Oglala Sioux Tribe
P.O. Box 2070
Pine Ridge, S.D. 57770
Phone: (605) 867-8420

Office of the President

Written Testimony of Frank Star Comes Out
President of the Oglala Sioux Tribe

House Committee on Natural Resources
Subcommittee on Indian and Insular Affairs

"Challenges and Opportunities for Improving Healthcare Delivery in Tribal Communities"
March 29, 2023

The Oglala Sioux Tribe appreciates the opportunity to submit testimony for the record for this important Subcommittee hearing. Improving the healthcare delivery to tribal communities, especially to our people on our Pine Ridge Indian Reservation, is one of our Tribe's highest priorities. It is past time for the Federal Government to take the bold actions required to finally ensure our people have the high quality of healthcare they deserve. Our Treaty requires it. For too long our people have suffered from inadequate healthcare delivery. We hope this testimony will help Congress finally fix this.

Introduction

The Oglala Sioux Tribe has approximately 54,000 members. It is a member of the Oceti Sakowin (Seven Council Fires, known as the Great Sioux Nation). The Tribe was a party to an 1825 Treaty (7 Stat. 252), which in Article 2, brought the Oglala Sioux Tribe under the protection of the United States and the Oglala Sioux Tribe has been a protectorate Nation of the United States ever since. This treaty established the legal relationship between the Oglala Sioux Tribe and the United States. The Oglala Sioux Tribe is also a signatory to the Fort Laramie Treaty of 1851 (11 Stat. 749) and the 1868 Sioux Nation Treaty (15 Stat. 635). The Fort Laramie Treaties of 1851 and 1868 cemented the United States' obligations to the Oglala Sioux Tribe. In Articles IV and XIII of the Fort Laramie Treaty of 1868 the United States specifically committed to providing healthcare to the Sioux people. In *Rosebud Sioux Tribe v. United States*, the Eighth Circuit affirmed that the United States Government has a judicially enforceable duty to provide competent physician-led healthcare to us as a signatory of the Fort Laramie Treaty of 1868, and because of the numerous promises and commitments the Federal Government has made to

provide healthcare for Tribes.[1] Despite this, the chronic underfunding of the Indian Health Service (IHS) and Indian Country programs in general has taken an enormous toll on our Tribe and our citizens.

We look to you to fulfill the Federal Government's obligations, and we look forward to working with this Subcommittee to ensure the legal and policy authorities are in place along with fully-dedicated funding for the IHS programs that serve Tribal Nations and Native people so that our people get the high-quality healthcare they deserve. We emphasize that our Tribe is a *direct service tribe*: our healthcare is delivered directly from the IHS as a treaty obligation, with certain programs that we have contracted to carry out ourselves. Thus, we need Congress to dedicate full funding to the IHS to carry out its treaty obligation to deliver high-quality healthcare to our people and full funding to the specific programs we carry out via 638 contracts with the IHS.

Full funding of Indian Country healthcare programs is demanded of the Federal Government because of the Treaty and trust obligations owed to our people. Any cuts to such programs would be devastating given the historic and severe underfunding of such programs and the impact that has had on our people. All of the Indian healthcare programs need attention. Below, however, we focus on certain specific high priorities for our healthcare. We also lay out the overarching needs of our Reservation and the Great Plains Area overall, which warrant congressional action to address.

First, to focus the vast and desperate need to correct the healthcare delivery inadequacies on our Reservation and in the Great Plains Area, we remind you of former Chairman Byron Dorgan's 2010 Senate Committee on Indian Affairs Report, *In Critical Condition: The Urgent Need to Reform the Indian Health Service's Aberdeen Area* (commonly known as the "Dorgan Report.") The Dorgan report identified "deficiencies in management, employee accountability, financial integrity, and oversight of IHS' Aberdeen Area facilities" and reported that "these weaknesses have contributed to reduced access and quality of health care services available to patients."[2] The Pine Ridge Service Unit, which provides healthcare for the Oglala Sioux Tribe, had the second highest incidence of employee grievances in the Aberdeen Area.[3] The Report chronicled "substantial" diversion of health care services due to a range of issues "including a shortage of providers, inadequate reimbursement from public and private insurers, and lack of bed availability.[4] The Dorgan report also identified a linkage between the understaffing of pharmacist positions in IHS facilities with a substantial issue in the area of loss and theft of narcotics and controlled substances from these pharmacies.[5] In addition, "[o]ther reasons for service diversions included: no available inpatient beds, nonworking equipment, water outages,

[1] *See Rosebud Sioux Tribe v. United States*, 9 F.4th 1018 (8th Cir. 2021); *and see Blue Legs v. U.S. Bureau of Indian Affairs*, 867 F.2d 1094 (8th Cir. 1989) (Snyder Act imposes affirmative obligations on Federal Government to provide healthcare to Tribes).
[2] U.S. Senate Committee on Indian Affairs, *In Critical Condition: The Urgent [Need] to Reform the Indian Health Service's Aberdeen Area*, 4 (Dec. 28, 2010) ("Dorgan Report").
[3] Dorgan Report, 14.
[4] *Id.* at 19.
[5] *Id.* at 15.

and high humidity."[6] We regret to report that, unfortunately, such severe problems have persisted almost thirteen years later.

More recently, the Government Accountability Office (GAO) testimony addressed the quality of healthcare provided by the IHS and concluded that the IHS provided limited and inconsistent oversight over the timeliness and quality of care provided in its facilities, and that those "inconsistencies in quality oversight were exacerbated by significant turnover in area leadership."[7] In addition, the GAO testimony reported that incomplete funding of the Purchased/Referred Care program has resulted in gaps in services that delay diagnoses and treatments, which can exacerbate patient issues and necessitate more intensive treatment.[8] We also point you to the 2018 Broken Promises Report, which conveys that the problems with the Federal Government's delivery of healthcare to Native people persist, stating "[O]ver the years, Native American health care has been chronically underfunded" and cites statistics showing that in 2017, IHS health care expenditures per person were $3,332, compared to $9,207 for federal health care spending nationwide."[9] These reports provide a mere sketch of what healthcare looks like for our people.

We support the testimony provided to the Subcommittee by Jerilyn Church on behalf of the Great Plains Tribal Leaders Health Board. However, we note that there were no witnesses presenting at the hearing representing direct service tribes. As a direct service tribe, we implore you to take action to address the following issues.

I. Protect & Strengthen the Indian Health System

Modernize the Funding Model: the President's FY 2024 Request

A. Move the Entire Indian Health Service Account to Mandatory Spending and Fully Fund the Indian Health Service

At present, Indian Country healthcare is frustratingly vulnerable to federal shutdowns and Indian Country healthcare is the *only* major federal healthcare system subject to this treatment. The healthcare provided by the Veterans Health Administration—the Federal Government's other non-entitlement health program—is not subject to federal shutdowns, and the same should be true for the Indian Health Service. *We, therefore, urge Congress to move the entire Indian Health Service (IHS) account over to mandatory spending*. Our Treaties call for this. These changes would ensure that our services are not interrupted by political machinations far outside

[6] *Id*. at 20.
[7] Government Accountability Office, *High Risk: Status of Prior Recommendations of Federal Management of Programs Serving Indian Tribes*, 2, GAO 17-790T (Sep. 13, 2017).
[8] *Id.* at 19.
[9] United States Commission on Civil Rights, *Broken Promises: Continuing Federal Funding Shortfalls for Native Americans* (December 2018) at 66-67; see all of Chapter 2 for discussion of Health Care; *see also* Government Accountability Office, *Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs*, GAO-19-74R (Dec. 10, 2018).

of our control. Continuous funding will also ensure that Native people are no longer treated as second class citizens—entitled only to a lesser type of federal healthcare.

Barring the mandatory and full funding of all IHS accounts, Congress must do everything in its power to minimize service interruptions for the Indian Health Service. The Consolidated Appropriations Act of 2023 took the monumental first step toward sustainable funding of the IHS by providing advance appropriations for FY 2024. But Congress must maintain this momentum and provide advance appropriations once again. We urge you to provide advance appropriations for FY 2025 and beyond so that health care programs can actually undertake long-term planning and our patients can rest assured that their treatments will continue even in uncertain political times. Relatedly, we support the proposal to immunize IHS from the federal budget sequestration process.[10] Healthcare cannot be something that is blindly cut as the collateral damage of a political impasse in Washington, D.C.

In addition to making the entire Indian Health Service Account mandatory spending, Congress must FULLY fund the IHS. The President's 2024 IHS budget includes a 10-year plan to close funding gaps, a move that we support because it would not only provide greater stability for the IHS but it would provide more money for healthcare programs. While we do support this request, the bottom-line is that Congress must fully support the IHS so it and the tribes that contract or compact its programs, services, functions and activities can do so at the level of need and without being extremely under-resourced, as they are now—especially in the Great Plains Region.

B. Permanently reauthorize the Special Diabetes Program for Indians

Congress must reauthorize the Special Diabetes Program for Indians and should do so before the program expires later this year. The Program has been a tremendous success story for public health and for Indian Country. From 2013 to 2017, diabetes in American Indian and Alaska Native adults decreased from 15.4% to 14.65%; and end-stage renal disease due to diabetes fell by 54% between 1999 and 2013.[11] What these numbers hide, however, is that the incidence of these health outcomes not only *did not rise*, but *fell* despite an increasingly unhealthy dietary and lifestyle environment of fast-food, processed and pre-packaged meals, and reduced mobility. In addition, the Office of the Assistant Secretary for Planning and Evaluation reported in 2019 that the 54% decrease in end-stage renal disease in American Indian and Alaska Native populations saved Medicare an estimated $436 million to $520 million over a ten-year period.[12] The Program is doing what Congress intended it to do, and it has returned measurable success. Permanent reauthorization and continued funding of this program will ensure that the

[10] Department of Health and Human Services, *Fiscal Year 2024 Indian Health Service Justification of Estimates for Appropriations Committees*, (hereafter IHS Budget) CJ-248.
[11] National Indian Health Board, SDPI Overview https://www.nihb.org/sdpi/sdpi_overview.php (accessed Mar. 30, 2023).
[12] Office of the Assistant Secretary for Planning and Evaluation, *The Special Diabetes Program for Indians: Estimates of Medicare Savings* (May 9, 2019) https://aspe.hhs.gov/reports/special-diabetes-program-indians-estimates-medicare-savings.

hard work and resources that made the last twenty years of the program a success will not be lost and that we will keep making strides for the next generation. Accordingly, we support the President's budget request of $250 million for the program for FY 2024, $260 million for the Program for FY 2025, and $270 million for the program for FY 2026,[13] and we implore Congress to permanently reauthorize the Program.

C. Implement the North And South Dakota State-Wide Purchased/Referred Care Delivery Area

We support the President's proposal to appropriate $12 million to actually implement the North and South Dakota State-wide Purchased/Referred Care Delivery Area (PRCDA).[14] However, the budget must also include additional funding to pay for the additional Purchase Referred Care (PRC) services that will be needed as a result of expanding the PRCDA. As the President's request notes, a 2010 amendment to the Indian Healthcare Improvement Act directed the IHS to establish this Purchased/Referred Care Delivery Area, but the IHS has not done so. Establishing this Delivery Area will ensure that tribal members located anywhere within those states are able to access needed Purchased/Referred Care services. This is critically important as many of our members live in the State but outside the current PRCDA and therefore are not eligible for PRC services even though they desperately need them. IHS estimates that implementing this provision will provide services to 24,000 tribal members in the Dakotas.[15] This provision of the Act must finally be implemented and adequate additional funding must accompany this authorization.

D. TRANSAM Program

The President's FY 2024 budget requests $500,000 for the TRANSAM program so that IHS can purchase medical equipment and ambulances from the Department of Defense. While we wholeheartedly support the acquisition of needed equipment and vehicles for IHS and tribal facilities, we object to this manner of acquisition. First, the Department of Defense and the Indian Health Service are both arms of the Federal Government. Under this model, the Indian Health Service—one of the most historically and egregiously underfunded federal agencies—is required to draw funds from its budget to pay the Department of Defense—one of the wealthiest and most excessively funded Federal agencies—to gain access to basic healthcare delivery necessities. Taxpayer dollars helped fund the Department of Defense's purchases of this equipment. There should not be another toll, especially one that will severely impact Native peoples via a reduction in IHS dollars. Congress must fix this facially inequitable policy and authorize the Defense Department to donate the equipment to the IHS.

[13] IHS Budget, CJ-242.
[14] IHS Budget, CJ-136.
[15] *Id*. at CJ-137

Modernize the Funding Model: Other Proposals

Congress must fully fund and implement all provisions of the Indian Healthcare Improvement Act.[16] Those heretofore unfunded authorities in that Act are expected to help with workforce development, behavioral healthcare, and substance use management, and are expected to improve access to healthcare generally, but for long-term and home-based care in particular.[17] Fully funding these provisions will provide long-overdue resources for IHS and tribal facility construction and maintenance projects to ensure that our community has access to modern, state-of-the-art healthcare facilities.

We support the 2022 policy recommendations of the National Indian Health Board regarding Medicare reforms to improve access to and obtain financial support for Indian healthcare.[18]

The Federal Government should facilitate tribal governments' decisions to assume healthcare delivery, but it also must acknowledge and act on the fact that even when those assumptions occur the federal government cannot evade its Treaty and trust obligations. That said, we support the expansion of contracting and compacting under Titles I, V, and VI of the Indian Self-Determination Education and Assistance Act and the opportunity for to decide for themselves how best to ensure their citizens have the best healthcare services possible. The Federal Government must support tribally run programs, but also continue to uphold its Treaty and trust obligations whether a Tribe is direct service, operates entirely under a 638 contract, or some combination. We emphasize that our Tribe is a direct service tribe: our healthcare is delivered directly from the IHS as a treaty obligation, with certain programs that we have contracted to carry out ourselves.

Provide Adequate Supportive Infrastructure

We have significant infrastructure problems in the Great Plains region. In particular roads, bridges, and culverts are in terrible shape, despite our repeated pleas for federal assistance. These conditions delay emergency response times and at times our roads are impassable. If we are going to seriously address the challenges of healthcare delivery in the Great Plains Region, we need Congress to also take bold measures to build and maintain our roads so that they do not pose a hindrance to routine and emergency medical care. Congress must adequately fund the Bureau of Indian Affairs roads accounts and create a new roads maintenance account, not subject to the formula, that targets backlogged road and bridge projects by taking mile inventory, remoteness, and weather conditions into consideration.

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[16] National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 14-15 https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf.
[17] *Id.*
[18] National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 47-49 https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf.

Conduct an Audit of the IHS

Tribes have a right to know *exactly* where federal appropriations to the IHS go, especially direct service tribes like ours. We ask Congress to require the IHS to conduct a comprehensive audit at the Central, Regional and Service Unit levels, and make that audit available for Tribes to review and comment on in government-to-government consultation.

II. Build the Healthcare Workforce

We need Congress to employ a multi-faceted approach to improve the healthcare workforce. Most urgently, we need Congress to appropriate funds and legislate additional enticements for the recruitment and retention of healthcare workers for Indian Country and specifically on our Pine Ridge Reservation. These funds and enticements must cover not only physicians, dentists, and other specialists, but must support the employment of administrative professionals and other staff. At a minimum, these resources must support full staffing of our current facilities. Salaries must be competitive with other healthcare positions so that we are not losing professionals to wealthier areas of this country. Moreover, given the unique hardships on the Pine Ridge Reservation, we support the idea that healthcare workers in our area be entitled to higher and/or hazard pay to incentivize them to come and serve our community.

Because of the urgent need to fill positions in our area, we support the President's proposals regarding discretionary Title 38 hiring authorities for IHS, authority for IHS to conduct 60-day mission critical emergency hiring, application of Title 38 on-call pay to IHS, and authority for IHS to hire and pay experts and consultants to address particularized needs.[19]

It is important to not only recruit healthcare workers to our Reservation, but also to retain them. This is the only way our people can even begin to receive any continuity of care: through healthcare providers who get to know them, which, importantly, will lead to our people coming to trust them. As it stands now, our people have very little trust in the IHS's Pine Ridge Service Unit. This is a core problem that needs to be addressed. Retainment of healthcare professionals on our Reservation would be a good first step toward addressing this core problem.

We also need Congress to provide funding for our community to build the housing units necessary to support our healthcare workforce. As we have testified before to many different committees, we have a housing deficit of 4,000 homes on our Reservation. We cannot attract (or retain) healthcare professionals to our area if we have no place for them to live. Our reservation is approximately the size of the entire country of Cyprus; it is simply too vast for healthcare providers to commute long-distance. We need housing directly in the vicinity of our facilities.

We need Congress to get to work on growing the healthcare professional pipeline for Indian Country. We need additional funding and authorities that would better facilitate an educational and training pipeline for more Native people to join the ranks of healthcare

[19] IHS Budget, CJ-287-88, CJ-295-96, CJ-298-99, CJ-296-97.

professionals. Congress should also expand the availability of scholarships and loans for medical education in service of Indian Country and should expand loan forgiveness for similar service. The cost of graduate medical education has surpassed the value of the incentives Congress is currently providing. These programs must also provide flexibility for graduating students to choose to go home to serve their communities. As a small step toward addressing these issues, we support the President's proposals to provide federal income tax exemptions for scholarship and loan repayment funds and to permit scholarship and loan repayment on a half-time but double duration basis.[20]

Our native community has brilliant, hard-working, and service-minded students who want to work for the benefit of our people. The Community Health Aide, Dental Health Aide, and Behavioral Health Aide Programs that debuted as pilot programs in Alaska work to train Native students to provide culturally informed community-based care. This is consistent with how we have healed our sick since time immemorial. Congress should fund these programs at scale across Indian Country as soon as possible.

Relatedly, we need resources to provide traditional healing to ensure that our healers can take care of themselves while they take care of others. It is often the case in our tradition that our healers do not ask for money or compensation in exchange for their services, as such a transactional concept is not native in origin. Nevertheless, we recognize that our healers need to be able to provide for themselves in a modern capitalist economy. Accordingly, we need for IHS and tribal facilities to have the flexibility to support our healers in various ways. First, reimbursement of traditional healing services through Medicare and Medicaid would help our facilities support our healers and our patients who request their services. Second, we need healthcare coverage for tribal healers to provide services outside of the physical clinic environment because some ceremonies are not appropriately conducted nor possible inside a health clinic. We need for our healers to be able to provide covered care in the manner they see fit, unrestrained by federal statute or regulation. We also need the Federal Government to respect us and our healers when we decline to provide details about sensitive traditional knowledge and ceremonial practices.

Finally, Congress should devote attention and funding to cultivating a pool of talented professionals able to competently teach our youth by focusing on culturally relevant professional development (in collaboration with Tribal colleges and universities). Science, technology, engineering, the arts, and mathematics (STEAM) training and education is especially important to building holistically trained healthcare professionals to serve our Tribe. With that in mind, our Tribe is working toward creating a Tribal Research and Training Center, which would encourage our citizens to pursue careers in STEAM fields. The Center would also serve as a data and research hub where we can research, collect, and analyze our own data for use in support of initiatives to benefit our citizens in a broad spectrum of areas from health to economic development. Facilities that house valuable professional development in the community improve

[20] IHS Budget CJ-291-92, CJ-289-290.

health outcomes and are the backbone of a healthy economy. We ask for financial support as we pursue this project.

III. Learn from the Pandemic

The pandemic taught us many lessons, the importance of an emergency response plan chief among them. We struggled to navigate federal bureaucracy during the pandemic to access life-saving personal protective gear and other resources from our federal partners. Tribes sought access to the Strategic National Stockpile and other federal repositories but were met with long wait times and insufficient communication. Knowing what we know now, we need Congress to cut through red tape to ensure that tribes have a direct through line to the federal government (not through states) to access federal emergency resources.

We also need the Federal Government to improve data sharing with our tribal health providers so that we can implement agile responses to quickly evolving crises and for everyday use. This should not require the implementation of data sharing agreements since Tribes (and tribal epidemiology centers) are federally recognized public health authorities.[21] Since there has been some confusion on this matter, we need Congress to legislate to clarify that data sharing agreements are not required for sharing public health data with Tribes. We also need the Federal Government to provide a national catalog of available resources.

We ask Congress to glean the best practices from the COVID-19 pandemic, which were developed in real-time during the pandemic and perfect them in consultation with Tribes for use in future public healthcare emergencies.

IV. Resources for Our Other Pandemics: Crises in Mental Health, Drug Addiction, and Crimes Against Our People

Mental Health

Between 2001 and 2020, suicide was the leading cause of death of American Indian and Alaska Native children in South Dakota aged 10 to 14 and the second leading cause of death for those aged 15 to 24 and 25 to 34.[22] On our Reservation alone, the suicide rate is twice the national average for all ages and four times the national average for teenagers.[23] Our children

[21] *See* 45 C.F.R. § 164.501 (defining "public health authority" to include a Tribe).

[22] Centers for Disease Control and Prevention, *WISQARS Leading Causes of Death Visualization Tool*, https://www.cdc.gov/injury/wisqars/fatal.html. Nationwide, suicide is the second leading cause of death for AI/AN across the same time frame for all three groups. However, in 2020 suicide became the leading cause of death in the 10-14 age range nationwide.

[23] Patrick Strickland, *Life on the Pine Ridge Native American reservation*, Al Jazeera (Nov. 2, 2016) https://www.aljazeera.com/features/2016/11/2/life-on-the-pine-ridge-native-american-reservation.

and youth are in distress. Worse, this is a well-known problem which we have all failed to correct.[24]

The United States has, for years, watched as the mental distress of American Indian and Alaska Native people has increased to the point where the despair of our people eclipses all others. Congress must act on this. These statistics prove that the United States has failed to honor its Treaty and Trust responsibilities to our people. Interpreting the same laws that affect our Tribe, the Eighth Circuit in *Rosebud Sioux Tribe v. United States* affirmed that the United States Government has a judicially enforceable duty to provide competent physician-led healthcare to the Rosebud Sioux Tribe. In coming to that conclusion, the court considered the promises the United States Government made to provide medical care in the Fort Laramie Treaty of 1868 (to which we are subject), to authorize appropriations for the "relief of distress and conservation of health" in the Snyder Act, and to raise the health status of Indians to the "highest possible level" in the Indian Healthcare Improvement Act.[25]

Congress needs to address the epic mental health challenges we face through funding and bold legislative actions. We need resources for behavioral and mental health prevention and intervention for all of our people. We need services for those who are depressed, have suicidal ideation, and have attempted suicide in the past. We need services for the family members, friends, and colleagues who lost someone to suicide. We need to be flexible and innovative in the delivery of these services and to reduce barriers to access and stigma associated with these services. We need to provide our youth and families with life and socio-emotional learning skills so that they are able to navigate the everchanging world in which we live in now. We need resources to recruit, retain, and house mental health professionals on our Reservation, including trauma resource counselors for our schools. All of these professionals must be paid competitive salaries so they will come and stay and help us turn the tide of mental health on our Reservation.

One of our top funding priorities is the completion of a Youth Rehabilitation Center to address the youth opioid, suicide, and alcohol abuse epidemic on our Reservation. The 29,987 square foot facility would provide targeted residential treatment services for female and male patients coping with opioid addiction, alcoholism, and sexual trauma. Through this facility, Lakota youth will be able to receive comprehensive mental and behavioral health services in their home community. We envision that counselors, caseworkers, therapists, medical professionals, and family members will be involved in creating and sustaining a safe environment for our youth to heal and make progress towards their goals. We need funding for facilities, administration, security, support services, and to hire a Project Manager. Financing this

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[24] National Indian Council on Aging, Inc., *American Indian Suicide Rate Increases* (Sep. 9, 2019) https://www.nicoa.org/national-american-indian-and-alaska-native-hope-for-life-day/ (suicide rate up 139% for AI/AN women and 71% for AI/AN men between 1999 and 2019); Deborah Stone, Eva Trinh, et. al. *Suicides Among American Indian or Alaska Native Persons—National Violent Death Reporting System, United States, 2015-2020,* CDC Morbidity and Mortality Weekly Report (Sep. 16, 2022) https://www.cdc.gov/mmwr/volumes/71/wr/mm7137a1.htm (suicide rates among non-Hispanic AI/AN persons increased nearly 20% from 2015 to 2020).

[25] *Rosebud Sioux Tribe v. United States*, 9 F.4th 1018 (8th Cir. 2021).

position would allow project development to move forward for the betterment of the mental, physical, and spiritual welfare of our Lakota youth.

Drug Addiction

Our Tribe is also fighting a tidal wave of substance use disorders. The problem escalated to the point that our Tribe declared a State of Emergency due to the increasing rates of homicide and methamphetamine use on our lands.[26] Such activities are antithetical to the Lakota way of life and the balance of our society. Despite the documented and increasing rates of these issues, we lack the facilities and trained personnel to mount a comprehensive response.

One of our most pressing needs is for on-reservation drug treatment facilities. We need detox facilities, and our existing residential and outpatient treatment facilities are in desperate need of renovations to accommodate additional patients. We would also like to offer skills-based transitional living facilities to assist patients with their long-term recovery goals, but we lack the necessary resources for their development and operation. We need funds for harm reduction services, medication-assisted treatment, diversion programs, and for peer recovery support systems.

We also desperately need funding to specifically address the law enforcement, public health, and mental health impacts of the opioid and methamphetamine epidemics on our Reservation. We need funding to purchase Naloxone and similar overdose kits for our public spaces, and to support training of law enforcement officers and other public officials on the use of such medicines. We need funding for education initiatives targeted at preventing drug use. We need funding to support families who have lost someone to this epidemic and for those who are dealing with the ongoing traumas of having a loved one struggling with this addiction. We need the Federal Government to focus on this crisis and develop and fund these initiatives and others to combat it. We also need support for us to provide culturally appropriate healing practices the way we see fit.

It should go without saying that our Native veterans deserve a proportional investment in mental health and substance use resources. American Indian and Alaska Natives serve in the United States Armed Forces at a rate five times the national average.[27] Like all veterans, our Native veterans face monumental struggles with depression, alcoholism, post-traumatic stress

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[26] In 2016, we saw the number of homicides on the Pine Ridge Reservation nearly double in what was widely reported to be crime fueled by an increase in methamphetamine use. In early 2017, the FBI reported that the drugs were coming to the Reservation from outside areas, such as Denver. Tiffany Tan, *FBI: Murders down 80% on Pine Ridge following meth-fueled spike in 2016*, RAPID CITY JOURNAL, (Mar. 4, 2018) https://tinyurl.com/498cz7dk; *see also* ASSOCIATED PRESS, *Homicides on Pine Ridge reservation nearly doubled in 2016*, (Feb. 12, 2017) https://apnews.com/article/6d7b7f5f215b47a299e65eca09466a16. Last year, this theory was confirmed after six individuals were convicted in a meth conspiracy after trafficking meth into South Dakota from Colorado, primarily to the Pine Ridge Reservation. Hunter Dunteman, *Six convicted in Pine Ridge meth conspiracy after 'pounds' of drug entered South Dakota*, MITCHELL REPUBLIC, (Mar. 17, 2022) https://tinyurl.com/bdctbk9v.

[27] Danielle DeSimone, *A History of Military Service: Native Americans in the U.S. Military Yesterday and Today*, (Nov. 8, 2021) https://www.uso.org/stories/2914-a-history-of-military-service-native-americans-in-the-u-s-military-yesterday-and-today#:~:text=Native%20Americans%20serve%20in%20the,the%20Armed%20Forces%20for%20centuries.

disorder, challenges adapting to civilian life and, devastatingly, suicide. We need resources and initiatives for them too.

Certain Crimes Against Our People

Concurrently with our mental health and substance abuse pandemics, Indian Country is facing a substantial domestic violence and human trafficking crisis that is finally starting to get the long overdue attention it needs.[28] More than four in five American Indian and Alaska Native men and women have experienced violence in their lifetime, including 56.1% of women who have experienced sexual violence.[29] American Indian and Alaska Native women die from homicide at a rate more than twice that of non-Hispanic white women.[30] Between the violence, the high rates of depression, suicide, and drug addiction, we have deeply traumatized communities. As noted above, we need resources for mental healthcare to address these issues head on. But, we also need health resources for support services for the families of our missing and murdered community members. They need access to counseling and they need financial support for their households, especially when their major income-earner goes missing. We also need the United States Government to step up and provide the resources to make our Reservation safe again. Our citizens will not be healthy if they are not safe.

On a related note, we support the President's proposed legislative initiative to withhold annuity and retiree pay for federal employees convicted of crimes against children.[31] The individual, Stanley Patrick Weber, whose case prompted the proposal, committed his crimes at our Pine Ridge IHS facility. This hideous issue demands protection of our children and retribution from their abusers.

V. Rural Cancer Care

We strongly support the President's request for funding to improve rural cancer care. The Pine Ridge Reservation is one of the largest reservations in the United States and also one of the most rural communities. There are no cancer treatment services available at the Pine Ridge Hospital. Instead, patients must travel 110 miles to Rapid City for access to chemotherapy, radiation therapy, surgery, and palliative care. Too many of our people live below the poverty line. They should not be faced with the decision of choosing to spend their scarce dollars on gas money to get to cancer treatments or putting food on the table for their families. We need cancer treatment services on our Reservation—for our patients, their families and our quality of life.

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[28] President Joe Biden, A Proclamation on Missing or Murdered Indigenous Persons Awareness Day, 2022 (May 4, 2022) https://www.whitehouse.gov/briefing-room/presidential-actions/2022/05/04/a-proclamation-on-missing-or-murdered-indigenous-persons-awareness-day-2022/.
[29] Bureau of Indian Affairs, *Missing and Murdered Indigenous People Crisis* https://www.bia.gov/service/mmu/missing-and-murdered-indigenous-people-crisis (accessed Mar. 29, 2023)
[30] National Indian Health Board, *2022 Legislative and Policy Agenda for Indian Health*, 26 https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf.
[31] IHS Budget, CJ-294.

In addition to the challenges of cancer care that all rural communities face, our people also have unique health disparities that make circumstances even more dire for us. As of late 2016, the cervical cancer rate on our Reservation is five times higher than the nationwide average.[32] Tribes of the Great Plains also have had significantly higher than average mortality rates for colorectal cancer (58%), lung cancer (62%), cervical cancer (79%) and prostate cancer (49%).[33]

The Susan G. Komen for the Cure Foundation identified the three counties, Oglala Lakota, Jackson, and Bennett Counties, where the Pine Ridge Reservation is located as high risk for breast cancer disparities due to socioeconomic factors like high unemployment, low education, high uninsurance, and high poverty.[34] Other reported obstacles to our members' care include communication difficulties, lack of information about side effects, cost of treatment, difficulty obtaining and maintaining insurance, fear, language barriers, lack of education, perceived racial, economic, and gender bias, lack of cultural competence in healthcare professionals, and transportation challenges.[35] These problems are compounded because our people are diagnosed at later stages because they "never enter the continuum [of care] due to lack of accessible screening sites and lack of Native-specific education."[36] Likewise, even though our people have a high rate of tobacco use, we also have a high rate of late-stage lung cancer diagnoses.[37]

Many of these disparities also relate to the health of our environment, though we are waiting for science to catch up and paint a clearer picture on that. Only three years ago we had to cap a community drinking water well after uranium in excess of the safe Drinking Water Standards was detected by our Department of Water Maintenance and Conservation.[38] Our springs have also returned elevated levels of arsenic, lead, and uranium, though some uranium may be naturally occurring.[39] As of late 2010, as many as 35% of private wells on the

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[32] Patrick Strickland, *Life on the Pine Ridge Native American reservation*, Al Jazeera, (Nov. 2, 2016) https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf.
[33] Deborah Rogers & Daniel G. Petereit, *Cancer Disparities Research Partnership in Lakota Country: Clinical Trials, Patient Services, and Community Education for the Oglala, Rosebud, and Cheyenne River Sioux Tribes*, Am. J. Public Health 95(12): 212902132 (Dec. 2005) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449496/.
[34] Susan G. Komen South Dakota, *Community Profile Report 2015*, at 6 https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf.
[35] Deborah Rogers & Daniel G. Petereit, *Cancer Disparities Research Partnership in Lakota Country: Clinical Trials, Patient Services, and Community Education for the Oglala, Rosebud, and Cheyenne River Sioux Tribes*, Am. J. Public Health 95(12): 212902132 (Dec. 2005) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449496/.
[36] Susan G. Komen South Dakota, *Community Profile Report 2015*, at 7 https://komengreatplains.org/wp-content/uploads/2013/03/Komen-South-Dakota-2015-Community-Profile-Report-updated-10.28.16.pdf.
[37] Monica M. Bertagnolli, *Cancer Care in the Rural United States: A Visitor's Perspective from Appalachian Ohio; Pine Ridge, South Dakota; and Sidney, Montana*, JCO Oncology Practice 16, no. 7 (July 1, 2020) https://ascopubs.org/doi/full/10.1200/OP.20.00244.
[38] Talli Nauman, *Native Sun News Today: Oglala tribal staff caps water well with uranium in it*, Indianz.com (Feb. 19, 2020) https://www.indianz.com/News/2020/02/19/native-sun-news-today-oglala-tribal-staf.asp.
[39] Allen J. Heakin, *Water Quality of Selected Springs and Public-Supply Wells, Pine Ridge Indian Reservation, South Dakota, 1992-97*, U.S. Geological Survey Water-Resources Investigations Report 99-4063 (2000) https://pubs.usgs.gov/wri/wri994063/.

Reservation contained arsenic in excess of the EPA's maximum contaminant limit and as many as 6% contained uranium in excess of the maximum contaminant limit.[40] According to the Keepers of the Waters, there are 272 abandoned uranium mines in South Dakota which are also contaminating our land and water.[41] These contaminants place us at a higher risk for cancer and other illnesses,[42] so our Tribe needs resources for environmental remediation to prevent further disease and for cancer care to address the existing legacy of contamination. We also need the Federal Government to ensure our Mni Wiconi Project (clean drinking water project) is finally completed (see details below).

VI. Environmental Health

Essential to our Lakota conception of health is understanding that we are at our healthiest when we are in harmony and balance with the world around us. Unfortunately, as our cancer statistics partially demonstrate, our environment is in a state of disarray. The legacy of hard rock mining has poisoned our water tables and our open lagoons pose an obvious public health risk to our community. Further, the Federal Government continues to invest in the fossil fuels we know are warming our climate and ultimately making our world less livable.

We need Congress to invest in clean water infrastructure for our people. Water is life, but unclean water leads to disease and death. We want to work with you to finally complete the Mni Wiconi Project, which, as you probably know, is a Bureau of Reclamation-funded rural water project. It is a monumental clean drinking water project that serves Missouri River water to our Reservation as well as to the Rosebud Reservation, Lower Brule Reservation, and neighboring non-Indian water districts. The Project's Service Area is 12,500 square miles, its pipelines run 4,200 miles, and will serve approximately 52,000 people. The Mni Wiconi Project Act specifically states the United States' trust responsibility to ensure adequate and safe water supplies are available to meet the economic, environmental, water supply, and public health needs of the Reservations.

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[40] Charles J. Werth, et al., *Final Report: Use of Bone Char for the Removal of Arsenic and Uranium from Groundwater at the Pine Ridge Reservation*, EPA Grantee Research Project Results https://cfpub.epa.gov/ncer_abstracts/index.cfm/fuseaction/display.abstractDetail/abstract_id/9210/report/F.

[41] Keepers of the Waters, Living Waters of the Cheyenne River, https://www.keepersofthewaters.org/projects/cheyenne-river#:~:text=There%20are%20currently%20about%2015%2C000,and%20people%20surrounding%20these%20waterways.

[42] *See* Maryalice Yakutchik, *Killer in the Water: Tracing arsenic's threats to health in the Badlands*, Johns Hopkins School of Public Health (2022) https://magazine.jhsph.edu/2022/killer-water (noting that arsenic in drinking water is "considered one of the prominent environmental causes of cancer death in the world" and that arsenic exposure is linked to cancer, diabetes, cognitive deficits, and cardiovascular disease); National Cancer Institute, Arsenic, https://www.cancer.gov/about-cancer/causes-prevention/risk/substances/arsenic#:~:text=Which%20cancers%20are%20associated%20with,skin%20cancer%20in%20epidemiological%20studies (reporting that arsenic in drinking water is linked to bladder cancer and skin cancer, and general exposure to arsenic has been linked to "cancers of the lung, digestive tract, liver, kidney, and lymphatic and hematopoietic systems.")

While the Project is a life-changing project for our Reservation, it is still not complete decades after its inception. We still need approximately $25 million to upgrade 19 existing community water systems on Pine Ridge and transfer them into the Project as intended by the Act. Once transferred, these systems will be operated and maintained pursuant to authorized funding under the Mni Wiconi Project Act. The Project will not be complete until this work is done.

We also need increases in Operations, Maintenance, and Replacement (OM&R) funding for the Project so this significant federal investment and important project for our people's health and welfare does not fall into disrepair due to inadequate funding. Further, we need increased Funding for Tribal Water Maintenance Departments. We need to do water systems upgrades, pipe construction and repairs, well maintenance, and address water tank needs and associated equipment maintenance. We also need support for Low Income Water Assistance Programs (which includes water hook ups, pump repairs, and minor home repair for sanitation and safety).

Similarly, we need resources to address our aging and overstressed lagoon system because our lagoons are at and beyond their limits. We also need resources to investigate the health of our local water sources because preliminary data we have collected indicates that we have dangerous chemicals in our rivers and streams. We need to be able to test our water sources, track the source of this pollution, and treat our water so that our people, animals, and crops have access to clean, unpolluted water. We need Congress to continue to provide resources for tribes through the Clean Water Act funds. We also need Congress to ensure that the IHS Sanitation Facilities Construction account is funded at a level sufficient to support *all* of the clean water infrastructure projects across Indian Country. The Infrastructure Investment & Jobs Act made a crucial investment in these issues, but the amounts to be appropriated under that law still will not meet our needs. In addition, we echo the recommendations made by the National Congress of American Indians that Congress should appropriate $100 million for the EPA Tribal General Assistance Program and $30 million for the Tribal Air Quality Management Program.[43]

Crucial to all environmental health is the very basic premise that poisons should not be spilled on our lands and in our waterways. We have opposed numerous federally approved mining, drilling, and pipeline projects over the years. Some have called us radicals, but the recent Keystone pipeline spill—the "largest U.S. crude oil spill in a decade"—underscores the importance of our fight and that it is reality-based.[44] That spill left a community in Kansas reeling from a spill of 14,000 barrels of oil onto livestock pasture and into a nearby creek. The spill is the third spill of several thousand barrels of oil since the Keystone pipeline opened in 2010. Yet local residents seem to acknowledge that pipeline breaks and oil spills are just a part

[43] National Congress of American Indians, *Written Testimony of President Fawn Sharp to U.S. Senate Committee on Indian Affairs*, 3 (Mar. 8, 2023) https://www.indian.senate.gov/sites/default/files/Testimony%20NCAI%20-%20SCIA%20-%20Tribal%20Priorities%20-%202023-03-08.pdf

[44] Erwin Seba and Nia Williams, *Kansas residents hold their noses as crews mop up massive U.S. oil spill*, Reuters (Dec. 11, 2022) https://www.reuters.com/world/us/residents-hold-their-nose-crews-mop-up-huge-us-oil-spill-2022-12-10/.

of life and business.[45] This has been one of our major concerns all along—there is no such thing as a safe pipeline just as there is no such thing as a clean mining operation. These activities endanger the health of our environment and they are conducted on our Treaty lands and on our sacred sites (Dakota Access Pipeline and Jenny Gulch gold mining exploration in He Sapa). The Federal Government must stop these activities. They are done without our consent, they are bad for our local environment, and the oil and gas activities are bad for our global climate. Instead, the Federal Government should be proactively investing in sustainable energy projects and forest restoration initiatives (with tribal consent!)—investments which actually improve our health.

Like water, quality food is the key to good health. The Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR), and the Supplemental Nutrition Program for Women, Infants, and Children (WIC) provide desperately needed meals and school lunches for our most vulnerable. Congress must protect and fully fund these programs in the upcoming Farm Bill. We also need for these programs to be expanded to incorporate more locally grown and raised foods. Locally sourced foods produce multi-pronged benefits for our people. First, inclusion of local crops and animal protein directly stimulates our tribal economies when these programs purchase from our tribal ranchers and farmers. Second, the inclusion of our local foodstuffs actualizes a return to traditional practices and provides a spiritual benefit to our people. Third, increasing variation of the foods provided by these programs maximizes health outcomes as we become empowered to turn away from the ultra-processed wheat flour and sugar-based meals that have defined the Indian Country culinary experience from the Federal Government. Finally, sourcing these foods locally reduces the greenhouse gas emissions needed to transport foods for these programs across the country. This helps the environment which in turn helps us, our crops, and our animals.

Similarly, we request that Congress invest more resources in developing meat processing facilities on tribal lands. We would like to be able to process animals, like the sacred buffalo, on our Reservation, in our traditional ways. Currently, a lack of funding is an obstacle, as are some U.S. Department of Agriculture laws, regulations, and policies requiring oversight by certain types of inspectors (ex. under the Federal Meat Inspection Act). We urge Congress to provide us funding to build and run these facilities and enact flexibility so that we are not hamstrung in our efforts by an overly fretful federal nanny state.

With respect to the food programs discussed above, Congress should expand 638 contracting and compacting abilities so that tribes can not only administer these programs but can design them from the ground up.

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[45] "Stuff breaks. Pipelines break, oil trains derail." Washington, Kansas resident Dana Cecrle, 56. "Hell, that's life." "We got to have the oil." Carol Hollingsworth of Hollenberg, Kansas, 70. Erwin Seba and Nia Williams, *Kansas residents hold their noses as crews mop up massive U.S. oil spill*, Reuters (Dec. 11, 2022) https://www.reuters.com/world/us/residents-hold-their-nose-crews-mop-up-huge-us-oil-spill-2022-12-10/.

VII. Conclusion

Thank you for your tireless work in service of Indian Country and for your consideration of these comments. As you can see from these comments: Mitakuye Oyasin, which means everything is connected. This is our philosophy and way of moving through the world. It is a fact and particularly evident when talking about healthcare. The health of our people relies not on only on having healthy bodies and dedicated professionals to treat us when we are sick or injured in body, but also having, among other things: (1) adequate behavioral and mental health prevention and intervention for healthy minds and spirit; (2) safe, clean, and modern healthcare facilities and safe and clean environs; and (3) fueling our bodies with clean and nutritious water and food. Our Tribe stands ready to work with this Subcommittee and Congress overall to make sure the Federal Government is living up to its Treaty and trust obligations and our people are getting the high-quality healthcare they deserve.