American Indian/Alaska Native

National Behavioral Health Strategic Plan

2011 - 2015

Division of Behavioral Health

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American Indian/Alaska Native National Behavioral Health Strategic Plan 2011-2015

Prepared by
IHS National Tribal Advisory Committee on Behavioral Health,
IHS Behavioral Health Work Group, and IHS

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August 2011

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The AI/AN National Behavioral Health Strategic Plan was produced under an IHS contract with Kauffman & Associates, Inc.

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Introduction

The American Indian/Alaska Native National Behavioral Health Strategic Plan (2011-2015) has been prepared collaboratively between the Indian Health Service (IHS), Division of Behavioral Health (DBH), the IHS National Tribal Advisory Committee on Behavioral Health (NTAC), and the IHS National Behavioral Health Work Group (BHWG).

This strategic plan is intended to inform the individual and collective efforts of substance abuse, mental health, and social work providers working in the IHS, Tribal, and Urban Indian health programs. This strategic plan responds to the growing evidence about how behavior and lifestyle affect health conditions. Across the Indian Health System, behavioral health initiatives are integrating primary health and treatment services with prevention and mental health approaches in an effort to improve overall health outcomes. According to the Centers for Disease Control and Prevention, health behaviors account for 50% of what determines life expectancy, and six of the top ten leading causes of death can be managed or prevented through behavior modification.[1]

The future of American Indian and Alaska Native (AI/AN) health depends largely upon how effectively behavioral health is addressed by individuals, families, and communities and how well it is integrated into community health systems. We know that successful and sustained behavioral change will require cultural reconnection, community participation, increased resources, leadership capacity, and the ability of systems to be responsive to emerging issues and changing needs.

The importance of including culture, cultural and traditional practices, and a variety of learning approaches should not be underestimated. AI/ANs see behavioral health as supporting their historic and continuing reliance on elders, languages, community, culture, and traditional practices as protective factors that restore balance and serve as both prevention and treatment. During the preparation of this strategic plan, recognizing and using cultural and traditional practices was repeatedly emphasized as essential to effectively address the devastating intergenerational impact of historical trauma and ongoing AI/AN experiences of situations where their culture is not valued. Cultural and traditional practices are prominently represented here as integral to realizing the hope envisioned by this strategic plan. Fortunately, many examples of culture as both prevention and treatment are being witnessed across the country today (e.g., equine therapy, canoe journeys, elders meditation, and healing circles), and the recently reauthorized Indian Health Care Improvement Act (IHCIA) specifically authorizes the use of cultural and traditional approaches.

Given the focus on integration contained within behavioral health, AI/ANs also look to holistic approaches that engage whole communities. The social determinants of health include factors such as education, economic development, justice, housing, and others that have a great impact on the health and well-being of AI/AN people and communities.

In addition to recognizing the broad scope of behavioral health, it is also critical to undertake strategic efforts to respond to changes in the current environment. This strategic plan responds to the priorities of the IHS Director, the March 2010 passage of the Patient Protection and Affordable Care Act (ACA), and the IHCIA amendments contained within that bill.

Immediately following her appointment in May 2009, IHS Director, Dr. Yvette Roubideaux, identified four priorities through which the IHS could be changed and improved. They now provide the framework for new and improved service delivery as well as improved relationships with AI/AN communities nationally.

The priorities are:

1. To Renew and Strengthen our Partnership with Tribes;
2. To Reform the IHS;
3. To Improve the Quality of and Access to Care; and
4. To Make All of Our Work Accountable, Transparent, Fair and Inclusive.

Each of these priorities has implications for behavioral health improvement throughout the Indian Health System. From these priorities, considerable progress has been made as described below and this progress provides context for this strategic plan.

IHS Priority 1: To Renew and Strengthen Our Partnership with Tribes

President Obama's November 5, 2009, Presidential Memorandum on Tribal Consultation gave added emphasis to this priority and resulted in concurrent efforts by the IHS Director and the Secretary of the Department of Health and Human Services (HHS) to promote ongoing Tribal consultation. While the HHS and IHS are perceived to have good Tribal consultation policies, improvements to the consultation process are ongoing. The IHS Director's conversations with Tribal leaders have also led to an effort to streamline the number of consultation committees and better coordinate their relationships with IHS. As a result, the NTAC and the BHWG have worked to support the overall IHS consultation effort with Tribes by better coordinating their political and technical advisory roles, and by providing other IHS committees (e.g., Suicide Prevention Committee) an avenue to secure both technical and political input on matters related to behavioral health.

The IHS National Tribal Advisory Committee on Behavioral Health (NTAC) was established by the IHS Director in the summer of 2008 as a policy and advocacy body of Tribal leaders providing advice and recommendations in support of the Indian Health Service's efforts to address behavioral health in AI/AN communities. NTAC is composed exclusively of elected Tribal leaders that represent each IHS Area.

The IHS Behavioral Health Work Group (BHWG) was established as a technical advisory group of subject matter experts charged with providing guidance to the IHS in the development of programs and services for behavioral health for AI/AN communities. The BHWG currently functions as a technical advisory group providing advice through the NTAC. The BHWG is composed of Tribal and Urban representatives who are providers and experts in the field of behavioral health and/or substance abuse.

IHS Priority 2: To Reform the IHS

During the development of the House and Senate bills regarding health care reform, the President and Congress worked to ensure that Tribal priorities were accommodated in the legislation. With the passage of the ACA, the health care reform effort moved to a new phase. This landmark legislation also included the long-awaited reauthorization of the IHCIA, which has specific provisions that address behavioral health programs and program improvements.

Section 10221 of the ACA enacts, with a few amendments, the revisions and extensions to the original Indian Health Care Improvement Act of 1976 that were contained in Senate Bill S. 1790 and makes the IHCIA permanent. From a behavioral health perspective, the key feature of the IHCIA is Title VII, which was amended to expand the IHCIA's previous focus on substance abuse to now include all behavioral health. Behavioral health is now defined in S. 1790 as "…the blending of substance (alcohol, drugs,

inhalants, and tobacco) abuse and mental health disorders prevention and treatment for the purpose of providing comprehensive services… (and)…includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach." (For summaries of the IHCIA and the ACA, see the Director's Corner on the IHS website at http://www.ihs.gov/PublicAffairs/DirCorner.)

Title VII directs IHS to establish a comprehensive behavioral health plan for Indians and authorizes the Secretary to provide, where feasible, a comprehensive continuum of behavioral health prevention, intervention/treatment, outpatient and aftercare programs, and services for the AI/AN population (e.g., children, adults, elders). Other sections of the IHCIA address domestic violence, suicide prevention (with a special focus on youth), primary prevention of childhood sexual abuse, and behavioral health research. The reauthorization of the IHCIA demonstrates Federal recognition of behavioral health service needs and promises ongoing support for identified behavioral health priorities in Indian Country.

Other Federal legislation in health care reform also supports the provision of behavioral health services, increasing insurance coverage for behavioral health services, and greater billing and reimbursement opportunities. The Mental Health Parity and Addictions Equity Act, passed in 2009, requires insurance plans to offer benefit coverage for mental health and substance abuse treatment services comparable with the plan's coverage for conventional medical or surgical services, a significant improvement over previous coverage practices where limitations in the number and scope of behavioral health services covered were often paired with higher cost sharing. For AI/ANs with insurance coverage through a private provider (such as employer-sponsored health insurance), more behavioral health services are now covered.

IHS Priority 3: To Improve the Quality of and Access to Care

This strategic plan sets out goals and objectives to improve both the quality and accessibility of behavioral health services. Indian Health System staff and facilities will be challenged to bring more structure and definition to behavioral health approaches and to focus on practices that work, including not only evidence-based practices, but also culture- and practice-based approaches. The large network of substance abuse and mental health providers, services, and facilities need to be a part of the overall healthcare delivery system and must collaborate to address behavior-related morbidity and mortality. This

plan reaches beyond the traditional separation of behavioral health and opens the door to expanded collaboration with other disciplines. Evidence-based, practice-based, and culture-based prevention, treatment, and research, as well as responsive behavioral health systems are specifically addressed within Strategic Direction 2 (p. 22).

IHS Priority 4: To Make All Our Work Accountable, Transparent, Fair and Inclusive

This priority emphasizes the importance of open communication while moving forward with changes and improvements. IHS leadership at all levels is directed to increase transparency and accountability in their areas and activities. They are also directed to make needed changes and improvements in line with the four IHS priorities.

Accountability, transparency, fairness, and inclusiveness are fundamental to achieving the vision of this strategic plan. This strategic plan has been developed collaboratively by the NTAC, BHWG, and the IHS. It will be implemented when public policy recognizes the powerful potential of behavioral health intervention to reshape the health and wellness of populations.

This strategic plan contains the following key sections.

- **Background Information:** A review of behavioral health-related statistics that provide insight into the scope of the problem and areas of improvement in recent years. This includes an identification of trends and the evolution of behavioral health initiatives within the Indian Health System.
- **Shared Vision:** A shared vision statement between IHS, Tribal, and Urban programs about how to focus behavioral health efforts over the next five years.
- **Challenges to the Vision:** A realistic inventory of the challenges, obstacles, and contradictions that IHS, Tribal, and Urban communities will need to address in order to move forward and achieve their shared vision.
- **Strategic Directions:** A framework for IHS, Tribal, and Urban programs to work in close partnership and collaboration to address the identified challenges and achieve the shared vision.
- **Implementation Strategy:** The goals, objectives, and related action steps developed for each strategic direction form the basis for the 5-year implementation strategy (2011-2015).

Background Information

The mission of the IHS is to improve the mental, physical, social, and spiritual health of approximately 2 million AI/ANs to the highest level while working in close partnership with Tribes and Urban Indian organizations. Behavioral health is a critical component in fulfilling this mission. The last 30 years have seen the development of innovative community-based approaches to addressing alcohol, substance abuse, social services, and mental health issues.

Significant disparities still exist, as demonstrated by statistical and descriptive evidence of AI/AN death rates and selected behavioral health problems in Indian Country, such as alcohol and substance abuse, suicide, domestic violence, and sexual assault. The information about these issues summarized in this section provides further context to the strategic directions and implementation strategies proposed in this plan. The overview of mortality statistics and selected behavioral health trends is followed by a discussion of data limitations and an explanation of the strengths and drawbacks of data sources. An introduction to alternative data sources is provided should readers desire to pursue further information about this complex topic.

Trends in Indian Health

The IHS publication titled *Trends in Indian Health* provides basic statistical information including but not limited to general mortality and community health statistics. Table 1 compares AI/AN death rates (age-adjusted per 100,000 population) as reported in IHS *Trends* for data years 1999-2001 and 2002-2003. These death rates varied most notably in drug-related deaths from data years 1999-2001 to 2003-2005, which nearly doubled. The AI/AN drug-related death rate (17.4) has increased 255% since drug-related rates were first introduced for AI/ANs in 1979.

Table 1. Comparison of AI/AN Death Rates Between Data Years 1999-2001 and 2003-2005 (Age-adjusted rate per 100,000 population)

CAUSE	DATA YEARS 1999-2001	DATA YEARS 2003-2005
Alcohol-related	43.2[1]	43.3[2]
Drug-related	9.2[1]	17.4[2]
Suicide	17.0[1]	18.8[2]
Males (all ages)	29.6[1]	30.3[2]
Males ages 15-24	45.9[3]	55.2[3]
Males ages 25-34	55.3[3]	58.0[3]
Homicide	11.4[1]	11.3[2]

Even with the slight decrease in homicide-related death rates reflected in Table 1, AI/AN death rates continue to increase alarmingly for suicide, especially for males ages 15-24, and for drug-related deaths, which nearly doubled. In addition, AI/AN death rates continue to significantly surpass U.S. all-races death rates, as reported in the most recent IHS *Trends* publication. Table 2 shows death rates for AI/AN populations as compared to the U.S. all-races rate for behavior-related causes.

[1] Age-adjusted rates (for data years 1999-2001) published in *Trends in Indian Health, 2002-2003 Edition* have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
[2] Age-adjusted rates (for data years 2003-2005), not yet published, have been adjusted to compensate for misreporting of AI/AN race on state death certificates.
[3] Suicide rates for males are age-specific.

Table 2. AI/AN Death Rates Associated with Behavior-Related Causes Compared to U.S. All-Races Rates (Age-adjusted rate per 100,000 population)

CAUSE	DATA YEARS 1999-2001	DATA YEARS 2003-2005
Alcohol-related	1,562% greater	519% greater
Accidents	153% greater (unintentional injuries) 212% greater (motor vehicle crashes)	149% greater (unintentional injuries) 209% greater (motor vehicle crashes)
Suicide	64% greater	73% greater
Homicide	97% greater	92% greater

The major health challenges facing AI/AN communities, whether in Tribal, rural, or urban areas, relate significantly to behavioral health factors, including alcohol, substance abuse, mental health, and violence. The following profiles provide a context for the behavioral health environment in which this strategic plan has been developed, focusing on alcohol/substance abuse (and particularly methamphetamine abuse); suicide; domestic violence; and sexual assault. Successes in addressing other aspects of AI/AN health provides hope that these myriad of behavioral health problems can and will be successfully addressed.

Alcohol and Other Substance Abuse

The serious abuses of alcohol and other illicit substances, and the effect they have on members of all Tribal communities, have long been a concern to Tribes as they continually work to heal their people. The Indian Self-Determination Act of 1975 (P.L. 93-638) was an important step in restoring Tribes' opportunities and resources for returning to self-governance, and with that came a renewed emphasis on cultural and traditional approaches to program delivery, including prevention and treatment programs.

Today, alcohol and substance abuse issues continue to threaten the health and well-being of AI/AN communities. AI/ANs are more likely than any other race to have a past-year alcohol or illicit drug use disorder.[2] Alcohol-related deaths for AI/ANs have remained the highest since at least 1995. As discussed previously, the most recent IHS *Trends* publication states that AI/AN alcohol-related death rate is 519% greater than the U.S. all-races rate.

Alcohol abuse also has tragic generational consequences for AI/AN communities. Fetal Alcohol Spectrum Disorders (FASD) are caused by alcohol consumed by a mother during pregnancy and affect AI/AN children at higher rates than the general population. FASD can cause physical, mental, behavioral, and/or learning disabilities with life-long implications.[3]

AI/AN drug-related deaths nearly doubled from 1999-2001 to 2003-2005 data years.[4] Substance abuse of all types is a serious problem with

Alcohol/Substance Abuse Statistics

- **AI/ANs are more likely than any other race to have a past-year alcohol use disorder.** [+]
- **AI/ANs are more likely than any other race to have a past-year illicit drug use disorder.** [+]
- **AI/AN alcohol-related death rate is 519% greater than the U.S. all-races rate.** [++]

[+] The National Survey on Drug Use and Health Report (2007).

[++] IHS/Division of Program Statistics, IHS data years 2003-2005, U.S. data year 2004.

[4] IHS aggregates data across 3 years when calculating AI/AN birth or death rates. When comparing these rates with U.S. all-races rates, the all-races rate for the middle year is used.

AI/ANs reporting a higher rate of marijuana, cocaine, and hallucinogen abuse than other minority groups. However, among illicit substances, methamphetamine represents one of the most formidable health and social concerns facing AI/AN communities today. Methamphetamine is increasing its devastation across AI/AN communities, creating public health, law enforcement, and intervention and treatment challenges. The IHS's 2008 Annual Report describes the serious concern of methamphetamine use among AI/ANs, stating "AI/AN people have a meth use rate that is over three times the rate for the general population."[4] The problems reported by individual Tribes are particularly troubling, demonstrating that the methamphetamine crisis is significantly more pronounced in some AI/AN communities than the straightforward "three times higher" rate would suggest. For example, one Tribe gave testimony to Congress in 2006, citing methamphetamine use rates of 30% among their Tribal employees.[5]

In a 2006 paper, the National Congress of American Indians (NCAI) stated that methamphetamine "has disproportionately devastated Native American Tribal communities"[6] and urged a comprehensive, coordinated response to address this threat to the stability of American Indian communities. The spread of methamphetamine is putting Tribal public health and community well-being at risk because this powerfully addictive drug devastates the mind and body, and also leads to a myriad of other social problems such as child abuse and neglect, domestic violence, and skyrocketing crime rates.[7] Other reports suggest a correlation between suicide risk and methamphetamine use. While the extent to which the correlation between methamphetamine use and suicide risk is not fully understood in the AI/AN population or the general population, a 2005 study conducted by the University of Utah found that the prevalence of methamphetamine in suicide completers was unexpectedly high and required further investigation.[8] The IHS Methamphetamine and Suicide Prevention Initiative programs provide an opportunity to address the lack of prevention and treatment programs. This lack of programs was described as follows by one NTAC Member: "In Montana the only way to get into the meth program is to go to prison. Locking up Indians is an easy way to deal with our problems. For us to help our people we need to find resources that are Indian friendly."

Despite dire needs in the area of alcohol and substance abuse for AI/AN communities, recent legislation promises important changes to the legal and policy context in which these issues are addressed. The Tribal Law and Order Act (TLOA), signed into law by President Obama in July 2010, contains provisions likely to have significant effects on the future of policy in this area. Section 241 of TLOA amends the Indian Alcohol and Substance Abuse Prevention and Treatment Act of 1986, expanding the number of Federal agencies that are required to coordinate efforts on alcohol and substance abuse issues in Indian Country. Agencies included in coordinated efforts are the IHS, Department of Justice (DOJ), and the Substance Abuse Mental Health Services Administration (SAMHSA), along with the Department of Interior (DOI) Bureau of Indian Affairs (BIA). This amendment also breathes new life into Tribal Action Plans (TAP), first authorized in 1986, and promises improved Federal interagency coordination on substance abuse policy by the establishment of an Office of Indian Alcohol and Substance Abuse within SAMHSA.

Co-occurring Disorders

Alcohol and other substance abuse can co-occur with mental health disorders, complicating the diagnosis and treatment of these conditions for individuals who suffer from both and adding another layer of complexity to treatment within behavioral health care systems.

Behavioral health research and practice indicate it is very common for alcohol or substance abuse and mental health disorders to overlap. In a survey of research on co-occurring disorders, SAMHSA found that persons in treatment for one condition (either a substance abuse disorder or a mental health disorder) had a co-occurrence of an additional condition at rates from 20% to 73%.[9] According to SAMHSA's National Survey on Drug Use and Health, there is a high rate of co-occurring substance abuse and mental health disorders within AI/AN communities.

Substance use disorders can coincide with a variety of mental health conditions, ranging in severity from temporary emotional disturbance to chronic mental illness, but an especially important condition to recognize is substance-induced disorders. Substance-induced disorders are mental health conditions that result from (rather than co-occur with) substance use. While substance-induced disorders are the direct result of substance use, their presentation can be clinically identical to other mental disorders.[10] An example of a substance-induced disorder may be the increased suicide risk, described above, that appears to accompany methamphetamine use.

When co-occurring disorders are left untreated, or if only one disorder is treated, both disorders usually become more acute, resulting in additional complications. These complications include the risk for physical health problems, unemployment, homelessness, incarceration, separation from families and friends, premature death, and suicide. The toll on AI/AN families, schools, communities, and workplaces is significant.

Suicide

Suicide in Indian Country is a significant behavioral health issue, and the suicide rates for AI/ANs are even more alarming than the rates for the general population. In fact, suicide rates for AI/ANs of all ages are 1.7 times higher than the U.S. all-races rate for all ages, impacting populations across the life cycle.[11] Alaska Natives commit suicide at rates four times the national average. It is the second leading cause of death for Indian youth between the ages of 15 and 24 (3.5 times higher than the national average).[12] For Alaska Native males of all ages, the suicide rate is six times higher than the national average, with teen suicide rates nearly six times the rate of non-AI/AN teens.[13]

Suicide Statistics[+]

- **The AI/AN suicide rate in the IHS Service Area is 1.7 times higher than the U.S. all races rate.**
- **Suicide is the 6th leading cause of death for AI/AN males.**
- **Suicide is the 2nd leading cause of death for AI/AN youth ages 15-24.**
- **AI/ANs aged 15-34 account for 63% of all suicides in Indian Country.**

[+] IHS/Division of Program Statistics, IHS data years 2003-2005, U.S. data year 2004.

In some communities, the suicide rate is even higher, often due to suicide clusters. In her September 2009 statement before the U.S. Senate Committee on Indian Affairs, IHS Director Dr. Yvette Roubideaux explained, "Indian Country has communities each year where suicide takes on a particularly ominous and seemingly contagious form, often referred to as suicide clusters."[14] In these communities, one suicide can influence others to attempt it, and thus increase quickly, much like a disease epidemic might spread.

Addressing these issues in AI/AN communities requires public health and community interventions as much as clinical interventions,[15] yet these services are not always available. In that same testimony, Dr. Roubideaux said, "Suicide and suicidal behavior and their consequences send shockwaves through many communities in Indian Country, including Urban communities. The pain only deepens when those seeking help for their loved ones in crisis, or those left behind as emotional survivors of such acts, are unable to access adequate care." [16]

Integrated behavioral health care systems and a holistic understanding of wellness are also critical in addressing the problem of suicide. The need for integrated care is highlighted by statistics from the U.S. Department of Health and Human Services indicating that the health conditions most consistently associated with suicide are mental illness and substance use and alcohol use disorders, which affect up to 90% of all people who die by suicide.[17] Given the significant role of other behavioral health factors in suicide, provider shortages and the fragmented behavioral health service delivery system is even more tragic.

Domestic Violence and Sexual Assault

Domestic violence and sexual assault are serious problems in Indian Country. According to the Centers for Disease Control and Prevention, 39% of AI/AN women have experienced intimate partner violence—the highest percentage in the U.S.[18] One out of every three AI/AN women is raped in her lifetime,[19] and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.[20] The NCAI Task Force on Violence Against Women explained that violence against AI/AN women "is undeniably linked to the steady erosion of the sovereign authority and resource-based ability of Indian Nations to protect women. The epidemic of violence directed at Indian women is genocidal and threatens the future existence of all Indian Nations."[21]

Women are not the only members of AI/AN communities affected by violence. Men, elders, and children are victims as well, and we know whole families and communities are affected by violence in many ways. Indeed, the violent crime rate for AI/ANs in every age group below age 35, including between 15 and 19 years is significantly higher than the general population of the U.S. Rates of illicit drug, marijuana, alcohol, smokeless tobacco, and tobacco use among AI/ANs is higher than Whites in any age group throughout the U.S. Moreover, drug and alcohol abuse is inexorably linked to violence. For example, the Bureau of Justice Statistics reports that in violent crimes against AI/ANs, 62% of victims reported the offender was under the influence of alcohol.[22]

Sexual Assault Statistics[+]

- **AI/AN women are over 2.5 times more likely to be raped or sexually assaulted than U.S. women in general.**
- **More than 1 in 3 AI/AN women will be raped in their lifetime.**
- **86% of AI/AN survivors report they were raped or sexually assaulted by non-Native men.**
- **The majority of sexual assault cases against AI/AN women by non-Native men go unprosecuted.**

[+]From *Maze of Injustice*, Amnesty International (2007).

The effects of violence and assault often transcend the short-term injuries such as cuts, bruises, and broken bones received by victims. For example, intimate partner violence has been linked to increases in heart disease, asthma, and stroke, as well as migraines and fibromyalgia.[23] Victims also experience significant psychological and mental health problems including acute traumatic and stress reactions, depression, anger, self-hatred, and post-traumatic stress disorder. Domestic violence and sexual

assault have also been correlated with an increase in risky health behaviors. People who have been victimized are more likely to smoke cigarettes, drink alcohol, and use drugs.[24] They are also more likely to engage in risky sexual behaviors, which can lead to increased risk of contracting sexually transmitted diseases and infections. Increased risk for drug use and increased likelihood of engaging in risky sexual behaviors have been documented among AI/AN physical and sexual assault victims as well as victims of domestic violence.[2526] All of these statistics paint a bleak picture, showing that the cycle of violence and substance abuse is continuing to threaten public health and community safety.

Recent Federal legislation promises to have an important impact on domestic violence issues as well. The TLOA makes the prosecution and prevention of violence against AI/AN women a priority. Two sections specifically address domestic violence and sexual assault. Section 263 of TLOA requires the IHS Director to respond in writing to any request or subpoena for evidence obtained by IHS employees that might pertain to a domestic violence or sexual assault case. Section 265 requires the development of IHS-standardized sexual assault policies and protocol, in order to improve the quality of and access to care.

Along with policy changes specific to the IHS, the TLOA's improvements for law enforcement training and evidence collection procedures, as well as its treatment of jurisdictional and sentencing issues in criminal prosecution, promise to increase the rate of domestic violence and sexual assault conviction. The TLOA offers more law enforcement authority to Tribes, increasing their ability to offer meaningful protection to their members. These legal changes may increase the reporting of domestic violence and sexual assault incidents and ultimately change the climate surrounding violence against women in AI/AN communities for the better. However, given the scope and severity of immediate needs, improved behavioral health resources for victims and offenders in AI/AN communities continue to be a necessity.

Data Limitations

The reporting and analysis of health statistics necessary to create a representative picture of any health issue is a complex process. Concerns particular to behavioral health needs in AI/AN communities cause further obstacles to reporting and analysis. While reported statistics can begin to describe current behavioral health needs in Indian Country, underreporting may occur because of many factors, including stigma around seeking behavioral health care services, a lack of access to professional services, and a lack of culturally acceptable practices.

Along with obstacles in reporting, there are important limitations in statistical validity present in any source for health statistics. The current section explains data limitations to the health statistics used in this strategic plan. It also presents and evaluates alternative data sources from which readers can gather additional information to gain a more comprehensive picture of behavioral health issues in Indian Country.

Strengths and Limitations in IHS *Trends* Data

To describe behavioral health issues in Indian Country, this strategic plan relies substantially on data from recent IHS *Trends in Indian Health* publications. The primary strengths of the *Trends* reports are their national scope and extensive analysis and data correction. The national scope of the data means that the strategic plan can confidently present an overview of behavioral health issues across Indian Country, including different AI/AN population groups.

IHS *Trends* adjusts for common statistical problems that can appear in national health data of all kinds, as well as reporting problems specific to AI/AN populations. One common drawback in national health data is that when figures from states or regions are aggregated on the national level without special error correction processes, duplication can occur. Individuals can be reported multiple times for the same health issue in different states or regions, depending on locations in which they receive treatment. Deaths can be

reported in multiple states as well. In addition, data collected about AI/AN populations face specific reporting obstacles. The most significant is misclassification of race, where AI/AN persons, identified as such on a birth certificate, may not be classified as belonging to the same race on death certificates or when included in tracking for reportable diseases. The result, from a statistical analysis standpoint, is a lower rate of reportable diseases and mortality for the AI/AN population, causing lower estimates of disease burden for the AI/AN population as a whole. Studies have demonstrated that racial misclassification of AI/AN individuals has resulted in reported rates of health conditions that are up to 80% lower than rates corrected for misidentification.[27]

Correct race identification is highest in regions where the majority of the AI/AN population lives on reservations, where health care is primarily provided by Tribal or IHS health centers and hospitals, where race is accurately recorded as a result of standardized documentation. Incorrect race identification occurs more frequently in areas where the AI/AN population lives off reservation and/or receives health care from non-Tribal providers. IHS Areas with the greatest misidentification of race include the Portland, California, and Oklahoma City Areas.

A second obstacle that can complicate data analysis related to AI/AN populations is the statistical measures necessary to ensure accurate reporting for minority populations. For diseases of low prevalence, reports must combine 2 to 3 years of data before calculating rates in order to adjust for potential significant changes in mortality rates. These potential shifts are greatest for racial or ethnic populations that are proportionately smaller in comparison to the entire population of a state or region. As a small segment of larger populations, statistics on AI/AN populations must be calculated carefully before they become accurately representative of health trends. When statistics for AI/AN populations undergo multi-year comparisons to accurately measure statistical significance, a report for AI/AN mortality published in 2010 may be limited to deaths occurring from 2006 to 2008.

The strength of IHS *Trends* data is that it addresses these obstacles. It is carefully corrected for duplication and for misclassification by race or ethnic groups, and is aggregated over multiple years to create the most accurate statistics about AI/AN populations possible. These strengths present an important advantage when describing behavioral health in Indian Country, but IHS *Trends* data also have limitations, the most significant drawback being lack of timeliness in reporting periods.

Several factors delay the release of mortality and morbidity statistics on a national basis, which limits the point-in-time accuracy of these data. For mortality statistics, state vital statistics offices do not report data on deaths to national data centers until 6 months or more after the end of the calendar year to allow adequate time for deaths late in the year to be reported as well as affording time for accurate determination of causes of death. Once yearly data is received, the National Centers for Health Statistics check data for accuracy and compare them across states to avoid duplicate reports. Although this lengthy data correction process ensures accuracy, it also means that national mortality statistics are not available for public release until approximately 1 1/2 years after the calendar year in question. For morbidity rates among small populations (such as AI/AN populations in comparison to the population as a whole), accurate reporting requires combining morbidity rates reported over 2 to 3 years, which delays reporting further. The measures necessary to adjust for this statistical issue are discussed in more detail below.

Strengths and Limitations in Data from Alternative Sources

There are various alternative sources of data available for timely information on behavioral health issues among specific AI/AN populations. While alternative data sources can offer recent and detailed data, it is important to note that they carry data limitations of their own. Several alternative sources and the strengths and challenges of reporting using these resources are described below.

First, state vital statistics offices often publish state-wide mortality data in print and online for access by the general public. This can be a reliable source of data and may be released sooner than data submitted to national data centers. Data from state vital statistics offices may be limited as they generally have not adjusted for racial misclassification and this data represents morbidity and mortality within a particular state only.

A second alternative data source is Tribal Epidemiology Centers (TECs). TECs may also have data available that are more recent than national sources. Frequently, data collected by TECs are specific to a special study or a specific disease or health issue. Types of data available will vary from center to center. However, TEC data are generally limited to special studies which have their own scope and data limitations. In addition, TEC data may or may not be adjusted for racial misclassification, depending on a study's methodology.

A third alternative data source is the IHS Resource and Patient Management System (RPMS) data that have been collected and compiled at a single facility or group of facilities using the RPMS clinical documentation and data management system. RPMS data can be accurate and useful if data is interpreted by an experienced epidemiologist or researcher. However, RPMS data have notable limitations, including: data may not be unduplicated between facilities, especially if patients have received treatment at more than one facility; and data will not include accurate mortality rates if death occurs at a facility outside a given RPMS area. In general, mortality studies based on RPMS data are not broadly applicable because of geographic limitations on the data available within RPMS collection systems.

Readers who desire additional data on trends in behavioral health for AI/AN populations are encouraged to investigate data from these sources, while bearing in mind limitations that may prevent the data from being generalizable across populations or to other groups.

Addressing These Data and Mental Health Issues

The seriousness of alcohol and substance abuse and suicide, along with domestic violence and sexual assault, calls for a serious focus on addressing these problems. However, solutions are not simple to achieve. These problems are multifactorial involving a large range of non-behavioral health factors from lack of economic opportunity to breakdown of cultural values. Addressing these problems requires engaging a range of services and resources. The IHS brings much needed attention to behavioral health and its relationship to the prevention of chronic disease, preventable mortality, and health promotion. The IHS Division of Behavioral Health is focused on the strength and resiliency of AI/AN communities and geared toward the implementation of strategies and techniques that integrate and adapt various types of mental health techniques toward the goal of improving the physical, mental, social, and spiritual well-being of AI/AN people. The IHS Division of Behavioral Health will identify and support innovative efforts within IHS Areas that highlight and apply methods such as behavioral change, prevention counseling, and interviewing methods toward the treatment of chronic illness and health promotion and disease prevention.

The mission of the IHS Division of Behavioral Health encompasses the following eight goals:

1. To improve the overall health care of AI/AN individuals, families, villages, communities, and Tribes;
2. To reduce the prevalence and incidence of alcoholism and other drug dependencies;
3. To reduce the prevalence and incidence of behavioral health diseases and conditions;
4. To maximize positive behavioral health and resiliency in individuals, families, and communities;

5. To support the efforts of AI/AN communities toward achieving excellence in holistic behavioral health treatment, rehabilitation, and prevention services for individuals and their families;
6. To advocate for and support Tribal and Urban Indian behavioral health treatment and prevention efforts;
7. To promote the capacity for self-determination, self-governance, and service delivery; and
8. To advocate for AI/ANs and service providers by actively participating in professional, regulatory, educational, and community organizations at the national, state, urban, and Tribal levels.

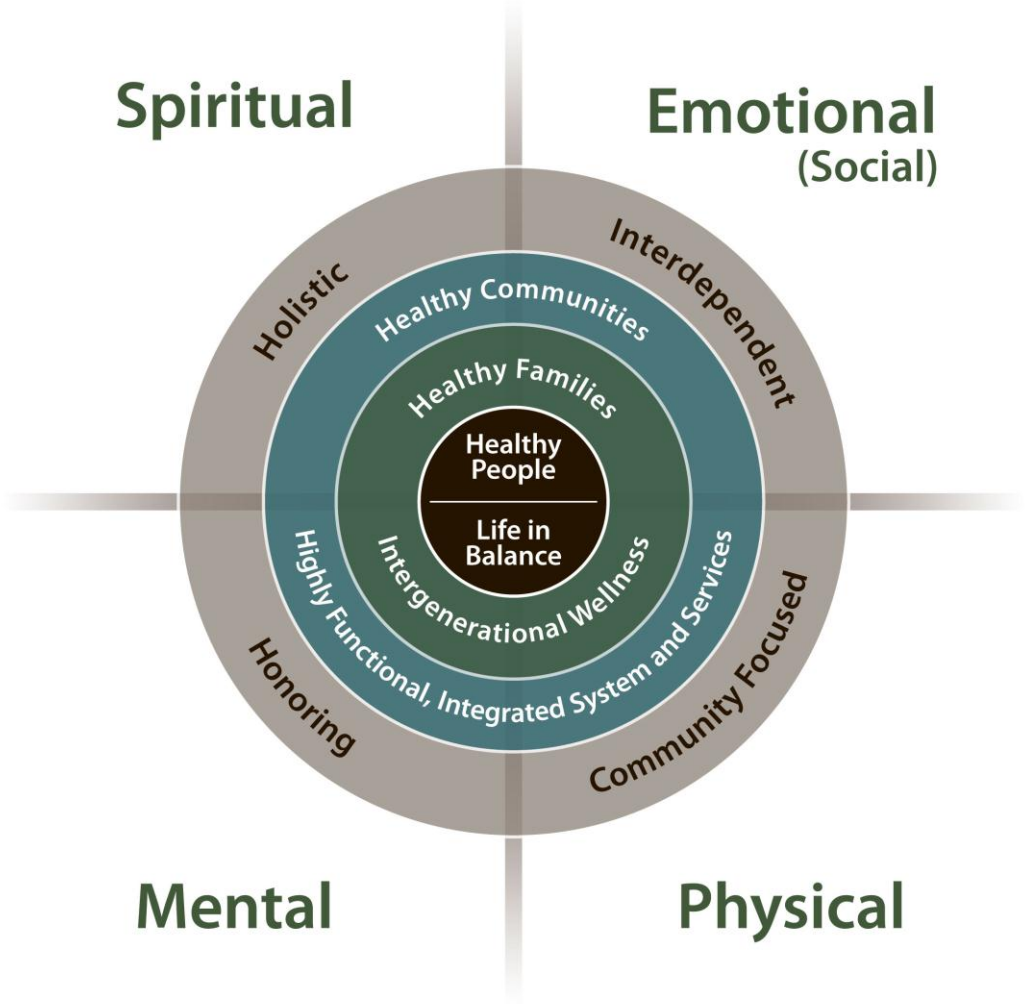
This strategic plan takes into account these goals and identifies some of the challenges that could arise in implementing a coordinated behavioral health response such as the impact of historical, intergenerational, and current trauma on people today and the widespread nature of the behavioral health problems. Despite new funding dedicated to addressing methamphetamine, suicide, domestic violence, and sexual assault, resources remain insufficient to address the needs of 565 Federally-recognized Tribes, as well as the multitude of Urban Indian programs that exist to serve AI/AN people who do not live on Tribal lands. There is also limited support available to address the emotional toll on workers in the behavioral health field.

The next section of this strategic plan describes a shared vision for behavioral health efforts—a vision that will be instrumental to making progress on these important issues by 2015.

A Shared Vision for Behavioral Health

Our Vision for Behavioral Health

"Our vision for behavioral health is integrated health and wellness that is holistic, encompassing all aspects of mental, physical, emotional (social), and spiritual needs of American Indian and Alaska Native individuals, families, and communities."



Challenges to the Vision

It is helpful to understand and appreciate the barriers or challenges that might stand in the way of our vision. The intention is to help ensure that our strategies reflect the realistic, practical steps needed to circumvent obstacles and move our communities closer to our ideal vision for behavioral health. Currently, Tribal, Urban, and Federal leadership share so many priorities and challenges. It will be important to find ways to sustain this shared vision. Additionally, leaders from diverse professional disciplines must come together around an integrated behavioral health agenda.

Limited funding and coordination is always a challenge. There is a need for more work to bring the mental health, medical, traditional medicine, and substance abuse fields together around integrated approaches, but this task will be difficult as long as institutional fragmentation persists. Currently, institutional fragmentation across the Indian Health System causes confusion among persons seeking services, as well as engendering territoriality and competition for funding among the agencies that provide services.

The emotional toll of working in very difficult behavioral health fields can lead to compassion fatigue for many quality providers. Limited support, emotional burnout, high turnover, hopelessness, stagnation, and overall work-related distress present an increasingly challenging environment for staff. These negative factors may impact the effectiveness of those trying to make positive behavioral health changes in AI/AN communities. More focused effort for those in this line of work will be needed in the future, including developing ways to better connect, support, and promote balance for those who give so much to help others heal.

Historical trauma inherent in the AI/AN experience has impacted most, if not all, of our Tribal and Urban Indian communities. Sources of historical trauma include the generational effects of Indian wars, forced relocation, genocide, isolation, removal of children to boarding schools, racism, poverty, and cultural loss. The loss of economic self-sufficiency for some communities has created multigenerational dependency. The mental health and substance abuse manifestations of this historical trauma include alcoholism/substance abuse, child abuse/neglect, sexual abuse, domestic violence, bullying, suicide, and other self-destructive behaviors, all of which create additional pressures on communities and behavioral health systems.

The multi-dimensional impact of historical trauma also means that communities have been forced into survival mode just to sustain their existence and are unable to work collaboratively to meet the needs of their citizens. This fragmentation is borne out in the reality of disconnected services in AI/AN communities and a general lack of coordination between government, schools, medical services, businesses, and spiritual practices. Uncoordinated care systems make finding and accessing resources available for behavioral health a challenge. In addition, while organizations such as schools and medical

services continue to offer vital services, they operate largely in isolation, unable to connect meaningfully with other community institutions to form a sustaining support network that can impact community health in a lasting way. This fragmentation of services and institutions is difficult to remedy while the scars of historical trauma remain because attempted institutional changes are met with heightened apprehension and resistance, consistent with an underlying fear for survival. The underlying role of a community's emotional health in addressing institutional fragmentation highlights the critical importance of cultural healing and restoration among AI/AN communities as a component of addressing behavioral health needs.

Traditional histories, cultures, and worldviews are emerging concepts in Western medical understandings of AI/AN health. However, the loss of identity that accompanies the AI/AN experience of historical trauma means that reconnecting to this traditional wisdom is a challenge. Limited community resources are often focused on meeting immediate and severe health needs, leaving fewer resources for the challenging work of cultural renewal.

Strategic Directions for the Future

This strategic plan provides three directions designed to move us beyond these challenges and into a future more closely aligned with our shared vision. Moving forward in each of these three areas simultaneously will create momentum over the next 5 years to change our systems and our communities to enhance behavioral health.

The strategic directions are:

I. To develop and promote Tribal, Urban, and IHS behavioral health programs in a cooperative, connected, and mutually supportive Indian Behavioral Health System by:

- **a.** Mutual Tribal, Urban, and IHS planning and development of treatment services and programs;
- **b.** Promoting national sharing of prevention, treatment, and education information;
- **c.** Connecting individual communities and programs with national information networks, including data sharing networks; and
- **d.** Convening and promoting Tribal, Urban, and IHS meetings, educational, program, and leadership activities to develop services and service leadership throughout the system.

II. To realize cultural renewal and wellness through an emphasis on sobriety, community, elders, and positive youth development by:

- **a.** Creating a common awareness of and supporting behavioral changes towards wellness, sobriety, and community health;
- **b.** Increasing resiliency and protective factors for AI/AN youth; and
- **c.** Ensuring that practice-based and culture-based approaches are accepted as evidence-based.

III. To build a strong foundation for effective behavioral health services by:

- **a.** Encouraging the development and promotion of behavioral health standards and credentials;
- **b.** Integrating behavioral health within the structure of health services;
- **c.** Developing a skilled and culturally competent workforce to meet the demand for services;
- **d.** Securing necessary reimbursement for behavioral health services; and
- **e.** Sustaining interagency partnerships in order to support behavioral health.

Implementation Strategy

Implementation Plan for Strategic Direction I: To Develop and Promote Tribal, Urban, and IHS Behavioral Health Programs in a Cooperative, Connected, and Mutually Supportive Indian Behavioral Health System

Strategic Direction I Goals

Four major goals were identified as being critical to this strategic direction, including:

- Mutual Tribal, Urban, and IHS planning and development of treatment services and programs;
- Promoting national sharing of prevention, treatment, and education information;
- Connecting individual communities and programs with national information networks, including data sharing networks; and
- Convening and promoting Tribal, Urban, and IHS meetings, educational, program, and leadership activities to develop services and service leadership throughout the system.

Strategic Direction I Discussion

Over the last approximately 30 years, there has been a generational change in the delivery and management of behavioral health services in Indian Country. With the increasing implementation of P.L. 93-638 Indian Self Determination contracting and compacting, Tribes and Tribal programs now directly manage over 85% of the Alcohol and Substance Abuse budget and its associated programming, and over 50% of the Mental Health budget and programs. This remarkable and important transition greatly expands Tribal service delivery and presents new challenges for connecting, supporting, and developing individual programs in a national network of high quality service and service delivery. To meet the challenges presented by these changes, IHS is now a partner in service rather than the sole direct provider of service. There are significant benefits that can be realized through focused attention to help Tribal and Urban Indian programs better develop, deliver, and manage their services; provide national standards for service delivery; provide programs with clinical documentation, billing, data analysis, and sharing tools; and connecting individual programs—most of which are small and isolated—in a national network to share information, practices, and leadership development.

Moving from individual systems toward an integrated and responsive IHS, Tribal, and Urban Indian behavioral health system may be the single most important area for strategic development in the next 5 years as it touches every other aspect of prevention, care, and education. Thoughtful evolution of services among Tribes, Urban programs, and IHS will require the involvement of all of the key participants and resources, including IHS and other Federal agencies; Tribal leaders; national, regional, and Tribal organizations; health directors and administrators; and communication experts. Developing means and methods to promote that involvement will also be critical.

Strategic Direction I Implementation Plan

The implementation plan tables that follow detail each major goal and corresponding objectives, the action steps seen as critical to reaching the objectives, who is responsible for each action step, and the approximate timeline for each action step to be completed, including: “short-term” (12 months or less); “intermediate-term” (12 to 36 months); and “long-term” (36 months or more).

Strategic Direction I – To develop and promote Tribal, Urban, and IHS behavioral health programs in a cooperative, connected, and mutually supportive Indian Behavioral Health System.

Goal A. Mutual Tribal, Urban, and IHS planning and development of treatment services and programs.

Objectives

- Staying current with emerging trends in behavioral health and substance abuse.
- Knowing service needs and developments.
- Developing response strategies to address emerging trends in behavioral health, substance abuse, suicide, and violence.
- Responding in a timely and effective manner to help all areas of the Indian Health System address emerging trends in behavioral health, substance abuse, suicide, and violence.

Action Steps		Responsibility	Type
I.A.1.	Develop a local planning model, like SAMHSA's Strategic Prevention Framework (SPF) Planning Model as a way to be current on issues and engage leadership around regional planning.	Indian Health System[5]	Short-term (12 Months or Less)
I.A.2.	Issue and widely disseminate an annual report on the state of AI/AN behavioral health, which includes mortality data, morbidity data (top 10 in behavioral health), trends (violence, suicides, co-occurring disorders, drug types), best practices, and information on resources. Include sub-sections for more focused trend analysis on priority areas, such as child mental health, youth suicide, etc.	IHS	Intermediate-term (12 to 36 Months)
I.A.3.	Work to identify funding for behavioral health IHS, Tribal, and Urban Indian Epi Center personnel to establish a central behavioral health Epi Center function for the Indian Health System and tracking national trends.	IHS	Long-term (36 Months or More)
I.A.4.	Develop recommendations and identify strategies to increase behavioral health data, generate aggregate data, and address data ownership issues. Utilize national, regional, and local data resources.	Indian Health System Leadership	Intermediate-term (12 to 36 Months)
I.A.5.	Provide a forum for Tribal- or regional-specific best practices for assessing current Tribal and AI/AN community needs.	IHS and SAMHSA	Long-term (36 Months or More)
I.A.6.	Consult with Indian Health System to conduct a national behavioral health needs assessment at least every 5 years, beginning with a national assessment of methamphetamine use in Indian Country.	IHS in consultation with IHS, Tribal, and Urban Indian health programs	Long-term (36 Months or More)
I.A.7.	Provide ongoing specialized prevention, intervention, and administrative training to better address new, emerging challenges in behavioral health and substance abuse clinical and program issues.	IHS in collaboration with SAMHSA, Tribal, and Urban Indian health programs	Long-term (36 Months or More)

[5]"Indian Health System" refers to the combination of the Indian Health Service (IHS), Tribal, and Urban Indian health programs, which more accurately describes the healthcare delivery system in Indian Country today.

Strategic Direction I – To develop and promote Tribal, Urban, and IHS behavioral health programs in a cooperative, connected, and mutually supportive Indian Behavioral Health System.

Goal B. Promoting national sharing of prevention, treatment, and education information.

Objectives

- Expand the formal relationship with existing partners to place increased emphasis on evidence-based, practice-based, and culture-based prevention, treatment, and research.
- Better coordinate the compilation of latest data, research, and information regarding AI/AN behavioral health trends, knowledge, and needs.
- Provide a way for best practices and promising practices to be shared.

Action Steps		Responsibility	Type
I.B.1.	Support community driven behavioral health research and the sharing of best practices through the HHS AI/AN Health Research Advisory Council and the Native American Research Centers for Health (NARCH).	IHS	Short-term (12 Months or Less)
I.B.2.	Promote dissemination of evidence- and culture-based research related to behavioral health through IHS, Tribal, Urban, and other research forums and gatherings, and support definitions of "evidence-based," which recognize cultural practices and knowledge, such as that of the World Health Organization (WHO).	IHS and SAMHSA	Short-term (12 Months or Less)
I.B.3.	Support the development of Tribal Institutional Review Boards (IRBs) through training and technical assistance.	Indian Health System	Intermediate-term (12 to 36 Months)
I.B.4.	Assess need for training and ongoing support of clinical supervisory positions in Tribal behavioral health programs and then collaborate with other Federal and Tribal resources, such as SAMHSA and research institutes, to promote train-the-trainer opportunities to enhance knowledge transfer and the application of agreed-upon behavioral health standards.	IHS	Intermediate-term (12 to 36 Months)
I.B.5.	Support local and regional efforts to utilize traditional AI/AN practitioners or practices within the service delivery framework for behavioral health.	Indian Health System	Intermediate-term (12 to 36 Months)
I.B.6.	Through collaboration with Tribal and Urban Indian health programs, develop a behavioral health data portal or data center for the aggregation and analysis of behavioral health trends and reporting while protecting small community confidentiality.	Indian Health System	Long-term (36 Months or More)

Strategic Direction I – To develop and promote Tribal, Urban, and IHS behavioral health programs in a cooperative, connected, and mutually supportive Indian Behavioral Health System.

Goal C. Connecting individual communities and programs with national information networks, including data sharing networks.

Objectives

- Provide Tribal, Urban, and Federal leaders with regular briefings and updates on emerging trends, knowledge, and needs regarding AI/AN behavioral health.
- Provide Tribal, Urban, and Federal leaders with the latest research and knowledge from existing scientific journal publications regarding emerging trends which may impact AI/AN communities.
- Consult with Tribal and Urban leaders on a regular basis to identify priority areas for behavioral health activities.

Action Steps		Responsibility	Type
I.C.1.	Continue support for and collaboration with Tribal and Urban leadership via continued support for NTAC and BHWG collaborations and advocacy.	Indian Health System Leadership	Ongoing
I.C.2.	Convene Tribal and Urban leadership to discuss emerging trends, understand local concerns, and identify strategies and priorities on a regular basis (at least yearly).	Indian Health System Leadership	Short-term (12 Months or Less)
I.C.3.	Support Tribal leader participation in SAMHSA activities (e.g., Tribal Technical Advisory Committee) through staff support, research, briefings, other support, and by providing an IHS/SAMHSA liaison.	IHS in consultation with Tribes and Area Health Boards	Short-term (12 Months or Less)

Strategic Direction I – To develop and promote Tribal, Urban, and IHS behavioral health programs in a cooperative, connected, and mutually supportive Indian Behavioral Health System.

Goal D. Convening and promoting Tribal, Urban, and IHS meetings, educational, program, and leadership activities to develop services and service leadership throughout the system.

Objectives

- Produce a succinct and definitive annual report on the status of AI/AN Behavioral Health to IHS Tribal and Urban partners.
- Provide an impetus for Tribal and Urban leadership to take action and respond to emerging trends, knowledge, and needs.

Action Steps		Responsibility	Type
I.D.1.	Convene an annual meeting to bring together all interested behavioral health participants to share clinical, educational, administrative, and system information across the Indian Health System.	IHS	Short-term (12 Months or Less)

Action Steps		Responsibility	Type
I.D.2.	Utilizing digital and other technologies, develop and disseminate regular informational meetings, webinars, etc., to provide information on emerging trends and system development information.	Indian Health System and Federal Partners	Short-term (12 Months or Less)
I.D.3.	Define the process for the production of a reliable, credible, and definitive report.	IHS	Short-term (12 Months or Less)
I.D.4.	Engage Indian Health System behavioral health leaders through surveys or other means to seek input and participation.	IHS	Short-term (12 Months or Less)
I.D.5.	The NTAC, with support from the BHWG, will provide input and monitor the development of the report.	IHS, NTAC, and BHWG	Short-term (12 Months or Less)

Implementation Plan for Strategic Direction II: To Realize Cultural Renewal and Wellness through an Emphasis on Sobriety, Community, Elders, and Positive Youth Development

Strategic Direction II Goals

Three major goals were identified as being critical to this strategic direction, including:

- Creating a common awareness and behavioral changes toward wellness, sobriety, and community health;
- Increasing resiliency and protective factors for AI/AN youth; and
- Ensuring that practice-based and culture-based approaches are accepted as evidence-based.

Strategic Direction II Discussion

To truly bring wellness and holistic care to AI/AN communities, the IHS and its Tribal and Urban Indian program partners must embrace the ancient wisdom and traditional knowledge that has sustained AI/AN communities since their beginnings. Finding and supporting opportunities to build upon our strengths as AI/AN people will be key to sustaining wellness. One of the three major strategies must target sustained wellness and restoration of cultural renewal.

The IHS can provide support and advocacy to Tribal and Urban Indian communities seeking to restore traditional practices. Offering to focus on resiliency over risk, strength over weakness, or community assets over community deficits is a challenging approach, given the great demand for care and gaps in funding for basic services. However, it is the only approach that will tap into the vast cultural wealth of the many traditions and practices that have sustained Tribes for thousands of years. In many cases, these efforts will require the IHS and its Tribal and Urban Indian partners to break through the limitations of Federal funding and look at unique and innovative ways of working with communities. It may require trusting local processes and local planning to solve local challenges. Traditional ceremonies and rituals can become the forum for families and whole communities to recognize, grieve, share, and commit to healing paths regarding some of the most difficult and painful aspects of behavioral health challenges facing AI/AN communities today.

AI/AN youth learn by observing the actions of the adults in their communities. Whether or not these healing paths are valid and effective will be determined by the interplay between generations of AI/AN community members. AI/AN youth are the most vulnerable to violence, suicide, and substance abuse.

They should be the priority for prevention efforts and involved in inclusive familial mental health interventions. These strategies promote a wellness agenda that embraces the richness of our AI/AN cultures. Additionally, moving toward cultural renewal and wellness will depend upon the involvement of key players and resources, including: spiritual and cultural leaders, IHS Area Directors, Tribal Health Directors, Chief Medical Officers, Tribal leaders and councils, existing local programs that are culture-based or strength-based, behavioral health directors and staff, Tribal area health boards, providers, the National Indian Health Board (NIHB); and the National Council of Urban Indian Health (NCUIH). The engagement of our elders and youth will be critical to prevent suicide, methamphetamine, substance abuse, and violence. Finally, there is a need to ensure that practice-based and culture-based approaches to behavioral health issues are accepted as evidence-based and are supported by a skilled and culturally competent workforce that can integrate these approaches into the range of behavioral health services they are able to provide.

Strategic Direction II Implementation Plan

The implementation plan tables that follow detail each major goal and corresponding objectives, the action steps seen as critical to reaching the objectives, who is responsible for each action step, and the approximate timeline for each action step to be completed, including: "short-term" (12 months or less); "intermediate-term" (12 to 36 months); and "long-term" (36 months or more).

Strategic Direction II – To realize cultural renewal and wellness through an emphasis on sobriety, community, elders, and positive youth development.

Goal A. Creating a common awareness of and supporting behavioral changes towards wellness, sobriety, and community health

Objectives

- Create a communication network for those working in behavioral health to stay up-to-date on practices, trends, and programs.
- Share best practices and promising practices among behavioral health professionals.

Action Steps		Responsibility	Type
II.A.1.	Prepare and issue a quarterly behavioral health bulletin for Tribes and Urban Indian programs via the Internet.	IHS	Short-term (12 Months or Less)
II.A.2.	Create a website portal to identify and disseminate best and promising practices in behavioral health.	IHS	Short-term (12 Months or Less)
II.A.3.	Work with Tribal Technical Advisory Group (TTAG) to ensure that culture-based and tradition-based approaches are designated as evidence-based practices for purposes of funding and reimbursement.	Indian Health System, CMS, and Behavioral Health Researchers	Intermediate-term (12 to 36 Months)
II.A.4.	Integrate cultural renewal and wellness within the healthcare institutions serving AI/AN populations, through a "Walk Your Talk" in behavioral health initiatives (alcohol, drug abuse, violence, gambling, lifestyle, exercise, nutrition, and self-care, etc.)	Indian Health System Leaders, NIHB, NCUIH	Long-term (36 Months or More)
II.A.5.	Support community-specific planning, readiness, and mobilization around the prevention of suicide, violence, and substance abuse by providing resources, collaborations, or connections to other Federal partners.	IHS, SAMHSA, BIA, BIE, DOJ, and other Federal partners	Long-term (36 Months or More)

	Action Steps	Responsibility	Type
II.A.6	Engage Area Health Boards in a coordinated effort of training, information sharing, and wellness promotion, including support for Area coordination.	IHS and Tribal Leaders	Long-term (36 Months or More)
II.A.7	Support continued work and development of gender-specific prevention and treatment issues and strategies within AI/AN communities.	Indian Health System	Short-term (12 Months or Less)

Strategic Direction II – To realize cultural renewal and wellness through an emphasis on sobriety, community, elders, and positive youth development.

Goal B. Increasing resiliency and protective factors for AI/AN youth.

Objectives

- Enhance strength-based and culture-based approaches to protect AI/AN youth, prevent suicide, prevent substance abuse, and promote positive development.
- Share prevention-based approaches and practices that are effective with AI/AN youth.
- Develop prevention efforts aimed specifically at youth suicide, methamphetamine abuse, substance abuse, and violence.

	Action Steps	Responsibility	Type
II.B.1.	Meet with the IHS Headquarters Health Promotion/Disease Prevention (HPDP) program to review strategies and opportunities to support strength-based prevention activities with AI/AN youth and to review the plan, explore partnerships, and support funding for culturally appropriate prevention programs.	IHS, NTAC, and BHWG	Short-term (12 Months or Less)
II.B.2.	Explore opportunities to share strength-based prevention strategies in schools by working with Tribal colleges and universities, the Department of Education (ED), BIE, and Tribal school boards and leaders.	IHS, ED, BIE, and Tribal Education Leaders	Short-term (12 Months or Less)
II.B.3.	Meet with the Department of Justice to coordinate behavioral health efforts aimed at mental health issues, substance abuse, and violence prevention.	IHS and DOJ	Short-term (12 Months or Less)
II.B.4.	Provide support that enables local areas, Tribes, and Urban Indian programs to collaborate more effectively with IHS Area Offices and Service Units in the development, training, and deployment of rapid response teams to bring best practices to prevent escalation of youth violence and suicide hot spots, such as utilizing Area Health Boards to house Area prevention trainers and resources.	Indian Health System and Area Health Boards	Short-term (12 Months or Less)
II.B.5.	Involve AI/AN youth in the identification and planning of strategies for the prevention of youth violence, substance abuse, and suicide.	Indian Health System in collaboration with National Youth Organizations	Short-term (12 Months or Less)
II.B.6	Focus on AI/AN youth and children through positive models that build upon resiliency and strengths, starting at early ages and in collaboration with child welfare, Head Start, and other existing resources.	Indian Health System	Short-term (12 Months or Less)

Action Steps		Responsibility	Type
I.B.7	Launch a system-wide collaboration between those working in child abuse/neglect prevention and those working in behavioral health in order to coordinate services for the whole family.	Indian Health System, BIA, States, and Tribes	Long-term (36 Months or More)
II.B.8.	Specifically address child sexual abuse and incest within the behavioral health framework to ensure a trained and prepared workforce within behavioral health and clinical settings.	Indian Health System	Intermediate-term (12 to 36 Months)

Strategic Direction II – To realize cultural renewal and wellness through an emphasis on sobriety, community, elders, and positive youth development.

Goal C. Ensuring that practice-based and culture-based approaches are accepted as evidence-based.

Objectives

- Identify and support culture-based approaches that have been proven over time to be effective across the life cycle in AI/AN communities.
- Develop a skilled, culturally competent workforce that understands and embraces the positive aspects of traditional culture and can integrate this into behavioral health approaches.

Action Steps		Responsibility	Type
II.C.1.	Survey the Indian Health System regarding the current evidence-based, practice-based, and culture-based approaches utilized in Tribal and Urban Indian communities and make those promising practices available as appropriate.	Indian Health System	Long-term (36 Months or More)
II.C.2.	Develop an Indian Health System Academy on practice- and culture-based approaches in order to provide training opportunities and instruction about best practices.	Indian Health System	Long-term (36 Months or More)
II.C.3.	In collaboration with AI/AN professionals in the field, develop a training manual to assist the Indian Health System to translate their practice- and culture-based programs into the "evidence-based language'' of the funding agencies and ensure fair treatment of traditional approaches.	Indian Health System	Long-term (36 Months or More)
II.C.4.	Provide a forum for local and regional providers to share best practices for engaging traditional practitioners within the behavioral health delivery system.	Indian Health System	Intermediate-term (12 to 36 Months)
II.C.5.	IHS will collaborate with Tribes and Urban providers to advance and promote cultural competency at all service levels, and to better understand and utilize the diversity of resources, from traditional to contemporary, that are needed to better communicate with AI/AN youth today (e.g., social media).	Indian Health System	Intermediate-term (12 to 36 Months)

Implementation Plan for Strategic Direction III: To Build a Strong Foundation for Effective Behavioral Health Services

Strategic Direction III Goals

Five major goals were identified as being critical to this strategic direction, including:

- Encouraging the development and promotion of behavioral health standards and credentials;
- Integrating behavioral health within the structure of health services;
- Developing a skilled and culturally competent workforce to meet the demand for services;
- Securing necessary reimbursement for behavioral health services; and
- Sustaining interagency partnerships in order to support behavioral health.

Strategic Direction III Discussion

There is a need to continue development of the integration of behavioral health within the overall Indian Health System. Behavioral health and behavioral health disturbances directly link to the leading causes of morbidity and mortality suffered by AI/ANs. Much more must be done to integrate behavioral health knowledge and practice at all levels of the delivery system. This plan seeks to:

1. Move the IHS, Tribal, and Urban Indian delivery programs toward seamless and holistic systems of care wherein persons served, their families, and communities can access an array of services and support designed to embrace the full spectrum of needs faced by our populations today;
2. Increase the behavioral health workforce in number and in terms of recognition within the overall Indian Health System. A more qualified and better integrated behavioral health workforce will benefit the overall system of care and recruiting and retaining qualified behavioral health providers, especially AI/AN providers, is a primary benefit;
3. Move the credentialing of behavioral health providers and the accreditation of programs to the forefront, with more effort to assist Tribal and Urban Indian programs to secure accreditation; and
4. Recognize the importance of securing additional or alternative resources through grants and through reimbursement of services. In order to secure additional funding, Tribal and Urban Indian programs will require more support from the IHS to ensure culture-based and practice-based interventions are respected and given fair and culturally appropriate assessments and consideration for designation as evidence-based approaches.

Building a strong foundation for behavioral health will depend upon the involvement of key participants and resources, including: IHS Headquarters staff; IHS Area Office staff; state behavioral health credentialing boards (alcohol, substance abuse, and mental health); health directors; Urban Indian health directors; and IHS, Tribal, and Urban Indian behavioral health providers. Some of the key agencies seen as having crucial roles in the achievement of the major goals, and who could provide critical resources to the effort, include: the Substance Abuse and Mental Health Services Administration; the Department of Interior Bureau of Indian Affairs and Bureau of Indian Education, the Department of Justice, Health Resources and Services Administration (HRSA); the Centers for Medicare and Medicaid Services (CMS); the National Institute on Alcohol Abuse and Alcoholism (NIAAA); the National Institute on Drug Abuse (NIDA); and the National Institute on Mental Health (NIMH).

Finally, specific information or data are necessary to reach the major goals of this strategic direction. These resources were identified as: IHS Trends in Indian Health; National Center for Health Statistics (NCHS); and the Centers for Disease Control and Prevention (CDC).

Strategic Direction III Implementation Plan

The implementation plan tables that follow detail each major goal and corresponding objectives, the action steps seen as critical to reaching the objectives, who is responsible for each action step, and the approximate timeline for each action step to be completed, including: "short-term" (12 months or less); "intermediate-term" (12 to 36 months); and "long-term" (36 months or more).

Strategic Direction III – To Build A Strong Foundation for Effective Behavioral Health Services.

Goal A. Encouraging the development and promotion of behavioral health standards and credentials.

Objectives

- Ensure that minimum behavioral health standards and credentials are developed and reached on a consistent basis.
- Ensure that there are more accreditation programs.

	Action Steps	Responsibility	Type
III.A.1.	Improve the quality of behavioral health programs by ensuring the distribution of the behavioral health standards from the Indian Health Manual to Indian Health System programs and Area Offices.	IHS and Area Offices in consultation with Area Health Boards and Tribes	Short-term (12 Months or Less)
III.A.2.	Study the feasibility of developing a national, culturally appropriate Indian behavioral health accreditation body that enhances the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission (JC), and Accreditation Association for Ambulatory Health Care (AAAHC) standards.	Indian Health System including Youth Regional Treatment Center (YRTC) Directors	Intermediate-term (12 to 36 Months)
III.A.3.	Develop and provide accreditation guidelines or manuals that will be available to Tribal and Urban Indian programs for program development and consistent quality improvement of services.	IHS in consultation with Tribes, Urban Indian programs, andYRTC Directors	Long-term (36 Months or More)
III.A.4.	Provide technical assistance to Indian Health System in healthcare accreditation, licensing, certification and credentialing and the development of protocols and processes for Tribal licensing of Tribal facilities, providers, and/or services.	IHS in collaboration with Tribes, Urban Indian programs, YRTC Directors, and CARF	Long-term (36 Months or More)
III.A.5.	Encourage all Indian Health System programs to apply clinical standards as a priority to clinical supervisory positions and the variety of ways these services are provided, including through tele-behavioral health and tele-psychiatry.	Indian Health System	Long-term (36 Months or More)
III.A.6.	IHS, in consultation with Tribal and Urban leaders, will examine the creation, development, and deployment of a nationally funded crisis team to respond to behavioral health crises without depleting local resources. The guidelines for declaring a state of emergency and processes required to access emergency resources will be made available to all communities on an ongoing basis.	Indian Health System	Long-term (36 Months or More)

Action Steps		Responsibility	Type
III.A.7.	Expand opportunities for integrated care through the Electronic Health Record and work to ensure and protect patient confidentiality.	Indian Health System	Long-term (36 Months or More)

Strategic Direction III – To Build A Strong Foundation for Effective Behavioral Health Services.

Goal B. Integrating behavioral health within the structure of health services.

Objectives

- Ensure integration, treatment planning, and assessment.
- Ensure behavioral health outreach and education for providers and persons served.
- Ensure access to needed medications, AI/AN traditional and other treatments, and facilities.
- Ensure integrated continuum of care.

Action Steps		Responsibility	Type
III.B.1.	Include a special track for integrated care in the annual behavioral health conference and integrate substance abuse, suicide, and mental health collaboration and cross referrals throughout the Indian Health System.	IHS	Short-term (12 Months or Less)
III.B.2.	Recognize the heavy influence of biomedical models in IHS as well as the need for more integrated care by creating a track within the various IHS health conferences and meetings that addresses behavioral health and integrated care.	IHS	Short-term (12 Months or Less)
III.B.3.	Assist the Indian Health System to make needed prescribed psychotropic medications available to persons served. Provide training to providers on medical, traditional, and other treatments for methamphetamine-related mood disorders, opioid detoxification, maintenance, and recovery.	IHS, CMS, and States	Short-term (12 Months or Less)
III.B.4.	Identify benchmarks and outcome measures to assess whether behavioral health is being integrated into health delivery systems. Existing efforts will be considered, such as GPRA indicators, etc. Sexual assault screening initiatives and referrals to behavioral health initiatives should also be considered. Methamphetamine and suicide interventions and prevention efforts should be a priority.	Indian Health System	Short-term (12 Months or Less)
III.B.5.	Share results and best practices between the Policy Academy on Co-Occurring Disorders for Tribal teams and Improving Patient Care sites. These measures and standards will be made available to IHS, Tribal, and Urban Indian programs for voluntary standard targets.	IHS and SAMHSA	Short-term (12 Months or Less)
III.B.6.	Explore joint sponsorship of a Policy Academy on co-occurring disorders for Tribal, IHS, and Urban Indian providers. Suicide and methamphetamine prevention should be directly addressed.	IHS and SAMHSA	Short-term (12 Months or Less)

Action Steps		Responsibility	Type
III.B.7.	Define quality standards of care for intervention and treatment of methamphetamine use and assess access to appropriate levels of care Area by Area.	Indian Health System	Long-term (36 Months or More)
III.B.8.	In partnership with local community members and persons served (including youth), conduct an education and awareness campaign to inform providers, persons served, and community members about behavioral health issues and resources.	Indian Health System	Intermediate-term (12 to 36 Months)
III.B.9.	Through local leadership, integrate behavioral health within the larger aftercare and prevention framework of housing, law enforcement, education, and social services.	Local Tribal and Urban Indian Leaders	Long-term (36 Months or More)

Strategic Direction III – To Build A Strong Foundation for Effective Behavioral Health Services.

Goal C. Developing a skilled and culturally competent workforce to meet the demand for services.

Objectives

- Promote workforce development through new recruitment.
- Ensure workforce retention through ongoing support, salary, training, and other benefits.
- Ensure ongoing continuing education and support of workforce.

Action Steps		Responsibility	Type
III.C.1.	Provide an annual report on the behavioral health workforce which will include overall numbers on services provided by the Indian Health System, vacancies, turnover, and other issues, such as licensure, salary parity, and general trends or needs.	Indian Health System	Short-term (12 Months or Less)
III.C.2.	Recognize the burnout of the workforce from compassion fatigue and internalizing trauma. Provide a forum for the workforce to deal with compassion fatigue at the annual behavioral health conference that will encourage local, mutual support of peers through meetings, wellness days, and other strategies.	Indian Health System	Short-term (12 Months or Less)
III.C.3.	Identify ways to provide ongoing culturally competent orientations for employees and contractors tailored to the specific population being served and the demographics of the workforce. The content of the orientation must reflect the cultural issues at the local level (e.g., language, local practices, beliefs, customs, protocols).	Indian Health System	Short-term (12 Months or Less)
III.C.4.	Create rotation opportunities at Indian Health System facilities for behavioral health professionals and other integrated health providers in existing and new (e.g., cultural liaison) positions.	Indian Health System	Intermediate-term (12 to 36 Months)

Action Steps		Responsibility	Type
III.C.5.	Address housing needs for behavioral health workforce. IHS will initiate discussions with the Department of Housing and Urban Development (HUD) to explore housing options for behavioral health internships and recruitments. They will also look into Indian Community Development Block Grants to support behavioral health housing. IHS will reconsider priority housing for behavioral health professionals within IHS Headquarters resources.	Indian Health System	Long-term (36 Months or More)
III.C.6.	Seek additional funding for health career scholarships and web-based certification and licensure training specifically targeted at behavioral health professions, such as social work, psychology, counseling, etc. Change the priorities for health scholarships to emphasize behavioral health professionals training.	Indian Health System	Long-term (36 Months or More)
III.C.7.	Implement a mentoring/internship/preceptorship initiative that provides recruitment of a new AI/AN workforce into behavioral health fields, by focusing resources and creating opportunities on a national and local level (e.g., National Behavioral Health Conference).	Indian Health System	Long-term (36 Months or More)
III.C.8.	Provide training to the workforce on culturally and evidence-based treatments for methamphetamine addiction, sexual assault, abuse, suicide prevention, violence prevention, and child abuse identification and intervention, issues that are often co-occurring/interdependent.	Indian Health System	Long-term (36 Months or More)
III.C.9.	Recognize leadership within the Indian Health System and create and maintain effective leadership training.	Indian Health System	Intermediate-term (12 to 36 Months)

Strategic Direction III – To Build A Strong Foundation for Effective Behavioral Health Services.

Goal D. Securing necessary reimbursement for behavioral health services.

Objectives

- Increase funding options for local programs.
- Resolve interstate billing barriers for multi-state providers.

Action Steps		Responsibility	Type
III.D.1.	Seek inclusion of behavioral health treatment in the "all inclusive rate" negotiated between CMS, Office of Management and Budget (OMB), and IHS for Tribal and Urban Indian providers.	IHS and CMS in consultation with Tribal and Urban Indian Leadership; NIHB, NCUIH, and State Division of Health Offices	Intermediate-term (12 to 36 Months)

Action Steps		Responsibility	Type
III.D.2.	Provide training and technical assistance to ensure behavioral health programs are able to access current and emerging billing opportunities for all services and included on provider lists for States, Tribes, and Federal reimbursement systems.	IHS in collaboration with CMS, Tribal, and Urban Indian Leadership; NIHB and NCUIH	Intermediate-term (12 to 36 Months)
III.D.3.	Work with SAMHSA to provide training and technical assistance to increase AI/AN-specific culture- or tradition-based interventions designated as effective under the National Registry for Evidence-Based Programs and Practices (NREPP).	IHS and SAMHSA in consultation with Tribal and Urban Indian Leadership	Intermediate-term (12 to 36 Months)
III.D.4.	Work with CMS to address unique situations experienced by behavioral health programs, such as broadening licensure requirements for billing purposes and cross-state border reimbursement issues.	Indian Health System	Intermediate-term (12 to 36 Months)
III.D.5.	Seek amendments to State Medicaid plans to take into consideration unique situations experienced by Tribal, Urban, or IHS operated behavioral health provider systems, in partnership with CMS and IHS leadership.	IHS in consultation with CMS, Tribal and Urban Indian Leadership, NIHB, NCUIH, State Division of Health Offices, and Tribal Liaisons	Long-term (36 Months or More)
III.D.6.	Seek support from CMS, IHS, and SAMHSA to ensure that cultural, traditional, or faith-based interventions and practices utilized in AI/AN behavioral health programs are considered as "evidence-based programs or practices" for purposes of reimbursement and provide training and technical assistance to secure evidence-based designation.	IHS, CMS, and SAMHSA in consultation with Tribal and Urban Indian Leadership	Long-term (36 Months or More)
III.D.7.	Initiate training and information to Indian Health System regarding new billing and reimbursement opportunities under the ACA and IHCIA.	IHS and CMS	Short-term (12 Months or Less)

Strategic Direction III – To Build A Strong Foundation for Effective Behavioral Health Services.

Goal E. Sustaining interagency partnerships in order to support behavioral health.

Objectives

- Maximize resources.
- Expand network and bring in new partners from other Federal agencies, Veterans Affairs (VA), DOJ, CDC, Temporary Assistance for Needy Families (TANF), SAMHSA, National Institutes of Health (NIH), Office of Minority Health (OMH), and the Department of Health and Human Services (HHS) Advisory Committee on Minority Health.

Action Steps		Responsibility	Type
III.E.1.	Seek support from the HHS Office of the Secretary by informing the members of the Interdepartmental Council on Native American Affairs and recruit their support for the strategic plan.	IHS	Short-term (12 Months or Less)

Action Steps		Responsibility	Type
III.E.2.	Work with Tribal leaders to pursue increased multi-agency behavioral health funding and the development of a multi-agency behavioral health allocation process, including but not limited to HHS, HUD, DOI, DOJ, ED, BIA, BIE, and other agencies.	IHS, Tribes, Urban Indian programs, BIA, BIE, DOJ, and other Federal agencies	Intermediate-term (12 to 36 Months)
III.E.3.	Develop and disseminate a policy brief to increase Tribal and Urban Indian access to behavioral health grants from other Federal agencies. Include communication strategies for remote communities with limited access to technology.	IHS and other National AI/AN Organizations	Short-term (12 Months or Less)
III.E.4.	Modify the IHS Epidemiology cooperative agreements to facilitate an inter-agency approach to the collection and use of aggregate behavioral health data in Tribal/Urban, regional, and national profiles.	IHS in collaboration with Epi Centers, Area Directors, Area Health Boards	Intermediate-term (12 to 36 Months)

References

[1] Center for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. Chronic Diseases and Health Promotion. In Chronic Disease Prevention and Health Promotion. Retrieved from http://www.cdc.gov/chronicdisease/overview/index.htm.

[2] The NSDUH Report. (2007). Substance use and substance use disorders among American Indians and Alaska Natives. Office of Applied Statistics. Retrieved Februrary 28, 2010, from http://www.oas.samhsa.gov/2k7/AmIndians/AmIndians.htm.

[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2007). *Fetal Alcohol Spectrum Disorders Among Native Americans*. Retrieved November 22, 2010, from http://www.fasdcenter.samhsa.gov/documents/NI_WYNTK_FASD_Among_AIAN.pdf .

[4] Indian Health Service. (2008). *2008 Indian Health Service Annual Report*.

[5] Vigil, D. (2006, May 17). *Testimony given before the United States Senate Committee on Indian Affairs. Oversight Hearing on the Tradegy of Indian Youth Suicide.* (GPO Publication 27-643 PDF). Washington, DC: U.S. Government Printing Office.

[6] National Congress of American Indians. (2006). *Methamphetamine in Indian Country: An American Problem Uniquely Affecting Indian Country.* Retrieved March 27, 2010, from https://www.ncai.org/ncai/Meth/Meth_in_Indian_Country_Fact_Sheet.pdf.

[7] Evans, M. (2006). *National Methamphetamine Initiative Survey: The status of the methamphetamine threat and impact on Indian lands, an analysis.* Retrieved August 26, 2009, from http://www.ncai.org/ncai/Meth/BIA_MethSurvey.pdf.

[8] Callor, W. B., Petersen, E., Gray, D., Grey, T., Lamoreaux, T., & Bennett, P. (2005). Preliminary Findings of Noncompliance with Psychotropic Medication and Prevalence of Methamphetamine Intoxication Associated with Suicide Completion. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 26*, 78-84.

[9] Center for Substance Abuse Treatment. (2007). *The Epidemiology of Co-Occurring Substance Use and Mental Disorders.* COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services.

[10] Center for Substance Abuse Treatment. (2006). *Definitions and Terms Relating to Co-Occurring Disorders*. COCE Overview Paper 1. DHHS Publication No. (SMA) 06-4163 Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services.

[11] Indian Health Service. (n.d.). *Trends in Indian Health*, 2002-2003. Rockville, MD: Indian Health Service.

[12] The Office of Minority Health. (n.d.) Suicide Prevention Research in Indian Country. Retrieved February 28, 2010, from http://minorityhealth.hhs.gov/hrac/templates/content.aspx?lvl=1&lvlID=43&ID=7768.

[13] Statewide Suicide Prevention Council. (2004). *Report to the Legislature 2004.* Fairbanks, AK.

[14] Roubideaux, Y. (2009, September 10). *Statement given before the Senate Committee on Indian Affairs on S. 1635, 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.* Washington, DC. Retrieved February 28, 2010, from http://indian.senate.gov/public/_files/YvetteRoubideauxtestimony0.pdf.

[15] Grim, C.W. (2006, May 17). United States. Indian Health Service. *The Senate Committee on Indian Affairs on Suicide Prevention Programs and Their Application in Indian Country*. Retrieved from http://www.indian.senate.gov/public/_files/Grim051706.pdf.

[16] Roubideaux, Y. (2009, September 10). *Statement given before the Senate Committee on Indian Affairs on S. 1635, 7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.* Washington, DC. Retrieved February 28, 2010, from http://indian.senate.gov/public/_files/YvetteRoubideauxtestimony0.pdf.

[17] LeFauve, Charlene E. (2005). Understanding Co-Occurring Disorders: Piecing the Puzzle Together. Presentation at Center for Substance Abuse Treatment National Advisory Council Meeting. Retrieved November 30, 2010 from http://coce.samhsa.gov/cod_resources/PDF/UnderstandingCo-OccurringDisorders-PiecingthePuzzleTogether05-05.pdf.

[18] Center for Disease Control (2008). Adverse health conditions and health risk behaviors associated with intimate partner violence-United States, 2005. *MMWR, 57*(05), 113-117. Retrieved March 2, 2010, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5705a1.htm.

[19] Sacred Circle and the National Congress of American Indians Task Force on Violence Against Women in Indian Country. (2006, September). Restoration of Safety for Native Women. *Restoration of Native Sovereignty. Vol. 5.*

[20] Department of Justice, Bureau of Justice Statistics National Crime Database.

[21] Sacred Circle and the National Congress of American Indians Task Force on Violence Against Women in Indian Country. (2006, September). Restoration of Safety for Native Women. *Restoration of Native Sovereignty. Vol. 5.*

[22] U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. (2004, December). *American Indians and Crime: A BJS Statistical Report, 1992-2002.* Retrieved March 4, 2010 from http://www.justice.gov/otj/pdf/american_indians_and_crime.pdf.

[23] Ibid.

[24] Ibid.

[25] Walters, K. and Simoni, J. (1999). "Trauma, substance use, and HIV risk among urban American Indian women." *Cultural Diversity and Ethnic Minority Psychology*. 5:3, 2369-248.

[26] Saylors, K. and Daliparthy, N. (2006). "Violence Against Native Women in Substance Abuse Treatment." *American Indian and Alaska Native Mental Health Research: The Journal of the National Center. 13:1*, 32-51.

[27] Kennedy, Richard D. and Roger E. Deapen. (1991, January-February). Differences Between Oklahoma Indian Infant Mortality and Other Races. *Public Health Reports, 106*(1), 97–99.

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2011 - 2015