

American Indian/Alaska Native National Behavioral Health Strategic Plan FY 2010/11 – 2014/15

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Prepared by the
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Introduction

Welcome to the 2010/11-2014/15 5-year strategic plan for behavioral health. It has been prepared collaboratively between the Indian Health Service, Division of Behavioral Health (IHS, DBH), the National Tribal Advisory Committee on Behavioral Health (NTAC), and the Behavioral Health Work Group (BHWG).

The 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 Services efforts to address behavioral health in American Indian/Alaska Native (AI/AN) communities. NTAC is composed exclusively of elected tribal leaders who are designated by the IHS Area Director from each IHS Area.

The IHS Behavioral Health Work Group (BHWG) was established as a technical group of subject matter experts charged with providing guidance to the Agency 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.

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, AI/AN tribes, and Urban Indian programs (I/T/Us) to respond to the growing evidence about how behavior and lifestyle affect health conditions. Across the I/T/U system, behavioral health initiatives are focused on integrating primary health and treatment services with prevention and mental health approaches in an effort to improve health outcomes. According to the Centers for Disease Control and Prevention, health behaviors account for 50% of what determines life expectancy, and 6 of the top 10 leading causes of death can be managed or prevented through behavior modification.

The future of 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, and community and cultural 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 historic trauma; ongoing AI/AN experiences of situations where their culture is not valued; and successfully achieving the hope envisioned within 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 passed *Indian Health Care Improvement Act* (IHCA) 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. In essence, social determinants of health approaches that recognize that factors such as education, economic development, justice, housing, and others have a great impact on the health and well being on AI/AN people and communities.

In addition to this broad scope of behavioral health, it is also critical that efforts to be more strategic respond to changes in the current environment. An initial draft of a behavioral health strategic plan was prepared in April 2008 and forms the basis of this draft. In particular, this current iteration of the strategic plan responds to the priorities of the IHS Director, the March 2010 passage of the *Patient Protection and Affordable Care Act*, and the IHVIA Amendments contained within that bill.

Immediately following her appointment in May 2009, IHS Director, Dr. Yvette Roubideaux (Rosebud Sioux), identified four priorities through which the work of the IHS could be changed and improved over the next few years. The priorities are listed below.

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

Since then, considerable progress has been made on those priorities, each of which has implications for behavioral health throughout the I/T/U system. Progress made toward the Director's priorities is described below to provide context for the environment in which this strategic plan has been developed.

IHS Director's 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 Health and Human Services (HHS) around tribal consultation. While the HHS/IHS is perceived to have a good tribal consultation policy, improvements to the process of how those consultations are managed are being pursued. The IHS Director's conversations with tribal leaders has also led to an effort to streamline the number of and better coordinate the relationships between various advisory and consultation committees and working groups within 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 Advisory Committee) an avenue to secure both technical and political input on matters related to behavioral health.

IHS Director's Priority 2: To Bring Reform to the IHS in the Context of National Health Reform

During the development of the House and Senate bills dealing with health insurance reform, IHS has focused on ensuring that tribal priorities were accommodated within the legislative process. With the passage of the *Patient Protection and Affordable Care Act* (PPACA), the health insurance reform debate moves to a new phase and, given the wide range of views on its impact, promises to be a major environmental factor for the foreseeable future. In addition, the landmark legislation also included the long awaited reauthorization of the IHCA, which has specific provisions that address behavioral health improvements.

Part III, Section 10221 of the PPACA enacts into law the revisions and extensions relating to the Indian Health Care Improvements contained in Senate Bill S. 1790, with a few amendments. The key feature of the IHCA from a behavioral health perspective is Title VII – Behavioral Health Programs, which was amended to encompass the broader focus of behavioral health as compared with the IHCA's previous focus on substance abuse (For summaries of the IHCA and the PPACA, see the IHS Director's website at <http://www.ihs.gov/PublicAffairs/DirCorner>).

Behavioral health is 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." Title VII calls for the development of Area-wide behavioral health service plans and authorizes the Secretary to provide where feasible, a comprehensive continuum of behavioral health prevention, intervention/treatment, outpatient and aftercare programs, and services throughout the AI/AN population (e.g., child care, adult care, elder care).

Within PPACA overall, the provisions enabling I/T/U health programs to secure insurance reimbursements for the large proportion of AI/AN without health insurance beyond Medicaid/Medicare could potentially support increased access to behavioral health programs and services and in the longer term contribute to improved health. Other Indian-specific/non-IHCA provisions relate to how I/T/U input will be incorporated into the work of several preventive, promotion, and population health mechanisms. It will be important to determine what advocacy efforts can be undertaken and what linkages can be made with the work of the National Promotion and Public Health Council, the Community Preventive Services Task Force, and in the education and outreach efforts particularly with primary care providers and specific segments of the Indian population.

IHS Director's 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 resources. I/T/U 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 health care delivery system and to be team members to address behavior related morbidity and mortality. This plan reaches beyond the traditional notion of behavioral health and opens the door to expanded collaboration with other disciplines. Evidence-based, culture-based, and practice-based prevention, treatment, and research as well as responsive behavioral health systems are specifically addressed within Strategic Direction 1.

IHS Director's Priority 4: To Make All of Our Work Transparent, Accountable, Fair, and Inclusive

This priority emphasizes the importance placed upon broad communication while moving forward on bringing about changes and improvements. IHS Area Directors will be asked to begin the process of increased transparency regarding their activities in their respective Areas. In addition, IHS Area Directors will also be asked how they plan to make needed changes and improvements in line with the four IHS Director's priorities. Transparency, accountability, 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 builds upon the work conducted when the IHS' Behavioral Health Initiative was first introduced in 2005, and it emerges at a time 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 I/T/U system.
- **Shared Vision:** A vision statement on where the behavioral health effort will be in 5 years, by 2015. This statement is intended to represent a vision that is shared between the IHS and the tribal and urban programs and helps to focus our work in the coming years.
- **Challenges to the Vision:** A realistic inventory of the challenges, obstacles, and contradictions that IHS and tribal and urban communities will need to address in order to move forward and achieve their shared vision.
- **Strategic Directions:** This plan provides a framework for how the IHS, working in close partnership and collaboration with tribal and urban communities can 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 how the strategic plan will be implemented over the next 5 years (2010-2015). Given the broad applicability of this strategic plan

throughout the I/T/U system, the process to be used to finalize it will no doubt provide additional insight into how these plans could be reflected at the local and Area levels.

Background Information

The IHS' mission is to improve the mental, physical, social, and spiritual health of approximately 1.9 million AI/ANs to the highest level while working in close partnership with tribes and urban organizations. Behavioral health is key to meeting 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 that have been integrated and shaped by the values and traditions of AI/AN cultures.

However, significant disparities still exist. This is demonstrated by statistical and descriptive evidence of AI/AN death rates and certain 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.

Trends in Indian Health

The IHS document titled *Trends in Indian Health* provides basic statistical information, including but not limited to general mortality and community health statistics. Table 1 shows AI/AN death rates (per 100,000 population) as reported in the IHS *Trends* documents (1998/99 and 2002/2003).¹ Notably, most rates appear to have decreased a small amount from the 1998/99 report to the 2002/03 report, with the exception of drug-related death rates, which nearly doubled. The 2002/03 report also pointed out that the 15.0/1000 rate for drug related deaths signified a 206% increase “since drug-related death rates were first introduced for AI/ANs in 1979.”

Table 1. Comparison of AI/AN Death Rates in 1998/99 IHS Trends and 2002/03 IHS Trends (per 100,000 population)

CAUSE	1998-1999 TRENDS REPORT	2002-2003 TRENDS REPORT
<i>Alcohol-related</i>	48.7	43.7
<i>Drug-related</i>	8.4	15.0
<i>Suicide</i>	19.3 (all ages) 53.5 (males aged 15-24) 66.7 (males aged 25-34)	17.9 (all ages) 51.9 (males aged 15-24) 61.0 (males aged 25-34)
<i>Homicide</i>	15.3	12.2

Even with the modest decrease in alcohol, suicide, and homicide-related death rates reflected in Table 1, AI/AN death rates continue to alarmingly surpass the death rates of U.S. all-races rates. Indeed, the statistics published in the two most recent IHS *Trends* reports provide a powerful glimpse of how certain behavioral health-related issues affect AI/AN death rates. Table 2 shows

¹ The rates published by the IHS in these two documents were adjusted to compensate for misreporting of AI/AN race on state death certificates.

death rates for AI/AN populations as compared to the U.S. all-races rate by behavior-related causes.

Table 2. AI/AN Death Rates Associated with Behavior-Related Causes Compared to U.S. All-Races Rates

CAUSE	1998-1999 TRENDS REPORT	2002-2003 TRENDS REPORT
<i>Alcohol-related</i>	627% greater	524% greater
<i>Accidents</i>	204% greater (all accidents)	235% greater (motor vehicle crashes) 153% greater (unintentional injuries)
<i>Suicide</i>	72% greater	66% greater
<i>Homicide</i>	63% greater	103% greater

The major health challenges facing AI/AN communities, whether in rural, tribal, 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, in particular, methamphetamine abuse); suicide; domestic violence; and sexual assault.

Alcohol and Other Substance Abuse

The serious issues of alcohol and other illicit substances, and the effect they have on all members of 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.¹ Alcohol-related deaths for AI/ANs have remained the highest since at least 1996. As discussed previously, the most recent IHS *Trends* publication states that AI/AN alcohol-related death rate is 524% greater than the U.S. all-races rate.

AI/AN drug-related deaths nearly doubled from the 1998-99 report to the 2002-03 report. This increase may be attributable to methamphetamine use, which represents one of the leading 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’ 2008 Annual Report describes the serious

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 524% greater than the U.S. all-races rate.*

⁺*from Trends in Indian Health, 2002-2003*

concern of meth use among AI/ANs, stating “AI/AN people have a meth use rate that is over three times the rate for the general population.”ⁱⁱ The problems reported by individual tribes are particularly troubling, demonstrating that the meth 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.ⁱⁱⁱ

In a 2006 paper, the National Congress of American Indians (NCAI) stated that methamphetamine “has disproportionately devastated Native American tribal communities”^{iv} and urged a comprehensive, coordinated response to address this threat on 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 physical body and brain and leads to a myriad of other social problems such as child abuse and neglect, domestic violence, and skyrocketing crime rates.^v 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 is unexpectedly high and requires further investigation.^{vi} The Methamphetamine Reduction funding and programs provided through the IHS’ Behavioral Health Initiative 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.”

Suicide

Suicide in Indian Country is a significant behavioral health issue putting AI/AN communities and villages at risk. 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 170% times higher than the U.S. all-races rate for all ages.^{vii} 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).^{viii}

Alaska Natives commit suicide at rates four times the national average. For Alaska Native males, the suicide rate is six times higher than the national average, with teen suicide rates nearly six times the rate of non-Native teens.^{ix}

In some communities, the suicide rate is even higher, often due to suicide clusters. In her September 2009 statement before the Senate Committee on Indian Affairs, IHS Director and enrolled member of the Rosebud Sioux Tribe, Dr. Yvette

Suicide Statistics⁺

- ***The AI/AN suicide rate in the IHS Service Area is 170% 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 64% of all suicides in Indian Country***

⁺*from Trends in Indian Health, 2002-2003*

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.”^x

Addressing these issues in Native communities requires public health and community interventions as much as clinical interventions,^{xi} yet these services are not always available. Indeed, in that same testimony IHS Director 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.”^{xii}

Domestic Violence and Sexual Assault

Domestic violence and sexual assault are serious problems in Indian Country. In fact, according to the Centers for Disease Control and Prevention, 39% of Native women have experienced intimate partner violence – the highest percentage in the U.S.^{xiii} In addition, one out of every three AI/AN women is raped in her lifetime,^{xiv} and AI/AN women are more than five times as likely to die from domestic violence-related injuries than women of any other race.^{xv} 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.”^{xvi}

Women are not the only members of AI/AN communities affected by violence. Men are victims as well, and we know whole families and communities are affected by violence in many ways. Indeed, the violent crime rate for Native Americans 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 of Native

Americans 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.^{xvii}

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.^{xviii} Victims also experience negative emotional and mental health problems such as stress, depression, anger, self-hatred, and post-traumatic stress

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***

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.^{xix} They are also more likely to engage in risky sexual behaviors, which can lead to an increased risk of contracting sexually transmitted 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.^{xxxxi} All of these statistics paint a bleak picture, showing that the cycle of violence and substance abuse is continuing to perpetuate itself, threatening public health and community safety.

Addressing These Issues

The seriousness of methamphetamine and other drug use, suicide, along with domestic violence and sexual assault calls for an equally serious focus on solving these problems. Solutions, however, are not simple to achieve. In this context, in July 2005, the IHS announced three major initiatives: the IHS Behavioral Health Initiative (BHI); the Chronic Care Initiative; and the Health Promotion and Disease Prevention Initiative in order to bring much needed attention to behavioral health and its relationship to the prevention of chronic disease, preventable mortality, and health promotion. The BHI, with its focus in four major areas (Methamphetamine Reduction, Suicide Prevention, Child Protection, and the Behavioral Health Management Information System), is focused on the strength and resiliency of AI/AN communities. The BHI is also geared toward the implementation of strategies and techniques within IHS, tribal, and urban health programs 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 BHI will identify and support innovative efforts within the 12 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 BHI encompasses the following 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 behavioral health treatment and prevention efforts;
7. To promote the capacity for self-determination and self-governance; 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 problems. Despite new grant programs dedicated to addressing methamphetamine, suicide, domestic violence, and sexual assault, resources remain insufficient to address the needs of 562 federally recognized tribes and the multitude of urban 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



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 not to get bogged down or distracted, but 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, that a common shared vision for behavioral health and wellness might not exist. It will be important to find ways to create this shared vision. Additionally, leaders from diverse professional disciplines must come together around an integrated behavioral health agenda. This can be challenging when professional disciplines have been separated for so many years.

Funding is always a challenge. Lack of funding for the vast network of systems needed to provide support to Native communities is well known. With limited funding, there is also institutional or programmatic turf protection leading to a resistance to new and integrated behavioral health models.

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 surmount to an increasingly challenging environment for staff. These negative factors may impact the effectiveness of those trying to make positive behavioral health changes in Native communities. More support for those in this line of work will be needed in the future.

Historical trauma inherent in the experiences of AI/AN communities, including the generational effects of Indian wars, forced relocation, genocide, isolation, removal of children to boarding schools, racism, poverty, and cultural loss have impacted communities. The loss of economic self-sufficiency for some communities created multigenerational dependency. The mental health and substance abuse manifestations of this historical trauma include alcoholism/substance abuse, child abuse/neglect, sexual abuses, domestic violence, bullying, suicide, and other self-destructive behaviors, all of which create additional pressures on behavioral health systems.

Behavioral health and wellness are emerging concepts in Western Medicine, but are historical, traditional concepts of world views shared by most Native tribes. Reconnecting with this ancient wisdom is a challenge when resources are limited to meeting basic health needs. Limited awareness of resources and systems within AI/AN communities that can be used for behavioral health activities is an additional challenge. There is a need for more work to bring the mental health, medical, traditional medicine, and substance abuse fields together around integrated approaches.

Strategic Directions for the Future

This strategic plan provides three strategic 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 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 Native youth; and
- c. Ensuring that practice-based and culture-based approaches are accepted as evidence-based.

II. 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 demand for services;
- d. Securing necessary reimbursement for behavioral health services; and
- e. Sustaining interagency partnerships in order to support behavioral health.

III. To establish targeted, prepared, and responsive behavioral health care throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs (I/T/Us) by:

- a. Providing epidemiological updates on behavioral health trends, hot spots, and emerging issues;
- b. Ensuring access to the latest research, training, and knowledge;
- c. Interfacing with tribal leadership to give voice and response to emerging trends and needs; and
- d. Developing and issuing an annual report on the State of AI/AN Behavioral Health.

Implementation Strategy

Implementation Plan Strategic Direction I:

To Realize Cultural Renewal and Wellness through an Emphasis on Sobriety, Community, Elders, and Positive Youth Development

Strategic Direction I 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 Native youth; and
- Ensuring that practice-based and culture-based approaches are accepted as evidence-based approaches.

Strategic Direction I Discussion

To truly bring wellness and holistic care to AI/AN communities, the IHS and its tribal and urban program partners must embrace the ancient wisdom and traditional knowledge that has sustained AI/AN communities. Finding and supporting opportunities to build upon our strengths as Native 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 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 partners to break through the limitations of federal funding and look at unique and innovative ways of working with community. 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.

Native 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. Native youth are the most vulnerable for violence, suicide, and substance abuse. They should be the priority for prevention efforts and involved in inclusive familial mental health interventions. The Workgroup offers strategies for the IHS to help tribal and urban leaders to push a wellness agenda that embraces the richness of our Native cultures. Additionally, moving toward cultural renewal and wellness will depend upon the involvement of key players and resources, including: Spiritual and cultural leaders (IHS

Traditional Initiative); IHS Area Directors; Division of 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 on 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 for evidence-based research underlying practice and culture as well as evidence supporting holistic approaches, such as treatment for children and family therapy.

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).

<i>Strategic Direction I – To realize cultural renewal and wellness through an emphasis on sobriety, community, elders, and positive youth development.</i>			
Goal A. Creating a common awareness of and supporting behavioral changes towards wellness, sobriety, and community health.			
Objectives			
<ul style="list-style-type: none"> • 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
I.A.1.	Prepare and issue a quarterly behavioral health bulletin and provide for tribes and urban programs via the Internet.	IHS BH	Short-term (12 Months or Less)
I.A.2.	Collaboratively create a website portal to identify and disseminate best and promising practices in behavioral health.	IHS	Short-term (12 Months or Less)
I.A.3.	Work with Tribal Technical Advisory Group (TTAG) to ensure that culture-based and traditional-based approaches are designated as evidence-based practices for purposes of funding and reimbursement.	IHS CMS in consultation with tribes, urban programs, and behavioral health researchers	Intermediate-term (12 to 36 Months)
I.A.4.	Integrate cultural renewal and wellness within the health care institutions serving Native populations, through a “Walk Your Talk” in behavioral health initiatives (alcohol, drug abuse, violence, gambling, lifestyle/exercise/nutrition, self-care, etc.)	IHS in consultation with tribal and urban leaders NIHB NCUIH	Long-term (36 Months or More)

I.A.5.	Support community-specific planning and mobilization around the prevention of suicide, violence, and substance abuse by providing resources, collaboration, or connections to other federal partners.	IHS, SAMHSA and other federal partners	Long-term (36 Months or More)
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Strategic Direction I – 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 Native youth.

Objectives

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

Action Steps		Responsibility	Type
I.B.1.	Meet with the IHS Headquarters Health Promotion/Disease Prevention (HPDP) Director to review strategies and opportunities to support strengths-based prevention activities with Native youth and to review the plan, explore partnerships, and support funding for culturally appropriate prevention programs.	IHS in collaboration with the NTAC and BHWG	Short-term (12 Months or Less)
I.B.2.	Explore opportunities to share strength-based prevention strategies in schools by working with the IHS education specialists, the Department of Education, and the Bureau of Indian Education.	IHS in collaboration with the Department of Education and Bureau of Indian Education	Short-term (12 Months or Less)
I.B.3.	Meet with the Department of Justice to coordinate behavioral health efforts aimed at mental health issues, substance abuse and violence prevention.	IHS	Short-term (12 Months or Less)
I.B.4.	Provide support that enables local areas, tribes, and urban 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.	IHS	Short-term (12 Months or Less)
I.B.5.	Involve Native youth in the identification and planning of strategies for the prevention of youth violence, substance abuse, and suicide.	I/T/U ² in collaboration with national youth	Short-term (12 Months or Less)

² I/T/U refers to the combination of Indian Health Service (IHS), American Indian and Alaska Native Tribes, and Urban Indian in a system of delivery

		organizations	
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Strategic Direction I – 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 approaches.

Objectives

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

I.C.1.	Survey I/T/Us regarding the current culture-based, practice-based, and evidence-based approaches utilized in tribal and urban communities.	IHS in collaboration with I/T/U programs	Long-term (36 Months or More)
I.C.2.	Develop an I/T/U Academy on practice- and culture-based approaches to provide training opportunities and best practices.	IHS in collaboration with I/T/U programs	Long-term (36 Months or More)
I.C.3.	Develop a training manual to assist I/T/Us to translate their practice- and culture-based programs into the “evidence-based language” of the funding agencies and ensure fair treatment of traditional approaches.	IHS in collaboration with I/T/U programs	Long-term (36 Months or More)
I.C.4.	Provide a forum for local and regional providers to share best practices for engaging traditional practitioners within the BH delivery system.	IHS in collaboration with I/T/U programs	Intermediate-term (12 to 36 Months)

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

Strategic Direction II 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 demand for services;
- Securing necessary reimbursement for behavioral health services; and
- Sustaining interagency partnerships in order to support behavioral health.

Strategic Direction II Discussion

There is a need for more structure, support, and integration of behavioral health within the overall IHS, tribal, and urban health delivery systems. In light of this significance, 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 and corresponding tribal and urban delivery programs toward seamless and holistic systems of care wherein patients, 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 health system. A more qualified and better integrated behavioral health workforce will benefit the overall I/T/U system of care. Recruiting and retaining qualified behavioral health providers, especially AI/AN providers, is a primary benefit targeted by this plan;
3. Move the credentialing of behavioral health providers and the accreditation of programs to the forefront. More effort to assist tribal and urban programs to secure accreditation is needed; 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 programs will require more support and advocacy 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 players 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 a crucial role in the achievement of the major goals, who could provide critical resources to the effort, include: the Substance Abuse and Mental Health Services Administration (SAMHSA); the 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 Chemically Dependent Anonymous (CDA).

Finally, specific information or data are necessary to reach the major goals of this strategic direction. These resources were identified as: IHS Trends (Chapters 8, 14, 18, and the new 27); National Center for Health Statistics (NCHS); and the Centers for Disease Control and Prevention (CDC).

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 Build A Strong Foundation for Effective Behavioral Health Services

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
II.A.1.	Improve the quality of behavioral health programs by ensuring the distribution of the behavioral health standards from the IHS clinical manual to the I/T/U programs and Area offices.	IHS BH and Area Offices in consultation with tribal area health boards and tribes	Short-term (12 Months or Less)
II.A.2.	Study the feasibility of developing a national, culturally appropriate I/T/U behavioral health accreditation body that enhances the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission (JC), Accreditation Association for Ambulatory Health Care (AAAHC) standards.	IHS in collaboration with tribes, urban programs, and Youth Regional Treatment Center (YRTC) Directors	Intermediate-term (12 to 36 Months)
II.A.3.	Develop and provide accreditation guidelines or manuals that will be available to tribal and urban programs for program development and consistent quality improvement of services.	IHS in consultation with tribes, urban programs, and YRTC Directors	Long-term (36 Months or More)
II.A.4.	Provide technical assistance to I/T/U in health care 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 programs, and YRTC Directors Partnership with CARF	Long-term (36 Months or More)
II.A.5.	Encourage all I/T/U programs to apply clinical standards as a priority to clinical supervision positions and the variety of ways these services are provided (e.g., tele-health, tele-psychiatry).	I/T/U	Long-term (36 Months or More)

Strategic Direction II – 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 patients.**
- **Ensure access to needed medications, AI/AN traditional and other treatments, and facilities.**
- **Ensure integrated continuum of care.**

Action Steps		Responsibility	Type
II.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 I/T/U systems.	IHS incollaboration with I/T/Us	Annually
II.B.2.	Recognize heavy influence of biomedical models in IHS and the need for more integrated care by creating a track within the Clinical Director and Combined Councils Annual Meeting that addresses behavioral health and integrated care.	IHS	Short-term (12 Months or Less)
II.B.3.	Assist I/T/Us to make needed prescribed psychotropic medications available to patients. Training of Indian Health providers in medical, traditional, and other treatments for methamphetamine-related mood disorders; opioid detox, maintenance and recovery.	IHS in collaboration with CMS, and State BH and Medicaid systems	Short-term (12 Months or Less)
II.B.4.	Identify benchmarks and outcome measures to assess whether behavioral health is successfully being integrated into health delivery systems, and if so, how much. Existing efforts will be considered, such as V Measures, Alcohol Service Brief Intervention (ASBI), 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.	IHS in consultation with tribal and urban providers	Short-term (12 Months or Less)
II.B.5.	Share results and best practices between the Policy Academy on Co-Occurring Disorders for tribal teams and Chronic Care Pilot Sites. These measures and standards will be made available to I/T/Us for voluntary standard targets.	IHS in partnership with SAMHSA	Short-term (12 Months or Less)
II.B.6.	Explore joint sponsorship of a Policy Academy on Co-occurring disorders for tribal, IHS, and urban providers, and suicide and methamphetamine prevention should be directly addressed.	IHS and SAMHSA	Short-term (12 Months or Less)
II.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.	IHS in partnership with I/T/Us	Long-term (36 Months or More)
II.B.8.	In partnership with local community members and consumers of care (including youth), conduct an education and awareness campaign to inform providers and patients about	I/T/Us	Intermediate-term (12 to 36 Months)

	behavioral health issues and resources.		
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Strategic Direction II – To Build A Strong Foundation for Effective Behavioral Health Services

Goal C. Developing a skilled and culturally competent workforce to meet 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
II.C.1.	Provide a semi-annual report on the BH workforce which will include overall numbers on services provided by I/T/Us, vacancies, turnover, and other issues, such as licensure, salary parity, and general trends or needs.	I/T/Us	Short-term (12 Months or Less)
II.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.	I/T/Us	Short-term (12 Months or Less)
II.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).	I/T/Us	Short-term (12 Months or Less)
II.C.4.	Create rotation opportunities at I/T/U facilities for behavioral health professionals and other integrated health providers in existing and new (e.g., cultural liaison) positions.	IHS BH	Intermediate-term (12 to 36 Months)
II.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.	I/T/Us	Intermediate-term (12 to 36 Months)
II.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.	I/T/Us	Long-term (prefer Intermediate but budgets have already been developed)
II.C.7.	Implement a mentoring/internship/preceptor-ship initiative that provides recruitment of a new Native American	IHS in consultation with	Long-term (36 Months or

	workforce into behavioral health fields, by focusing resources and creating opportunities on a national and local level.	local and regional I/T/Us and at the conference.	More)
II.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.	IHS in collaboration with I/T/Us	Long-term (36 Months or More)
II.C.9.	Recognize leadership within the IHS and create and maintain effective leadership training.	IHS in consultation with I/T/Us	Intermediate-term (12 to 36 Months)

Strategic Direction II – 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
II.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 providers.	IHS and CMS in consultation with tribal and urban leadership: NIHB, NCUIH, State Division of Health Offices	Intermediate-term (12 to 36 Months)
II.D.2.	Provide training and technical assistance to ensure BH programs are able to access current and emerging billing opportunities for all services and included on provider lists for states.	IHS in collaboration with CMS, tribal, and urban leadership: NIHB and NCUIH	Intermediate-term (12 to 36 Months)
II.D.3.	Work with SAMHSA to provide Training and Technical Assistance (T/TA) to get more Native specific culture- or traditional-based interventions designated as effective under the National Registry for Evidence-based Programs and Practices (NREPP).	IHS SAMHSA in consultation with tribal and urban leadership	Intermediate-term (12 to 36 Months)
II.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.	I/T/U Behavioral Health Staff	Intermediate-term (12 Months to 36 Months)
II.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 leadership: NIHB, NCUIH State Division of Health offices and Tribal Liaisons	Long-term (36 Months or More)
II.D.6.	Seek support from CMS, IHS, and SAMHSA to ensure that cultural, traditional, or faith-based interventions and practices utilized in Native BH	IHS CMS SAMHSA in consultation	Long-term (36 Months or More)

	programs are considered as “evidence-based programs or practices” for purposes of reimbursement and provide T/TA to secure evidence-based designation.	with tribal and urban leadership	
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Strategic Direction II – 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), Department of Justice (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
II.E.1.	Seek support from the HHS Office of 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)
II.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.	IHS in consultation with tribes, and urban programs, and other federal agencies.	Intermediate-term (12 to 36 Months)
II.E.3.	Develop and disseminate a policy brief to advocate tribal and urban access to behavioral health grants from other federal agencies like states do (unless explicitly prohibited by law).	IHS and other national Indian organizations	Short-term (12 Months or Less)
II.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 Boards	Intermediate-term (12 to 36 Months)

Implementation Plan for Strategic Direction III: To Establish Targeted, Prepared, and Responsive Behavioral Health Care throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs (I/T/Us)

Strategic Direction III Goals

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

- Providing epidemiological updates on behavioral health trends, hot spots, and emerging issues, such as methamphetamine and opiates;
- Ensuring access to the latest research, training, and knowledge;
- Interfacing with tribal leadership to give voice and response to emerging trends and needs; and
- Developing and issuing an annual report on the status of AI/AN Behavioral Health.

Strategic Direction III Discussion

There is a significant benefit that could be realized through focused attention on recent emerging trends, data, and knowledge related to behavioral health among AI/ANs. The existing infrastructure of the IHS and related Epidemiology Centers could be better coordinated to fulfill the need to better understand the status and changes occurring in AI/AN behavioral health in a more timely manner. In order to do this, the IHS must take a leadership role to ensure more focused analysis occurs as a part of the annual Trends in Indian Health reporting process so that emerging concerns, such as problems with methamphetamine, co-occurring disorders, prescription drug abuse, and youth suicides, are better and more quickly identified. A more structured monitoring system will allow Indian Country the ability to track trends and to intervene more quickly, rather than waiting for problems to overtake entire communities. Overall services will improve, as systems and providers seek the necessary resources and training to respond to emerging trends. More resources will be available to communities when they are able to plan for emerging trends and seek new funding opportunities. Moving beyond the quick response mode and into a planning and preparation mode is the focus of this major strategy.

Additionally, moving toward targeted, prepared, and responsive behavioral health systems will depend upon the involvement of key players and resources, including tribal leaders; national, regional, and tribal organizations; health directors and administrators; and communication experts.

Finally, tribes will need to have information technology assistance in order to participate; and behavioral health data will need to be linked somehow to the issue of wellness. The existing behavioral health feature of the Resource and Patient Management System (RPMS) will need to be more responsive and accessible to produce local, regional, and national profiles of current needs in the behavioral health arena.

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 Establish Targeted, Prepared, and Responsive BH Care Throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs

Goal A. Providing epidemiological updates on behavioral health trends, hot spots, and emerging issues.

Objectives

- **Staying on top of emerging trends in substance abuse.**
- **Knowing when service needs change.**
- **Developing response strategies to address emerging trends in substance abuse, suicide, or violence.**
- **Responding in a timely and effective manner to help all areas of IHS to address emerging trends in substance abuse, suicide, and violence.**

Action Steps		Responsibility	Type
III.A.1.	Develop a local planning model, like SAMHSA’s Strategic Prevention Framework (SPF) Planning Model as a way to stay on top of issues and engage leadership around regional planning.	IHS in collaboration with I/T/Us	Short-term (12 Months or Less)
III.A.2.	Issue and widely disseminate an annual report on the state of Native American 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.	IHS	Short-term (12 Months or Less)
III.A.3.	Work to identify funding for behavioral health I/T/U Epi Center personnel to establish a central behavioral health I/T/U Epi Center function for I/T/Us and tracking national trends.	IHS	Intermediate-term (12 to 36 Months)
III.A.4.	Develop recommendations and identify strategies to resolve the lack of behavioral health data, generate aggregate data, and address data ownership issues.	IHS in consultation with tribal and urban leadership	Intermediate-term (12 to 36 Months)
III.A.5.	Provide a forum for tribal or regional specific best practices for assessing current tribal and Indian community needs.	IHS and SAMHSA	Long-term (36 Months or More)
III.A.6.	Consult with I/T/Us to conduct a national behavioral health needs assessment at least every 5 years, beginning immediately with a study to include a national assessment of methamphetamine use in Indian Country.	IHS in consultation with I/T/Us	Long-term (36 Months or More)
III.A.7.	Provide ongoing specialized intervention training to providers to better address new, emerging challenges, including methamphetamine and opiates use, suicide, and other issues.	IHS in collaboration with SAMHSA and I/T/Us	Long-term (36 Months or More)

Strategic Direction III - To Establish Targeted, Prepared, and Responsive BH Care Throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs

Goal B. Ensuring access to the latest research, training, and knowledge.

Objectives

- Expand the formal relationship with existing partners to place increased emphasis in evidence-based, culture-based, and practice-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
III.B.1	Advocate for 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)
III.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).	SAMHSA IHS	Short-term (12 Months or Less)
III.B.3	Support the development of tribal Institutional Review Boards (IRBs) through T/TA.	IHS DBH	Intermediate-term (12 to 36 Months)
III.B.4	Assess need for training and ongoing support of clinical supervision positions in tribal BH programs and then collaborate with other 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)
III.B.5	Support local and regional efforts to utilize traditional Native practitioners or practices within the service delivery framework for behavioral health.	IHS in collaboration with I/T/Us	Intermediate-term (12 to 36 Months)

Strategic Direction III- To Establish Targeted, Prepared, and Responsive BH Care Throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs

Goal C. Interfacing with tribal leadership to give voice and response to emerging trends and needs.

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 regarding 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 BH activities.

Action Steps		Responsibility	Due
III.C.1.	Convene tribal and urban leadership to discuss emerging trends, understand local concerns, and identify strategies and priorities on a regular basis, at least yearly.	IHS in consultation with tribal and urban leadership	Short-term (12 Months or Less)
III.C.2.	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 III- To Establish Targeted, Prepared, and Responsive BH Care Throughout the IHS, Tribal Health Programs, and Urban Indian Health Programs

Goal D. Developing and issuing an annual report on the State of AI/AN Behavioral Health.

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	Due
III.D.1.	Define the process for the production of a reliable, credible, and definitive report.	IHS	Short-term (12 Months or Less)
III.D.2.	Engage I/T/U behavioral health leaders through surveys or other means to seek input and participation.	IHS	Short-term (12 Months or Less)
III.D.3.	The NTAC, with support from the BHWG, will provide input and monitor the development of the report	IHS/NTAC/BH WG	Short-term (12 Months or Less)

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- ⁱ The NSDUH Report. (2007). Substance use and substance use disorders among American Indians and Alaska Natives. Office of Applied Statistics. Retrieved February 28, 2010, from <http://www.oas.samhsa.gov/2k7/AmIndians/AmIndians.htm>
- ⁱⁱ Indian Health Service. (2008). *2008 Indian Health Service Annual Report*.
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