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FENTANYL IN NATIVE COMMUNITIES: NATIVE PERSPECTIVES ON ADDRESSING THE GROWING CRISIS

HEARING

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ONE HUNDRED EIGHTEENTH CONGRESS

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FENTANYL IN NATIVE COMMUNITIES: NATIVE PERSPECTIVES ON ADDRESSING THE GROWING CRISIS

WEDNESDAY, NOVEMBER 8, 2023

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

The Committee met, pursuant to notice, at 2:35 p.m. in room 628, Dirksen Senate Office Building, Hon. Brian Schatz, Chairman of the Committee, presiding.

OPENING STATEMENT OF HON. BRIAN SCHATZ, U.S. SENATOR FROM HAWAII

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

Today the Committee will hear directly from tribal leaders, practitioners specializing in Native behavioral health and a Native public health expert on opioid use disorder about the devastating impacts of fentanyl in Native communities.

We will also learn about specific culturally based practices, dedicated facilities and other promising tools Native communities have developed and tailored to address their own needs. This is a really important conversation.

Fentanyl, a potent synthetic opioid, is contributing to a rapid rise in opioid related deaths across the Country. Native communities are getting hit extra hard. From 2020 to 2021, American Indians and Alaska Natives experienced an alarming 33 percent rise in drug overdose deaths, the second biggest of all groups in the United States. Native Hawaiians and Pacific Islanders saw the largest increase at 47 percent.

These overdose death rates are nothing short of staggering. In the past year, several tribes issued emergency declarations over the rate of fentanyl deaths among their members, and accidental overdoses, where users are unaware their drug of choice is mixed with fentanyl, also on the rise among American Indians, Alaska Natives, and Native Hawaiians.

Last August, tribes from across the Country came together to strategize on solutions and offer policy recommendations to address the fentanyl crisis in their own communities at the National Tribal Opioids Summit. White House officials, Federal and State leaders, members of Congress, including Senator Cantwell, also partici-

pated. I want to thank her for sounding the alarm and asking for today's hearing.

This growing crisis is rooted in longstanding structural inequities in Native communities. Lack of affordable housing, limited access to high quality health care, and underfunded public safety programs compound fentanyl's impact on Native communities. Other unique factors, such as checkerboard tribal lands, which create a jurisdictional maze for law enforcement, and a lack of available public health data further complicate our response.

It has been more than five years since we last held a hearing on the opioid epidemic in Native communities. COVID–19 contributed to a significant increase in substance abuse and overdoses nationwide. New threats from synthetic opioids, including fentanyl, have shifted the response paradigm. The time is now for the Committee to reengage.

Our work doesn't end by simply identifying the problems. There is no one-size-fits-all solution. We have to listen to Native leaders and organizations, health care providers and support Native-led solutions to fight fentanyl in their home lands and surrounding communities.

I look forward to hearing from all of our witnesses today and thank them for joining us in this important discussion.

Vice Chair Murkowski, you are recognized for your opening statement.

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

Senator MURKOWSKI. Thank you, Mr. Chairman. I do appreciate the fact that we are having this very important hearing in front of us today, and Senator Cantwell, thank you for making sure that it was scheduled here as we hold this hearing. Hopefully it is the first in a series of how we respond, how we deal with what we have in front us.

You have cited the statistics. It is just really disturbing to know that among American Indians and Alaska Native populations we see the highest drug overdose rates in the Country for both 2020 and 2021 in terms of population. We have certainly seen it in Alaska, the significant increase in overdose and deaths due to fentanyl, due to opioids.

Thanks to ANTHC's epidemiology center, we know that from 2018 to 2022 the annual number of opioid deaths among Alaska Natives increased by 383 percent. During the COVID pandemic, opioid overdose mortality rate among Alaska Native people doubled.

There was a very, very troubling article in our statewide Anchorage paper, the Anchorage Daily News, on the 6th of November. Mr. Chairman, I would ask that a full copy of this article be included as part of the record.

The CHAIRMAN. Without objection, so ordered.

Senator MURKOWSKI. It speaks to the situation that we are seeing in Alaska right now. This involved a drug ring operated within a prison.

What the article states is during a 15-month period, members in this ring sent 58.5 kilos of fentanyl, that is nearly 130 pounds of

fentanyl, to Alaskan communities. They sent it to communities like Savoonga, population 826 people, like Tyonek, population 415 people, like Good News Bay, New Stuyahok, Togiak, Ketchikan, Dillingham, Sitka, islanded communities where the population is so small and predominantly Native populations.

Why are they doing this? Why are they doing this? Because they know that they can get ten times more for this lethal poison that is being sent. The comment that was provided here was that a dose of fentanyl that might sell in Anchorage for $15 could be worth $40 in Utqiagvik, $80 in Kodiak, or $100 in Bethel.

So they are targeting these small, remote, rural, vulnerable communities. It is the worst predation there can possibly be.

Last year, the Alaska Federation of Natives approved a resolution calling for support for increased resources to combat the drug epidemic that we are seeing in our Alaska Native communities. It speaks to the lack of resources for education, for treatment, for preventive services and public safety in Alaska Native communities. We are working on so many different levels.

But I think it is so important today to understand from our witnesses how they are specifically addressing fentanyl, whether it is tribal law enforcement investigations and seizures, more opioid treatment centers in rural communities, how we deal with the stigma that we know is attached.

I have introduced a bill that we call Bruce's Law to educate the public about the lethality of fentanyl, particularly with our youth.

And then just last week we introduced the Tele-health Response for E–Prescribing and Addiction Therapy Services, we call it the TREATS Act. It seeks to continue access of tele-health services when prescribing opioid treatment program medications.

So there is a lot to talk about. I want to welcome our Alaska witness, Mr. Eric Gettis. He is going to be joined by Dr. Corey Cox during the question period of the hearing.

Mr. Gettis is the Senior VP for Behavioral Health at SEARHC in Juneau, and Dr. Cox is a dual board certified family medicine and addiction medicine physician, also with SEARHC. He is currently working to expand access to quality addiction treatment services in rural Southeast Alaska.

I am pleased that they are going to be with us today with their input.

Again, thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Vice Chair.

I will now recognize Senator Cantwell, who has been, as a lot of members on this Committee, a leader on this particular challenge. Senator Cantwell was instrumental in making sure that this hearing happened.

Senator Cantwell?

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

Senator CANTWELL. Thank you, Chairman Schatz, you and Vice Chair Murkowski, for holding this very, very important hearing today to hear directly from Indian Country how they are fighting this battle, and how they need a better Federal partner.

I want to take a moment to introduce one of the witnesses, the Chairman of the Lummi Nation, Anthony Hillaire. I want to acknowledge the presence of multiple Lummi Nation leaders who are with us, key staffers, and Council Member Maureen Kinley and Jim Washington.

In addition, the Lummi National Policy Advisor, Merisa Jones, Recovery Specialist Tabitha Jefferson, and the Lummi Nation youth leaders who are here as a delegation. Thank you all for traveling all this way to make this voice heard, and to get people to understand the scourge of this crisis.

Your presence here today is a testament to the devastating impact the fentanyl crisis has had on the Lummi Nation. When I visited Lummi Nation in October of last year, fentanyl was already taking its toll. But a year later, the Lummi community lost five people to fentanyl overdoses within one week.

In 2022, the Centers for Disease Control and Prevention reported that American Indians and Alaska Natives had the highest drug overdose rate of any ethnic group for both 2020 and 2021. The rise of this illicit fentanyl is a problem.

We have hosted nine roundtables throughout the State of Washington and have spoken at many of the organizational meetings to talk about what are the solutions. In fact, the National Tribal Opioid Summit was also held in the State. That was partly organized by the Northwest Portland Indian Health Board, it happened at Lummi Nation.

We have talked to tribal leaders in Spokane, Colville, Yakama, Cowlitz, Jamestown, the Puyallups, the Tulalips, and many people about how their particular communities are being impacted. What we know is we must increase treatment and recovery capacity. As one doctor told me, "We should have access to recovery be as easy as access to the drug, and at this point, it is not."

We need to better educate young people and get them involved in prevention and recovery. That is why I am glad to see the youth delegation that is here today, because they can help us understand how we can better reach out to young people.

The next generation can lead the way in educating their peers. In August, as I spoke to the National Tribal Opioid Summit at Tulalip, a key theme raised by many of the officials gathered at the session was how understanding where illicit fentanyl is coming from, and how we respond to it is a top priority. Data is needed and vital to our response in the pandemic. Adequate resources, whether that is helping them recognize the crisis or addressing it in responding, is critical.

But a few examples. The Jamestown S'Klallam opened a healing clinic which provides addiction and MAT treatment, and averages 120 patients per day. The Native Project in Spokane is working to build the youth and child services that will focus on tribal children's services to stay away from opioids and fentanyl. And the Lummi Nation opened a new stabilization and recovery center for their community members, and is currently working to construct and open a detox and health care center.

So I welcome Chair Hillaire today to share the breadth and depth of your unique experience. I am so sorry that this is what the Lummi Nation has had to deal with.

I know that you as a tribal leader and a community council member in the past know what it is like to deal with these issues and to prioritize them. Hopefully, we can work better together as a Federal partner.

I thank you again, Madam Chair, for the opportunity for this hearing to take place, and hopefully our Committee to come up with ideas to better help Indian Country and our whole United States deal with this crisis.

Thank you.

Senator MURKOWSKI. [Presiding.] Thank you, Senator Cantwell.

Are there other members wishing to make an opening statement? Senator Hoeven?

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

Senator HOEVEN. Thank you, Ranking Member Murkowski. I want to thank both you and Chairman Schatz as well as our witnesses for being here this afternoon. I appreciate the Committee holding this very important hearing on the impact of fentanyl in our tribal communities. It is a huge problem for the entire Country, in essence every State, and the tribe as well has become a border State or border reservation because of the fentanyl that is pouring in over the southern border, a lot of it of course originating in China.

So this is a problem we have to address across the County. We are seeing record numbers of overdose deaths, and of course, it is a huge problem on the reservation as well.

And Senator Cantwell, as well, for everyone who said we need to have a hearing on this problem, they are right. We do, and we need to find ways to address it. We need to do that now.

Again, I want to welcome all of our witnesses today, and I would particularly like to take a minute to welcome and introduce Chairman Azure. Jamie Azure is Chairman of the Turtle Mountain Band of Chippewa Indians. He attended the University of Minnesota, and we don't hold that against him in North Dakota, that is okay.

He earned Bachelor of Science degrees in both business management and political science. He has served on the tribal council since December 2016, and has been chairman since 2018. He continues to build up his community, foster economic development, and advocate on behalf of both tribal youth and elders.

He also serves on the United Tribes Technical College board of directors. He owns the J. Azure Construction Company, and through his company is involved in community philanthropic efforts such as dedicating a percentage of the company's profits to supporting youth organizations. He resides in Belcourt with his wife, Denise, and their two children.

Again, Chairman Azure, I want to thank you for being here today, but even more than that for the important work you do as chairman for your tribes and the good work that you do both through your company as well as through your leadership as tribal chairman. Thanks so much.

Thank you, Madam Chair pro tem.

Senator MURKOWSKI. Pro tem. Thank you, Senator Hoeven.

Senator Tester, I know you want to introduce your witness and maybe make an opening statement.

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

Senator TESTER. I do. I first want to thank you and the Chairman for hosting this hearing that I think we can all say is really important. Thank you, Senator Cantwell, for your leadership.

I want to welcome everybody who is here testifying, the people who are here in person and the people who are here virtually. I also want to have a special introduction for Councilman Bryce Kirk, who is here in the Indian Affairs room I think for the first time. He is from the Fort Peck Assiniboine and Sioux Tribes, joining us from that metropolis of Poplar, Montana, which is incredibly rural.

Chairman Kirk is serving a second term on the tribal council. He sits on the Law and Justice Committee there, and also the Tribal Education Committee.

Chairman Kirk knows first-hand the effects of fentanyl in his community, and he does important work combatting this drug on the reservation. Bryce, it is an honor to have you here today to testify to us. When your time comes up, we look forward to your testimony.

Senator MURKOWSKI. Thank you, Senator Tester.

Senator Luján, do you care to make any comments?

STATEMENT OF HON. BEN RAY LUJÁN,
U.S. SENATOR FROM NEW MEXICO

Senator LUJÁN. Madam Chair, thank you so much for this important hearing and the leadership of the Committee, and for each of you traveling to share these stories, to share your thoughts and your ideas of what needs to be done, where there is negligence as well with lack of support or jurisdictions where there are questions where criminals learn to take advantage of them as well.

I certainly look forward to your testimony and thank you all for being here. Thank you, Madam Chair.

Senator MURKOWSKI. Thank you.

We will now turn to our witnesses. Senator Cantwell has introduced our first witness, Chairman Hillaire, from the Lummi Nation. He will be followed by Chairman Azure, who has been introduced by Senator Hoeven, with the Turtle Mountain Band of Chippewas.

Next, we will turn to Councilman Kirk, who has been introduced by Senator Tester, from the Fort Peck Reservation. I understand that Dr. Aukahi Austin Seabury will be virtual with us. She is the Executive Director and Licensed Clinical Psychologist at I Ola Lāhui, Inc. in Honolulu.

We will also be joined virtually by Mr. Eric Gettis, who is with Southeast Alaska Regional Health Consortium as introduced previously. He will be accompanied by Dr. Corey Cox, Clinical Director for Addiction Services, also there at SEARHC.

Our final witness will be Claradina Soto, Ph.D., Associate Professor, Department of Population and Public Health Sciences at the Keck School of Medicine at UCLA.

I want to remind our witnesses that your full written testimony will be made part of the official record. So we would ask that you try to keep your comments to no more than five minutes so members have an opportunity to ask questions. But we realize that these comments that you make are very important and the information will gain today is exceptionally important.

So for those of you who have made the trip to be here, thank you, and for those of you who are giving your time online, thank you very much.

Chairman Hillaire, if you will proceed, please.

STATEMENT OF HON. TONY HILLAIRE, CHAIRMAN, LUMMI NATION

Mr. HILLAIRE. Ey'skweyel e ne schaleche si'iam, Tony Hillaire tse ne sna, Tse Sum Ten tse ne sna, che' xlemi sen. My dear friends and relatives, my name is Tony Hillaire, my name is Tse Sum Ten. I come from Lummi. I serve as the Chairman of the Lummi Indian Business Council.

Good afternoon, Vice Chair Murkowski and Chairman Schatz and distinguished members of this Committee. Thank you for having us here today. I am here with my team. Thank you, Senator, for introducing them. We are traveling from afar, from Lummi Nation, located in Washington State. We are here on behalf of our great Lummi Nation, we are here on behalf of our ancestors, our elders, our children, our fishermen, our fisherwomen.

But most of all and most importantly, we are here on behalf of the grieving grandmothers and mothers who are burying their children to drug overdose. It is becoming way too normalized. Just yesterday, we had a funeral for a 26-year-old Lummi woman who passed away from a drug overdose, leaving behind two children who will grow up now without a mother.

These are not just anyone to us, these are our family, these are the people we grew up with, these are our future chairmen and chairwomen, our future cultural leaders, language speakers, the ones who will carry the torch into the next generations.

We want to thank you and this Committee for holding this hearing so we can discuss this important matter, so that we can change the world for the better for these next generations. And a special thank you to Senator Cantwell, our dear friend, for your immediate response when we have five deaths within three days at Lummi Nation, four of them being drug overdose. Senator Cantwell helped respond immediately and gave us some assistance.

In addition to calling this hearing as well as for introducing the Parity for Tribal Law Enforcement Act, as well as attending the National Fentanyl Summit hosted at Tulalip Tribes, thank you for standing with us and for your ongoing friendship.

I want to start real quick just acknowledging our resilience as Lummi people. When we talk about these issues and the drastic scenes of the fentanyl crisis at home, it goes without saying how resilient we are as a people, and that we are self-determining, that we want to take care of ourselves and that we know how to do that.

The impacts of fentanyl and opioids at home have been very drastic and very overwhelming. I just ask rhetorically to the Committee, how many funerals have you been to in the last year? How

many have you ben to in the last month, in the last week? For us, it is pretty much every day. That is not just for fentanyl overdose, which is completely devastating, but also all of the health disparities that we see at Lummi Nation that we are up against.

We don't have time to meet, and I understand that it is much needed, but right now our people need leadership, they need hope. That is our responsibility, to ensure that we never take away hope from our people.

So when we had those deaths, and when I was talking to Senator Cantwell, we responded immediately. At Lummi Nation, we declared a state of emergency. We implemented checkpoints to limit the amount of drugs that were coming onto our reservation. We got K–9 units, Senator Cantwell helped us get FBI agents who helped us get drugs off of the street. That was the first response, was immediate action is the best message to the mothers who are grieving at Lummi Nation. So we did just that.

As we continue to intervene, we are learning the need for better outreach, better treatment services. The more drugs we get off the street, the more we disrupt the market of drugs. Our people who struggle with addiction are really needing that fix.

So we opened up a stabilization center which is an expansion of services for medication assisted treatment, and is open 24–7. Since our drug interdiction efforts, the beds have been completely full.

In addition to that, we have noticed children being in the homes of where we found drugs and where we shut down drug homes. That brings up the need for our Lummi Youth Academy, which is a residential facility next to our Lummi Nation School, that ensures that our children can be home, that they can be closely tied to our people, our culture, and our way of life as a way of ensuring prevention.

Finally, our need for a detox facility is an immediate need right now. The severity of withdrawals to fentanyl is really concerning. Right now, we have plans to build a detox facility, but through the bureaucracy and through the lack of funding resources, it has been really challenging. We have raised $15 million over the last few years, lobbying for this very issue. We need $12 million more to finish the project.

There is so much more to this, more time is needed for really, really grasping and getting into the weeds of what needs to be done. But those are the three top priorities for Lummi Nation.

[Phrase in Native tongue.] Thank you.

[The prepared statement of Mr. Hillaire follows:]

PREPARED STATEMENT OF HON. TONY HILLAIRE, CHAIRMAN, LUMMI NATION

Good afternoon, Chairman Schatz, Vice-Chair Murkowski, and the distinguished members of this Committee.

Ey'skweyel e ne schaleche si'iam, Tony Hillaire tse ne sna, Tse Sum Ten tse ne sna, che' xlemi sen.

My name is Tony Hillaire, my name is Tse Sum Ten. I come from Lummi. I serve as the Chairman of the Lummi Indian Business Council.

I am here today with my fellow council members, my team, our Lummi Youth Council members, and Community Leaders. And we are here today on behalf of the great Lummi Nation, our ancestors, our elders, our children, our fishermen and fisherwomen. But most of all, we are here today on behalf of our grieving mothers and grandmothers. Burying our children is a mother's worst nightmare, and this nightmare is becoming way too normal.

We want to thank you for holding this hearing so we can discuss this very important matter. So that we can change the world for the better, for our next generations. A special thank you to Senator Cantwell, our dear friend, for her immediate support, for calling the hearing, for introducing the Parity for Tribal Law Enforcement Act, and for attending the National Fentanyl Summit.

The impacts of the opioid/fentanyl crisis that have hit our community are devastating, heartbreaking, and personal.

As I give this testimony, I ask that you reflect on how many people you know that have lost their lives to fentanyl. How many funerals have you been to this year that were due to fentanyl-related overdoses? The Lummi Nation has had a total of seven overdose-related deaths in 2023, with five of those deaths occurring just from September to October.

In the Lummi Nation, we are not only battling fentanyl but have also come across Carfentanil, a drug 100 times more lethal than fentanyl and 10,000 times stronger than morphine. Just when we think we have a grasp on how we are handling this drug epidemic and reducing harm, a new, more robust version of fentanyl appears and comes back at us with even deadlier effects. These fentanyl-related deaths have impacted every area of our lives, as our community is left in constant grief and sorrow as we are barely able to lay our loved one to rest before we get word of the next.

In late August this year, we had the opportunity to escort Dr. Delphin-Rittmon, Assistant Secretary of SAMHSA, to a homeless camp in Bellingham Whatcom County, Washington. At the time, we had over 70 tribal members who were living in squalor with no sanitation facilities. The conditions in which these tribal members are living are like nothing I have seen before, and it truly is heartbreaking. Our people are sick, and they are all crying and begging for help.

When our nation took action against the drug epidemic and began shutting down drug homes, we learned that there are children who are living within these homes. This is when we understood the need for a safe place for our children living in an unsafe environment. Previously, we had a facility that did just this that we called the Lummi Youth Academy, and there are many success stories of children attending.

The Lummi Youth Academy provided our children with access to shelter, food, education, and mental health services. There is an urgent need for funding to help support programs such as this, which is crucial as it is a form of Youth Prevention that allows them the tools needed to break the intergenerational traumas they've endured. Unless we address the root causes of addiction, we will continue in this cycle.

Another crucial step is Detoxification and treatment. When our people want help, too often, we must turn them away because we do not have beds or capacity. The Lummi Nation has accumulated almost $15 million to build a culturally attuned detox center, but we need another $12 million.

Currently, our tribal members have a deep fear of getting off fentanyl, as the withdrawal symptoms are unbearable. When a tribal member seeks assistance in withdrawing, there is only a tiny window of time, and we must get them into detox before they change their mind. Sometimes, it can take a few days for a detox bed to open, and by the time a bed opens, most of them do not return. The Lummi Nation has been lobbying for the funds to build their own detox center and has the support of 29 other tribes in the region.

Despite all we have been through, I do want to say that our people are strong and resilient. We know how to take care of our people, and our cultural-based recovery programs have shown that we do recover.

We have sought funds from HHS and IHS, and so far, we have been unsuccessful despite all the evidence we have provided on loss of life and suffering. We would like to highlight the importance of Congress passing the opioid supplemental funding request as this includes a $250M transfer to the Indian Health Service (IHS), representing an almost 16 percent set aside of the overall amount to help tribes specifically address the crisis. We hope some of these funds will be accessible to support us finalize construction of the SWMS, which has been endorsed by all Portland Area. The longer we struggle to get funds or wait for resources, the more likely people are to overdose or die due to overdose-related deaths.

Law enforcement is another critical area. We need more resources from the BIA, DEA, and FBI. Due to the lack of prosecutions from the DOJ and local authorities, we also need the ability to prosecute and hold accountable non-Indian drug dealers who are killing our people through this drug crisis. The lack of tribal jurisdiction over non-Indian drug dealers coming onto our reservation undermines our efforts to combat the drug crisis and protect our community. We urge Congress to recognize

special criminal jurisdiction over non-Indians who committed drug offenses in our communities.

Lastly, to fully confront this crisis, we must address issues of poverty, homelessness, and unresolved trauma that are not only catalysts for addiction but also perpetuate its vicious cycle.

Conclusion

Our plea for assistance is urgent; the loss of even one individual in our small community not only ends a lineage but also extinguishes future generations. The pain and sense of loss affects us all. We know what we need to help heal our people, but we have barriers that keep us from doing so.

In September of 2023, the Lummi Nation Declared a State of Emergency in response to the Drug Crisis. This allowed us to remove our internal barriers and create policies that allowed us to respond in an urgent manner. We ask that the federal government hear our cries and declare this a National Emergency. Declaring a National Emergency would allow us to tear down the barriers and bureaucracy that hinder our ability to take care of our people. In these times of darkness and sorrow, our people are looking for hope, and they are looking to leadership for answers and action.

On behalf of the Lummi Nation, I thank the Committee for convening this important hearing on the fentanyl crisis. Thank you for listening, for really hearing us, and for standing with us as we face this terrible crisis. At this time, I would be happy to answer any questions that the Committee may have. Thank you.

Senator MURKOWSKI. Thank you, Chairman Hillaire. We so appreciate your testimony.

We will next turn to Chairman Azure.

STATEMENT OF HON. JAMIE S. AZURE, CHAIRMAN, TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS

Mr. AZURE. Good afternoon, Vice Chairman Murkowski and Committee. Thank you for the opportunity to present testimony at today's hearing entitled Fentanyl in Native Communities: Native Perspectives on Addressing the Growing Crisis.

My name is Jamie Azure. I am an enrolled member of the Turtle Mountain Band of Chippewa Indians and Chairman of the Tribe. It is an honor to be here with you today.

According to the Centers for Disease Control, nationwide over 150 people die every day from overdoses related to synthetic opioids like fentanyl. In 2020 alone, there were over 56,000 people who died of a fentanyl overdose. This threat is real all over the United States and in my home State of North Dakota.

According to recent statistics from the North Dakota Department of Health and Human Services, there has also been a significant increase in overdose deaths. The fentanyl and opioid overdose death rate has steadily increased from 2019 where one individual per 10,000 died of an opioid or fentanyl overdose to 2022 where 2 per 10,000 in North Dakota have passed away.

On average two North Dakotans die each week from opioid and fentanyl overdoses, with the highest percentages of those deaths coming from Native Americans. That is right, in North Dakota, home of five tribes, Native Americans die at a rate of almost nine individuals per 10,000.

More alarming and closer to our home in Benson County, North Dakota, we have seen the one of the largest increases of fentanyl and opioid deaths in the State at almost two times higher than the State's average. Those numbers continue to tick upward as we end 2023.

Within the Turtle Mountain Reservation we also have seen family members perish at the hands of this deadly poison. In response, we have set up several drug task forces that work with State and local authorities to stop this drug trafficking before it reaches our communities.

For example, last year the Turtle Mountain Band of Chippewa Indians authorized its own tribal Division of Drug Enforcement, the DDE, with tribal resources. We hired a director, who along with the Law and Policy Department, formulated policy and procedures to get the DDE operational. We hired some experienced staff and became effective in March of 2023.

As of today, we have four staff on this team. Prior to this we had to rely on BIA–OJS's Drug Unit's agents. At one point we relied on one agent, among five North Dakota reservations. As you can imagine, this was ineffective. This was far too large of an area to assign to one drug agent.

Since March of 2023 we have had four major fentanyl drug busts. The DDE stopped a large quantity of drugs from reaching our people. We utilized tribal intelligence and were able to intercept large shipments before they were on the streets of the community.

Please understand that these shipments are coming mostly from the Detroit metropolitan area, and sometimes as far as Las Vegas. In intercepting these shipments, we coordinated with State and Federal partners for arrests coming off Amtrak in Rugby, North Dakota, around 40 miles from the Turtle Mountains.

Please note that all these drug shipments are from non-Indians delivering to the reservation. We have also learned through our law enforcement efforts that these drug dealers often move into our HUD units with promises of wealth from drug proceeds for our vulnerable populations. These individuals have significantly disrupted the lives of our children, resulting in foster parents when the parents are arrested. Also, note that these drug dealers are also using social media platforms such as Facebook, TikTok, Instagram, Snapchat, and more.

Because of the effectiveness of the DDE, the drug dealers are complaining about loss of profits and reduction of supply. I am hopeful that we can continue to develop effective partnerships with State and Federal agencies. But let me be clear: the BIA Office of Justice Services must step up their job.

As the Committee has been made aware, we have been strapped with limited BIA law enforcement resources. For example, the Bureau of Indian Affairs Law Enforcement continues to shift away resources from Turtle Mountain. In fact, BIA law enforcement has recently shifted away our Chief of Police to work elsewhere. I as tribal chairman wasn't even notified. I found out by a text from the Chief of Police asking if I was notified.

These decisions have made Turtle Mountain members less safe. Can you imagine if in a major city such as Detroit or Chicago law enforcement was suddenly transferred someplace else? What kind of message would that send?

I want to take a moment to thank Senator Hoeven for looking into this important matter for us. Hopefully the Senator can get answers from the Department of Interior before any more tribal members are victims of crime or drug overdose.

I would also like to take a moment and offer my continued support for the following. Number one, S. 465-BADGES sponsored by Senator Cortez Masto and Senator Hoeven. This bill will help expedite background checks for BIA law enforcement so they can get hired more expeditiously. Part of the problem of hiring law enforcement is how long it takes to go through the background process. It should not take nine to twelve months.

Number two, advance BIA Law Enforcement Training Center at Camp Grafton, North Dakota. This training center is the only BIA law enforcement training center located in the Great Plains region. This training center helps those communities that cannot send their police officers all the way to New Mexico and allows for specialized investigation classes to occur such as drug interdiction classes.

And number three, keeping the Drug Elimination Program in the Native American Housing Assistance and Self Determination Act, NAHASDA funding, which is currently in the Senate version of the National Defense Authorization Act, NDAA. This program will allow my community to utilize housing dollars to provide drug treatment services, rehabilitation, education, and relapse prevention in a cultural manner.

In closing, I want to thank you all for allowing me to speak to this important subject. I look forward to answering any questions that may come after.

I would also like to mention that on behalf of the tribal leadership that is sitting at this table, that is watching, that is sitting here in support, this Committee needs to remember that we took a vow to sit in the chairs that we sit in, in the leadership roles that we have taken on for that next generation. We are very close to losing a generation to an opioid, to a synthetic drug. We need to figure out a way that we can work together to address a lot of these I sues that are going to be bought up today, and a lot that we don't have time to get into.

It is not in my nature to read off the paper that I just read off. But it was important to get the right facts across. These are our children; these are the next generation. As Chairman Hillaire had mentioned earlier, these are the next round of leaders that we are fighting for.

We as tribal leaders refuse to allow a generation to be lost. I just wanted to get that point across.

Thank you very much.

[The prepared statement of Mr. Azure follows:]

PREPARED STATEMENT OF HON. JAMIE S. AZURE, CHAIRMAN, TURTLE MOUNTAIN BAND OF CHIPPEWA INDIANS

Dear Chairman Schatz and Vice Chairwomen Murkowski:

Thank you for the opportunity to present testimony at today's hearing entitled, "Fentanyl in Native Communities: Native Perspectives on Addressing the Growing Crisis." I am Jamie Azure; I am an enrolled member of the Turtle Mountain Band of Chippewa Indians and Chairman of the Tribe. Its great to be with you today.

According to the Centers for Disease Control, nationwide over 150 people die every day from overdoses related to synthetic opioids like fentanyl. In 2020 alone, there were over 56,000 people who died of a Fentanyl overdose. This threat is real all over the United States and in my home state of North Dakota.

According to recent statistics from the North Dakota Department of Health and Human Services, there also been a significant increase in overdose deaths. The

fentanyl and opioid overdose death rate has steadily increased from 2019 where 1 individual per 10,000 died ofan opioid or fentanyl overdose to 2022 where 2 per 10,000 in North Dakota pass away. On average 2 North Dakotans die each week from opioid and fentany 1 overdoses with the highest percentages of those deaths coming from Native Americans. That's right, in North Dakota, home of five tribes, Native Americans die at a rate of almost 9 individuals per 10,000. More alarming and closer our home of Benson Country, North Dakota has seen the one of the largest increases of fentanyl and opioid deaths in the State at almost 2 times higher than the States average. And those numbers continue to tick upward as we end 2023.

Within the Turtle Mountain Reservation we also have seen family members perish at the hands of this deadly poison. In response, we have set up several drug task forces that work with state and local authorities to stop this drug trafficking before it reaches out communities.

For example, last year the Turtle Mountain Band of Chippewa Indians authorized its own tribal Division of Drug Enforcement, (DDE), with tribal resources. We hired a director, who along with the Law and Policy Department, formulated policy and procedures to get the DDE operational. We hired some experienced staff and became effective in March of 2023. Today we have four staff on this team.

Prior to this we had to rely on BIA–OJS 's Drug Unit's agents. At one point we relied on one agent, among five North Dakota reservations. As you can imagine, this was ineffective. This was far too large of an area to assign to one Drug Agent.

Since March of2023 we have had four major fentanyl drug busts. The DDE stopped a large quantity of drugs from reaching our people. We utilized tribal intelligence and were able to intercept large shipments before they were on the streets of the Community. Please understand that these shipments are coming mostly from the Detroit metropolitan areas, and sometimes as far as Las Vegas. In intercepting these shipments, we coordinated with State and Federal partners for arrests coming off Amtrack in Rugby, North Dakota.

Please note that all these drug shipments are from non-Indians delivering to the reservation. We have also learned through our law enforcement efforts, that these drug dealers often move into our HUD units with promises of wealth from drugs proceeds for our vulnerable populations. These individuals have significantly disrupted the lives of our children resulting in foster parents when the parents are arrested. Also, note that these drug dealers also use social media platforms such as Facebook, Tic Toc, Instagram, Snapchat, and more.

Because of the effectiveness of our DDE, the drug dealers are complaining about loss of profits and reduction of supply. I am hopeful that we can continue and develop effective partnerships with state and federal agencies but let me be clear the BIA Office of Justice Services must step up do their job.

As the Committee has been made aware, we have been strapped with limited BIA law enforcement resources. For example, the Bureau of Indian Affairs Law Enforcement continues to shift away resources from Turtle Mountain. In fact, BIA Law Enforcement recently shifted away our Chief of Police to work elsewhere. These decisions have made Turtle Mountain members less safe. Can you imagine if a major city such as Detroit or Chicago law enforcement were suddenly transferred someplace else? What kind of message would that send? I want to take a moment to thank Senator Hoeven for looking into this important matter for us. Hopefully you Senator can get answers from the Department ofinterior before any more tribal members are victims of crime and drug overdose.

I also want to take a moment and offer my continued support for the following:

1) S. 465- BADGES sponsored by Senator Cortez Masto and Senator Hoeven. This bill will help expedite background checks for BIA Law Enforcement so they can get hired more expeditiously. Part of the problem of hiring law enforcement is how long it takes to go through the background process. It should not take 9–12 months for this.

2) Advance BIA Law Enforcement Training Center at Camp Grafton, North Dakota. This training center is the only BIA law enforcement training center located in the Great Plains region. This training helps those communities that cannot send their police officers all the way to New Mexico and allows for specialized investigation classes occur such as drug interdiction classes.

3) Keeping the Drug Elimination Program in the Native American Housing Assistance and Self Determination Act (NAHASDA) which is currently in the Senate version of the National Defense Authorization Act (NDAA). This program will allow my community to utilize housing dollars to provide drug treatment services, rehabilitation, education, and relapse prevention in a cultural manner.

Senator MURKOWSKI. Thank you, Chairman Azure.
Mr. Kirk?

STATEMENT OF HON. BRYCE KIRK, COUNCILMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION

Mr. KIRK. Hi, I am Bryce Kirk, Councilman for the Fort Peck Assiniboine and Sioux Tribes on the Fort Peck Indian Reservation. I would like to thank the Committee and Vice Chair Murkowski, for allowing me to testify on fentanyl in our communities.

I will start off with a story of a couple brothers that I have lost because of fentanyl that leave behind, both entail six kids, a wife, two wives, and kids that continue to lose their parents. When I was coming in the door, I remembered a young lady that I coached in seventh and eighth grade in basketball. Right now, she is a ninth grader, addicted to fentanyl right now, today.

As we continue to sit here, fentanyl has no boundaries. It affects men, women, children, and the elderly from all walks of life. People deal drugs, including suboxone, to pay for their own habits. They deal, who will buy to feed their habits? Our people can go to Spokane with $1,000 and bring 1,000 pills back and make $120,000 off those pills. This is destroying families. We have higher crime rates and increased violent rapes, murders, kidnappings. Suicide remains a large leading cause of death of our people.

Where did we get that it is okay for people to continue to lose their loved ones from walking in front of trains, that it is just okay for them to deal with the pain that they have dealt with their whole lives and stuffing it down with drugs, deadly drugs, just to feed the pain that they feel growing up, the abuse, sexually, physically, emotionally, abuse that no kid, no person should ever go through?

I myself am a recovered addict. I have been clean and sober for 11 years, and have now been elected to our tribal council to be able to lead our people and fight for our people. While the crisis is daunting, it is not hopeless. I am there with them, but a mentor also. Before I got on the council, I had a business that actually helped people come off the streets that were just like myself, to reach down and start reaching our people that we have an obligation.

In the end of our swearing in ceremony, we say, "So help me God." As you guys take an oath, we take an oath too. This isn't just a red or blue issue. This issue is everybody. It contains our kids. We on Fort Peck have lost a generation of kids right now. We have grandparents taking care of great-grandchildren because the grandchildren that they were taking care of are now lost to the addictions that we face today.

What we need is more law enforcement. We don't need doors slammed in our face when we try to reach out to our Federal partners. We need them opened. We need to be able to work together with information that they have with people coming onto our reservation.

We need more mental and behavioral health. One of the biggest things is there is always talk about funding. There can never be

enough funding to catch up where we are. It is sad to say that it is going to get worse before it gets better.

Without the help of Federal Government and Congress and acts that we need on reservations to be able to help support our people, we need the direct funding to come to our tribes, to come to our reservations, to where we know what it takes us as leaders, we know what our people need, we know traditional ways that our people need to go. We could lead our people there.

We need jobs and training for our people. We need more housing, we need more community facilities. One of the biggest things, in conclusion, is my wife and I are a testament to this, and no matter what happens, we as Indian people are resilient and will continue to come out of this as we always have.

But we need additional support from all parts of the Federal Government, and we need Federal agencies to be true partners with us in this effort. We don't need bureaucrats in D.C. telling us how to solve the problem. We already have the blueprint for how to solve the crisis in the way that is best for our communities, which is informed by our experiences on the ground and successes we have already achieved.

What we need is support and tools to grow our efforts and start helping us reach the people that are already lost, so that way we don't lose any more grandparents, grandchildren, moms, dads and kids, kids that haven't even graduated yet.

I thank you for the time. I thank you for everything. Hopefully we can move forward.

Thank you.

[The prepared statement of Mr. Kirk follows:]

PREPARED STATEMENT OF HON. BRYCE KIRK, COUNCILMAN, ASSINIBOINE AND SIOUX TRIBES OF THE FORT PECK RESERVATION

I am Bryce Kirk, Councilman for the Assiniboine and Sioux Tribes of the Fort Peck Reservation. I would like to thank the Committee for the invitation to testify on the impact of fentanyl in Native communities.

The Fort Peck Reservation is in northeast Montana, forty miles west of the North Dakota border, and fifty miles south of the Canadian border, with the Missouri River defining its southern border. The Reservation encompasses over two million acres of land. We have approximately 12,000 enrolled tribal members, with approximately 7,000 tribal members living on the Reservation. We have a total Reservation population of approximately 11,000 people.

As I will discuss in greater detail, there is no greater crisis on the Fort Peck Reservation than addressing the trade and trafficking of drugs, in particular fentanyl, on the Reservation. I think the Fort Peck Tribes are as capable a Tribe as any in the country to combat this crisis, but we need the support of our federal partners. We stand ready to work with our partners from law enforcement, social service agencies and health care agencies to do this necessary work.

At Fort Peck, we have long believed that a strong tribal government is the way to best keep our community safe. So, we have taken action to maximize our authorities to protect everyone living within our boundaries. In this regard, the Fort Peck Tribes have provided law enforcement and correction services on our Reservation since 1996 under an Indian Self-Determination and Education Assistance Act contract. We were also one of the first Indian tribes in the nation to enter into a cross-deputization agreement with state, county and city law enforcement agencies. Under this agreement, first ratified more than twenty years ago, tribal officers are deputized to enforce state and local law on the Reservation and state and local officers are authorized to enforce tribal law.

For more than fifty years, the Fort Peck Tribes have had an independent judicial system, including an appellate court. It is through this system that we provide justice to our victims and our defendants. Currently, our judicial system includes law-trained judges, law-trained prosecutors, law-trained public defenders, probation offi-

cers, a published tribal code, and experienced court clerks and court reporters. Our court's opinions are published and available to the public. Notwithstanding a strong Tribal government and strong governmental institutions, we still are facing a crisis of fentanyl use in our community that threatens every aspect of our Reservation.

This drug has infested every corner of our community, from the young to the old and without regard to gender or any other demographic. What we as tribal leaders are the most worried about is our youth. We fear this drug is robbing us of an entire generation: our very future.

This crisis happened almost overnight. According to the Montana Attorney General's Office, since 2019, fentanyl seizures in the state have risen 11,000 percent. *See, https://www.kfyrtv.com/2023/02/24/ag-reports-skyrocketing-fentanyl-crisis-montana.* In 2022, the State Task Force agencies seized 206,955 dosage units of fentanyl, triple the amount recorded in 2021. *Id.* Throughout the entire state of Montana, the fentanyl-related overdose deaths increased by 167 percent from 2016 to 2020. *See, https://leg.mt.gov/content/publications/fiscal/2023-Interim/IBCD/MT_Fentanyl_Trends_2021.pdf.* The largest percentage of these deaths is adults between the ages of 24 and 44. *Id.* These are the people who should be the most productive in our communities. These people are our future leaders. Instead, they are dying. The Montana Department of Justice Division of Criminal Investigation reports that 10 percent of all high school students in Montana had taken a prescription drug without a prescription. *Id.* These children are not taking Lipitor. They are taking painkillers—opioids. Tragically for the Tribes in Montana, the opioid overdose death rate for Indian people is twice that of non-Indians. *See, https://www.npr.org/sections/health-shots/2022/06/01/1101799174/tribal-leaders-sound-thealarm-after-fentanyl-overdoses-spike-at-blackfeet-nation.*

On the Fort Peck Reservation, what our law enforcement officers report is that an average opioid user's daily dosage is between 10–20 pills. In an urban area, the average cost per pill is $1. On the Fort Peck Reservation, the average cost per pill is $120. So how does a user support this habit? He deals. According to our law enforcement, the average user is selling at least 50 pills a day to pay for his 20-pill habit.

To put these numbers in context, a single illicit fentanyl pill can contain a potentially lethal dose. *See, Facts about Fentanyl (dea.gov).* In fact, DEA analysis of counterfeit pills found that 42 percent of pills tested for fentanyl contained a potentially lethal dose. *Id.* This means that many in our community—and especially many of our young people—are gambling their lives 10 or 20 times a day.

The toll that this is having on our community is devastating. I lost two men I considered my brothers this last year. Now their children will grow up without a father. We have children as young as middle school taking fentanyl. Suicide remains extremely high on our Reservation. Unfortunately, suicide remains a leading cause of death across all the Reservations in Montana. The crimes against our children—our babies—are unspeakable.

This drug affects all families from all walks of life on the Reservation. We had a Tribal law enforcement officer plead guilty to stealing drugs from our tribal evidence room. This man is a decorated military veteran. He is the grandson of a former Chairman and son of a former Councilman. More importantly, he is a husband and father. But he was suffering from PTSD from his time in the military and from what he experienced as a law enforcement officer on the Reservation. We are thankful that he took the opportunity that the arrest presented him to go to the VA and get the treatment services he needed, and the federal judge gave him a sentence that recognized he could come back to our community and be a productive husband and father—opportunities that not many of our members who battle addiction receive and, as a result, some people who could be productive members of our Tribe end up in the federal criminal justice system for their entire productive life.

I battled with addiction myself. But for a man who mentored me and is still very much like a father to me, I would not be here today. My children would not have a dad. I never would have been elected to serve my people. I am thankful every day for my life that I have now.

In March 2023, we had to close our Tribal Court because someone chose to smoke fentanyl in one of the bathrooms. An officer was poisoned simply by entering the bathroom in question. The cleaning of the Court facility and its air systems took time and was costly.

Another indicator of the fentanyl crisis is the increased crime rate on the Reservation. In September, the Tribal Executive Board issued a state of emergency due to the severe increase in juvenile crime. The increase in crime is across all sectors of crime from property crimes to violent crimes, including sexual assaults, kidnapping and murders. Men, women and juveniles are the perpetrators. And virtually every crime can be attributed to fentanyl: Either a person was high when they per-

petrated the crime, or they committed the crime to secure money to buy drugs, or they committed an act of violence in retaliation for something related to fentanyl use or distribution.

While this crisis is daunting, it is not hopeless, and we must continue to take action to combat it. This is why I appreciate the Committee's attention to this issue. There is no single solution. We must look at this problem from every angle. It is a law enforcement problem, a mental health problem, a social services problem, an economic development problem and a community development problem. Thus, we must craft solutions in all these areas so that we are responding to the cause of the whole sickness and not just the individual symptoms.

In the area of law enforcement, we need the Department of Justice and Drug Enforcement Agency to remain strong partners in the investigation and prosecution of drug crimes on the Reservation. I want to commend our U.S. Attorney's Office for the hard work they do. One area where we would like more attention is the level at which a U.S. Attorney is prosecuting a drug trafficking case. It is our understanding that a person must be in possession of more than fifty pills, to be prosecuted for possession with the intent to distribute. As I stated above, many people are possessing 50 to 100 pills simply to fund their own drug habit—and this is true especially of the young people. We must stop these transactions before these people become much larger dealers.

In this regard, we need our federal partners to be true partners. In one instance, the DEA knew there was a known high level drug dealer traveling through Fort Belknap, Rocky Boys and Fort Peck and at no time did DEA share this information with the Tribal law enforcement agencies. It seems like to us there is a turf battle related to who is going to bust who, and no one cares about the ultimate victims of these crimes. They just care about who is going to get the major bust.

While we need strong federal law enforcement, I must acknowledge that the federal criminal justice system adds additional layers to the problem. Therefore, we need creative solutions from our federal partners. The federal criminal system disproportionately impacts Native people. And due to statutory mandates, federal criminal sentences are lengthy. Data shows increased incarceration is linked with increased recidivism. Moreover, there are no federal BOP facilities in Montana, which means Fort Peck members incarcerated are sent to federal facilities far away from home, community, and support systems. This increases the barriers to successful reintegration into our community after incarceration—thereby aggravating many of the problems that may have led to substance use and incarceration in the first place. While the Residential Drug Abuse Program (RDAP) within the BOP system has proven to be highly effective, it is a lengthy program to complete, and the wait list to get into the program can be very long. This means that it may not be available for individuals unless they are incarcerated for many years and, even then, the program maintains strict eligibility criteria that disqualify many individuals altogether.

Again, we need our federal partners to explore creative solutions that can help combat this crisis. What we know is that just arresting and putting people in prison and letting them out when they have done their time does little to combat this crisis. We need Federal prosecutors and the federal court system to expand opportunities for deferred prosecution and programs that emphasize rehabilitation over incarceration—especially for nonviolent simple drug offenses—not major drug dealing. This work must also look to develop programs that provide culturally appropriate treatment and counseling.

In addition, our law enforcement officers need greater support. Like every law enforcement agency in the country, we are having difficulty recruiting and retaining officers. There are several reasons this problem is exacerbated in in Indian country. These jobs are dangerous. They frequently involve dealing with the heaviest—even traumatic—situations and events, which would be difficult to witness for anyone but may be especially so for officers who are from our community. Yet, these officers do not have access to adequate benefits and resources to manage the stress of the job. As my story earlier indicated, our officers need specific mental health services and a support system. And they must, at the very least, receive the same benefits—in particular pensions—as other federal officers. Thus, we would ask that Congress take up the Tribal Law Enforcement Parity Act, S. 2695, which would ensure that Tribal Officers operating pursuant to a Self-Determination Act contract, like ours at Fort Peck, would have access to the federal pension program as they would if they were BIA officers.

Another area of greater support is the need for additional K–9 Units in Indian country. We had one K–9 unit from Northern Cheyenne for a week and it shut down drug trafficking on the Reservation for that week. We need greater support for the technology that can assist in this work, whether it is additional cameras and moni-

toring equipment or drones. We have too few officers and they cannot be everywhere they need to be. These tools will help our officers see what is happening on the Reservation.

In the area of mental health: We need more mental health and substance abuse treatment services. We remain thankful that Montana adopted Medicaid expansion as this has allowed for greater access to mental health services. We are thankful for the Veterans Administration and its work to provide mental health and treatment services to Native Veterans.

We urge Congress to continue to fund the Substance Abuse and Mental Health Administration's programs that allow Tribes to develop treatment and prevention programs and initiatives that are culturally appropriate. We urge Congress to fund the $80 million that was authorized last year specifically to support Native Behavioral Health and Substance Abuse Disorders within our communities. In addition, we need greater support within the Indian Health Service for treatment. Right now, we only have an outpatient treatment facility on our Reservation. While I acknowledge this is more than many Reservations have, it is not enough—we do not have the capacity to provide services to all who need it, and many people on our Reservation need inpatient treatment. Thus, we need additional facilities to provide inpatient treatment to people within our communities.

We also voice our support for the President's supplemental funding request of $250 million for the Indian Health Service (IHS), as part of a $1.55 billion total investment in the fight against opioids and addiction in America which was transmitted to Congress on October 25, 2023. This funding is urgently needed to help Tribal communities address the severe impacts of the opioid and fentanyl crisis. Tribal nations and Tribal health systems are innovating when it comes to behavioral health. By focusing on holistic care, traditional healing practices, and indigenous ways of knowing, we have seen remarkable results in Tribal communities for treatment of opioid use. This investment of $250 million will build on these important successes and will save lives for generations to come. We call upon Congress to swiftly enact this funding.

In addition, we need the Indian Health Service to better support self-determination on the Reservation. For the last 14 months, the Fort Peck Tribes have sought to assume the Dental and Public Health Nursing programs on the Reservation, and we have encountered nothing but resistance from the Fort Peck Service Unit. It is as if the Indian Health Service wants the Tribes to fail. By assuming the operation of both programs, we will improve the health status on the Reservation, and thereby combat one factor that leads to addiction. We can't do this if the Indian Health Service continues to put up barriers to our assumption of these programs.

In the area of social services: We need more foster homes on the Reservation. Far too often when someone loses their children, we have no other option but to place the child in non-Indian homes off the Reservation. This simply continues the cycle of trauma for our children. We also need a real mentorship program on the Reservation. As I said, it was a mentor who made the difference in my life. If we had a sustained, intentional program that matched people with others willing to serve as mentors, I believe this could make a difference. We think the Tiwahe Program within the BIA must be expanded to all Reservations to be able to provide these kinds of services. This program is intended to provide full wrap around support services to families, which is what is needed for families in recovery.

In the area of economic development: We need jobs and job training for our people. A job gives a person the means to support their family; it also gives them a sense of purpose and fulfillment, which helps their mental health, as well as the physical and mental health of those in their household. My wife operates a coffee shop on the Reservation. She has made it her mission to provide hope through employment for our youth and now adults are coming to her asking for the opportunity to work. She is making a difference for our people and is an important asset in battling this crisis on the Reservation. Thus, supporting more job training and workforce development programs and entrepreneurs like my wife is critical to this effort. The Department of Labor's Indian Employment and Training Program must be better funded and streamlined to provide better services throughout Indian country.

Finally, community development: We need more housing on the Reservation. I want to thank Senator Schatz for his work to reauthorize the Native Housing Assistance and Self-Determination Act. People are living in overcrowded homes, which adds to stress and contributes to addictions. But also, as we learned with the incident at the Tribal Court, fentanyl can easily contaminate a space which places every person living in a home with a user at risk of being poisoned. We need transitional housing for people who have received treatment so that they are not forced back into the same environment that led them into addiction. We also need community facilities that are safe for our children, whether it is more recreational opportunities

like our skate park or additional Head Start facilities to lay a strong educational foundation. These facilities are needed across Indian country.

My community is resilient—my wife and I are a testament to this. We will survive this latest crisis, but we need additional support from all parts of the federal government, and we need federal agencies to be true partners with us in this effort. We do not need bureaucrats in D.C. telling us how to solve the problem. We already have the blueprint for how to solve this crisis in the way that is best for our communities, which is informed by our experiences on the ground and the successes we have already achieved. What we need is the support and tools to grow our efforts.

Thank you for the opportunity to testify on the vitally important issue of addressing this crisis that is facing our communities. I would be pleased to answer any questions and to provide any additional information that may assist the Committee.

The CHAIRMAN. [Presiding.] Thank you very much, Mr. Kirk.

Next, I am pleased to introduce and welcome online Dr. A. Aukahi Austin Seabury, Ph.D., Executive Director and Licensed Clinical Psychologist, I Ola Lāhui, Inc. in Honolulu, Hawaii. Welcome, Dr. Seabury.

STATEMENT OF A. AUKAHI AUSTIN SEABURY, PH.D., EXECUTIVE DIRECTOR/LICENSED CLINICAL PSYCHOLOGIST, I OLA LĀHUI, INC.

Ms. SEABURY. Aloha mai kakou.

The CHAIRMAN. Aloha.

Ms. SEABURY. Mahalo nui loa, thank you so much for this welcome. In Hawaii, we have a saying about health as being contained in [phrase in Native tongue] the four corners of the body, speaking about the two shoulders and the two sides of the hips as holding the most vital organs. So if this convening is about all of America and the continent, then Hawaii represents the right hip. And so welcome and greetings from that part of the vital organs of the Country.

Aloha. It is a pleasure to speak with you. I feel a lot of gratitude for the time today, to be among my brothers, sisters, and cousins throughout the Country who are coming to speak today about the First Nations people. We are in a important time when all of us are being together to speak about the needs of our specific communities is very critical to this moment, especially as the people performing the sharing because of how important it is that we contribute the ways in which our specific traditional wisdom has been a promising factor in recovery for people in healing and well-being.

The solutions that come from our traditional cultural practices and well-being have been shown to be so vital to how this is all going to work. So Native-led, Native voices is the sort of resounding call from across all of these parts of the world. So I am appreciative to be able to join the voices in that way.

A little bit about the porch that I am speaking from. I am a licensed clinical psychologist by training and run a non-profit behavioral health organization whose focus is on culturally minded, evidence-based behavioral health services for Native Hawaiian, medically underserved, and rural communities. I have spent my career in the service of my people as a therapist, as a healer, specifically as an advocate and program builder, and someone who builds and maintains relationships as a Hawaiian health leader.

What I share today is informed by my patients that I serve, the communities that I have listened to and been a part of, and the

community partners that I have maintained and their sharing of their experience of this.

The parts I probably don't need to spend too much time on is that there are similar factors that affect the First Nations peoples across the world, such as cultural and historical trauma, systemic bias and marginalization that is going on currently, and of course the social determinants that directly impact all of our health outcomes, including economics and housing.

In Hawaii specifically we have a really big housing crisis occurring at the moment as well as very significant impacts and threats to our freshwater sources. All of those things being factors that predict the higher rates of substance use and misuse in the Native community here probably in some ways probably parallel what occurs in other First Nations.

And those trends tend to be over time. If fentanyl follows the same path as opioids have and meth have before that, then what we tend to see is that we follow behind the continent a few years. So where everyone else is at what I am hoping is at the peak of the fentanyl, the impacts that you are at that sort of crisis state, in Hawaii we are seeing that increasing and rising trend. I don't believe that we are yet at the peak that we will see for this particular substance.

So if we are to believe that it is going to follow the same path, that is what we can predict, because we saw cases initially among individuals who have acquired fentanyl for prescriptive purposes, but then it was part of their care plan, and that misuse and that was following along with a lack of information about the risks of its use, and then of course, into that sort of misuse category.

And then seeing fentanyl as mixed in with other substances as a street drug, that is following behind but not reached its sort of influx, at least in my experience in the communities that I work in. It is not yet at that peak, widely accessible utilization component just yet. So we are not seeing as many.

Now, we are seeing opioid deaths, of course. But the rise, we are still on that increasing arc at this time. So my hope is that participating in this conversation today, we are talking in two categories. One of course is about preventive strategies to help us not follow the way that each of the other substances has followed across the Country from the continent to us in Hawaii, to prevent that and sort of stave it off. Because as you can imagine, our health system is finite, we are an isolated island nation, and in that way that we have the substance services that are available; they are all that exist. So it is vital for us.

So with respect to prevention and intervention, there are some very specific things that I will focus on. Those are that for some of our communities, standard, evidence-based western practices work fine. But for everybody else, that something else seems to give real promise in the use of cultural practice as part of healing and recovery. Those programs that have emphasized those things seem to have really wonderful outcomes. We even have some third party insurers that have been experimenting with models for how to fund it.

So with respect to an ask of this Committee, it is to support those initiatives that find ways to fund through Medicare, Medicaid

funding, because our third party insurers tend to follow those of the leaders, that they fund those mechanisms for funding traditional cultural practices as a vital aspect of healing for our communities.

I would say that is probably the greatest ask that I would have of this Committee with respect to different, any other requests that have already been made with respect to supporting prevention initiatives that include education or health providers more generally, both in the risks of inappropriate use and of course misuse of fentanyl, as well as the value add and necessity of culturally informed care as well as the use of traditional cultural practices for healing and well-being as part of the inclusive health system, instead of as sort of viewed as marginal the way that it has been historically.

For our community in particular, our folks would much rather see a traditional healer than a western medical doctor, especially our men. So in that way that this could be legitimized and valued in our community we need that training for our health system and providers alongside support and funding mechanisms for the programs that are already using cultural practices as healing.

[The prepared statement of Ms. Seabury follows:]

PREPARED STATEMENT OF A. AUKAHI AUSTIN SEABURY, PH.D., EXECUTIVE DIRECTOR/LICENSED CLINICAL PSYCHOLOGIST, I OLA LĀHUI, INC.

Welina me ke aloha mai ke one kaulana o Kakuhihewa.

Greeting with aloha from O'ahu, Hawai'i, the famous sands of the great chief Kakuhihewa.

It is with great respect that I come before you today to provide information, insight, and perspective on the impacts of Fentanyl and other substance use on Native Hawaiians in the communities that I serve.

A little about the porch that I am speaking from. I am a licensed clinical psychologist and director of I Ola Lāhui, a nonprofit behavioral health organization that provides culturally-minded, evidence-based behavioral health services to Native Hawaiian, medically underserved, and rural communities. I have spent my career in the service of my people as a therapist, healer, advocate, community builder, program developer, pilina relationship maintainer, and Hawaiian health leader. What I share is informed by direct patient care, community listening and observation, and feedback from other community health partners.

Due to similar factors affecting other first nations peoples of the world including cultural and historical trauma, systemic bias and marginalization, and the social determinants directly impact our health outcomes including economics and housing, Native Hawaiians experience high rates of substance use and suffer the more serious consequences of misuse including judiciary involvement and incarceration, loss of social support and global impacts on families, and health impacts that result in poor functioning, heavy reliance on health system resources, and shortened lifespan.

What we are seeing with respect to Fentanyl seems to follow a pattern similar to what we have seen with other substances over the past several decades where the extent of use in Hawai'i tends to lag a few years behind what is occurring on the continent. Cases of misuse were initially just seen among individuals who had acquired Fentanyl initially for a prescription purpose that then changed into misuse, dependence, and the whole host of known health risks. In the typical pattern, increased availability and use as a street drug is following, although use in communities I serve does not seem to have reached the high rates that are seen elsewhere on the continent yet. The "yet" there is the critical note. Access, cost of the drug, and its addiction potential will likely impact the speed with which this drug will flood our community.

Looking at this as an opportunity to intervene sooner and reduce the scope of impact overall, the question of best practices for Native communities becomes central to the conversation.

It has long been recognized in substance use treatment that interventions that don't just address substance avoidance, but include healing, a spiritual component,

and support for rebuilding a life are effective in recovery and relapse prevention. For some portion of our community, conventional western best practices work fine. For that portion, access and affordability of care are the main predictors of success.

I will focus my comments here on the rest of our community, and I would argue the greater portion, who need something beyond what is conventionally offered. This "something beyond" is the incorporation of traditional Native Hawaiian cultural practices and worldview. Given the high occurrence of cultural and historical trauma, Adverse Childhood Experiences, and current systemic factors, an approach that focuses on healing and restoration of balance is critical to recovery. Hawaiian cultural practices provide stability, focus, and growth opportunities through the learning process that is more easily accepted than traditional western substance use treatment approaches. They show a person how to live a life instead of just how to avoid the life they used to have which was solely focused on substances.

For this type of care to be broadly available requires support in two areas. The first is prevention. Funding that supports developing healthy relationship skills, leadership development, and self-efficacy in youth is a critical deterrent for substance misuse pathways. Policies and resources that educate prescribing health providers, limit access to the substance, and make it less available as a street drug further support this effort.

Looking further upstream, funding and initiatives to address the desperate housing shortage and affordability, safety of our land, water, and natural resources, and support for native voices in leadership will make a significant impact in this and other health areas for years to come.

The second type of support needed is for intervention. Currently, traditional native cultural practices are not a universally reimbursed service as part of Medicare/Medicaid plans. This limits the capacity of already underfunded substance use programs to provide the healing services needed by this community. They provide the care when and how they can, given these constraints, making it very difficult to sustain and offer more broadly. Some promising efforts are occurring in our state related to reimbursement for cultural practices that could serve as a model.

An addition support in this area is needed for health provider trainings related to knowledge of traditional healing as a valid treatment approach and the incorporation of Hawaiian worldview and culture into health services. Increasing the number of providers with these competencies will improve health and well being outcomes overall for this and other Native communities.

Mahalo for your time.

The CHAIRMAN. Thank you, Dr. Seabury. Mahalo.

Mr. Gettis, please proceed with your testimony.

STATEMENT OF ERIC M. GETTIS, SENIOR VICE PRESIDENT OF BEHAVIORAL HEALTH, SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM; ACCOMPANIED BY COREY P. COX, M.D., CLINICAL DIRECTOR FOR ADDICTION SERVICES

Mr. GETTIS. Chairman Schatz, Vice Chair Murkowski, and members of the Committee, and those who have spoken so expertly and passionately today, thank you for the opportunity to testify on the issues of fentanyl, the opioid crisis, and the impact on Native communities.

My name is Eric Gettis. I serve as Senior Vice President for Behavioral Health at Southeast Alaska Regional Health Consortium, known as SEARHC. SEARHC is an Alaska Native-controlled tribal health organization. We are authorized by the resolutions of 15 federally recognized Alaska Native tribes to administer a comprehensive health care delivery for the Tlingit, Haida, Tsimshian and other residents of Southeast Alaska.

Founded in 1975, SEARHC is one of the oldest and largest Native-run health organizations in the Nation with a service area stretching over 35,000 square miles. SEARHC is accredited by the Joint Commission and operates two critical access hospitals, two long-term care facilities, and 22 rural Community Health Centers.

The decades-long opioid crisis has impacted communities across the United States and multiple studies, confirmed here today, show that Alaska Native and American Indian people are disproportionately impacted by opioid use, opioid related overdose, and opioid related deaths. The Native Communities of Southeast Alaska continue to suffer through the heartache and despair brought about by substance use.

SEARHC has addressed opioid use disorder over the past 10 years by significantly reducing opiate prescriptions, promoting holistic interventions for pain management, implementing harm reduction services and activities, and providing buprenorphine and naltrexone throughout the region. Recognizing more services were needed, in February 2022 SEARHC opened an Opioid Treatment Program, or OTP, in Juneau.

OTPs are the only facilities that offer patients all three forms of medication for opioid use disorder: methadone, buprenorphine, and naltrexone. No other setting is permitted to provide methadone. OTPs are critical to reducing overdose deaths and providing lifesaving addiction treatment.

In the past year, SEARHC added two additional OTPs; in Sitka and in Klawock. Before these programs opened, those with opioid use disorder had to physically move hundreds of miles away, to Anchorage or Seattle, to engage in treatment. Our programs have dramatically improved people's lives, yet serious challenges remain.

Fentanyl has rapidly replaced prescription opiates and heroin as the primary driver of opioid misuse in Southeast Alaska. Fentanyl is profoundly potent, quickly physically addictive, easily attainable, and has a very short half-life leading to escalating quantities of use and lethality. This has led to yet another widespread wave of opioid use resulting in more overdoses and preventable deaths.

We consistently find patients developing dependence on fentanyl over relatively short periods of time. It is essential that treatment and medication for opioid use disorder be available and expanded. The COVID pandemic allowed several long-standing OTP regulations to be eased. These revised rules improved treatment availability by permitting telemedicine and allowing prescribers more clinical discretion for some methadone take-home administration. SEARHC wholeheartedly supports maintaining these relaxed emergency regulations.

However, there are efforts around the Country seeking to ease methadone regulations even further. We urge great caution with these proposals and recommend that methadone remain part of a comprehensive opioid treatment program.

Access to and availability of harm reduction services and overdose reversing medications is paramount for saving lives. Oftentimes these medication supplies are limited. Additionally, preconceived beliefs about substance use and associated stigma prevent harm reduction services from being accepted in some communities.

Changing our words and descriptions, helping communities reframe beliefs, and realizing that people can and do recover are all essential components to battle stigma.

Finally, as a nation, we must recognize the necessity of developing a strong behavioral health workforce. Native communities

across Alaska continually struggle with inadequate staffing. Behavioral health specialists and peers have long operated in an underresourced system that discourages many from entering or remaining in the field.

Effective treatment requires qualified compassionate professionals grounded in culturally responsive practices and relationships. These are the fundamental elements that foster healing and recovery.

In conclusion, SEARHC truly appreciates the opportunity to speak before the Committee today on this very important issue.

Thank you.

[The prepared statement of Mr. Gettis follows:]

PREPARED STATEMENT OF ERIC M. GETTIS, SENIOR VICE PRESIDENT OF BEHAVIORAL HEALTH, SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

Chairman Schatz, Vice Chair Murkowski, and members of the Committee, thank you for the opportunity to testify today on the issues of Fentanyl, the opioid crisis, and the impact on Native communities. My name is Eric Gettis. I serve as Senior Vice President for Behavioral Health at Southeast Alaska Regional Health Consortium (SEARHC). SEARHC is an Alaska Native-controlled tribal health organization. We are authorized by the resolutions of 15 federally-recognized Alaska Native tribes to administer a comprehensive health care delivery system for the Tlingit, Haida, Tsimshian and other residents of Southeast Alaska under a Self-Governance Compact with the Indian Health Service entered into pursuant to Title V of the Indian Self-Determination Act.

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In the past year, SEARHC added two additional OTPs; in Sitka, Alaska, in March 2023, and in Klawock, Alaska, in October 2023. Before these programs opened, those with opioid use disorder had to physically move hundreds of miles away, to Anchorage or Seattle, to engage in treatment. Our programs have dramatically improved people's lives, yet serious challenges remain.

Fentanyl has rapidly replaced prescription opiates and heroin in Southeast Alaska as the primary driver of opioid misuse. Fentanyl is profoundly potent, quickly physically addictive, easily attainable, and has a very short half-life leading to escalating quantities of use and lethality. This has led to another widespread wave of opioid use resulting in more overdoses and preventable deaths. We consistently find patients developing dependence on Fentanyl over relatively short periods of time.

It is essential that treatment and medication for opioid use disorder be available and expanded. The COVID pandemic allowed several long-standing OTP regulations to be eased. These revised rules improved treatment availability by permitting telemedicine and allowing prescribers more clinical discretion for some methadone takehome administration. SEARHC wholeheartedly supports maintaining these relaxed emergency regulations. However, there are efforts around the country seeking to ease methadone regulations even further. We urge great caution with these proposals and recommend that methadone remain part of a comprehensive OTP.

Access to and availability of harm reduction services and overdose reversing medication is paramount for saving lives. Oftentimes these medication supplies are limited. Additionally, preconceived beliefs about substance use and associated stigma prevent harm reduction services from being accepted in some communities. Changing our words and descriptions, helping communities reframe beliefs, and realizing that people can and do recover are all essential components to battle stigma.

Finally, as a nation, we must recognize the necessity of developing a strong behavioral health workforce. Native communities across Alaska continually struggle with inadequate staffing. Behavioral health specialists and peers have long operated in an under resourced system that discourages many from entering or remaining in the field. Effective treatment requires qualified compassionate professionals grounded in culturally responsive practices and relationships. These are the fundamental elements that foster healing and recovery.

In conclusion, SEARHC truly appreciates the opportunity to speak before the Committee today. Thank you.

Senator MURKOWSKI. [Presiding.] Thank you, Mr. Gettis.

Our last witness will be Dr. Soto. Thank you for joining the Committee today.

STATEMENT OF CLARADINA SOTO, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF POPULATION AND PUBLIC HEALTH SCIENCES, KECK SCHOOL OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA

Ms. SOTO. Thank you for having me. Before I begin, I would like to make a correction that I am from the University of Southern California. I know it is a rival to UCLA, but that is okay. Actually, my daughter is there at UCLA.

I am Claradina Toya, or Soto-Toya. I am an urban Indian born and raised in the east bay area of California. I am Navajo from my mother's side and Jemez Pueblo from my father's side.

Thank you, Chairman Schatz, Vice Chairman Murkowski, and all the members of the Senate Committee on Indian Affairs for this opportunity to address to you today about the fentanyl crisis that is killing my people.

In my written testimony, I offer information about this critical issue, the work that we are doing specifically in California reaching tribal and urban Indian populations, and several policies that fall within the scope of your Committee's duty to address the issues affecting our Native people today.

I would like to mention that the work here in California, our populations are very unique and diverse. We have the largest American Indian and Alaskan Native population of any other State. We have 109 federally recognized tribes in California, as well as numerous State recognized tribes and non-federally recognized tribes, plus a large urban Indian population.

Today I would like to discuss how American Indian and Alaska Native communities face unique challenges and vulnerabilities that have contributed to the opioid crisis. I would like to offer four recommendations to the Committee. This is based on our community engaged research work with community organizations, tribal governments, Indian health clinics and our community advisory boards. We understand that effective change requires a deep understanding of both the challenges faced by and strengths inherent to our Native communities. I would like to note, my recommendations may vary by community and when implementation is considered, it should be decided by each community.

My first recommendation, and this has been shared by others, is to increase the accessibility, quality and sustainability of residential detox and sober living facilities for tribal and urban Indian populations. We need residential treatment programs in counties and tribal communities with high opioid use and overdose deaths. Discussions with our leaders and stakeholders must immediately happen to expand Native-specific and culturally centered services, especially among regions where no recovery services exist.

We must expand medication assisted treatment, MAT, also known as medication for opioid use disorder. Yes, this is use of medication, in combination with counseling and behavioral therapy. That is essential to support and promote opioid use recovery. So as we think about this critical infrastructure, this is important in the treatment life cycle for opioid use disorders. So there is a need for detox and sober living homes serving our Native community.

One of the critical components missing from the Indian health care network, particularly here in California, is detox, that coordinates on a system level with Indian health clinics. When individuals graduate from residential or other outpatient treatment programs, sober living and traditional housing for American Indian and Alaska Natives are critical to providing a safe culturally centered recovery experience for individuals to integrate recovery tools into their home and community settings.

My second recommendation is to integrate cultural modalities into recovery treatment programs. This includes but is not limited to healing ceremonies such as prayers, smudging, sweat lodges, and meeting with traditional healers that offer safe, sober, and supportive spaces to gather and express traditional ways of healing. Studies have found that many Native community members do strongly favor traditional healing over strict medication use, and I have indicated that healing begins with culture, and with practices that are grounded in our traditional way of life.

Access to these approaches and practices and healing for patient wellness is one of the most critical junctures in the recovery cycle of change. This is very apparent.

My third recommendation again as also mentioned by others is to focus on our Native youth in urban and rural areas, with community based and culturally relevant opioid use prevention and treatment services. According to CDC, in 2021, Native adolescents experienced the highest overdose deaths from fentanyl due to the increased availability of illicit fentanyl, again highlighting the need for harm reduction education and greater access to naloxone and mental health services.

Specifically, there is a need for youth rehab programs to treat and reduce opioid use disorders. We must use family cohesion, cultural and traditional practices, and culturally based youth programs as protective factors against our youth engaging in opioid substance use.

My fourth recommendation, and last, is to address the challenges of collecting reliable data for our populations to ensure accurate demographic data and respect the cultural and ethnic identities of our Native people. All too often, we are racially misclassified, especially in urban areas, where we are assumed to belong to another

ethnicity based on appearance. We are not invisible, and we must improve our data collection methods and collaborate with tribal governments and Native organizations that are working on these data issues to advocate for policies that provide data collection and representation of our Native communities. This will help us determine our impact in addressing the opioid epidemic in Indian Country.

Thank you so much for your time and this opportunity to share.

[The prepared statement of Ms. Soto follows:]

PREPARED STATEMENT OF CLARADINA SOTO, PH.D., ASSOCIATE PROFESSOR, DEPARTMENT OF POPULATION AND PUBLIC HEALTH SCIENCES, KECK SCHOOL OF MEDICINE, UNIVERSITY OF SOUTHERN CALIFORNIA

Chairman Brian Schatz, Vice Chairman Lisa Murkowski, and all members of the Senate Committee on Indian Affairs, thank you for the opportunity to address you today about the fentanyl crisis that is killing my people.

Fentanyl in the American Indian and Alaska Native (AIAN) community is a public health crisis. I offer information below about this critical issue, the work that we are doing, and several policy recommendations that fall within the scope of your committee's duty to study the issues affecting the AIAN people and report recommendations to the Senate.

The Obligation

There are 574 federally recognized Tribal Nations distributed across Turtle Island; there are also stateonly-recognized Tribes in 16 states,[1] Tribes without any official recognition, and AIAN people who are not enrolled members of any Tribal nation. These non-federally recognized Tribes and individuals do not receive federal benefits or have the same political status as federally recognized Tribes. Below, I describe the factors impacting my people as they relate to health disparities around the opioid crisis, and I explain the federal responsibility to address these concerns.

Although we once knew how to be healthy, living in balance and harmony, we have experienced centuries of violence, discrimination, and disparity resulting from settler colonialism and its associated harms. Sovereign AIAN nations negotiated treaties with the federal government over a period of nearly 100 years (1774–1871),[2] trading "400 million plus acres of land and our way of life and our very lives for peace and for the provisions that are provided in the treaties and a basic human dignity of having basic services for AIAN people."[3] Invaded by European conquerors and ravaged by new diseases such as smallpox, my people traded their land—their connection to the earth, their source of wealth, life, food, water, spirituality, and medicine—in hopes of receiving health and public health services (among other treaty obligations). In turn, the United States government took upon itself the federal trust responsibility, "moral obligations of the highest responsibility and trust"[4] to be provided to the Indian Nations. Critical aspects of AIAN policy were created and affirmed in the Marshall Trilogy (early 1800s, identifying Tribes as "domestic dependent nations"), the Snyder Act (1921), and the Indian Self Determination and Education Assistance Act (Public Law 93–638) (1975),[5] as well as in more recent executive orders 13175 (2000) and 13647 (2013).[6]

However, access to health care is limited and has been complicated by federal policies. Congress initially funded Indian health care and defined the federal government's responsibility in the Snyder Act,[7] but termination and relocation policies in the 1950s and 1960s impeded the ability of many to access care by stripping Tribes of their federal recognition and moving AIANs off of Tribal reservations into urban areas.[8] Many Tribes had their federal recognition restored, but others have not.[9] The broadening of the Snyder Act under the Indian Health Care Improvement Act of 1976 ensured the provision of health care specifically for AIAN individuals.[10] But although the Indian Health Service (IHS), an agency within the Department of Health and Human Services, is intended to provide direct medical and public health services, access to health care within California can be complicated because IHS facilities in California are limited.[11]

The federal government has not met its obligations to the Tribes. Despite the obligations the US government has to provide health services to members of Tribal nations, IHS is not an entitlement program like Medicaid, and its spending comes out of discretionary funding appropriations; IHS is currently funded at 60 percent of need.[12] As described in the US Commission on Civil Rights 2018 report, titled "Broken Promises: Continuing Federal Funding Shortfall for Native Americans," the In-

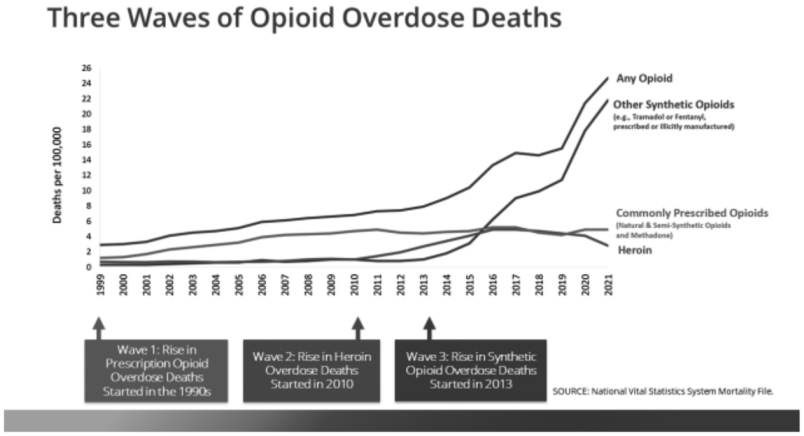
dian Health Service is significantly and disproportionally underfunded, covering only "a fraction" of the physical and mental health needs of Tribal and Urban Indians and failing to increase the budget to keep up with population growth and rising costs; for example, in 2016, IHS allocated only $2834 per person compared to $9,990 nationwide. [13]

Lastly, in addition to the federal obligations the US government owes to federally recognized Tribes, I argue that there is a separate moral responsibility to make restitution to all AIAN communities, which have been so harmed by federal policies and other forms of mistreatment, violence, and discrimination. For example, historical and intergenerational trauma are frequently cited as reasons contributing to the use of substances; we know that people use harmful substances to cope with pain and trauma. Since so much of this trauma was inflicted directly or indirectly by federal policies such as relocation, termination, and boarding schools, as discussed more in detail below, I argue that the federal government is directly responsible, at least in part, for the dire rates of substance use in AIAN communities today. [14]

The Opioid and Fentanyl Crisis

National data

Figure 1



The United States has been experiencing an opioid and fentanyl crisis. The Centers for Disease Control and Prevention (CDC) Injury Center reports that nearly 645,000 people died due to overdoses between 1991–2021, with three waves of overdoses starting respectively in the 1990s, in 2010, and in 2013. [15] Figure 1 below, from the same source, depicts how significantly deaths have spiked since 2013 due to both 1.) all opioid overdoses and 2.) synthetic opioid overdoses specifically.

Table 1 Overdose Death Rates Involving Opioids, by Type, United States (deaths per 100,000 people)

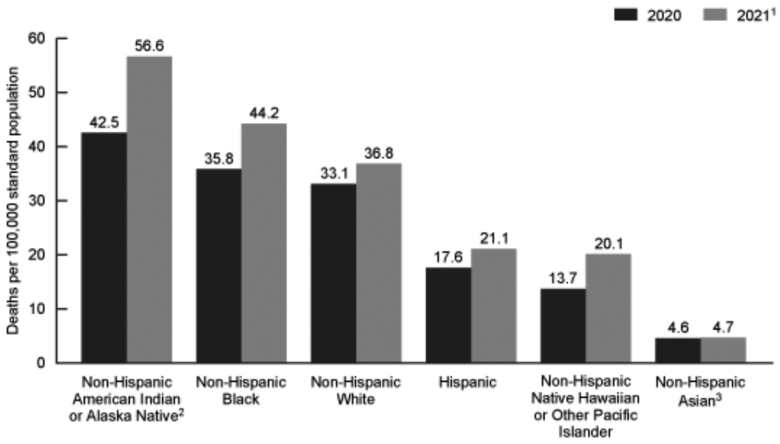
Any opioid	Any opioid	Synthetic opioid analgesics excluding methadone
1999	2.9	0.3
2006	5.9	0.9
2010	6.8	1.0
2012	7.4	0.8
2014	9.0	1.8
2016	13.3	6.2
2018	14.6	9.9
2020	21.4	17.8

Fentanyl is a synthetic opioid up to 100 times stronger than morphine that can be prescribed pharmaceutically or created illegally; most overdoses are related to the illegal form, which can be mixed into other illegal drugs such as heroin and

meth, resulting in dangerous effects due to its strength.[18] For example, the National Institutes of Health (NIH) National Institute on Drug Abuse (NIDA) reports that 20 percent of benzodiazepine-related deaths included fentanyl in 2015, increasing to 70 percent just six years later.[19] The COVID pandemic only exacerbated the opioid crisis. While fentanyl resulted in 53,480 preventable deaths in 2020, this increased 26 percent to $67,325 only one year later, in 2021.[20]

Nationally, AIAN communities face significant disparities in the opioid crisis. In 2020 and 2021, AIANs experienced the highest death rates from drug overdoses compared to all other racial and ethnic groups, as shown in the graphic below, even though rates rose for all groups in 2021.[21]

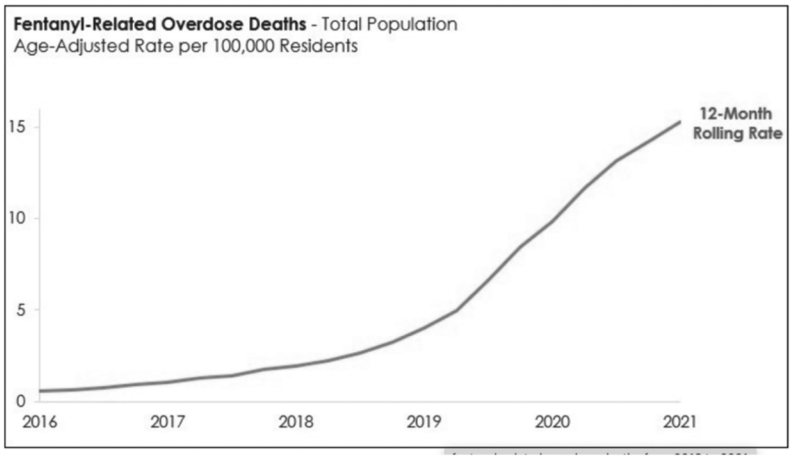
Figure 2 *Age-Adjusted Rate of Drug Overdose Deaths, by Race and Hispanic Orig*



California data

Fentanyl-related deaths in California have also increased exponentially between 2016 and 2021, as shown in the figure below from the California Department of Public Health (CDPH) Substance and Addiction Prevention Branch.[22]

Figure 3 *Fentanyl-Related Overdose Deaths in California*



Preliminary 2022 data from the California Overdose Surveillance Dashboard estimates 6,959 deaths related to any opioid overdose and 6,095 specifically related to fentanyl; additionally, 21,316 overdoses are estimated to have led to an emergency department visit.[23] According to the California Department of Justice, the 2022 data above shows a quick and significant rise from 2020, when nearly 4,000 deaths were estimated to be fentanyl related.[24] While much of the data focuses on overdose deaths, it is important to remember that these numbers show only a fraction of the impact of addiction. Each individual and their loved ones may struggle with addiction and its challenges for years before an overdose occurs, if it occurs.

These grim statistics show the terrible consequences of the rise in fentanyl. To help put this into perspective, more people died in California in 2021 from fentanyl-related drug overdoses than from all car accident deaths, with certain groups—men, Black and AIAN racial groups, and 30–34-year-olds—disproportionally affected.[25]

AIAN health disparities overall

Considering AIAN policies and historical and social factors described above, it should be unsurprising that AIAN communities face extensive disparities in a variety of health issues around both diagnosis and outcome. This section describes the challenges AIAN face in overall health and how these existing disparities interact with and lead to OUD/SUD disparities.

According to IHS, the life expectancy of AIAN people is 5.5 years below the average, and the AIAN community faces disparities in mortality from many infectious and chronic diseases (e.g., diabetes, influenza), from violence (e.g., suicide, assault/homicide), and from drug- and alcohol-induced deaths.[26] These disparities arise not only from the underfunded health system but also from a wide range of social and historical determinants of health, historical trauma and other forms of trauma, the losses experienced by the AIAN community, factors such as education level and income, geographic isolation and technological access challenges, high rates of interpersonal violence and abuse, health care access challenges, and limited access to culturally and linguistically appropriate services. Moreover, the significant underfunding and access to health care issues discussed above and other inequities (e.g., the reservation system, housing insecurity, poverty) help perpetuate the cycles of family dysfunction, such as abuse, domestic violence, and adverse childhood experiences, that have harmed AIAN families.

Urban Indians

As mentioned above, in the 1950s and 1960s, federal relocation policies pushed AIAN to move into urban areas. Additionally, many AIANs also moved to urban areas voluntarily for better economic, educational, and housing opportunities as well as improved access to health care and other services. Today, the combination of these factors has led to 87 percent of the AIAN population living in urban areas today as a diverse and inter-tribal community according to the 2020 census.[27] Many Urban Indians have made California cities their new homes; "1 in 7 American Indians in the United States lives in California and 1 in 9 American Indians in the United States lives in a California city."[28]

Although urban areas theoretically offer more geographical access to healthcare and other services, in fact, Urban Indians have less access to the IHS and Tribal services they are entitled.[29] Urban Indians continue to face disparities in many different areas compared to other ethnic groups. For example, Urban Indians experience 54 percent higher rates of diabetes, 126 percent higher rates of liver disease and cirrhosis, and 178 percent higher rates of alcohol-related deaths compared to general population.[30] Some small studies have reported up to 30 percent of all AIAN have depression, with strong reasons to believe that the number is even higher among AIAN living in cities.[31] The unemployment rate of Urban Indians is 11.2 percent compared to 4.9 percent of non-Hispanic whites in urban areas.[32] Some cities have reported poverty rates among Urban Indians of 30 percent to 50 percent.[33] The numerous poor health outcomes, economic challenges, sense of cultural loss, assimilation, and historical trauma has led to a much more challenging life experience for Urban Indians compared to the general population.

AIAN communities: reasons for opioid use

AIAN communities have been and continue to be disproportionately affected by health disparities related to substance use and the opioid epidemic. Substances have been used as a "tool of genocide" against the AIAN people since before the United States was a country; as early as 1749, Benjamin Franklin wrote about the plan and blessing of "Providence" to annihilate "these savages" with alcohol to get rid of them so colonists could capture their land.[34] Many complex factors go into the high rates of substance use in the AIAN community, to include historical trauma, lack of resources, lack of opportunity, isolation, discrimination, loss of culture and land,

loss of identity, feelings of hopelessness, and numerous other factors. Unfortunately, the use of substances perpetuates this cycle by setting up individuals and families for further trauma, such as adverse childhood experiences, which may increase the likelihood of future substance use.

As one of our study participants stated, "Hopelessness. I mean, that's pretty much rock bottom. I think that if you have a plan, strong backing, and a sense of purpose, you will steer clear of those things. But if you don't, you will fall prey to making bad decisions." This quote summarizes some of the challenges AIAN face that contribute to OUD/SUD.

The following statistics come directly from our team's original research, which is discussed further below:

- Eight of 19 urban AIAN individuals experiencing homelessness attributed their substance use to trauma in the form of family separation or loss. A specific challenge among female participants with children was navigating child protective services, losing custody of their children, and coping with these lifechanging and traumatic situations. Participants mentioned coping with family loss such as death or separation. One participant mentioned drinking to cope with their mother's passing. [35]
- Intergenerational trauma was a common theme among the 19 homeless participants. Boarding school was identified as a main factor for intergenerational trauma among their parents, which led to substance use in the household growing up and subsequently their own substance use. Some participants mentioned they were raised by relatives because their parents were unable due to their substance use.

National AIAN data

According to recent data from the Centers for Disease Control and Prevention, AIANs experienced the second highest rate of overdose from all types of opioid use in 2017 (15.7 deaths/100,000 persons) when compared to other racial and ethnic groups. [36] In 2017 and 2018, AIAN communities experienced a rapid increase in opioid and synthetic opioid overdose mortality rates. AIAN communities currently have the second highest rate of opioid overdose when compared to other racial and ethnic groups. [37] These disparities have only been magnified by the COVID–19 pandemic over the last several years. According to the Indian Health Service (IHS), fentanyl and other synthetic opioids were associated with increases in opioid overdose deaths among AIANs during the COVID–19 pandemic. Between January to September 2019 and January to September 2020, AIAN drug overdose deaths increased disproportionately compared to deaths among non-Hispanic Whites, Hispanics, and Asians. [38] In 2019, 22.3 AIAN overdose deaths were reported per 100,000 persons, and in 2020, reported overdose deaths increased to 29.8 per 100,000; although this number includes overdoses from several drugs, most of these deaths involved opioids. [39] Limited access to care and organizational closures during the COVID–19 pandemic contributed to these increases, alongside increased stress and disruptions in people's lives (e.g., work schedules, stay-at-home orders) were also associated with increases in opioid deaths. [40]

California AIAN data

California has the largest AIAN population in the US, with over 772,394 AIAN individuals (approximately 2 percent of the total California population). [41] There are 109 federally recognized Tribes in California, as well as numerous state-recognized Tribes and non-federally recognized Tribes. [42, 43] Additionally, there are an estimated 78 state Tribes petitioning for federal recognition [44]. AIANs in California, including California Indians and AIANs who relocated from other states, are dispersed throughout rural and urban areas around the state, primarily due to federal policies relocating AIANs from reservations to urban areas. [45] This data clearly shows the high need within California's Native communities.

According to the California Rural Indian Health Board, Inc. (CRIHB) California Tribal Epidemiology Center (TEC), California AIANs experience the highest rate of opioid overdose deaths and have borne the greatest burden of suffering from opioid deaths since 2006, but even these numbers are growing: from 2019 to 2020, there was a 39 percent increase among AIANs opioid-related overdoses nationwide. [46]

For fentanyl-related overdoses specifically, Figure 4 below shows the rising rates of fentanyl among all California racial and ethnic groups but highlights that AIANs are the hardest hit, and Figure 5 visually depicts the counties where AIANs have been most greatly impacted by fentanyl deaths. [47] However, the same source shows that both Black and White patients surpass AIAN for fentanyl overdose emergency

department visits and hospitalizations both, perhaps due to challenges around equal health care access.

Figure 4 *Fentanyl-Related Overdose Deaths by Race/Ethnicity*

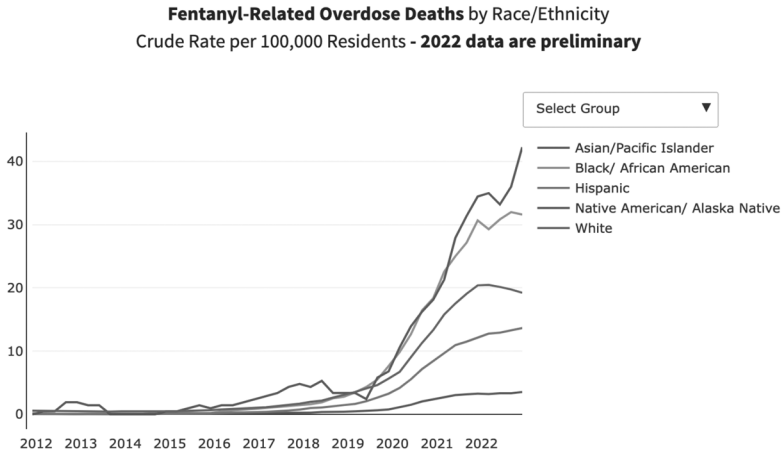
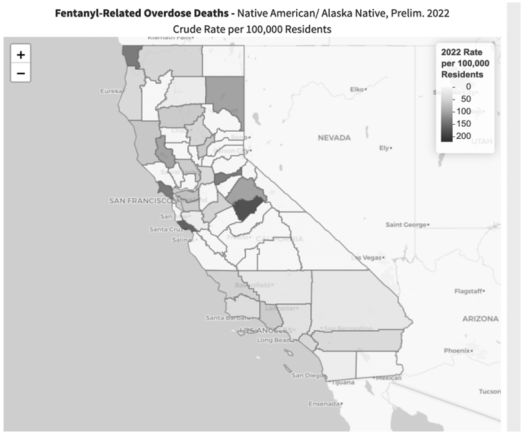
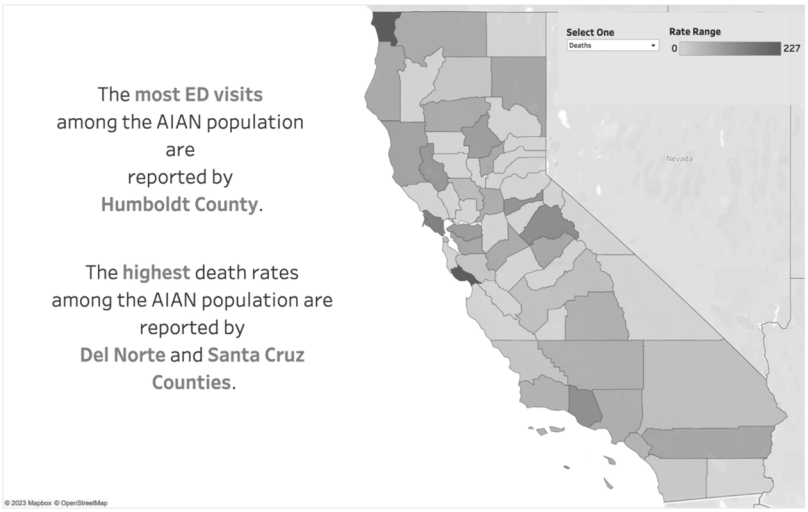


Figure 5 *Opioid Overdose Deaths by Race/Ethnicity (2006–2022)*[*]



* A warning notes that data for many of the counties is or may be unstable.

Figure 6 *Opioid Overdose Deaths among the AIAN Population by County 2022*



Data Challenges

Obtaining comprehensive and accurate data about the AIAN population is a challenge for many complex reasons. As cited in the California Consortium for Urban Indian Health's 2020 report, "A Profile of Data Availability on American Indians & Alaska Natives in California," there is extensive documentation in the literature regarding "data capacity issues which under-report health conditions and causes of death" among this population.[48] The report elaborates that AIAN, are frequently subject to racial misclassification, especially in California urban areas where they are assumed to belong to another ethnicity based on appearance; being wrongly classified as non-AIAN 30–60 percent of the time often renders this group "invisible," for example, when AIAN data is not reported due to a small sample size. Compounding this issue is the fact that the AIAN population is already proportionally small compared to other racial and ethnic groups; as cited earlier in this document, AIAN make up only around 2 percent of California. Another consideration is that a full 61 percent of AIAN individuals reported identifying with multiple racial groups on the 2020 census, the highest rate of any other group, compared to only 13 percent of White, 12 percent of Black, and 17 percent of Asian respondents.[49] This is particularly concerning, the same source elaborates, since individuals of multiple races are often combined into one category regardless of racial background (i.e., mixed individuals of any races in combination would also be part of this category), further rendering the unique needs of the AIAN population invisible. This is so severe that it has been called a "data genocide."

Furthermore, there are challenges collecting reliable data among AIAN due to unique considerations such as high mobility, variations in definitions of AIAN groups, residences in extremely rural areas or without designated addresses, and challenges around question phrasing and survey completion, among others.[50]

For example, some questions include different definitions (e.g., are indigenous Central American populations included?) and terms (e.g., "Native American" vs. "AIAN" or "indigenous") or ask for specific Tribal affiliations. Challenges also arise around identity vs. official Tribal enrollments, eligibilities for membership in varying Tribes, and the differing political statuses of federally vs. staterecognized or unrecognized Tribal nations. CCUIH also identifies challenges around collaboration and data sharing, such as limited access to data among AIAN organizations and non-Native data not being affirmed by Urban Indian organizations.[51] Even though TECs are designated "public health authorities,"[52] there may be misunderstandings or lack of knowledge about this that lead to reluctance to share data.

Figure 7 below, from a presentation at the NIHB 2023 Tribal Health Equity Data Symposium created by the Northwest Portland Area Indian Health Board, groups these issues into three primary categories: data access, data collection, and data analysis.[53] The presentation also includes a very telling quote that speaks to the cycle of invisibility from a 2019 journal article published by Michelle Connolly (Blackfeet/Cree) et al.: "It is not clear if invisibility results from lack of data or if lack of data leads to invisibility." These challenges are extremely complicated, and there may be factors even beyond these mentioned here, such as concerns about data sovereignty, collaboration challenges, poor relationships, past negative experiences, structural issues, state vs. federal considerations, and others. Whatever the specifics, it is clear that accurate data is critical to reliably gain a picture of AIAN issues and gain the funding and support needed to address them.

Figure 7 *Health Data Challenges for AIAN Communities*

Our Work and Findings

I lead the Initiative for California American Indian Health Research and Evaluation (I–CAIHRE) at the University of Southern California (USC). Our mission is to improve the lives of individuals in California's AIAN communities by conducting high-quality research that is informed by and responsive to the community's needs and perspectives. We understand that effective change requires a deep understanding of both the challenges faced by and strengths inherent to our Native communities, which can only be achieved through gathering relevant, community-informed data. Therefore, we are committed to providing research that incorporates community perspectives and supports meaningful, sustainable improvements in health and well-being for AIAN communities in California.

The bulk of I–CAIHRE's work focuses on substance use and commercial tobacco. Our substance use work is funded by DHCS [contract # 17–94722], through the California Opioid State Targeted Response (STR) to the Opioid Crisis Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) as part of the state's Tribal Medication-Assisted Treatment (MAT) Project.

Details about our past and current projects are available on our website: *https://pphs.usc.edu/center/icaihre/with* the substance use-related work falling under the Tribal Medication-Assisted Treatment (TMAT) sub-section: *https://pphs.usc.edu/center/i-caihre/tribal-medication-assisted-treatment-projects/*.

Several highlights and the associated findings and recommendations are available below.

Addressing the Opioid Crisis in American Indian & Alaska Native Communities in California: A Statewide Needs Assessment:[54] This 2019 report publishes research conducted using a participatory action approach to gather community perspectives from Tribal and Urban Indians across the state. A total of 279 AIAN individuals (including 83 youth) participated in key informant interviews or focus groups. They indicated a high presence of substances in AIAN communities, including a shift from prescription drugs to heroin. This research found that youth have access to a wider range of substances than in the past, and substance use is common within families. Community and individual stressors were found to be risk

factors for opioid use, while historical and intergenerational trauma drive mental health issues and substance use. Barriers to treatment were found to include stigma and structural barriers such as cost, insufficient insurance coverage, unstable housing, fragmented service delivery, and a lack of residential treatment facilities. Youth prevention programs and services were found to be lacking, and recommendations arose around enhancing prevention and recovery services overall. Another critical finding was the need for culturally centered activities and treatment/preventive services to promote whole-person development and maintain community resiliency.

In summary, this research found that California AIAN communities have a significant need for OUD/SUD service development and implementation; furthermore, these services should expand and better integrate cultural and traditional approaches. This research resulted in recommendations at the individual, interpersonal, organizational, community, and policy levels. Policy recommendations include the following:

- Provide funding for and increased access to MAT
- Recognize and fund community-defined evidence-based practices
- Remove prior authorization requirements and limits on coverage, provide financial incentives for medical providers to become MAT certified, charge a fee on opioid sales to be deposited into a recovery fund, increase rigor on reporting requirements to limit access to addictive substances, and adopt policies supporting more time at patient visits
- Allocate funding for AIAN programs specifically and include Urban Indian Health Programs in federal opioid response dollars and all federal opioid grants and allowing funding for AIANs (e.g., through Tribal Opioid Response Grants) to go to Urban Indian Health Programs as well
- Fund further research regarding the impact of homelessness and housing insecurity
- Provide more funding and attention to understand the link between the opioid crisis and AIAN youth in foster care

Urban American Indians and Alaska Natives Experiencing Homelessness in California: Strategies for Addressing Housing Insecurities and Substance Use Disorder:[55] This 2020 report and published in 2021, stemmed from a recommendation in the above 2019 report to explore SUD/OUD issues related to homelessness. Nineteen AIAN adults who were experiencing homelessness and impacted by SUD/OUD in California's urban areas were interviewed. The report describes how AIAN individuals experience disproportionate rates of homelessness and displacement due to federal policies such as the Indian Removal Act of 1830, the Indian Relocation Act of 1956, the boarding school policies forced upon AIAN families, and overcrowding in housing. The report also discusses the high rates of homelessness in California, the greater risk of SUD among unhoused individuals (17 percent of homeless individuals experience chronic substance use), and challenges around access to treatment. Policy recommendations include the following:[56]

- Address individual needs for AIAN individuals experiencing homelessness, for example supporting and funding California AIAN Housing First programs (prioritizing housing to provide a foundation for recovery), AIAN housing education and home ownership programs, housing cash assistance programs for AIANs, affordable housing programs for AIANs, meal programs for homeless AIANs, hotel voucher programs for AIANs, employment placement programs for homeless AIANs, and emergency shelters
- Provide harm reduction services for AIANs
- Increase education and awareness of SUD treatment options, for example offering mentorship programs and service guides
- Increase the availability of and access to SUD treatment services, including transportation support, simplifying intake and application processes, simplifying communication, and offering more welcoming, compassionate, and culturally appropriate staff and environments
- Increase the availability of culturally centered recovery programs, to include increasing program outreach capacities to target homeless AIANs and offering culturally centered detox programs for AIANs

Tribal Response to the Opioid Epidemic in California:[57] This 2020 report presents our evaluation of five programs that received funding from DHCS's Tribal MAT Program. These programs serve the AIAN community in California used Tribal MAT funding to increase the accessibility and use of MAT services with the larg-

er goal of reducing opioid deaths. Policy recommendations derived from this work include the following:

- Continue and increase funding for Tribal MAT
- Advocate for AIAN communities to be included in future funding opportunities
- Provide trainings to community members to empower them to develop future policies
- Outreach to address issues of stigma and trust
- Fund community-based navigators to serve as resources for information; continued funding will also support the incorporation of traditional healing and recovery approaches
- Ensure sustainability, include training that prepares stakeholders to apply for MAT and OUD funding while retaining their community workforce
- Incorporate increased access to technology in future funding (e.g., broadband Internet to support telehealth access)

Mapping the Network of Care: Substance Use Treatment and Recovery Services for American Indians and Alaska Natives in California:[58] This research, published May 2021, explored another recommendation from the above 2019 report to increase the availability of detox, residential, and sober living facilities. During this research, the USC team gathered and compiled information on available services and facilities. This research resulted in the following key recommendations:

- Create access to the Drug Medi-Cal Program for AIANs and Indian Health Providers through an Indian Health Program Organized Delivery System (DMC IHP–ODS)
- Develop a more integrated and collaborative system of care, to include culturally based service inclusion and the availability of culturally centered recovery programs such as healing ceremonies
- Increase the availability of AIAN residential treatment facilities, including those that allow treatment of parents with children
- Increase the availability of AIAN-specific detox treatment programs
- Increase sober living and transitional housing for AIANs
- Increase job placement and workforce services for AIANs
- Increase youth treatment and recovery programs
- Develop permanent sources of funding for community-defined evidence-based practices
- Increase awareness of AIAN-specific community and service needs

Implementation of Medication for Opioid Use Disorder Treatment in Indian Health Clinics in California: A Qualitative Evaluation:[59] This study, published in the *Journal of Substance Use and Addiction Treatment* in 2023, explored needs, barriers, and successes related to implementing medications for opioid use disorder (MOUD)* in Indian health clinics. Eleven clinics and 29 staff participated in the interviews. Results found challenges including a lack of education around MOUD, few clinic resources, and limited provider ability. MOUD effectiveness was limited by challenges integrating medical and behavioral care, patient barriers such as geographic isolation, and limited workforce capacity. Stigma at the clinic level was a barrier to implementation. Implementation challenges also included insufficient waivered providers and unmet needs for technical assistance and MOUD policy and procedure development. MOUD program maintenance was limited by staff turnover and physical infrastructure limitations. Recommendations based on this study include the following:

*Note that the terms "MOUD" and "MAT" are both used to refer to medications treating addiction. "MAT" is used for much of our work because it is funded by the state "Tribal MAT" project. However, some people are shifting from the term "MAT" to other terms like "MOUD" because some find the term "MAT" to be less preferred or even stigmatizing.

- Strengthen clinical infrastructure
- Integrate culture into clinical services
- Increase AIAN staff to represent the served population
- Address stigma at various levels
- Consider complex barriers AIAN communities face related to MOUD implementation and outcomes

Tribal and Urban Indian Community-Defined Best Practices (TUICDBP) and California Native Medications for Addiction Treatment (NMAT) Network for Healing and Recovery Projects:[60] These projects are currently underway, with our team taking on evaluation and technical assistance support roles. The TUICDBP grant, acknowledging that culture is medicine, provides funding for grantees to identify and integrate traditional cultural healing practices into recovery. The NMAT grant funds grantees to develop, operationalize, and sustain medications for addiction treatment services. The current round of funding provides up to $150,000 for each grantee per project. Preliminary data shows the critical role of these projects and the importance of incorporating traditional practices into OUD/SUD treatment and prevention. Current policy recommendations include the following:

- Provide sustained funding to heal disparities through a return to tradition
- Make systemic policy changes that would support continued funding of cultural practices (e.g., allow reimbursement through Medicaid/Medi-Cal)
- Provide/fund data collection support tailored to AIAN needs to help address challenges around AIAN data collection
- Continue and expand technical assistance

State, Local, and Tribal Collaboration Project:[61] This project, also ongoing, conducted a needs assessment around state, local, and Tribal partnership challenges related to SUD/OUD, with the eventual goal of addressing some of the identified issues. While this project focuses on state and local collaboration, which is different from federal collaboration due to the trust responsibility and federal agencies responsible for Tribal partnership and services, identified issues include challenges that likely exist at the federal level as well: staff turnover, lack of knowledge and awareness about Tribal considerations, different worldviews, lack of resources, lack of infrastructure, existing Tribal disparities, poor communication, past negative experiences, bias, bureaucracy, differences between different communities and individuals, etc. We recommend including Tribes, Tribal organizations, Urban Indian organizations, and other AIAN-serving applicants in federal funding opportunities and encouraging and facilitating their applications. We recommend including provisions that states and localities receiving federal funding include Tribal constituents at a rate that considers not only their population but also their high level of need. This funding may be offered as pass-through funding from the state/locality to the Tribes in its area (which more fully respects Tribal sovereignty and self-determination) or via state/locality efforts to outreach to AIAN constituents or AIAN partners; it could also include training for funding recipients around Tribal considerations.

Substance Use Disorder Policy Advocacy Training Program:[62] This current project helps address the need for policy advocates focused on SUD issues in California's AIAN communities by providing beginner/intermediate-level training around public and AIAN policy, policy development, and policy advocacy as well as information about SUD trends and data. Data from previous training cohorts (2021–2022) show that participants reported that their knowledge and skills related to the training program goals were "greatly improved" and that participants found the knowledge, resources, step-by-step guidance, and peer interaction were the most beneficial aspects. Our team recommends additional funding for policy training to support AIAN SUD/OUD advocacy and policy development. Additionally, we recommend federal funding to provide resources and training or workforce programs for AIAN to support greater AIAN participation in policy-making processes.

Policy Recommendations

In the section above, we provide recommendations from our projects and other findings.

In addition, I recommend the following based on my experience and perspectives:

- Provide sufficient funding appropriations for IHS to provide the support truly needed for all IHSeligible individuals. Ideally, IHS could be shifted to become an entitlement program rather than relying on discretionary funding during each budget period. Regardless of mechanism, the IHS underfunding needs to be addressed to provide adequate treatment for OUD/SUD and also support prevention. This includes the provision of OUD/SUD treatment but also mental health treatment (e.g., for historical trauma and adverse childhood experiences) that can help build healthier individuals, families, and communities, preventing and reducing OUD/SUD rates overall. An adequately funded system will support lowering OUD/SUD rates beyond simply funding direct OUD/SUD treatment. For example, better physical health care may lead to improved mood,

greater employability and thus higher socioeconomic status, less hopelessness, greater access to care, etc.

- Increase enrollment of IHS-eligible AIANs in entitlement programs like Medicaid as well as other insurance coverage options. Since IHS is the "payer of last resort," additional health care payment options save IHS funding (including purchased referred care) for those who need it most, taking the burden off IHS and improving access to care, particularly in urban areas or other areas without IHS services.
- Gather input from Tribes, including via Tribal consultations with federal agencies, in areas regarding relevant policies and funding around the opioid crisis. Follow best practices for engagement with Tribal Nations and facilitate participation. Tribal consultations should be offered consistently and begin early. Tribal Nations have extremely varying needs, and participation and decisionmaking should reflect the diversity of Tribes. Tribal solutions are not "one size fits all" and must consider varying factors like need, size, location, infrastructure, culture, etc.
- Facilitate access to grant funding for Tribes from the federal government and mandate a reasonable portion of state funding with federal origins be used to support Tribal constituents.

Closing Statement

Thank you again, Chairman Brian Schatz, Vice Chairman Lisa Murkowski, and all members of the Senate Committee on Indian Affairs, for this opportunity to speak to you and share information about the AIAN community. I hope that you will consider the great impact of the opioid crisis on my people and do your part to address these disparities and remedy the harms done throughout history. I implore you to use this information to bring about change for one of the most vulnerable and underserved populations: the first Americans.

I want to thank the following individuals for their assistance in the written testimony, Mrs. Angelica Al Janabi and Mrs. Ellen Rippberger, with the University of Southern California Tribal Medication-Assistant Treatment (TMAT) Project research team.

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14FOOTNOTE WAS MISSING

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FOLLOW–UP COMMENTS

Chairman Brian Schatz, Vice Chairman Lisa Murkowski, and all members of the Senate Committee on Indian Affairs, thank you for the opportunity to present at your recent hearing. I also appreciate the opportunity to submit follow-up comments regarding the fentanyl crisis in Indian Country.

During the hearing, I heard discussion around the importance and effectiveness of culturally relevant care, as well as how this differs from care that is broadly compassionate and respectful. I would like to share several thoughts and perspectives for your consideration.

1. Generally, the benefits of cultural competence/cultural humility and the importance of access to culturally and linguistically appropriate health care services have been widely documented without being specific to any one population. Access to appropriate and relevant care for marginalized groups is particularly important considering the health disparities and other disparities faced by many of these populations. The lack of culturally appropriate, culturally relevant, respectful care may contribute to and exacerbate these disparities. It is also widely known that bias and discrimination are embedded in the current health care system.

   Many aspects of modern medical treatment in the US, particularly around mental/behavioral health, are rooted in Western worldviews and ideals that may not align with all cultures. For example, seeing a therapist has helped people from many backgrounds, but it is closely aligned with a White, middle-class worldview and workforce, and it may be inaccessible, unnatural, or uncomfortable for some individuals or communities. When communities offer alternate solutions, nothing should stand in the way of their self-determination.

2. When people think of different cultures, many may think of factors like music, dance, food, and style of dress, but there are often far deeper considerations. For the American Indian and Alaska Native (AIAN) population, for example, culture is "a cognitive map on how to be."[1] In other words, culture is a way of understanding one's identity, relationships, sense of purpose, and place/role in the world. While there are many commonalities across AIAN cultures, specifics may vary (e.g., by Tribe or community).

   For example, the Swinomish Indian Tribal Community in Washington State formally developed their own "Indigenous Health Indicators," reflecting "non-physiological aspects of health"; the community identified many indicators that are not typically considered aspects of health in today's broader US cul-

[1] *https://pubmed.ncbi.nlm.nih.gov/37085784/*

ture, such as sense of place, the teachings of Elders, and practice, which includes being "able to honor proper rituals, prayers, and thoughtful intentions" as well as "able to satisfy spiritual/cultural needs, e.g., consume foods and medicines in order to satisfy Spirit's 'hunger.'" [2] Similar ideas have been repeatedly discussed in indigenous communities.

3. Indigenous communities have raised concerns around the emphasis on "evidence-based" treatment.

First, the focus on evidence may not always align with Native ideas around indigenous ways of knowing or traditional ecological knowledge; it forces Native peoples to adopt a Western model of thinking. Native communities may be reluctant to start from scratch and "lab test" practices that have been carried out in their communities for thousands of years, with lived experience demonstrating their effectiveness.

Furthermore, the Western, "evidence based" model may be particularly burdensome for Native communities to accommodate with their often-limited staff and resources. In some cases, even when Western model testing or evaluation is desired, the resources and funding may not be there to support, especially if non-Native individuals and organizations deprioritize Native practices.

As indigenous conceptions of health are largely much more holistic than those of Western medicine, providing evidence of effectiveness can be particularly challenging. For example, Native communities have repeatedly expressed the importance of (re)connecting with culture and tradition to build or maintain the community's health; however, the cause and effect may not be as immediate and clear as, for example, taking a pill and seeing tangible, concrete results (e.g., lower blood sugar levels). Many of these concepts are difficult, if not impossible, to isolate, randomly assign to participants, and laboratory test, as may occur in a clinical trial.

Finally, AIAN communities may be reluctant to share their knowledge for Western testing. This can occur for several reasons: 1.) the knowledge may be considered sacred or only considered appropriate for those in the community, and there may be restrictions on sharing outside the Tribe, in some cases, even with other Tribal communities, and 2.) the community may have concerns around exploitation, theft, or misuse of their knowledge, or they may simply fear that the knowledge may be disrespected or mocked. These fears are valid and arise from historical precedent, including several '"high-profile' cases of patenting of traditional medicines, without consent from or compensation to their holders." [3] Unsurprisingly, Native communities may hesitate to turn over their knowledge, passed down by generations of ancestors and maintained at great cost due to extensive loss (e.g., of knowledge keepers, of natural medicine on their traditional homelands before relocation) and bans on traditional culture to 1.) pharmaceutical companies hoping to sell their sacred wisdom or take the Tribe's own resources away for profit, potentially so the Tribal citizens can no longer access it (e.g., due to limited availability or high cost) or 2.) to a broader society that has disrespected, harmed, mocked, and exploited them for centuries.

In short, I argue that it is the US government's moral obligation to listen to our communities and Nations, as the original inhabitants of this land and as the experts in our people, when we speak. Since time immemorial, we have known how to keep our bodies, minds, spirits, and communities healthy, but centuries of trauma and genocide have led to the disparities we are facing today, including the crisis around substance use that is another means of destruction and genocide. The fact that we are still here today is testament to our resilience and brilliance. Furthermore, we have repeatedly heard that disconnection from culture is one of the causes of substance use, and that culture, tradition, and connection are medicine—they are healing for the whole person, the community, and future generations.

With these considerations in mind, I ask that you consider the following regarding the fentanyl crisis:

- Provide funding to the Tribes and to Tribal organizations to address these issues, including the 16 percent of funding that is being considered for this purpose from the larger $1.5 billion SAMHSA Opioid Response funding.

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[2] *https://pubmed.ncbi.nlm.nih.gov/27618086/*
[3] *https://pubmed.ncbi.nlm.nih.gov/12821021/*

- Allow Tribes and Native communities to self-identify needs, priorities, and solutions, including those that prioritize culture and may not align with standard Western models of evaluation or implementation.

Thank you for your time and consideration.

The CHAIRMAN. [Presiding.] Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman, and thank you for allowing me to proceed with the questioning.

I want to talk about law enforcement specifically, since several of the chairmen and council members brought that up. I want to say that the Opioid Summit held by the Northwest Portland office at Tulalip, I see some fascinating treatment work being done by Indian Country, holistic, simplistic, and certainly responsive to on-reservation focus. I don't want to diminish that side of the equation.

But what I feel and hear particularly, Mr. Chairman, from the Lummi is that without adequate tribal law enforcement resources, I almost feel like Indian Country is being targeted, that people know that you don't have the law enforcement, that you don't have the capabilities, and that is where people are setting up shop.

Consequently, what is happening is the most powerful, the money is so good everywhere, that the drug is just being made as quick as possible and as powerful as possible, and people don't even know the impact of it, and the consequences. You had, I am not clear if it was four or five deaths, five deaths, four related to this in one week.

Chairman Azure mentioned the fact that he wants help from the BIA justice law enforcement, and in your case, we tried to partner with the FBI. But that was even, I am not saying kludgey, but there are issues of how you all coordinate and how we get the FBI to come out and do a bust with you, because you had to get that product off your reservation. You knew how deadly it was, and you had to respond.

But who were you calling? Who were you calling to help you respond to this crisis? I want to know, Senator Mullin and I have introduced the Parity for Tribal Law Enforcement, a self-determination contract for Federal law enforcement officers, making them eligible for benefits as way to try to build capacity on reservations.

But what are the two or three things we need to do to help right away with better law enforcement tools for Indian County to help fight this? If I could hear from each of the three tribal chairs here.

Mr. HILLAIRE. Thank you, Senator, and again thank you to the Committee for holding this hearing.

Yes, law enforcement is a big issue. Not only the severity of this drug and us being a close-knit community, just one, the smallest amount is deadly to us. It impacts our future generations. So it is a really serious problem.

At Lummi Nation, we come against issues that pertain to jurisdiction, especially when we have a reservation that is a peninsula, a road that goes, we call it going around the horn at Lummi Nation, it is surrounded by water. The road has a right-of-way by the county which is an access road for non-tribals living on fee land as well as for the Lummi Island ferry residents, which is not reservation land. So what do we do when we implement checkpoints and we have somebody who is non-tribal, and there is no reasonable

cause, and they are bringing drugs on the reservation? It is always an ongoing issue.

I want to back up just a little bit before I mention a little bit more on some of the law enforcement thing. This is a leadership issue. Even just based on everything we have heard in this short amount of time, we can already see the complexity of how we are supposed to address it. It is law enforcement, it is prevention, it is intervention and it is rehabilitation. It is workforce, it is housing. There is so much to this.

I think a way for us to ensure that we have resources, and the area of law enforcement being one of them, is that the United States declare an emergency, a national emergency to fentanyl. That way we can tear down the barriers, tear down the bureaucracy, everything that is hindering our ability to take care of our people, ensure that we don't have to compete with our brothers and sisters across Indian Country for a grant that helps us with law enforcement through DOJ or through other program services, to ensure that we don't have such extensive reporting systems, to ensure that we have direct funding, because as you can hear, we know how to take care of ourselves.

But going back to enforcement, I think we definitely need more resources, BIA, DEA, and the FBI, the lack of prosecutions from DOJ and local authorities. We also need the ability to prosecute and hold accountable non-Indian drug dealers who are murdering our people through this drug, fentanyl and carfentanil and all the various versions of it. The lack of tribal jurisdiction over non-Indian drug dealers coming onto reservation undermines our efforts to combat the drug crisis and protect our community.

We urge Congress to recognize a special criminal jurisdiction over non-Indians who commit drug offenses in our communities. I am sure we will see more through the track that is being introduced.

Right now, we do everything we can to exert our sovereignty, to protect our children. We have this very scary image of carfentanil which seems to be reaching our smaller communities, which is 100 times stronger than regular fentanyl, 10,000 times stronger than morphine, and if it is sitting on a coffee table where there are children, then we have to get this drug off of our reservation. Right now we are doing everything that we can with the resources that we have.

With the ability of getting the FBI agents to Lummi Nation, we worked closely with them, we got over 4,500 pills off of the reservation just within a few days, with the checkpoints and the K 9 units. So we are going to keep doing, doing everything we can. But it does come down to a matter of resources, and brings up what we mentioned earlier, when we go into a drug interdiction, when we get over 4,500 pills off of the road, our beds become full at our stabilization center. That is why there are so many different pieces to this.

But if we start with the highest level possible, that the United States of America declares this a national emergency, I believe that we can overcome a lot of the barriers that we are facing. Thank you.

Senator CANTWELL. I know my time is expired, Mr. Chairman, so I will either take it for the record, or you can give me 30 seconds.

The CHAIRMAN. Go ahead.

Senator CANTWELL. I didn't know if they wanted to respond quickly, 30 seconds, I know that is not a lot of time to respond.

Mr. AZURE. Sure, and I want to thank Chairman Hillaire for hitting the major points. But to break it all down, what we are asking for are resources that cannot be taken away. I know I mentioned earlier with the detailing of our law enforcement. Let's just be honest: in the State of North Dakota we have five tribes and one FBI agents. We do understand that violent crimes will take that FBI agent to a different case, and it prolongs the cases and the investigations.

Right now the Bureau is currently sitting on a mutual aid agreement that we had brought forward, still sitting on that, which is why I mentioned earlier that the Turtle Mountains have moved forward in self-determining our own tribal drug task force. Because we can't wait any more. I speak on behalf of all tribes, that we refuse to wait any more, and we will do what we can to save our next generations.

Thank you.

The CHAIRMAN. Mr. Kirk?

Mr. KIRK. One of the things for me is Amtrak. Right now, Amtrak flows right through reservations in Montana. When do we become sovereign and be able to inflict that when it comes to our reservations? I can go, as Jon Tester, to Spokane without an i.d. and somebody just buys me a ticket and they scan it off my phone. When are we going to be able to put drug dogs and enforce those as soon as that Amtrak hits our reservation boundaries?

As we continue to battle that, the other thing just at the tip over here, at the BIA formulation, they are bringing data to the Congress that states that major crimes, rapes, homicides and everything are down in Indian Country 50 percent. So when we come for more funding in those aspects, in public safety and justice, that is why we don't get an increase, because it shows there is a decrease.

But once you talk to tribal leaders and you talk to people, we need to get the right data out there that helps us when it is coming to you guys to be able to help us with the funding that we need. If there is a decrease, you guys don't see a reason for an increase. So without numbers and the right numbers, we are not going to be able to fund and be able to do the things that my brothers and sisters need on different reservations and also on ours.

Thank you.

The CHAIRMAN. Thank you very much. Vice Chair Murkowski?

Senator MURKOWSKI. [Presiding.] Thank you, Mr. Chairman. And just to follow up on that point here, we know the numbers, we know that Native Americans, Alaska Natives as a population demographically are dying in the past two years of drug overdoses more than any other populations out there.

We just had a hearing in Appropriations this morning on an emergency supplemental. This was domestic, we talked about the border, several of my colleagues were there in Committee, we talked about fentanyl. There is a significant increase, significant

provision in the supplement to combat fentanyl. There is $250 million directed to IHS. I am looking at the situation in Indian Country, I am looking at the situation in again, communities like Tyonek, Savoonga, Dillingham, tiny little Native communities that are so far off the grid most people don't even know that they exist. And yet the drugs are coming in, and they are killing people.

So we need this data. We need to understand how it is moving so rapidly. I think we all recognize we have to be doing more when it comes to treatment. But we are dealing with a drug the lethality of which is almost incomprehensible for most people. So when we talk about treatment facilities, you just can't take your standard five-week treatment facility and get somebody who is addicted to fentanyl and somebody who got addicted in less than a month and think that in five weeks you are going to flip this, and you are going to have somebody that is now clean.

We have a challenge that is so big and so enormous, it is going to take exactly what you all are doing in Lummi Nation, Chairman, with saying as a community, we have to wrap our arms around it, we pretty much have to figure out how we do this from within. So I know that resources will be a challenge.

I would ask the three of you as tribal leaders, knowing that IHS is going to be receiving a specific increment to go toward these services, where would you specifically direct that? Give that to us in writing. I think that would be helpful for us.

I want to ask Mr. Gettis about what you have been able to do. You have established these three different opioid treatment programs. You have them in Juneau, in Sitka, now in Klawock. We know that for far too many of our communities, whether you are islanded like you are in Southeast, or in many parts of Indian Country where the distances are just so great that tele-health is really one way where we can make a difference.

Can you describe how the tele-health authority has helped to improve treatment for patients who aren't able to get to it, but also speak to the stigma part of it? I am hearing more and more and more that people, they don't want to go into the behavioral health clinic, because they are going to get tagged as, that guy has a problem, we all know what it is, don't want to even be seen in there. But through tele-health, it gives you that level of anonymity that might help address this stigma.

Mr. Gettis, can you speak to that, please?

Mr. GETTIS. Thank you, Senator Murkowski. Yes, as you pointed out, Southeast Alaska is a group of islands that span 600 miles, very, very small Native communities throughout the region, and much of Alaska is the same way.

With the advancement and availability of tele-health services we were able to create follow-up after-care programs, because once you enter into a service and maybe work on sobriety or abstaining, then you need to return home. Because people need to be part of their communities, they need to be part of their families. They need to have that family kinship.

Being able to return home and participate in an after-care program is just essential. Tele-health has been a big component of that. Not only has it allowed people to enter by phone or by a Teams meeting or some sort of venue like this, but you can then

do that without stepping into sometimes that stigmatizing treatment facility that doesn't fit for everyone.

So we have been able to see significant gains with tele-health access. It is particularly valuable here throughout our region We have seasonal workers who need to go fishing, who need to go hunting, who need to be out, and then with tele-health, we can bring that in.

We have also seen, and I don't want this lost, I have heard from communities across Alaska, about elders also having improved ability for any sort of tele-health access. It improves health care, it improves and reduces disparities. I strongly support improving and keeping tele-health opportunities as available as possible.

Senator MURKOWSKI. Thank you.

Just to our panelists, know that we have been in a series of votes, so when you see us popping up and down, it is not because we are not being attentive. Because we do have to go over and vote. That is where the Chairman is now and that is where I will be going when he comes back. But not for lack of attention.

Senator Tester?

Senator TESTER. Thank you, Vice Chair Murkowski, and thanks for having this hearing. I want to thank everybody who testified.

Councilman Kirk, let's say that a non-Native is selling drugs on your reservation. Does the tribal justice system have the ability to arrest and prosecute them?

Mr. KIRK. No.

Senator TESTER. So to further clarify, you can't arrest them?

Mr. KIRK. We can work with our cross-deputization that we do have with the county. The county then, if they have beds available, can hold them. But we cannot prosecute non-Natives in tribal court on reservations.

Senator TESTER. So what happens to a drug dealer that is peddling dope, peddling fentanyl on your reservation and they get caught? What happens to them? Where do they go? Anything?

Mr. KIRK. Hopefully if the county has enough room, they are able to house them there.

Senator TESTER. But if the county does not, do you let them loose?

Mr. KIRK. Have to let them loose or try to find the nearest county that has a bed for them.

Senator TESTER. So let's just talk about that problem, because that indeed is a problem. What can we do about that? Is it simply prison space, or is it a jurisdictional space?

Mr. KIRK. Give us the criminal jurisdiction to be able to charge them in tribal court, so we are able to hold them in our jails.

Senator TESTER. Okay. Is that done, let's say somebody murders somebody, and it is a non-Native, do you have the ability to arrest them?

Mr. KIRK. Now, pertaining to kids and police officers, and with the VAWA, we are able to.

Senator TESTER. So there is a precedent that has been set here.

Mr. KIRK. Yes.

Senator TESTER. So we need to tweak it a little bit on our end.

I know that Senator Cantwell talked about law enforcement. What are the barriers for you right now, the major barriers on the

ground when it comes to law enforcement? Is it FBI? Because I think we are in the same both North Dakota is in, by the way. Is it lack of BIA personnel? Is it a lack of tribal enforcement? I don't know if you guys do your own law enforcement up there or not in Fort Peck. You do?

Mr. KIRK. Yes, we are a 638 through the BIA, and we control our own.

Senator TESTER. Do you get the money from the BIA to be able to hire the officers you need, or are you understaffed?

Mr. KIRK. Yes, but we are also understaffed because our people start out at $20 an hour, and nobody wants to come live in northeastern Montana for $20 an hour.

Senator TESTER. So how much do you think it would take?

Mr. KIRK. Right now, we can use another 100 officers, but we will never get it. Right now we are trying to get our pay up to $27 an hour, so that way we are able to bring more interest to our reservation.

Senator TESTER. Do you have the funding to do that, or does that mean you have to limit the number of officers you hire?

Mr. KIRK. For the lack of people that we have had there, and with the carry-over that we had, making $27 sustainable, is it's going to sustain itself for long, just using carry-over from the previous years that we are able to use.

Senator TESTER. I got you. If you were sitting on this side of the rostrum, what would you do?

Mr. KIRK. I would properly fund BIA to be able to help Indian Country. Because I would want that for every part of the Nation, to be able to give them the right, adequate stuff to fight this and stop this from killing our people.

Senator TESTER. So your number one priority would be funding for law enforcement?

Mr. KIRK. Yes.

Senator TESTER. Thank you very much for your testimony. I appreciate it. I yield to the Senator from Montana.

Senator MURKOWSKI. Senator Daines?

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

Senator DAINES. Thank you, Senator Tester, and to Chairman Schatz and Vice Chairman Murkowski, thanks for this important hearing. Councilman Kirk, you have come a long way. When you come from northeast Montana, there is no quick and easy way to get here. Thanks for coming all the way for Poplar, no less, to be here.

I know first-hand that the Fort Peck Reservation has been hit hard by massive amounts of fentanyl coming into the Country. A few years ago I was down on the southern border, in fact, I spent the night from about 10:00 p.m. to 6:00 a.m. with border patrol, doing a ride-along in their pickups. We would get out, we literally were apprehending illegals coming into the Country.

That was on a Monday when I did that. I went back to Washington, D.C. and then came back to Montana Thursday night, and was out in Wolf Point Friday morning of that same week. I was talking to the folks in Wolf Point, their law enforcement. I asked

the officer there, so, I was on the border Monday night, drugs were coming across the border Monday night on the southern border between Texas and Mexico, when did those drugs get here to Wolf Point, do you think? He said, sir, those drugs got here before you did.

The ongoing fentanyl crisis is devastating. It is destroying communities, families, lives. And the Montana tribal communities are ground zero for this destruction. The Montana crime lab has reported a 1,000 percent increase in fentanyl-related overdoses since 2017. Native Americans are suffering the highest overdose death rate by a massive margin. It is not even close.

In fact, in Montana, Native Americans are twice as likely to die over an overdose than any other Montanan. The Blackfeet Nation recently had to declare a state of emergency because of the staggering number of overdoses they are seeing. Fentanyl seizures at the border are up 18 percent since 2019. The drugs that aren't stopped are making their way to Montana.

Here is a staggering stat. Montana Highway Patrol, in the first half of 20213, seized enough fentanyl to kill 300,000 people. That is nearly a third of our entire State. This is the human cost of the open border catastrophe that is going on right now on our southern border.

The crisis at the border is not a funding problem. It is not a funding problem. I was down there again just three weeks ago with Border Patrol. They will tell you, we don't need more money. They will take some money and turn it into some more personnel, they would like to get the wall built, put in other video camera surveillance systems and so forth. That would be needed. But they say the most important thing you can do is to slow the flow of the flood of people coming across the border. It is policies, policies that President Biden reversed that were working in the prior Administration. This is not a political statement, it is just a fact.

Law enforcement solutions are needed to combat this problem. The consequences of fentanyl bleed into every part of our communities. When you have the flood of encounters, some 8 million since the President took office, plus $1.6 million known got-aways. Known got-aways means Border Patrol seized the people coming across either physically or through a video camera, but they were not able to apprehend. We don't know who these people are.

On top of that, there is probably another 500,000 that come across, we have no idea. It is a massive problem. And by flooding the zone with all the encounters, our Border Patrol is stretched, and they can't stop the drugs coming across. It is a zero sum situation.

Councilman Kirk, I know this issue is deeply personal to you. We spoke this morning at Montana Coffee. I would like to give you a moment to speak on how this crisis has affected you, the tribe. You told me that just in the last 24 hours, we have had more deaths to fentanyl. Councilman Kirk?

Mr. KIRK. Yes, most definitely. It seems like without Narcan, we would have one every hour. There are people overdosing even right now at the moment. But the Narcan is what is saving them.

As we discussed this morning, talking to one of the agents that goes throughout Indian Country for us, lives on our reservation, I

went in and I was like, okay, I want to learn more. What do we do? What do we do to be able to subside everything that we are going to do?

I never thought I would hear it from anybody, and the first thing he said was, shut the border down. Give us a chance. Give us a chance to stop the flow of whatever is going on here. Because how does it make it all the way from down there to a little tiny place in northeastern Montana? How do we get that there, or in Turtle Mountain, or up in Lummi, or up in Alaska? All these places are devastated with this.

So again, it is just being able to work together to find the right answers and the right things for us to do, so that way we don't lose any more parents, mothers, daughters, grandchildren, grandparents. We need to work together to be able to make this happen. Thank you.

Senator DAINES. Thank you. I am out of time, but I just hope we can come together, there is a chance right now to actually get a bipartisan solution, we are dealing with Israel, Ukraine, Taiwan and the Pacific challenges as well as the border. This is a moment we can do something to change the policies and slow the flow. We don't need to put more money into processing people through faster. We need to put money toward actually slowing the flow.

Councilman Kirk, then I am done.

Mr. KIRK. We see that in Indian Country, we see all these billion dollar packages going to Ukraine and going to Israel. When is Indian Country going to matter? When are the treaties and obligations and trust obligations going to matter to us? When is one of those bills going to reach us so that we are able to adequately take care of our people?

If packages and bills can be like that, but we have been underfunded all these years on everything, when is a package going to come so we can start fighting for our people the right way? Thank you so much.

Senator DAINES. Thanks, Councilman.

The CHAIRMAN. [Presiding.] Thank you, Senator Daines.

Before moving on, I wanted to address your point. First of all, I want to acknowledge your point. Generations of disinvestment, disenfranchisement, disintermediation of culture and language and land, and water, all of it. So I don't mean to diminish the point you are making. I do think it is worth pointing out that this Committee, both through IIJA, through the various COVID relief bills and through IRA, made the biggest investment in Indian Country and Native communities in American history.

So both things are true, that we did that, and also that it is not nearly enough. But I did think it was worth pointing out that we have made a down payment in a way that is historically unusual. Again, it doesn't solve anything, but it is the first, most important step in the right direction.

Senator Cortez Masto?

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

Senator CORTEZ MASTO. Thank you. Thank you, Mr. Chairman.

I too agree, I think we have to do an all-of-the-above approach to address fentanyl that is not only coming into all of our communities, but our tribal communities, and address the needs there. I think it is important.

And I want to talk about one of them, the law enforcement piece of it. I see it in my tribal communities.

But before I do, I have to address some of the conversation here from some of my colleagues. There is a comprehensive approach, we can work in a bipartisan way to address what is happening at the southern border, it is something I worked on as attorney general, to address the drug trafficking. What I hear from those on the border is additional funds to help that drug trafficking.

That is why the current President, in his supplemental, has actually requested from Congress $849 million for the procurement of non-intrusive inspection systems to make sure that cars and trucks are being scanned and can counter illicit drug activity, including that fentanyl, and human trafficking. The President is also requesting $4.4 billion for Customers and Border Patrol to be able to hire additional agents and officers to make sure that the criminals and traffickers can't get into the Country.

There is additional funding he has also put in to address the migrant flow, to really focus on this issue. This is part of what I think is the all-of-the-above approach. I am here to tell you, as somebody who worked to fight these transnational criminal cartels, you can shut down the border, but those drugs are going to find it here another way, ports of entry, other ways in.

Unless we are doing an all-of-the-above approach, we are really not going to make a dent in this. I support HIDA, I support law enforcement, I support our tribal communities helping them really address the gaps that I see in some of the cross-jurisdictional issues that we have. I see in my own tribes, I was just with Fort McDermott Paiute Shoshone Tribe, which is on the Nevada-Oregon border. They don't have enough resources to even hire tribal police. We know that. Some of our communities don't even have tribal police, so they have to rely on BIA.

Well, that one BIA agent has to cover a region the size of Nevada and other territory. And there is only one or two of them, let alone one FBI agent and maybe one AUSA to prosecute at a Federal level. That is ridiculous.

That is where we come in as well. I think at a Federal level it is important for us to really focus on how we address the BIA issue, to support and supplement what our tribes already, if they have the ability to hire tribal police, but those that don't, we actually have adequate law enforcement in this communities.

That is where we really have to come together in this Committee to focus on what is necessary.

I will tell you, there are 28 tribal communities in Nevada. As a former attorney general, I worked with them. One of the things that we did was enter into memoranda of understanding between Federal, State, and local law enforcement, because of the cross-ju-

risdictional issues, because of the lack of law enforcement in some of our tribal communities.

I understand, Councilman Kirk, you have done something similar with the cross-deputization. What are the benefits that you see of that cross-deputization? If you would talk a little bit about that, if that helps address some of the gaps and services until we fix those?

Mr. KIRK. Most definitely. The cross-deputization is with the county, the Montana Highway Patrol and also the City of Wolf Point. It works really great to have more boots on the ground to be able to combat more, to be able to have other people fighting. Right now, our tribal cops are in the major cities like Poplar and Wolf Point. And on the outer communities we also have an MOU with Valley County, also. So they are able to cover, Valley County covers our west end, and also Roosevelt County covers our east end.

So we are able to implement different things, but also implement a security program back home to be able to help us alleviate different parts of it.

Senator CORTEZ MASTO. Thank you. I am going to ask Chairman Azure, talk about some of the challenges people don't realize. I think if you have maybe three or four BIA officers, that is going to be enough. But they forget that there is a large territory to cover, places like Nevada and in the west, there is a lot of coverage, travel time between some cities where unfortunately a lot of illicit activity can occur. If you want to hide somewhere, you are able to do it because of the lack of coverage.

Do you see that in your area, in your State and in your community and your tribal Nation, as you are working with the State and Feds as well? I am curious if that is a part of a barrier that we need to deal with as well.

Mr. AZURE. In the Turtle Mountains, we are a unique demographic. We are a smaller land base, but we have a large population. They call it The Old Six by Twelve, on our land base back home. But we have over 14,000 people living on or right off that Six by Twelve on our reservation. Sometimes that is where the frustration with the details come into play. Sometimes we are down to two officers on the weekends.

And that is a major misconception with people, where they think that the bad guys aren't very smart. Bad guys are smart, and that is why they prey on reservations, because they know the red tape, they know the bureaucracy, they know that if they make a phone call saying that there is an issue on the southeastern side of our reservation, while the drugs are being transferred onto the northwest side of it, there are how many people in that 45-minute drive that they are driving by, or how many phone calls are coming in. So they know what they are doing.

And it is another major misconception that this is only happening on tribes. It isn't. It is happening in small town America. There is a microscope over the top of our tribes because of who we are. They know the red tape and they know how to get away with things. As an attorney general, you know that there is a number some of the States have where you have to hit $50,000 to prosecute on a drug charge. Forty thousand and ninety-nine dollars is what people will be caught with.

So there are so many issues. That is why it needs to be a joint partnership of everybody working together and taking down the bureaucracy and taking that red tape down and figuring out a way of how are we going to protect that next generation. Not only tribes, but citizens of this great Country.

Senator CORTEZ MASTO. Yes, thank you. I know my time is up, but I am hopeful, Mr. Chairman, I think when I first got here, we may have had a conversation around this. It is time for us to have another conversation about how we fund BIA along with our U.S. attorneys and FBI as they coordinate as partners with our tribal communities and our local communities as well. I don't think we are doing a service here to really address what we are hearing that is happening in our communities right now. I think it is time for us to revisit that conversation.

Thank you.

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

Senator Smith?

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

Senator SMITH. Thanks, Mr. Chair, and thank you, Senator Cortez Masto, for those great questions.

Thanks to all of you for being here. I am so glad to be with you.

As I was listening to all of this, I want to talk mostly about the criminal problems that we have around drug trafficking. I also want to acknowledge that we also have a severe mental health crisis, behavioral health crisis that we need to be looking at as well. To my mind, substance use disorder is a disease. The fact that you have that is a health challenge that needs to be addressed.

I want to note that there are just far too few resources and tools available to address that, and to address it in the context of the generational trauma that we know is driving so much of that.

There is a very important piece of legislation that we passed called the Native Behavioral Access Improvement Act. This is legislation that is built on something that we passed, which is the Special Diabetes program. Modeled on that Special Diabetes program is this behavioral health program that would allow for tribes to be able to use their best knowledge and their sovereignty to be able to understand how to put together programs that are going to be able to address that mental health challenge.

I want to draw attention to that, because I think it is important.

But this crisis is also, as we have been hearing from many of you, a result of this legal quagmire where drug traffickers exploit, as you are saying, to keep opioids flowing into tribal communities without any accountability. Take the Red Lake Nation in northern Minnesota, Minnesota is a Public Law 280 States. Red Lake Nation is not under Public Law 280, so it is a closed reservation.

What happens there is that they repeatedly pick up the same drug traffickers who are not Native, they then take those folks to the border, those folks are then picked up by county or Federal law enforcement and a week later, those folks are right back there again doing exactly the same crime. It is a revolving door that there is no end to, and no accountability for.

So this question of how to address the need for criminal jurisdiction on tribal lands is important. It has gotten a lot more complicated following some of these Supreme Court decisions that we are dealing with. As you have been saying, those complications have been exploited by these criminal networks that are trafficking fentanyl and other drugs.

I am going to ask this question to you, Chair Hillaire, because I think Senator Cantwell was getting at this a little bit. If you think about what we accomplished with that special criminal jurisdiction for missing and murdered indigenous people on reservations, so that you had that special criminal jurisdiction, can you speak to how that has been working, what you see as the strengths of that, and anything we can learn for what we could do if we were able to extend it to drug trafficking, for example?

Mr. HILLAIRE. Yes, absolutely, I think that is a great idea. I want to add on to some of the things you mentioned. We were reminded by some of our elders that this mental health crisis and fentanyl crisis is one and the same. So it is a holistic, comprehensive approach that is needed to address it.

Also, you mentioned two weeks, that somebody is taken to the border, handed over to other jurisdictions, and then you see them two weeks later. For us, try two hours later. We are a sovereign nation and we have to do what is in the best interests of our people.

So when we go to a known drug home where there is known drug activity, known drug dealing, and we get them off the reservation, I do want to mention we also have MOA with our county as well, which allows us to at least enforce, but then we hand them over to the county authorities, and then two hours later, they are hitchhiking back onto the reservation. It is an ongoing issue.

I think that would be an absolutely great idea, along with our ability to, if there is a way we can have special prosecutors that we can prosecute ourselves, because that is another big barriers, again, we prosecute them federally, but who is going to take up a case for something that could be seen as a small crime compared to the vast amount of crime that can happen in this world.

We would be fully supportive of something like that. It would just be a matter of narrowing down the details of how that would work with VAWA.

Senator SMITH. Yes. I really appreciate that. We are working on legislation to accomplish that. I think the feedback you are giving us, which is we need resources to be able to do the accountability, but we also need jurisdiction, as we have learned from VAWA, we have learned from the extensions we did in VAWA how that can work. I think we should put that learning into action. Thank you.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Smith. Senator Luján?

Senator LUJÁN. Thank you, Mr. Chairman. I want to thank everyone for being here today.

One issue, Mr. Chairman, I want to raise before I get to my questions, in New Mexico, thousands of tribal members over the last couple of years have fallen victim to extensive sober home Medicaid fraud schemes, where people were being kidnapped and driven hundreds of miles away into the State of Arizona under the

false promise of treatment, and left there without means to return home, left homeless, when they were at their most vulnerable state.

While this has been tragic not just to the families, but to everyone who has paid attention to this, to the entire community, it also highlighted the extreme need in communities to have more treatment. I very much appreciate the conversations we have had today in all spaces, especially the line of questioning coming from Senator Cortez Masto and Senator Smith. I certainly agree with their assessments.

Now, Councilman Kirk, it is my understanding that there is a presence of a treatment facility on your tribal lands to help reduce overdose deaths and overall substance use disorder. Is that facility making a difference?

Mr. KIRK. Right now, with the facility, we are waiting on sprinkler systems, and also with it being an old residential place, we have to do commercial water, commercial sewer. So that continues to back up. There are 12 beds now at the bottom of it.

So right now what is going on in Montana is throughout the region, the Rocky Mountain region, tribes that cover Montana, Idaho, and Wyoming, there is a regional healing center right now that is going right now that we are starting from the ground up and working on it. We are trying to get a 62-bed facility.

Right now I believe it is about $28 million to get it going. But that is for all the tribes. So if we are able to get funding with that and also bring the holistic healing and everything that needs to happen with that, that would be great. But as for the facility back home, it has not been going for the past five years.

Senator LUJÁN. So that facility needs help.

Mr. KIRK. Yes.

Senator LUJÁN. So let me ask the question differently, Councilman, will more treatment facilities closer to home make a difference?

Mr. KIRK. Yes. Because we are also all the way in northeastern Montana, we are victims that are being left down in Arizona, and we are still continuing to fly them back. As of yesterday we got a woman back, and paying for her luggage and everything to get back home. So we are also subject to that.

Senator LUJÁN. I appreciate that, Councilman.

Dr. Soto, in your written testimony you discussed a study you authored on medications for opioid use disorders in Indian health clinics. Were these IHS clinics Urban Indian Organizations or tribally run clinics?

Ms. SOTO. Can you repeat the question, please?

Senator LUJÁN. In your written question, you discussed a study you authored on medications for opioid use disorders in Indian health clinics. Were these IHS clinics Urban Indian Organizations or tribally run clinics?

Ms. SOTO. Yes, they were Urban Indian health clinics. Tribal health programs and Urban Indian health clinics as well throughout the State of California. California does have over 50 Indian health clinics in the State.

Senator LUJÁN. From your research, how available is culturally competent treatment for American Indians and Alaska Natives in the IHS system and the UIO system, or in other clinical systems?

Ms. SOTO. It is offered, and I really want to advocate for the need for more culture being integrated into our programs. I can't stress it enough. I am a behavioral health scientist working with our tribal communities. I have just learned in engaging and talking with them that culture really is the foundation of our Native people. It has been there before colonization, and it is still strong and alive today. It really is what has kept our people resilient against systemic racism, structural violence, all the things that we are talking about.

It is really essential to be able to help our communities recover. So it is good for prevention as well as recovery, because without this, people in recovery need these cultural ways to heal. There is so much grief, and there is so much healing in our communities, I have heard many say today. There is a lot of unintended grief. We need more of that healing.

So having our traditional ways, and that may be very different for many of our different communities, drumming, dancing, song, traditional ceremonies, bringing in our community, our elders. One of the other things that we have learned is it would be great if they are advocating to approve reimbursements by tribal clinics for the cost of traditional healing services, healers themselves, or these services to help bring them into these programs.

So they have them, but it takes a lot of resources, it takes a lot of time. But to have those would really help support. Culture is essential. As many have said, culture is prevention and culture is the way of life.

Senator LUJÁN. Dr. Soto, the data that I have seen shows that this works. I think that it is something I fully support, and I have seen work, especially with lessons I have learned from leaders on the Navajo Nation. So I am hopeful we can find a path forward there.

If I may, Mr. Chairman, I do have one question that is technical for Dr. Soto. It is about purchase-referred care coverage for AIAN patients living outside their service area. Does that present an obstacle to accessing medication assisted treatment, MAT?

Ms. SOTO. I guess it depends on who has it, but that purchase-referred care is additional funding, it is never enough. Sometimes one person can take that entire cost, as they may need that to help support their travel or support their rehab, to support the service that they need that may not be offered at that clinic. Every clinic is obviously very different. Some of them specialize in certain services.

So that is really important for us to think about. I really appreciate that comment, because more funding needs to go within that as well. It is not quite reaching all of our communities or individuals when support is needed.

Senator LUJÁN. Thank you very much.

Mr. Chairman, I have other questions, I will submit them into the record. But just to reiterate what Senator Smith and Senator Cortez Masto said, associated with resources to the Bureau of In-

dian Affairs, to be more supportive as well in planning and jurisdictional questions.

I hope that there can be time for us to have a conversation about cross-commissioning and MOUs. In New Mexico, I constantly hear that liability is an issue where there is an unwillingness sometimes to enter into these agreements. I don't understand that.

But if that is an impediment, then what can be done through the Bureau of Indian Affairs or others, so that we have more eyes, more ears, more people on the ground to keep us safer? I always felt safer when there were more patrols through where I lived as opposed to fewer patrols. Living adjacent to Nambe Pueblo and Pojoaque Pueblo and the communities where I live and where I have the honor of visiting, those constraints are making it less safe for people as opposed to more safe, not supporting that.

Then lastly, with the Bureau of Indian Affairs, as more conversations are taking place specific to law enforcement, I certainly hope that we can gather and have a much larger conversation about the Bureau of Indian Affairs being supportive of sovereign nations as opposed to punitive in many areas. I think the times have definitely grown and moved and matured from the inception of the Bureau of Indian Affairs as we look to what that could become to provide more support to our sovereign nations and to our brothers and sisters.

Thank you, Mr. Chairman, and thank you all again for being here today. I really appreciate it.

The CHAIRMAN. Thank you, Senator Luján. Just on the particular line of questioning you had around fraud, I would be happy to work with your staff on anything that we can do to follow up and make sure there is accountability but also prevent it going forward. Thank you for that.

My first question is for Dr. Seabury. I guess it is a bit of a broad one. I am always cautious not to use words that people outside of the hearing room might not understand. I want to put a fine point on what do we mean by culturally competent care? I think I know. But I want to describe it both as a concept, but also maybe, Dr. Seabury, you can give me an example in the Native Hawaiian community of what that actually looks like.

Ms. SEABURY. Mahalo for the question. It is actually a favorite opening conversation for me. I usually use the words culturally mindful care, instead of competent. Competent sounds like you take a class and you get certified and we check off and you have your papers. When it comes to being relevant and responsive to a Native community, like the Native Hawaiian community, the needs are dynamic.

So in this moment in time, we are talking about 2023 culturally mindful or culturally competent care, there are probably sort of two domains of knowledge. So if you are talking about a regular health provider, like a primary care physician or a behavioral health provider, then the aspects of what they would need to know to be culturally competent or relevant for working with a Native person might include specifics such as an awareness of what are the contemporary issues facing our community today.

So why, related to our review, and our emphasis on our connection to land and water, for example, why are we having so many

conversations about water use and access? What are the current stressors and coming issues that face this community right now related to housing and water, relevant to their history and situation currently socially.

So I would say part of cultural competence is really about contemporary issues.

Then the second piece, which is more foundational, is an understanding of how our shared history as a people and values show up in the way that we engage in the world. For example, there is a lot of research that shows that in primary care situations, health providers interrupt their patients after about 15 seconds of saying what is wrong. When they look at cultural understandings of that, we see, Native Hawaiians, like many other Native people across the Country and other represented groups, they wait until they are sicker before they come, because they have had more experiences where they are bouncing off of the health system, feeling that they were not seen, but they were criticized or scolded, that assumptions were made about them because of the group they belong to, that they don't care about their health, for example.

The CHAIRMAN. Doctor, let me interrupt, because I have a very specific question here. How does that differ from just being kind and nice and respectful? I do think it differs, but I want you to put a find point on it. What you are describing is someone who interrupts their patient, which should be bad in any context.

Ms. SEABURY. Yes, so specifically, in general good western care is great. Here is the thing. It is not just that part. It has to do specifically with assumptions that are made about the person and what are the aspects of their life that are helpful. So there is discrimination that we can talk specifically about, assumptions about income, where you live, biases about your diet and what you might be doing that affect the quality of the care that they are then provided.

So yes, when we are talking about patient engagement, we are not just talking about being warm, receptive, sort of general trauma-informed approach, although that is very helpful. We are talking specifically about recognizing that every instance of engaging with the health system without these modifications of cultural competence and awareness can re-traumatize members of the Native Hawaiian community because of the assumptions that are made about them that then make them not want to seek help in the future.

So they are not able to access it. And when they do, the assumptions that are made about them impact the quality of the care they then receive. That is the issue with respect with competence, in my opinion.

The CHAIRMAN. And the assumptions are, I don't want to repeat a bunch of stereotypes with the microphone on, but the assumptions are some series of assumptions that it is their fault?

Ms. SEABURY. Yes. That means behaviors are their fault, that they must come from a violent family, for example, or that they are unemployed or don't have secure housing because of a lack of effort, knowledge, education or wisdom on their part. Those are also assumptions that are made.

And so in many ways I think the sort of lack of recognition of what are the current systemic factors that impact health far beyond whether or not you took the medication I told you to take is vital when we are talking about Native communities, because 90 percent of health has nothing to do with the health system. Access to safe sidewalks, street lights matter, law enforcement in your community, how many fast food joints and liquor stores are in your community versus libraries and farmer's markets.

Those things affect health in ways that then the individual person seeking help bears the responsibility for in the bias of the provider. So their assumption is that they are not eating healthy foods because they don't want to, rather than because they don't have access.

The CHAIRMAN. Thank you so much for that.

Just one final request to all the testifiers. It is not mandatory, because some of you may have access to data and some may not. I do think it is important that this hearing establish a record of the efficacy of culturally mindful care. Because part of what we have to do, this is what we had to do with Native Hawaiian education and health and what we have had to do with immersion schools, is that we had to prove that meeting people where they are culturally actually gets you better outcomes, even if you have entirely western metrics. You are still going to get better test scores, attendance rates, graduation rates, medical outcomes, if you meet people where they are.

I think there is a tendency in the medical establishment, in the executive branch of various Federal and State administrations, that this stuff is not backed up by hard science. I think that is wrong. But it would be great if we can be at least a little bit of a repository of the record that demonstrates, this is the most efficacious way for us to deliver care, so that we can translate some of that cultural competency into the kind of western analysis that basically enables us to get more money for the projects.

I appreciate all of your work. I appreciate the challenges in front of us together in fighting fentanyl, but also just generally in trying to keep our communities safe and healthy.

If there are no more question for our witnesses, members may also submit follow-up written questions for the record. The hearing record will be open for two weeks.

I want to thank all the witnesses, both online and in person, for their time and their testimony. This hearing is adjourned.

[Whereupon, at 4:20 p.m., the hearing was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE NATIONAL INDIAN HEALTH BOARD

Members of the Senate Committee on Indian Affairs, on behalf of the National Indian Health Board (NIHB) and the 574 sovereign federally recognized American Indian and Alaska Native (AI/AN) Tribal nations we serve, thank you for the opportunity to provide testimony.

Introduction

The United States recently experienced what some have called a once-in-a-generation crisis. The COVID–19 pandemic reshaped the very fabric of our economy, society, culture, relationships and our personal livelihood. Tribal Nations stood up, when the federal government would not, to protect our people from this devastating pandemic. As a result, AI/AN people had a life expectancy at birth of 65.2 years in 2021—equal to the life expectancy of the total U.S. population in 1944. AI/AN life expectancy has declined 6.6 years from 2019 to 2021, according to the 2021 Report of the Centers for Disease Control and Prevention (CDC).[1] To date, there has been no response to this crisis of the loss of life expectancy.

Now, two short years later, our Tribal Nations are facing another pandemic. This pandemic looks different than that of COVID–19, but has the potential to shift the very fabric of our communities in the same profound way. Fentanyl and opioids are spreading through our communities like an uncontained, unchecked virus. Every day, Tribal communities across the country grapple with the lives that are being cut short by this plague. While we wish we could provide some glaring statistics that would awaken a sense of urgency, such data does not exist, and what data that does exist is grossly out of date or inaccurate. Like during the COVID–19 pandemic, the federal government has an opportunity to take swift action to protect our communities. We hope Congress will not wait until it's too late.

Today, our nation is confronted by the fentanyl and opioid pandemic that continues to disproportionately ravage the most marginalized among us, and Indian Country has been ground zero. In order to understand how to address and overcome these challenges and realize the opportunity for transformation before us, we must first insist on an honest reckoning of our history.

The challenges we face today—most recently evidenced through the impacts of COVID–19 on Tribal communities—are the fruits of colonization. This system of exploitation, violence and opportunism is the foundation on which this Nation was constructed. Despite the poor social determinants of health most frequently found in the Indigenous and other communities of color—circumstances that proceed from hundreds of years of colonization—we are often blamed for our poor circumstances. What our communities are experiencing from the rise of fentanyl and opioid overdoses is simply the expected outcome of this historical truth.

Centuries of genocide, oppression, and simultaneously ignoring our appeals while persecuting Our People and our ways of life persist and are now manifest in the vast health and socioeconomic inequities we face. The historical and intergenerational trauma our families endure, all rooted in colonization, are the underpinnings of our vulnerability to substance use disorders. Indeed, we tell our stories of treaties, Trust responsibility and sovereignty—over and over—and it often appears the listeners are numb to our historic and current truths. But the truth does not change: that is the ground we stand on. The underpinnings of colonization may finally be loosening as a consequence of the exposed neglect, abuse, bad faith and inequities AI/AN People have experienced during the COVID–19 pandemic. But it did

[1] U.S. Department of Health and Human Services, Centers for Disease Prevention and Control, Provisional Life Expectancy Estimates for 2021 (hereinafter, "Provisional Life Expectancy Estimates"), Report No. 23, August 2022, available at: *https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf*, accessed on: March 20, 2023 (total for All races and origins minus non-Hispanic American Indian or Alaska Native).

not start with COVID–19. We hope that Indian country is not once again ground zero for another once-in-a-generation pandemic.

Opioid Crisis in Indian Country

Opioids are the latest face of a mental health and substance use crisis in America that is disproportionately impacting our Tribal communities. AI/ANs experience some of the highest rates of substance use issues as compared to other racial and ethnic groups, which has been attributed—in significant part—to the ongoing impacts of historical trauma. The high rates of substance use naturally lead to high rates of overdose from illicit substances, like fentanyl. According to the CDC,[2] AI/ANs have experienced the highest age-adjusted overdose death rates of any group for the past decade, with many of those deaths resulting from opioid use, including fentanyl and fentanyl-laced substances.

In the past year, several Tribes issued emergency declarations over the rate of fentanyl deaths among their members. Accidental overdoses—where a person using drugs is unaware that a substance is mixed with fentanyl—are also on the rise among American Indians and Alaska Natives. CDC reports that AI/ANs had the highest overdose rate of any ethnic group for both 2020 and 2021, driven by a 33 percent rise in drug overdose deaths during the same period.[3] The Alaska Native Tribal Health Consortium's (ANTHC) Alaska Native Epidemiology Center reported that the annual number of opioid deaths among Alaska Natives increased by 383 percent between 2018 and 2022, with the rate of opioid overdose mortality doubling during the COVID–19 pandemic.[4] AI/AN adolescents experienced the highest overdose deaths from fentanyl in 2021.[5] Those numbers are gravely concerning, and if we do not do more to prevent substance use among our children, then our culture, heritage, and way of life are at risk. It is up to all of us to ensure that our children can carry on our traditions into the next generation.

Social injustices, perpetuated over multiple generations, have had enduring consequences for many American Indian and Alaska Native individuals, families and communities. Research documents massacres, genocidal policies, pandemics from the effects of introduced diseases, forced relocations, forced removal of children through boarding school policies, and prohibition of spiritual and cultural practices (including the prohibition of the use of Native languages[6]).[7] This ongoing and pervasive historical trauma has contributed to the high rates of opioid and fentanyl use in AI/AN communities. The symptoms and long-term effects of historical trauma include psychological distress, poor overall physical and mental health, and unmet medical and psychological needs, evidenced by increased exposure to trauma, depressive symptoms, substance misuse, and suicidal thoughts and attempts.[8]

Tribal leaders and federal partners must work together to protect our Tribal communities with effective and well-funded policy solutions to address the opioid crisis. Tribes are targeted by those in the drug trade because it is not a secret that Tribes lack the resources (and sometimes jurisdictional sovereignty) to adequately police their communities. As a result, it is difficult for Tribes to stop illicit opioids from entering and being distributed through their communities. Legislative solutions are needed to address the targeting that Tribes are experiencing. Senators Hoeven and Cortez Masto introduced S. 465, the "Bridging Agency Data Gaps & Ensuring Safety (BADGES) for Native Communities Act." The bipartisan legislation would expedite background checks for those seeking employment as law enforcement with the Bureau of Indian Affairs (BIA), thereby reducing what is currently a 12-month process. Senators Cantwell and Mullin introduced S. 2695, the "Parity for Tribal Law Enforcement Act." The bipartisan legislation would allow Tribal law enforcement to be

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[2] *https://www.cdc.gov/nchs/products/databriefs/db457.htm#Key__finding*

[3] Spencer MR, Miniño AM, Warner M. Drug overdose deaths in the United States, 2001–2021. NCHS Data Brief, no 457. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: *https://dx.doi.org/10.15620/cdc:122556*

[4] Senate Committee on Indian Affairs Hearing on "Fentanyl in Native Communities: Native Perspectives on Addressing the Growing Crisis." (2023). Testimony of the Record. Washington, DC: U.S. Senate Committee on Indian Affairs. *https://www.indian.senate.gov/hearings/oversight-hearing-titled-fentanyl-in-native-communities-nativeperspectives-on-addressing-the-growing-crisis/*

[5] Friedman J, Godvin M, Shover CL, Gone JP, Hansen H, Schriger DL. Trends in Drug Overdose Deaths Among US Adolescents, January 2010 to June 2021. JAMA. 2022 Apr 12;327(14):1398–1400. doi: 10.1001/jama.2022.2847. PMID: 35412573; PMCID: PMC9006103.

[6] Stannard, D.E. (1992). American Holocaust: The Conquest of the New World. New York, NY: Oxford University Press.

[7] Thornton, R. (1987). American Indian holocaust and survival: A population history since 1492. Norman, OK: University of Oklahoma Press.

[8] Tribal Behavioral Health Agenda. (2016). Available at: *https://www.nihb.org/docs/12052016/FINAL%20TBHA%2012-4-16.pdf*

cross-deputized as federal law enforcement, thereby shrinking the divide between Tribal and federal law enforcement partners and granting Tribal law enforcement access to federal benefits. We appreciate the efforts that Congress is putting toward addressing policing shortages in our communities, but more can be done and must be done to address this opioid crisis.

Supplemental Funding Request

Tribes must see a substantial increase in funding to address the opioid crisis. NIHB and Tribal nations were glad to see the President's recognition of this crisis through the inclusion of funding in his recent supplemental budget request to Congress. The President's proposal to address the crisis would provide $1.55 billion in additional funding to the Substance Abuse and Mental Health Services Administration (SAMHSA), including $250 million that would be transferred to the IHS and made available for two years. Despite the clear need in Indian Country, few federal dollars have been solely dedicated for this purpose to Tribal nations. For example, in FY 2023, State Opioid Response (SOR) funding was $1.575 billion, and the Tribal Opioid Response (TOR) Grants were $55 million, which is roughly 3 percent of the total. Given the impact of the opioid crisis in Indian Country, $250 million will be a long overdue investment that will save lives for generations to come.

Policy Recommendations

The opioid crisis has created serious and complex issues across Indian Country. Despite these serious challenges, Tribal nations and Tribal health systems are innovating when it comes to behavioral health. By focusing on holistic care, traditional healing practices, and Indigenous ways of knowing, we have seen remarkable results in Tribal communities for the treatment of opioid use. Tribes have combined culturally centered prevention, treatment, and recovery services with the implementation of key evidenced-based practices, including medications for Opioid Use Disorder (OUD); syringe service programs; training, administration, and distribution of the lifesaving overdose reversal medication naloxone; peer recovery support services; outpatient therapy and behavioral health integration. Nearly 50 years of self-determination and self-governance policy have clearly demonstrated that empowering Tribes works and results in better outcomes at the same dollar-for-dollar investment. In simple terms, good governance. Additional funding through the supplemental will allow Tribes to improve and expand this programming that we know is effective.

Any policies or initiatives designed to improve Tribal behavioral health must be grounded in culture, tradition, language, and Native ways of knowing. To that end, in order to reduce AI/AN behavioral health inequity and improve health outcomes, Congress should pursue the following priorities:

- *Advance Comprehensive Tribal Prevention, Treatment, and Recovery Services to Address the Opioid, Fentanyl, and Suicide Crises in Indian Country.* The lived experiences of AI/AN historical trauma and adversity have contemporary descriptions and diagnoses: adverse childhood experiences (ACEs), substance use disorders (SUDs), and suicidal ideation—all of which intersect and have accompanying strategies for prevention, treatment, and recovery. Following an intervention, services should provide ongoing, comprehensive support for an established continuum of care. Congress should work to strengthen and assess the availability of critical services, gaps in services, and opportunities for improvement to meet community needs related to the opioid and fentanyl crisis.
- *Improve Federal Standards for Data Collection and Reporting to Improve AI/AN Visibility and Better Measure Health Inequities.* High-quality, meaningful AI/AN health data is essential for identifying disparities, setting priorities, designing strategies, and highlighting successes related to health equity. However, racial misclassification, missing data, and other quality issues impede the representation of AI/ANs in many data sets. With AI/AN people and communities so often missing from the data, this becomes one more form of erasure of AI/ANs—our experiences are not represented, our needs are not heard, and our very existence becomes invisible. In addition, the way federal data is reported often excludes the many AI/ANs who identify as Hispanic or with multiple racial identities. Reframing the data away from focusing on race and instead focusing on "AI/AN" as a political status is a more effective, empowering, strengths-based approach supporting Tribal self-determination. Congress must improve data practices as this is a crucial step to undo the centuries of AI/AN erasure contributing to the ongoing health inequities in Tribal communities, including the opioid and fentanyl crisis.

- *Elevate a Tribal Perspective in Federal Health Equity Plans and Initiatives that Honor Trust and Treaty Obligations to Tribal Nations.* Effective efforts for health equity in Indian Country must approach health equity plans through the lens of Tribal sovereignty, the nation-to-nation relationship, and the federal trust responsibility. In addition, these plans must conceptualize this work around understanding AI/ANs as a group with a unique political status, not as a racial minority. Health programs and initiatives need to prioritize Tribal self-determination and supporting connection to culture and community. Tribes know their people, communities, social and historical context, needs, and strengths best—Tribes are the experts in charting a path to health equity for their people. In addition, achieving health equity requires recognizing and rectifying historical injustices and providing resources according to need.
- *Create and Invest in an Indigenous Model of Social and Structural Determinants of Health.* Decades of research have documented health inequities experienced by AI/ANs—including those inequities around SUD and OUD—and the powerful role played by underlying social and structural determinants of health. However, these determinants that drive health inequities for AI/ANs are often distinct and require a unique perspective and customized approach to address. Current research on social determinants of health is missing this Indigenous perspective. Health equity for AI/ANs will advance with a Tribally created and Indigenous model of social and structural determinants of health that will identify root causes of inequities and priorities for intervention. In July 2023, the 76th World Health Assembly (WHA) adopted a resolution prioritizing the health of Indigenous Peoples around the World, including developing a global action plan by 2026. We call on the United States to invest in, adopt and advance these priorities as a Tribally-informed path toward achieving health equity and end crises like the opioid and fentanyl crisis in our communities.
- *Address Housing and Homelessness in Indian Country.* All Tribal members should have access to stable, safe, sanitary, and affordable housing. Individuals cannot have access to recovery or treatment services without first having safe, adequate and secure housing. Tribal housing issues and challenges exacerbate health disparities and lower health status experienced by AI/AN individuals and communities. Congress must reauthorize the "Native American Housing Assistance and Self- Determination Act of 1996" (NAHASDA) and advocate for additional resources for Tribal housing needs. Housing policies should focus on "housing first" before individuals may be able to live in recovery.
- *Address Historical and Intergenerational Trauma.* SUDs are among the many health problems worsened by discrimination and oppression, both historical and current. Research has directly linked historical trauma, colonization and its methods to substance use among AI/AN Peoples. Traumatic events experienced by American Indians and Alaska Natives are not confined to a single catastrophic period in the past, nor are they confined to a single event but from many sources; they are ongoing and present in modern times. Additionally, the detrimental, intergenerational harm from boarding school policies is associated with increased SUDs, mental illness, and numerous chronic health conditions. As we examine our past, we must continue to look toward the future to identify and address these policies' impact on our communities, our cultural integrity including tradition-informed ways of being healthy. One of the most insidious aspects of historical trauma is its heritability. It is passed down through families and communities—most often unknowingly—exposing future generations to centuries-old sorrow and trauma. Opportunities to intervene in this process are often overlooked or not identified, and so the cycle continues. An important way to actively promote healing is to break this cycle and interrupt the passing down of messages that contribute to trauma. Trauma should be proactively addressed in informed ways by the appropriate tribal (e.g., family members, teachers, leaders, traditional practitioners, behavioral health professionals) and non-tribal parties. [9]
- *Promote Culturally Centered and Tribally Driven Behavioral Health Policy and Programs.* AI/AN cultures serve as key protective factors and primary prevention of many mental health and substance use disorders. Historically, traditional healing and culturally centered ways of living provided holistic mental wellness. Forced assimilation policies and programs harmed Tribes and created behavioral health disparities and negative health outcomes. Just as federal policy and programs once sought to eradicate AI/AN identity, there must be an

[9] *Ibid.*

equally vigorous contemporary response that assists in reconnection and revitalization of identity. Cultural restoration is an essential aspect to the needed approach to these programs. Support for traditional healing practices and modalities and investment in community restoration are essential if we are going to recover from the many policies of colonization.

To that end, Congress must provide that the funding for these programs be available through self-governance contracts and compacts, and tribally driven, and informed. Too often, federal policies seek to fit support to tribal communities in a system that was originally designed without their input, and in many cases, designed to eradicate our people. Instead, programs serving Tribal communities should focus on culture, healing, and traditional ways of knowing. Without federal policy supporting the restoration of culture, community and traditional knowledge, we will not be able to heal from the trauma of colonization.

All prevention and treatment programs are not designed to meet the diverse needs of differing communities, nor are they designed to readily incorporate traditional American Indian and Alaska Native worldviews that promote health and healing. Tribal communities must have the flexibility, support, and resources to implement prevention, treatment, and recovery programming that meet the needs of their populations. Congress should:

Create and support culturally and spiritually based programming and healing that aligns with the diversity and needs of the local Tribal population and engages communities in the development of diversion and reentry programs.

Support and coordinate reentry programming across service sectors and programming for incarcerated persons and their families, especially their children.

Support and promote Tribal Healing to Wellness Courts, Veterans Courts (or the VA Diversion Courts Peer-to-Peer Support Program), and other courts that support recovery

Formulate and implement long-term, communitywide engagement and mobilization strategies that emphasize community ownership of their issues and solutions.

Support and train community members to serve as peer counselors. [10]

- *Strengthen Tribal Behavioral Health Systems.* Many barriers impact access, quality, and availability of health, behavioral health, and related services for AI/AN people. These issues include provider and personnel shortages, limited resources, and obtaining services without traveling great distances. Additionally, there are concerns related to funding, such as amounts, distribution mechanisms, allocations, sufficiency, and reporting requirements. Congress must invest in adequate resources to address the chronic behavioral health needs of Indian Country. This includes providing funding at the full authorized amount for the newly enacted the Behavioral Health and Substance Use Disorder Resources for Native Americans located at SAMHSA. Congress should also enact legislation to expand the use of contracts and compacts under the "Indian Self-Determination and Education Assistance Act" (ISDEAA) for programs outside of the IHS.

  We believe that one of the ways to do strengthen behavioral health systems is to follow other effective programs. One of the most successful models for addressing chronic health issues is the Special Diabetes Program for Indians. This program provides funding to over 300 grantees to treat and prevent type 2 diabetes through approaches that are culturallydriven and tailored to local community needs. Data shows the program being remarkably successful with type 2 diabetes onset and complications for AI/ANs decreasing year after year. Congress should enact a similar program for behavioral health challenges that would focus on local needs, and cultural practices.

Conclusion

For centuries, AI/AN people have endured genocide, destruction of culture, poverty, removal, forced assimilation, and countless traumas that have all contributed the crisis of OUD and SUD that we see in Tribal communities today. Addressing the opioid and fentanyl crisis is a complex issue that involves all sectors including health, public safety and justice, child welfare, economic opportunity, and many others. While there is not one policy answer that will eradicate the impacts of opioids

[10] *Ibid.*

and fentanyl in our communities, we do know that the core of this answer is restoration of culture.

Restoring Tribal culture, honoring tribal sovereignty, and supporting self-determination will ensure that Tribal nations have the tools available to support their communities. This includes enacting policy that is focused on individualized communities, and does not force our communities to fit in to the boxes determined by federal officials. We know what to do. We know how to heal. We need support to achieve it. This includes investments in behavioral health facilities are necessary to ensure that those who suffer from opioid use disorders and the detrimental effects of illicit fentanyl can seek the treatment they need. We must have investments in housing support, employment, and public safety. But most of all, cultural and traditional healing practices that protect AI/AN communities should be a priority and fully funded through self-governance. There is no quick fix to this crisis, but adequate funding for Indian country is the first step in preventing more overdoses and treating those with addiction.

PREPARED STATEMENT OF NICKOLAUS D. LEWIS, COUNCIL, NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

Greetings Chairman Schatz and Vice Chairman Murkowski, and Members of the Committee. My name is Nickolaus D. Lewis, and I serve as Council on the Lummi Indian Business Council, and as Chair of the Northwest Portland Area Indian Health Board (NPAIHB or Board). I thank the Committee for the opportunity to provide testimony on "Fentanyl in Native Communities: Native Perspectives on Addressing the Growing Crisis."

NPAIHB was established in 1972 and is a tribal organization under the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93–638. The Board advocates on specific health care issues in support of the 43 federally-recognized Indian tribes in Idaho, Oregon, and Washington (Northwest or Portland Area). The Board's mission is to eliminate health disparities and improve the quality of life for American Indians and Alaska Natives (AI/AN) by supporting Northwest Tribes in the delivery of culturally-appropriate, high-quality health care. "Wellness for the seventh generation" is the Board's vision. We thank the Subcommittee for their continued support in improving the delivery of healthcare services in Indian Country.

I provide the following testimony on the fentanyl crisis in the Northwest:

Opioid and Fentanyl Epidemic in the Northwest

AI/AN people in the Northwest are facing a devastating opioid and fentanyl epidemic with increased overdoses and deaths. The rate of drug overdose deaths, specifically for opioid and fentanyl deaths, are disproportionately higher among AI/ANs in the U.S. compared to other racial groups. But, the death rate from drug overdose among AI/ANs in Washington state is almost three (3) times higher than the national AI/AN rate and the Washington state average. Alarmingly, the overdose death rate among AI/AN in Oregon has more than doubled from 2015 to 2020. While the national and state averages have also increased during this timeframe, the rate among AI/AN in Oregon has increased more—a 158.5 percent increase.

The COVID–19 pandemic caused isolation from familial, social, and cultural activities, increased anxiety and depression, significant deaths, economic instability, and barriers accessing mental health services and substance use treatment. As a consequence, the pandemic precipitated this devastating opioid and fentanyl epidemic and Northwest Tribes are experiencing significantly poor mental health and substance use outcomes. This opioid and fentanyl epidemic is overwhelming tribal programs and services, including health care, public safety and tribal justice systems, child welfare, housing, social services and elder care programs.

The Northwest Tribal Leaders advocated for a convening of Tribes nationally to develop policy priorities and strategic action items to address this crisis. In August, the NPAIHB hosted the National Tribal Opioid Summit which convened over 1,000 tribal leaders, frontline workers, and federal and state policymakers in Tulalip, Washington to develop solutions, collaboration, and policy recommendations to directly address the devastating impacts of fentanyl and opioid drug abuse in tribal communities. The National Tribal Opioid Summit (NTOS) Resource Hub, available at *https://www.npaihb.org/national-tribal-opioid-summit/*, houses all ongoing resources and materials related to the Summit, including a draft set of policy recommendations and Executive Summary. A NTOS Report will be forthcoming and posted to the Resource Hub webpage.

Based upon the NTOS and NPAIHB priorities, we make the following recommendations to the Committee to address the fentanyl crisis:

Declare a National Emergency for the Opioid Epidemic

We request the Committee calls upon the President to declare a national emergency for the opioid epidemic devastating Tribal communities under the National Emergencies Act, 50 U.S.C. § 1601 et. seq., the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121 et. seq., and Public Health Service Act, 42 U.S.C. § 247d. We also request that the Administration utilize all authorities under the Stafford Act, National Emergencies Act, and Public Health Service Act to:

- allow Medicaid and Medicare reimbursement at the Indian Health Service (IHS) encounter rate for traditional healing and tribal based practices and all services furnished by behavioral health providers;
- facilitate access to community wide harm reduction training and access to supplies, including Narcan and fentanyl test strips, from the Strategic National Stockpile and the Indian Health Service's National Service Supply Center;
- fully fund tribally operated treatment facilities, wrap around services, and medically assisted treatment programs;
- streamline certification requirements for treatment facilities and Opioid Treatment Programs; and
- provide flexibility for Tribes to incorporate and fund tribal and cultural practices and to address social determinants of health, including addressing safe housing, food security, and training and workforce opportunities.

Expand the use of ISDEAA Self-Determination Contracts and Self-Governance Compacts

Northwest Tribes have had longstanding requests to the IHS and Health and Human Services (HHS) to move away from grant funding and allow tribes the option to receive funds through their contracts and compacts. Self-determination and Self-governance contracts and compacts honor tribal sovereignty and the government-to-government relationship and authorize Tribes to rapidly deploy programs and services to meet the needs of their communities. IHS and other HHS agencies continue to provide funding through grant programs. Grant programs result in significant administrative costs to operate the grant program that are not reimbursable. We need HHS funding to be flexible and allow us to address the mental health and substance use needs within our communities as the needs arise and without restrictions. This Committee must support an option for tribally-operated facilities to receive all HHS grant funds through their ISDEAA contracts and compacts.

In addition, HHS agencies have previously allocated funding to IHS that was distributed to tribes through existing formulas and ISDEAA contracts and compacts (e.g., Centers for Disease Control and Prevention). This process successfully allowed tribes to receive funds quickly from CDC and to use those funds to best meet the needs in their communities. All HHS funding should be allocated to Tribes through this mechanism. This Committee must support legislation expanding ISDEAA contracting and compacting to HHS and its agencies.

Support for Increased Funding to Address Opioid Response

The President is proposing to provide $1.55 billion in additional funding to the Substance Abuse and Mental Health Services Administration (SAMHSA) to address the opioid crisis, including $250 million that would be transferred to the IHS and made available for two years. We support this long overdue investment to tribal opioid response but request that IHS is directed to provide those funds to Tribes and Tribal organizations through their existing ISDEAA contracts and compacts. We also request support for increased funding to construct facilities for detox and treatment and to address housing shortages for individuals in recovery and their families.

Improve Opioid Treatment Program (OTP) Service Delivery

Currently, it's an onerous process to open an opioid treatment program (OTP) due to the number of inspections, reviews, policies, and procedures necessary to be in place prior to opening. Under 42 C.F.R. § 8.2, the medical director of an OTP is defined as "a physician, licensed to practice medicine in the jurisdiction of the location of the OTP." However, there are numerous medically trained providers such as ARNPs or PA-Cs working for tribes who have the experience and knowledge to serve in the medical director role. By limiting the credentials of who can be an OTP medical director, tribes are paying exorbitant salaries to people who may not be the best

fit for the tribe's needs. We request this Committee to urge SAMHSA to initiate rulemaking to streamline the certification and accreditation process for OTPs and to give Tribes the flexibility to choose other medically trained providers to serve as medical director.

Expand the Community Health Aide Program (CHAP) in the Lower 48

Tribal Leaders in the Portland Area support long term sustainable solutions that build up our communities, create opportunities for our youth and tribal citizens, educate our healers and train the next generation of work force. Lack of behavioral health providers is a significant issue and need in the Portland Area. The Community Health Aide Program (CHAP) is a program that was designed and implemented by the Alaska Native Health system over 60 years ago. In nationalizing it to the rest of the country, tribes everywhere have an important opportunity to tackle social determinants of health while improving healthcare workforce and retention especially focused on behavioral health workforce. CHAP is unique because it not only increases access to care, but creates access points to health education so that tribal citizens can become health care providers with professional wage jobs on reservations and in tribal health programs throughout the country. Thus, CHAP is critical to addressing poverty and supporting economic viability in Tribal communities. The education programs associated with CHAP are the foundation of the program.

In the Northwest, we have established a Dental Therapy Education Program, two Behavioral Health Aide Education Programs, and in the process of developing the Community Health Aide Education programs. We have also worked with the Portland Area IHS Office to standup a CHAP Certification Board to certify our Portland Area CHAP providers. Portland Area Tribes and NPAIHB have been innovative and creative in securing funding for CHAP expansion despite only receiving one IHS grant of $1 million (of the $20 million appropriated to IHS for the expansion of CHAP in the lower 48). This Committee must consider this crucial opportunity to address workforce shortages in Tribal communities and further support increased access to behavioral health services.

Support the National Tribal Opioid Summit (NTOS) Recommendations

The NTOS Policy Recommendations and Final Report are being reviewed and finalized by Tribal Leaders. The Policy Recommendations and Final Report will be available on the NTOS Resource Hub available at *https://www.npaihb.org/national-tribal-opioid-summit/*. We urge the Committee to support the NTOS Recommendations in order to address this devastating epidemic affecting Indian Country.

During the NTOS, Tribal Leaders and other Summit attendees participated in a policy survey that requested their input on how Congress and the President could address the fentanyl crisis. The policy survey results are being compiled and will be posted on the NTOS Resource Hub. We encourage the Committee to review the policy results when posted.

Conclusion

Thank you for this opportunity to provide testimony on the fentanyl crisis in the Northwest. As evidenced by our testimony, Tribes need resources now to save lives from this devastating epidemic. I invite you to visit the Northwest to learn more about the fentanyl crisis in our Area. I look forward to working with the Committee on our requests. [1]

PREPARED STATEMENT OF THE SENECA NATION

Chairman Brian Schatz, Vice Chair Lisa Murkowski, and Members of the Committee, these comments are being submitted on behalf of the Seneca Nation in response to the two recent hearings the Committee held regarding the epidemic of fentanyl use in Native American communities. The Seneca Nation appreciates the Committee holding two hearings on this public health crisis in such a short time, and we request you continue to hold additional hearings and roundtables on the matter throughout 2024. After monitoring both hearings and reviewing the written statements of the witnesses, we think it is critical that the Committee continue to shine a light on this matter through formal hearings (including field hearings) and roundtable discussions for the following reasons:

[1] For more information, please contact Karol Dixon, NPAIHB, Director of Government Affairs/Health Policy.

1. Effectively combatting the fentanyl crisis is a multi-government effort and will require resources from the federal and state governments along with Native Nation governments. The Seneca Nation and other Native Nations need to be at the table and need to be a part of the dialogue about potential solutions and information sharing regarding the fentanyl crisis. The federal government has a treaty obligation to help us respond to this epidemic, and federal partnership is necessary to make any effective progress in this fight. Holding additional hearings and roundtable discussions ensures that our Native voices are heard and creates transparency and accountability for making meaningful progress on this matter; and
2. In addition to ensuring that we are at the table and are a part of the discussions, hearings improve the level of information sharing between governments and communities. The recent hearings shared useful information about the public health crisis experienced in other parts of Indian Country. This information helps guide strategies for combatting the surge of fentanyl use in our own community. The Seneca Nation submits these comments to ensure our experiences are placed on the record to inform the federal government and other Native Nations about what we are doing to combat fentanyl and its root causes within our community. One thing that is clear from the hearings is that Congress and federal agencies are taking too long to adopt protective laws and policies and to develop best practices. Fighting the scourge of fentanyl cannot wait for changes in laws and policies, and sharing information is vital for those of us who are not getting the same level of outreach and support from our local federal and state government entities. The Seneca Nation cannot wait for federal laws and policies to change. We are taking an active role in addressing our growing fentanyl crisis. This is why we created our own Opioid Taskforce, compromised of Seneca Nation leadership and community members, committing our own resources to develop an action strategy to combat the root causes of the fentanyl crisis. Despite committing our own resources, it is still the federal government's responsibility to aid us and provide additional funding.

The Seneca Nation is one of the largest of the six Native Nations from the historic Iroquois Confederacy, a democratic government that predates the formation of the United States. We are located in what is now called Western New York State. We have over 8,500 enrolled members, most of whom reside on or within fifty miles of our multiple non-contiguous territories. Our territories span four counties: Erie, Cattaraugus, Chautauqua, and Niagara. Our judicial system is comprised of a Peacemakers Court that focuses on civil matters, a Surrogates Court that oversees probate matters, and a Court of Appeals. The primary enforcers of Seneca Nation laws are the Seneca Nation Marshals and Conservation Officers. The Nation does not have its own criminal code or criminal laws and, therefore, the Nation's law enforcement officers do not enforce any criminal laws and the Nation's Courts do not process any criminal complaints. Federal and state law enforcement officials share authority under federal law to exercise criminal jurisdiction over the Nation's territories, but their limited resources and competing interests often mean that the enforcement of criminal laws on Nation territories may not receive the same attention as neighboring off-territory communities.

Like other Native Nations, the Seneca Nation experiences drug-related challenges and a surge in opioid abuse and fentanyl related overdoses and deaths. No family in our Nation has been spared from this heartache, and we all know someone who is suffering from the fentanyl crisis. We have had instances where babies are born addicted to opioids and our community must watch these babies go through the detox process. Many of our children have lost their parents due to overdose, and many more watch their parents struggle with active addiction. These situations place additional burdens on extended families and our foster care system who must now care for these children. A spiritual person in our community had a dream in which an elder Seneca woman on the other side came back to our community and expressed concern about all the Seneca children without parents. This woman delivered a message that we need to do more for these children who have lost their parents to opioids.

We have seen some of our young adults overdose on opioids, including fentanyl, and discarded on the street instead of rushed to a hospital where they might have a chance to survive. In one case, a 24-year-old Seneca man was discarded only several houses away from his mother's house. Worse is that these stories have become so frequent that our people are becoming numb and desensitized to the crisis and long-term trauma it is causing.

The effects of addiction and loss ripple through our community. Like other Native Nations, our community feels like an extended family, and we are all connected. Thus, deaths affect all of us-neighbors, friends, and family. Over the past 10 years, the number of funerals in our community has increased tremendously and the devastation that untimely and unnecessary deaths leave behind is often unbearable. Between 2015–2020 alone, there were 110 documented overdoses on two of our territories. There have been so many funerals within our community over the past year that a group of Senecas formed a grass roots organization to help grieving families. It is the custom and tradition of Seneca people to bring the bodies of our loved ones home when they pass away so that our community may care for them with traditional ceremonies. This can involve hundreds of people coming to a home to participate in the ceremonies and grieving process. Since most homes cannot fit this many people, large canopies, tables, and chairs are set up outside the home to accommodate the number of mourners who visit throughout the day and night. Given the increased number of funerals in our community, the grass roots organization also provides resources to Seneca families for the mourning process and provides grief support.

The opioid epidemic, particularly fentanyl, is our number one priority, which is why we are so grateful that the Committee held two hearings on the matter. Fentanyl is such an important issue to us that the Seneca Nation representative attending the annual White House Tribal Nations Summit left the Summit to attend the Committee's hearing on December 6th. These hearings allow for much information to be shared and conveyed on the record and highlight why it is so important for the Committee to continue holding additional hearings and shed more light on this critical issue that impacts all Native Nations. There are three key things we took away from the two hearings held by the Committee:

1. There is a significant need for more data collection and data sharing to help combat this crisis;
2. The experiences of Native Nations across the country with respect to fentanyl and access to federal and state resources varies greatly; and
3. More federal and state resources are needed now, and needed quickly, for Native Nations to effectively combat fentanyl.

The hearings highlighted the disparity in data collection and sharing across the country and how better data can help each community develop targeted action items. Councilman Bryce Kirk from the Assiniboine and Sioux Tribes of the Fort Peck Reservation provided very good data collected by his government, in combination with data that was shared by the state government. This data allowed the Assiniboine and Sioux Tribes' government to develop concrete recommendations for what is needed to combat the fentanyl crisis on their reservation. The Seneca Nation has been collecting data but we also have encountered barriers to accessing data collected by local governments. For instance, we know from our own data that the use of Narcan has helped prevent deaths from opioid overdoses. Our Seneca Emergency Management Services tracks the number of calls for dispatch and how many get cancelled and for what reason. We have had a number of cancelled calls over the past few months because Narcan was successfully administered. From this data, we know that increasing the availability of Narcan and educating people on how to use it reduces the number of overdoses in our community.

We also know from data collected by Erie County that Senecas are disproportionately impacted by fentanyl and overdoses. Over one-third of the Seneca population resides in Erie County and data from the County government indicates that overdoses among Native Americans is triple that of other groups. However, data from Cattaraugus County, where many Seneca people also live, is lacking because of discrepancies in the data collection methods and available funding. In Cattaraugus County, the specific cause of death for many opioid overdoses is listed as heart attacks because the County only has a coroner, not a medical examiner. Not having the financial resources to hire a medical examiner means that Cattauragus County is unable to adequately collect the data surrounding deaths related to fentanyl overdose. Thus, we do not have an acurate picture of the impact on our people in Cattauragus County.

The hearings also highlighted the disparities in the level of interactions between the Bureau of Indian Affairs (BIA) and Department of Justice with various Native Nations across the country. The Director of the BIA's Office of Justice Services shared valuable information about some of the threats of opioids in Indian Country. However, the information also highlighted what the BIA fails to know, such as the impacts on each Native Nation's community, government and social services. Additionally, very few, if any, Native Nations in the Northeast have a BIA presence in

our territories. The Eastern Region Office of the BIA is located in Nashville, Tennessee, and serves 34 Native Nations located in 12 states East of the Mississippi River. BIA law enforcement officers have a very limited presence in any Native Nations in the Eastern Region, with field offices only in three Native communities and all of those are in the Southeast. The Director of the BIA's Office of Justice Services provided the Penobscot Nation's Healing to Wellness Court as an example of a Native Nation combatting the fentanyl crisis even though the BIA has no presence on the Penobscot Reservation. The New York Field Office formerly located in Syracuse, NY no longer exists and is temporally located in Cherokee, North Carolina. The hearings show how the BIA's Office of Justice Services needs additional resources to offer any real assistance to Native Nations across the country.

The same is true with regards to the various entities within the U.S. Department of Justice. We were surprised to hear the testimony of U.S. Attorney Vanessa Waldrefin which she conveyed very detailed data about fentanyl in Eastern Washington State, the level of coordination between her office, Native Nations in the district, the FBI, the BIA, and the DEA. Also surprising was the number of consultations her office convenes with Native Nations, the Safe Trails Task Force, and the DEA's Operation Engage, which focuses on prevention and education. Our interactions in Western New York are far different from what U.S. Attorney Waldref describes as occurring in Eastern Washington. There has been only limited outreach in recent years to us from the U.S. Attorney for the Western District of New York, and even less from the BIA or FBI. We are impressed with the level of coordination and outreach that U.S. Attorney Waldref described in her testimony and believe that the U.S. Department of Justice could increase its effectiveness if similar levels of coordination and outreach were performed throughout Indian Country.

The Seneca Nation shares many of the same experiences as those Native Nations in Eastern Washington. Our lands are in rural areas, our people suffer from intergenerational trauma, and our communities and government are still recovering from broken treaties and promises made by the United States. We believe that our territories and people are being specifically targeted by drug cartels and dealers for the same jurisdictional complexities and lack ofresources that U.S. Attorney Waldreftestified about for Eastern Washington. Our territories border the State of Pennsylvania and are close to the Canadian border, and we are positioned in a main corridor to access New York City. Thus, drug dealers seeking to smuggle drugs into New York City often target the Seneca Nation territories as places to set up shop for strategic access. Yet, the amount of interaction and information we are receiving from the federal government and State of New York is far less than what U.S. Attorney Waldref describes as occurring in Eastern Washington.

Finally, the hearings highlighted that additional resources are needed in Indian Country to combat the fentanyl crisis. All the data shared during the hearings point to how Native Americans and our communities are disproportionately impacted by opioid abuse and are targeted by drug dealers and smugglers because of complex jurisdictional issues and a lack of information sharing and coordination with the federal and state governments. Yet, we receive no additional resources to mitigate these disproportionate impacts. We need more resources, and we need them now! We need more financial resources, more information and consultation, and more flexibility and less red tape from the federal government on how we use our federal funding so we can address this crisis with the flexibility it requires.

As several of the Native Nation leaders testified during the hearings, there is no single solution to the fentanyl crisis, and we must take a holistic approach to solving the problem and its root causes. A holistic approach means that we need to focus on supporting cultural practices, mental health, detoxification, and treatment, in addition to law enforcement. Like other Native Nations, our people lack access to detox treatment and adequate mental health services. We need federal funding to address these issues and the flexibility to develop comprehensive communitybased programs in a culturally relevant manner. Many states receive federal funding for addiction services and support services, but this federal funding is not making its way to Native Nations even though we are disproportionately impacted by the fentanyl crisis. New York State has an Office of Addiction Services and Support, but the Seneca Nation receives no funding or assistance from this office. We need direct funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) rather than relying solely on State resources. And, we should not have to compete with other Native Nations for such vital funding; every Native Nation should receive fundin to address mental health issues and intergenerational trauma. As a part of the Seneca Nation's commitment to take an active role in addressing fentanyl abuse and its root causes, we are hosting the World Indigenous Suicide Prevention Conference in the summer of 2024. This will be the first time the Conference will be held in the United States and held on Indigenous lands. Yet,

we are not receiving any federal funding to host the Conference even though opioid and fentanyl use is directly related to suicides in Native American communities. Our hope is the Department of Health and Human Services and the Indian Health Service will become partners with us on this Conference.

In addition to increased federal funding, Native Nations need far more flexibility in how we can use federal funding so that we can quickly take actions targeted towards various health crises, such as fentanyl, without having to wait for Congress to make changes to existing laws or agencies to revise policies and regulations. We appreciate President Biden issuing Executive Order 14112 To Promote the Next Era of Tribal Self Determination. This Executive Order is intended to make federal funding more accessible, flexible, and equitable for Native Nations by reducing red tape and allowing Native Nations to exercise more autonomy over how we use federal funds. Additionally, the Executive Order creates a one-stop-shop website for Native Nations to research the federal funding available to us and requires the federal government to better assess its unmet obligations to Native Nations. It sounds like good progress, but how long will it take to implement this Executive Order, and specifically what can be done now pursuant to the Executive Order to help the Seneca Nation and other Native Nations to combat the fentanyl crisis in our communities? We need the Committee to push for the Executive Branch to answer these questions and to provide answers quickly versus a year from now.

In closing, the Seneca Nation again thanks the Committee for holding its two recent hearings on the fentanyl crisis, and we ask that the Committee continue to hold hearings on this important issue in 2024.

PREPARED STATEMENT OF THE UNITED SOUTH AND EASTERN TRIBES SOVEREIGNTY PROTECTION FUND

As the Committee well knows, the opioid crisis 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 at rates higher than non-Indian communities. According to the Centers for Disease Control and Prevention (CDC), American Indians and Alaskan Natives (AI/ANs) experienced the highest rates of opioid overdose deaths of any racial or ethnic group in both 2020 and 2021. Between 2020 and 2021 alone, Tribal communities experienced a staggering 33 percent rise in overdose deaths,[1] the vast majority of which are the result of opioids, particularly synthetic opioids like fentanyl. Despite the disproportionate impact opioid use has had in Indian Country, Tribal Nations continue to lack access to sufficient, critical resources to address the damaging effects of opioid abuse in our communities. USET SPF offers the following comments and recommendations to the Committee to underscore the need for Congressional action, in accordance with trust and treaty obligations, to ensure Tribal Nations have the resources necessary to address this epidemic.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of thirty-three (33) federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico.[2] USET SPF is dedicated to promoting, protecting, and advancing the inherent sovereign rights and authorities of Tribal Nations and in assisting its membership in dealing effectively with public policy issues.

Data Collection and Access Challenges Result in Insufficient Resources

It is unquestionable that opioid abuse, deaths, and trafficking have reached epidemic levels in the United States, but particularly in Indian Country. Available sta-

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[1] "Drug Overdose Deaths in the United States, 2001–2021," Centers of Disease Control and Prevention

[2] USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe-Eastern Division (VA), 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), Monacan Indian Nation (VA), Nansemond Indian Nation (VA), 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), Rappahannock Tribe (VA), 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), Upper Mattaponi Indian Tribe (VA) and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

tistics already show that AI/AN peoplehad the highest rates of drug related deaths in recent years, and information from the Indian Health Service (IHS) indicates that AIANs are more likely than any other race/ethnicity to have an illicit drug use disorder. According to the National Institutes of Health (NIH), opioid mortality rates for AI/AN populations have risen almost continuously for nearly two decades.

However, USET SPF suspects that rates of AI/AN opioid overdose and addiction among Tribal Nations are likely much higher than even national statistics and current data reveal. Per the CDC, misclassification of race on death certificates "results in the underestimation of death rates by as much as 34%" for AI/AN people. Further, currently available data fails to fully illustrate the impacts opioids are having in Tribal communities, as data access within the Indian Health System is limited and often incomplete. To assess the full scope of impacts opioids are having in our communities, Tribal Nations require strengthened data collection activities at all levels. However, no funding is currently available to Tribal Nations to create data systems that could more adequately and appropriately illustrate the impacts of the opioid crisis, and access to necessary federal data sets.

As we have testified in the past, an overall lack of data surrounding the opioid crisis, as well as barriers to data collection and dissemination within the Indian Health System, has not only impeded Tribal Nation prevention and treatment efforts, but also efforts to secure increased federal funding. In the absence of robust, comprehensive data demonstrating the disproportionate effects of opioid use in Indian Country, effort to expand treatment and prevention services are greatly hampered.

To remedy this, Congress must provide direct funding to Tribal Nations and Tribal Epidemiology Centers (TECs) in order to improve opioid data collection. Without access to critical data, direct funding, or Congressional champions when strategies are being developed, 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 direct funding to improve opioid data and provide for the treatment and prevention of substance abuse.

Moreover, Tribal Nations and Tribal Epidemiology Centers (TECs) continue to experience frequent challenges in accessing not just public health data on both the federal and state level, but Tribal data as well, which often is not reported back to the Tribal Nation when collected by other jurisdictions. Despite being designated as Public Health Authorities, a Government Accountability Office Report, and Congressional oversight measures, both Tribal Nations and TECs continue to experience frequent challenges in accessing data on both the federal and state level—on top of the consistent lack of investment in TECs and Tribal public health capacity. As Public Health Authorities, TECs provide invaluable Tribal Nation-specific public health data and information to Tribal leaders, health directors and public health professionals in Indian Country. TECs continue to petition both the CDC and state public health departments for this vital information but have only received state data where there are positive Tribal-state relationships.

Congress must remedy this problem, including through compelling the CDC and states to share all relevant data sets with Tribal Nations and TECs. CDC must ensure that TECs have access to critical public health data from federal and state governments. Both should be statutorily required to share all available public health data with TECs and Tribal Nations. This should be made a requirement of state cooperative agreements with CDC. CDC must also take steps to improve the quality of public health data shared with TECs and Tribal Nations. This includes requiring states work with Tribal Nations to correct racial misclassification.

Increased, Direct Funding for the Indian Health System

The federal government has trust and treaty obligations to ensure Tribal Nations have access to resources, financial and otherwise, to combat the opioid epidemic. The federal government has affirmed many times over its requirement to "provide all resources necessary" to ensure "the highest possible health status" for Tribal Nations and citizens. This necessarily includes flexible and substantial funding to create programs and services that are responsive to the challenges facing our communities. Though the data on this issue is incomplete, that which is available shows that Indian Country is being disproportionately and significantly affected by the opioid crisis. And yet, we remain without access to critical resources, particularly direct federal dollars. USET SPF urges the Committee to prioritize addressing this shortfall by working to ensure Tribal governments have access to direct funding.

Access to funding for federal opioid grant programs is also important for Tribal Nations and communities. Programs like the Tribal Opioid Response (TOR) Grant Program at the Substance Abuse and Mental Health Services Administration

(SAMHSA) are valuable tools in fighting the opioid epidemic in Indian Country. USET SPF urges Congress to increase funding for this program, as well as appropriate dedicated funding for the $80 million Behavioral Health and Substance Use Disorder Program for Native Americans authorized (but not funded) at SAMHSA last year. In addition, USET SPF continues to support and urge the immediate passage of The Native Behavioral Health Access Improvement Act, legislation authored by Senator Tina Smith that would establish and provide substantial funding for a Special Behavioral Health Program for Indians, with dollars eligible for receipt through self-governance compacting and self-determination contracting.

Further, USET SPF supports the adoption of the President's supplemental funding request to combat the opioid epidemic. This $1.55 billion request includes a $250 million transfer to the IHS via the State Opioid Response (SOR) grant program. However, it is yet unclear how the funding would be disbursed from the IHS. USET SPF asserts our expectation that these funds will be eligible for self-governance contracting and compacting so that Tribal Nations can directly access these dollars and determine how best to utilize them in our communities.

It is important to note that while existing federal programs have been valuable tools in the fight against the opioid epidemic so far, there remain significant issues with the provision of funding to Indian Country through grants and other mechanisms that do not uphold Tribal sovereignty and self-determination. Many federal grant programs require funding to pass through the states before it can be delivered to Tribal Nations if it is delivered at all. Further, when applying for these grants, states will often include Tribal population and prevalence numbers in the overall state data 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. Even when grant programs are specifically provided for Tribal Nations and organizations, the grant funding is often extremely limited, and the sheer nature of competitive grants often excludes many Tribal Nations that would benefit from the programs. Tribal Nations must not be made to compete with one another for these limited resources, as funding to Tribal Nations is provided in fulfillment of federal trust and treaty obligations—not in response to relative "need" or circumstances. To force Tribal Nations to compete for limited resources through competitive grants is an abrogation of the trust responsibility and an affront to Tribal sovereignty.

To ensure that Tribal Nations are able to access federal funds fully and meaningfully in the future, USET SPF recommends the Committee and Congress:

- Pass and implement "The Native Behavioral Health Access Improvement Act" legislation and provide substantial funding for a Special Behavioral Health Program for Indians, with dollars eligible for receipt through self-governance compacting and self-determination contracting.
- Fully fund and implement programs such as the Behavioral Health and Substance Use Disorder Resources for Native Americans Program at SAMHSA;
- Expand language within grant funding programs to specifically include Tribal Nations such that states cannot exclude us in grant funding disbursements and are held accountable by the federal government for delivering funds directly to Tribal Nations; and
- Enact delivery of all federal dollars, including opioid funding, to Tribal Nations via self-governance contracting and compacting in recognition of Tribal sovereignty and self-determination.

Telehealth and Medication Assisted Treatment

Well before the COVID–19 pandemic increased the prevalence and availability of telehealth services, USET SPF advocated for expanded telehealth services in Indian Country to combat the rising substance abuse crisis. Existing telehealth programs within Indian Country have made significant improvements in their communities when it comes to access to care, diagnosis, and treatment. In response to the COVID–19 pandemic, the federal government eased several long-standing regulations regarding opioid treatment programs. For example, prior to 2020, people suffering from opioid use disorder were required to meet in-person with a health care provider to start medication assisted treatment. During the COVID–19 pandemic, the federal government implemented flexibilities that allowed practitioners to prescribe medications like buprenorphine remotely to new patients via telehealth. They also allowed for expanded payment for telehealth services and flexibility on accepted communication technologies (like audio-only services) to deliver care for substance use disorders via telehealth. Expanding the use of telehealth for treating substance use disorders is a vital component in efforts to address the opioid epidemic in Tribal communities. A study by the National Institutes of Health (NIH) demonstrates that

opioid use disorder treatment via telehealth was associated with an increased likelihood of staying in treatment, as well as an increased in treatment access overall. USET SPF urges the permanent adoption of these temporary authorities so that expanded access to services may be maintained.

However, though Tribal telehealth continues to make strides, Indian Country continues to fall behind in establishing sustainable, standard telehealth system due to limited, or often, lack of existing infrastructure and bandwidth. The same NIH study referenced above found that the "benefits of telehealth are not reaching all populations equitably." It is crucial that Congress invest not only in opioid addiction telehealth services within Tribal Nations and communities, but also in infrastructure and bandwidth capabilities. Telehealth funding and expanded authorities will not be beneficial if barriers to access, such as infrastructure and bandwidth issues, are not addressed.

Increased Law Enforcement Resources

In addition to health and treatment resources, USET SPF member Tribal Nations require adequate law enforcement infrastructure to combat the opioid epidemic. Opioid trafficking is a persistent and growing problem in Indian Country, as several witnesses noted, and the USET region is not an exception. In order sufficiently address the growing opioid abuse and trafficking within our Tribal Nations, our BIA Drug Enforcement Region needs additional resources, including human capital.

Tribal Nation law enforcement agencies, much like other entities operating in Indian Country, face chronic underfunding, understaffing and other challenges due to inadequate federal appropriations. Additional resources 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.

In a March 2023 report to Congress (as required under the Tribal Law and Order Act), the Bureau of Indian Affairs (BIA) indicated that, "the total estimated costs for public safety and justice programs is $1.4 billion for law enforcement programs, $247.7 million for existing detention centers, and $1.2 billion for Tribal courts." At approximately $2.9 billion, this exceeds the entire current BIA budget. This underscores the chronic underinvestment in law enforcement and other public safety programs, and the need for this Committee to support full and mandatory funding for Tribal programs, including Public Safety & Justice line items.

Culturally Competent Treatment and Services

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 been successful 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 member Tribal Nations include:

- Extended, culturally-based recovery support in a sober living environment
- Trauma informed care training for health and behavioral health staff
- Establishment of innovative, culturally-appropriate Tribal restorative justice models, such as the Penobscot Nation's Healing to Wellness Court.

With additional funding and guidance, Tribal Nations could expand these best practices and incorporate additional practices such as rapid entry into acute care

facilities and additional prevention and control interventions. USET SPF encourages the Committee to explore how it might expand these models through legislative action and provide direct funding to support the best practices that have already been implemented.

Conclusion

USET SPF appreciates the Committee holding a hearing to hear specifically from Tribal Nations and leaders as the opioid crisis continues to disproportionately affect our communities. Opioid addiction is unquestionably causing devastating effects and suffering in Indian Country. As Congress considers legislative action on combatting the opioid crisis nationwide, as well as Fiscal Year 2024 federal funding, it must prioritize Tribal Nation access to all the resources necessary to address this crisis.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. BRYCE KIRK

Questions. Councilman Kirk, in your written testimony, you wrote about the lack of information sharing between the Drug Enforcement Agency (DEA) and Tribal law enforcement. I have heard similar concerns from Tribes in New Mexico, including the Navajo Nation. Can you expand on this? Have you broached this concern with the DEA? What has been the response?

Lack of prosecutions in the Missing and Murdered Indigenous Peoples space is an area where I've tried to hold DOJ accountable, and I'm frustrated that the same problem applies to drug dealers. Are you also having problems with DOJ and local law enforcement failing to prosecute non-Indian drug dealers on Tribal lands?

Senator Luján thank you for the question.

Answer. Our law enforcement officials have let the DEA and the ATF know our frustration that they were aware of a known drug dealer on our Reservation and that they failed to inform us or include our law enforcement in their investigation. The response from the federal agencies is that they were engaged in an investigation and that they cannot compromise their investigation by sharing information with the Tribes' law enforcement agencies. Our sense is that this is almost a turf war, where one agency wants the big bust and the credit for the bust, rather than focusing on what should be the objective, which is removing drug dealers from our communities and working with all involved law enforcement agencies to accomplish this goal.

We think this can be addressed by supporting multi-agency drug task forces, which include ATF, DEA, FBI, the Tribal and State law enforcement agencies. We should all know where the threats are and how we as cooperative law enforcement agencies are responding to these threats. Such a task force could report to the Attorney General's office directly and that way he could ensure that all the agencies within his purview are working cooperatively.

Regarding your question if we are having problems with DOJ and local law enforcement failing to prosecute non-Indian drug dealers on tribal lands, the answer is two-fold.

First our challenge with the Department of Justice is that they focus on the big drug dealers, transporting pounds of illegal drugs. However, a significant issue on the Fort Peck Reservation is that there are people who are dealing 50 pills or less, and the Department of Justice has no interest in prosecuting these people. As to working with local agencies, we have a cross-deputization agreement with Roosevelt County, the State Patrol, the City of Poplar and the City of Wolf Point where we work to ensure that criminals, including drug dealers, are properly prosecuted. However, we appreciate that the State of Montana respects our sovereignty and the proper role of the federal government to prosecute crimes by non-Indians against Indians. Again, the challenge for us is that the DOJ does not have the resources to arrest and prosecute the "smaller" drug dealers and thus they are left to continue to poison our community 20–30 pills at a time.

We would support the federal recognition of the inherent sovereignty of tribes to prosecute non-Indians engaged in drug dealing on the Reservation, akin to when Congress recognized the inherent authority of tribes to prosecute non-Indians who commit domestic violence crimes and crimes against children on our Reservation.

We look forward to working with you to address this crisis in our community.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO
HON. JAMIE S. AZURE

Question. The National High Intensity Drug Trafficking Area (HIDTA) Program under the Office of National Drug Control Policy partners with federal, state, local and tribal law enforcement to combat drug trafficking. Would expansion of the program to include Turtle Mountain help with your tribe's enforcement efforts?

Answer. Thank you, Chairman Schatz, for the question, the nearest HIDTA that we could participate is in Kansas City, Missouri for the Great Plains region. There is a North Dakota Interdiction Trask force that is headed by the DEA and the North Dakota State Police. Although we have good relations with the North Dakota State Police, this task force is primarily a DEA/State oriented task force. However, what's missing from HIDTA and the most recent 2021 DEA Drug Threat Assessments is the lack of information or intelligence regarding drugs in Indian Country. What would be useful would be a requirement that DEA conduct a separate drug threat assessment focusing on Indian Country especially where a Federally recognized tribes are within the HIDTA. This information would be critical for intelligence gathering and resource deployment.

Turtle Mountain Band (TMB) DDE (Division of Drug Enforcement) Drug Supervisor Brock Baker worked on several HIDTA task forces throughout North Dakota over the last 20 years, namely the Grand Forks Narcotics Task Force and Cass County Drug Task Force. Mr. Baker has a great working relationship with both task forces. However, many of the relationships have been formed through previous work relationships he had with them.

Mr. Baker estimates that 75 percent of their cases come from the Red River Valley area with the majority coming from Grand Forks and Fargo metro areas. Both locations have a huge urban Native population and many drug traffickers use our Native people for entrance or introduction to tribal members on the reservations.

Mr. Baker spoke with ND BCI Director Lonnie Grabowski, and he and his Task Force Coordinators in Grand Forks and Fargo, and all are supportive of placing a tribal officer on one of their task forces to create a "liaison" between the tribe and state HIDTA task forces. This officer would bridge a state task force and the tribal drug unit.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO
HON. JAMIE S. AZURE

Question. What has been your experience in working with the DEA? Are they good partners?

Answer. Thank you, Senator Lujan, for the question. DEA traditionally has been a good partner, but the partnership has been difficult recently due to the DEA being short-staffed and being detailed out to other areas of the country. One of the areas that the DEA lacks is a consistent presence in Indian Country to conduct drug operations and investigations.

Historically, the DEA is known to conduct larger-scale investigations, such as drug conspiracy cases involving large-scale dealers who may target Indian Reservations. Many of the cases involving tribal members mainly involve non-enrolled individuals who conspire with a tribal member to traffic drugs on or near tribal lands.

DEA did conduct a large arrest operation in the summer/fall of 2022. TMB DDE assisted in the arrest operation.

TMB DDE has attempted to conduct investigative operations with the DEA RO Fargo office; however, due to that office being short-staffed, they have had to push back operations several times in 2023 and canceled an operation set for September 2023.

Mr. Baker, who had previously been assigned to the DEA Task Force Fargo from 2010 to 2014, inquired about placing a tribal drug investigator with the DEA Task Force. The DEA Resident Agent in Charge was very interested, and several meetings were held between Mr. Baker and the DEA supervisor over the course of 2023 to discuss placing an officer with DEA Fargo RO.

Although being with the DEA Task Force would be beneficial, having an officer on a state-run HIDTA task force may provide the most benefit in connecting street-level drug crimes and larger-scale, multi-jurisdictional investigations on or near tribal lands.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. BEN RAY LUJÁN TO HON. TONY HILLAIRE

Question 1. The IHS Community Opioid Intervention Pilot Project awarded 35 grants in 2021 using a little over $16 million in funding appropriated by Congress, including one to the Albuquerque Area Indian Health Board in New Mexico and one to the Lummi Nation in Washington. Chairman Hillaire, what was the impact of these grant funds on the Lummi Nation?

Answer. We are pleased to report significant progress in our healthcare services, made possible through the Indian Health Service Community Opioid Pilot Project. The Lurnmi Nation received $300,000 in 2021. With this grant we have successfully reached and provided services to over 500 individuals. This milestone is a testament to the effectiveness of our outreach and support strategies, which have been crucial in engaging with individuals struggling with addiction and connecting them with necessary care.

Specifically, our efforts have focused on outreach to homeless camps, jails, and patients who have left medical facilities against medical advice. Our staff provided counseling to encourage those who have disengaged to re-enter treatment and offered guidance on harm reduction around drug use as well as providing access to overdose reversal kits, information on clinical care access for health-related concerns and wound care. By going directly to where the need is greatest, we have been able to make a tangible difference in the lives of those most affected by the opioid crisis. Additionally, some of the funding has been used towards transportation services for patients being admitted to supports such as clinical, outpatient and in-patient care. Transportation continues to play a crucial role in our strategy, ensuring that logistical and geographical challenges do not hinder individuals from accessing ccntinuous care. This support has been vital in maintaining treatment adherence and fostering overall health. healing, and recovery.

Question 1a. And, given that this pilot grant program is not permanently authorized, wty is it so important that Congress support the President's domestic supplemental request, including the 16 percent set-aside for IHS within the $1.55 billion he requested to combat the fentanyl crisis?

Answer. The President's domestic supplemental request, particularly the 16 percent set-aside for the Indian Health Service (IHS) within the $1.55 billion proposed to combat the fentanyl crisis, is of paramount importance. The Lumrni Nation, like many other Tribal nations, is facing an acute and escalating crisis due to fentanyl. The potency and prevalence of this drug have led to a drastic increase in overdoses and deaths and our Tribe is in urgent need of resources to combat this crisis effectively. Without adequate funding, the efforts to tackle this epidemic are significantly hampered.

Currently, our Tribe faces a heartbreaking situation where individuals seeking help for their addiction are often turned away due to the lack of resources and treatment capacity. This reality is devastating. When an individual courageously seeks assistance for addiction, facing rejection due to lack of available treatment options can be devastating and potentially fatal. Often, by the time a treatment bed becomes available, it may already be too late for those who were previously denied access. Many may have fallen deeper into their addiction or reached a point where they are unable or unwilling to seek further help. This creates a pattern of relapse and missed opportunities for meaningful intervention and recovery.

With sufficient funding, we can significantly expand our treatment facilities and services. This expansion means more beds for inpatient care, enhanced outpatient services, and the availability of medically assisted treatments. Additionally, increased funding can be allocated to prevention and education programs. By informing our community, especially the youth, about the dangers of fentanyl and other opioids, we can prevent addiction before it takes hold. Furthermore, recovery from addiction is a long-term process. Additional funding would allow us to provide essential support services, including counseling, job training, and aftercare programs, to help individuals reintegrate into the community after treatment.

Question 2. Chairman Hillaire, in your testimony you stated that due to a lack of prosecutions from the DOJ and local authorities, Tribal law enforcement is unable to hold accountable non-Indian drug dealers on Tribal lands. Lack of prosecutions in the Missing and Murdered Indigenous Peoples space is an area where I've tried to hold DOJ accountable, and I'm frustrated that the same problem applies to drug dealers. Can you tell me more about this problem?

Answer. One of the main challenges is the jurisdictional limitations imposed by federal law. Tribal authorities do not have the power to prosecute and punish non-Indians for drug trafficking offenses committed within our reservation. This situa-

tion creates a significant legal loophole that non-Indian drug traffickers exploit. They operate on tribal lands, knowing that the Tribal government lacks the authority to prosecute or incarcerate them. This has been a persistent issue, despite past legislative efforts to enhance tribal authority in criminal matters.

One of the critical challenges is the categorization of these drug-related offense, as non-violent crimes. As a result, when state authorities apprehend non-Indian drug dealers on our reservation, they are often immediately released due to the non-violent classification of their offenses. This practice has led to a "catch and release" pattern, where offenders are briefly detained but quickly return to their illicit activities, either on our lands or in the neighboring non-Indian communities.

Cross-deputization agreements, which allow for shared enforcement authority between tribal and non-tribal law enforcement agencies, have been seen as a potential solution. However, in practice, these agreements often have significant gaps. They may not comprehensively cover all aspects of law enforcement needs or may not be adequately supported by the necessary resources. In the context of drugrelated crimes, these gaps become particularly pronounced.

Over the years, Congress has passed laws to strengthen tribal authority in certain areas, like the Tribal Law and Order Act of 2010 and the Violence Against Women Act Reauthorization Act of 2022. However, these measures have not effectively addressed the issue of drug trafficking by non-Indians on tribal lands.

The lack of effective jurisdictional authority not only allows drug trafficking to flourish but also contributes to other related crises, such as the Missing and Murdered Indigenous Peoples issue. Drug trafficking and its associated violence and exploitation are often intertwined with these broader social challenges.

A proposed solution is to amend the Indian Civil Rights Act to explicitly recogrjze the authority of tribal governments to prosecute non-Indian drug traffickers. This amendment would be a significant step forward, providing Tribes with the legal framework necessary to address this critical issue. It could include provisions for incarcerating convicted offenders in federal prison, thereby offering a more robust deterrent against drug trafficking in Indian Country.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TINA SMITH TO HON. TONY HILLAIRE

Question. Given the high overdose data in urban and rural Native communities alike, how can Congress support Tribal members living off-reservation and in urban communities in our response to rising levels of fentanyl use?

Answer. We are in an opioid crisis of critical proportions, the likes of which we have never before seen. Drug harms are ravaging for Native Americans and Alaska Natives (AI/AN) no matter where they reside across the United States, and across the age spectrum from infants to Elders [1, 2]. Even with all the services we need in place right away, it will take a generation to address even the basic harms of the opioid crisis. This is a complex and multi-faceted challenging situation and we must be prepared to mitigate these harms over the short and long-term utilizing all the resources and flexibilities of policies and legislation possible to the fullest extent of laws and be prepared to modify these where necessary. Right now, we urgently need improvements in law enforcement, health services, prevention, education and access to culturally attuned, based care. The right approach to treatment and full access to services is vital. There is a grave lack of resources provided for infrastructural support for Indian health care substance use treatment which undermines the availability oflife saving detox stabilization and withdrawal services. This is one of the acute needs. This gap represents a barrier to recovery and perpetuates long standing health disparities especially for those who experience the disease of addiction in this time of the fentanyl crisis.

Indian Health Service's (IHS) has no sufficient funds allocated for the construction of detox facilities despite the fact Tribes have sounded the alarm and provided data over multiple years which shows all across the Nation, Tribes are being hit hard by deadly and deadlier drugs. Despite all the evidence that has been provided to date, which shows we experience higher levels ofloss and demonstrated an acute and urgent need; we still have not been able to secure all the funds needed to build

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[1] Indian Health Service *IHS Supports Tribal Communities in Addressing the Fentanyl Crisis May 2023 Blogs* [Accessed 3/7/2024)

[2] Centers for Disease Control and Prevention *Drug Overdose In Tribal Communities Drug Overdose Prevention in Tribal Communities Drug Overdose CDC Injury Center* [Accessed 3/7/2024)

a facility.[3],[4] The Lummi Nation has put in requests for funding assistance through demonstration funds as well as for help from the Health and Human Services (HHS) Non-Recurring Expense Funds (NEF), to no avail. On multiple occasions we have met with federal representatives and leaders to ask for assistance. To date, as far as funding goes, only the Department of Commerce and Legislators of the State of Washington have authorized some financial support towards constructing a detox facility. The facility would be designed to serve both urban and rural based Tribal members, as well as any others who are eligible. The need is great, and the facility is supported by the 29 Tribes in our state as well as the Portland IHS Area regional Tribes. This lack of funding support from our federal trustees for what is one of the crucial pillars to begin recovery is unfathomable given the acuity of the situation.

One other area of support we seek is to ask that you review the funding allocated for Indian health care programs especially for alcohol and substance use services and Public Health. Lummi Nation receives limited funds for these programs, which does little to provide the level of services and support staff we actually need given we are in an emergency. Secretary from HHS, on multiple occasions, has renewed the opioid public health emergency pursuant to the authorities vested in his office under section 319 of the Public Health Service Act, 42 U.S.C § 247d,[5] originally determined by Secretary Eric Hargan from HHS in October 26th 2017 under the Trump Administration. This ongoing acknowledgment by the Secretary that a public health opioid crisis exists, flies in the face of reason when funding and resources are not forthcoming from one of the federal trustee administrations and whose actions do not match the scale of the problem we are facing.

Fentanyl as well as new types of synthetic opioids cut with deadly additives such as TRANQ and Carfentanil are now so widely available, we are seeing a dramatic increase in opioid related health conditions as well as deaths country wide. We consider what is occurring as a genocidal and existential threat to our very survival. This crisis is impacting Tribal members equally in both urban and rural locations, whole generations and future lineages have been lost.

We have repeatedly requested support from the President to declare a national emergency. In effect, this would create greater flexibility for federal resources and assistance to supplement existing state, tribal and local efforts, and capabilities to save lives, protect property, as well as bolster public health and safety. In addition, these measures would contribute significantly to help address gaps and barriers in addressing treatment, recovery, traditional healing, housing and rehabilitation, supply and demand and prevention. With all of these considerations the availability of resources and increased flexibility will help lessen the catastrophic threat facing tribal communities, urban and rural and others within the United States. The opioid crisis is a major national disaster affecting us all and causing untold damage, loss, hardship, and suffering.

In closing, we want to thank you for this opportunity to provide testimony and for your ongoing support to help bring this devastating situation to an end. If you have any further questions regarding this additional testimony, please contact us.

RESPONSE TO WRITTEN QUESTIONS SUBMITTED BY HON. TINA SMITH TO CLARADINA SOTO, PH.D.

Question. Given the high overdose data in urban and rural Native communities alike, how can Congress support Tribal members living off-reservation and in urban communities in our response to rising levels of fentanyl use?

Answer. While it is true that fentanyl abuse is a problem for Native communities who live on designated tribal areas, the profound disparities faced by American Indian and Alaska Native (AIAN) communities in off-reservation urban and rural areas regarding the opioid epidemic is equally urgent. Recent data highlights an alarming trend where, in both 2020 and 2021, AIANs experienced the highest death rates from drug overdoses compared to all other racial and ethnic groups, even as rates surged across the board in 2021. Presently, approximately 87 percent of the AIAN population resides in urban areas, constituting a diverse and inter-tribal community, with a significant concentration in California cities.

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[3] Drug Overdose Deaths in the United States, 2001–2021 *NCHS Data Brief. Number 457. December 2022 (cdc.gov)* [Accessed 3/7/2024)

[4] Opioid Deaths Risen 5–FoldAmong Indigenous Americans *Opioid overdose deaths risen 5-fold among Indigenous Americans BMJ* (3/7/2024]

[5] ASPR Administration for Strategic Preparedness and Response *Renewal of Determination that a Public Health Emergency Exists as a Result of the Continued Consequences of the Opioid Crisis Affecting our Nation (hhs.gov)* [Accessed 3/7/2024]

Despite the theoretical advantages of urban living, Urban Indians, constituting 1 in 7 American Indians nationwide and 1 in 9 in California cities, face substantial barriers to accessing essential healthcare and tribal services. This reality is exacerbated by disparaging health statistics, with Urban Indians experiencing higher rates of diabetes, liver disease, cirrhosis, and alcohol-related deaths compared to the general population. Congress must take swift and comprehensive action to address these disparities, ensuring equitable access to healthcare and addressing the root causes of the opioid crisis in offreservation AIAN communities.

While opioid treatment services are available to tribal members through IHS and Tribal Health Programs, rural and urban Indian health programs serve disproportionally larger AIAN populations with a fraction of the funding and resources needed to address the crises. Furthermore, tribal members utilize services such as residential SUD treatment located off-reservation and rely on these services when their tribe may not offer them. These recovery services however lack components that would fill those gaps for a more complete continuum of care including culturally responsive detox centers, residential treatment that can accommodate families with children, sober living facilities both on and off tribal lands, and comprehensive reentry programs to assist tribal members with reintegration back into their home communities that sustain their sobriety and foster healthy and positive contributions to their communities.

Below are 7 steps recommended for Congress to act in addressing the fentanyl abuse and opioid epidemic for off-reservation, urban, and rural AIAN communities.

1. Funding for Prevention and Treatment Programs: Congress can increase allocations of funding specifically earmarked for urban AIAN and rural off-reservation AIAN communities to develop and implement prevention and treatment programs targeting fentanyl and other substance use disorders. This funding can support culturally appropriate interventions, outreach efforts, and access to mental health services.

2. Enhanced Law Enforcement Resources: Congress can provide additional resources to law enforcement agencies to combat fentanyl trafficking and distribution in off-reservation and urban areas. This may include funding for specialized training, equipment, and task forces dedicated to addressing the opioid crisis in partnership with Urban Indian Health Programs and AIAN serving agencies.

3. Expansion of Healthcare Services: Congress can support the expansion of healthcare services in urban AIAN and off-reservation communities, including access to medication-assisted treatment (MAT) programs, mental health counseling, and substance abuse rehabilitation services. This may involve increasing funding for Indian Health Service (IHS) facilities and expanding IHS treatment and detox facilities nationally, in addition to expanding Medicaid coverage for Tribally enrolled and state recognized Tribal members.

4. Culturally Centered Education and Outreach: Congress can support initiatives aimed at increasing awareness of the dangers of fentanyl use within urban AIAN and off-reservation communities through culturally competent education and outreach campaigns. This may involve partnering with AIAN leaders, elders, youth, and community organizations to develop messaging and materials that resonate with AIAN community members.

5. Data Collection and Research: Congress can allocate funding for research and data collection efforts to better understand the scope of fentanyl use among Tribal members living off-reservation and in urban areas. This data can inform policy decisions and resource allocation strategies to effectively address the issue and strengthen University partnerships with urban AIAN and off-reservation communities.

6. Support for Housing and Economic Development: Congress can provide support for urban AIAN and off-reservation housing programs and economic development initiatives to address underlying social determinants of health that contribute to substance abuse, including poverty, unemployment, and lack of stable housing. Primarily, the expansion of sober living and transitional housing for urban AIAN and offreservation individuals is a critical need.

7. Collaboration and Coordination: Congress can encourage collaboration and coordination among urban Indian Health Programs, federal agencies, state and local governments, and community organizations to develop comprehensive strategies for addressing fentanyl use and its associated harms in Tribal communities.

By taking these steps, Congress can play a critical role in supporting Tribal members living off-reservation and in urban communities in their response to rising levels of fentanyl use, ultimately helping to prevent overdose deaths and improve the health and well-being of Tribal communities.

Responses to the following questions were not available at the time this hearing went to print

WRITTEN QUESTIONS SUBMITTED BY HON. BRIAN SCHATZ TO
A. AUKAHI AUSTIN SEABURY, PH.D.

Question. How is I Ola Lāhui using American Rescue Plan funds to meet the behavioral health needs of rural Native Hawaiian communities?

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