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OVERSIGHT HEARING
Fentanyl in Native Communities: Native Perspectives on Addressing the
Growing Crisis
United States Senate Committee on Indian Affairs
Wednesday, November 8, 2023

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 state-only-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

¹ National Conference of State Legislatures: <https://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes#State>

² National Archives: <https://www.archives.gov/research/native-americans/treaties>

³ Stacy Bohlen, CEO of the National Indian Health Board

⁴ Department of the Interior, Indian Affairs: <https://www.bia.gov/faqs/what-federal-indian-trust-responsibility>

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% 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 Indian Health Service is significantly and disproportionately 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

⁵ National Indian Health Board, Working with Tribal Nations training:

https://www.nihb.org/public_health/wtt/story.html

⁶ US General Services Administration, Relevant Federal Laws, Regulations, Executive Orders:

<https://www.gsa.gov/real-estate/historic-preservation/historic-preservation-policy-tools/legislation-policy-and-reports/section-106-of-the-national-historic-preservation-act/native-american-tribal-consultations/relevant-federal-laws-regulations-executive-orders>

⁷ Warne, D., & Frizzell, L. B. (2014). American Indian Health Policy: Historical trends and contemporary issues. In *American Journal of Public Health* (Vol. 104, Issue SUPPL. 3, pp. S263–S267). American Public Health Association Inc. <https://doi.org/10.2105/AJPH.2013.301682>

⁸ California Rural Indian Health Board: <https://crihb.org/about/history/>

⁹ <https://www.kcet.org/shows/tending-the-wild/untold-history-the-survival-of-californiasindians>

¹⁰ <https://oig.hhs.gov/oei/reports/oai-09-87-00027.pdf>

¹¹ Indian Health Service California office: Fiscal Year 2015 Annual Report.

<https://www.ihs.gov/california/tasks/sites/default/assets/assets/File/FY2015IHSCAOAnnualReport.pdf>

¹² Indian Health Service: <https://www.ihs.gov/forpatients/faq/>

¹³ US Commission on Civil Rights, Broken Promises Report: <https://www.usccr.gov/files/pubs/2018/12-20-Broken-Promises.pdf>

The Opioid and Fentanyl Crisis

National data

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.

Figure 1

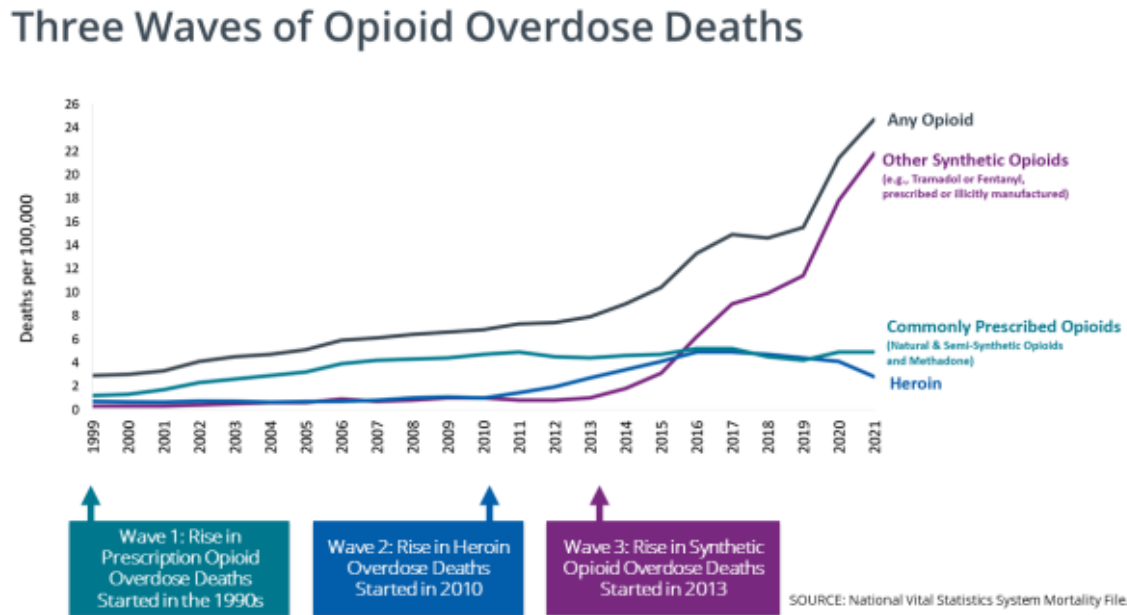


Table 1 below shows a selection of overdose deaths by type within the same time period.¹⁶ Note that fentanyl falls into the category of “synthetic opioid analgesics.” Deaths related to synthetic opioids not including methadone and primarily including fentanyl continue rising, increasing almost 7.5 times between 2015 and 2021 and resulting in a total of 70,601 overdoses in 2021.¹⁷

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

¹⁵ Centers for Disease Control and Prevention (CDC): <https://www.cdc.gov/opioids/data/analysis-resources.html>

¹⁶ CDC: <https://www.cdc.gov/drugoverdose/data/OD-death-data.html>

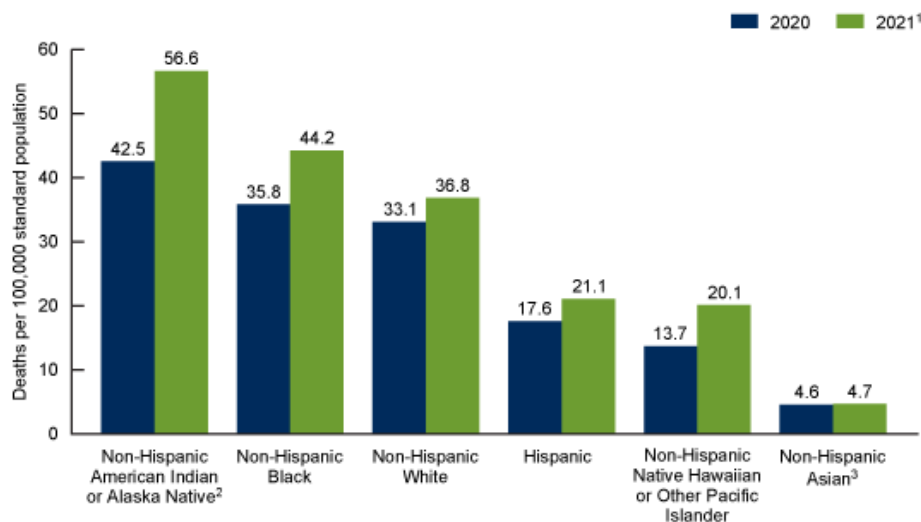
¹⁷ National Institutes of Health (NIH): <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>

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% of benzodiazepine-related deaths included fentanyl in 2015, increasing to 70% 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% 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 Origin, US, 2020 and 2021



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

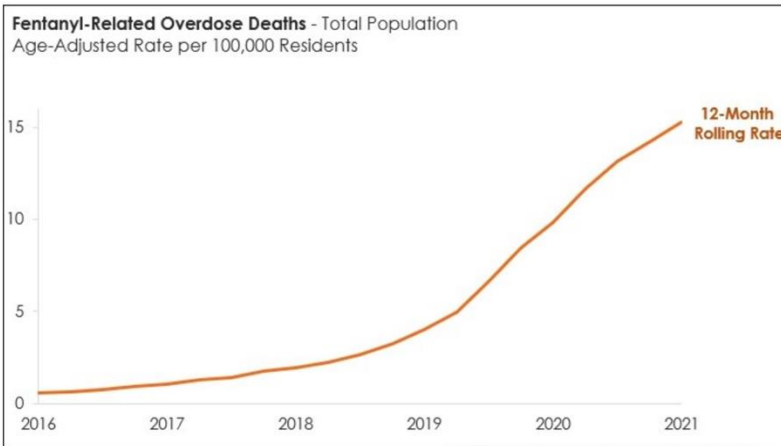
¹⁸ CDC: <https://www.cdc.gov/stopoverdose/fentanyl/index.html>

¹⁹ NIH: <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>

²⁰ NIH: <https://injuryfacts.nsc.org/home-and-community/safety-topics/drugoverdoses/data-details/>

²¹ CDC: https://www.cdc.gov/nchs/products/databriefs/db457.htm#Key_finding

²² California Department of Public Health: <https://www.cdph.ca.gov/Programs/CCDPPP/sapb/Pages/Fentanyl.aspx>



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

²³ California Overdose Surveillance Dashboard: <https://skylab.cdph.ca.gov/ODdash/?tab=Home>

²⁴ <https://health.ucdavis.edu/blog/cultivating-health/fentanyl-overdose-facts-signs-and-how-you-can-help-save-a-life/2023/01>

²⁵ CAL MATTERS: <https://calmatters.org/explainers/california-opioid-crisis>

²⁶ Indian Health Service: <https://www.ihs.gov/newsroom/factsheets/disparities/>

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% 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% higher rates of diabetes, 126% higher rates of liver disease and cirrhosis, and 178% higher rates of alcohol-related deaths compared to general population.³⁰ Some small studies have reported up to 30% 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% compared to 4.9% of non-Hispanic whites in urban areas.³² Some cities have reported poverty rates among Urban Indians of 30% to 50%.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

²⁷ Office of Minority Health: <https://minorityhealth.hhs.gov/american-indianalaska-native-health>

²⁸ California Consortium for Urban Indian Health: <https://ccuih.org/about/about-urban-indians/>

²⁹ Office of Minority Health: <https://minorityhealth.hhs.gov/american-indianalaska-native-health>

³⁰ National Urban Indian Family Coalition: <https://assets.aecf.org/m/resourcedoc/AECF-UrbanIndianAmerica-2008-Full.pdf>

³¹ Urban Indian Health Commission: <https://www2.census.gov/cac/nac/meetings/2015-10-13/invisible-tribes.pdf>

³² The National Council on Aging. <https://www.ncoa.org/article/american-indians-and-alaska-natives-key-demographics-and-characteristics>

³³ New York Times. <https://www.nytimes.com/2013/04/14/us/as-american-indians-move-to-cities-old-and-new-challenges-follow.html>

³⁴ <https://nativephilanthropy.candid.org/events/alcohol-as-tool-of-genocide/>

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% of the total California population).⁴¹ There are 109 federally recognized Tribes in

³⁵ https://pphs.usc.edu/wp-content/uploads/2023/04/NAH-Report_-_Tribal-MAT.pdf

³⁶ Scholl, L., Seth, P., Kariisa, M., Wilson, N., & Baldwin, G. (2018). Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. *MMWR. Morbidity and Mortality Weekly Report*, 67(5152), 2013–2017. <https://doi.org/10.15585/mmwr.mm675152e1>

³⁷ Wilson, N., Kariisa, M., Seth, P., Smith, H., & Davis, N. L. (2020). Drug and Opioid-Involved Overdose Deaths — United States, 2017–2018. *MMWR. Morbidity and Mortality Weekly Report*, 69(11), 290–297. <https://doi.org/10.15585/mmwr.mm6911a4>

³⁸ Kaiser Family Foundation: <https://www.kff.org/coronavirus-covid-19/press-release/drug-overdose-deaths-rose-during-the-covid-19-pandemic-particularly-among-black-and-american-indian-alaska-native-people/>

³⁹ The Hill: <https://thehill.com/changing-america/well-being/prevention-cures/3476061-indigenous-americans-see-five-fold-increase-in-fatal-opioid-overdoses-over-two-decades-study-says/>

⁴⁰ IHS: <https://www.ihs.gov/opioids/covid19/>

⁴¹ US Census Bureau: <https://data.census.gov/cedsci/table?q=S0201&t=009 - American Indian and Alaska Native alone or in combination with one or more other races&g=0400000US06&tid=ACSSPP1Y2019.S0201>

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% 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.

⁴² Bureau of Indian Affairs: <https://www.federalregister.gov/documents/2014/01/29/2014-01683/indian-entities-recognized-and-eligible-to-receive-services-from-the-united-states-bureau-of-indian>

⁴³ <http://2010.census.gov/news>

⁴⁴ Judicial Council of California: <https://www.courts.ca.gov/3066.htm>

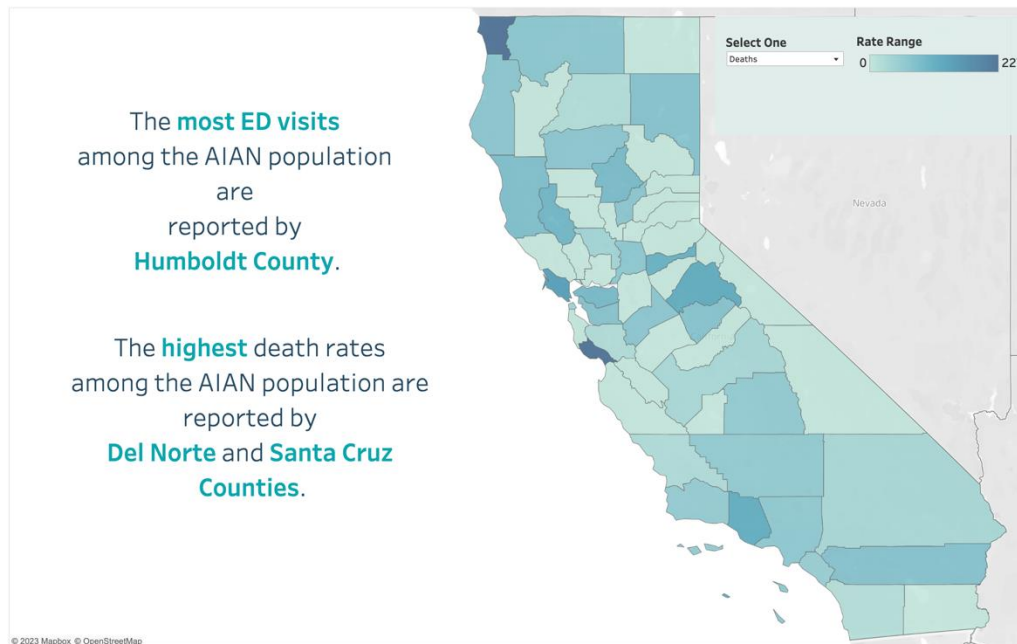
⁴⁵ Intertribal Friendship House. (2002). *Urban Voices: The Bay Area American Indian Community* (S. Lobo (ed.); 1st ed.). University of Arizona Press.

⁴⁶ California Rural Indian Health Board:
<https://public.tableau.com/app/profile/krista7713/viz/HealthEquityDashboardOpioids/OpioidsFinal>

⁴⁷ California Overdose Surveillance Dashboard: <https://skylab.cdph.ca.gov/ODdash/?tab=CA>

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

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% 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% of California. Another consideration is that a full 61% of AIAN individuals reported identifying with multiple racial groups on the 2020 census, the highest rate of any other group, compared to only 13% of White, 12% of Black, and 17% 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

⁴⁸ California Consortium on Urban Indian Health: https://ccuih.org/wp-content/uploads/2021/03/AIANDC_Report_Draft_3_23_Edited.pdf

⁴⁹ Brookings: <https://www.brookings.edu/articles/why-the-federal-government-needs-to-change-how-it-collects-data-on-native-americans/>

⁵⁰ National Library of Medicine: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5967841/>

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. state-recognized 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 NIH 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

⁵¹ CCUIH: https://ccuih.org/wp-content/uploads/2021/03/AIANDC_Report_Draft_3_23_Edited.pdf

⁵² <https://tribalepicenters.org/>

⁵³ <https://www.nihb.org/resources/2023DataSymposium/MondayAfternoonPresentations.pdf>

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/i-caihre/> 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

⁵⁴ https://pphs.usc.edu/wp-content/uploads/2022/11/USC_AI_Report.pdf

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/ODU issues related to homelessness. Nineteen AIAN adults who were experiencing homelessness and impacted by SUD/ODU 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% 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 larger 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

⁵⁵ https://pphs.usc.edu/wp-content/uploads/2023/04/NAH-Report_-_Tribal-MAT.pdf

⁵⁶ Ramos GG, West AE, Begay C, Telles VM, D'Isabella J, Antony V, Soto C. Substance use disorder and homelessness among American Indians and Alaska Natives in California. *J Ethn Subst Abuse*. 2023 Apr-Jun;22(2):350-371. doi: 10.1080/15332640.2021.1952125. Epub 2021 Aug 2. PMID: 34339341

⁵⁷ https://pphs.usc.edu/wp-content/uploads/2023/04/NAH-Report_-_Tribal-MAT.pdf

⁵⁸ <https://pphs.usc.edu/wp-content/uploads/2023/04/Residential-Tx-Project-Report-for-Community.pdf>

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 waived 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:

- 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

*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.

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

⁵⁹ Soto C, Miller K, Moerner L, Nguyen V, Ramos GG. Implementation of medication for opioid use disorder treatment in Indian health clinics in California: A qualitative evaluation. *Journal of Substance Use and Addiction Treatment*. 2023 Jul 1:209115

⁶⁰ <https://pphs.usc.edu/research/data-collection-and-analysis-technical-assistance-for-tribal-mat-grantees/>

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/ODU, 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/ODU 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 IHS-eligible 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

⁶¹ <https://pphs.usc.edu/research/collaboration-improvement-project/>

⁶² <https://pphs.usc.edu/research/substance-use-disorder-policy-advocacy-training-program/>

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 decision making 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 parts 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.