

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**STATEMENT**

**OF**

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OFFICE OF THE DIRECTOR  
INDIAN HEALTH SERVICE**

**BEFORE THE**

**SENATE COMMITTEE ON INDIAN AFFAIRS**

**OCTOBER 13, 1999**

**STATEMENT OF THE INDIAN HEALTH SERVICE**  
**HEARING ON S.1507, Native American Alcohol and Substance Abuse Program**  
**Consolidation Act**

October 13, 1999

Good morning Mr. Chairman, I am the Deputy Director of the Indian Health Service (IHS). Accompanying me today is Dr. Craig Vanderwagen, Director of the Division of Clinical and Preventive Services, Office of Public Health in IHS. I am here today to present the views of the Department of Health and Human Services (DHHS) on S.1507, a bill to authorize the integration and consolidation of alcohol and substance programs and services provided by Indian Tribal governments, and for other purposes. The Department strongly supports the goals and intent of the legislation and would like to take this opportunity to provide a few constructive comments on the proposal. The Administration is committed to preparing a report addressing the most effective and efficient means to implement the concept outlined by S. 1507 early in the next session of Congress. The report will be prepared in consultation with Tribal governments, affected Federal agencies and other interested parties. Further, the Administration believes that the bill should be amended to specify the DHHS as the lead agency responsible for implementation of the bill's provisions. I will discuss the rationale for this recommendation in my statement.

The issue of alcohol and other substance abuse is significant to American Indian/Alaska Native (AI/AN) communities. The death rates associated with alcoholic cirrhosis and other direct alcohol diseases for AI/AN are well above general U.S. population. In addition, injuries are the leading cause of death for AI/AN's between the ages of 15 and 44 years. The majority of these deaths, whether intentional (such as suicide and homicide) or unintentional (such as motor vehicle crashes) are associated with alcohol and other chemical abuse.

The IHS and Tribes have initiated a significant program of injury prevention and in fact the deaths related to injuries has declined. These programs have generally aimed at making the environment safer through targeted intervention such as seatbelt use and roadside safety enhancements. Notwithstanding, deaths due to injuries are still 2-3 times more likely in the AI/AN population. Suicide deaths in our service population are 1.5 times more frequent than in the general U.S. population and certain age groups in some communities may be 3 times more likely to die in this manner. Domestic violence associated with chemical abuse is especially lethal for AI/AN women. A recent University of New Mexico study revealed that American Indian women are the population most likely to die as the result of domestic violence when compared to other ethnic populations. This is a social and clinical issue of significant proportion.

The first official authorization for the IHS and Indian Tribes to provide alcoholism treatment services was established in 1976 within the Indian Health Care Improvement Act, Public Law (PL) 94-437. The Anti-Drug Abuse Act of 1986, PL 99-570, and the Omnibus Drug Bill Amendments, PL 100-690, expanded this authority to include alcoholism and other substance abuse treatment and prevention services for AI/AN youth, women, children, dual diagnosed youth and family members. All of these authorities were later combined under Title VII of the Indian

Health Care Improvement Act Amendments of 1992, which is the existing authority for the IHS/Tribal/Urban (I/T/U) programs.

The IHS receives close to \$100 million in appropriations for its alcohol activities. Greater than 90% of these funds are provided directly to the Tribes under Indian Self-Determination agreements for programs which they design and implement. The Tribes and IHS have addressed this problem persistently and have some demonstrated success. The IHS has had significant and successful experience in developing and executing partnerships with tribal governments. In the last 5 years Self-Governance agreements in IHS has expanded from 14 tribes to well over 40% of the tribes we serve. This process of transferring the Federal functions related to health programs has taught both Tribes and the IHS many lessons in planning and implementing comprehensive health and social programs. Indeed, the evidence suggests that tribes can address these issues in ways that the Federal partners cannot.

The IHS and tribes have established outcome measures through the Government Performance Results Act (GPRA) to evaluate the success of their health programs and have been lauded for the appropriateness of the indicators associated with the anticipated outcomes. The death rate due to alcoholism has in fact generally declined over the last 20 years. Alcohol related illnesses that have been targeted (such as FAS and FAE in some high risk communities) have been reduced. Inhalant abuse also appears to be on the decline. The youth regional treatment activities are demonstrating clear success in treatment.

While the death rate due to alcoholism has declined 17% since 1980, current data shows that this downward trend has stopped. Since 1990, the rate has been rising and is now 7 times greater than the U.S. All Races rate. These deaths are preventable, but only through a comprehensive program of medical, behavioral, and preventive services. In fact, the evidence suggests that comprehensive community wide efforts (including medical treatment programs) are the most appropriate approach to prevention. This has been demonstrated in a variety of IHS and DHHS funded programs to prevent alcohol and chemical abuse related illness. The K'e project in Navajo is only the most recent example of success. This effort, funded by SAMHSA, operated by the Navajo Tribe, and in collaboration with IHS, utilized traditional tribal culture, more standard alcohol prevention efforts, and clinical care activities to demonstrate a reduction in chemical abuse among young people. The Tribes and the Federal agencies are seeking ways to work collaboratively to develop the comprehensive and coherent programs to achieve the dramatic changes in the health behaviors and social structures needed to redress these challenges.

Within DHHS there is a significant partnership among the agencies with health and social programs targeting chemical abuse built around the highest quality professional approaches to treatment and prevention. The IHS has working relations with the Substance Abuse and Mental Health Services Administration (SAMHSA) for Mental Health Services (CMHS), Substance Abuse Treatment (CSAT), and Substance Abuse Prevention (CSAP). These programs provide will over \$15 million in funding through the competitive grant processes for service to AI/AN communities in a coordinated effort with IHS.

The Centers for Disease Control (CDC) also provides funding for prevention services in

partnership with IHS in the area of tobacco use. The CDC has also provided support to a partnership between IHS and the Bureau of Indian Affairs to develop and disseminate an HIV comprehensive prevention for school aged children and adolescents. The National Institute for Alcoholism and Alcohol Abuse has provided support to research efforts examining the characteristics of chemical abuse in AI/AN populations. Lastly, the IHS partnership with the Headstart program has provided support and technical assistance to Indian Headstart prevention program efforts.

There have also been significant efforts among the Department of Justice (DOJ), the Department of Health and Human Services (DHHS), and the Department of the Interior (DOI), and other Federal departments to plan and implement coherent programs of prevention and treatment. A major vehicle for this effort has been the Domestic Policy Council Working Group on Native Americans chaired by Secretary Babbitt. This forum has developed innovative approaches to streamlining tribal access to government-wide programs through inter-agency efforts and methods. The concept of integrated service access has been a theme and focus for this group. Specific partnerships between DOJ, DOI, DHHS, and the tribes are now being implemented to address chemical abuse and other behavioral problem among Indian youth in detention. These principles should be formalized and validated more effectively in the Federal relations with Tribes.

Accordingly, the IHS believes that the principles addressed by this bill reflect an appropriate public health and intra- and inter- government approach to the issue. We are concerned about how the distribution of funds authorized and appropriated under existing competitive or formula grant authority will be affected. For example, SAMHSA is concerned that given the broad scope of the bill, it might be construed (a) to make tribes eligible for funding under a program for whose funding they are not currently eligible, or (b) to guarantee tribes a share of funding from a discretionary grant program or other similar program under which they are eligible for funding but have to compete for funding. There are concerns that the technical assistance and other “in-kind” services and relationships between Tribes and Federal agencies will decline significantly under this approach. The partnerships that are functioning could be lost. There are also concerns that the funding levels keep pace with identified need and that resource flexibility which works to the advantage of tribes not be lost.

Because of these and other potentially complex issues involved in applying the P.L. 102-477 model of program consolidation to Federally funded alcohol and substance abuse programs serving the AI/AN population, we would recommend that a careful and comprehensive report be prepared to ascertain the implications of applying this model to existing programs. We need to ensure that the critical contributions of the multiple Federal, Tribal and other health, social and community service agencies along with judicial and law enforcement agencies are not compromised. A report to outline the issues at hand and recommendations to address those issues prior to implementation would be sound investment of time and resources. As I stated earlier in the testimony, the Administration will be consulting with the appropriate Tribal governments in the preparation of this report.

The Administration believes that the DHHS, with its demonstrated record of health improvements in public health, is a more logical choice to ensure that improved social and health status changes

are the outcomes. Based on these considerations, the Administration recommends that DHHS be given the lead responsibility for the implementation of the provisions of this proposed bill. The DHHS would work closely with the Department of the Interior, other Federal agencies and Tribal governments to achieve the bill's objectives.

Thank you for this opportunity to provide testimony on S. 1507. I will address any questions you may have at this time.