

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT HEARING ON

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

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Chairman and Members of the Committee:

Good afternoon, I am Robert G. McSwain, Principal Deputy Director of the Indian Health Service.

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

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

Introduction

The economic costs of alcohol and drug misuse are enormous. The Centers for Disease Control and Prevention estimated the costs of excessive alcohol consumption in 2006 to be \$223.5 billion in lost productivity, healthcare, and criminal justice costs.¹ According to the National Drug Intelligence Center, in 2007 alone, illicit drug use cost our Nation more than \$193 billion in lost productivity, healthcare, and criminal justice costs.² However, examining the true costs of alcohol and illicit and nonmedical prescription drug use for Native communities is challenging, although we know it is substantial. In the absence of studies on the scope and costs of alcohol and drug misuse for Native communities, IHS depends largely on measures of prevalence, morbidity, and mortality related to alcohol and drug misuse for American Indians and Alaska Natives (AI/AN). In 2007-2009, the AI/AN age-adjusted death rates for the following causes were considerably higher than those for the U. S. all races population in 2008:³

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

While these data are staggering, IHS data have shown improvements in the age-adjusted alcohol-related death rate for AI/AN people in recent years with rates decreasing from 77.5 per 100,000 people between 1979-1981 to 49.6 in 2007-2009 per 100,000 population. However, the age-adjusted drug-related death rate for AI/AN residing in IHS service areas increased from 4.1 deaths per 100,000 in 1979-1981 to 22.7

¹ Available at: <http://www.cdc.gov/features/alcoholconsumption/>

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

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

in 2007-2009. By comparison, the 2007-2009 age-adjusted drug-related death rate is 1.8 times greater than the U.S. all races rate for 2008. These data speak to the need for a public health strategy, informed by Tribes, to address alcohol and drug use. The human cost is too great to ignore this problem.

IHS Alcohol and Substance Abuse Program

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

Treat Individuals Struggling with Substance Use Disorders

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

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

⁵ *Ibid*

American Indian students' annual heroin and OxyContin use was about two to three times higher than the national averages in those years.⁶

To help youth with substance use disorder, IHS funds ten Youth Regional Treatment Centers (YRTC). The YRTCs provide a range of clinical services to provide treatment services rooted in culturally relevant, holistic models of care including group, individual, and family psychotherapy, life skills development, medication management, aftercare relapse prevention, and post-treatment follow up. YRTCs also provide education, culture-based prevention activities, and evidence- and practice-based models of treatment to assist youth in overcoming their challenges and to become healthy, strong, and resilient community members.

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

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

Train Healthcare Providers to Identify Substance Use and Intervene Early

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

Screening, Brief Intervention, Referral to Treatment (SBIRT) is a comprehensive approach for early intervention and treatment for people with substance use disorders and those at risk of developing these disorders. IHS is broadly implementing SBIRT as an evidence-based practice designed to identify, reduce, and prevent problematic use, substance use disorders, and dependence on alcohol. SBIRT is a payable service under state Medicaid plans, while Medicare pays for medically reasonable and necessary SBIRT services in the physician office setting and outpatient hospitals through the Medicare Physician Fee Schedule or the hospital Outpatient Prospective Payment System. Another activity IHS is developing

promoting is Medication Assisted Treatment (MAT) for opioid use disorder, which uses Food and Drug Administration approved pharmacological treatments, in combination with psychosocial treatments. IHS will continue to provide the necessary MAT training through its TBHCE.

Prevent Alcohol and Drug Use Before It Begins

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

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

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

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

Federal Coordination to Address Indian Alcohol and Substance Use Disorders

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

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

substance misuse, child abuse, and family violence.

Conclusion

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