

TESTIMONY ON S. 1507, THE NATIVE AMERICAN ALCOHOL AND SUBSTANCE  
ABUSE PROGRAM CONSOLIDATION ACT OF 1999

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THE NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE

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Thank you Senator Campbell and distinguished members of the committee for providing us this opportunity to testify concerning the Native American Alcohol and Substance Abuse Program Consolidation Act of 1999. We believe this is important legislation and we appreciate the opportunity to offer our thoughts and experience.

The National Council on Alcohol and Drug Dependence is the oldest voluntary health organization dedicated to reducing the incidence and prevalence of alcohol and other drug addiction in the United States. NCADD provides education, information, help and hope in the fight against the chronic, often fatal disease of alcoholism and other drug addictions. Founded in 1944, NCADD is a voluntary health organization with a nationwide network of Affiliates. NCADD advocates prevention, intervention, research and treatment and is dedicated to ridding the disease of its stigma and its sufferers from their denial and shame.

NCADD's Committee on Treatment Benefits (COB) was created in 1995. Its purpose is summed up by the fact that in 1985, there were approximately 35,000 beds available in the US for the treatment of addictions; in 1995, there were less than 3,500- a 90% decrease. This translates into lives lost as people's addictions went untreated and they lived lives of misery degradation, and often tragically died from their diseases. COB convened a group of the foremost health care economists, and experts in the field of addictions medicine and treatment to look at reasons and possible solutions to this grave situation. It continues to focus on removing barriers and increasing the availability of effective treatment for people of all ethnic and socioeconomic groups.

Part of COB's mission is to improve the availability of treatment for all parts of the population. In that connection, in recent times COB personnel both on their own and as part of COB initiatives have offered their assistance to providers of substance abuse services to Native Americans, principally tribally operated and Indian Health Service funded programs and facilities. I

particularly wish to make note of the contributions of Dr. Walter Hillabrant the President of Support Services International, Inc. (SSI) and Dr. Norman Hoffmann, who are conducting a nationwide study for the IHS of Native American women who receive alcoholism treatment. I believe it is the first study of its size that concentrates on this important group.

We have also provided assistance and information on management information services, health care financing issues, grant writing and technical assistance to the National Steering , Committee for the Reauthorization of the Indian Health Care Improvement Act. In this process we have learned a good deal about substance abuse issues in Indian Country.

Alcohol and other drug-related problems are undeniably among the major health issues we face in the United States. While the nation as a whole faces major problems of alcoholism drug addiction and the related health and social costs, the crisis in the Native American population is of epidemic proportions, as Senator Campbell's remarks upon the introduction of S. 1507 point out. According to Trends in Indian Health 1997 the rate of deaths from alcoholism among Native Americans was 579 percent greater than that for the U.S. population as a whole.

Alcoholism and other drug addictions are chronic, often fatal diseases. Fortunately, these illnesses can be treated, effectively and efficiently, because of the great strides in research and practice over the last several decades. Studies consistently show that people who go through treatment, including out-patient, inpatient, self-help and/or continuum of these services, are returning as productive members of society. Crime is reduced, work productivity is increased, and personal health (mental and physical) is improved. In short, the cost-benefit of treatment to taxpayers is enormous. In 1992, the state of California reported that the cost of treating approximately 150,000 participants represented in the study sample was \$209 million, while the benefits received during the treatment in the first year afterwards were worth approximately \$1.5 billion in savings to taxpaying citizens, due mostly to reduction in crime.' Health care was also affected, including a reported decline by about one-third in hospitalizations, before and after treatment.

Other research in both the public and private sector finds the same thing. The U.S. Department of Health and Human Services, in a major before and after drug abuse treatment study of 4,411 people in federally funded treatment, reported that the prevalence of illicit drug abuse was cut by about one-half for each illicit substance (i.e. cocaine, marijuana, crack, or heroin), and the number of those troubled by alcohol abuse dropped by more than two-thirds 5 16 months after treatment. The percentage of people selling drugs, shoplifting, or beating someone up in the past year dropped by almost 80 percent 5 - 16 months after treatment. In addition, the percentage of clients receiving welfare declined from 40 percent to 35 percent an almost 11 percent overall decrease.

On the private side businesses are increasingly recognizing the need to provide workers with appropriate and adequate care for addiction. Employers know that a healthy workforce is a

productive workforce. Major corporations are reporting increased productivity and a healthier work environment:

\* The Northrup Corporation saw productivity increase 43 percent in the first 100 employees to enter an alcohol treatment program. After three years of sobriety, savings per rehabilitated employee approached \$20,000;

\* Oldsmobile's Lansing, Michigan, plant saw the following results one year after employees with alcoholism problems received treatment: lost man-hours declined by 49 percent, health care benefit costs by 29 percent, absences by 56 percent, Grievances by 78 percent, disciplinary problems by 63 percent and accidents by 82 percent.

We welcome Senator Campbell's initiative because we believe that it offers a way to increase the federal and tribal resources that will actually go to providing treatment services to those who need them. Each federal program which provide funds for substance abuse treatment and education have various kinds of accounting, administration and auditing requirements as well as specific limitations on funding. All of the tribal and IHS substance abuse programs that we are familiar with are underfunded and understaffed. They also tend not to have adequate computer information systems. It is common to hear tribal substance abuse personnel tell stories of spending disproportionate amounts of time, effort and funds just to deal with the reports required by the funding agencies.

This bill should make it possible to get more money to where it is needed and spend much less time and resources on complying with different and complex regulations which take time and resources away from actual service to patients. We suggest that the actual uniform planning and reporting system be designed by actual treatment personnel in consultation with auditors and planners, so that it is easily integrated into the actual process of operating the programs. Such systems to capture clinical effectiveness and financial data are currently being developed in the private sector and could be done here. Such a sin-le, easy to use new management information system could also be invaluable toward accomplishing the goals of this legislation.

Alcoholism and substance abuse are fundamentally health problems. It has been our experience that, as with any health issue, people who have experience in dealing with a particular illness are best equipped to evaluate and provide the appropriate services. Addiction, with the unique needs for the people who suffer from it (including the casework for job training, domestic violence, and of course, the treatment itself) particularly needs oversight by an agency trained and equipped to deal with it. Thus we would strongly recommend that the Committee carefully consider assigning principal agency responsibility for administering and coordinating treatment funds and service to an agency or department with experience in health care and specifically in treatment of alcoholism and other substance abuse. It could be helpful to convene a series of meetings with key stakeholders in order to assure that the legislation most fully and efficiently accomplishes it purposes. NCADD is available to assist with such a process.

Despite the fact that its work is woefully underfunded the Indian Health Service's is the principal provider of health services and alcoholism and substance abuse services for the American Indian Alaska Native population. Its work in the field is very important. It spends about 100 million dollars directly on alcoholism and substance abuse services. Portions of its mental health, health education and contract health budgets are also used for these purposes. Most of the substance abuse treatment and prevention activity that it funds are carried out by the tribes under self-governance compacts and contracts with technical assistance, training and funding from IHS. There are several regional youth treatment programs and many other facilities and programs run in this tribal/IHS cooperative way. IHS also correctly views this problem as integrally related with many other aspects of the overall health problems of the Native American population and thus integrates its treatment in other aspects of the health and mental health systems.

The National Council on Alcoholism and Drug Dependence and its Committee on Treatment Benefits considers this an important bill and will provide whatever assistance it can to the Committee as it further develops this initiative. Thank you very much for this opportunity to contribute to your deliberations. We hope it has been helpful.