Testimony of the California Rural Indian Health Board
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House Subcommittee for Indigenous Peoples of the United States
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Good afternoon Chairman Gallego, Ranking Member Cook, and other distinguished Members of the House Subcommittee for Indigenous Peoples of the United States (US). Thank you for holding this important hearing. I am honored to testify on behalf of the California Rural Indian Health Board, Inc. (CRIHB).

My name is Anna Scrimenti and I am a Health Policy Analyst for CRIHB. CRIHB was founded in 1969 and operates as a Tribal organization under the authority of the Indian Self Determination Act to provide health care related services to federally recognized Tribal Governments in the state. We have a membership of 59 Tribes and 19 Tribal Health Programs.

All branches of the federal government have a trust responsibility to partner with Tribes. This includes administrative services such as the Indian Health Service (IHS). The Mission of IHS is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AIAN) to the highest level. Given this, I am here today to recommend this subcommittee support H.R. 4495, introduced by Congressman Ruiz.

The bill would authorize the Secretary of Health and Human Services, acting through the Director of the IHS, to acquire private land to facilitate access to the Desert Sage Youth Wellness Center in Hemet, California (CA), and for other purposes.

The Desert Sage Youth Wellness Center is a 35,500-square-foot IHS Youth Regional Treatment Center (YRTC). Desert Sage provides culturally-sensitive substance use treatment for AIAN youth. This facility is a necessary resource for AIAN youth as it is the first YRTC in the state of California. The co-ed in-patient residential treatment facility has 70 full-time staff and 32 beds for youth ages 12-17 with substance abuse and co-occurring disorders.

In addition, there are five suites for families to facilitate their participation in treatment on-site. Previously, AIAN youth attended out-of-state treatment facilities that inconveniently removed them from their critical support systems during recovery. Effective treatment is important not only for these youth and these families, but for the continued survival of their tribal communities.

AIAN youth are disproportionately impacted by substance use, addiction, overdose and suicide. A 2018 study found that AIAN youth in 8th, 10th, and 12th grades were significantly more likely

than non-Native youth to have used alcohol or illicit drugs in the past 30-days.[1] According to the Centers for Disease Control and Prevention, suicide rates for AIANs across 18 states were reported at 21.5 per 100,000 – 3.5 times higher than demographics with the lowest rates.[2] Drug overdose deaths among AIANs increased 519% from 1999 to 2015 – the highest percentage increase of any population.[3] According to the Substance Abuse and Mental Health Service Administration, in 2013 AIAN youth aged 12 and older reported the highest percentage of Substance Use Disorders, more than any other racial/ethnic group at 14.9%.[4] Access to Desert Sage is critical to address these disparities.

The only access to Desert Sage is a dirt and gravel road. The extreme wet and dry seasons in CA cause significant access issues to the facility. When the facility was built in 2016, the IHS was unable to reach an agreement with the private landowners between the facility and the main road to build a driveway that went across the edge of the property. As such, the facility is currently accessed only by that dirt and gravel road which frequently washes out or cracks.

H.R. 4495 gives IHS the authority to purchase the required land, build the road to Desert Sage, and then transfer the road to the county for operation and maintenance as a county road.

Again, I respectfully recommend the subcommittee support H.R. 4495. It is critically important to acquire and construct the road as soon as possible to ensure adequate accessibility to life-saving services.

Thank you again for the opportunity to offer this statement. Please do not hesitate to contact the CRIHB office directly if you have any questions or if you require additional information.

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[1] 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. doi:10.1001/jamanetworkopen.2018.0382

[2] Leavitt RA, Ertl A, Sheats K, Petrosky E, Ivey-Stephenson A, Fowler KA. Suicides Among American Indian/Alaska Natives — National Violent Death Reporting System, 18 States, 2003–2014. MMWR Morb Mortal Wkly Rep 2018;67:237–242. DOI: http://dx.doi.org/10.15585/mmwr.mm6708a1

[3] Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12. DOI: http://dx.doi.org/10.15585/mmwr.ss6619a1

[4] Substance Abuse and Mental Health Services Administration (SAMHSA) Tribal Affairs, SAMHSA Native American and Alaska Native Data Handout: https://www.samhsa.gov/sites/default/files/topics/tribal_affairs/ai-an-data-handout.pdf