THE OPIOID CRISIS IN TRIBAL COMMUNITIES

OVERSIGHT HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON NATURAL RESOURCES
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

Tuesday, April 5, 2022

Serial No. 117–16

Printed for the use of the Committee on Natural Resources

Available via the World Wide Web: http://www.govinfo.gov
or
Committee address: http://naturalresources.house.gov

U.S. GOVERNMENT PUBLISHING OFFICE
47–278 PDF WASHINGTON : 2022

COMMITTEE ON NATURAL RESOURCES

RAÚL M. GRIJALVA, AZ, *Chair*
JESÚS G. "CHUY" GARCÍA, IL, *Vice Chair*
GREGORIO KILILI CAMACHO SABLAN, CNMI, *Vice Chair, Insular Affairs*
BRUCE WESTERMAN, AR, *Ranking Member*

Grace F. Napolitano, CA
Jim Costa, CA
Gregorio Kilili Camacho Sablan, CNMI
Jared Huffman, CA
Alan S. Lowenthal, CA
Ruben Gallego, AZ
Joe Neguse, CO
Mike Levin, CA
Katie Porter, CA
Teresa Leger Fernández, NM
Melanie A. Stansbury, NM
Nydia M. Velázquez, NY
Diana DeGette, CO
Julia Brownley, CA
Debbie Dingell, MI
A. Donald McEachin, VA
Darren Soto, FL
Michael F. Q. San Nicolas, GU
Jesús G. "Chuy" García, IL
Ed Case, HI
Betty McCollum, MN
Steve Cohen, TN
Paul Tonko, NY
Rashida Tlaib, MI
Lori Trahan, MA

Louie Gohmert, TX
Doug Lamborn, CO
Robert J. Wittman, VA
Tom McClintock, CA
Garret Graves, LA
Jody B. Hice, GA
Aumua Amata Coleman Radewagen, AS
Daniel Webster, FL
Jenniffer González-Colón, PR
Russ Fulcher, ID
Pete Stauber, MN
Thomas P. Tiffany, WI
Jerry L. Carl, AL
Matthew M. Rosendale, Sr., MT
Blake D. Moore, UT
Yvette Herrell, NM
Lauren Boebert, CO
Jay Obernolte, CA
Cliff Bentz, OR
Vacancy
Vacancy

David Watkins, *Staff Director*
Luis Urbina, *Chief Counsel*
Vivian Moeglein, *Republican Staff Director*
http://naturalresources.house.gov

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

KATIE PORTER, CA, *Chair*
BLAKE D. MOORE, UT, *Ranking Member*

Nydia M. Velázquez, NY
Jesús G. "Chuy" García, IL
Steve Cohen, TN
Jared Huffman, CA
Raúl M. Grijalva, AZ, *ex officio*

Louie Gohmert, TX
Jody B. Hice, GA
Vacancy
Bruce Westerman, AR, *ex officio*

CONTENTS

OVERSIGHT HEARING ON "THE OPIOID CRISIS IN TRIBAL COMMUNITIES"

Tuesday, April 5, 2022

U.S. House of Representatives

Subcommittee on Oversight and Investigations

Committee on Natural Resources

Washington, DC

The Subcommittee met, pursuant to notice, at 10 a.m., via WebEx, Hon. Katie Porter [Chairwoman of the Subcommittee] presiding.

Present: Representatives Porter, García; Moore, Gohmert, and Westerman (ex officio).

Also present: Representatives Stansbury, Rosendale, and Gonzales.

Ms. PORTER. The Subcommittee on Oversight and Investigations will come to order. The Subcommittee is meeting today to hear testimony on opioids in tribal communities. Under Committee Rule 4(f), any oral opening statements at hearings are limited to the Chair and the Ranking Minority Member or their designees. This will allow us to hear from our witnesses sooner and help keep Members to their schedules.

Therefore, I ask unanimous consent that all other Members' opening statements be made part of the hearing record if they are submitted to the Clerk by 5 p.m. today or the close of the hearing, whichever comes first. Hearing no objection, so ordered. Without objection, the Chair may also declare a recess subject to the call of the Chair.

As described in the notice, statements, documents, or motions must be submitted to the electronic repository at HNRCDocs@mail.house.gov. Additionally, please note that as with in-person hearings, Members are responsible for their own microphones. As with our in-person meetings, Members can be muted by staff only to avoid inadvertent background noise. Finally, Members or witnesses experiencing technical problems should inform Committee staff immediately.

I want to start this hearing by congratulating my colleague, Blake Moore, on becoming the new Ranking Member of this Subcommittee. We have been able to find common ground with the previous Ranking Member, and I'm optimistic that we can continue that good working relationship as we make the return to hybrid hearings.

I would also like to take a moment to pay tribute to former Natural Resources Chair Don Young. Representative Young was a longtime champion on tribal issues, and his hard work advocating for Alaskan Natives will not be forgotten.

STATEMENT OF THE HON. KATIE PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. PORTER. Today, we will hear from tribal leaders about the opioid crisis in their communities. Opioids are harming tribal communities more than any other group in our nation. Before COVID-19, Native Americans were almost 50 percent more likely to die of an opioid overdose than members of any other demographic group.

During the pandemic, while American Indian and Alaskan Natives were getting sick and dying at some of the highest rates in our country, opioids claimed even more lives. Opioid overdose deaths during the pandemic increased more in Native American communities than in communities for any other racial or ethnic group.

American Indians and Alaskan Natives have kept their cultures and governments alive through centuries of colonial violence, dispossession, and forced assimilation. Today, opioids are another assault on tribal cultures, separating families, claiming lives, and disrupting ways of life. Tribal public services are stretched to the breaking point dealing with the consequences of opioid addiction. First responders are overwhelmed with drug-related calls, entire families are made homeless by drug-related evictions, and scarce healthcare resources are being diverted into opioid treatment and response.

The Federal Government is legally required to deliver health care to all tribal people. This fiduciary trust obligation is a promise, a promise that the United States made in hundreds of treaties with Tribal Nations in return for land and peace. It has been codified into law, and it has been upheld by the courts. But the U.S. Government has never delivered on this promise.

Due to decades of underfunding, the Indian Health Service, IHS, can spend only $3,779 per patient. This compares to the national average of $9,409 per person. The Indian Health Service is so underfunded, compared to other Federal healthcare programs, that the U.S. Civil Rights Commission called it either "intentional discrimination or gross negligence."

Delayed or denied health care results in American Indians and Alaskan Natives living sicker and dying younger than other Americans. Only one in eight American Indians who need substance abuse treatment get it. Our failure to deliver on our nation's promise costs lives. It costs marriages, it orphans children, it robs communities of elders and the wisdom they hold, and it drives families into poverty.

To address this crisis, we need to provide more resources for tribal governments and urban Indian health organizations to treat the opioid epidemic. The treatment and prevention programs run by tribes are effective and cost efficient, and they center the local needs and cultures of the tribal citizens they serve.

Unfortunately, Federal funding for tribal health care has been woefully insufficient. Base funding for tribal health systems through IHS is far too restrictive. It can take years and an Act of Congress to take simple steps such as remodeling a facility. Grants have not been much better. Competitive grants needlessly pit tribal governments against other tribal governments, and the administra-

tive costs of running grant programs divert funds from patient care.

Congress needs to provide long-term, sustainable funding for tribal-run treatment and prevention programs if we want to truly combat the scourge of opioids in Native American communities.

I am pleased that we have Mr. Wayne Cortez as a witness testifying today. Mr. Cortez is a Peer Support Specialist at Riverside-San Bernardino County Indian Health, and he has seen firsthand the need for more resources to address this epidemic. I commend his work in Southern California, and I am grateful for his bravery in sharing his story today.

Tribal citizens across the United States are working to heal their communities on their own terms. It is time that Congress supported them.

[The prepared statement of Ms. Porter follows:]

PREPARED STATEMENT OF THE HON. KATIE PORTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

I would like to start by congratulating my colleague, Blake Moore, on becoming the new Ranking Member of this Subcommittee. We have been able to find common ground with the previous Ranking Member and I'm optimistic we can continue that good working relationship as we make the return to hybrid hearings.

I would also like to take a second to pay tribute to former Natural Resources Chairman, Don Young. Representative Young was a long-time champion of tribal issues, and his hard work advocating for Alaska Natives will not be forgotten.

Today we will hear from tribal leaders about the opioid crisis in their communities.

Opioids are harming tribal communities more than any other group in our nation. Before Covid-19, Native Americans were almost 50 percent more likely to die of an opioid overdose than members of any other demographic group. During the pandemic, while American Indian and Alaska Natives were getting sick and dying at some of the highest rates in our country, opioids claimed even more lives. Opioid overdose deaths during the pandemic increased more in Native American communities than in communities for any other racial or ethnic group.

American Indians and Alaska Natives have kept their cultures and governments alive through centuries of colonial violence, dispossession, and forced assimilation. Today, opioids are another assault on tribal cultures: separating families, claiming lives, and disrupting ways of life. Tribal public services are stretched to the breaking point dealing with the consequences of opioid addiction. First responders are overwhelmed with drug-related calls, entire families are made homeless by drug-related evictions, and scarce healthcare resources are being diverted into opioid treatment and response.

The Federal Government is legally required to deliver healthcare to all tribal people. This fiduciary trust obligation is a promise the United States made in hundreds of treaties with tribal nations in return for land and peace. It has been codified in law and upheld by courts.

But the U.S. Government has never delivered on this promise. Due to decades of underfunding, the Indian Health Service, IHS, can spend only $3,779 per patient, compared to the national average of $9,409 per person. The IHS is so underfunded compared to other Federal healthcare programs that the U.S. Civil Rights Commission called it either "intentional discrimination or gross negligence."

Delayed or denied healthcare results in American Indians and Alaska Natives "living sicker and dying younger" than other Americans. Only one in eight American Indians who need substance abuse treatment get it. Our failure to deliver on our nation's promise costs lives. It costs marriages, orphans children, robs communities of elders and the wisdom they hold. It drives families into poverty.

To address this crisis, we need to provide more resources for tribal governments and urban Indian health organizations to treat the opioid epidemic. The treatment and prevention programs run by tribes are effective and cost-efficient, and they center the local needs and cultures of the tribal citizens they serve.

Unfortunately, Federal funding for tribal healthcare has been woefully insufficient. Base funding for tribal healthcare systems through IHS is far too restrictive—it can take years and an Act of Congress to take simple steps such as remodeling

a facility. Grants have not been much better. Competitive grants needlessly pit tribal governments against other tribal governments, and the administrative costs of running grant programs divert funds from patient care. Congress needs to provide long-term, sustainable funding for tribal-run treatment and prevention programs if we want to truly combat the scourge of opioids in Native American communities.

I am pleased that we have Mr. Wayne Cortez as a witness testifying today. Mr. Cortez is a Peer Support Specialist at Riverside-San Bernardino County Indian Health. He has seen firsthand the need for more resources to address this epidemic. I commend his work in Southern California and I am grateful for his bravery in sharing his story today.

Tribal citizens across the United States are working to heal their communities on their own terms. It is time that Congress supported them.

Before I yield to the Ranking Member, I want to apologize that I will not be able to attend the rest of this hearing. I thank Representative García for serving as Chair in my absence.

Ms. PORTER. Before I yield to the Ranking Member, I want to apologize that I am not going to be able to attend the rest of this hearing. I want to thank Representative García, a champion for just and healthy communities in every part of this country, for serving as the Chair in my absence.

I am now prepared to yield to Ranking Member Moore for his opening statement.

STATEMENT OF THE HON. BLAKE D. MOORE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Mr. MOORE. Thank you, Chair Porter. Thanks for the note of congratulations as well, and more importantly, your comments about the late Representative Don Young. Don Young was an individual that cared deeply about this institution. My first conversations with him reflected his desire for good working order and for us to be able to find ways to solve some of America's biggest problems. So, thank you for that note.

First, before I give my remarks, I ask unanimous consent that Mr. Rosendale of Montana and Mr. Gonzales of Texas be allowed to participate in today's hearing.

Ms. PORTER. So ordered.

Mr. MOORE. Thank you. Today's hearing on the opioid crisis draws attention to a somber milestone for our nation. Tragically, a record-breaking number of more than 100,000 people in the United States died of a drug overdose between April 2020 and April 2021, in one calendar year. In other words, approximately 274 Americans died each day from drugs during the last 12 months.

This crisis is impacting communities across the United States. In 2014, my home state of Utah was hit particularly hard by the opioid pandemic. We had the fourth highest number of overdose deaths in the nation. My state then dedicated resources to combat the epidemic and significantly decreased overdose deaths. I think we all can agree that treatment options and education are important aspects of addressing the opioid epidemic. But these steps alone are not enough.

To effectively combat this opioid crisis, we must disrupt the supply of drugs flowing into our communities and address the clear threats cartels pose to our neighborhoods and tribal communities.

The American Medical Association identified three drugs—fentanyl, methamphetamine, and cocaine—as the drugs driving the overdose epidemic. These are the very same drugs that agents are seizing at our southern border.

In this fiscal year alone, U.S. Customs and Border Protection reports confiscating more than 4,200 pounds of fentanyl, more the 77,000 pounds of methamphetamine, and more than 23,000 pounds of cocaine. These outrageous numbers should alarm anyone who cares about this crisis.

Cartels are responsible for bringing these drugs into our communities. The Drug Enforcement Agency's 2020 National Drug Threat Assessment identified Mexican transnational criminal organizations as "the greatest drug trafficking threat to the United States."

Additionally, the DEA identified Mexican criminal organizations as the primary source of illicit substance on Indian reservations. Not only do the cartels make drugs available on reservations, but they also exploit tribal lands in their trafficking efforts. For example, the Tohono O'odham Reservation, colloquially also referred to as TO Reservation, covers about 4 percent of the southwest border. Mexican cartels utilize the remoteness of the highways on this reservation to traffic drugs across the border.

To combat the cartels' operations and protect American families, we must ensure our law enforcement officers have the support they need. In addition to the work of Border Patrol agents, we have seen the effectiveness of targeted policing efforts.

For example, in 2018, the Interior Department created the Joint Opioid Task Force to address the threat opioids pose to tribal communities. The following year, the Task Force reported seizing more than 2,000 pounds of illegal narcotics. During one operation, the Task Force disrupted a Mexican cartel's smuggling efforts with the TO Nation and confiscated 30,000 fentanyl pills. Law enforcement operations for drug interdiction, however, also necessitates increased border security.

Mr. Art Del Cueto joins us today. He's a 19-year veteran Border Patrol agent. From his experience patrolling the TO Reservation, Mr. Cueto will provide the Committee with a firsthand account of the crisis at the southern border and associated cartel activity.

As the Department of Homeland Security prepares for yet another surge of people attempting to cross the border, we must call attention to all the consequences of President Biden's decisions. One of those consequences is diverting Border Patrol agents from their post to assist with processing of illegal immigrants. As a result, cartels are given a prime opportunity to evade detection and traffic illicit drugs across the border. After exploiting our nation's open border, cartels will funnel deadly drugs into the nation.

Until our southern border is secured and cartel activity is curtailed, the opioid crisis will rage on. If we want to end the crisis, we must get the people the help they need to recover, but that is only part of it. We need to secure the border, prevent drug smuggling, and cut off the supply killing American communities. And with that, I yield back.

Mr. GARCÍA [presiding]. Thank you, Mr. Ranking Member. And now I would like to turn to our witness panel. Before introducing the witnesses, I will remind them that they are encouraged to

participate in the Witness Diversity Survey created by the Congressional Office of Diversity and Inclusion. Witnesses may refer to their hearing invitation materials for further information.

Let me remind the witnesses that under our Committee Rules, they must limit their oral statements to 5 minutes, but that their entire statement will appear in the hearing record. When you begin, the timer will start. It will turn orange when you have 1 minute remaining and red when your time has expired.

I recommend that Members and witnesses joining remotely pin their timer so that it remains visible. After your testimony is complete, please remember to mute yourself to avoid any inadvertent background noise. I will also allow the entire panel to testify before questioning witnesses. The Chair now recognizes the Honorable Chuck Hoskin, Jr., Principal Chief of the Cherokee Nation.

STATEMENT OF THE HONORABLE CHUCK HOSKIN, JR., PRINCIPAL CHIEF, CHEROKEE NATION, TAHLEQUAH, OKLAHOMA

Mr. HOSKIN. Wado. Chair Porter, I know she couldn't stay, but I appreciate her introduction. Ranking Member Moore, Chairman Grijalva, Ranking Member Westerman, Acting Chair García, and distinguished members of this Subcommittee, we appreciate you holding this important hearing. It is my honor to speak with you today on behalf of the 410,000 citizens of the great Cherokee Nation.

For two decades, the opioid epidemic has affected every facet of our society, from our economy, to our health system, to schools, to our families. The pharmaceutical industry flooded the communities within our reservation with hundreds of millions of pills. Hundreds of Cherokee citizens have died from overdoses as a consequence. Tens of thousands more have suffered.

In 1 year, approximately 184 million opioid pills were distributed within the Cherokee Nation Reservation. This is enough to supply every person living in our reservation with 153 pills each in 1 year. Cherokee Nation is less than 6 percent of Oklahoma's population, yet nearly a third of the opioids that were distributed in the state went into our communities, and this was no accident.

The multi-generational trauma that still lingers within our communities made Cherokee Nation and the Cherokee people a prime target. The pharmaceutical industry knew our history, and it exploited it for profit. The number of opioid pills shipped into our communities far exceeded the national average. It was eclipsed only by the amount that was shipped into Appalachia.

Today, a Cherokee adult is more likely to die of an overdose than to die in a car accident. Across Indian Country, the number of overdose deaths increased by 500 percent between 1999 and 2015. Five years ago, we sued the country's largest distributors and pharmacies for their role in targeting Cherokee Nation and flooding our communities with prescription opioids.

This landmark case was the first brought by a Native American tribe. We wanted this case not only to bring justice to our tribe, but to be a precedent for other Tribal Nations fighting the opioid epidemic. Last year, we settled with the main distributors—McKesson, AmerisourceBergen, and Cardinal Health—for $75 million, to be paid over 6½ years.

Earlier this year, we settled with Johnson & Johnson for $18 million over 2 years. Our claims against Walmart, Walgreens, and CVS remain pending. We believe these pharmacy chains also greatly contributed to the crisis. With these settlements, we will increase our investments in substance use disorder, mental health treatment, and other programs to help our people recover.

This work is needed now more than ever as increased isolation, health fears, and economic insecurities, brought about by the COVID-19 pandemic, have heightened anxiety among our people and increased the rates of self-medication.

And my administration plans to put $15 million of our settlement dollars toward the construction of drug treatment facilities over the next 3 years, a minimum of $15 million. These treatment centers will help bring about transformational change and provide some measure of justice by bringing healing to our people, using funds from the very industry that injured us.

But the settlement funds alone will not be enough to end the opioid crisis. We need the Federal Government to fulfill its trust obligation to tribes and fully fund these vital programs to help our tribal citizens recover from addiction and access behavioral health services.

One of the most significant gaps that we have had to face is prevention in the workforce. Without a significant investment in building a highly trained prevention workforce, we will continue to just plug holes in the dam rather than repair the issues causing the leaks. We need tribal workforce development programs. We need non-competitive funding for community-based prevention efforts. We need to return to our traditional communal values so that we can address the effects of addiction for the next generation.

We need supportive services. We need the Government of the United States to meet its obligation. Frankly, we need the United States to follow the lead of the Cherokee Nation as we lead in efforts to heal our people and address this epidemic. Wado.

[The prepared statement of Mr. Hoskin follows:]

PREPARED STATEMENT OF CHUCK HOSKIN, JR., CHEROKEE NATION PRINCIPAL CHIEF

Chair Porter, Ranking Member Moore, Chairman Grijalva, Ranking Member Westerman, and distinguished members of the Subcommittee on Oversight and Investigations:

Osiyo, and thank you for holding this important hearing. It is my honor to speak with you today on behalf of the 410,000 citizens of Cherokee Nation.

My predecessor, Principal Chief Bill John Baker, said in 2017, "Tribal nations have survived disease, removal from our homelands, termination, and other adversities, and still we prospered.

"However, I fear the opioid epidemic is emerging as the next great challenge of our modern era."

Chief Baker was correct. There is an epidemic of opioid abuse sweeping through Indian Country and across the Cherokee Nation, leaving in its wake addiction, disability, and death.

For two decades, the opioid epidemic has plagued Cherokee Nation. It has affected every facet of our society—our economy, our health system, our schools, and tragically, our families. Hundreds of Cherokee Nation citizens have died from overdoses. Tens of thousands more have suffered.

It has caused generational health issues and vast trauma. It has put the future of our nation at risk.

The pharmaceutical industry knowingly and purposely flooded the communities within our 7,000 square-mile reservation in northeast Oklahoma with hundreds of millions of pills.

In one year, an estimated 845 million milligrams of opioids—between 360–720 pills for every prescription opioid user—were distributed within our reservation. From 2015–2016 alone, about 184 million pills were distributed—enough to supply every man, woman, and child living on our land with 153 pills each.

Cherokee Nation makes up less than 6 percent of Oklahoma's population, yet nearly a third of the opioids distributed in the state went into our communities.

This was no accident. The complex, multi-generational trauma that still lingers within our communities made Cherokee Nation, and more broadly, Indian Country, a target for exploitation and saturation.

Traditionally, Native people have a communal sense of self. This means decisions are made with family and community input. Through the detrimental effects of cultural assimilation, forced removals, and boarding schools, Native people have been stripped away from their traditional practices. Experiencing repeated loss and trauma without a sense of self or opportunity to grieve has left our Native people to turn to negative ways of coping. These coping skills exist in the form of turning to substances to help cope with feeling of depression, anxiety, and tremendous loss.

The pharmaceutical industry knew our history, and exploited it for profit.

The number of opioid pills shipped into communities in Oklahoma far exceeded the national average and was eclipsed only by the amount that was shipped into Appalachia. In 2012, the per-capita rate of prescriptions for the nation was 81.3 prescriptions, while the per-capita rate in Oklahoma was 127.4, and in the 14 counties of the Cherokee Nation Reservation it was 108.78 prescriptions per capita.

The opioid oversupply has led to significant economic and social harms to the health, safety, and welfare of the Cherokee Nation. Today, a Cherokee Nation adult is more likely to die of an overdose than die in a car accident. Across Indian Country the number of overdose deaths increased by 500 percent between 1999 and 2015. According to the CDC, Native Americans are far more likely to use—and die from—opioids than other groups.

In 2014 we began to see the full impact of the opioid crisis. That year we observed a spike in the number of children taken into Tribal custody because of parental addiction. Since that time more than 1,700 Cherokee children have gone into state or Tribal custody—at least 40 percent of those cases are due to opioid use. Additionally, there has been a staggering increase in the number of Cherokee babies born addicted to opioids. These infants are placed in our foster system, tearing a family apart before it even has a chance to be whole.

Five years ago, we sued the country's largest distributors and pharmacies for their role in targeting Cherokee Nation and flooding our communities with prescription opioids. It was a pioneering case—one of the first opioid-related lawsuits in the United States. It was the first case brought by a Native American tribe.

We filed our lawsuit to hold distributors and corporate pharmacies accountable for their negligence and greed. We wanted this case to bring justice to our tribe and to be a precedent for other communities fighting the opioid epidemic—particularly, the hundreds of other Native American nations that sued the opioid industry in our wake.

In 2021 we settled with McKesson, AmerisourceBergen, and Cardinal Health for $75 million, to be paid over 6½ years. Earlier this year we settled with Johnson & Johnson for $18 million over two years. Our claims against Walmart, Walgreens, and CVS, however, remain pending, and we intend to vigorously pursue those claims at trial. We believe these pharmacy chains greatly contributed to the crisis.

With the case against the distributors resolved, we can begin the healing process for our tribe and our citizens. With these settlements, we will increase our investments in substance use disorder, mental health treatment, and other programs to help our people recover. That work is needed more than ever, as the increased isolation, health fears, and economic insecurities brought on by the COVID-19 pandemic have led to heightened anxiety and higher rates of self-medicating.

These funds will support our efforts to rescue Cherokees from addiction. Deputy Chief Bryan Warner and I propose a commitment of $15 million from that settlement over the next three years to help construct drug treatment facilities. These settlement dollars, while important to our future, fall short of what it will take to build the kind of comprehensive mental health and drug treatment center the Cherokee people deserve, although it provides a solid start. It is also a measure of justice by bringing healing to our people using funds from the very industry that injured us. It will help bring about something transformational—knocking down the barriers between mental health and physical health.

But these funds alone will not nearly be enough to end the opioid crisis.

We know how to prevent substance abuse, delinquency, teen pregnancy, and suicide. We know what strategies need to be deployed and we know how to use data to prioritize locations and people and we know how to use data to measure our effec-

tiveness both short and long term. The bad news is that these problems are complex, multi-faceted, and take a long time to address.

One of most significant gaps in capacity is that we do not have the prevention workforce to address the problems facing Cherokee Nation. Without a significant investment in building a highly trained prevention workforce that will become embedded into our community fabric, we will continue to plug holes in the dam rather than repair the issues causing the leaks.

One solution would be to increase access for tribal workforce development programs within our own tribal communities. Human capital is our greatest asset. Building pipelines to universities to help our own tribal citizens to become a part of the workforce will be key to defeating the opioid and drug epidemics.

We also need our federal partners to fulfill its trust obligation to Indian Country and fully fund programs that will allow us to guarantee our tribal citizens access to addiction and behavioral health services. These programs are a vital component of our efforts to heal from this crisis, and we call on Congress to provide more in these areas.

We need direct, non-competitive funding for community-based prevention efforts, as this will allow us to build a community-based prevention system that is ground in Cherokee culture. This system would build upon the local and historical culture to identify risk factors that contribute to substance abuse and mental health issues, while at the same time serve as an appropriate cultural intervention that protects and educates our youth.

Additionally, there are barriers that prevent this funding from being as effective as it could be.

- Federal funding restricts the use of grant funding for items that would significantly improve our ability to serve the target audiences for our programs. For example, celebrating culture through food is a key component of engaging youth and families. The food purchase restriction is limiting for programs and seems almost punitive to communities as a response for some bad actors in the past. Restricting the ability to provide food when serving marginalized communities who deal with trauma, poverty, and food insecurity is counter to the values of our culture.
- Program requirements often ask a tribal community to conform to structures and systems that do not exist in their community.
- Funding periods are often too short to provide meaningful assistance. The Tribal Opioid Response grant is large in scope and funding amount, but the funding period is only two years. A minimum of 5-year funding cycles would give tribes the ability to build strong foundations for sustainability.
- Reporting requirements are complicated, frequent, and can be duplicative. Although we understand the need for reporting and accountability, the administrative burden placed on grant personnel for reporting can be significant. The reporting burden is constantly pulling the program staff away from service delivery in order to meet all the quarterly, biannual, and annual deadlines. Approvals for formally submitted changes take months for approvals. A budget revision or carryover request can take anywhere between three and nine months to be approved, and if there are additional questions, that cycle starts over.

Finally, expanding traditional reimbursement mechanisms to include nontraditional services is essential to the overall success of treatment programs. The current limited reimbursement mechanisms for treatment of substance use disorder do not make these programs sustainable for tribal communities. Mental illness and substance use disorder are not short-term problems. We need long-term solutions and financial sustainability is essential to address these problems for the future of our people.

While more federal resources are needed, we will not wait around for the federal government to address this crisis. Last year, we passed legislation that will improve access our substance abuse treatment and wellness centers. We will earmark 7 percent of the unrestricted revenue generated by Cherokee Nation Health Services, including health insurance claims or billings to health insurance carriers and providers, for public health programs. This will provide an additional $12 million in annual funding for improved access to wellness centers and substance abuse treatment.

Our Behavioral Heath staff are already providing many free resources for drug diversion, overdose prevention, and addiction treatment, and are working at an exhaustive pace to serve the mental health and addiction related needs of our people.

Our team is taking an integrated approach to address opioid use disorder, offering both Medication Assisted Treatment and behavioral healthcare. Additionally, our Cherokee Marshals are trained to carry and use Narcan, a medication used to treat opioid overdose.

Native people are known for their ability to adapt and persevere in the face of adversity. We can address challenges by enhancing and creating services within our communities' specific to our Tribal population. Our communities may present our people with challenges, but they also present us with amazing strengths to build on. Having services that are supportive and providing a healing path for those lost in their addiction can greatly improve the lives of those suffering and their families. We can begin our journey on the road to recovery through introducing programs addressing trauma and recovery through cultural enriched interventions. Returning to our traditional way of communal values is the key to changing the effects of addiction for our next generation of Native people.

I am very thankful that through the efforts of our Office of the Attorney General and our Behavioral Health Department, we are not only bringing justice for our tribe, but beginning to repair the long-term damage caused by the flood of opioids into our communities.

Thank you for this opportunity to testify on this important topic. Wado.

QUESTIONS SUBMITTED FOR THE RECORD TO THE HONORABLE CHUCK HOSKIN JR., PRINCIPAL CHIEF, CHEROKEE NATION

Questions Submitted by Representative Cohen

Question 1. What has been the rationale, if any, for the historically low level of funding for the Indian Health Service?

Answer. Indian Health Service spending is classified as discretionary spending, which makes it subject to the annual appropriations process. IHS falls under the Interior appropriations measure, and Interior, with a FY 2022 allocation of $38 billion, is one of the smaller annual appropriations bills. Such a meager allocation makes it difficult to achieve substantial funding increases. Moving IHS to the mandatory side of the ledger—as the President's FY 2023 budget request calls for—would allow for significant funding increases that could not be achieved under the current restraints.

Question 2. Do you have a sufficient number of residential treatment programs available for individuals who want to detox off opioids completely, including relapse prevention medication and culturally responsive counseling?

Answer. Cherokee Nation does not currently have a sufficient number of residential treatment programs available. That is why we are looking to build our own residential treatment facility that will also include outpatient supports in the communities.

Question 3. Can you discuss how your treatment and wellness centers have helped the community?

Answer. We are in the process of constructing these facilities. In the meantime, we are providing other tiers of treatment for those who are dealing with addiction, such as transitional living centers.

When completed, we expect our facilities to turn the tide by generating hope and giving our citizens a welcome space here at home to focus on healing. We are developing long-term plans for a comprehensive behavioral health system that features in-patient and out-patient services, and plan to the best facilities that can be built for Cherokee citizens.

Question 4. How significant of an impact do you anticipate the 7 percent earmark for public health program to be? How much more of an investment is this in public health programs than currently exists?

Answer. Last month I signed legislation to expand our existing Public Health and Wellness Fund Act. Through this legislation we are broadening the type of third-party revenue Cherokee Nation Health Services sets aside for drug treatment purposes, which will increase our investment to $15 million over the next three years. This amount, combined with our initial opioid settlement money, will go toward drug treatment facilities and other opioid remediation, prevention, treatment, and harm reduction programs.

Questions Submitted by Representative Huffman

Question 1. What specific actions is the Bureau of Indian Affairs taking to stem the flow of illicit opioids—especially fentanyl—to tribal lands and people?

Answer. I would refer this question to BIA.

Question 2. What further actions would you like to see from the Bureau of Indian Affairs on this matter, if any?

Answer. BIA and congressional appropriators must look to remove some of the barriers that prevent prevention and treatment funding from being as effective as it could be. These barriers include the following:

- Federal funding restricts the use of grant funding for items that would significantly improve our ability to serve the target audiences for our programs. For example, celebrating culture through food is a key component of engaging youth and families. The food purchase restriction is limiting for programs and seems almost punitive to communities as a response for some bad actors in the past. Restricting the ability to provide food when serving marginalized communities who deal with trauma, poverty, and food insecurity is counter to the values of our culture.
- Program requirements often ask a tribal community to conform to structures and systems that do not exist in their community.
- Funding periods are often too short to provide meaningful assistance. The Tribal Opioid Response grant is large in scope and funding amount, but the funding period is only two years. A minimum of 5-year funding cycles would give tribes the ability to build strong foundations for sustainability.
- Reporting requirements are complicated, frequent, and can be duplicative. Although we understand the need for reporting and accountability, the administrative burden placed on grant personnel for reporting can be significant. The reporting burden is constantly pulling the program staff away from service delivery in order to meet all the quarterly, biannual, and annual deadlines. Approvals for formally submitted changes take months for approvals. A budget revision or carryover request can take anywhere between three and nine months to be approved, and if there are additional questions, that cycle starts over.

Mr. GARCÍA. Thank you, Chair Hoskin, for that testimony.

The Chair now recognizes Mr. Art Del Cueto, Vice President of the Western Region of the National Border Patrol Council.

Mr. Del Cueto, you are on.

STATEMENT OF ART DEL CUETO, VICE PRESIDENT, WESTERN REGION, NATIONAL BORDER PATROL COUNCIL, TUCSON, ARIZONA

Mr. DEL CUETO. Chair Porter, Acting Chair García, Ranking Member Moore, and distinguished members of the Subcommittee, I would like to thank you for inviting me to testify before you today. I hope that my testimony will assist the Subcommittee in better understanding how the executive actions taken by President Biden and his administration have directly resulted in an increase in illicit fentanyl coming across our southern border with Mexico and into our communities, including vulnerable tribal communities.

My name is Art Del Cueto. I currently serve as Vice President of the Western Region of the National Border Patrol Council, where I represent Border Patrol field agents and support staff. I was born on the border, I grew up on the border, and I have more than 18 years of experience as a Border Patrol agent, as well as a thorough understanding of the policies affecting border security and illicit narcotics trafficking.

Throughout my career in Border Patrol, I have served in the Tucson Sector and have personally engaged in narcotic enforcement activities in and around tribal communities in Southern Arizona. Since he took office in January of last year, the policies enacted by President Biden and his Department of Homeland Security have directly resulted in the least secure border that I have observed in my 18-year career.

Due to the Biden administration's border and immigration policies, we have seen historically high numbers of individuals, families, and children illegally crossing the border over the past year, which has forced the Border Patrol to dedicate more than 50 percent of its resources to activities other than patrolling the border, creating gaps on our border.

Criminal cartels have consistently exploited these gaps over the past year and have been able to easily cross high-value products, such as illegal aliens from special interest countries, weapons, and narcotics in massive quantities. The amount of illicit fentanyl, a synthetic opioid pouring into our country across our southern border, is staggering and, frankly, terrifying knowing that just 2 milligrams is considered a lethal dose.

According to publicly available data from Customs and Border Protection, the Border Patrol seized over 1,000 pounds of fentanyl nationwide from February 2021, the first full month of President Biden's Open Border policies, to February 2022. The Tucson Sector accounted for over 40 percent of that figure, which amounted to 427 pounds of fentanyl seized by Tucson agents. To give some perspective to that figure, 427 pounds of fentanyl converts to over 193 million milligrams, enough to potentially kill over 96 million people.

With agents forced to process huge numbers of traffic, and unable to patrol the border, and criminal cartels consistently exploiting the situation, these circumstances have led to a huge increase in the flow of hard narcotics making their way into the United States and wreaking havoc on communities as drug overdoses soar to over 100,000 annually.

In September of last year, 8 months after President Biden's open borders policies went into effect, the DEA issued a public safety alert warning of the sharp increase in fake prescription pills containing fentanyl and methamphetamines.

The DEA Administrator, Anne Milgram, stated in the alert that the United States is facing an unprecedented crisis of overdose deaths fueled by illegally manufactured fentanyl. The alert goes on to allude the fact that fentanyl is illegally being trafficked across our southern border with Mexico. They say the vast majority of counterfeit pills brought into the United States are produced in Mexico, and China is supplying chemicals for the manufacturing of fentanyl into Mexico.

While the alert only implies that lethal doses of fentanyl are being illegally smuggled into the United States across the southern border with Mexico, and uses the word brought, the DEA's own "Facts about Fentanyl" web page makes the situation very clear.

As illicit fentanyl streams into the country at a horrifying rate, sadly, tribal communities are not immune. Where I work in the Tucson Sector, there is a long history of illicit narcotics trafficking

on the Tohono O'odham Nation, the land that shares the border with Mexico.

According to information shared publicly by the Tohono O'odham Department of Public Safety in 2017, from 2002 to 2016, the Tohono O'odham Police Department and Border Patrol worked to seize over 313,000 pounds of drugs.

In 2019, ABC News made a public year-long investigation of smuggling activities on the nation and called the tribal land one of the busiest corridors in North America. Tribal leader David Garcia is quoted on a report saying, "We are killing our own people. We have to do something. And if we don't do anything, we are just as bad within the problem."

Garcia stated that a lot of the tribal members are involved in drug smuggling of migrants and drugs. I have worked in and around this area. Mr. Garcia is absolutely correct, especially on illicit narcotics like fentanyl that are constantly coming through the Tohono O'odham Nation.

And just like communities all over the country, when narcotics come in, the outcomes are devastating for tribal members. As one example of fentanyl being seized by the nation, in 2019, the Bureau of Land Affairs seized 30,000 fentanyl pills as part of an investigation.

The Subcommittee and Congress do not need to enact new legislation or appropriate money to address this issue. Thankfully, we have laws on the books that we need to stop destroying public health humanitarian and national security crisis. And we have more than enough funding appropriate to DEA each year to do so. We simply need a change in policy. It starts with policy and President Biden's policies have made our borders the least secure in our nation.

I want to thank the Subcommittee for your time through answering any questions you may have.

[The prepared statement of Mr. Del Cueto follows:]

PREPARED STATEMENT OF ART DEL CUETO, ON BEHALF OF THE NATIONAL BORDER PATROL COUNCIL

Chair Porter, Ranking Member Moore, and distinguished Members of the Subcommittee, I would like to thank you for inviting me to testify before you today. I hope that my testimony will assist the Subcommittee in better understanding how the executive actions taken by President Biden and his Administration have directly resulted in an increase in illicit fentanyl coming across our Southern border with Mexico and into our communities, including vulnerable tribal communities.

My name is Art Del Cueto and I currently serve as Vice President, Western Region, of the National Border Patrol Council (NBPC), where I represent Border Patrol field agents and support staff. I was born on the border, grew up on the border and have more than 18 years of experience as a Border Patrol Agent, as well as a thorough understanding of the policies affecting border security and illegal narcotics trafficking. Throughout my career in the Border Patrol, I have served in the Tucson, Arizona Sector and have personally engaged in narcotics enforcement activities in and around tribal communities in Southern Arizona.

Since he took office in January of last year, the policies enacted by President Biden and his Department of Homeland Security (DHS) have directly resulted in the least secure border I've ever observed in my 18-year career. Due to the Biden Administration's border and immigration policies, we have seen historically high numbers of individuals, families and children illegally crossing the border over the past year, which has forced the Border Patrol to dedicate more than 50% of its resources to activities other than patrolling the border, creating gaps along our border.

Criminal cartels have consistently exploited these gaps over the past year and have been able to easily cross their high-value products such as illegal aliens from special interest countries, weapons and narcotics in massive quantities. The amount of illicit fentanyl, a synthetic opioid, pouring into our country across our Southern border is staggering and frankly terrifying knowing that just two milligrams is considered a lethal dose.

According to publicly available data from Customs and Border Protection (CBP), the Border Patrol seized 1,045 pounds of fentanyl nationwide from February 2021—the first full month of President Biden's open border policies—to February 2022.[1] The Tucson Sector accounted for 40.86% of that figure which amounted to 427 pounds of fentanyl seized by Tucson Agents during that same time period.[2] To give some perspective to that figure, 427 pounds of fentanyl converts to over 193 million milligrams, enough to potentially kill over 96 million people.

With our Agents forced to process huge numbers of illegal aliens and unable to patrol the border, and criminal cartels consistently exploiting the situation, these circumstances have led to a huge increase in the flow of hard narcotics making their way into the U.S. and wreaked havoc on communities as drug overdose deaths soar to over 100,000 annually.[3]

In September of last year, eight months after President Biden's open borders policies went into effect, the Drug Enforcement Administration (DEA) issued a Public Safety Alert warning of the "Sharp Increase in Fake Prescription Pills Containing Fentanyl and Meth."[4] President Biden's DEA Administrator appointee, Anne Milgram, stated in the Alert that, "*The United States is facing an unprecedented crisis of overdose deaths fueled by illegally manufactured fentanyl . . . DEA is focusing resources on taking down the violent drug traffickers causing the greatest harm . . .*"[5] The Alert goes on to allude to the fact that fentanyl is being illegally trafficked across our Southern border with Mexico, stating, "*The vast majority of counterfeit pills brought into the United States are produced in Mexico, and China is supplying chemicals for the manufacturing of fentanyl in Mexico.*"[6]

While the Alert only implies that lethal doses of fentanyl are being illegally smuggled into the U.S. across our Southern border with Mexico and uses the word "brought," the DEA's own "Facts about Fentanyl" webpage makes the situation very clear, "*Illicit fentanyl, primarily manufactured in foreign clandestine labs and* ***smuggled into the United States through Mexico****, is being distributed across the country and sold on the illegal drug market.*"[7] (Emphasis added)

As illicit fentanyl streams into the country at a horrifying rate, sadly, tribal communities are not immune to this crisis. Where I work in the Tucson Sector, there is a long history of illicit narcotics trafficking on the Tohono O'odham Nation lands that shares their border with Mexico.[8] According to information shared publicly by the Tohono O'odham Department of Public Safety in 2017, "From 2002 to 2016 the Tohono O'odham Police Dept. and U.S. Border Patrol working together have seized on average over 313,000 pounds of illegal drugs per year."[9]

In 2019, ABC News made public a year-long investigation on smuggling activities on Tohono O'odham Nation lands and called the tribe's land, "*One of the busiest*

---

[1] U.S. Dep't of Homeland Security, U.S. Customs and Border Protection, *Drug Seizure Statistics*, (Data current as of Mar. 3, 2022), https://www.cbp.gov/newsroom/stats/drug-seizure-statistics.

[2] *Id.*

[3] Press Release, Centers for Disease Control and Prevention, *Drug Overdose Deaths in the U.S. Top 100,000 Annually*, (Nov. 17, 2021), https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm.

[4] Press Release, U.S. Dep't of Justice, Drug Enforcement Administration, *DEA Issues Public Safety Alert on Sharp Increase in Fake Prescription Pills Containing Fentanyl and Meth*, (Sept. 27, 2021), https://www.dea.gov/press-releases/2021/09/27/dea-issues-public-safety-alert.

[5] *Id.*

[6] *Id.*

[7] U.S. Dep't of Justice, Drug Enforcement Administration, *Facts about Fentanyl*, https://www.dea.gov/resources/facts-about-fentanyl.

[8] Press Release, U.S. Dep't of Homeland Security, U.S. Immigration and Customs Enforcement, *Ring leader, 20 others sentenced for drug smuggling on Tohono O'odham Nation*, (August 19, 2012), https://www.ice.gov/news/releases/ring-leader-20-others-sentenced-drug-smuggling-tohono-oodham-nation; Press Release, U.S. Dep't of Homeland Security, U.S. Immigration and Customs Enforcement, *NATIVE Task Force shuts down smuggling ring operating on Arizona tribal land*, (Feb. 20, 2014), https://www.ice.gov/news/releases/native-task-force-shuts-down-smuggling-ring-operating-arizona-tribal-land; Press Release, U.S. Dep't of the Interior, *Trump Administration Taskforce Completes Successful Opioid Bust in Arizona*, (May 31, 2018), https://www.doi.gov/pressreleases/trump-administration-taskforce-completes-successful-opioid-bust-arizona.

[9] Tohono O'odham Nation, *THE TOHONO O'ODHAM NATION OPPOSES A "BORDER WALL"*, (Feb. 19, 2017), https://www.youtube.com/watch?v=QChXZVXVLKo.

smuggling corridors in North America." [10] A tribal elder, David Garcia, is quoted in the report as saying, "*We're killing our own people . . . We have to do something. And if we don't do anything, then we're just as much the problem as well*." Mr. Garcia went on to add, "*It's no secret*," Garcia said, "*that a lot of our tribal members are involved in the smuggling of migrants and drugs*." [11]

I've personally worked in and around the area of responsibility (AOR) that includes the Tohono O'odham Nation and Mr. Garcia is absolutely correct—illicit narcotics like fentanyl are constantly coming to and through the Tohono O'odham Nation. And just like communities all over the country, when narcotics come in, the outcomes are devastating for tribal members. As one example of fentanyl being seized on Tohono O'odham Nation lands, in 2019, a Bureau of Indian Affairs task force seized roughly 30,000 fentanyl pills as part of an "investigation into fentanyl pills being trafficked onto tribal lands." [12]

The Subcommittee and the Congress do not need to enact new legislation or appropriate new money to address these issues. Thankfully, we already have the laws on the books that we need to stop this growing public health, humanitarian and national security crisis. And we have more than enough funding appropriated to DHS each year to do what we need to operationally to address these issues. We simply need a change in policy. It starts with policy, and President Biden's policies have made our borders the least secure in our nation's history.

I want to thank the Subcommittee for your time this morning and I look forward to answering any questions you may have.

Mr. GARCÍA. Thank you, for your testimony, Mr. Del Cueto.

The Chair will now recognize Ms. Maureen Rosette, a Board Member of the National Council on Urban Indian Health.

Ms. Rosette.

STATEMENT OF MAUREEN ROSETTE, BOARD MEMBER, NATIONAL COUNCIL OF URBAN INDIAN HEALTH, WASHINGTON, DC

Ms. ROSETTE. Good morning. My name is Maureen Rosette. And I am a citizen of the Chippewa Cree Nation and serve as a Board Member for the National Council of Urban Indian Health, which represents the 41 Urban Indian Health Care Organizations across the nation who provide high quality, culturally competent care to urban Indians, constituting over 70 percent of all American Indians and Alaskan Natives. I am also Chief Operating Officer of the NATIVE Project, an Urban Indian Organization located in Spokane, Washington.

Let me start by saying thank you to Chairwoman Porter, Ranking Member Moore, and members of the Subcommittee to share how the opioid crisis is plaguing our Native communities and to request inclusion of Urban Indian Organizations, referred to as UIOs, in the critical opioid response funding.

The codified Declaration of National Indian Health Policy states that it is the policy of this nation in fulfillment of its trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to affect that policy.

In fulfillment of this policy, the Indian Health Service funds three health programs to provide health care to Native people, IHS

---

[10] ABC News, *On tribal land along US-Mexico border, drug and human smuggling corrupts an ancient culture*, (May 16, 2019), https://abcnews.go.com/US/tribal-land-us-mexico-border-drug-human-smuggling/story?id=63064992.

[11] *Id.*

[12] ABC News, *30,000 fentanyl pills seized in Arizona drug bust*, (March 15, 2019), https://abcnews.go.com/Politics/30000-fentanyl-pills-seized-arizona-drug-bust/story?id=61714688.

sites, tribal sites, and Urban Indian Organizations referred to as the I/T/U System.

Unfortunately, this system has been hampered by decades of chronic underfunding. Additionally, while the majority of the Native population resides in urban areas, only 1 percent of the entire Indian health budget is provided for Urban Indian Health.

Our UIO, the NATIVE Project, provides medical, dental, behavioral health, pharmacy, care coordination, wellness, and prevention services. Our patients include Native people from over 300 different tribes. This year, we have had virtual wellness nights with activities like pow wow, dancing, painting, regalia making, planting, and cooking where we bring to life the meaning behind "culture is medicine." Along with the 40 other UIOs, we play a critical role in addressing the opioid crisis impacting Native communities.

A review of one UIO's records from 2018 to 2021, showed that over 80 percent of clients that engage with behavioral health services had co-occurring mental health and substance abuse disorders. Opioid disorder was the most common substance abuse diagnosis. However, as we will illustrate today, UIOs are cut off from critical funding resources designed to help Native communities, negatively impacting the health outcomes for urban Indians.

Additionally, the opioid crisis and the COVID-19 pandemic are intersecting with each other and presenting unprecedented challenges for Native families and communities. A study found that 1 out of every 168 Native children experienced orphanhood or death of caregivers due to the pandemic. Native children were four times more likely than white children to lose a parent or a grandparent caregiver. This has exacerbated mental health and substance use issues among our youth.

During the last government shutdown, one UIO suffered 12 opioid overdoses, 10 of which were fatal. This represents 10 relatives who are no longer part of our community. These are mothers, fathers, uncles, and aunties no longer present in the lives of our families. These are tribal relatives unable to pass along the cultural traditions that make us, as Native people, who we are.

To address the opioid overdose epidemic in Indian Country, Congress has provided funding for tribal opioid response grants. We have long advocated for UIOs to be added to these grants given the extent of the impact of the opioid epidemic on all American Indians and Alaskan Natives, regardless of residence.

However, the final language in the Omnibus removed UIOs as eligible, so UIOs, like mine, working against the same column are again left without the resources. This is a failure of equity and the trust responsibility. Therefore, I want to emphasize the importance of explicitly mentioning Urban Indian Organizations and legislation to ensure funding designed to reach Native communities actually does.

As one advocate stated, the language everywhere has to include the word urban. They have to say it, they have to write it, and then it will reach a critical mass eventually. Because they don't get it, we are just invisible.

In conclusion, more needs to be done to address the opioid crisis and ensure that all Natives have access to life-saving health care. I urge Congress to take this obligation seriously and provide UIOs

with all the resources necessary to protect the lives of the entirety of the Native population regardless of where they live.

Thank you for the opportunity to speak today. I have provided a written testimony to the Committee, and I am happy to answer any questions. Thank you.

[The prepared statement of Ms. Rosette follows:]

PREPARED STATEMENT OF MAUREEN ROSETTE (CHIPPEWA CREE NATION), BOARD MEMBER, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

My name is Maureen Rosette, I am a citizen of the Chippewa Cree Nation and serve as a board member of the National Council of Urban Indian Health (NCUIH) and Chief Operating Officer at NATIVE Project, an Urban Indian Organization (UIO) in Washington state. On behalf of NCUIH, the national advocate for health care for the over 70% of American Indians and Alaska Natives (AI/ANs) living off-reservation and the 41 UIOs that serve these populations, I would like to thank the members of this committee for the opportunity to testify on the opioid crisis in Indian Country.

First, I would like to begin by reviewing some information about the trust responsibility and how UIOs fit into the provision of health care for Native people. The Declaration of National Indian Health Policy in the Indian Health Care Improvement Act states that: "Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy." In fulfillment of the National Indian Health Policy, the Indian Health Service funds three health programs to provide health care to AI/ANs: IHS sites, tribally operated health programs, and Urban Indian Organizations (referred to as the I/T/U). Unfortunately, this system has been hampered by decades of chronic underfunding. Additionally, while the majority of the Native population resides in urban areas, only 1% of the entire Indian health budget is provided for urban Indian health.

Our UIO, the NATIVE Project provides medical, dental, behavioral health, pharmacy, patient care coordination, wellness, and prevention services. Our patients include Natives from over 300 different tribes. Specifically, we currently offer Youth Mental Health Services and Substance Use Assessments, Substance Use Outpatient and Inpatient Treatment. From January through March, we held virtual wellness nights with prevention, culture, and nutrition activities. Activities like pow wow dancing, painting, regalia making, planting, and cooking, we bring to life the meaning behind "culture is medicine". We also believe in fostering better outcomes for our children and are hosting an Indian Youth Leadership Camp later this month for secondary students. Along with the 40 other UIOs, we play a critical role in addressing the opioid crisis impacting Native communities. However, as we will illustrate today, UIOs are cut off from critical funding resources designed to help Native communities and this, thusly, negatively impacts the health outcomes for urban Indians.

Opioid Epidemic in AI/AN Communities

As you are aware, the opioid crisis has plagued Native communities long before the pandemic we're currently facing that is also causing devastating loss. A review of one UIO's records from 2018 to 2021 showed that over 80% of clients that engaged in behavioral health services had co-occurring mental health and substance abuse disorders. Opioid use disorder was the most common substance abuse diagnosis with alcohol use disorder as the second most common. Roughly 24% of these patients died of a known or suspected opioid overdose. Between November 2018 and March 2019, the UIO in Baltimore suffered 12 opioid overdoses, 10 of which were fatal. This represents 10 relatives who are no longer part of our community. These are mothers, fathers, uncles, and aunties no longer present in the lives of their families. These are tribal relatives unable to pass along the cultural traditions that make us, as Native people, who we are.

Additionally, AI/ANs are deeply impacted by the opioid crisis and continue to see an overwhelming increase of deaths, addiction, and overdoses above the national average. AI/ANs had the second-highest rate of opioid overdose out of all U.S. racial and ethnic groups in 2017, and the second and third highest overdose death rates

from heroin and synthetic opioids, respectively, according to the Centers for Disease Control and Prevention.[1]

Since 1974, AI/AN adolescents have consistently had the highest substance abuse rates than any other racial or ethnic group in the U.S.[2] The centuries of historical trauma do not heal overnight, and the government has failed Indian Country by not giving us the resources needed to heal our communities. Unfortunately, the majority of the nation's AI/ANs living on and off reservations have limited access to substance abuse services due to transportation issues, lack of health insurance, poverty, inadequate healthcare facilities, and a shortage of appropriate treatment options in their communities.[3] Some of the disparities in treatment that occur within the AI/AN population can be resolved through the increased availability of culturally sensitive treatment programs. Studies have shown that cultural identity and spirituality are important issues for AI/ANs seeking help for substance abuse, and these individuals may experience better outcomes when traditional healing approaches (such as drum circles and sweat lodges) are incorporated into treatment programs.

Urban AI/AN populations are at a much higher risk for behavioral health issues than the general population. For instance, 15.1% of urban AI/AN persons report frequent mental distress compared to 9.9% of the general public.[4] While behavioral health problems such as substance abuse, suicide, gang activity, teen pregnancy, neglect, and abuse ravage urban AI/AN communities, poor health and lack of access to adequate health care services continue to exacerbate these issues that AI/AN populations encounter.

Impact of COVID-19 on Behavioral Health and Substance Abuse in AI/AN Communities

Additionally, the opioid crisis and COVID-19 pandemic are intersecting with each other and presenting unprecedented challenges for AI/AN families and communities. On October 7, 2021, the American Academy of Pediatrics published a study on caregiver deaths by race and ethnicity. According to the study, 1 of every 168 AI/AN children experienced orphanhood or death of caregivers due to the pandemic and AI/AN children were 4.5 times more likely than white children to lose a parent or grandparent caregiver.[5] Unfortunately, this has exacerbated mental health and substance use issues among our youth. In the age group of 15–24, AI/AN youth have a suicide rate that is 172% higher than the general population in that age group.

The pandemic has also created challenges for providers as they work to serve our communities. We have shifted to expanding telehealth services, changing how we provide traditional healing practices while addressing the demand for more services. Despite these challenges, we have taken on the tireless work of addressing the epidemic and providing care to our communities. However, UIOs often find themselves excluded from funding meant to address these challenges.

UIOs Left Out of State Opioid Response Grants

Specifically, UIOs have repeatedly been left out of funding designed to help AI/AN communities address the opioid crisis. To address the opioid overdose epidemic in Indian Country by increasing access to culturally appropriate and evidence-based treatment, Congress provided funding for Tribal Opioid Response grants. NCUIH has long advocated for UIOs to be added to the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Opioid Response (SOR) grants given the extent of the impact of the opioid epidemic on all AI/ANs regardless of residence. Since FY 2018, Congress has enacted set asides in opioid response grants to help Native communities address this crisis. However, it was only available for Tribes and Tribal organizations, so UIOs like mine working against the same problem are left without the resources necessary to reach the highest health status for our people as required of the federal government. This is a failure of equity. Without the necessary funding to address health crises in Indian Country, urban AI/AN people will again be left out of the equation.

---

[1] https://www.cdc.gov/drugoverdose/deaths/index.html.

[2] Swaim RC, Stanley LR. Substance Use Among American Indian Youths on Reservations Compared With a National Sample of US Adolescents. JAMA Netw Open. 2018;1(1):e180382.

[3] https://ncuih.org/2022/01/14/ncuih-endorsed-comprehensive-addiction-resources-emergency-care-act-includes-funding-for-urban-indian-organizations/.

[4] Westat (2014). Understanding Urban Indians' Interactions with ACF Programs and Services: Literature Review OPRE Report 2014–41, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[5] https://publications.aap.org/pediatrics/article/148/6/e2021053760/183446/COVID-19-Associated-Orphanhood-and-Caregiver-Death.

Last Spring, Congress introduced the *State Opioid Response Grant Authorization Act of 2021* (H.R. 2379), which included a 5 percent set-aside of the funds made available for each fiscal year for Indian Tribes, Tribal organizations, and UIOs to address substance abuse disorders through public health-related activities such as implementing prevention activities, establishing or improving prescription drug monitoring programs, training for health care practitioners, supporting access to health care services, recovery support services, and other activities related to addressing substance use disorders. NCUIH worked closely with Congressional leaders to ensure the inclusion of urban Indians in the funding set-aside outlined in this bill, which eventually passed the House on October 20, 2021. Despite this effort, UIOs were removed from the SOR Grant reauthorization, which saw a $5 million increase (9 percent increase from FY 2021), included in the recently passed FY 2022 Omnibus (H.R. 2471). The final language in the Omnibus only listed "Indian Tribes or Tribal organizations" as eligible and did not use the language from H.R. 2379. When UIOs are not explicitly stated as eligible entities, we are excluded from critical resources and grants, which is a violation of the trust obligation. As one advocate stated, "The language everywhere has to include the word 'urban'—urban Indian or urban Native. They have to say it, they have to write it and then it'll reach a critical mass, eventually. Because they don't get it, you know. We're just invisible."[6]

We were disappointed to yet again be left out of this key resource as our communities are plagued by the opioid crisis. Inclusion in this program could have enabled UIOs to expand services or workforce or to help address the catastrophic impacts of the opioid epidemic in Indian Country. We urge you to work to ensure funding designated to help AI/AN communities have the proper language to prevent UIOs from lacking access to these critical funds.

The Importance of UIO Inclusion in Opioid Funding

On December 16, 2021, the NCUIH-endorsed *Comprehensive Addiction Resources Emergency (CARE) Act* (S. 3418/H.R. 6311) was reintroduced and aims to address the substance use epidemic by providing state and local governments with $125 billion in federal funding over ten years. Of the nearly $1 billion, the CARE Act sets aside $150 million a year in funding to Native non-profits and clinics, including to urban Indian organizations. NCUIH worked closely with Congressional leaders to ensure the inclusion of urban Indians in this important legislative response to the nation's substance use epidemic.

NCUIH has also continued advocacy around funding and preserving behavioral health initiatives for UIOs under the Indian health care system by working with Congress on the introduction the Native Behavioral Health Access Improvement Act of 2021 (H.R. 4251/S. 2226), which would require IHS to allocate $200 million for the authorization of a special program for the behavioral health needs of AI/AN populations. The availability of these critical resources would allow Congress to fulfill its trust obligations to AI/AN populations.

We are grateful for urban Indian inclusion in these Acts and want to emphasize the importance of mentioning urban Indians in legislation, to ensure funding reached across all AI/AN communities and urban Indians are not excluded or forced to prove their eligibility under the intent of the laws created. NCUIH appreciates that these bills have detailed specific language that ensures urban Indian organizations are listed as eligible entities.

Conclusion

More needs to be done to address the opioid crisis and ensure that all AI/ANs are cared for when it comes to substance abuse disorders, both during this crisis and in the critical times following. It is the obligation of the United States government to provide these resources for AI/AN people residing in urban areas. We urge Congress to take this obligation seriously and provide UIOs with all the resources necessary to protect the lives of the entirety of the AI/AN population, regardless of where they live.

---

[6] https://www.usatoday.com/story/news/politics/2022/03/07/opioids-native-americans-funding/9380063002/?gnt-cfr=1.

QUESTIONS SUBMITTED FOR THE RECORD TO MAUREEN ROSETTE, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Questions Submitted by Representative Cohen

Question 1. What has been the rationale, if any, for the historically low level of funding for the Indian Health Service?

Answer. There is no rationale for the historically low level of funding for Indian Health Service (IHS) other than the federal government's failure to uphold the trust and treaty obligation to provide healthcare to all American Indians and Alaska Natives (AI/ANs). Although funding has gradually increased over the past few years, Tribal and IHS facilities only receive around $4,000 per patient, while the national average for healthcare spending is around $12,000 per person. Urban Indian Organizations (UIOs) receive just $672 per IHS patient—that is only 6 percent of the per capita amount of the national average. That's what our organizations must work with to provide health care for urban Indian patients. Full funding for IHS is a way for the federal government to finally, and faithfully, fulfil its trust responsibility.

For Fiscal Year 2022, the House included full funding for urban Indian health at $200.5 million, which was the amount recommended by the Tribal Budget Formulation Workgroup. However, the final omnibus bill reduced the urban Indian health line item to just $73.4 million, 7.7% of the full FY23 amount ($949.9 million) requested by Tribes and UIOs to fully meet the needs for the majority of the AI/AN population. Full funding will empower UIOs to hire more staff, pay appropriate wages, as well as expand vital services, programs, and facilities.

Because IHS is subject to discretionary funding, critical funds for Native healthcare can be easily cut depending on the whim of Congress. As such, mandatory funding for IHS is necessary and long overdue to ensure stable and predictable funding for Native healthcare that is exempt from the political process. We strongly urge the House Committee on Natural Resources as the relevant authorizing committee to hold a hearing on mandatory funding, as proposed in the President's Fiscal Year 2023 budget, as soon as possible.

Questions Submitted by Representative Huffman

Question 1. Ms. Rosette, what educational efforts are in motion to ensure tribal people are aware of the risks of addiction and have access to treatment?

Answer. Some Urban Indian organizations (UIOs) have undertaken educational efforts around the risks of addiction and access to treatment for their community. For example, several UIOs provided training for community members to recognize the signs of an opioid overdose and how to administer NARCAN, and collaborated with departments of health to provide free NARCAN kits to the community. However, funding and staffing limitations has made it difficult for many UIOs to provide educational efforts that are needed for their communities. This is why it is critical that UIOs be included in important opioid grant funding to ensure that American Indians and Alaska Natives are aware of the risks of addiction and have access to culturally competent treatment.

Question 2. How does the Bureau of Indian Affairs and other Federal agencies track opioid prescriptions in tribal clinics?

Answer. Several federal agencies, including the Indian Health Service (IHS), utilize a Prescription Drug Monitoring Program (PDMP), which is an electronic database that tracks controlled substance prescriptions in a state. IHS requires healthcare providers working in IHS federal-government-operated facilities, including doctors, pharmacists, nurse practitioners and other providers who prescribe opioids, to check state PDMP databases prior to prescribing and dispensing opioids for pain treatment longer than seven days and periodically throughout chronic pain treatment.

Mr. GARCÍA. Thank you, Ms. Rosette, for your testimony.

The Chair now recognizes Mr. Wayne Cortez, Peer Support Specialist at Riverside-San Bernardino County Indian Health, Inc.

Mr. Cortez.

STATEMENT OF WAYNE CORTEZ, PEER SUPPORT SPECIALIST, RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH, INC., SAN JACINTO, CALIFORNIA

Mr. CORTEZ. Good morning to all of you. A little bit of a time difference, but I thank the two guests that spoke before me. My name is Wayne Cortez. I am from Torres Martinez Desert Cahuilla Indians, here at Riverside County.

As you know, we are talking about the opioid epidemic here. I see it on a daily basis down here. Being a peer support specialist, yes, we do have a problem here, and opiates do not discriminate. It is every family member that deals with that kind of drug there. Yes. For me, I would like to see a lot of changes and more education with this crisis here.

But for me, being in that lived experience, I lived that life right there, of a user, a heroin addict, for over 30 some years now. So, it really bothers me to hear a lot of stuff about Native Americans, the problem with it there. It is not coming from inside the reservation, it is coming from outside the communities.

I live in an area where it is a pipeline in the Coachella Valley area, right there next to Mexicali. But a lot of these so-called drug dealers, cartel members, they use Native Americans because of the revenue that we do get. They feed off of us a lot. But for me being in that peer support, bringing the education to them, encouraging them to do a better job in their life, helping their kids, supporting them in school, just being that mentor, a father, a brother, a son, uncle, even as a grandparent. I encourage a lot of the Native people in my community to step up and teach them that culture more to get them involved in the communities, get them involved in the different tribes, because we have nine different reservations down here, and it is very important. But being here in Riverside County, I have seen a lot of this so-called fentanyl epidemic. I have seen how a lot of the drugs are getting more creative nowadays, through vape pens, through pill form. They have like 10 different names just for fentanyl alone.

So, just bringing that awareness, bringing some light to the subject here, like I said, it is very important. I just want to say thank you for everybody to hearing what they have to say today. It is not going to stop until we all acknowledge it. This is something that continues to go on and on.

I am not sitting here reading from something that I have written. I am coming from my heart and lived experience here. And I don't know, all I can say is that it is just something that needs to be addressed more.

I thank the whole Committee here for giving me this opportunity. It is early morning, and to get going, you guys are better suited than me. But like I said, this is not going to go away. This drug does not discriminate. It doesn't. So, how can we be part of the change? How can we be part of the solution? How can we make this thing a little bit more understanding, that we can kind of slow it down?

It is not going to go away. That is all I can say. Yes. Usually, we start off with a prayer. Today, I had to say some prayers to help me and give me the right things to say, the right things to do. How can we open up Congress' eyes? How can we open up the eyes of

the people we are representing to make them listen to that? Close the doors when they try to come up to the reservations. It is just a big struggle.

Like I said, I really appreciate you guy's time, just hearing just a little bit from me and the rest of the Committee here. And like I said, if you guys have any questions or anything, feel free to ask. But we do stay in culture here, sweat lodges, bird singing, bird dancing, all-night wakes. We have a lot of things going on down here.

We do spend a lot of time with the kids, though. The kids are our future. That is my passion, the kids, helping them to understand that they have a purpose in life, to not give up on them but to walk beside them, to teach them something is more important than sitting there picking up a can, or picking up that needle, or picking up that pipe right there.

So, for me, yes, I really appreciate this. But if there is anything that I could do for my tribe, I am going to do it, or just any people in general. That is what I am here for is just to get that message across to people. So, I really thank you guys. And like I said, if you have any questions or concerns, please feel free to ask. Thank you.

[The prepared statement of Mr. Wayne Cortez follows:]

PREPARED STATEMENT OF WAYNE CORTEZ, PEER SUPPORT SPECIALIST, RIVERSIDE-SAN BERNARDINO INDIAN HEALTH, INC.

I would like to introduce myself, my name is Wayne Cortez. I am a 54 year old Native American in recovery; my drug of choice was heroin. I started using heroin at the age of 13. I started getting high once or twice a week then it turned into an everyday thing. Before I knew it I was strung out with no hope in life. I had no knowledge of what the drug was doing to me, so when I wanted to take a break I couldn't. I would get sick: cold sweats, chills, and I would be vomiting. I felt like my skin was crawling with ants. I couldn't sleep or eat, I had no idea what was going on with me. I thought I had the flu but, I was actually in withdrawals and the only way to make it go away was to get high again. There I was up and running again; a 13 year old kid with a habit that could kill a grown a man. To tell you the truth I wanted to die. I felt it was better than living with parents that didn't care about what was happening to their kids. My home life took a toll on me. I have been through a lot mentally, physically, and emotionally.

A lot of people are dealing with trauma, and it starts at an early age. We are all seeking escape from abuse. That was my life. The older I got the worse things became. Now a lot of adults and youths are getting creative with drugs. The one that is the biggest issue today is Fentanyl. This drug alone has ten different names. These dealers will do anything to make the drug look appealing.

Many people think drugs are something that they can take without having any consequences. I don't want to sit here and talking about how it's only affecting Indian people, because drugs do not discriminate. Drugs destroy lives. I thank the creator that I was one of those who survived this sickness. Everyone I grew up with has passed away from an overdose or blood diseases related to heroin use.

The other day I saw two of my native brother that I use to get high with still fighting with their addiction. I stopped to ask two questions, "aren't you tired of waking up and having to hustle for a morning fix?" and "aren't you tired of abusing your body living day by day like a zombie?" I said these things to them because I care. This is probably something they haven't heard in a long time, I CARE! I let them know if they want help I will help them. I am very grateful to be alive, and now I can make a difference.

Today I get out in the community educating as many people as I can about the current opiate addiction affecting the tribal communities. talk about how I got my life back, by going to Indian Health counseling, Wellbriety Meetings, Ceremonials, Sweat Lodge, Traditional songs, and surrounding myself with positive people. As long as the creator gives me the strength to live another day, I will continue to help those in need. Please forgive me if this is not the normal testimony of a heroin

addict. I believe we can get our point across without having to go into detail about our lives and the ones who suffered the most. My wife, my kids, and grandkids are my biggest supporters, and I love them with all my heart.

Thank you for giving me the opportunity to express a little bit of my life as a heroin addict in recovery.

QUESTIONS SUBMITTED FOR THE RECORD TO MR. WAYNE CORTEZ, PEER SUPPORT SPECIALIST, RIVERSIDE-SAN BERNARDINO COUNTY INDIAN HEALTH, INC.

Questions Submitted by Representative Cohen

Question 1. What has been the rationale, if any, for the historically low level of funding for the Indian Health Service?

Answer. The United States has a trust responsibility to the Indian Country and through treaty obligations to improve the health care status of American Indian and Alaska Native people. Native Americans exchanged large portions of their ancestor's land based on agreements and promises in the many treaties between the US Government and Indian Tribes, to include the obligations for health care services through funds appropriated by Congress. These federal responsibilities are carried out, in part, by the Indian Health Services (IHS). The IHS and Indian health care delivery system are unique among federal health-care related agencies in this regard.

American Indian and Alaska Native people often face the most significant behavioral health disparities among all populations in the U.S. The rates of diabetes, suicides (youth and adult), depression, behavioral health challenges, and deaths are higher than most other populations. Now, with COVID, many Indian tribes suffered much higher rates of COVID than the population in general. Yet, the Indian health care delivery system is underfunded by nearly 50% of the necessary levels to address all these health care disparities. This yearly underfunding to tribes through IHS leaves the Indian health care system vulnerable to the instability of funding in the event of a government shutdown. Riverside-San Bernardino County Indian Health, Inc., (RSBCIHI) is susceptible to sequestration should a government shutdown exist. Health care services and other operations are significantly impacted, delays, or disrupted during periods of a government shutdown.

Question 2. Do you have a sufficient number of residential treatment programs available for individuals who want to detox off opioids completely, including relapse prevention medication and culturally responsive counseling?

Answer. There are few, if at all, Indian based programs in southern California for the purpose of treating Native Americans for chemical dependency or alcohol abuse. The best course of treatment is often through the local Indian health program. A support group of Native Americans counselors who have experienced the very same chemical or alcohol issues can better offer the mentoring and support system needed to keep a patient on the red road to recovery. The Desert Sage Youth Regional Treatment center took decades to fund, construct and staff and then the criteria for placement may sometimes prevent a youth from being accepted into the program. Often once the addiction is faced head-on, the patient may go back into the very same environment which placed them in this situation in the first place. Recovery is a challenge and the first attempt may not always be successful based on the program and its teaching toward the unique challenges Native Americans face.

Questions Submitted by Representative Huffman

Question 1. Mr. Cortez, what commitments does the Federal Government make to ensure tribal communities are treated equitably and with sensitivity to their unique tribal communities as it addresses this crisis?

Answer. The major commitment is toward funding through IHS—but the insufficient funding limits the number of behavioral health specialists available to our patients. Often, it seems the need for behavioral health is as great as the need for an MD in clinics. Competitive grant funds through SAMHSA pits one Indian Health clinic system against another and although these grants provide tremendous opportunities for the benefit of the patient, another tribal health program may suffer because their data may not meet the scoring criteria for ranking within a grant. Yet, the need and lack of funding for a smaller clinic system may not give the patient an opportunity to receive the mental and physical healthcare they need. The

IHS has many needs to fulfill in meeting its obligations, and with the support of Congress, small steps can be taken to improve overall health status of the first people of this country.

Mr. GARCÍA. Thank you, Mr. Cortez, for your testimony. And, of course, I want to thank all of the panelists for their testimony. I would like to remind Members that Committee Rule 3(d) imposes a 5-minute limit on questions. The Chair will now recognize Members for any questions that they may wish to ask.

But before I begin, I request unanimous consent that the following Members of Congress be authorized to question the witnesses in today's hearing: New Mexico Representative Stansbury.

Without objection, so ordered.

I now would like to recognize myself for 5 minutes of questions.

First, Chief Hoskin and Ms. Rosette, why is tribally administered care for opioid addiction more effective than care that is non-tribally run?

Mr. HOSKIN. Well, Representative, if I could respond, I think it comes down to something essential in health care in Indian Country, which is that we know the people that we serve and we are experts about our own families. There is something about Native Peoples delivering health care to Native Peoples that is not only special, but I think effective.

If we are a healthcare practitioner or a policymaker, we share with those patients the same historic trauma. We have been through this together for generations. That sense of self that we have is important.

There are unique aspects of health care in Indian Country that go beyond the issues of substance abuse to other health ailments that are unique to Indian Country or exacerbated in Indian Country, and our healthcare practitioners know this. Treating people from a holistic standpoint is something we aim to do at the Cherokee Nation. And I think health care delivery by tribes directly is important.

Of course, that means we need that stream of revenue flowing from the Government of the United States so that we can meet that health care obligation. But I think in no area is it more important than dealing with substance abuse, and we have a great deal of work to do.

Mr. GARCÍA. Thank you. Ms. Rosette?

Ms. ROSETTE. Yes. I would echo what Chief Hoskin said. We are definitely subject matter experts of our own people. So, I believe we would be providing culturally focused care and traditional healing practices that no other type of healthcare system would be able to provide, and we know our patients. So, the best way to treat them is by knowing your patients. Thank you.

Mr. GARCÍA. Thank you for that. I would like to ask Mr. Cortez. First, thank you for your courage in coming here to tell your story. It must be so powerful for those struggling with opioid addiction to know someone with your lived experience and that you have their back.

I ask you to help us understand more about the process. When someone seeks treatment to beat their addiction to opioids, what are their struggles and how do you help them overcome those struggles? And would you please walk us through that process for you and for them, if you would?

Mr. CORTEZ. Yes. Thank you for that. A lot of times they just want to be heard, so just listening to them, building that relationship, letting them know that you are going to walk beside them whether they succeed or fail, identifying their strengths. I let them know that I care.

A lot of times they have been through a lot all their life through trauma. That is something that is not said enough, that I care. So, helping them, bringing them to the lodge, helping them to get that healing. A lot of times they are not ready to surrender. Dealing with opiates, it is hard dealing with that. It is not easy to take that first step. They have to want it.

Dealing with it from my lived experience, it took me over 30 some years just to overcome that. It was a lot to process. But for me, not giving up on my people, being there for them, educating them to what is out there, just encouraging them that they do have a purpose in life, in a traditional way and as a tribal member, but also as a friend. You have to build that relationship with them. It is very important that consistency is there, because a lot of times they were abandoned. So, not to give up on them. Yes. Thank you.

Mr. GARCÍA. Thank you for that. And very briefly, I want to ask Ms. Rosette, what services could Urban Indian Organizations provide to fight opioid addiction if we had more funding?

Ms. ROSETTE. Again, we would be providing culturally focused care and traditional healing practices that are tailored to combat the specific health disparity of Indian health programs. And the problem with us is the money always. We have to be able to hire more people. We only get 1 percent of the IHS budget so that is the problem. We don't get enough resources ever because we are Urban Indian Organizations.

Mr. GARCÍA. Thank you for that. I would now like to recognize the Ranking Member for his time to ask questions.

Representative Moore.

Mr. MOORE. Thank you, Mr. García. Mr. Del Cueto, thanks for taking the time just to be here today. Thanks for sharing with this Committee the reality of your experience, the reality of President Biden's border policies—that simple changes were made that increased volume in all sorts of different areas from just the amount of traffic with respect to drugs, as well coming across our southern border.

Your testimony describes the gaps in coverage that are created when agents are tasked with processing migrants. Can you share how cartels exploit these gaps to bring drugs like fentanyl, cocaine, and methamphetamine into our country?

Mr. DEL CUETO. Yes, sir. Thank you, Ranking Member Moore. What has been happening and happens frequently lately is the cartels have been working the southern border, and they have been working for quite some time. They control what comes in through the gaps. They control what comes in specifically between the ports of entry.

So, what they have been doing is knowing that if they bring across large groups, agents are going to have to respond. They are going to have to remove those individuals from that area, they are going to have to take them to a processing center. The cartels are aware of that. And they tell the illegal migrants that are entering the country, you don't have to worry because you are going to get released anyway.

So, they turn themselves in in large numbers. The cartels wait for that to happen. As they see that Border Patrol agents are now distracted or now have to deal with processing and transporting these individuals at the processing sites, that is when the drug cartels take full advantage to bring products across, which is more drugs.

And I will add that at the same time, the number of got-aways has gone up on the southern border. And it is then when agents have been distracted, when agents are out in the processing centers, that they'll bring in not only drugs, but many, many other individuals that we know nothing about who they are or what country they are.

It is causing a lot of problems, obviously, on the reservation, specifically on the Tohono O'odham Reservation. But those drugs are not just staying on the reservation, they are going throughout the rest of America.

Mr. MOORE. Thank you. Chair, I have two reports here, one from the Drug Enforcement Agency and one from the Department of the Interior, that simply highlight that the traffickers were responsible for most illicit drugs on Indian reservations. And they also detail how Mexican TCOs, these criminal organizations, took advantage of reservation land.

We would like to submit these two reports for the record.

Mr. GARCÍA. No objection.

Mr. MOORE. Thank you. And Mr. Del Cueto, continuing on with that, based on your work on the Tucson Sector of the southern border, can you describe how drug smuggling activities have impacted the TO Nation?

Mr. DEL CUETO. It has impacted it in many ways. You see the individuals on the reservation themselves that are involved in the illicit drugs. I talk to the people down here all the time. And as I said earlier in my statement, I grew up here. I grew up down here on this land. I grew up right next to the Tohono O'odham Reservation.

And you speak to them and you see them, and they will tell you themselves that there is a problem. They don't want to be caught in that situation. They don't want to be involved in drugs. But, unfortunately, the government doesn't do enough to allow Border Patrol to work those areas, to work that land.

If you look at some of the gaps that have been done, when the wall was being built down on the southern border, that area on the Tohono O'odham Nation, the wall wasn't built and there are several gaps.

Now, a lot of people are going to say that the walls wouldn't have stopped a lot of it anyway. But the reality is it would create a funnel, and then it allows the agency to be able to use their resources and put them in areas where it can help. Right now, the

Tohono O'odham Nation is a bonanza for the drug cartels bringing heroin, meth, and fentanyl into our country.

Mr. MOORE. Thank you for that perspective. Mr. Cortez, I wanted to just finish. I just want to say sincerely thank you for your candid testimony. This is affecting numerous different tribes across various reservations—we have seen the Lummi Nation, the Blackfeet Nation. All have quotes that this is the worst one yet.

You are getting at the point we are trying to make. We can't just throw money at the problem. We really have to stop the flow. Any last, additional thoughts to share about how stopping the flow can help improve this situation?

Mr. CORTEZ. That has to come within the tribe. That has to come with a lot of the tribal members when they have their general meetings. They have to bring awareness of what is going on. They can't just brush it under the rug.

It comes from a lot of tribal members marrying outside their race. That creates an avenue, they get caught up in it, they get manipulated in it. So, that is a hard one, it really is a hard one. We just have to really bring more of an understanding of what is going on, because it is not going to stop.

The way things are now, the way I look at it, it is always going to be there. We can slow it down. They are going to find other ways to do it. It is a moneymaker for them. But for the Native community, we have to step up to the plate. We have to bring more structure for our reservations. We have to police our reservations.

And they are doing it. They are doing it the best they can. I love my people, all nations. But the fact is that you will get a couple of them out there that go outside the reservations, and they will bring that in there. But it is our job, that is all I have to say. Thank you very much.

Mr. MOORE. Thank you so much. I yield back.

Mr. GARCÍA. Thank you, Ranking Member Moore. We are going to go to Round 2 of the question and answer period. I would like to begin by coming back to Chief Hoskin and to ask you, regarding your settlement money from the opioid litigation that you won from opioid distributors, you could have invested it in any number of ways to help the Cherokee. Why did you choose to use that money to build a clinic?

Mr. HOSKIN. Representative, our goal is to build a comprehensive behavioral health system in the Cherokee Nation with a focus on addiction treatment using the latest and best practices. Investing in capital projects is a great use of those limited opioid industry settlement funds.

At Cherokee Nation, we do a great deal of contracting out of our addiction treatment. In other words, we look to third parties to provide that treatment. In many cases, it is very good.

But as I mentioned in the response to the earlier question, directly delivering healthcare services to the Cherokee people by the Cherokee people is the best regardless of ailment. And in the case of addiction treatment, there is something particularly important about Cherokees delivering it to Cherokees because of our shared experience in history.

We want to create a system in terms of addiction treatments that provides not only the initial detox type response to addiction, but

a long-term commitment to healing. And that includes residential treatment programs, that includes getting people back into the workforce, and that includes making sure that moms and dads can be with their children as they are going through recovery when the setting and situation is appropriate.

So, these opioid industry dollars will go to build those clinics because I think it is the most effective long-term strategy—Cherokees taking care of Cherokees.

I should mention that of the opioid settlements, as I mentioned in my testimony, $15 million I have proposed to our council, our legislative branch, over the next 3 years to start building some of these facilities. That won't be enough. That is a minimum number. We will commit more of those opioid settlement dollars to these efforts. But it is a start, and it is a start down a path of healing.

I should also mention in that same legislation I have proposed to our council, not using the opioid dollars but using our own third-party revenues, we are actually starting a harm-reduction program. We are taking an all-of-the-above approach to addressing addiction, and I think we are leaders in that regard in Indian Country.

We think this investment of opioid settlement dollars will yield so much in a return on investment in the form of opening up opportunities for our people. Because the opioid epidemic has foreclosed so many opportunities for individuals and really suppressed us collectively, we can change that by making these investments.

Mr. GARCÍA. Thank you for that. And if I could just piggyback one more related question on this vein. What opioid recovery services could the Cherokee provide, if the Federal Government's fiduciary trust obligation was fully met?

Mr. HOSKIN. Well, certainly, if we had additional operating dollars, in particular, we could start, for example, with children. I mean that is where we find in Indian Country, and I think all over the world, you find the greatest hope for your people is in the children. But you also know that children can go down a path that leads them into the same type of challenges, including addiction, that the generation before them are dealing with.

So, getting involved early in terms of education and prevention is important. Peer recovery is something I would like to see us do more in the Cherokee Nation. I visited our brothers and sisters in the Eastern Band and saw what they were doing in terms of providing addiction treatment. And, often, it involved staff members or even volunteers that themselves were recovering from addiction.

But there is something very powerful about utilizing people who had been through that direct trauma to provide services to their brothers and sisters. And I think we can do more of that if we had additional operating dollars, and I am very optimistic in that regard. So, focusing on youth and focusing on peer counseling. There is a host of other things we can do. These facilities that we are building will take a great deal of staff. Recruiting, recruiting people into these professions is also key.

Congressman, I can build all the buildings in the world, but if I can't fill them with the best and brightest of staff and retain them, I have really not done what we need to do. We have not done what we need to do. So, recruiting talent and creating that pipeline

of professionals, that is key for Indian Country. I think the Government of the United States can help us in that regard.

Mr. GARCÍA. Thank you for that. Now I would like to ask the Ranking Member if he has more questions.

Mr. MOORE. Thank you again, Mr. García. Yes. I do have a few more questions I will jump into for our witness, Mr. Del Cueto.

I mentioned Utah in my opening statement. And as I have been in my community and going to the doctor's office—I have young kids, so we tend to be there more often than I would like—I see a lot of communication. I see posters about this. I see it is more palpable, everything related to opioids and the potential negative effects and side effects of this.

So, I am proud of that. I think that is something to celebrate. I think that is something that we have done well in this society over the last 6 or 7 years. But the point we are trying to make today is that no amount of additional spending, or no additional advertising, or physicians being more hyper-focused on this with their individual patients can overcome the amount of volume that we have seen at our borders over the last year, a 1,066 percent increase.

The South Texas ports of entry reported seizing 588 pounds of fentanyl, a 1,066 percent increase compared to FY 2020. I mean that is astronomical, right? And that is the point that we are trying to make. Increased education, yes. We need to be doing better as a society. We need to be talking about this more with our families. Absolutely. Particularly on the reservations, we need to keep seeing the momentum that we have seen. But that amount of increase is unsustainable to curb this problem.

So, again, Mr. Del Cueto, in your opinion, if President Biden does not change his policies, will these drugs remain readily available to be sold on the illegal drug market?

Mr. DEL CUETO. Ranking Member Moore, we have seen the increase. Obviously, what we talk about is the increase in what we have seized, the increase in the apprehensions, and they are astronomical. But what people need to continue to concentrate on, and some people forget, is with these huge amounts of seizures, there are huge amounts that are getting through. The drugs are still cheap which means there is a lot of it coming through. And that is a direct effect because of the lack of border security created by the current administration.

And I will go on to say, and I have said it many times before, it has nothing to do with whether you are on the right side of the aisle or the left side of the aisle. At the end of the day, we all lock our doors at night. We all want security for our families. The reservation wants security for their tribal members. We want security for Americans.

The cartels do not care who we voted for. The cartels do not care who is in office. The cartels just want to bring their drugs across. And if we need security in our homes, and we care about security of our homes, and we lock our doors at night, there should be no difference with our borders. This is a nation of laws, and we need to feel secure in this country.

Mr. MOORE. Thank you for that. I will also highlight Mr. Cortez' comments too, where he mentioned there is no discrimination with

the cartels, and these drugs do not discriminate. They are an equal-opportunity aggressor on our communities.

And I guess one last question that I will ask with my time is, can you describe for the Committee the ways in which cartels smuggle drugs across the border? And from your experience, very simply, do they use vehicles or send drugs with migrants attempting to illegally enter our country? Just give some perspective there.

Mr. DEL CUETO. The cartels, they don't care. They will use vehicles to come across in between the ports. They will try to smuggle drugs at the ports of entry. They will use females and males as body carriers, where they will carry the drug inside their bodies. They will use children. They will use anything they can to bring drugs into this country because they simply do not care. It is a profit for them. And they see when there is an administration that is allowing that profit to grow by weak border security policies.

Mr. MOORE. And with respect to profits?

Mr. DEL CUETO. Monetary profit.

Mr. MOORE. Cartels, do you see that they are still able to profit off of this ongoing activity? Has that been curbed in any way or is that getting worse?

Mr. DEL CUETO. It has gotten worse over the last year. And as I said, it doesn't just show with the amount that is being apprehended and the seizures. Obviously, there is a lot of it getting away. The got-away numbers themselves have gone up on the southern border. And that is a direct effect of the cartels distracting agents from one area so they can bring their drugs into gaps.

Mr. MOORE. Thank you so much. I appreciate it. I yield back.

Mr. DEL CUETO. Thank you.

Mr. GARCÍA. Thank you, Ranking Member Moore. The Chair next would recognize Representative Stansbury.

Ms. STANSBURY. Thank you so much to Chair Porter, Representative García, and also to our Ranking Member for convening this important hearing on such an important topic. I also want to thank all of our witnesses for joining us today and sharing your stories and your work to serve and protect the health and well-being of our communities.

New Mexico is ground zero for the opioid epidemic. We have one of the highest rates of drug overdose in the United States. In some New Mexico counties, the overdose rates are more than five times the national rate. In 2019 alone, we lost 605 New Mexicans to drug overdoses.

That is 605 family members, brothers, sisters, parents, children, co-workers and neighbors. And every single one of those lives lost was a preventable tragedy. A person who was loved, who was cared for, a part of the fabric of their communities. Opioid addiction touches nearly every New Mexican life. Nearly two-thirds of our population knows someone who is addicted to opioids, including myself.

In fact, in 2019, my life was personally changed forever by the opioid epidemic, as I lost one of my oldest friends to a fentanyl overdose. An artist, a father, a friend, someone who became

addicted like millions of Americans after he received a prescription from his doctor.

His story was unique, but also like that of thousands of people across our communities and the tragedies that we have heard about today, and that we hear about every single day across the country and across our tribal communities.

Our tribes, our pueblos, our governments, and law enforcement are working every day to address this crisis, to stem the flow of drugs into our communities and the public safety crisis that is emerged from it, to address the crisis of addiction that is touching every member of our communities, and to provide opportunities for healing and addiction recovery.

But the system is broken, and we need action now. And that is why it is crucial that this body pass legislation and meaningful budgets that will help to enable our communities to fight this crisis at home. Already in this chamber, several bills have been introduced that would help to support our tribal communities. For example, Representative Maloney's Care Act would award grants to tribes who are disproportionately impacted by high drug overdose rates and help to distribute opioid reversal drugs for tribal communities.

I am also proud to co-sponsor Representative Tonko's Mainstreaming Addiction Treatment Act which would help community health workers treat substance abuse disorders in their own communities. And within New Mexico, our office is working every day to try to identify how to address the public safety and the public health crisis that has emerged around the opioid epidemic.

But in order to address this crisis across our tribal communities, we need an approach that is community centered, that is culturally relevant, that empowers our communities to make the changes on the ground that they need, whether that is in law enforcement, in youth opportunities, in healthcare services, and in healing opportunities for our communities.

So, with that in mind, Mr. Chairman, I would like to ask Ms. Rosette because of the important work that you do, especially with our Urban Indian Organizations, can you please take just a moment to share with us some of the things that you think that this body can do to help support your work on the ground?

Ms. ROSETTE. Well, first, thank you for the question. And as I stated in my testimony, it is to include Urban Indian Organizations in the legislation. Funding is always an obstacle for us. Grants like the State Opioid Response Grant would allow us to provide culturally appropriate treatment in our community, but we were not included. You have to specifically say urban along with tribal. Otherwise, we are not allowed to get the funding.

So, that is what needs to happen to be included in all these funding grants. Include urban and tribal, and then that would assist us with creating the services that are needed to help with this crisis.

Ms. STANSBURY. Thank you so much. And for any other members of the panel, are there any additional items that you feel very strongly that this body can do to help support your work on the ground? Folks are being shy here.

So, I will just wrap up my comments here and say thank you for your service and for the important work that you do. And I want to thank the Chairman and Ranking Member for convening this important hearing. It is clear that we have to do everything possible to help empower our communities to provide resources and to address this crisis. Thank you. With that, I yield back.

Mr. GARCÍA. Thank you, Representative Stansbury. Before we go to Round 3 of questions and answers, I just want to point out that the steady increase in fentanyl at the border started in 2016 and increased steadily under President Trump. So, this is not a Biden problem. This is a fentanyl problem that we have to grapple with.

I would like to now go to Round 3, and I have a couple of questions. Again, back to Chief Hoskin. Can you please explain the roles of pharmaceutical distributors and manufacturers in the tribal opioid crisis? If doctors are prescribing the pills and controlling their distribution, how did the situation get out of control?

Mr. HOSKIN. Thank you, Congressman. It is a fair and natural question to ask if doctors are involved as a point of contact in the prescribing of these drugs. How does that interplay with the opioid industry? What we know is that doctors don't have a particular idea of other doctors writing the same prescriptions. We know that.

But we also know that the opioid industry, the pharmaceutical chains and providers, in particular, had or should have had checks in place. In fact, there are checks in place that should have been adhered to in limiting the distribution of these drugs. There should have been flags.

There were flags that were raised. They were ignored. They were ignored because of profit. They were ignored because the distributors and manufacturers knew full well the communities they were impacting. I am talking, of course, about tribal communities, but you could go to other marginalized communities in this country and find a similar targeting.

I believe that Indian Country was targeted, and I believe Cherokee Nation communities were targeted. And I think the stats, in many ways, speak for themselves. As I mentioned in my testimony, when you have this deluge of pills coming into the reservation, such that you have 153 pills in 1 year for every man, woman, and child in the Cherokee Nation Reservation, that is indicative of an industry that is driven by profit, not care.

So, I would submit that that is the problem. We are getting some measure of justice through our historic litigation. And I have to say that building drug treatment centers using the very funds we have finally extracted from this industry gives us some satisfaction. But more than satisfaction, it gives us a path toward hope.

If we can couple that with increased funding streams from the Government of the United States that allow us to do what we can do, which is to bring healing to our people, I think we can get on the way again to that idea of holistic healing that Indian Country needs, Cherokee Nation, in particular, needs.

Mr. GARCÍA. Thank you for that. Now I would like to turn to Ms. Rosette. When we think about the impacts of opioids, we typically think about death and addiction. Does opioid addiction cause disabilities among American Indian and Alaskan Natives as well, and what are they?

Ms. ROSETTE. Can you repeat that, please? I am sorry.

Mr. GARCÍA. Yes. Usually, when we think about opioid addiction, we think about death and addition. But my question is with the opioid crisis, is this causing disabilities among the American Indian or Alaskan Native population as well?

Ms. ROSETTE. I believe it is. I believe there would be—my answer, I need more time to think about it really, because that came out of nowhere. I used to deal with clients that had that. And, oftentimes, it created some mental health conditions or they went hand in hand. So, there is that, and they were not able to work. So, there are disabilities, but it depends on the length, I guess, and how hard it hit them. So, there are lots of answers to that, I guess, and I believe there are other disabilities.

Mr. GARCÍA. OK. Thank you. And one final quick question for Chief Hoskin. In your testimony, you said that between 2015 and 2016, there were enough opioid pills to give every man, woman, and child on your land 153 pills each. Did those pills come illegally over the border?

Mr. HOSKIN. Mr. Chairman, not to my knowledge. I mean our focus has been on the source of the pills coming from your neighborhood pharmacy or more often, because of their size, the chains. I am assuming that Walgreens didn't get their pills from across the border. I am assuming they got them from normal distribution channels.

We have had to check that enormous amount of pills coming into the Cherokee Reservation from businesses and corporations that have seen fit to profit off the pain imposed by their own actions.

Mr. GARCÍA. Thank you, sir. The Chair now recognizes the Ranking Member for a third round.

Mr. MOORE. Mr. Chair, may I ask that the gentleman from Texas, Tony Gonzales, go first? Is that possible?

Mr. GARCÍA. Absolutely. The gentleman from Texas, Mr. Gonzales, is recognized.

Mr. GONZALES. Thank you, Chairman. And thank you, Ranking Member, for allowing me to be on this hearing today. I represent 42 percent of the southern border. A large part in this crisis is forefront in everything that I see. And one of the things that I see regularly is the coordination between Border Patrol agents and tribes and pueblos. I represent part of the Tiguas out in El Paso County.

My question is for Mr. Del Cueto. Part of what worries me is the morale of the Border Patrol Agency in general. Can you describe the toll the policies have had on the Border Patrol agents that you work with? What is morale like?

And I will just preface that—on Christmas day, I did a swing through the district, visited six different stations, three different sectors, and one of the things I heard was Border Patrol agents, in particular, have a mandatory 6-day overtime. And I don't care what line of work you are in, if you are working 6 days with no end in sight, that has to cause some damage.

But what is the morale like there in Border Patrol with this crisis?

Mr. DEL CUETO. Well, to be honest, yes, it is a 6-day of overtime that they are working, but it is not to be out there on the field protecting our nation's borders. It is more so to be processing the huge

number of individuals that have come into the country. And, yes, there has been a problem with drugs coming through the Tohono O'odham Nation, and different nations, and the southern border for quite some time.

But now, when you look at it, everything you see on the news, it is constantly one load after another load of either fentanyl or heroin or cocaine. It has gone through more astronomical numbers than it ever has before. And it is evident because you have agents that are too busy having to do the processing. Because the cartels, as I said, they know what they are doing.

Listen, I have been down here my whole life. I have seen it. I have seen it through different administrations. This is the worst we have seen. The agents have shown it. The agents are fed up. They are tired. We have agents that are leaving the agency more than before.

You speak to them constantly and they say, we can't hold up at this pace. A couple of years ago, individuals were worried of whether they were going to call it a crisis. Should we call it a crisis? Should we call it chaos? I don't think it matters at this point what we are going to call it. There are too many individuals that have been dying on both sides of the border. There are too many individuals, Americans as a whole, that have been dying. And something needs to be done.

And when you look at the policies that are currently going on, of the Catch and Release, and you are seeing huge numbers of individuals from all over the world that are coming across, some of them they will stay on the border themselves. You will have agents that will come to the line. They will transport them to areas so they can process them. And the rest of the group, they stay there. They don't even leave. They stay there. And they say I am just waiting for the ride. The agents that picked up the other group are coming right back to pick up the other group.

Mr. GONZALES. Yes. I appreciate all the hard work that your agents are doing to keep us all safe. You know my next question is about coordination. Can you speak a little bit about what kind of coordination that you have with tribes or pueblos? And once again, I will go back to the Tiguas because they represent a portion of that border area. And they are always talking about some of the coordination that the Border Patrol has. I am curious, how are things going on that end?

Mr. DEL CUETO. So, you obviously have coordination. There are different radio communications that could be a problem at times.

And I will just share this story with you. Just a couple of weeks ago, Border Patrol was trying to stop a vehicle that was known to be smuggling individuals coming across the border. As they were behind that vehicle, the driver of the vehicle, at 80 miles an hour on the Tohono O'odham Reservation, decided to start throwing the individuals he was transporting out the vehicle while he was still moving.

Agents had to stop and assist these individuals. Obviously, they had to have medical attention. The Tohono O'odham Reservation assisted. They later found that vehicle abandoned in one of the villages with a weapon inside the car. I do not know, or I do not believe that the individual that was driving has been captured.

But that is something that we see here every day. It is not the numbers. It is not who is coming across and who is not. We are seeing the chaos on the border. We are seeing the chaos on the nation. And there has never been a time more chaotic than there has been during this administration.

Mr. GONZALES. Well, thank you Agent Del Cueto, and thank you, Chairman, for the time and the opportunity to be at this hearing today. And I yield back.

Mr. GARCÍA. Thank you, Mr. Gonzales. The Chair would next recognize Mr. Westerman.

Mr. WESTERMAN. Thank you, Mr. Chair. And thank you to the witnesses. And thank you for at least having a hybrid hearing today.

The border crisis is exacerbating our nation's opioid crisis. And I think with all the other crises going on in the world, it is kind of masking what is really happening at the border. We are not only facing a surging number of migrants but increasing amounts of illicit substances.

And as has already been stated in here, fentanyl is one of those substances that is doing great damage in our country. And to think that we have apprehended enough fentanyl to give a lethal dose to every American citizen is just outrageous.

And, Mr. Del Cueto, the deadly drug, we know a lethal dose can be just 2 milligrams. This seems to me like not just a national security issue, but a public safety issue. Can you describe the concerns that you have specifically about fentanyl flowing into our country?

Mr. DEL CUETO. Obviously, the deaths that we have spoken about. But at the same time, you have agents that are out there having to arrest these people. They are having to deal with some of the fentanyl that they seize. There are a limited number of NARCAN setups out there, which is pretty much the injection that you would get if you were directly in contact with fentanyl.

We see the problem constantly. We see it at the checkpoints. You open up the news, and you constantly see body carriers coming across. And, yes, there are pills. It is in powder form. There are different ways that they are bringing it across. And as somebody else on the panel spoke earlier, that it is hard to tell where it is coming from.

But I can tell you by being down here, I am seeing the number of those illicit drugs coming through our southern border higher than they have ever been before.

Mr. WESTERMAN. And that was going to be a question I asked you. Do you see it improving or getting worse? And, obviously, it is getting worse. And we talk a lot about hockey stick charts in this Committee.

How steep is the increase, from your experience, on the number of illicit drugs that are being seized? And what would you say is the No. 1 driving force behind this increase?

Mr. DEL CUETO. I would have to look into the numbers specifically to give you a percentage. I don't have those numbers so I can't give them to you—I would hate to give you a number that was incorrect. But I can tell you that we are seeing a huge amount compared to other years, and a lot of it is because agents are being

distracted. And I will add that, yes, a lot of people focus on what is being detained. And they say, hey, the numbers of what is being seized is huge, which is correct.

But at the same time, when you are seeing the amount of got-aways that are coming through our border, and then you realize that a lot of these got-aways, they are waiting for agents to be out of the area. So, the cartels are the ones that are directly sending them across. The number that is getting through is astronomical.

Mr. WESTERMAN. Right.

Mr. DEL CUETO. And it is like this because they are all working with the cartels themselves.

Mr. WESTERMAN. But do you see a correlation between the number of illegal migrants that you are detaining, along with the number of the quantity of illegal drugs that is being stopped at the border?

Mr. DEL CUETO. Most definitely. We hear the term so often Catch and Release. Individuals are coming across. They realize that if they come in big numbers, they will have to distract the agents from the areas that they are working. Now they have to transport them.

During that entire time, there are gaps on our southern border. And those gaps are the ones that are utilized by the cartels. They are exploited by the cartels, not just with illegal drugs coming across, but the sex trafficking, the human trafficking, the unaccompanied children.

They will distract agents with unaccompanied children. They will drop a huge group of unaccompanied children in one area, knowing agents are having to respond to there. Now they are having to transport them. All the while as they leave, you see the got-way numbers go up. And that is where some of these other individuals are coming across and/or the drugs.

Mr. WESTERMAN. And if the administration goes through with their current plans on the border, what do you expect to see happen to both the number of illegal migrants and the amount of fentanyl coming across the border?

Mr. DEL CUETO. It will become a free-for-all. And, basically, what will be happening is we will be handing over the key to the front door to the drug traffickers, to the human traffickers, and the sex trafficking in this country.

Mr. WESTERMAN. Yes. I am out of time but thank you for what you and all your colleagues do. I have been to the border several times, and it is just even more eye-opening every time I go. And I think if the general public could see what we see as Members of Congress, there would be a huge outrage about what is happening on the southern border and our policies there. I yield back.

Mr. GARCÍA. The gentleman yields back. Mr. Gohmert of Texas is recognized.

Mr. GOHMERT. Thank you, Mr. Chairman. Mr. Del Cueto, with regard to border states, in particular Arizona, you do have part of our international border with Mexico that runs through tribal lands there were in Arizona. Are you familiar with that area?

Mr. DEL CUETO. I am, Congressman. That is the area I specifically have been working for over 18 years. That is the Tohono

O'odham Nation. It is over 60 linear miles with the Mexican border.

Mr. GOHMERT. Have you seen any problems with the drug cartels using that area for bringing in drugs?

Mr. DEL CUETO. Definitely. They scout. They put scouts on both sides of the border many times in order so they can coordinate the drug trafficking that they are bringing into the United States. It happens continuously. And they exploit that area specifically because they know the barrier in that area is less than anywhere else, specifically in the Tucson Sector.

And at the same time, there are different gaps that they can get through. There are different villages that they utilize on tribal land to assist them with bringing their drugs across.

Mr. GOHMERT. Is there a difference in Border Patrol's ability to patrol that area of the border that runs through tribal lands, as opposed to those areas that are with Arizona, New Mexico, Texas, or California?

Mr. DEL CUETO. When you are working with tribal land, there are different roles. There are different things that you must respect. Some of it is sacred land that they are very proud of, which is very much understandable. So, there are different ways that you have to go about patrolling in those spots.

There is also limited coverage at times when it comes to radio traffic because you can't just put towers wherever you want. So, definitely it is a different way to work there. A lot of the agents out there, they are still using the old method of tracking. They track the drug smugglers through. Many times, they will be tracking drug smugglers all the way to some kind of highway where they lose track of them, and those are some of our got-aways.

There are different methods that they use to track to be able to recognize if some of these individuals may be carrying backpacks of drugs or regular backpacks. There are just different methods. I would hate to go into it because I don't want to give any more information to the drug traffickers themselves so they can know what we are looking for.

Mr. GOHMERT. Well, do you see any solutions that should be pursued that are not being in that area?

Mr. DEL CUETO. Definitely.

Mr. GOHMERT. That you care to tell us about?

Mr. DEL CUETO. Obviously, more funding when it comes to some kind of barriers that you can funnel individuals in the correct place. That is a huge plus. More prosecutions of the individuals when they do get detained and get arrested. And at the same time, you have to apply other immigration policies. It is a domino effect.

But when you are telling individuals that they can enter this country illegally and there will be no consequences for their actions, that is pretty much inviting people to come here and break the law, and the cartels are aware of that.

So, obviously, the Remain in Mexico policy is something huge. Maybe bring some more immigration judges and/or asylum officers down there so they can see a lot of these cases for asylum are not true asylum claims. And that way, they can have agents actually

working these areas to stop the flow of drugs that are entering our country.

Mr. GOHMERT. Do you think it would help to have immigration judges right there on the border working in shifts so that you could give people immediate hearings as soon as they were obtained or taken in custody?

Mr. DEL CUETO. Definitely. When you do something like that, you send a clear message to the drug smugglers. You send a clear message to the human smugglers that the United States is not going to tolerate individuals just false claiming to come into the United States.

When you do that, it will lower the flow. And I know people get upset, but the reality is when President Trump first took over office, he lowered those numbers just by rhetoric alone. Right now, rhetoric is not going to do it. We need policies that are going to affect this change. And we owe that to the tribal people that are on this panel. We owe it to the tribal lands. We owe it to all Americans, frankly. And, again, the cartels don't care.

Mr. GOHMERT. One last question very quickly, though. Does that affect just the areas on the border, or does it affect the whole country?

Mr. DEL CUETO. It affects the entire country. The drug cartels are making money off of people in the entire country. They transport their drugs everywhere in the United States.

Mr. GOHMERT. Thank you very much. I appreciate all you do for us.

Mr. DEL CUETO. Thank you.

Mr. GARCÍA. The gentleman yields. The Chair will now recognize Ranking Member Moore.

Mr. MOORE. Thank you again, Chair. Let me reiterate just one more time that we are not denying that there is a role that pharmaceutical companies can play in improving the situation. And I think we have seen that play out over the last several years.

What we are trying to hit, the point we are trying to continue to make, is that the abundance of drugs coming across our southern border will make it so we can't get out ahead of this issue. That it will continually be compounded on itself. And not just border states, but every state in our nation will continually face this epidemic.

And I will read from this—President Biden's DEA Administrator Appointee, Anne Milgram, stated in the alert that we have here, "The United States is facing an unprecedented crisis of overdose deaths fueled by illegally manufactured fentanyl. DEA is focusing resources on taking down the violent drug traffickers causing the greatest harm." OK. That is President Biden's appointee in the DEA.

And, Mr. Del Cueto, I want to continue talking about solutions, but focus it specifically on how the DEA can best support Border Patrol agents. Could you share with us your thoughts on, again, how the DEA can best support Border Patrol agents?

Mr. DEL CUETO. I think a lot of it could happen if there was more communication and more working together with this. Obviously, it is two different entities, it is two different departments. But we have to work hand in hand, as I have said. It is not

something that just one particular party is going to help. And the cartels don't care what party you are at.

I know I have done several different tours out here on the southern border. We have gone down to the Tohono O'odham Nation many times. Congressman, some of them that have spoken here today, they have taken that trip. They have seen the problem. And they can see the gaps that are happening. They can see what is coming through. And it is going to take a joint effort, not just by Border Patrol and DEA, it is going to take a joint effort by all individuals that actually truly want to do something about it.

It is a hard subject because people, they get upset or they look at one thing about the traffic from human traffic that is coming through the border, but it goes hand in hand. It is a domino effect.

And I have said it many times, and I will continue saying it. We owe it to the future of Americans. Illegal is not a race. It comes down to we all need to get together. And if we really care about stopping the flow of drugs, we are going to have to focus on policies that have been enacted allowing individuals to come across the border without any consequences.

Mr. MOORE. And we will see from many of my colleagues. Not just from border states, but we have seen a direct call for two of these policies that you mentioned. Particularly, I will mention the Remain in Mexico policy. This should not have been a hyper partisan issue.

This should have been something that President Biden was willing to embrace for the exact reasons that we are talking about today. From our witness, Mr. Del Cueto, and from the Majority's witness, Mr. Cortez, there is no discrimination of this drug. It will hit everybody.

Those policies did not need to be hyper politicized. They just needed to be enforced. And Title 42 is what is currently taking place.

Do you have any thoughts on my last 60 seconds on those particular two policies? And anything else that you would say that would make the biggest difference to improve Border Patrol agents' ability to secure our borders?

Mr. DEL CUETO. Those two policies alone will have tremendous impact. Because it will send a clear message that you cannot just come across, claim asylum, and be released in the United States, waiting for a court date later on. So, that is a huge deal.

When you do that, the illegal alien flow in those areas that are distracting agents will come down. And, thus, agents will be able to interdict the fentanyl that is coming into our country and killing Americans in every single state of our country, not just on the border.

Mr. MOORE. Thank you, sir. I yield back.

Mr. GARCÍA. The Ranking Member yields back. The Chair will recognize Mr. Rosendale.

Mr. ROSENDALE. Thank you, Mr. Chair. First, I would like to thank Chairman Porter, Acting Chair García, and Ranking Member Moore for putting this hearing on today. Also, thank you to all the witnesses for joining us and for your testimony on this important issue.

We have heard a lot of testimony today about how Big Pharma is responsible for the opioid crisis and rampant drug addiction in the United States. While these pharmaceutical companies may share some of the blame, we cannot ignore the issue of our poor southern border and raging border crisis.

Joe Biden's failed immigration policy has empowered Mexican cartels to smuggle fentanyl and drugs across the southern border undeterred, killing over 100,000 Americans last year alone. Make no mistake, the border and immigration crisis in our nation is at the worst point that we have ever seen.

I met with my State's Attorney General for the last 2 weeks, and he said that 100 percent of the fentanyl and methamphetamine entering Montana is coming across the southern border. In Fiscal Year 2021, 11,000 pounds of fentanyl was seized by CBP, enough to give a lethal dose to every American. And this year alone, 173 pounds has been confiscated at the border.

Unfortunately, tribal communities do often face the brunt of this burden in the fight against opioids and addiction. Mr. Del Cueto, thank you so much for joining us again today. It is always good to be with you. Thank you for securing our southern border. Do you think that this will help tribal communities and American communities by reducing the prevalence of fentanyl and drugs securing our southern border?

Mr. DEL CUETO. It most definitely will. We have seen it before when different policies are enacted, the cartels, they try to get a different way to bring their product across where agents are able to interdict it. And right now, as I stated earlier, it is a free-for-all. And getting rid of Title 42 authority is handing over the key to the drug cartels.

Mr. ROSENDALE. Do you get any feedback from the Attorney Generals around our nation on what kind of time frame it takes from these drugs to enter our country until they are being distributed around the entire nation?

Mr. DEL CUETO. I haven't gotten that feedback from them. I don't know. Maybe the individuals that run the agency, they may have gotten some type of feedback. I haven't. All I can testify to is I see the amount of drugs that are coming through. You see the issues that are happening throughout the country. You see it in the news. And you know the drug cartels, they are aware of policies that are enacted in the United States. And they use whatever they can to bring their drugs across.

Right now, it happens to be the catching and releasing of individuals and distracting agents from one area to the other with a huge volume of people that they bring across.

Mr. ROSENDALE. Unfortunately, I have spoken with the Attorney General about this issue. And, apparently, the cartels are operating with the efficiency of UPS. And it takes approximately 48 hours for those drugs to cross the southern border before they are distributed around Montana.

Are there reasonable estimations of the amount of fentanyl that came across the southern border that was not seized?

Mr. DEL CUETO. There is not. And I know that is not a good answer. But I will tell you what often happens is the way you track the got-aways, one, it could be used with sensor, and it could be

used with cameras. But, oftentimes, the drug cartels are aware of where some of these things are. So, they will go through different areas. It could be as rudimentary as just counting footprints in the sand.

So, it is a guesstimate on the number of got-aways, and it would be a complete guesstimate on the amount of drugs that are coming through. However, when you see that the price of fentanyl, the price of heroin, the price of meth is still cheap in America, that is because there is a huge supply coming through.

Mr. ROSENDALE. What are the relationships that CBP has with the tribal law enforcement and what can be done to improve those to try to get some kind of collaboration in the law enforcement efforts to reduce this fentanyl problem?

Mr. DEL CUETO. It comes down to, obviously, you are dealing with Federal lands. But when agents arrest some of these individuals that are bringing drugs into the country, if it would fail to meet any prosecution guideline within the Federal Government, that the local tribal land might be able to take over the case.

Mr. ROSENDALE. Very good. And as the conditions continue to deteriorate as we speak, what would you take as your main priority message to this body?

Mr. DEL CUETO. We need to enact policies or bring back policies that were under effect before that lowers the amount of individuals coming across because there are actually consequences for them. And as always, if anybody wants to come down here, I know you and several other Congressmen have taken me up on the offer, and they have come down here, and they have seen the reality.

When you come down here and you see the reality of what is happening and how those gaps have been made under the current administration, perhaps individuals will see the difference.

Mr. ROSENDALE. Thank you so much. And, Mr. Chair, I would yield back.

Mr. GARCÍA. The gentleman yields back. A little food for thought. Drug smugglers themselves, with respect to this topic, tell a different story. El Chapo's cartel members testified that they move high value drugs through ports of entry, not across the border. The numbers back that up. Border Patrol agents, for example, seized 332 pounds of fentanyl in 2018, while customs officers at ports seized 1,357 pounds.

Again, this is not a border problem. This is an opioid problem, so just to enrich the conversation.

But before we conclude with this witness panel, are there any Members who have not had their 5 minutes who seek recognition to ask questions now?

If not, I thank the witnesses for their valuable testimony and the Members for their questions. The members of the Committee may have some additional questions for the witnesses. And we will ask you to respond to these in writing under Committee Rule 3(o).

Members of the Committee must submit questions within 3 business days following the hearing, and the hearing record will be held open for 10 business days for these responses.

If there is no further business, without objection, the Committee stands adjourned.

[Whereupon, at 11:40 a.m., the Subcommittee was adjourned.]

[ADDITIONAL MATERIALS SUBMITTED FOR THE RECORD]

PREPARED STATEMENT OF THE HON. STEVE COHEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Thank you, Chair Porter, Ranking Member Moore, Chairman Grijalva and Ranking Member Westerman for holding this important hearing.

The opioid crisis in our country has unfortunately affected millions. The crisis is more profound in minority communities—black, Hispanic, and Native American—than in white communities. Unfortunately, the data is not much of a surprise. Those communities have higher rates of co-morbidities and have historically received less funding for health care. The Native American Community is a prime example of the underfunding.

The Indian Health Service (IHS) has traditionally been underfunded, especially when compared to other health care programs: Medicare spends $13,257 per beneficiary, the Department of Veterans Affairs spends, $9,574, and Medicaid spends $8,093. Yet, the IHS spending per user is a paltry $3,779.

Under President Biden and a democratic majority in the House and Senate, the IHS has seen an increase in funding. In Fiscal Year (FY) 2021, it was funded at $6.2 billion. In the FY22 Omnibus that we passed and was signed into law in March, the IHS received $7.61 billion, an increase of $1.38 billion, or 22 percent more. For FY23, President Biden's budget request recommends $9.1 billion, a $1.5 billion increase over the enacted level for FY22, another 20 percent increase. It would also move the IHS from discretionary spending to mandatory spending. Despite these increases, total IHS per beneficiary will still be at $5,500, approximately 2/3 of what was spent per Medicaid beneficiary in 2021.

I am hopeful that Congress will find the will to continually expand the IHS so that it is more in line with other public health programs and can fulfill its mission to ensure the highest possible health status for Indians and urban Indians. It's the right thing to do.

Statement for the Record

National Indian Health Board

Good morning, Chairman Porter, Ranking Member Moore, and Members of the Subcommittee. On behalf of the 574 federally recognized Tribal nations and the member organizations the National Indian Health Board serves, thank you for the opportunity to provide written testimony on "The Opioid Crisis in Tribal Communities".

Background

The U.S. Constitution recognized the political and government-to-government relationship between the U.S. and Tribal nations. As sovereign nations, the U.S. and Tribal governments entered treaties—which exist in perpetuity—in which the Tribes exchanged millions of acres of land for the federal obligations and responsibilities, including the obligation for the provision of comprehensive health care from the federal government.

The U.S. Supreme Court decisions acknowledged this relationship while also recognizing a trust relationship and obligation to Tribes existed to honor these agreements, among other duties. This trust and treaty obligation extends and applies throughout the federal government, including all agencies. These responsibilities are carried out, in part, by the primary agency, Indian Health Service, within the Department of Health and Human Services (HHS). This agency provides both direct care and resources for health care services to American Indian and Alaska Native (AI/AN) people. Among all federal health care-related agencies, the IHS and the Indian health care delivery system are unique in this regard.

The IHS provides health care services either directly to AI/AN people, or through contracts or compacts with Tribal nations which provide the services. The IHS may also enter contracts with urban Indian organizations to provide health care services to AI/AN people in certain urban locations. For specialty care and other services not available within the Indian health system, the IHS may—contingent upon available funding—purchase or provide funding to Tribes to purchase such care through the Purchased Referred Care program.

According to the IHS, "[t]he IHS provides comprehensive primary health care and disease prevention services to approximately 2.6 million American Indians and Alaska Natives through a network of over 600 hospitals, clinics, and health stations on or near Indian reservations. Facilities are predominantly located in rural primary care settings and are managed by IHS, Tribal, and urban Indian health programs." [1]

Tribal Communities in Crisis

In his December 2021 Advisory, the U.S. Surgeon General found that Native youth were at a higher risk for mental and behavioral health challenges during the pandemic. While the Advisory focused on youth, these findings could also apply to our adults and other health challenges.

Before the pandemic, Tribal communities were already in a behavioral health crisis. According to the National Center for Health Statistics, American Indian and Alaska Native women experienced the highest increase in suicide rates of 139% from 1999 to 2017. The men between the ages of 15 to 44 experience the highest rates of suicide of all race and ethnicity groups.

The overall death rate of adults from suicide is about 20 percent higher compared to the non-Hispanic white population.[2] Suicides have skyrocketed for Native veterans, from 19.1 to 47 in 100,000 persons.[3] But most shocking, for those aged 18 to 39, it was 66 in 100,000 persons.

These facts, combined with down-spiraling health disparities experienced by AI/ANs, demonstrate the human consequences of underfunding IHS. Deferral of care due to funding and workforce shortages has pushed more and more Tribal members into health conditions wherein prescription opioids are used to treat chronic pain that would otherwise successfully be treated earlier with non-opioid therapies, if they were available. Failure to address basic health needs through routine visits

---

[1] Justification of Estimates for the Appropriations Committees. Department of Health and Human Services. Fiscal Year 2022. Indian Health Service. At CJ-1.

[2] Office of Minority Health. Minority Population Profiles, American Indian and Alaska Natives. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=39. Accessed on March 21, 2018.

[3] High suicide rates in American Indian/Alaska Native veterans—Wolters Kluwer.

and preventative care also has led to preventable diseases becoming fatal when the diagnoses are too late to seek treatment.

Congress Must Invest in Tribal Communities for Prevention and Treatment

Congress must tackle these issues head-on with aggressive funding for prevention and treatment measures for Tribes. The Indian health system is underfunded by nearly 50% of the minimum levels necessary to begin addressing the existing health care disparities. In FY 2020, the national health expenditure was $12,530 per capita which also accounted for COVID-19 relief spending. In FY 2019, the national health expenditure was $11,582 per capita. In FY 2019, based on the latest information provided by the IHS, the IHS expenditure was only $4,078 per user population. As funding gaps grow and the IHS funding increases cannot close those gaps, the AI/AN people suffer.

The persistent chronic underfunding of the IHS, historical trauma, and other social and economic conditions contribute to the unacceptable health conditions. The AI/AN people often face the most significant health disparities among all populations in the United States—besides behavioral health challenges—including diabetes, suicides, and COVID-19 infections, hospitalizations, and deaths.

The pandemic devastated our communities. It highlighted the consequences of chronic underfunding. For example, according to the Substance Abuse and Mental Health Service Administration, 13% of the Native population needs substance abuse treatment, but only 3.5% receives any treatment.

Programs with treatment approaches that include traditional healing and cultural practices have been reportedly more successful. However, again, due to lack of funding availability and the challenges with the grant-funded model, several culturally responsive in-patient treatment centers have had to close their doors leaving major gaps in service availability and more specifically availability of detox beds with the rising number of opioid and/or other addictions. Opioid and heroin use is high in many IHS regions, with limited treatment facilities available.

In FY 2008, Congress appropriated $14 million to support a national methamphetamine and suicide prevention initiative to be allocated at the discretion of the IHS director. Today, those funds continue to be allocated through competitive grants, despite Tribal objections. For over a decade, Tribes have noted that IHS reliance on grant programs is counter to the federal trust responsibility and undermine self-determination tenets. Furthermore, because grant funding is never guaranteed, vulnerable communities, with the greatest needs but least capacity, often slip through the cracks. The needed increase must be applied to IHS funding base and away from the inefficient use of grants in order to stabilize programs and ensure the continuity of the program and care to our struggling Tribal members and their families.

Tribes have recommended full funding of the Indian health care system at $49.8 Billion beginning in FY 2023. The fundamental responsibilities of IHS to deliver excellent health care and reduce health care disparities—including opioid overdoses and use—cannot happen without the appropriate support and resources from Congress.

However, these services must be provided in appropriate settings and facilities. Specialty care and other health care facilities are also necessary to make an impact on these problems. In 2010, Congress authorized the construction of inpatient behavioral health and other specialty facilities, such as long-term care and dialysis. While suicides, other health problems, and costs escalate, construction of these specialty care facilities has yet to be funded. In fact, Congress has not funded the completion of several health care facilities still on a nearly 30-year-old, 1993 waiting list. The IHS has indicated that the health care and specialty care facilities construction cost alone is now up to $22 Billion—yet Congress funded the entire Indian health care **system** at only $6.6 Billion for FY 2023.

As a result, Tribal leaders and health policy experts determined that full funding of the IHS at $49.8 Billion is required to make a difference. This figure takes into account medical and non-medical inflation, compliance with costly federal mandates, and other emerging needs. It also uses a more accurate per user benchmark based on the national health expenditure.

Congress Can Swiftly Adopt Legislative Behavioral Health-Related Improvements

Native Behavioral Health Access Improvement Act. The bill, H.R. 4251, the Native Behavioral Health Access Improvement Act, was introduced by Representatives Frank Pallone and Raul Ruiz on June 30, 2021. It was referred to the House Committee on Energy and Commerce, Subcommittee on Health, and the Committee on Natural Resources.

There is a Senate companion bill as well, S. 2226, introduced by Senators Smith and Cramer on June 24, 2021. The bill was referred to the Senate Committee on Indian Affairs, but no further action has been taken.

This bill would amend the Indian Health Care Improvement Act by establishing a special behavioral health program for Indians to treat and prevent mental health and substance use disorders. It would provide funding through grants to the IHS, Tribes and urban Indian health programs at $200 Million for each fiscal year from 2022 to 2026 according to a formula developed through consultation with Tribes and urban Indian organizations. The grantees would agree, as a condition of receiving funds, to submit data and reports consistent with the submission requirements established through consultation.

This base funding is important to Tribal communities and would complement the comprehensive behavioral health provisions of Title VIII of the Indian Health Care Improvement Act. Likewise, the interplay of the Indian Self-Determination and Education Assistance Act with the funding approaches, data collection, and reporting requirements is a necessary consideration to ensure this legislation is most effective for Tribal communities in reducing the opioid and other behavioral health crises. We urge Congress to move swiftly on finalizing this bill in close collaboration with NIHB and Tribal nations.

Comprehensive Addiction Resources Emergency Act of 2021. On December 16, 2021, Representative Maloney introduced the Comprehensive Addiction Resources Emergency Act of 2021. There are 105 co-sponsors. This Senate companion bill, S. 3418, was introduced by Senator Warren and is currently pending before the Senate Health, Education, Labor, and Pensions Committee.

The bill requires the Secretary of the Department of Health and Human Services to provide grants to address substance abuse and increase access to preventive, medical, and recovery care. It includes direct funding to Tribal nations and includes Tribal representation on the planning council, among other things.

The bill has been referred to four Committees including the Natural Resources Committee. We urge this Committee to secure swift passage of this bill and NIHB and Tribal nations stand ready to join you in this effort.

Conclusion

Aggressive solutions are needed to make a difference. The President challenges Congress to move the bar through his FY 2023 Budget Request for the IHS and his mental health initiative introduced in his State of the Union address. Indian Country challenges Congress to also make a difference and move in the right direction. NIHB and Tribal nations stand ready to join in this fight for the lives, health, and future of American Indians and Alaska Native people.

[LIST OF DOCUMENTS SUBMITTED FOR THE RECORD RETAINED IN THE COMMITTEE'S OFFICIAL FILES]

Submissions for the Record by Rep. Moore

—Report titled, "2020 Drug Enforcement Administration National Drug Threat Assessment," from the U.S. Department of Justice, Drug Enforcement Administration, dated March 2021.

—Report titled, "FY 2019 Year End Report: U.S. Department of the Interior, Bureau of Indian Affairs—Office of Justice Services, Division of Drug Enforcement," dated 2020.

○