DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT

OF

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BEFORE THE

SENATE COMMITTEE ON INDIAN AFFAIRS

ON

"ADDRESSING HARMFUL EFFECTS OF DANGEROUS DRUGS ON NATIVE COMMUNITIES"

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STATEMENT OF THE INDIAN HEALTH SERVICE

Mr. Chairman, Mr. Vice Chairman and Members of the Committee:

Good morning. I am Robert McSwain, Acting Director of the Indian Health Service (IHS). I am accompanied by Susan V. Karol, M.D., IHS Chief Medical Officer, and Beverly Cotton, DNP, Director of the Division of Behavioral Health. I appreciate this opportunity to appear before the Committee on behalf of the IHS to offer the Agency's efforts on addressing the harmful effects of dangerous drugs in American Indian and Alaska Native (AI/AN) communities.

As you know, the IHS plays a unique role in the U.S. Department of Health and Human Services (HHS) to meet the Federal trust responsibility to provide health care to AI/AN people. The IHS provides comprehensive health service delivery to 2.2 million American Indians and Alaska Natives through a system of IHS, Tribal, and urban Indian operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. The mission of the agency is to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level, in partnership with the population we serve. The agency aims to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to the service population. Our foundation is to promote healthy AI/AN people, communities, and cultures, and to honor the inherent sovereign rights of Tribes.

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, P.L.67-85, and the Indian Health Care Improvement Act (IHCIA), P.L.94-437, as amended. 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.

The IHS, in partnership with Tribes and Urban Indian health programs, provides essential medical and mental health services. These services include medical and surgical inpatient care, ambulatory care, mental health and substance abuse treatment and prevention, and medical support services such as laboratory, pharmacy, nutrition, diagnostic imaging, medical records, and physical therapy. Other services include public and community health programs to address issues such as diabetes; maternal and child health; communicable diseases such as influenza, HIV/AIDS, tuberculosis, and hepatitis; suicide prevention; substance abuse prevention; women's and elders' health; domestic violence prevention and treatment; and regional trauma/emergency medical delivery systems.

The widespread use of illicit drugs is staggering nationwide. In 2013, an estimated 24.6 million Americans aged 12 or older were current illicit drug users.[1] Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics (pain relievers, tranquilizers, stimulants, and sedatives) used non-medically.[2] Among persons aged 12 or older, the rate of current illicit drug use was 12.3 percent among American Indians or Alaska Natives.[3]

A review of the literature reveals the problem of methamphetamine use in AI/AN communities has not been widely studied by the academic and scientific community. However, Tribes and AI/AN organizations report regularly on the seriousness of the epidemic in AI/AN communities. Methamphetamine is a low cost, highly addictive stimulant drug. Its introduction to already at-risk AI/AN communities destabilizes and disrupts entire health and social systems. Chronic methamphetamine abusers may display psychotic manifestations, including paranoia, visual and auditory hallucinations, and delusions.[4] Persons abusing methamphetamine are at higher risk of contracting HIV, hepatitis, and other sexually transmitted diseases.[5] In Fiscal Year (FY) 2014, there were over 31,000 methamphetamine-related encounters in the Indian health care system.[6] Funds to address the methamphetamine problem were appropriated by Congress in 2008 to

[1] Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
[2] *Ibid.*
[3] *Ibid*
[4] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2014). *The DAWN Report: Emergency Department Visits Involving Methamphetamine: 2007 to 2011*. Rockville, MD.
[5] *Ibid*
[6] U.S. Department of Health and Human Services. Indian Health Service, Division of Behavioral Health. (2015). *Methamphetamine Encounters Report for Fiscal Year 2014.* Behavioral Health Data Mart and Reporting System.

allow IHS to develop pilot programs and potential larger scale interventions for Indian Country.

In September 2009, Congress appropriated funds to IHS to address the dual crises of methamphetamine abuse and suicide in AI/AN communities. As a result, the IHS began the Methamphetamine and Suicide Prevention Initiative (MSPI), a pilot demonstration project for IHS, Tribal, and Urban Indian health programs. Funded projects focused the scope of their activities on the issue facing their communities. Approximately 20 percent of MSPI projects address methamphetamine use and abuse and 80 percent of MSPI projects focus on suicide prevention. The MSPI supports the use and development of evidence-based and practice-based models which are culturally appropriate prevention and treatment approaches to methamphetamine abuse and suicide in a community driven context. The MSPI supports 130 programs across the country. The seven guiding principles of the MSPI are to effectively prevent, reduce, or delay the use and/or spread of methamphetamine abuse; build on the foundation of prior methamphetamine and suicide prevention and treatment efforts to support the IHS, Tribes, and Urban Indian health organizations in developing and implementing Tribal and/or culturally appropriate methamphetamine and suicide prevention and early intervention strategies; increase access to methamphetamine and suicide prevention services; improve services for behavioral health issues associated with methamphetamine use and suicide prevention; promote the development of new and promising culturally and community relevant services; and demonstrate efficacy and impact. From 2009 to 2014, the MSPI resulted in over 9,400 individuals entering treatment for methamphetamine abuse; more than 12,000 substance

abuse 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] Tribes on the Fort Washakie reservation in the State of Wyoming have contributed to the success of the MSPI. The Eastern Shoshone Tribe works to increase access to methamphetamine prevention and treatment services, while the Northern Arapaho Tribe provides support to the White Buffalo Recovery Center for methamphetamine addiction treatment. The IHS is thankful to both of these Tribes, and the many others participating in the MSPI, for their continued work and support to serve the people of their communities in substance abuse treatment.

The FY 2016 Budget includes key investments to launch Generation Indigenous, an initiative addressing barriers to success for Native American youth. This integrative, comprehensive, and culturally appropriate approach across the Federal Government will help improve lives and opportunities for Native American youth. The HHS Budget Request includes a new Tribal Behavioral Health Initiative for Native Youth with a total of $50 million in additional funding for IHS and SAMHSA. Within IHS, the request includes $25 million to expand the successful Methamphetamine and Suicide Prevention Initiative 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. The Budget includes a $25 million increase for SAMHSA to support mental health promotion and substance use prevention activities for

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

high-risk Native youth and their families, enhance early detection of mental and substance use disorders among Native youth, and increase referral to treatment. These activities will both fill gaps in services and fulfill requests from tribal leaders to support Native youth.

The non-medical use of prescription drugs and its consequences have been a major public health problem for the Nation and in Indian Country. Recognizing that prescription drug abuse and deaths due to overdose from prescription medications are national public health concerns, the IHS convened a national Prescription Drug Abuse, or PDA, workgroup at the IHS National Combined Councils meeting in Rockville, MD, on July 11, 2012. The workgroup developed a number of recommendations that were grouped around six focus areas: patient care; policy development/implementation; education; monitoring; medication storage/disposal; and law enforcement. The IHS PDA workgroup supports the HHS Assistant Secretary for Planning and Evaluation (ASPE) action plan to address the opioid and heroin related overdose, death, and dependence. This initiative has identified three priorities: providing training and education resources, including updated prescriber guidelines, to assist health professionals in making informed prescribing decisions; increasing use of naloxone; and expanding the use of medication assisted treatment (MAT).

Significant prevention strategies were developed as a result of the IHS PDA workgroup. Those strategies included improving medical practice in prescribing opioids by establishing a national IHS Chronic Non-Cancer Pain Management Policy in the Indian Health Manual and standardizing pain management formularies. The majority of healthcare providers receive

minimal education regarding addiction. Therefore, IHS developed a plan to require mandatory prescriber education. The mandatory training focuses on safe prescribing habits and treatment of chronic pain to reduce prescription drug diversion and deaths due to opiates.

IHS partnered with the Bureau of Indian Affairs to make naloxone, a drug for opiate overdose reversal to prevent deaths, available to first responders such as police officers and fire and emergency medical personnel working in Indian communities as a part of our overdose or "harm reduction" program. Additionally, IHS sponsors participation in state-based Prescription Drug Monitoring Programs to make data available to assist in reducing and preventing the misuse, abuse, and diversion of prescription controlled substances. IHS provides basic information for its healthcare providers about managing chronic pain – including opioid prescribing – through its IHS Pain Management website. The IHS also supports proper medical disposal through community outreach and "Prescription Drug Take-Back" events. The IHS PDA workgroup continues to be progressive by anticipating needs and developing best practices in advance of agency requirements. One example is an inter-agency PDA subgroup formed in 2014 by the IHS PDA workgroup. The subgroup consisted of representation from SAMHSA, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, National Institute on Drug Abuse, and other stakeholders. The subgroup developed a cross-agency approach to addressing prescription drug abuse in AI/AN communities. The resources developed in the cross-agency approach will be disseminated through SAMHSA to Tribes and key stakeholders involved in the work to combat prescription drug abuse.

Nationally, IHS participates as a Federal partner in the White House Office of National Drug Control Policy's Interagency workgroups and its *National Drug Control Strategy* to ensure that strategy implementation is informed by IHS and Tribal healthcare systems. IHS assists in specific objectives to support the *National Drug Control Strategy*, and IHS accounts for its drug control funding through annual Accounting and Performance Summary reports for National Drug Control Activities.

One performance measure supporting the National Drug Control Activities is the accreditation of IHS and Tribal Youth Regional Treatment Centers (YRTCs). To help youth battling substance abuse, IHS administers ten YRTCs that provide inpatient treatment for substance abuse and co-occurring mental health disorders among AI/AN youth. Compared with other racial/ethnic groups, AI/AN tend to use alcohol and drugs at a younger age, use them more often and in higher quantities, and experience more negative consequences from them.[8] One recent analysis of the 2005 and 2007 Youth Risk Behavior Survey found that 10.3 percent of AI/AN youth reported methamphetamine or heroin use at least once in their lifetime.[9] This has serious implications for disease prevention, as injection drug users have high rates of viral hepatitis C (HCV) infection with an estimated 64 percent chronically infected with HCV.[10]

[8] http://www.cdc.gov/hiv/risk/racialethnic/aian/
[9] Ramisetty-Mikler, S. and Ebama, M. S. (2011), Alcohol/Drug Exposure, HIV-Related Sexual Risk Among Urban American Indian and Alaska Native Youth: Evidence From a National Survey. Journal of School Health, 81: 671–679. doi: 10.1111/j.1746-1561.2011.00643.x
[10] Grebely and Dore. Prevention of Hepatitis C Virus in Injecting Drug Users: A Narrow Window of Opportunity J Infect Dis. (2011) 203 (5): 571-574.doi: 10.1093/infdis/jiq111

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.

IHS has also recognized an increasing prevalence of intrauterine drug exposure, Neonatal Abstinence Syndrome (NAS) and associated pediatric adverse childhood experiences (ACE) across Indian Country. NAS is a treatable syndrome which results after exposure to many prescribed drugs and heroin. This can happen whether these drugs are used non-medically or by prescription. In 2012, 44 percent of infants born in one AI/AN community were reported to be exposed to drugs and/or alcohol in utero: 37 percent involved opioids, with 50 percent of those exposures due to buprenorphine, and 15 percent of newborns were exposed to methamphetamine.[11] As a result of staggering figures such as these, IHS has instituted programs that promote positive and protective resiliency for early identification of childhood trauma for AI/AN children. IHS in partnership with the Committee on Native American Child Health developed recommendations on organizational practices to shape and improve the health and safety of AI/AN children. Also, IHS developed a local strategy on workforce development for healthcare providers and developed recommendations on the community education IHS should promote to reach people with information and resources to promote health and safety to reduce

[11] American Academy of Pediatrics Committee on Native American Child Health. (2013). *Child Health Consultation Visit Report, Blackfeet Service Unit.* Washington, DC.

childhood trauma and toxic stress. To improve maternal and child health, a team comprised of healthcare professional representation from obstetrics, pediatrics, nursing and behavioral health instituted best practices, policies and procedures for screening during the prenatal period, screening at birth, and treatment of NAS. Although NAS is costly to treat and unpleasant to witness when untreated, NAS should be regarded as an expected consequence of medication assisted treatment for women with substance use disorder. Moreover, NAS resulting from such treatment is highly preferable to pregnant women remaining untreated and unmonitored.

Alcohol is a teratogen, and alcohol consumption during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome Disorders (FASD). FASD can include abnormal facial features, brain damage, impaired growth, and cognitive and behavioral abnormalities. Individuals with FASD may have neurodevelopmental abnormalities, but no observable physical abnormalities. There is no known safe amount of alcohol, type of alcohol, or safe time during pregnancy to drink. To prevent FASD, a woman should not drink alcohol while she is pregnant, or when becoming pregnant is possible. [12] Other actions taken by IHS to prevent FASD include access to all FDA-approved contraceptives, pregnancy testing, prenatal care and alcohol use counseling. Health education on the dangers of fetal exposure to alcohol and the fact that alcohol is a teratogen are provided during pregnancy testing, medical visits for contraceptive care, prenatal care, and at other appropriate encounters. All prenatal patients receive a verbal alcohol screening for alcohol use and are informed about the dangers of prenatal alcohol consumption during their prenatal care.

[12] http://www.fasdcenter.samhsa.gov

The Tribal Law and Order Act of 2010, or "TLOA" outlined important steps toward improving the delivery and administration of public safety in Indian country. The IHS has worked hard to implement both the spirit and the letter of the law. In my testimony this morning, I will address the sections of the Act that have most directly assisted the IHS and its Federal partners in addressing the harmful effects of dangerous drugs.

The purpose of the TLOA is to institutionalize reforms within the Federal Government so that justice, safety, education, youth, and alcohol and substance abuse prevention and treatment issues are on the forefront of Federal efforts. Section 241 of the TLOA amends the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, expanding the number of Federal agencies required to coordinate their efforts on alcohol and substance abuse issues in Indian Country. Specifically, TLOA directs the Secretaries of HHS and the Department of the Interior (DOI), together with the Attorney General, to develop and enter into a Memorandum of Agreement (MOA). IHS is an active member of the Interdepartmental Coordinating Committee on Indian Alcohol and Substance Abuse (IASA) and the MOA workgroups tasked to carry out the TLOA activities through collaboration with Federal partners.

In 2014, the Phoenix IHS Area and Billings IHS Area funded two two-and-a-half day sessions to provide training and technical assistance resources for Tribes in those IHS Service Areas to develop tribal action plans which address alcohol and substance abuse issues in their

communities. The regional sessions were held in partnership with SAMHSA, Department of Justice, and DOI and support the work of the TAP workgroup.

Chairman Barrasso, Vice Chairman Tester, members of the Committee, we at the IHS fully recognize the profound impact of dangerous drugs in Indian country. While our public health approaches to establish comprehensive policies, programs, funding, training, and partnerships to promote a multifaceted range of activities for the prevention of the harmful effects of dangerous drugs continue, we recognize IHS bears a deep responsibility for ensuring AI/AN people live in healthy communities free of the dangerous impact these drugs have on their physical, mental, social, and spiritual health.

On behalf of the Department, I personally want to thank the Senate Committee on Indian Affairs for recognizing this important issue. I look forward to continuing to work with you on these vitally important issues. This concludes my remarks, and I welcome any questions that you may have. Thank you.