ongoing basis. The task force could advise Congress and/or relevant federal agencies about the challenges they face and what they need to effectively fight the opioid crisis.

—Such a task force could be modeled on what the PGST is doing with Washington State and our neighboring counties. It could be set up on a regional level with multiple regions.

- Encourage the use of Medicaid Demonstration Waivers for experimental, pilot, or demonstration projects found by the Secretary of Health and Human Services to be likely to assist in promoting the objectives of the Medicaid program. Washington State’s waiver formed regional Accountable Communities of Health, which have helped form partnerships that were not otherwise easily accessible or workable.
- Include a provision in opioid legislation mandating state and local governments to work together with tribes to respond to the opioid crisis. One potential vehicle is S. 2437, the Opioid Response Enhancement Act, which, in part, amends the 21st Century Cures Act of 2017 (the “Cures Act”) to encourage community and local government engagement.

—Section 2(a)(2)(B)(i)(1) of S. 2437 would amend Section 1003(c)(2) of the Cures Act to read, “Grants awarded under this subsection shall be used for carrying out activities, *including activities supported by community-based organizations and counties*, that supplement activities pertaining to opioids undertaken by the State agency responsible for administering [the grant].” The new language is in italics. Congress could include a statement that directs state and local governments to work coordinate with tribes on opioid response efforts.

—Another place in S. 2437 for additional language is Section 2(a)(4), the Technical Assistance provision. Through this proposed new mandate, Congress could direct the Secretary of Health and Human Services to assist tribes, states, and local governments with coordinating strategies and developing collaborative responses.

- Allow special access to funding for consortium projects that involve tribes together with state agencies or local governments, which would incentivize intergovernmental collaboration. Such a provision could be included in pending opioid legislation.

- Provide monetary incentives for states and local governments to coordinate with tribes.
- Include a requirement for a GAO report examining the hurdles that prevent effective state, local, and tribal government coordination on opioid response efforts.

—A potential vehicle for this could be H.R. 994, the Examining Opioid Treatment Infrastructure Act of 2017. This is a bipartisan bill specific to Indian Country that currently calls for a GAO report on: (1) inpatient and outpatient treatment capacity, availability, and needs, including detoxification programs, clinical stabilization programs, transitional residential support services, rehabilitation programs, and treatment programs for pregnant women or adolescents; (2) treatment availability and effectiveness through Indian health programs; and (3) the barriers to real-time reporting of drug overdoses at the federal, state, and local level and ways to overcome those barriers. The scope of the GAO report under this bill could be expanded to include an examination of the barriers relating to positive state and local government coordination with tribes.

Additional Issue

We would like to make one additional point that is consistent with our responses above, but which does not neatly fit under any one of the specific questions asked. At the local level, a major challenge has been integrating behavioral health with primary care in order to optimize patient outcomes. This is the work that will reach people grappling with the opioid epidemic on the front lines. Federal law and regulations complicate the complexities of integrating health systems with behavioral health systems. Federal regulations at 42 CFR Part 2, related to the privacy of substance abuse treatment records, currently prevent the Tribe's primary care and mental health providers from accessing patient records from dependency providers so the whole person can be treated. This lack of access is a barrier to coordinated, safe, and high-quality medical care and can cause significant harm. Part 2 regulations may lead to a doctor treating a patient and writing prescriptions for opioid pain medication for that individual without knowing the person has a substance use disorder. There remains a strong need for technical assistance and a potential legislative fix to align the varying levels of patient privacy under the Health Insurance Portability and Accountability Act of 1996 (HIP AA) and 42 CFR Part 2 that challenge the integration process.

Conclusion

Thank you for the opportunity to speak on behalf of the PGST regarding the opioid epidemic facing this Nation. We look forward to further opportunities for discussion and to actively working with the Committee to tackle the opioid epidemic. We hope that you and the entire Committee will accept our Tribe's invitation to come visit the Port Gamble S'Klallam Reservation to see our work and significant needs in responding to the opioid crisis.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
STACY A. BOHLEN

Federal Funding Access for Tribes and Native Communities

Question 1. Your written testimony states, "access to critical opioid prevention and treatment dollars are not reaching many of the Tribal communities that are in serious need of these funds." The Senate is currently considering three different legislative proposals that would give tribes direct access to dedicated funding to address opioid addiction and other behavioral health challenges (i.e., S. 2270, Mitigating METH Act; S. 2437, the Opioid Response Enhancement Act; and S. 2545, the Native Behavioral Health Access Improvement Act of 2018). Do you have an estimate of how much funding from the 21st Century CURES Act State Targeted Response program is reaching Native communities?

Answer. No, we do not have an overall estimate, because states are not required to report this data. We do know that some states have chosen to include Tribes in their funding distribution, but this is not guaranteed or required due to the current funding scheme. Of the 36 states with Tribes, only 13 have included Tribes in their State Targeted Response (STR) or somehow identified American Indians and Alaska Natives (AI/ANs) as a target population with specific needs.

California and a few other states have used their funds to create Tribal MAT projects to improve the delivery of treatment services in AI/AN communities, and that other states like Minnesota, Washington and Oregon have outlined AI/ANs as

one of their primary target populations for the funds. In Washington for example, the state is looking to pilot a low-barrier buprenorphine program in Tribal communities, and is engaging at least 5 Tribes to develop a Tribal treatment outreach and education campaign.

But this is far less than adequate. At the Ho-Chunk Nation in Wisconsin they have seen an increased number of infants born with substance addiction and neonatal abstinence syndrome, as well as an increase in opioid-related overdose deaths in the community. The Tribal government declared a State of Emergency regarding the opioid crisis and is in the process of developing a Tribal Action Plan within their departments. A major problem for the Tribe is that the grant money the state receives and distributes to the Tribes is not sufficient to meet the added burden the Tribe's behavioral health facility is experiencing.

Question 1a. Do you support the correction to the State Targeted Response program's state pass-through funding model proposed by S. 2270 and S. 2437?

Answer. Yes, the inclusion of Tribes in the correction to the STR program's model is a very important first step Congress must make to address the opioids crisis in Indian Country. NIHB is supportive of the provisions in S. 2270, the "Mitigating METH Act" from Senator Daines, and S. 2437, the "Opioid Response Enhancement Act" from Senator Baldwin. By ensuring Tribes can receive federal funds directly, Congress would ensure that the funds reach Tribal communities experiencing desperate need of relief. This change would also uphold the federal trust responsibility by ensuring Tribes do not need to go through their states' health department or sub-granting process to receive the care that is historically promised and legally owed. Finally, allowing Tribes to receive these funds authorized by the 21st Century CURES Act of 2016 would alleviate the states of the burden of having to provide care to Tribes. Not all states have the expertise or capacity to provide care to Indian Country. Changing the STR program to include direct, formulaic federal funding for Tribes directly would uphold the trust responsibility, respect states, and most importantly, ensure Tribes have the resources to care for themselves.

Question 1b. Would the authorization of a "Special Behavioral Health Program for Indians" (SBHPI) as proposed by S.2545 help your Tribe in its opioid response efforts? And, are there any particular characteristics of the SDPI model that are important to carry over to an SBHPI?

Answer. Yes, the creation of SBHPI is a priority for the National Indian Health Board. American Indian/Alaska Native 12th graders are roughly twice as likely to have used heroin or OxyContin as 12th graders nationally. Additionally, the chronic underfunding of the Indian health system leaves many healthcare facilities unable to offer preventative services, instead resorting to distributing painkillers when the health issue becomes acute. The opioids crisis is real in Indian Country. The proposed SBHPI would provide funding to Tribes to develop Substance Use Disorder treatments at the Tribal and community level.

A program like this would provide broad-based funding in Tribal communities for addressing behavioral health challenges. If the program is designed in a similar way to SDPI, it will be recurring, formula based funding that Tribes can count on from year to year. This will allow for investment in Tribal communities that focuses on traditional healing combined with clinical measures. The flexibility permits Tribes to focus on both prevention and treatment, and to create programs that are tailored to their communities. We know the SDPI model works.

The SDPI model offers Tribes the flexibility they need to develop culturally competent and tailored programs that have shown enormously successful results since SDPI began in 1997. By supporting each Tribe's work, SDPI reflects that a one-size fits all approach is inappropriate for Indian Country. NIHB is glad to see the same level of flexibility in Senator Smith's SBHPI legislation.

As impactful as SDPI is, NIHB would suggest that the legislative model for the program is imperfect. Historically, Congress has renewed SDPI on a 2-year cycle. Last year, SDPI renewal was tied to the CHIP reauthorization bill and became caught in a larger political battle. For several months, Tribal administrators of SDPI-funded programs did not have the certainty needed for effective long term planning. Long-term reauthorization for SDPI, such as found in the Vice Chairman's bill, S. 747, would prevent this from happening again. SBHPI should be authorized and funded for no fewer than the five years found in S. 2545. Additionally, SDPI's funding level has plateaued since 2004, with about one third of the buying power lost to medical inflation. NIHB would recommend that legislation for both SDPI and SBHPI include funding adjustments over time to compensate for rising healthcare costs.

As promising as the Native Behavioral Health Access Improvement Act is, this is really just one small step. The \$150 million outlined in this legislation will not

be nearly enough to get to Tribal communities to generate systems change. What we really need is comprehensive investments in IHS funding, improved staffing for medical professionals in our rural communities, and access to training for first responders and other enforcement activities.

Federal, State, Tribal Intergovernmental Coordination

Question 2. Port Gamble S’Klallam Tribe’s testimony lists “cross-government coordination” as one of the most important components of designing an impactful tribal response to public health crises. It goes on to cite the Tribe’s work with three local county efforts as evidence of the effectiveness of this recommendation to prioritize crossgovernment coordination. Unfortunately, not all tribes find their state and local counterparts willing to partner with them to address issues that span across multiple jurisdictions. What else could Congress do to help encourage states and local governments to coordinate with tribes on their opioid response efforts?

Answer. Port Gamble S’Klallam Tribe is right to point out the potential of a well-coordinated and interconnected collaboration across various government entities in creating an effective opioid response plan. Some Tribes are in ideal positions to leverage intergovernmental relationships to ensure their members receive services; however, this cannot be the federal government’s fallback strategy to upholding its trust responsibility to Tribes. As stated in the question, not all state and local governments have the will, capacity, or expertise to deliver cross-government coordinated services to Tribal communities adequately. The most productive course of action would be for Congress to require Tribal consultation in the earliest stages of opioid targeted response at the state and local level. Tribes need to be at the table, not to evaluate an otherwise-final state proposal, but to help states and local governments craft the proposals from the beginning, ensuring that the final product respects Tribal needs and sovereignty.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
CAPTAIN CHRISTOPHER JONES

Tribal Access to SAMHSA Grants

Your testimony cites a number of grant programs operated by SAMHSA that allow communities to address opioid and substance abuse issues. In your written testimony, you mention several SAMHSA grant programs aimed at addressing the opioid crisis (e.g., State Targeted Response grants, two separate Strategic Prevention Framework Programs, the First Response-Comprehensive Addiction and Recovery Act Program, etc.). In your oral testimony and in the course of answering questions at this oversight hearing, you noted a residential program with 19 grantees that addresses intergenerational addiction and an outpatient program authorized by the *Comprehensive Addiction and Recovery Act*.

Question 1a. Are tribes, tribal organizations, and urban Indian health organizations eligible for all of the SAMHSA grants noted above?

Answer. By statute, eligibility for the State Targeted Response to the Opioids Crisis (section 1003 of the 21st Century Cures Act) and State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (section 508(r) of the Public Health Service Act) grant programs are limited to states. Tribal entities are eligible for the Strategic Prevention Framework for Prescription Drugs, Strategic Prevention Framework Partnerships for Success, First Responders—Comprehensive Addiction and Recovery Act, and Residential Treatment for Pregnant and Postpartum Women programs.

Question 1b. If tribal grantees are eligible for the programs mentioned in your written testimony (e.g., State Targeted Response grants, two separate Strategic Prevention Framework Programs, the First Response-Comprehensive Addiction and Recovery Act Program, etc.), what percentage of grant recipients are tribal grantees? And, what percentage of total grant funds do those tribal grantees receive from each of those grants?

Answer. By statute, eligibility for the State Targeted Response to the Opioids Crisis (section 1003 of the 21st Century Cures Act) and State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (section 508(r) of the Public Health Service Act) grant programs are limited to states.

In FY 2015, tribal entities represented and received the following funds through the *Strategic Prevention Framework Partnerships for Success Program* (awards are for the first year of the grant):

- SAMHSA awarded grants to 7 of the 8 applications received from organizations that self-identified as tribal organizations (88 percent success rate)

- SAMHSA awarded grants to 24 of the 24 applications received from non-tribal organizations (100 percent success rate)
- Tribal entities represented 23 percent of recipients (7 of 31)
- Tribal entities received 10 percent of awarded funds (\$3,874,777 of \$38,687,939)

In FY 2016, tribal entities represented and received the following funds through the *Strategic Prevention Framework for Prescription Drugs Program* (awards are for the first year of the grant):

- SAMHSA awarded grants to all 4 applications received from organizations that self-identified as tribal organizations (100 percent success rate)
- SAMHSA awarded grants to 21 of the 24 applications received from non-tribal organizations (88 percent success rate)
- Tribes/tribal organizations represented 16 percent of recipients (4 of 25)
- Tribes/tribal organizations received 19 percent of awarded funds (\$1,751,982 of \$9,322,676)

In FY 2017, tribal entities represented and received the following funds through the *First Responders—Comprehensive Addiction and Recovery Act Program* (awards are for the first year of the grant):

- SAMHSA awarded grants to all 4 applications received from organizations that self-identified as tribal organizations (100 percent success rate)
- SAMHSA awarded grants to 17 of the 48 applications received from non-tribal organizations (35 percent success rate)
- Tribes/tribal organizations represented 19 percent of recipients (4 of 21 awards)
- Tribes/tribal organizations received 8 percent of awarded funds (\$936,724 of \$11,235,881)

Question 1c. If tribal grantees are eligible for the programs mentioned in your oral testimony and question responses (i.e., a residential program with 19 grantees and an outpatient program authorized by the Comprehensive Addiction and Recovery Act), what percentage of grant recipients are tribal grantees? And, what percentage of total grant funds do those tribal grantees receive from each of those grants?

Answer. In FY 2017, there were no tribal recipients of the Residential Treatment for Pregnant and Postpartum Women Program and by statute only states are eligible for the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (section 508(r) of the Public Health Service Act).

In FY 2016, there were no tribal recipients of the Residential Treatment for Pregnant and Postpartum Women Program.

Your testimony also states that Assistant Secretary for Mental Health and Substance Use McCance-Katz is actively looking for ways to improve tribal access to SAMHSA's grant programs.

Question 2a. What metrics, if any, has SAMHSA identified to determine if tribal access to SAMHSA grants is improving?

Answer. Dr. McCance-Katz has provided strong leadership on this priority and over the past five months, she has:

- Reestablished the Addiction Technology Transfer Center (ATTC) Program: American Indian and Alaska Native Support Center Cooperative Agreement.
- Will be establishing Tribal TA Centers for Mental Health as well as for Prevention.
- Established a \$5 million set-aside as part of the SAMHSA Enhancement and Expansion of Treatment and Recovery Services for Adolescents, Transitional Aged Youth, and their Families Program.
- Will make awards to three tribal entities, out of the nine total projected awards, under the Statewide Consumer Network Program.
- Will ensure that at least one of the four Healthy Transitions grants goes to tribes/tribal organizations.
- Will ensure that at least four awards of Project AWARE grants go to tribes/tribal organizations.

Additionally, in report language on the Consolidated Appropriations Act, 2018, Congress directed SAMHSA to ensure that \$5 million in funding from the Medication-Assisted Treatment—Prescription Drug and Opioid Addiction program goes to tribes/tribal organizations; that act also included a \$50 million set-aside in the State Opioid Response Program for tribal awardees.

The metrics used for success will be the number and proportion of grant awards made to tribes/tribal organizations in these programs.

Question 2b. Does SAMHSA have any information on the overall number of tribal applicants for all SAMHSA grant programs? If so, please provide a summary of that information.

Answer. In FY 2016, SAMHSA received 126 applications from organizations that self-identified as tribal organizations. In FY 2017, SAMHSA received 82 applications from organizations that self-identified as tribal organizations.

Question 2c. Does SAMHSA have any information on the success rate of tribal grant applicants compared to other types of applicants for competitive grant programs within the Agency? If so, please provide a summary of that information.

Answer. In FY 2016, SAMHSA awarded grants to 79 of the 126 applications received from organizations that self-identified as tribal organizations (63 percent success rate). In FY 2016, SAMHSA awarded grants to 527 of the 1,410 applications received from non-tribal organizations (37 percent success rate).

In FY 2017, SAMHSA awarded grants to 37 of the 82 applications received from organizations that self-identified as tribal organizations (45 percent success rate). In FY 2017, SAMHSA awarded grants to 412 of the 1,025 applications received from non-tribal organizations (40 percent success rate).

Your testimony notes that Assistant Secretary McCance-Katz included a \$5 million dollar tribal set-aside in a recent funding opportunity announcement for “Enhancement and Expansion of Treatment and Recovery Services.”

Question 3a. Has SAMHSA included a tribal set-aside within this funding opportunity in previous funding application rounds? Or is this \$5 million set-aside a first time occurrence?

Answer. This set-aside was done at the direction of Dr. McCance-Katz. FY 2018 is the first time that SAMHSA included a \$5 million set-aside for tribes and tribal organizations in its Funding Opportunity Announcement (FOA) focused on substance use disorder treatment services for adolescents, transitional aged youth, and their families.

Question 3b. Please provide information about the number and amounts of tribes awarded to tribal applicants for this grant program under any previous grant award rounds.

Answer. SAMHSA previously awarded grants to tribes and tribal organizations under the State Youth Treatment Initiative from FY 2012 to FY 2017. This Initiative helps to further the use of, and access to, effective evidence-based family-centered treatment approaches for adolescents (ages 12 to 17) and transitional age youth (ages 18 to 25) with substance use disorders and co-occurring substance use and mental disorders. Under this Initiative, 62 total grants have been made across 35 states/tribes/territories. Of the 62 total awards, seven awards totaling \$13,158,595 have been made to the following tribes and tribal organizations (the amounts listed represent the first-year funding award):

- Chickasaw Nation (OK)-one grant award (FY 2013: \$555,333)
- Fallon Paiute Shoshone (NV)-one grant award (FY 2013: \$950,000)
- Pascua Yaqui Tribe (AZ)-one grant award (FY 2015: \$800,000)
- Fairbanks Native Association (AK)-two separate grant awards (FY 2016: \$464,173; FY 2015: \$249,767)
- Kickapoo Tribe (OK)-two separate grant awards (FY 2017: \$800,000; FY 2015: \$250,000)

Fostering Tribal-State Partnerships

Your testimony discusses how the Cures Act State Targeted Response (STR) grant program interacts with Indian Country through state-tribal partnerships.

Question 4a. Please provide a list of the states receiving STR funds that used tribal engagement as part of their plans for utilizing STR resources.

Answer. Please see Chart below.

Question 4b. Please provide a summary of the types of tribal engagement states identified as part of those STR plans.

Answer.

State	State Plan Information on Tribal Engagement
Alaska	Funding to 17 tribal health organizations

State	State Plan Information on Tribal Engagement
Arizona	Arizona's needs assessment included focus on the Hopi Tribe and Navajo Nation in Chochino and Navajo counties. As a result, the STR funds are being used to address prescription drug misuse in these focus areas.
California	American Indian/Native Alaskan (AI/NA) communities have significant challenges in accessing MAT services and their issues with the opioid epidemic are also on the rise. The death rate from unintentional drug poisoning is almost twice as high in the AI/NA population compared to the population nationally. STR project goals for tribal communities include: improve MAT access; increase the total number of tribal waived prescribers certified; provide expanded MAT services that include tribal values, culture, and treatments; provide innovative telehealth in rural and underserved areas and increase community capacity to support OUD prevention and treatment; and, increase treatment engagement by enhancing clinical decision tools using health information technology.
Colorado	The State will work with the two recognized tribes to help them each identify needs and develop their own strategic plans.
Michigan	The State identified the following objectives: (1) build the capacity of the Inter-Tribal Council (ITC) Tribal OUD Prevention Initiative using train the trainers combined with extensive technical assistance (facilitators will be trained using the Gathering of Native American Model to either initiate the creation of a Tribal Action Plan (TAP) or enhance existing TAP efforts to focus specifically on the opioid epidemic); and, (2) provide assistance with treatment costs for American Indian and Alaskan Native (AI/AN) under and uninsured patients with an OUD (the ITC will implement the Tribal Opioid Treatment and Recovery initiative using the existing Access to Recovery infrastructure, entitled Anishnaabek Healing Circle). 500 uninsured or underinsured AI/AN OUD patients will be served.
Minnesota	A contract to provide treatment to Native Americans and five contracts to provide recovery support services focused on pregnant and parenting women to tribes. Funds have also been distributed to develop a culturally appropriate awareness campaign.
Montana	The State will contract with the Rocky Mountain Tribal Leaders' Council to work with Montana's Peer Network to develop culturally tailored version of the current peer mentoring trainings and peer supervisor trainings. Rocky Mountain Tribal Leader's Council will also be involved in the outreach on reservations and with tribal providers for the implementation of peer mentoring.
Nevada	The STR Director is working with Tribal Health Medical Directors to promote naloxone distribution and overdose education and integration with tribal primary health providers and public health through sharing of data and resource referral.
New Mexico	New Mexican Pueblo communities will receive priority for overdose prevention education and Narcan distribution. Anecdotally, opioid overdose death rates on tribal lands are increasing. Tribal leaders, police, community members, and health and social service providers are all reporting an increase in heroin and prescription opioid use. Indigenous champions and local ambassadors are being identified to build the necessary and complex relationships with tribal leaders to expand STR into those communities. The State is also utilizing its Native American employees to advise and consult on the project. The Eight Northern Pueblos (ENP) currently participate and recently Pojoaque Tribal Police received training to respond to an opioid overdose. The ENP are geographically located in Rio Arriba and Taos Counties—Rio Arriba County is consistently the county with the highest overdose death rate in the United States. From 2012 to 2016, the mortality rate in Rio Arriba County is almost 90 per 100,000. Recent discussions with tribal members reinforce the requirement that historical trauma will inform the development of overdose prevention projects with the Pueblos and be led by the community. Intervention and prevention programs will be coordinated with the Indian Health Service. This collaboration is already in place with the central hub through the ECHO project. Incorporation of current trainings and consultation regarding OUD treatment, addiction and Chronic pain, etc. are present in the STR. Finally, the State behavioral health department currently holds a liaison position to ensure incorporation of tribal health agencies and "638s" and use of this liaison will occur to disseminate training materials from the STR.

State	State Plan Information on Tribal Engagement
New York	A targeted media campaign is being supported. The objectives are to: (1) conduct listening forums for input in developing targeted media campaigns; (2) deliver statewide media campaigns that include Native American communities; (3) media will focus on radio, television, digital, and social media; and (4) customized messages will focus on opioid overdose prevention to raise awareness of the opioid crisis, educate target populations on the risks and dangers of opioid use; and inform individuals on how to seek and access appropriate treatment and recovery services.
North Dakota	The action items within the strategic plan are inclusive of tribal nations. Proposals have been received from two tribal nations to increase access to MAT through the utilization of telehealth.
Oklahoma	Targeted media campaign
South Dakota	Develop educational materials that are culturally sensitive for Native Americans, and work with providers and service agencies to utilize those materials. Draft and issue a request for proposals for a vendor to develop materials and distribution. Select vendor and execute agreement/implement scope of work. Distribute materials/videos to Native American communities through education and medical services.
Washington	Tribal Entities are part of the strategic planning process and are engaged in all of the strategic goals for both prevention and treatment.
Wisconsin	STR funding has been awarded to tribal entities through application process to provide SUD/MAT. Other STR funding initiatives will focus on working within tribal communities. Areas of interest we are aware of from tribes are recovery coaching, naloxone training/distribution, prevention, and looking to expand OUD treatment. The application process for Wisconsin counties and tribes is complete to apply for STR funds to provide MAT, counseling and recovery support for individuals on their waitlists. Approximately \$2.4 million was awarded to 19 counties and tribes who will be able to provide MAT for 841 additional Wisconsin residents with OUDs.
Wyoming	Treatment and prevention activities are targeted for the Wind River Reservation. Volunteers of America possesses a working relationship with Indian Health Service and has expressed intentions in their application to enhance that relationship to better serve those populations. VOA is a Wellbriety Certified Treatment Center through White Bison, Inc. VOA's certification further enforces a positive working relationship between the treatment center and regional tribes/tribal entities by utilizing culturally appropriate interventions.

Question 4c. Does SAMHSA have an estimate of what percentage of the funding awarded to the states identified in response to part (a) is being used for those tribal-specific portions of the STR plans? If so, please provide that estimate.

Answer. This level of detail is not required in the STR budgets as tribal participation is not a statutory requirement.

Your written testimony notes, “We have heard from tribal leaders that SAMHSA also has a responsibility to improve tribal-state relationships.” It then describes two efforts undertaken by the Agency and Assistant Secretary McCance-Katz in response to this tribal feedback—hosting a Tribal-State Policy Academy (TSPA) and a letter to state governors.

Question 5a. Please provide more specific information about the TSPA, including any available information on participation, tentative dates or locations, and goals for the event.

Answer. The TSPA is part of SAMHSA’s approach for supporting improvements in tribal-state relations as well as advancing a more comprehensive and collaborative approach to addressing opioids and other substances of abuse in tribal communities. This first academy is planned for August 2018 and will include approximately 100 participants (50 state and 50 tribal representatives). Tribes and states with varying levels of engagement have been identified and planning is underway.

On February 28, 2018, Assistant Secretary McCance-Katz sent a letter to governors with federally-recognized tribes within their borders. The letter shared the disproportionate impact of substance abuse on tribal communities and that addressing the behavioral health of American Indians and Alaska Natives is a priority. The letter further called upon governors to ensure that tribes, tribal organizations, and American Indians and Alaska Natives are engaged and involved in state programs in a meaningful and beneficial manner. These programs include the Substance Abuse Prevention and Treatment Block Grant and State Targeted Response to the

Opioids Crisis Programs. The collaborative plans developed through the TSPA will help advance the intent of Assistant Secretary McCance-Katz's letter.

Question 5b. How will SAMHSA and Assistant Secretary McCance-Katz ensure that any TSPA-identified best practices/takeaways are shared with states and tribes that are not able to participate directly?

Answer. Outcomes from the TSPA will be shared with tribes and states immediately following the academy and as tribes and states complete their plans. Multiple channels will be used to disseminate information about the tribal-state plans and all completed plans will be posted on SAMHSA's website to facilitate access.

Question 5c. What other plans or initiatives, if any, does SAMHSA or Assistant Secretary McCance-Katz plan to undertake to improve state-tribal coordination for behavioral health challenges that impact both state and tribal communities?

Answer. Technical assistance for tribal and state collaborators is planned following the TSPA to support continued engagement and progress on their plans. Two additional TSPAs are proposed to ensure that the remaining tribes and states are afforded an opportunity to develop collaborative plans. SAMHSA is also identifying opportunities for engaging tribes and states such as the State Block Grant Conference and other Agency events.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP TO
CAPTAIN CHRISTOPHER JONES

Tribal Access to SAMHSA Grants

It is my understanding tribes must apply through their respective states to access State Targeted Response (STR) funds made available in the Cures Act. I worked with colleagues to introduce legislation to address this barrier for tribes and increase STR resources—the Opioid Response Enhancement Act (S. 2437) with Senator Baldwin.

Question 1a. How can we better ensure tribes have access to these funds?

Answer. By statute, eligibility for the State Targeted Response to the Opioids Crisis (Section 1003 of the 21st Century Cures Act) grant program is limited to states. However, on February 28, 2018, Assistant Secretary McCance-Katz sent a letter to governors of states with federally-recognized tribes within their borders. The letter shared the disproportionate impact of substance abuse on tribal communities and that addressing the behavioral health of American Indians and Alaska Natives is a priority. The letter further called upon governors to ensure that tribes, tribal organizations, and American Indians and Alaska Natives are engaged in state programs in a meaningful and beneficial manner. These programs include the Substance Abuse Prevention and Treatment Block Grant and State Targeted Response to the Opioids Crisis Programs.

SAMHSA continues to work with states to encourage them to ensure tribes have access to these funds and to monitor states' compliance with their plans as noted in the following State Plan Information on Tribal Engagement. (See Table in Senator Udall's questions)

Additionally, the Consolidated Appropriations Act, 2018 included a \$50 million set-aside in the State Opioid Response Program for tribal awardees.

Question 1b. What feedback have you received from tribal communities on the types of collaborations, technical assistance, and flexibility they need to ensure STR funds are best serving their communities?

Answer. As noted in written testimony, tribal leaders have communicated to SAMHSA their desire to see improvements in tribal-state relationships. In response, SAMHSA has issued the letters to state governors noted above, reestablished the Addiction Technology Transfer Center (ATTC) Program: American Indian and Alaska Native Support Center Cooperative Agreement and will be hosting a Tribal-State Policy Academy (TSPA) to improve collaborative relationships.

The TSPA is part of SAMHSA's approach for supporting improvements in tribal-state relations as well as advancing a more comprehensive and collaborative approach to addressing opioids and other substances of abuse in tribal communities. This first academy is planned for August 2018 and will include approximately 100 participants (50 state and 50 tribal representatives). Tribes and states with varying levels of engagement have been identified and planning is underway.

Outcomes from the TSPA will be shared with tribes and states immediately following the academy as tribes and states complete their plans resulting from the TSPA. Multiple channels will be used to disseminate information about the tribal-state plans and all completed plans will be posted on SAMHSA's website to facilitate access. Technical assistance for tribal and state collaborators is planned fol-

lowing the TSPA to support continued engagement and progress on their plans. Two additional TSPAs are proposed to ensure that the remaining tribes and states are afforded an opportunity to develop collaborative plans. SAMHSA is also identifying opportunities for engaging tribes and states such as the State Block Grant Conference and other Agency events.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
RADM MICHAEL TOEDT

Opioid Prescription Monitoring

Question 1. Your written testimony states that IHS has Prescription Drug Monitoring Program (PDMP) partnerships with 17 out of 18 states where federally-operated IHS facilities are located. Please identify the state with which IHS does not have a partnership. When does IHS anticipate that it will finalize a partnership with that state?

Answer. Since August 2016, Indian Health Service (IHS) has worked closely with the State of Nebraska to develop a Memorandum of Understanding (MOU) for a PDMP partnership. In 2018, Nebraska changed its PDMP to a web-based system that will now allow IHS pharmacies to access the PDMP. IHS is waiting for the state to sign the MOU and has been told it is “on the roadmap in 2018.” IHS is eager to start reporting dispensing data to the State of Nebraska.

Question 1a. Does IHS track whether states are working with tribally operated facilities and Urban health programs on PDMP database access?

Answer. IHS does not track states’ work with tribal or Urban Indian Organizations on PDMP access.

Question 1b. What is IHS doing to help tribally-operated facilities and Urban IHS facilities develop similar partnerships with states to access their PDMP databases?

Answer. IHS responds to requests for information from tribal/urban IHS facilities that are interested in developing MOUs with state PDMPs. Information includes state key contacts, MOU language, and assistance explaining requirements, and Health Insurance Portability and Accountability Act provisions related to PDMP reporting. Technical assistance is provided to tribal facilities that utilize the IHS Electronic Health Record (EHR), Resource Patient Management System (RPMS).

Question 2. In FY 2017, Congress gave IHS \$1 million to develop its own PDMP database. Your testimony mentions the ongoing development of a “data reporting system.” Is the “data reporting system” mentioned in your testimony the same as the PDMP system for which Congress appropriated \$1million in FY2017?

Answer. The data reporting system referred to in the testimony is an application developed by IHS called “Safe Opioid Monitoring.” It differs from a PDMP in that it does not provide individual patient and prescriber level data.

The “Safe Opioid Monitoring” software extracts data from the IHS National Data Warehouse including opioid prescription rates, naloxone utilization, methadone prescriptions, and percentage of opioids prescribed compared to all prescriptions. This tool allows IHS to compile selected data into user friendly reports used to monitor opioid metrics by service unit and area, to determine trends within IHS. These reports identify trends and potential areas of concern that require a deeper look.

Question 2a. What is the status of IHS’s efforts to launch its own PDMP system?

Answer. IHS is working with the states to report to PDMPs through their systems and is in the planning phases for FY 2018 PDMP funding to enhance our current interoperability of PDMP reporting.

Question 3. The National Indian Health Board’s testimony states that the Board is not aware of any tribally-specific PDMP system. Their testimony goes on to state that the organization is not aware of IHS’s efforts to utilize the FY 2017 funding for development of such a system. Is IHS communicating with tribes and urban Indian health programs about its efforts to develop a more robust tribal PDMP system? If so, how?

Answer. Yes. In FY 2017, IHS transferred funding as tribal shares to support tribal PDMP improvements.

In addition, tribes that use the IHS EHR/RPMS have access to the IHS PDMP platform and have the ability to submit data to state PDMPs. As RPMS PDMP improvements are implemented, IHS communicates the instructions for installation and related procedures for the software updates to all RPMS users, including the tribes.

Secondary Public Health Implications

Question 4. According to a recent report highlighted by the Centers for Disease Control and Prevention, the increase to the growing number of intravenous drug users, including intravenous opiates, correlates to a simultaneous increase in acute hepatitis C infections.¹ Does IHS have any data on changing numbers of IHS patients presenting with opioid or substance abuse-related blood borne infectious diseases like hepatitis C or HIV/AIDS? If so, please provide a summary of that data.

Answer. IHS does not have data on the changing numbers of IHS patients presenting with opioid or substance abuse-related blood borne infectious diseases like hepatitis C (HCV) or HIV/AIDS. Moreover, IHS does not have the ability to monitor this correlation with its existing EHR infrastructure or personnel. However, IHS, in collaboration with the Centers for Disease Control and Prevention (CDC), is currently undertaking a vulnerability study looking at the risk of HIV or HCV transmission from injecting drug use.

Question 4a. Is IHS aware of any other increases in secondary health complications related to rising rates of substance abuse (e.g., neonatal abstinence syndrome, respiratory illnesses, etc.)? If so, please provide a summary and description of any such secondary health complications.

Answer. The IHS is in the process of quantifying the impact of secondary health complications related to opioids and developing strategies to reduce these health complications, such as Neonatal Abstinence Syndrome (NAS), or also known as Neonatal Opioid Withdrawal Syndrome (NOWS).

Question 4b. Does IHS have a plan to address any of the increased demand caused by any increase in secondary health complications related to rising rates of substance abuse discussed above? If so, please provide a description of the plan here.

Answer. The HHS five point strategy to address the opioid crisis in the United States is central to our response to increased demand. This includes:

- Improving access to prevention, treatment, and recovery support services, including medication-assisted treatment;
- Targeting the availability and distribution of overdose-reversing drugs;
- Strengthening our understanding of the epidemic through better public health data and reporting;
- Supporting cutting edge research on pain and addiction; and
- Advancing better practices for pain management.

As part of the overall HHS strategy, IHS believes in a holistic approach integrating physical, mental, spiritual, and cultural components is essential to addressing substance use prevention, treatment, and recovery.

The IHS established the Heroin, Opioids, and Pain Efforts (HOPE) Committee to ensure appropriate and effective pain management, reduce overdose deaths from heroin and prescription opioid misuse, and expand access to culturally appropriate treatment. The HOPE response includes creating guidelines, endorsing best and promising practices surrounding secondary complication of opioid use, creating training modules for ITU providers, as well as developing mechanisms to track impact of these interventions. In addition to the HOPE Committee, IHS has involved all of the departments within the Agency to be more responsive and effective in addressing all needs related to substance use, including secondary health complications.

Specific to HCV, IHS provided all IHS facilities with *Guidelines for Screening, Management and Pre-Treatment for HCV* that can be modified as needed for local or regional use. This guideline follows national recommendations from established authorities such as the United States Preventive Services Task Force, CDC, and the American Association for the Study of Liver Diseases. In October 2017, the IHS Chief Medical Officer convened the first ever IHS, tribal, and urban Hepatitis C Elimination Workgroup, which informs overall federal responses and strategies.

The IHS also actively collaborates with other federal agencies through MOAs to leverage resources and provide more coordinated approaches to the substance use crisis. For example, IHS is collaborating with the American Academy of Pediatrics Committee on Native American Child Health to develop guidelines to manage NOWS including early identification and referral of mothers with suspected opioid

¹Zibbell, Jon E., et al. "Increases in Acute Hepatitis C Virus Infection Related to a Growing Opioid Epidemic and Associated Injection Drug Use, United States, 2004 to 2014." *American journal of public health* 0 (2018): e1-e7.

use disorders, obstetric care and delivery at IHS facilities, and care and treatment of babies born with NOWS.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP TO
RADM MICHAEL TOEDT

Rear Admiral Toedt, during the opioid roundtable the Committee held in November, there were a couple of points mentioned that you said you would look into, and I'd like to follow up on those.

Question 1. Vice Chairman Headdress of the Fort Peck Assiniboine and Sioux Tribes asked why service units or tribes can't funnel some of their purchase and referred care (PRC) dollars for prevention and treatment of opioid misuse, if they have adequate means from third-party billing. Is this a matter of flexibility or a matter of resources for IHS?

Answer. The Indian Health Service (IHS) consulted with tribes on whether or not there should be a set-aside of Purchased/Referred Care (PRC) funds for prevention services. Input from this consultation indicated support for funding more prevention services. With this in mind, IHS Areas or Service Units, in consultation with the tribes, can decide whether they want to set-aside a percentage of their PRC program funds for prevention services. This would apply to either individual patient referrals at the local IHS Service Unit or for area-wide prevention services available to all IHS Service Units. The IHS area office and local tribes would have to consult and decide on the best approach.

Question 2. I also asked you what IHS is doing to build resources to license practitioners to dispense methadone. You said you would get back to me on how many providers of Medication Assisted Treatment (MAT) there are within IHS and where they are located. Have you looked into this?

Answer. Medication Assisted Treatment (MAT) with methadone is provided through Opioid Treatment Programs (OTPs), which are certified by the Substance Abuse and Mental Health Services Administration, registered by the Drug Enforcement Administration, and licensed by the state. MAT cannot be provided through office-based settings that are not OTPs. IHS has focused on buprenorphine containing products for MAT that are provided through office-based opioid treatment. This form of office-based MAT has been very effective in the treatment of opioid use disorders.

Additionally, IHS is in the process of implementing a robust medical staff credentialing platform that will deliver the capability to query a national database to determine the number of federally-credentialed IHS prescribers with Drug Addiction Treatment Act of 2000 (DATA) waivers.

IHS has collected information from its federal facilities and identified 21 providers who have a DATA waiver and are actively prescribing MAT in the following locations: Jicarilla Apache Health Care Facility in Dulce, New Mexico; Gallup Indian Medical Center in Gallup, New Mexico; Northern Navajo Medical Center in Shiprock, New Mexico; Hopi Health Center in Polacca, Arizona; Fort Duchesne Indian Health Center in Fort Duchesne, Utah; Southern Bands Health Center in Elko, Nevada; and Whiteriver Indian Hospital in Whiteriver, Arizona. In addition to these federal locations, it is important to note that MAT services are also provided through a combination of tribal, direct, and contract health services.

IHS supports tracking buprenorphine prescriptions and acquisitions data for buprenorphine containing products. While IHS is in the final stages of implementing its Safe Opioid Monitoring data mart, preliminary data reveals that buprenorphine prescriptions have increased significantly. With the completion of this data mart, IHS will be able to determine the number of facilities providing buprenorphine directly to patients from IHS pharmacies.

Question 3. Can you share the progress in data sharing and two-way communication between IHS and state Prescription Drug Monitoring Programs (PDMPs)?

Answer. IHS has initiated a process to report (share data) and query (receive data) with Prescription Drug Monitoring Program (PDMP) partnerships in 17 out of 18 states where federally-operated IHS facilities are located. IHS is actively pursuing partnership with the last state to implement PDMP data sharing across all IHS pharmacies and state PDMPs.

Question 4. When do you expect the IHS Strategic Plan will be finalized and published?

Answer. The *IHS Strategic Plan FY 2018-2022* is expected in September 2018. A final release date is subject to the feedback received during a 30-day public comment period, including comments from tribes and Urban Indian Organizations.

On September 15, 2017, IHS consulted and conferred with tribes and Urban Indian Organizations on the IHS Strategic Plan. An initial framework was developed and IHS requested comments from tribal and Urban Indian Organization leaders, and IHS employees, through October 31, 2017. In November 2017, an IHS-tribal workgroup was formed to review the hundreds of submitted comments and recommendations. Over a four month period, the workgroup developed recommendations that form the basis of the draft *IHS Strategic Plan FY 2018–2022*. IHS is in the process of finalizing a Federal Register Notice (FRN) asking for comments on the draft IHS Strategic Plan FY 2018–2022. The FRN is expected to be published in July 2018. IHS plans to conduct tribal consultation and Urban Confer sessions on the draft IHS Strategic Plan in July and August.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP TO
STACY A. BOHLEN

Question 1. Mr. Moose, On Tuesday, March 13th I spoke on the phone with Secretary Azar about IHS and what they are doing to support and improve services. We talked about things like workforce recruitment and patient wait time data. One thing he said to me is that IHS/HHS should target a few top priorities from the IHS Quality Framework that was published in late 2016 and focus on those. In your opinion, what should the top three priorities be to improve patient experience and outcome and ensure the delivery of high quality health care?

Answer. Senator Heitkamp, thank you for the question and for your continued dedication to improving the quality of health services for all of Indian Country. Ensuring the delivery of the highest quality of care is a top priority across all IHS health service delivery areas, but is especially key in curbing the national opioid overdose epidemic. As you very well know, the excessive and often times indiscriminate prescribing of opioid analgesics for both chronic and acute pain symptoms were, and continue to be, a pervasive issue fueling the crisis. Within the Indian Health System, provider shortages—particularly behavioral health providers who have the knowledge and expertise in the intersection of addiction, mental illness and public health—have forced an overextended health workforce to be overly reliant on opioid medications to treat pain, as opposed to having opioid medications be the last resort. According to the IHS, the physician vacancy rate in 2014 was 22 percent nationally, with some areas experiencing far higher vacancy rates.

Access to care remains a critical need, but meeting quality of care goals are just as crucial. While we applaud the IHS for imposing new rules and procedures such as requiring all federally employed prescribers and dispensers to check the state prescription drug monitoring program, and updating the Indian Health Manual to align with the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain, much more needs to be done to improve the delivery of high quality health care. Issues include gaps in the availability and infrastructure of telemedicine, underfunded and understaffed substance use treatment facilities, low numbers of providers with waivers to prescribe buprenorphine for treatment of opioid use disorder, inconsistent access to naloxone, and low provider familiarity with and implementation of the CDC Guideline.

Undoubtedly, all five of the quality priorities embedded within the 2016 IHS Quality Framework are essential if we are to stem the tide of this epidemic. Within the context of the opioid overdose epidemic, the three most critical priorities are to:

- 1.) Strengthen Organizational Capacity to Improve Quality of Care and Systems
 - Providers need more training and education on the CDC Guideline and on the signs, symptoms and risk factors for substance misuse, addiction and overdose. Given that providers are at the frontlines of this epidemic, it is critical that concerted investments be made towards raising provider capacity to effectively deliver care to patients in need of pain management.
- 2.) Align Service Delivery Processes to Improve Patient Experience
 - IHS efforts to align their policies with the CDC Guideline are an important step towards ensuring accountability and consistency in care. NIHB is hopeful that these changes will lead to reductions in overprescribing, but much more needs to be done to improve the patient experience overall. For instance, high provider turnover and chronic workforce shortages pose significant barriers and create disparities in the quality of care. In addition, limited attention to wraparound and comprehensive care that includes mental health treatment, case management, job training and housing services mean that patients are encountering gaps across the care continuum.

3.) Ensure Patient Safety

- The crux of reducing unsafe and ineffective prescribing of opioids is ensuring patient safety. Too often has provider misconduct and malpractice led to tragic and yet largely preventable deaths within the Indian Health System. NIHB encourages Congress to review reports from the United States Department of Health and Human Services Office of Inspector General on deficiencies in system security and physical controls at IHS hospitals and how this impacts patient safety.

Responses to the following questions were not available at the time this hearing went to print

WRITTEN QUESTIONS SUBMITTED BY HON. TOM UDALL TO
HON. JOHN C. ANDERSON

Opioid Funding and Utilization in Indian Country

Question 1. The Department of Justice’s FY2019 Budget Request summary states, “[The Department’s FY2019 Budget Request] provides the needed resources so that Federal, state, local and tribal law enforcement agencies can fight the opioid epidemic that is destroying neighborhoods.”¹

- Please summarize how this Budget Request reflects the stated goal of addressing the opioid epidemic in tribal communities.
- What additional law enforcement and prosecution resources, if any, does this Budget Request propose specifically for tribal communities?
- Did the Department consult with tribes about design of the opioid epidemic response proposals included in this Budget Request?
- Did the Department, its budget and performance personnel, its law enforcement agencies, or the Executive Office for United States Attorneys coordinate with the Department of the Interior’s Bureau of Indian Affairs-Office of Justice Services in the design of proposals for Indian country in this Budget Request?

Question 2. Your written testimony states, “An important element of the Department’s support [for response to the opioid crisis] is providing opportunities for funding.” It goes on to include several references to Department programs that grantees can use to address the opioid crisis—including Drug Courts funding and Office of Justice Programs’ Comprehensive Opioid Abuse Program. The testimony highlights two tribal grantees under these programs. Please provide detailed information on how much funding the Department awards to tribal grantees for drug courts and substance abuse prevention, including a list of tribes that receive such funds and estimates of the amount of funding available to each such tribal grantee.

Investigations and Prosecutions of Crimes on Indian lands

Question 3. At the hearing, several Members of the Committee discussed case referral statistics included in a December 2017 report issued by the Department’s Office of the Inspector General.² This report includes a description of the numbers of investigations referred to U.S. Attorney Offices (USAOs) for prosecution by various law enforcement agencies.

- Please provide an estimate of the number of investigations referred to USAOs by the Bureau of Indian Affairs, the Drug Enforcement Administration, the Federal Bureau of Investigation, and Tribal law enforcement in CY 2015, CY 2016, and (if available) CY 2017.
- Please provide information on the types of investigations most frequently referred to USAOs by the law enforcement agencies listed in part (a) and, if possible, an estimate of the percentage of referred cases that are related to drug crimes.

Question 4. The same report notes that the number of declinations for prosecution of crimes in Indian country by USAOs increased by 20 percent from CY 2013 to CY

¹Staff of Dep’t of Just., 2019 Budget Summary (2018). Available at <https://www.justice.gov/jmd/page/file/1033086/download#page=2>.

²Staff of Dep’t of Just., Review of the Department’s Tribal Law Enforcement Efforts Pursuant to the Tribal Law and Order Act of 2010 11 (2017). Available at <https://oig.justice.gov/reports/2017/e1801.pdf>.

2015.³ Please provide an estimate of the number of declinations and the number of defendants against whom charges were filed for crimes in Indian country nationally in CY 2016 and, if available, CY 2017.

WRITTEN QUESTIONS SUBMITTED BY HON. HEIDI HEITKAMP
HON. JOHN C. ANDERSON

Question 1. I hear one consistent from all five tribes in North Dakota when it comes to drugs—not just opioids—but drugs in general. . . . “Please help us, we are being overrun”. I know the jurisdictional challenges, the lack of law enforcement on the reservations, little to no DEA presence, lack of detention and treatment facilities, and the tendency for U.S. Attorney’s Offices to not pursue dealers arrested with small quantities on the reservation.

(a) When you hear and know all of this—do you think we can honestly say that we are upholding our treaty responsibilities to our tribes? Do you truly think that the Department of Justice is doing everything it can to shut down the drug trafficking problem in Indian Country?

(b) Do you think we need more FBI and DEA agents available to assist in these types of crimes and investigations in Indian Country in order to stem the flow of illicit drugs? Do you agree that FBI and DEA agents should be forming relationships with our tribes and operating on the reservation as much as possible as opposed to only responding in a crisis or in response to a major crime?

(c) You mentioned HIDTA Drug Task forces in your testimony—do you know how many of these task forces are currently operating within Indian Country? My understanding is that right now in North Dakota the number is zero—is that acceptable if we all admit that there is a problem of illicit drugs flowing freely into and through Indian Country?

(d) DOJ also has Safe Trails Task Forces that are specifically focused on combating in crime in Indian Country—do you know how many Safe Trails Task Forces we have in North Dakota? Zero. So why is DOJ not doing everything in their power to stand up as many of these Task Forces as possible to address the supply side of the illicit drug problem in Indian Country?

WRITTEN QUESTIONS SUBMITTED BY HON. LISA MURKOWSKI
HON. JOHN C. ANDERSON

Thank you Mr. Chairman and gentlemen thank you all for what you do, respectively. I apologize I was not able to hear some of the questions from my colleagues. But again, these are issues that are so key and so important and I appreciate your testimony. Thank you Captain Jones for mentioning the Project Hope Program and how it is working or helping in Alaska. In my opening statement, I didn’t just talk about the opioid epidemic and how that’s ravaged our communities. I also talked about alcohol and how it seems to be an underlying issue in Alaska.

I will just cite to our annual drug report that says acknowledges there is a multifaceted drug abuse problem in the state and that drug abusers in Alaska tend to abuse more than one substance. Often times they are abusing multiple drugs at once. The Alaska State Troopers emphasized in their report that alcohol was the single most abused substance. So as we have been focusing our efforts here in Congress on opioids, I don’t want us to lose sight of the fact that there is an underlying issue and that is alcohol. We have to provide the support for programs and grants in that alcohol space as well and so when we’re talking about substance abuse, we have to make sure that we are talking about alcohol and substance abuse programs, too. Everyone in the crowd is shaking their heads, like they agree with me.

We don’t need to bifurcate all of these drug issues. We all have one big, ugly, horrible problem that we are dealing with. Let me ask you this, I’ll call it a workforce issue, but our reality is that we have identified the problem and some of the solutions. But, we know that so much of this comes back to making sure that we have mental health professionals that are able to be there to and support those who need it. I have been working with my colleague from Indiana, Senator Donnelly, on an effort that would incentivize those to go into the field and work to find the best treatments for substance use disorders. Basically, it’s a loan forgiveness program that we think will be helpful in incentivizing more people to enter the mental health profession. I have to assume that part of the challenges that we’re facing is we sim-

³*Id.* at 10.

ply don't have enough mental health professionals to address the substance abuse epidemic in the United States. I'm also getting head nods for this too.

Question. So, here's my question to you and this is this is intended to help at least three individuals that are in the audience. One of which I have met with and she is the Mayor of Utqiagvik. She, and two others that are part of her council, met with us today and they've mentioned that Utqiagvik has an issue with drugs, not just opioids. They said that we can't single out a single drug from a law enforcement perspective and I'll look to you Mr. Anderson to answer this. They are saying that they don't have a district attorney and they're (the City of Utqiagvik) is responsible for the prosecution of these drug offenses and they are not moving forward as fast as they would like because the drugs are coming in by mail the drugs and by plane. And that's it. We know how they get in, but because we can't get attention on anything unless it's at full federal, full felony level, that people think they can get away with selling and dealing. They can use and there's no here's no follow up and no consequence. What would you tell the Mayor of Utqiagvik?

