GREAT LAKES INTER-TRIBAL COUNCIL, INC.

GLITC Inter-Tribal Prevention Strategic Plan

Funded by the Substance Abuse Mental Health Services Administration (SAMHSA)

Strategic Prevention Enhancement Grant #18649

Great Lakes Inter-Tribal Council, INC.

INTER-TRIBAL PREVENTION STRATEGIC PLAN

For a listing of abbreviations and acronyms used within the document please see

Appendix E: Acronyms and Abbreviations

Please cite as:

Great Lakes Inter-Tribal Council, INC. (2012). *Great Lakes Inter-Tribal Council's Inter-Tribal Prevention Strategic Plan* funded by Substance Abuse Mental Health Services Administration's Center for Substance Abuse Prevention Strategic Prevention Enhancement Grant #18649. Lac du Flambeau, Wisconsin.

FOREWARD

Boozhoo!

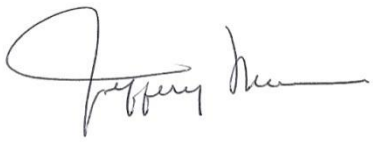
This has been an exciting time for Great Lakes Inter-Tribal Council and our member Tribes. GLITC has recently completed a SAMHSA SPFSIG grant which paved the way for this new ground breaking opportunity. Partnering with some of our SPFSIG grantees, GLITC has now been able to embark on the development of a five year strategic prevention plan. This plan was developed with input from multiple sectors within our communities and representatives with the State of Wisconsin. Their names and the sectors they represent are indicated on page v. This is one of the first times that such a diverse group from the Tribes has been able to come together to formulate an inter-tribal plan that can potentially have such a positive effect on our communities.

GLITC was awarded this grant in September of 2011 and the first Policy Consortium (PC) meeting was held that November. By implementing a culturally responsive and holistic approach for the logic models (the traditional medicine wheel), the Consortium, with assistance from the SPE staff and consultants, has developed a five year strategic plan to address prevention for AODA issues, including prescription drug abuse, suicide prevention, and behavioral health promotion. Using the required target areas of data, coordination, technical assistance, and evaluation, a comprehensive prevention plan has been developed.

This is a flexible plan that can be utilized in part, or in whole by all twelve GLITC member Tribes. While some initiatives will require a funding base, there are many things that can be done without additional funding. In keeping with the mission of GLITC, we are committed to working with all of the Tribes to the extent that the Tribes request and to the extent that our capabilities allow. We will be using Great Lakes Inter Tribal Epidemiology Center (GLITEC) and other existing assets that will increase our internal capacity to store prevention data for use by the Tribes, as well as to provide technical assistance to implement the strategic plan.

I would like to take this opportunity to applaud the work of the members of the Policy Consortium and to the leadership of their Tribes for allowing them to engage in this very important work. I encourage Tribal Leadership to support the frequent use of this document as a guide for their Tribes as they continue their efforts to provide a comprehensive approach in prevention planning.

Sincerely,



Jeffery Muse
Deputy Director, Education and Human Services
GLITC
jmuse@glitc.org
715-588-1016
July 11, 2012

ACKNOWLEDGEMENTS

The SPE staff and consultants would like to take this opportunity to give well-deserved recognition to all of our SPE Policy Consortium members and special acknowledgement to two particular members – Brian Jackson and Jo Ann Schedler.

Brian, as a recognized spiritual leader from Lac du Flambeau, was instrumental in adding clarity and depth to our understanding and interpretation of the medicine wheel. He not only reviewed what we proposed but also added his personal insights on the "directions." We have, with his permission, quoted his thoughts within the strategic plan document. His guidance and thoughts have been much appreciated. *Miigwitch*, Brian!

Jo Ann joined our group about half way through the planning process. As a former health director and as a current Tribal Council member of the Stockbridge-Munsee community, she has been a champion for the plan, particularly with Tribal leadership. She not only garnered support for the plan with her Tribe's President, but also engaged the GLITC Board of Directors (Tribal Leaders of the 12 member Tribes) by presenting "talking points" and distributing information sheets to the Board during their June 2012, meeting. Our Board of Directors has many competing priorities, and with Jo Ann's assistance, the support of the Board for this project was greatly strengthened. Thanks, Jo Ann!

EXECUTIVE SUMMARY

On September 15th, 2011, Great Lakes Inter-Tribal Council was awarded a one-year SAMHSA Strategic Planning Enhancement grant to develop an inter-tribal five-year strategic plan to address alcohol and other drug abuse prevention efforts, including prescription drug abuse, behavioral health promotion, and the decrease in suicide attempts. The SPE Strategic Plan utilizes the Strategic Prevention Framework as the foundation for improving the prevention system for GLITC and member Tribes. GLITC's mission and vision is furthered with the SPE Strategic Plan by creating a plan of action for the member tribes and GLITC that promote both sovereign rights and self-determination. Additionally the Strategic Plan lays out a framework by which behavioral health, ATODA including prescription drugs, and suicide prevention can be addressed within the cultural context of the region and utilize effective evidence-based prevention.

The Policy Consortium, which acted as the advisory group to the project, made the recommendation to use a traditional framework by which to structure the plan. The plan and logic models describe the theory of change using familiar symbols and concepts that could be more easily translated and culturally responsive. More specifically, the Policy Consortium recommended the logic models for the SPE Strategic Plan be designed using a "traditional medicine wheel" as the central symbol and that they be strength based rather than problem focused.

There are seven recognized directions in this interpretation of the medicine wheel: East, South, West, North, Earth, Sky, and Inner Self. While developing the plan, the project team worked closely with tribal representatives to create definitions and translations that best fit the tribal perspective. In addition, the plan is based on growing recognition and evidence from prevention science at the national level that "Culture is Prevention." The directions represent the overall goals of the plan and the four major components required of the plan, which are: Data Collection, Analysis and Reporting, Coordination of Services, and Technical Assistance and Training. The goals of each component and the direction represented in the medicine wheel logic models are listed below and covered in detail within the body of the plan. The plan is designed to be implemented in its entirety, which is the ideal situation, or each direction can be implemented separately as resources allow.

The key concepts that are developed through the strategic plan include:

- Advance "Culture is Prevention" through systematic evaluation and validation methods
- Promote coordination of services inter-departmentally and inter-tribally
- Create data repositories at the Tribal Nations and at GLITC for inter-tribal use, along with the supporting systems that more effectively measure and promote Tribal practices as prevention methods
- Provide technical assistance and training for workforce development and strategic plan implementation
- Identify minimum competencies for prevention staff and project evaluators

It is the belief of the Policy Consortium and SPE staff that the following strategic plan provides tribal communities and organizations a comprehensive way to address the current gaps in prevention service and build off of the assets of GLITC and the GLITC Member Tribes to strengthen prevention services for the tribal communities.

POLICY CONSORTIUM MEMBERSHIP

Teresa Barber
GLITC
Program Director WNATN

JoAnn Barylski
Bad River
AODA Coordinator

Nancy Bennett
GLITEC
MIS Analyst

Julie Black Elk, Ph.D.
Lac Courte Oreilles
Behavioral Health Director

Sandy Bird
Lac Courte Oreilles
Community Health Director

Robert Brandenburg
LDF Police Chief/Native American
Drug & Gang Initiative President

Isaiah Brokenleg
GLITEC
Epidemiologist/Program Director

Joseph Corbine, Ph.D.
Red Cliff
Psychotherapist

Gregg Duffek
Stockbridge-Munsee
Tribal Health Director

Brian Jackson
WIEA President/GLITC NARCH
Director

Kelly Jackson
State of Wisconsin
DOT Tribal Liaison

Gloria Jean Johnston
Lac Vieux Desert
Behavioral Health Director

Jeremy McClain
GLITC Drug Free Communities PAC
Program Director (former)

Cleo Monette, LICSW
I.H.S. Bemidji MN
Behavioral Health Consultant

Jeff Muse
GLITC
Deputy Director of EHS

Christine Niemuth
WI DHS/DMHSAS/BPTR
Prevention Coordinator

Louis Oppor
WI DHS/DMHSAS/BPTR
Substance Abuse Services
Section Chief

David Raasch
Stockbridge-Munsee
Associate Judge
Stockbridge-Munsee Tribal Court

Randy Samuelson
Lac du Flambeau
PCHC Health Director

Jo Ann Schedler MSM, RN
Stockbridge-Munsee
Tribal Council

Rachel Semrow
Stockbridge-Munsee
Behavioral Health Director (acting)

Julia Sherman
WI Alcohol Policy Project,
Center on Impaired Driving
University of WI Law School

Cindy Smith
Lac Courte Oreilles
Prevention Specialist (former)

Linda Sporakowski
Lac du Flambeau
Law Enforcement

Lydia Vitort
Stockbridge-Munsee
Behavioral Health Director
(former)

Mike Williams, MSE
LCO Community Health Center
Behavioral Health, IT, Site
Manager, CAC

Sue Wolfe, MSW
Lac du Flambeau
Public School Federal Program
Coordinator

EPI/ EBP/ PBE WORKGROUP

JoAnne Barylski
Bad River
AODA Coordinator

Nancy Bennett
GLITEC
MIS Analyst

Kristin Hill
Great Lakes Inter-Tribal
Epidemiology Center Director
(ad hoc)

Brian Jackson
WIEA President/GLITC NARCH
Director

Christine Niemuth
WI DHS/DMHSAS/BPTR
Prevention Coordinator

Rachel Semrow
Stockbridge-Munsee
Acting Behavioral Health Director

Julia Sherman
WI Alcohol Policy Project,
Center on Impaired Driving
University of WI Law School

Lydia Vitort
Stockbridge-Munsee
Behavioral Health Director
(former)

Mike Williams, MSE
LCO Community Health Center
Behavioral Health, IT, Site
Manager, CAC

Sue Wolfe, MSW
Lac du Flambeau
Public School Federal Program
Coordinator

STAFF AND CONSULTANTS

Carol Wright MSHSA, RN
Great Lakes Inter-Tribal Council
SAMHSA SPF SIG/SPE
Project Director
cwright@glitc.org

Jacob Melson, MS
Great Lakes Inter-Tribal
Epidemiology Center
Behavioral Health Epidemiologist
jmelson@glitc.org

Paula Fralick
Great Lakes Inter-Tribal Council
SPF SIG/ SPE
Administrative Assistant

Stevie Stephens Burden, BA
Specializing in Substance Abuse Prevention
Burden and Burden Consulting
stevieburden@msn.com

Nicole M Butt, MS Ed
Project Evaluator
BEAR Consulting, LLC
bear.consulting.llc@gmail.com

CONTENTS

FOREWARD II

ACKNOWLEDGEMENTS III

EXECUTIVE SUMMARY IV

POLICY CONSORTIUM MEMBERSHIP V

EPI/ EBP/ PBE WORKGROUP VI

STAFF AND CONSULTANTS VI

INTRODUCTION 1
- SPE Background 1
- Strategic Prevention Framework 1
- GLITC Mission Statement 2
- GLITC Vision Statement 3
- Context of GLITC 4
- GLITC Organizational Chart 7
- Lessons Learned from SPF SIG 8

LOGIC MODEL 10
- Overall Logic Model 10
- Explanation of Logic Model Concept 11

THE SEVEN DIRECTIONS 15
- Explanation of the Strategic Plan's Seven Directions 15

THE EARTH, SKY, AND INNER SELF: OVERALL GOALS OF THE STRATEGIC PLAN 20
- Earth, Sky, and Inner Self Logic Model 20
- Earth, Sky, and Inner Self Narrative 21
- Earth, Sky, and Inner Self Considerations 21

THE EAST: DATA COLLECTION, ANALYSIS, AND REPORTING 23
- Eastern Logic Model 23
- Eastern Narrative 24
- Looking East 29
- Eastern Further Considerations 33

THE SOUTH: COORDINATION OF SERVICES 34
- Southern Logic Model 34
- Southern Narrative 35
- Looking South 38
- Southern Further Considerations 41

THE WEST: TECHNICAL ASSISTANCE AND TRAINING 42
- Western Logic Model 42
- Western Narrative 43

Looking West 46
Western Further Considerations 51

THE NORTH: PERFORMANCE AND EVALUATION 52
Northern Logic Model 52
Northern Narrative 53
Looking North 55
Northern Further Considerations 58

REFERENCES 59

APPENDIX A: SPE SYSTEMS SURVEY SUMMARY 61

APPENDIX B: DATA "WISH" LIST 62

APPENDIX C: SPE FACT SHEETS 65

APPENDIX D: ONE WITH ALL PROJECT 81

APPENDIX E: ABBREVIATIONS AND ACRONYMS 82
Plan Abbreviations and Acronyms 82
Tribal Abbreviations 83

INTRODUCTION

SPE Background

On September 15th, 2011, Great Lakes Inter-Tribal Council was awarded a one-year SAMHSA Strategic Planning Enhancement grant to develop an inter-tribal five-year strategic plan to address alcohol and other drug abuse prevention efforts, including prescription drug abuse (AODA), as well as behavioral health promotion and the decrease in suicide attempts. This effort was begun with the development of four mini-plans to address data collection, analysis and storage, coordination of services across prevention, AODA, behavioral health and primary care systems, technical assistance and training, and evaluation. Those mini-plans are the basic components of implementation of the Strategic Plan and are included in this document.

The impetus for the strategic plan evolved out of the work of prior prevention funding with the Strategic Prevention Framework State Incentive Grant (SPF SIG). In October 2006, Great Lakes Inter-Tribal Council was awarded a five-year Strategic Prevention Framework–State Incentive Grant. In March 2007, the first Substance Abuse Prevention Advisory Coalition composed of ten Wisconsin Tribal Nations met to begin the process of defining substance abuse priorities. The Coalition determined that underage drinking and binge drinking were the most pressing problems for the Tribal communities. As the coalition evolved they named themselves the "Wisconsin Native American Prevention Counsel" and developed a mission statement. Each of the ten Tribal Nations received funding to implement evidence-based strategies in their communities to address the priorities of underage and binge drinking. With the implementation of the SPF SIG, a greater understanding of the necessity of systems improvement and coordinated efforts became apparent. This Strategic Plan is the result of the knowledge gained through the SPF SIG and extensive collaboration with the Policy Consortium including the Epidemiological Workgroup and the Evidence Based Practices/ Practice Based Evidence Workgroup (EBP/PBE).

Both of these efforts are housed within the Great Lakes Inter-tribal Council (GLITC) and follow the basic tenants of the Strategic Prevention Framework (SPF) that outline a series of steps that, if followed, result in making data-driven decisions and focusing on priorities that have the highest potential for impacting the problems of substance abuse, suicide, and behavioral health. This plan creates a structure and steps to achieve those goals.

Strategic Prevention Framework

The Strategic Plan utilizes the Strategic Prevention Framework as the foundation for improving the prevention system for GLITC and member Tribes. The steps of the Strategic Prevention Framework guided the development of the Strategic Plan so that each component of the Strategic Plan can be implemented in such a way as to move through the process of the SPF.

**graphic from SAMHSA*

Assessment Profile population needs, resources, and readiness to address problems and gaps in service delivery. A substance abuse issue must be assessed correctly through the collection and analysis of data that show the extent and location of a problem, risk and protective factors associated with it, community assets and resources, gaps in services and capacity, and readiness to act.

Capacity Mobilize and build capacity to address needs. Key tasks include convening leaders and stakeholders, building coalitions, and training community stakeholders to help keep activities going.

Planning Develop a prevention plan. The strategic plan expresses a vision for prevention activities and a roadmap for conducting them. It describes policies and relationships, incentives for groups to work together, and evidence-based actions that will be taken. The plan also identifies milestones and outcomes for gauging performance.

Implementation Conduct prevention activities. Supported by training and technical assistance, local stakeholders select programs, policies, and practices proven to be effective in research settings and in communities. Culturally competent revisions are made without sacrificing core elements of the program.

Evaluation Monitor and evaluate results and the ability to continue. Ongoing monitoring and evaluation are vital to determining whether the desired outcomes are achieved, to assessing the quality of service delivery, and to identifying needed improvements. Sustaining what has worked well should be an ongoing process.

GLITC Mission Statement

The Great Lakes Inter-Tribal Council (GLITC) will support member tribes in expanding sovereignty and self-determination.

GLITC Vision Statement

GLITC will support member Tribes in expanding self-determination efforts by providing services and assistance. GLITC will use a broad range of knowledge and experience to advocate for the improvement and unity of tribal governments, communities, and individuals. Throughout these activities, GLITC will maintain deep respect for tribal sovereignty and community values.

How the Strategic Performance Enhancement Strategic Plan Furthers GLITC Mission and Vision

The SPE Strategic Plan furthers the mission and vision of GLITC by creating a plan of action for the member tribes and the GLITC organization that promotes both sovereign rights and self-determination. The SPE plans lays out a framework by which behavioral health, ATODA including prescription drugs, and suicide can be addressed within the cultural context of the region and utilize effective evidence-based prevention/ practice-based evidence.

- Federal Evidence-Based Practice Mandate
    - Sovereignty and Consultation Rights lay the groundwork for approaching the evidence-based program mandate from a culturally appropriate perspective. The structure of the plan will allow GLITC and its member tribes to implement effective culturally responsive prevention services and activities through the utilization of local and inter-tribal approaches that are rooted in the customs and culture of the tribes, agencies, and communities involved, thus furthering self-determination.
    - This plan outlines a framework by which the GLITC service area can make decisions about evidence-based prevention that are in line with local beliefs and practices and which can be evaluated and therefore acceptable to federal funders as well.
    - With the implementation of this plan and a commitment to seeking the most effective means by which to address the ATODA prevention needs of the GLITC membership, local tribes will benefit by programming, policies, and practices that significantly increase the effectiveness to reduce the negative consequences that alcohol, tobacco and other drugs of abuse have on tribal members and communities.
- SPF and SPE have both sustainability and cultural responsiveness as basic principles.
    - Priorities and decisions are based on both GLITC service area (GLITC) and local needs assessments (Member Tribes and Communities) and data that are determined by the community and tribes. By using a strategic planning framework that is based on local priorities and needs, GLITC will provide assistance and guidance to help member tribes to expand self-determination through exercising sovereign rights.
    - GLITC will work with member tribes to determine the best projects, programs, strategies, activities, and practices for communities and provide services that will support the implementation at the local level.
    - Protocols and systems will be implemented that will allow the GLITC service area to utilize culturally based programming.
- The framework and structure of the plan is rooted in traditional approaches and local cultural beliefs and is strength based.
    - Medicine wheel is the central framework for the plan.
        - Each component of the plan is designed to respect and reflect the seven directions of the medicine wheel. This concept was developed through the participation of the SPE

Policy Consortium, which has a diverse membership that includes local tribal representation

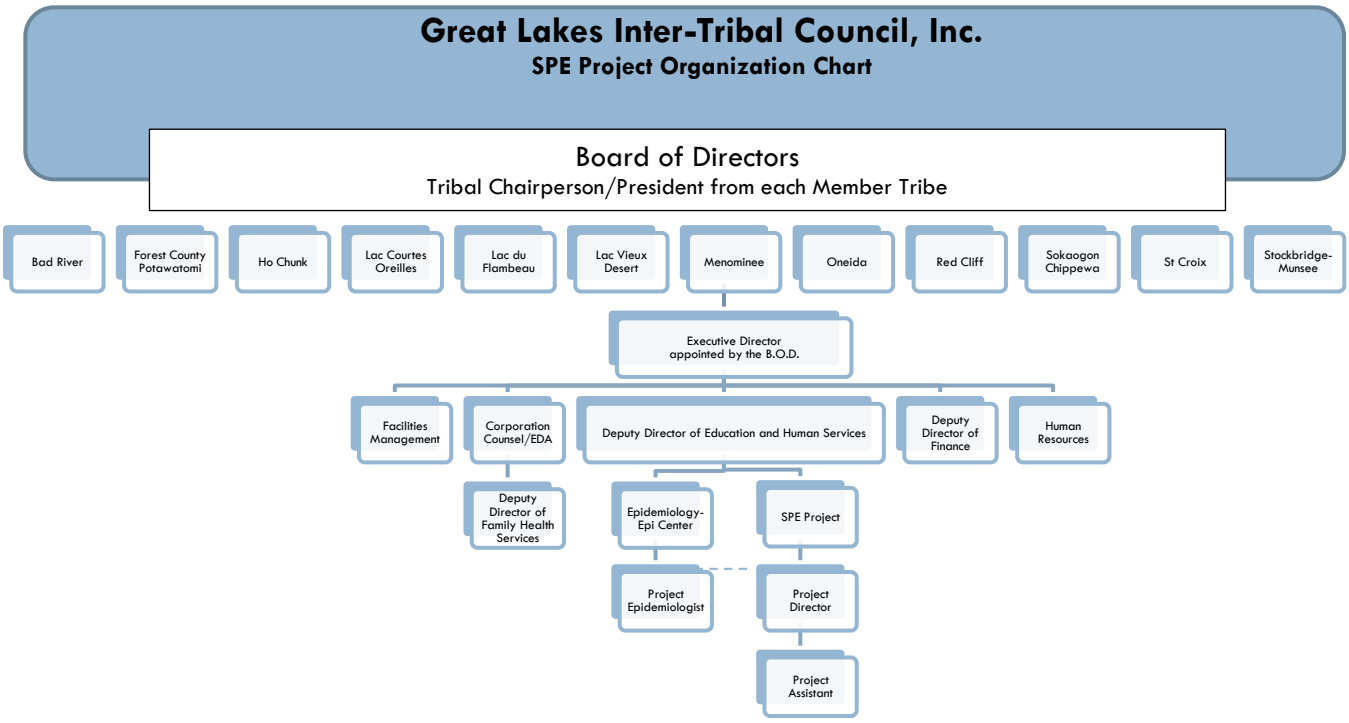
Goals of the plan are based on traditional world views that respect the member Tribes' cultural perspectives.

Context of GLITC

Great Lakes Inter-Tribal Council, Inc. (GLITC), the applicant agency, is a consortium of twelve federally recognized Indian Tribes in Wisconsin and Upper Michigan. The organization was chartered as a non-profit corporation under Wisconsin law in 1965. The original purpose of GLITC was to provide a means by which member Tribes could unite against the threat of termination. Today the GLITC mission is to support member Tribes in expanding self-determination efforts by providing services and assistance. For nearly 50 years, GLITC has used a broad range of knowledge and experience to advocate for the improvement and unity of tribal governments, communities, and individuals while supporting the sovereignty rights of all member Tribes.

The 12 GLITC member tribes include: Bad River Band of Lake Superior Chippewa, Forest County Potawatomi Community, Ho-Chunk Nation, Lac Courte Oreilles Band of Lake Superior Chippewa, Lac du Flambeau Band of Lake Superior Chippewa, Menominee Indian Tribe, Red Cliff Band of Lake Superior Chippewa, Sokaogon Chippewa Community, St. Croix Band of Lake Superior Chippewa Indians, Stockbridge-Munsee Community, Oneida Tribe of Indians of Wisconsin, and Lac Vieux Desert Chippewa in Upper Michigan. Organizational

goals and objectives are established by the unanimous approval of our Board of Directors, which is composed of the Tribal Chairperson or President (or his/her delegate) of each member tribe. (See Organizational Chart on next page). Each board member speaks for the interests of his or her tribe. The member Tribes of GLITC represent six Indian Nations on twelve reservations, residing on these reservations, with a land base spanning 45 counties. According to the United States Census Bureau, in 2010 there were approximately 44,630 American Indians/Alaska Natives living on GLITC Tribal member reservations.



GLITC currently manages 61 programs with a 2011 budget of $9,005,362. The programs are housed within three GLITC Departments: Education and Human Services, Family Health, and Finance. The Deputy Director of Education and Human Services, Jeffery Muse, oversees all SAMHSA and most other related alcohol and other drug abuse (AODA) prevention programs. A tobacco prevention program—Wisconsin Native American Tobacco Network—is housed under the Family Health Department and other maternal child health programs under that Department also include prevention efforts in their work with families. GLITC has formalized agreements in place with Tribes and other key partners for programs detailing scopes of work, expected outcomes, reports, and expenditure parameters. GLITC also has an IT department that supports the agency wide network.

Great Lakes Inter-Tribal Council, Inc. is the parent organization to the Great Lakes Inter-Tribal Epidemiology Center (GLITEC), one of the 12 Tribal Epidemiology Centers across the United States initially authorized by the Indian Health Care Improvement Act of 1996 and permanently reauthorized by the 2009 Affordable Health Care Act. Tribal Epidemiology Centers are Indian Health Service, division-funded organizations that serve American Indian/Alaska Native Tribal and urban communities by managing public health information systems, investigating diseases of concern, managing disease prevention and control programs, responding to public health emergencies, and coordinating these activities with other public health authorities. Since 1996,

GLITEC has worked with the 34 American Indian Tribes, four urban clinics, and three service units located in Michigan, Minnesota, Wisconsin, and Chicago, Illinois. Each year GLITEC produces an aggregate Community Health Profile report which includes mostly cost-free, publicly available, and accessible health and disease information. The Great Lakes Inter-Tribal Epidemiology Council uses this data to provide a broad overview of the state of health and disease for American Indian/Alaska Native communities in Michigan, Minnesota, and Wisconsin.

GLITC programs frequently collaborate with GLITEC on epidemiological capacity building activities such as data collection and evaluation. GLITC has extensive experience in the area of AODA prevention. Recent grant projects include: the SAMHSA Drug Free Communities grant (awarded in 2005 and again in 2010) and the SAMHSA Strategic Prevention Framework State Incentive Grant (10/2006 – 6/2012). Most of the Tribal staff were either certified as Prevention Specialists or have "in-training" status and are well versed in the SPF process. These staff will be integral to the implementation of the strategic plan of the current Strategic Prevention Enhancement Grant. Additionally, most Tribes have looked at sustainability issues and have written a variety of different grants to continue their prevention work. Some Tribes have their own Behavioral Health Departments, while others contract out for those services.

GLITC Organizational Chart

Board of Directors
Tribal Chairperson/ President from each Member Tribe

Executive Director
Appointed by the Board of Directors

Facilities Management

Human Resources

Executive Assistant

Receptionist

Corporation Counsel/ EDA

Deputy Director of Family Health Services

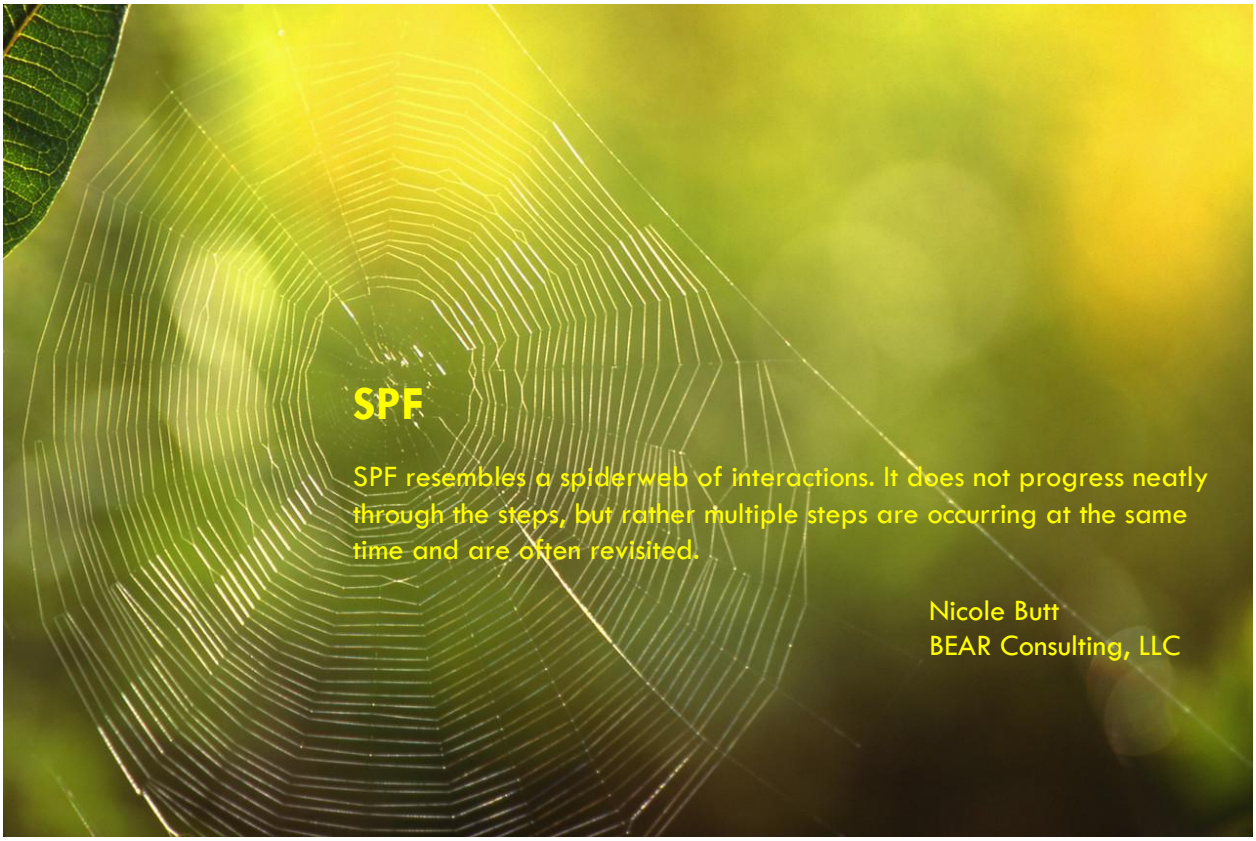
Birth to Three Program
Children and Youth with Special Health Care Needs
Dental Sealant Program
Honoring Our Children Project
Honoring Our Families
Healthy Marriages
Doula Project
Wisconsin Family Foundations Home Visiting Project
Rural Infant Health Project Supplemental Nutrition Assistance Program— Nutrition Education
(SNAP-Ed)
Wisconsin Native American Tobacco Network
Women, Infants and Children Program (WIC)

Deputy Director of Education and Human Services

American Indian Economic Development Technical Assistance Program (AIEDTAP)
American Indian Vocational Rehabilitation (AIVR)
American Indians with Disabilities (AIWD)
Communities Putting Prevention to Work CPPW)
Community Transformation Grant (CTG)
Cooperative American Indian Health
Diabetes Control Program
Diabetes Data Improvement and Prevention
Epidemiology—EpiCenter
Foster Grandparent Program
Lincoln Hills Youth Outreach
Native American Research Center for Health
Positive Alternatives Coalition
Rural Business Enterprise Grant (RBEG)
Rural Business Opportunities Grant (RBOG)
Senior Companion Program
SPE—Strategic Prevention Enhancement Project
State Pharmaceutical Assistance Program
Tribal Benefit Specialist
Tribal Disabilities Benefits Specialists
Tribal Technical Assistance Program
Wisconsin Tribal Community Reintegration Program
Wisconsin Tribal Cooperative Agreement Prevention Program

Deputy Director of Finance

Contract Compliance
Financial Administration
Grant Development
Information Technology



Lessons Learned from SPF SIG

Through the work of the Strategic Prevention Framework State Incentive Grant (SPF SIG), some significant outcomes were achieved:

- The past-30-day use of alcohol by youth was reduced by 18.2%.
- The percentage of youth indicating they first used alcohol at age 8 or younger decreased 7.06%.
- The percentage of youth who reported never having a drink increased 25.24%.
- The percentage of youth who reported riding in the past 30 days with a driver who had consumed alcohol decreased by 16.6%.

In addition, through training and technical assistance, a significant improvement in the readiness of SPF SIG coalition members to utilize needs assessment data was developed (57.9% reported "low readiness" or "not ready" at baseline; 77.8% reported "medium readiness" or "high readiness" in the fifth year of the grant). Likewise, a dramatic positive shift in the readiness to collect data on substance abuse was reported from 2008 (baseline) to 2011 (the fifth year of the grant period); only 5.3% of Wisconsin Native American Prevention Counsel coalition members reported a "high readiness" to collect data on substance abuse in 2008, while 50.0% reported "high readiness" in 2011.

These are positive examples of things done well with the SPF SIG. We learned many lessons and acquired knowledge during the SPF SIG that can be used to guide future projects. These include:

- Evaluation is not inherently valued; programming staff must experience evaluation in context.
- Centralized data collection and storage for processing are essential for cross-grantee data sharing (creating an aggregate out of the individuals).
- Provide training, training, training. Then provide more training and supply technical assistance to incorporate the training.
- Timely turn-around of data is essential if sub-grantees are to get value from it; people expected to make data-driven decisions must have access to current data.
- Although the SPF is presented in a circular fashion, in practice it more resembles a spiderweb of interactions. It does not progress neatly through the steps; rather, multiple steps occur at the same time and are often re-visited.
- If policies and protocols don't exist, accountability becomes nearly impossible.
- A way of sharing and exchanging experiences is highly desired among tribal grantees.
- If the *why* isn't communicated, don't expect sub-grantee buy-in and participation.

It is important to recognize tribal sovereignty when working within an inter-tribal AODA prevention consortium and with local tribes. It is critical to the implementation of culturally responsive and appropriate prevention strategies and practices that they be rooted in methods and modalities that are relevant to the communities in which they are being implemented, so that there will be buy-in at the tribal level.

Unfortunately, sovereignty was sometimes used as an excuse for not completing the work or being accountable. Varying interpretations of what sovereignty meant in terms of the grant and a lack of clear policies and procedures at project outset sometimes resulted in tension within the consortium, since each tribal community had a unique epidemiological capacity to collect and evaluate data and was able to implement the grant its own way.

Therefore, we suggest the primary grantee engage in pre-planning and develop clear policies and procedures for increasing tribal sub-grantees' epidemiological capacity, program implementation, and evaluation to maintain consistency throughout the life of the grant. This plan should be presented to tribal sub-grantees at the beginning of the grant. The primary grantee should request feedback on not only the plan, but also on data collection and evaluation instruments to ensure cultural appropriateness and increase project buy-in.

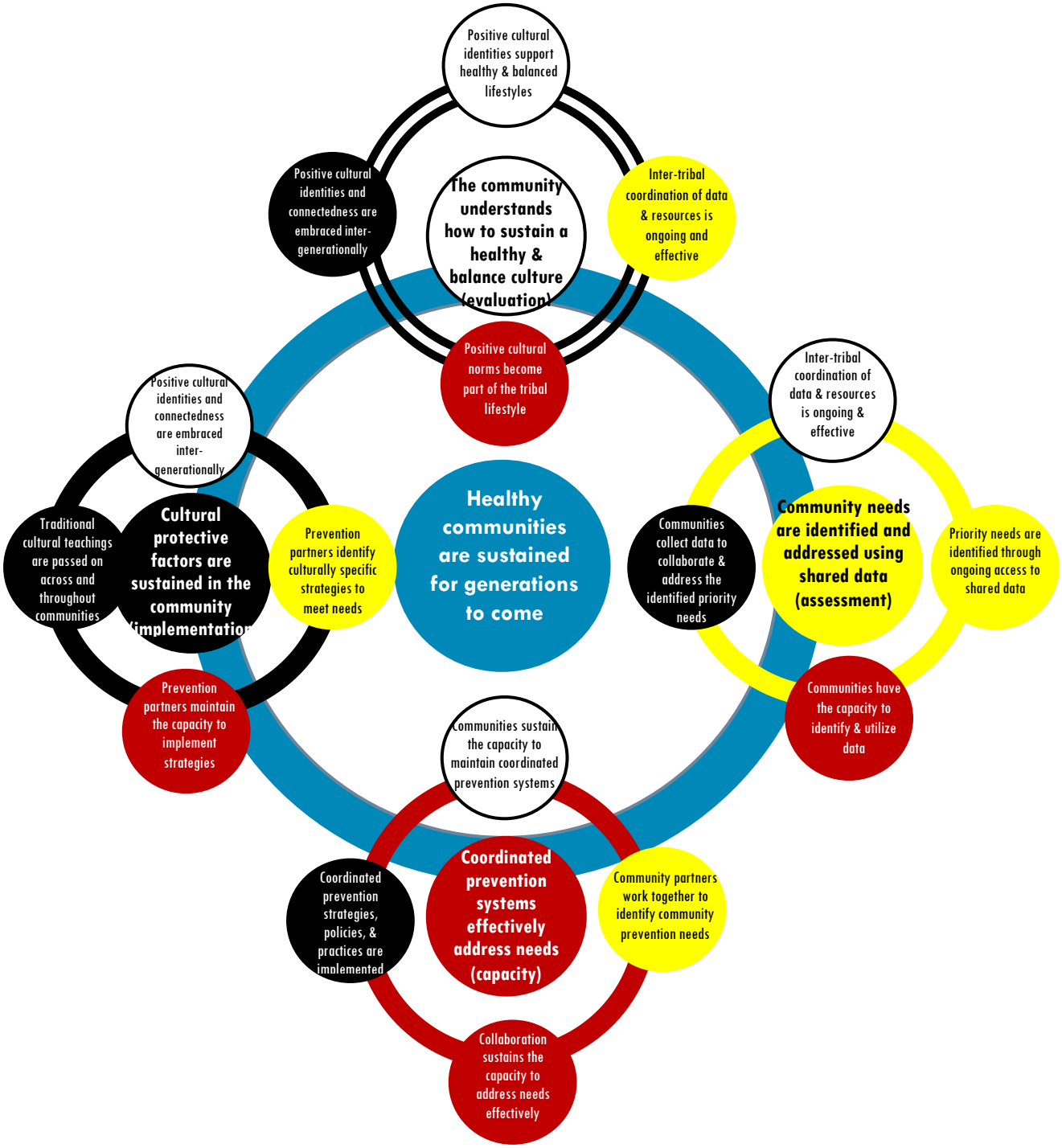
As administrators of the grant, it is important to find balance between recognizing tribal sub-grantees as individual entities and building a consistent level of epidemiological capacity to collect and evaluate data. The "one size fits all" approach did not work for all tribal communities, especially since each tribal community had a unique epidemiological capacity. Plan on things taking longer than you would expect them to. Do not underestimate the lack of access to technology or ability to use technology in tribal communities.

It's important to have staff (at the primary grantee and tribal sub-grantee level) who are dedicated to working the lifetime of the grant. Turnover in staff, who may have different directions and visions, sometimes creates chaos.

SPE project staff have taken all these lessons learned from SPF SIG to heart when working collaboratively with the Policy Consortium to create the SPE Strategic Plan!

LOGIC MODEL

Overall Logic Model



Explanation of Logic Model Concept

Although logic models are typically created based on the deficit model, our Policy Consortium felt it was important to create a strength-based logic model. Using a strength-based approach to prevention allows communities to use traditional methods to reach positive goals for their people. The strength-based structure respects local and inter-tribal world views and frameworks for living life. The Policy Consortium's recommendation also included using a traditional framework by which to structure the logic models so that they used familiar symbols and concepts that could be more easily translated at the local and GLITC service area levels. More specifically the Policy Consortium recommended that the logic models for the SPE strategic plan be designed using a "traditional medicine wheel" as the central symbol.

The process of change and growth using the medicine wheel has been developed over time from traditional Native belief systems. Currently the medicine wheel is often recognized as an inter-tribal symbol across contemporary Indian Country. Although not all tribes draw, interpret, or use the medicine wheel in the same way, it is a shared approach to life and the world in general and functions as a holistic model. It stems from the belief that all things in life and on earth should be in balance and harmony to grow in a healthy way. Each quadrant of the medicine wheel is both unique and equal to the other aspects of the wheel. Each direction is given unique developmental aspects so that following the circle will allow a person/process/task/community to move through growth in a productive, effective, and culturally responsive way. It is not uncommon for people/processes/tasks/or communities to be in different directions on multiple things at any given time.

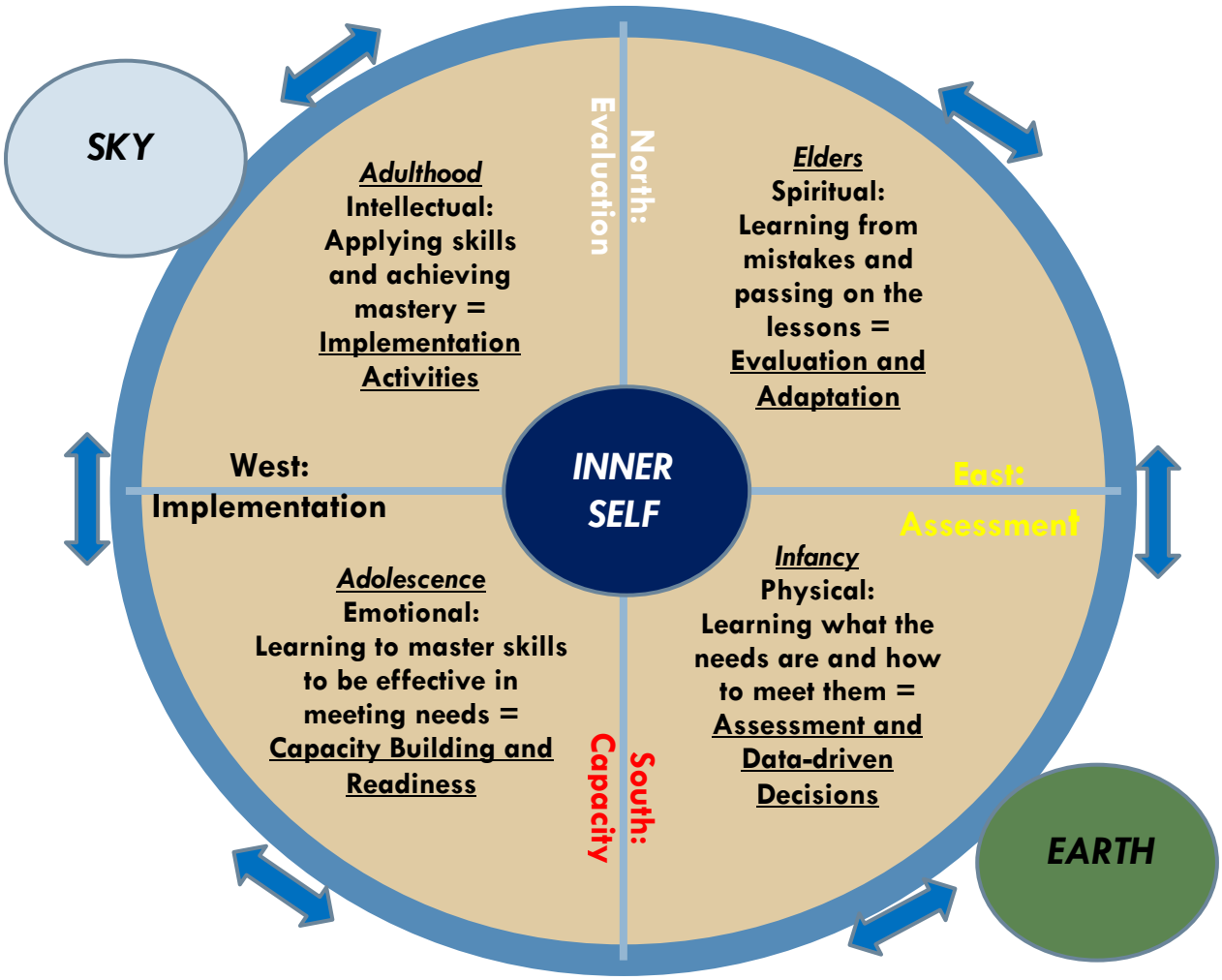
The overall description and use of medicine wheel model provided for the purposes of this plan is not identical to any specific tribal model; it was developed with respect to the tribes involved and the collective definition of the medicine wheel as an inter-tribal cultural icon. The definitions and descriptions given here are for the purposes of this plan and based on the feedback of both tribal members and the Policy Consortia that participated in its development.

Any differences to specific tribal models are not meant to be disrespectful. This model is an affirmative attempt to integrate many approaches to the medicine wheel in order to provide a culturally responsive way to bring logic to the requirements of the SPE grant requirements. The GLITC staff and consultants have worked to develop a model that is respectful of many tribal approaches, while also meeting the requirements of the federal funders. For the purposes of this plan and logic models, each direction has been given a general description/definition both from the "traditional" perspective as well as from the perspective of the Strategic Prevention Framework model that is used by the funders. This is a story of translation meant to serve as the guide for the approach and structure of this plan and not as an exclusive definition of the tribal meaning or approaches to the medicine wheel in general or particular.

There are seven recognized directions in this interpretation of the Medicine Wheel: East, South, West, North, Earth, Sky, and Inner Self. Each of those directions holds its own unique definition, character, and "lessons." While developing this plan, the project team worked closely with tribal representatives to create definitions and translations that best fit the tribal perspective.

In order to develop the medicine wheel as a proper structure for the SPE planning, it was necessary to translate and define it in such a way that the requirements of the grant and the planning framework could be met. For the purposes of this plan, the seven directions are defined below along with an outline of how they fit in with the steps of the strategic prevention framework and the SPE.

The Medicine Wheel and the Strategic Prevention Framework: A Story of Translation



Overall SPE Plan = Earth, Sky, and Inner Self

"…Above and below, or Up and Down, represent Mother Earth and Father Sky. These directions show me the partnership between the environment and the elements. Through these two directions I have learned the importance of living in harmony with the Earth. The most important direction of all is the direction of the Inner Self, the center of the Wheel where all directions come together. All aspects of life are represented through the Medicine Wheel…" Brian Jackson, Lac du Flambeau Tribal Member and SPE Policy Consortium Member, 2012

- Earth = Individual Tribes and Communities where the steps are implemented to benefit the people
- Sky = The GLITC service area and the big picture support and service to improve effective ATODA prevention for all member tribes and communities
- Inner Self = GLITC Board of Directors, SPE Policy Consortium, Tribal Chairs, individuals and organizations that participate and champion the plan

Data Collection, Analysis, and Reporting

"The East is my favorite direction, the direction of renewal. The East is where humans are encouraged to see as a child sees; the direction of illumination. The East for me is a place to develop leadership skills. Looking to the East, I can look through complex situations and see the simple answers in life. I've had to revisit the East many times in my life." Brian Jackson, Lac du Flambeau Tribal Member and SPE Policy Consortium Member, 2012

East = Assessment

- *Infancy* – Physical
- Learning what the needs are and how to meet them = Assessment.
- All groups, ideas, tasks, individuals, and responsibilities have a beginning in which the process is new and in its infancy; so it is with the East, the birthplace of all things.
- This is where, for the purposes of the plan, an assessment of the data will be conducted and priorities will be set through the use of data-driven decision making.

Coordination of Services

"The South is the direction of sensitivity and compassion. Through the South, I have learned to put my trust in and listen to others. This is the direction that I gained the power to carry out my vision." Brian Jackson, Lac du Flambeau Tribal Member and SPE Policy Consortium Member, 2012

South = Capacity

- *Adolescence* – Emotional
- Learning to master skills and resources to be effective in meeting needs = Capacity Building and Readiness.
- The South is the time of adolescence; as with most adolescents, this can be a difficult time. This is often when people have questions and look for ways to balance what they know with new ideas they are being presented with. Through conflict comes mastery and new avenues of growth. Be prepared for stormy waters during this time, but success in the South leads to change and new agreements and learning.
- In order to increase the reach and effectiveness of behavioral health initiatives and prevention efforts for ATODA and suicide, a broad group of partners will need to work together in collaboration. This can be both difficult and ultimately rewarding. The enhancement of coordination allows a sharing of resources and practices that create more efficient and successful systems.

Technical Assistance and Training

"The West is the direction of within. In the West, I have learned to accept myself for who I truly am; having learned to listen to my inner voice and intuition. I've learned to look inside myself to judge my hopes and ideas." Brian Jackson, Lac du Flambeau Tribal Member and Policy Consortium Member, 2012

West = Implementation

- *Adulthood* – Intellectual
- Applying skills and achieving mastery = Implementation activities.

- To the West is a time of application and accomplishment. It is here that new learning and skills are put into practice and many tasks are accomplished and much work is completed. It is a very productive time in which new norms can be established that lead to interdependence and strength for everyone.
- The acquisition and implementation of skills, knowledge, and capacity are achieved at the regional and local levels through a systematic web of technical assistance and training so that the readiness to act is established and maintained throughout the process and sustained into the future.

Evaluation and Performance

"The North represents the mental aspect of life. This is the direction from which I have learned the power of knowledge in my everyday life. The North represents my intellectual being. The North is an important direction for a person to visit! Time and effort are required in the North to succeed where I've also learned the power of hope over all." Brian Jackson, Lac du Flambeau Tribal Member and SPE Policy Consortium Member, 2012

North = Evaluation

- *Elders* – Spiritual
- Learning from mistakes and passing on the lessons = Evaluation and Adaptation
- At this point new norms, learning, skills, and lessons become a standard part of the community as a whole. It is a time when the wisdom of the elders is passed on, becomes routine, and is incorporated into everyday life. Elder does not refer just to age but also to experience, respect, and expertise. A group or coalition can become the elder and "messenger" for the community.
- To the North is a time of reflection and evaluation; it is the point at which those who have both participated in and witnessed the implementation consider the work and seek to discover what went well and what needs to be changed in order to support the next generation in ways that will be healthy and balanced.

One of the other unique aspects of this approach to planning and logic models is the decision of the Policy Consortium that, to be truly respectful of tribal approaches, the logic models needed to be strength based and not problem centered. Although problems are there, each of the directions of the plan speaks to the goal and strength that is required to address and diminish that problem.

In addition, this plan is based on a growing belief and evidence from prevention science, nationally, that "Culture is Prevention." There is a growing body of evidence that supports the idea that if people and communities are reconnected with their own culture or with what has evolved into the contemporary inter-tribal Native culture they will have increased protective factors and will exhibit behaviors that are healthy, balanced, and successful. While much of traditional teachings differ from tribe to tribe and many traditional practices have been lost, there still remains a core set of beliefs, ceremonies, activities, and values that are uniquely applicable to modern tribal culture. It is those iconic and archetypal values, beliefs, activities, and protective factors that are at the core of the model presented in this plan and the basic fundamental principle that guides it, "Culture is Prevention."

THE SEVEN DIRECTIONS

Explanation of the Strategic Plan's Seven Directions

The first three directions–Sky, Earth, and Inner Self–represent the overall goals of the SPE plan and how the Policy Consortium, GLITC staff and consultants, local tribes, evaluators, agencies, and individuals (referred to as key stakeholders throughout the plan) will play a role in the successful implementation of the plan. The directions also represent ways in which the GLITC strategic plan goes above and beyond the basic grant requirements. Throughout the development of this plan it became clear that the format and structure of the SPF–when taken beyond substance abuse prevention and applied to scale in a broader context that includes suicide prevention and behavioral health–provides an approach that is both effective and respectful of the culture.

Bringing together the best of both *culturally-based approaches* and *western evidence-based methods* to allow data-driven decision making, the SPF and the SPE allow GLITC and the member tribes to create and structure a system for addressing multiple problems. When the SPF's basic theory of change is applied in this way, the potential for significant change is increased exponentially. It is with these ideas that the overall goals and logic model for the Plan were developed.

The remaining four directions–East, South, West, and North–represent data collection, analysis and reporting, coordination of services, technical assistance and training, and performance/evaluation. They are all interconnected and they overlap. Data collection, for instance, includes a survey of coordination of services (and other related issues) that will help direct technical assistance and training services, and which–in part–will drive the performance/evaluation process. All four directions include objectives that involve GLITC project staff, GLITEC, the Policy Consortium and the tribes that will participate in developing tribally specific plans. At the end of each direction is a section titled "Further (directional) Considerations." These sections either add additional context and thoughts or comment on other issues that the individual tribes may want to consider as they implement the strategic plan.

In order to develop and implement a sustainable prevention infrastructure that uses both culturally responsive and state-of-the-art prevention programs, practices, and policies, a system of training and technical assistance must be implemented that will provide the participants with ongoing access to information and knowledge. This knowledge and information should cover a wide variety of issues and priorities if the goal of creating and sustaining healthy balanced communities for generations to come is to be accomplished. Furthermore, it is imperative that they be kept in the forefront as planning and implementation move forward.

Community readiness will play a key role in both the speed and the efficiency with which a plan like this moves forward. If a community, group, or tribe is not sufficiently prepared to move forward, barriers may result that can and often do stop the process. One of the major considerations in assessing initial readiness is to review the capacity of the participating organization(s) to develop and maintain sufficient organizational infrastructure, staff, and ongoing training and technical assistance. Key to this issue is the commitment at all levels to actively seek ways in which to increase and stabilize funding and resources for ongoing prevention efforts and systems. Often prevention systems at both the regional and local level, especially when working with tribes, are forced to rely on discretionary and grant funding to maintain their efforts. When this system is the prevailing model, programs and organizations are forced to continually reinvent themselves and their directives to match the format and requirements of the grants/funding available to them. Instead, prevention systems must be allowed stable funding and resources so that they can use data to prioritize their needs and implement programs and policies to address them without being subjugated to the imposed restrictions from outside funding sources. Through the development of capacity, within the local communities and at the GLITC

service area level, and by means of policy development and by acquisition of ongoing funding through taxation, fees, and/or other means, a concerted effort must be made to support prevention systems that are effective and that will protect future generations from the negative and devastating consequences of alcohol and other drug abuse, suicide, and other behavioral health issues.

Another key area to be addressed is the development of a process, system, and infrastructure at the GLITC service area level and within member tribes to actively understand and pursue evidence-based, informed culturally relevant prevention programs, activities, symbols, practices, and policies. The means by which practice-based evidence (PBE) is reviewed and approved for implementation and funding must be well thought out and constructed if the work being done is to be effective for the people being served and acceptable to funders and policy makers. It is important that the approach designed to approve PBE be recognized as viable and credible by tribal, state, and national entities.

Evidence-based intervention or practice-based evidence intervention may be confusing in part because of multiple definitions including, but not limited to: promising practice, exemplary practice, best practice, practiced-based evidence, community-defined evidence, and evidence-based practice (Echo-Hawk, 2011). For the purpose of our SPE strategic plan, evidence-based practices are defined as "practices that integrate the best research evidence with clinical expertise and patient values" (Bartgis and BigFoot, 2010). Practice-based evidence is "a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. They are accepted as effective by the local communities, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework" (Isaacs et al., 2005). Evidence-based practices and practice-based evidence are identified as distinctly different.

Evidence-Based Practices vs. Practice-Based Evidence		
QUESTIONS	**Evidence-Based Practices (EBPs)**	**Practice-Based Evidence (PBEs)**
Who created these?	Some theories and evidence-based practices were created after researchers studied Native populations. For example, Maslow is given credit for Maslow's Hierarchy of Needs when these ideas originally came from the teachings of the Blood/Blackfeet Indians in Canada (Blood & Heavy Head, 2011).	Tribal community members and others. For example, the practice of cognitive behavioral therapy, which seeks to modify a person's thoughts, feelings, and actions, is nothing new in tribal communities. Native people have used this intervention for years in many ways. Veterans returning home from deployment and participating in a sweat lodge or smudging or other sacred ceremonies to restore overall wellness is but one illustration (BigFoot, 2012).
What evidence, and who, supports these interventions?	Academics and researchers often study evidence-based practices and publish the results in journals. Unfortunately, many times these interventions do not include Indigenous populations or they are lumped into the "other" category. Many agencies, organizations, and states require EBPs in grant applications (Nebelkopf, et al., 2011)*.	Unfortunately, there are not as many individuals in Indian Country evaluating PBEs as there are academics and researchers studying EBPs. The Gathering of Native Americans (GONA) curriculum, which emphasizes Native values, traditions and spiritually, was funded by SAMHSA and the IHS; however, it is not listed in SAMHSA's NREPP (Nebelkopf, et al., 2011).

When are these interventions required?	In order to receive funding from different federal agencies (i.e. SAMHSA), organizations, and some states, grantees are required to implement an EBP (Nebelkopf, et al., 2011).	PBEs are required when someone needs to restore overall wellness or balance; therefore, there are not specific requirements to implement them, although many tribal communities use them in addition to the required EBPs.
Where are these interventions promoted?	Currently there are only three or four Native evidence-based practices on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP).	Currently there are no practice-based evidence interventions on SAMHSA's NREPP list; therefore, PBE's are promoted by Tribal communities, Native advocates, and others.
Why are these interventions significant?	Quantitative experiential studies such as randomized control trials or comparison studies show EBPs can create statistically significant outcomes for individuals (Nebelkopf, et al., 2011).	Interventions such as Sweats and Smudging have stood the test of time in tribal communities. PBEs that were originally practiced in Native communities are now being practiced in other communities (i.e., cognitive behavioral therapy) (BigFoot, 2012).
How do these interventions work in the real world?	It is difficult to determine how effective EBPs are in Tribal communities because most of the studies are experimental while everyday life is not. In addition most EBPs focus on only individual outcomes instead of the overall community.	Interventions like Sweats and Smudging have stood the test of time in tribal communities. PBEs that were originally practiced in Native communities are now being practiced in other communities (i.e., cognitive behavioral therapy) (BigFoot, 2012).

** To review the in-depth history of evidence-base practices and practice-based evidence, please read: Nebelkopf et al., 2011).*

Furthermore, evidence-based practices are given more validity than practice-based evidence interventions. SAMHSA's National Registry of Evidenced-based Practices and Programs (NREPP) currently recognizes evidence-based practices but not practice-based evidence. Additionally, it has become common practice in the field of substance abuse prevention for funders to require that states, tribes, and communities use "evidence based" practices and programs. This is, in part, due to the fact that evidence-based practices have gone through rigorous study while practice-based programs generally are not as rigorously studied.

The irony in this is that many "evidence-based practices" are misappropriated Indigenous intellectual property. Essentially, from the time Europeans stepped on the lands of Indigenous peoples they have gained access to native people's knowledge. There is nothing wrong with this in itself, but the practice has not stopped at the use of this knowledge for betterment of life; rather, the knowledge has been used for profit and personal advancement, For example, indigenous plants have been patented by large transnational corporations, requiring indigenous peoples to buy back the ability to use those plants (Shiva, 1997). Continuing to label native practices as "evidence-based practices" because they have been appropriated and packaged for consumerism, giving them "scientific validity" while simultaneously discounting practice-based strategies or de-valuing them, is an ongoing example of stripping away Native assets and refusing to recognize them.

Evidence based practices and programs have been a difficult issue for many tribes and tribal organizations across the country because there has been such limited understanding and research available regarding what works in Indian Country. "The focus on individual outcomes that characterizes most EBPs is too narrow and does not aid in reducing disparities in behavioral health services; this also cannot be achieved through the evidence-based research process. The cumulative and interactive nature of disparities is more complex and

multifaceted than an approach that isolates single variables. Disparities cannot be addressed through a single intervention. Scientific processes have yet to develop research designs or tools to accommodate this level of complexity" (ICF Macro, 2011).

Until relatively recently there was not a focus on producing "evidence-based" research for prevention with Native Americans. The prevailing belief was that if a program or practice worked in one group or sample, then it could be duplicated (with fidelity) in most or all other environments and be equally successful. There are clearly some problems with that simplistic paradigm for approaching the complex issues of more than 567 federally recognized tribal nations–each with its own form of government, culture, history, environment, and issues. Nor was there a place for some of the basic tenets of many tribal belief systems or for the role of more "culturally traditional" means of effectively addressing these types of problems. For many tribes, the reality of what works in Indian Country is rooted in practice-based evidence as opposed to evidence-based practice. It is an important distinction that greatly impacts the ways in which cultural competency and, more importantly, cultural responsiveness, must be addressed when designing and implementing prevention within tribes and tribal organizations.

One of the outcomes within Indian Country has been a movement to use standard federally recognized models such as the SPF SIG and the Service to Science model to begin a process of reviewing, implementing, and evaluating culturally appropriate and responsive prevention planning and practice, with very good results. One such effort was in Oregon, where the state legislature passed a law that required the use of "evidence-based programs and practices" across the board. The nine recognized tribes in Oregon worked together in a collaboration to address this issue at the state level through a process of dialogue and engagement with the State that resulted in an accepted method to address the issue of the "best practice" mandate in Indian Country that is referred to as the Oregon Tribal Best Practices (TBP) initiative.

After reviewing literature and existing models, the Policy Consortium has recommended that a formalized process be implemented. It will include established criteria for application to a peer reviewed approval process that will use established policies to operationalize the review process. This process will be a means of translating tribal practice-based evidence interventions into the formalized language of the prevention field and move the tribal practices along the continuum to evidence-based practices.

In a recent article in the *Journal for Psychoactive Drugs* (Volume 43, Number 4, October-December 2011), Drs. Walker and Bigelow summarize the TBP process in Oregon with the foundational idea that this is a model that other tribes and tribal agencies could promote as a prototype to begin the process of effectively translating culturally responsive and evidence-informed programs, policies, and practices in other tribal settings.

To address cultural content, the TBP looked at local context and culture to address the variables that are not usually contained within a standard program curriculum or in the research of evaluation design of model programs, at least not to a large degree. Those most relevant cultural contexts that should be considered when implementing in Indian Country include these: choice (personal and group level); self-healing beliefs; relationships; and the complex web of interrelationships that must be considered to give a "model program" culturally appropriate applications. The cultural context of such endeavors is critical to the development of a theory of change that is both salient to the community and reflects a process of change that will help the empirical world of science and the practical world of Native practitioners to better understand and appreciate the strengths and barriers to implementation in Indian Country. Although it has been difficult, over the past decade there has been a recognition by many who work with tribes and tribal organizations across the country that community based processes and methodologies must be evaluated so that a body of evidence is built that shows how in fact "culture is prevention." Culturally responsive programs can be informed by evidence, utilize state-of-the-art prevention models and theories of change, and move toward credible

evaluation processes. This can be accomplished when programs are being designed and implemented using logic models, such as those noted in this plan, and explicit theories of change that identify both prioritized needs and logical outcomes. In Oregon the tribes use a thirteen-item form that makes up the logic model when completed; it is designed so that filling in the boxes completes all of the questions necessary to describe the program or practice seeking "evidence based" status. The items included in the Oregon logic model are: name, brief description, replications (other examples), culture-based evidence, goals, target population, risk and protective factors, tribal personnel, activities, materials, optional elements, outcomes, and contact persons.

Walker and Bigelow went on to describe three important aspects that programs must be aware of and replicate if they are to be culturally responsive.

- Credible program personnel and/or practitioners
- Culturally based prevention activities that include: participation in traditional ceremonies and rituals, sharing stories, oral instruction and modeling, and fun
- Materials that include culturally relevant and specific aspects such as: setting, dress and ornamentation, symbols and graphics, sensory substances, and food

All of the above considerations should be designed and implemented to address specific, observable, measurable, immediate outcomes that are defined in cultural terms such as: restoring balance, strengthening connections, establishing identity, creating meaning, creating a sense of hope, establishing self-esteem, and fostering healthy community norms.

Even with the TBP review process in place, Walker and Bigelow recognize that while these steps will take community based cultural prevention programs far in addressing the evidence-based mandate, there is still a long way to go before they are given the same level of credibility as those found on the National Registry of Effective Prevention Programs (NREPP) or other comparable lists. There is work yet to be done in strengthening this approach to the recognition and implementation of culturally based programming, but more than a dozen programs have been reviewed and approved by a peer review panel in Oregon. Those on the current approved list include local versions of well-known activities such as Canoe Journey, Talking Circles, and Culture Camps.

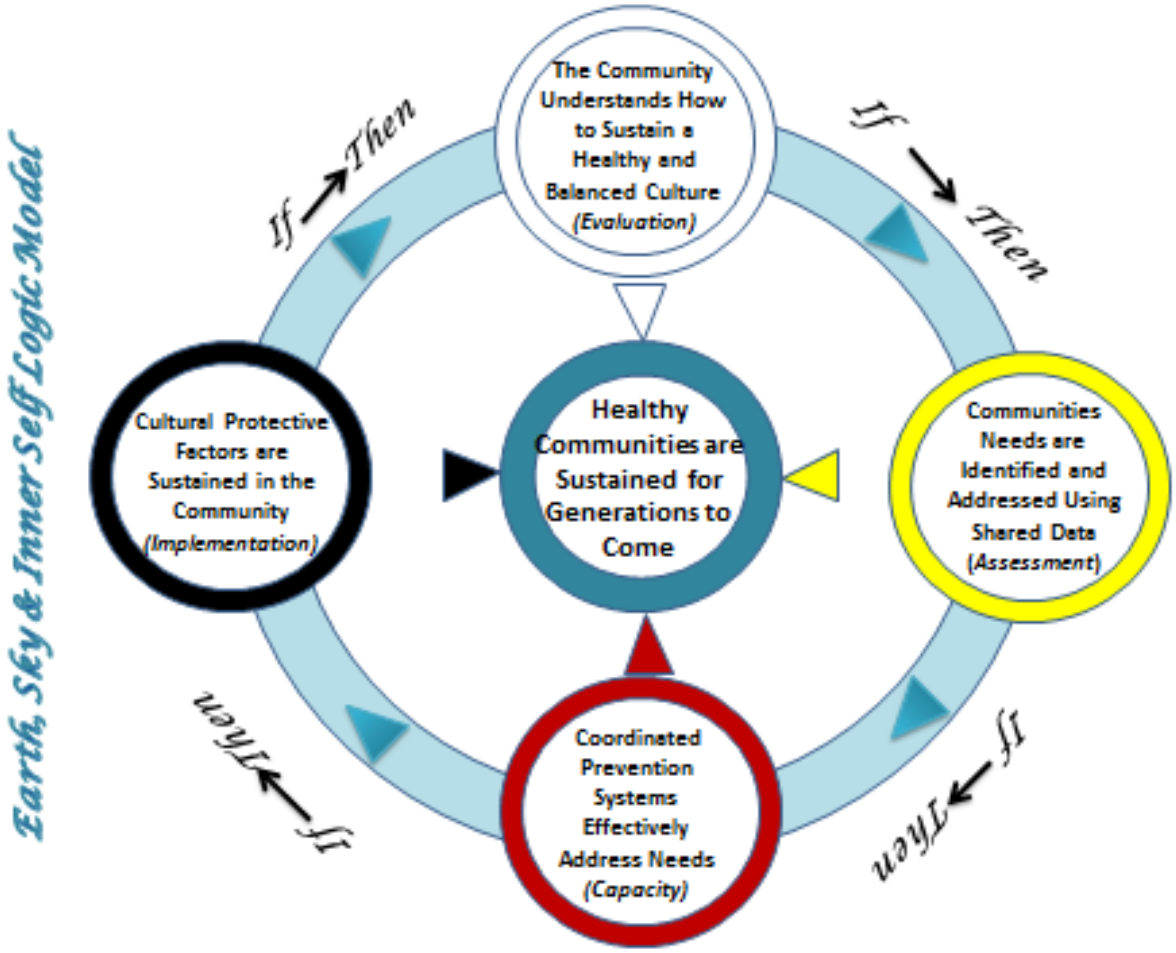
In a review of material and options, the GLITC Policy Consortium recommended that the Oregon model serve as a prototype for the adoption and implementation of a culturally responsive and capacity building approach to prevention efforts.

As mentioned early in the plan, this process is like a spider web and the steps will not necessarily line up in a linear sequential path with a beginning, a middle, and an end. Instead it should be approached on all fronts necessary to accomplish the goals as they come up. Questions, concerns, goals, and capacity will be returned to strengthen, evaluate, adapt, and grow. Through the use of an ongoing and active technical assistance and training plan, GLITC and the member tribes will increase their potential to create and sustain lasting change for the people and communities they serve. With the exception of activities that were accomplished during the planning process, completion dates and times in the four directional plans are not included. The goals and activities in each direction are laid out in short term, intermediate, and long term ranges rather than with specific end dates. This will allow GLITC and local tribes to design target dates as implementation is initiated.

THE EARTH, SKY, AND INNER SELF: OVERALL GOALS OF THE STRATEGIC PLAN

The earth, sky, and inner self speak to the different perspectives that must be observed to create a truly balanced plan. When we look to the sky for perspective we see the "big picture." From the sky we can see how all of the pieces fit together and evaluate what needs to be strengthened, changed or eliminated to increase the effectiveness of our efforts. The sky allows us to see how we can adapt what we do to benefit all of the people and generations to come; the sky represents the communities and tribes and agencies that work together for the benefit of their people. With the earth we are in touch with all of those things that happen at the ground level; it is the perspective of detail and finding the small pieces that will make up the whole. As we walk on the earth we learn to pay attention to the path that we take. The inner self represents what we do as individuals both in our professional capacity and in our personal journey. No plan or prevention strategy or program can be enacted without the commitment of individuals and people who believe in the value of protecting and building healthy communities for the generations of children yet to come.

Earth, Sky, and Inner Self Logic Model



Earth, Sky, and Inner Self Narrative

It became clear as this plan was developed that it would not be a simple five-year strategic plan that would meet the requirements of a grant. As the Policy Consortium, project staff, consultants, and key stakeholders participated in the process, what evolved was a structure for approaching the serious problems of substance abuse, suicide, and behavioral health in the service area far into the future. It is common in Indian Country to hear an elder refer to considering seven generations back and seven generations forward before deciding how to proceed. In this way, the evaluation of past endeavors informs how to move forward to protect those that come after.

By adopting the medicine wheel as a framework for the development of the plan, five interconnected yet self-standing logic models were developed. Like the SPF, the medicine wheel is much like a spider web. Different directions will be addressed as part of the whole and independently and they will be revisited many times. For the purposes of the SPE Strategic Plan, each direction and logic model is set up to be implemented as part of the entire plan, which is the ideal. If needed, each of the logic models and components of the plan can be implemented independently. In this way, if the plan in its entirety is not funded, GLITC or member tribes can still use it and implement those sections for which they have need, staff, and/or funding. In this way each direction can be implemented and revisited as needed so that over the course of time the overall goals can be accomplished.

Earth, Sky, and Inner Self Considerations

- Take steps toward GLITC and the member tribes making a commitment to developing culture-based prevention and health promotion systems of care and adopting the working "philosophy" that culture Is prevention.
- Assist local tribes and GLITC to support interdisciplinary teams to review and adopt concepts, tasks, and strategies outlined in the SPE Strategic Plan.
- Participate locally, regionally, and nationally to further the evolution of evidence-based prevention in Indian Country through developing processes and methods that will allow approaches that have practice-based evidence to become evidence-based practices within a culturally responsive context.
- Promote the SPE Strategic Plan as a "*living asset of the GLITC service area*" to the GLITC Board of Directors (BOD), individual tribal leadership, GLITC and GLITEC staff, and community prevention specialists.

- Members of the Policy Consortium will work with GLITC staff to disseminate the SPE Strategic Plan to the GLITC Board of Directors to:
    - Seek support for the overall SPE Strategic Plan
    - Encourage a commitment to implement the plan, either as a whole or in part, with or without outside funding sources
    - Work with member tribes to increase their awareness of the SPE plan
    - Increase member tribes capacity to implement the goals of the SPE plan
- Identify "champions" who will assist in carrying the message of the SPE plan forward to the GLITC BOD, local tribes, and throughout the GLITC service area.

- Disseminate the SPE Strategic Plan to tribal leadership, GLITC service area tribal health directors, and other policy making groups to gain support for the SPE as a model plan.
    - Understand and utilize the SPE Strategic Plan as a prototype for ATODA, including prescription drug abuse, as well as behavioral health promotion and the decrease in suicide attempts.
    - Increase capacity of key stakeholders to promote the adoption of the SPE Strategic Plan as a model for "doing the business" of prevention and behavioral health promotion.

- Tribal representatives from the SPE Policy Consortium will disseminate the strategic plan to local tribes and tribal councils across the GLITC service area and to its member tribes.

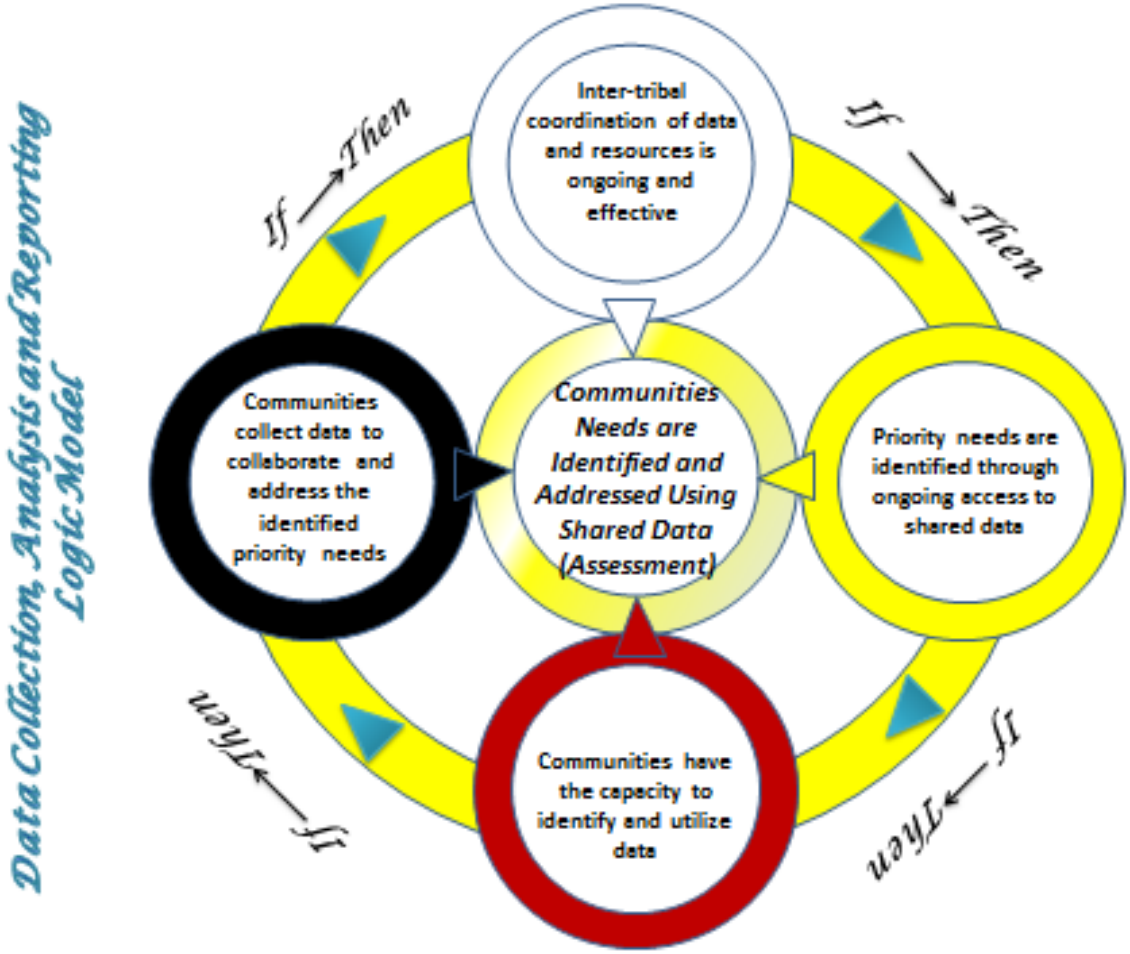
- The Policy Consortium and GLITC project staff support participation in efforts to partner with other tribes and inter-tribal organizations throughout the state and nationally to further the development of Native evidence-based programs, policies, strategies and practices.

- Work with local tribes and inter-tribally through GLITC to set up a system to identify tribal best practices and methods for approving them for implementation.
- Communicate to the GLITC service area that this plan can be implemented as a whole or in part. It represents not just the basic requirements of the grant but also a commitment to increasing the capacity of the GLITC service area and member tribes to effectively address substance abuse (including tobacco and prescription drug abuse) and suicide prevention, as well as behavioral health promotion within the context of developing a culturally-based and responsive system.

THE EAST: DATA COLLECTION, ANALYSIS, AND REPORTING

As with the beginning of most things (life or plans), the first order of business is to identify the needs of the individual or community, prioritize those needs, and develop a plan of action. Much like infants gathering information about the environment from experience and exploration, the first step in developing a sound plan to approach the problems of substance abuse, suicide, and behavioral health issues is the assessment of the current state of those problems. This is where the plan begins. In order to understand how to build healthy tribal communities and people, data must be gathered and analyzed to identify the greatest negative consequences, barriers, problems, or gaps. At the same time, in any assessment it is important to identify protective factors and strengths to deal with these issues. Once data have been gathered and prioritized, it is then possible to move forward knowing that the most severe problems in those areas will be addressed first. It also sets up a system by which the GLITC service area can successfully replicate the process for other areas of concern such as commercial tobacco abuse, teen pregnancy, HIV/STDs, and nutrition.

Eastern Logic Model



Eastern Narrative

Issues with Data Quality

According to the 2010 GLITEC Community Health Profile, there are a number of issues with American Indian/Alaska Native secondary level data including:

- Racial misidentification is common. Reports vary in their estimates for the frequency this occurs. One investigation by the Indian Health Service estimated that American Indian/Alaska Natives in the Bemidji Area were undercounted by 16.1 percent, the third highest area for misclassification; overall misclassification was found to be 10.9 percent across the country (U.S. Department of Health and Human Services, 1996). Another estimate states that American Indians in general are undercounted by 38 percent (Sondik, 1999).

- In many data sets, small racial and ethnic populations are lumped together as "others"; in "others" they are excluded from analysis altogether, or are deliberately excluded during data collection.

- American Indian/Alaska Natives, like other small populations, are not commonly oversampled. Oversampling collects data from enough people in small populations so the results are statistically significant. Furthermore, it allows for that the same analyses to be done as in larger populations. Therefore, —drilling down through the data is possible, allowing comparisons between sub groups- between men and women, or adults and adolescents, for example. Examples of major national surveys that do not routinely oversample American Indian/Alaska Natives include the National Health and Nutrition Examination Survey, Behavioral Risk Factor Surveillance System, and the Youth Risk Behavioral Surveillance System.

- A lack of continuous and reliable funding hinders the collection of quality data for American Indian/Alaska Native populations. When funding is variable from year to year, planning is difficult and it becomes more difficult to be consistent; when budgets are cut, statistically insignificant populations frequently are not prioritized.

- Many Tribal communities are interested in receiving community level data, preferring this over state-level estimates.

- It is difficult to collect data in Tribal communities for various reasons.
    - As in all smaller communities, sampling is generally more difficult than in larger communities. For statistical validity a larger proportion of population must be sampled.
    - Community members complete more surveys, leading to fatigue and disinterest.
    - Historical mistrust factors into the willingness of leaders and community members to agree to surveys. Because research projects have been done poorly in the past, community members likely are more cautious about participating. It also increases pressure to do things the right way, which can be intimidating and may deter future research or surveys originating from outside Tribal communities.

While working on SPF SIG and SPE, those involved discovered that many tribal communities do not systematically collect or analyze data; furthermore, without a data surveillance system and without consistent data sharing and storage policies it is even more difficult to collect data at the local level. We can speculate that the lack of systematic data collection and analysis is due to the fact that many organizations are trying to meet grant requirements while working in silos. Instead of coordinating services they are duplicating work.

Therefore, GLITC and SPF SIG staff had to work on data collection and evaluation extensively with the State Incentive Grant.

SPF SIG Primary Data

While much work has been done with the SPF SIG tribes to build capacity around data collection, reporting, and analysis, this is an area that continues to need a great deal of time and effort. The GLITC SPF SIG grant (completed May 31, 2012) collected data from the ten tribes through the end of September 2011. Additional data were collected from three of those tribes as part of a mini-grant award and collected through mid-May 2012. All of the local level SPF SIG data were collected by the tribes and analyzed by an outside contractor and not collected and stored in any type of GLITC or GLITEC data base. As GLITC moves forward with strategic planning, increasing tribal capacity to collect and report data to a central repository at Great Lakes Inter-Tribal Epidemiology Center is now an area of focus. Unfortunately, there are no mechanisms to require data reporting through this new system unless additional SAMHSA funding to individual tribes and GLITC is realized. Our target communities, as part of this strategic planning, have increased to include the two member tribes that were not part of the SPF SIG grant. In addition to a central repository, assistance in developing tribal-specific data repositories will also be necessary. It must be remembered that GLITC is working with twelve Sovereign Nations that may at any time decide to cease GLITC membership or not participate in the central repository if grant funding does not dictate the need to do so.

Systems Surveys

An initial systems survey of current prevention data collection systems, as well as coordination of prevention activities, was conducted with key stakeholders during the spring of 2012. This shed light on the multiplicity and range of systems being used within the tribal communities, the types of data being collected, and how those data are being used to drive prevention programming. According to the SPE Systems Survey, over one-fourth of participants (27.3%) reported that they were "unsure" if there was cross-departmental data sharing in their tribe. We intend to re-survey the participating tribes to look for positive changes as intermediate and long-term activities.

In addition to the systems surveys being done at the tribal level, a systems survey to assess coordination at GLITC and the capability of GLITEC to function as a central repository is in process. The indicators of success of the central repository will be developed and assessed. This is planned for year five of the strategic plan.

Indian Health Service Data Sharing Agreements

Alcohol and Other Drug Abuse/Behavioral Health clinical data from our member tribes has been collected by the tribes and is routinely submitted to Indian Health Service Behavioral Data Mart. The Bemidji Area Office has authorization to retrieve data from the Indian Health Service Data Warehouse. Negotiations have been going on for several years to have these data released to the Tribal Epidemiology Centers (in our case GLITEC) in order to give tribes more timely feedback. GLITEC is close to finalizing an agreement with the Bemidji Area Office. While this would potentially give GLITEC access to data, the individual tribes, as Sovereign Nations, would need to give permission to GLITEC to use tribe-specific data from the EPI Datamart (part of the IHS Service Data Warehouse) and define how it could be used. Under the Data Sharing Agreement with the Bemidji Area Office, GLITEC will be authorized to access and use area wide aggregate data in data profile reports.

GLITC and GLITEC will continue to work toward developing relationships with its member tribes to encourage the use of these data to help guide prevention activities. The Resource and Patient Management System data (RPMS), however, is not "prevention" data but gives a snap shot of the type of alcohol, tobacco, and other drug abuse/behavioral health issues being experienced by the tribes.

Better Local Data

Data available to the individual tribes, as well as the capacity to collect that data, has been discussed by both our SPE Policy Consortium and our EPI/EBP-PBE workgroup. A "wish list" has been developed and attempts to find reliable and consistent data in those areas pursued. There remain, however, numerous gaps in available data. The workgroup will continue to advise the Policy Consortium on improvements that can be made.

One of the data areas looked at as problematic but necessary is related to law enforcement. Nine of the twelve member tribes have tribal law enforcement but generally have very small forces that are stretched thin, that experience frequent staff turnover, and that depend upon backup from the local sheriff. When non-tribal citations are issued, assumptions of ethnicity are frequently made based upon surname or residence. These data have not been found to be accurate and often are difficult to get from non-tribal law enforcement entities. While tribes will work with tribal law enforcement for inclusion of increased and more accurate data, they have no control over what non-tribal law enforcement collects. The SPE Policy Consortium recognizes this as important data, but it will take time and relationship building to bring tribal and non-tribal law enforcement together to develop some consistency for data collection and reporting. This is an example of one of the numerous data challenges that the Strategic Plan will impact.

Data Repositories

As mentioned previously, neither a central repository nor tribal-specific repositories were in place for the SPF SIG. Early in the grant, the external evaluator set up a system of data collection and analyzed and reported tribal data to SAMHSA based upon what was available from sub-grantee tribal submissions. Due to the very small populations in our tribal communities, an agreement for cross-site data submission was developed so individual tribal-level data remains unidentifiable. The sharing of individual tribal data remains an area of deep concern for tribes and work will be needed to assure that protections remain in place in regard to this issue. Input from our PC has shown strong support for a central repository at GLITEC and this will be pursued; according to the SPE Systems Survey, 61.3 percent of participants indicated they were more than "somewhat interested" in a central data repository for both their tribe and inter-tribal use. It is important to note, again, that our twelve member tribes are Sovereign Nations and, as such, can agree to participate or disengage themselves from working with the central repository at any given time. The development of individual agreements for interaction between the central repository and GLITC/GLITEC will take time. An assessment will be conducted with the Epidemiology Center staff of the effectiveness and helpfulness of a central repository, including ease of data submission, timeliness of analysis, and helpfulness in determining direction for prevention programming and activities, etc. This is planned for the fifth year of the strategic plan implementation.

With 43.2 percent of SPE System Survey participants indicating they were "very interested" in tribal-specific data repositories; in addition to a central repository, access to individual data repositories at the twelve tribes will be explored. Some tribes are currently at a point where this is a possibility; others are not due to lack of resources. The Epidemiology Center has a tool with which tribes can conduct data source inventories. The GLITEC Data Inventory Tool helps them to identify the data they have and where there are gaps. Once this is completed, individual tribes can decide whether having a tribal repository is something that makes

sense for them. This Inventory is currently being piloted by one of the twelve member tribes and will be offered to the remaining tribes during the early part of the fiscal year of implementation. Those tribes wishing to create their own repositories will be provided guidance for next steps in making that a reality.

Our vision is to develop a data collection, analysis, and storage system that is effective and useful to the tribes as individual communities and to all tribes, as a whole, as they use that data to guide prevention planning. A central repository will allow for the storage of data that individual tribes can retrieve for their own use or aggregate data for the GLITC service area that is useful for grant writing and GLITC service area planning. GLITC will continue to pursue data agreements with the BAO so that tribes will have access to individual and GLITC service area data/trends in a timely manner. Additionally, tribes will be given access to a data inventory to help them determine what data they might want to collect and store locally. Finally, GLITC/GLITEC will be looking at their own internal systems to ensure that tribes receive the best possible guidance as they move forward with prevention planning.

Ownership, Control, Access and Possession

Native people have participated in more information gathering projects (defined broadly as documentaries, interviews, interventions, program evaluation studies, research studies, etc.) than any other racial or ethnic group. It is not a surprise when many tribal communities voice, "We have been surveyed to death." Although some of these projects have unintentionally benefited Native people, others have not. For example, an initial assessment of the number of fish caught by Native and non-Native people during the 1990s fishing riots/protests in Lac du Flambeau found that Natives took fewer fish out of the lakes each year than commercial fisherman. A recent example of research gone wrong involves the collection of blood samples of 400 Havasupai Tribal members for use in a diabetes study; the blood samples were then later used without consent by Arizona State University and University of Arizona to study schizophrenia and other mental health issues.

Although the strategic plan does not directly address fishing or collecting and analyzing bio-specimens, it addresses overall wellness for Native people; this is why the review of documents created by the First Nations in Canada that address issues of ownership, control, access, and protection (OCAP) were important to the strategic plan. These core principles are used by the First Nations of Canada whenever any organization (Native or non-Native) is working on any aspect of information creation or management. OCAP is not a prescriptive document nor a checklist, but rather a principle or theory that helps guide each project in terms of data. Since GLITC currently does not have universal data sharing, storage, and release policies, this has posed some difficulty–not only for GLITC programs but also for the tribes. Some of the issues to be considered are: 1) determining who should have access to the data; 2) who stores these data; 3) and what protections and policies should be in place. It is essential to review OCAP and other relevant documents/models to create appropriate data sharing, storage, and release policies to deal with tribal-specific data. Additionally, GLITC will create policies to govern internal polices related to data to reduce redundancy in data collection by multiple programs.

GLITEC Data Inventory Tool

The *Great Lakes Inter-Tribal Epidemiology Center's Data Source Inventory for Tribal Programs* is a tool developed in order to complete an assessment of the different programs that are happening within each tribal community. This tool allows a tribe to review current data sets they possess and a number of data dimensions including accessibility, accuracy, reliability, security, and validity.

Working with the SPE, it became apparent that there are numerous coalitions, groups, and organizations collecting data from the same individuals and that these groups are not sharing this information. According to the SPE Systems Survey, 31.8 percent of participants reported their tribe had more than one AODA

prevention coalition, group and/or organization while 34.1 percent of participants were unsure. Tribal community members will continue to be over-surveyed, causing survey fatigue, because of the lack of data-sharing systems and because programs are not coordinating resources.

As each tribe completes this data source inventory, the initial step in creating tribal-specific data warehouses will occur. The tool is currently being piloted with one of the tribes and the feedback from that pilot will help determine changes needed to make this a tool that is relevant in helping Tribes not only deal with prevention data, but with all data they collect. Building data capacity at the tribes has been identified as an important aspect for prevention work and this will be offered to those tribes that elect to adopt this strategic plan.

Data Collection, Analysis, and Reporting

Community Needs are Identified and Addressed Using Shared Data *(Assessment)*

Goal 1: Standardize data collection measures and methods across service area Tribal Nations to allow for more useable data.

Objective 1: Great Lakes Inter-Tribal Council, Inc. (GLITC) will conduct a systems survey of key stakeholders and others, as appropriate.

	Action Steps	Responsibility	Timeline	Completion
1.1.1	A systems survey will be developed with which to assess systems coordination/collaboration in GLITC member tribes to promote behavioral health, prevent alcohol and other drug abuse (including prescription drugs) and suicide.	Epidemiologist (EPI) with feedback from Project Director (PD), Evaluator, and Consultant	Prior to plan implementation period	12/01/11
1.1.2	Systems Survey will be piloted with the SPE Policy Consortium (PC).	EPI	Prior to implementation period	12/15/11
1.1.3	Edit Systems Survey.	EPI with feedback from PD, Evaluator, and Consultant	Prior to implementation period	3/29/12
1.1.4	Systems Survey will be administered to key stakeholders.	EPI, PD, and GLITC Deputy Director	Prior to implementation period	4/12/12
1.1.5	Analysis of Systems Survey.	EPI /Great Lakes Inter-Tribal Council Epidemiology Center (GLITEC) /Evaluator	Prior to implementation period	5/31/12
1.1.6	Re-administer and analyze systems survey.	GLITEC	Intermediate-term (12 to 36 months)	
1.1.7	Re-administer and analyze systems survey.	GLITEC	Long-term (36 months or more)	

Objective 2: Tribes will be aware of existing/potential ongoing data systems that can give them credible data upon which to build prevention programming related to behavioral health (BH) that will promote behavioral health, prevent alcohol, tobacco, and other drug abuse (including prescription drugs) and suicide.

	Action Steps	Responsibility	Timeline	Completion
1.2.1	Assess use of data collection methods and measures being used by GLITC member Tribes to promote behavioral health, prevent alcohol, tobacco, and other drug abuse (including prescription drugs) and suicide.	EPI, Project Director, Consultants, EPI Workgroup	Short-term (12 months or less)	
1.2.2	Clarify pros/cons of using various data collection methods and measures related to behavioral health, ATODA (including prescription drugs) and suicide.	GLITC with input from the EPI Workgroup	Short-term (12 months or less)	

1.2.3	After presenting these data (in previous two steps) to tribes and reviewing SPE Date Wish List, have brainstorming sessions to examine unmet data needs.	GLITEC	Short-term (12 months or less)	
1.2.4	Make recommendations for standardization of data collection methods and measures (i.e., YRBS, BRFSS questions, etc.), so participating Tribes can aggregate data for greater analysis power, if desired.	Policy Consortium with input from the EPI Workgroup	Intermediate-term (12 to 36 months)	
1.2.5	Tribes implement community-wide surveys using agreed upon methods and measures to collect data annually or bi-annually. All survey instruments will be stored on GLITC website for easy access.	GLITC, GLITEC, and Tribes	Intermediate-term (12 to 36 months)	
1.2.6	Participating tribes will use their individual data to drive current and future prevention programming.	Participating Tribes	Long-term (36 months or more)	
Objective 3: GLITC and GLITEC will continue to develop relationships and build new relationships with multiple entities that have data resources.				
	Action Steps	Responsibility	Timeline	Completion
1.3.1	Through focus groups and surveys, assess GLITC member Tribes readiness to collect behavioral health, AODA including prescription drugs, and suicide data.	GLITEC and participating Tribes	Short-term (12 months or less)	
1.3.2	Provide an EPI 101 training to Great Lakes Inter-Tribal Council member Tribes including methodology and purpose.	GLITEC and participating Tribes	Short-term (12 months or less) and on-going	
1.3.3	Continue to provide technical assistance and work with Great Lakes Inter-Tribal Council member Tribes to develop epidemiological capacity to collect and evaluate behavioral health, ATODA including prescription drugs, and suicide data.	GLITEC, GLITC and participating Tribes	Short-term (12 months or less) and on-going	
1.3.4	Work with IHS BAO to develop a better understanding of RPMS and how we can access these clinical data that may impact prevention efforts.	GLITEC, GLITC	Short-term (12 months or less) and on-going	
1.3.5	Continue to work with HIS BAO and advocate that Area Wide data be released to Tribal Epidemiology Centers.	GLITEC	Long-term (36 months or more)	
1.3.6	Continue to work with IHS Division of Behavioral Health and advocate for analysis of data in a timely manner.	GLITEC	Long-term (36 months or more)	
1.3.7	Continue to work with IHS Division of Behavioral Health and advocate that area-wide data be released to Tribal Epidemiology Centers.	GLITEC	Long-term (36 months or more)	
1.3.8	Explore and advocate for greater inclusion of data measures on law enforcement citations and other data identified by the EPI Workgroup and PC.	Project Director, Policy Consortium, EPI	Long-term (36 months or more)	

1.3.9	Use *Ownership, Control, Access, and Procession (OCAP) or other appropriate* principles to develop relationships in order to protect these data.		Short-term (12 months or less) and on-going	
Objective 4: GLITC will develop a Prevention Data Repository in coordination with GLITEC.				
	Action Steps	Responsibility	Timeline	Completion
1.4.1	Engage key stakeholders in discussion regarding the benefits of a central repository at GLITC.	SPE staff, PC members	Prior to implementation period	2/23/12
1.4.2	Explore the feasibility of a central repository.	Participating Tribes, GLITEC	Prior to implementation period	2/23/12
1.4.3	Makes recommendations for inclusion in mini-plan/strategic plan related to the Data Repository	PC with assistance from SPE staff	Prior to implementation period	2/23/12
1.4.4	Determine which SPF SIG data continues to be collected at the 10 Tribes	EPI with assistance from SPE staff	Short-term (12 months or less)	
1.4.5	Determine what the gaps are, locally, that should be addressed at the 10 SPF SIG Tribes and the two non-SPF SIG Tribes	EPI with feedback from the EPI workgroup, which will make recommendations to the PC	Short-term (12 months or less)	
1.4.6	Using OCAP or similar principals, develop a system that includes *policies and procedures* or reporting data to GLITC repository.	EPI, GLITEC with input from the EPI workgroup	Short-term (12 months or less)	
1.4.7	Begin to build local capacity to address the gaps in data collection and analysis and the ability to report to a central repository	Tribes with assistance from the EPI, GLITEC and support of PC	Short-term (12 months or less)	
Objective 5: Participating Tribes will have increased access to and capacity to store Tribal-specific data at the local level and at a central warehouse.				
	Action Steps	Responsibility	Timeline	Completion
1.5.1	Make recommendations for inclusion in mini-plan/strategic plan related to the Data Repository.	PC with assistance from SPE staff	Prior to implementation period	2/23/12
1.5.2	Participating Tribes will learn about the Data Source Inventory developed by GLITEC.	GLITEC	Prior to implementation period and on-going	
1.5.3	Participating Tribes will learn about OCAP or similar principles in order to create policies and procedures for data protection.	EPI, GLITEC with input from the EPI Workgroup	Short-term (12 months or less)	
1.5.4	Explore the feasibility of individual *tribal* warehouses.	Participating Tribes, GLITEC	Intermediate-term (12 to 36 months)	
1.5.5	Train participating Tribes on the usability and relevance of data warehousing.	GLITEC, contractors	Intermediate-term (12 to 36 months)	
1.5.6	Conduct data source inventories.	Participating Tribes with assistance from GLITEC	Intermediate-term (12 to 36 months)	
1.5.7	Explore system possibilities to create a data sharing network where multiple entities can contribute data.	Project Director, GLITEC, Policy Consortium	Intermediate-term (12 to 36 months) and ongoing	

1.5.8	Establish individual Tribal data warehouses and a central warehouse.	Participating Tribes with assistance from GLITEC	Long-term (36 months or more)	
1.5.9	Conduct an analysis of the usefulness of the data warehouse(s).	GLITEC and participating Tribes	Long-term (36 months of more)	

Eastern Further Considerations

- The vision is to develop a data collection, analysis, and storage system that is effective and useful to the Tribes as individual communities and to all Tribes, as a whole, as they use that data to guide prevention planning. Therefore, we will work on creating a GLITC system-level central repository and also work with individual Tribes, upon their request, to assist in creating Tribal-specific data repositories.

- Using the results of the SPE system survey assessment as a baseline, we will continue to provide technical assistance and training to GLITC member Tribes and other data partners to further build their epidemiological capacity to collect and evaluate data.

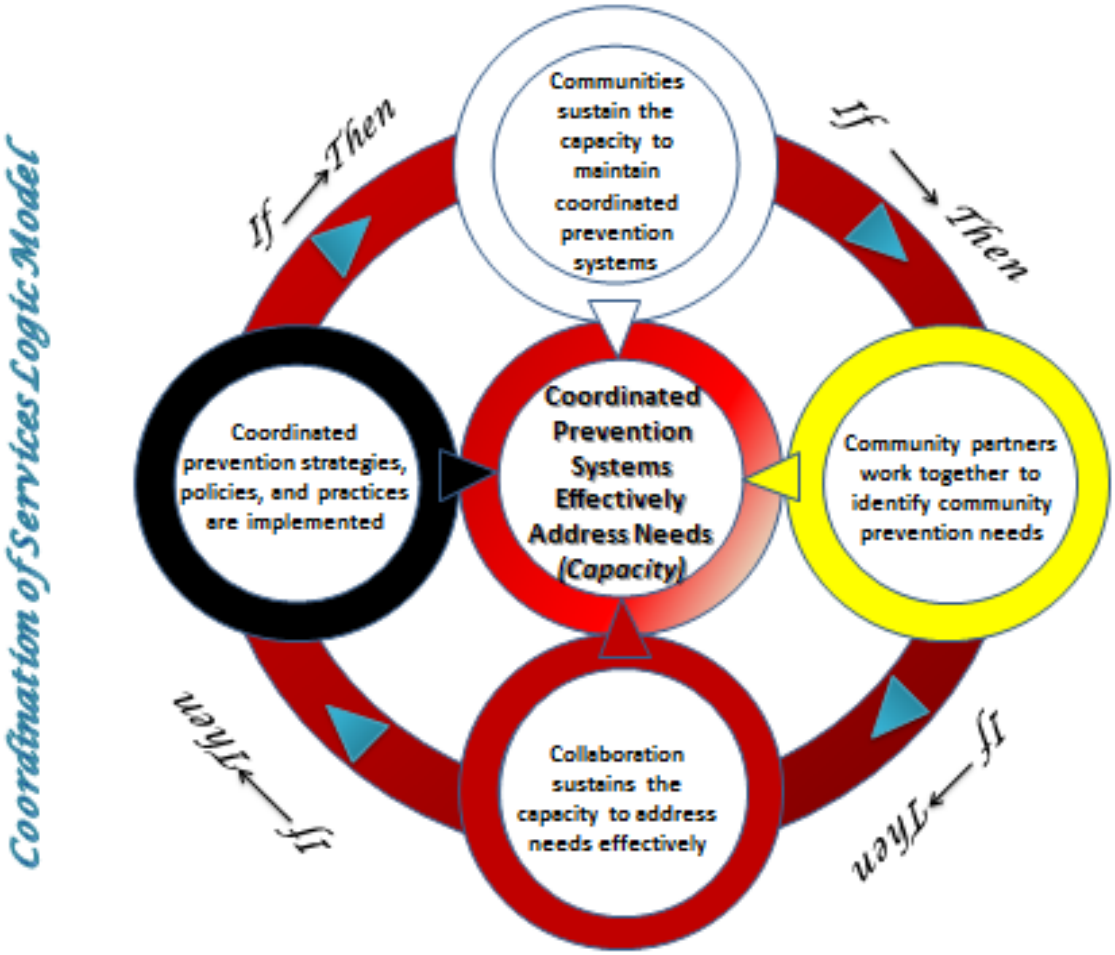
- GLITC will continue to build relationships with GLITC member Tribes and others to create data sharing agreements using OCAP and other applicable documents so it is "done in a good way."

- Many of the steps noted as completed in the "prior to implementation period" in this and the other three plans may need to be accomplished/repeated at the individual Tribes, particularly if there is a significant time span between the publication of this plan and actual implementation.

THE SOUTH: COORDINATION OF SERVICES

Once data have been collected and analyzed and decisions have been made about how to address what was identified, it comes time for building the skills necessary to address the issues. Much like an adolescent learning the skills necessary to function in the adult world, the Southern logic model addresses capacities. What should be developed, modified, or changed in order to be successful in meeting the goal? In this case, capacity building refers to how a strong coordinated system of care will be developed to answer the needs of the communities/tribes.

Southern Logic Model



Southern Narrative

Unintentionally, GLITC and its member Tribes have, like many other entities, tended to operate in an environment of silos. Although a certain amount of coordination has previously occurred, much more can be done to address basic communication among programs and the coordination of activities, budgets and reimbursements to improve the leverage of resources for prevention efforts. GLITC will move forward in addressing this issue using information gleaned from the Tribal Systems Survey (Spring 2012) and the GLITC Systems Survey (Summer-Fall 2012), in addition to other information available regarding Tribal systems.

Systems Survey

As noted in the discussion under the data plan, a systems survey will be conducted at both mid-plan and at the end of the five-year strategic plan allowing for a comparison to the baseline data to be conducted. In so doing we will be able to evaluate the effectiveness of coordination efforts at various points in the implementation of the SPE Strategic Plan and be able to reflect and adjust as needed to maximize coordination efforts.

Community Coalitions

Community coalitions were developed or joined with others as a result of the SPF SIG in ten of the twelve GLITC member Tribes. Some of those continue or have transitioned into other coalitions that encompass more than the underage drinking and binge drinking that was the primary purpose for the SPF SIG (gang issues is a common one). Others have disbanded due to the lack of continued funding after SPF SIG. The baseline systems survey done in the spring of 2012 has given us a better picture of the current status of coalitions. Using this information, project staff can move forward to support those still in existence and advocate for the creation or re-creation of those that don't exist. Coalitions will need to consider more than just alcohol misuse/abuse/addiction. Prescription drugs have been of great concern for most of the Tribes and will have support, but the importance of including suicide prevention and general behavioral health (BH) promotion may need education and data support to incorporate into prevention efforts. Both GLITC/GLITEC and the SPE will look at ways to advance those approaches (which may be unique to each community) at those Tribes who choose to participate in the implementation of the SPE Strategic Plan.

SPF Process

Ten of the twelve GLITC member Tribes have used the SPF process but some of that knowledge may have been lost due to staff turnover or to lack of funding to continue SPF efforts during the SPE planning year. GLITC has a baseline measure of those Tribes that incorporated use of the SPF in their prevention specialist position descriptions. GLITC will build upon this information and continue to use the Policy Consortium to assist in making recommendations for use of the SPF. GLITC, through current prevention programs, has core staff that understands the SPF and can promote its use with the Tribes. Special efforts will be made to assist the two non-SPF SIG Tribes, if they decide to participate, to bring their staff up to speed. As SAMHSA continues to refine the process and as prevention certification becomes more common at the Tribal level, GLITC intends to promote SPF as the process of choice in leading prevention efforts. A reassessment of Tribes actively using SPF will be conducted at grant's end.

Coordination at the GLITC Level

GLITC, as referenced under the data section, is in the process of conducting (Summer-Fall 2012) an internal assessment of its systems of coordination for not only prevention grants but for the agency as a whole. This assessment should be completed in late 2012 with results available early 2013. As a result of this assessment, GLITC intends to improve grant coordination and model a more synchronized and communicative approach to handling the multiple grants that are administered with the Tribes. Currently, there are two major departments within GLITC – Education and Human Services (EHS) and Family Health Services (FHS). Education and Human Services houses ATODA prevention, the EPI Center, Aging, Disability, Business, and Education grants. Family Health Services houses programs working with mothers, children, and families as well as tobacco prevention and senior volunteers. The maternal/child health programs cross over into ATODA prevention, particularly during pregnancy. This GLITC assessment will allow us to look more closely at the potential for coordination, not only as it pertains to prevention but in other areas as well, and to make recommendations for improvement. The GLITC Board of Directors has approached management to ask about strategic planning for the agency. Doing this assessment will not only promote coordination among AODA/BH grants and those that have components of prevention within them, but will also assist the agency as it moves forward in developing a strategic plan that furthers our mission to "support member tribes in expanding sovereignty and self-determination."

Coordination at the Tribal Level

Those Tribes that elect to take part in Strategic Plan implementation will have the benefit of reviewing their own results from the systems survey conducted in spring 2012 and they will have access to the aggregate results as well. Building upon that information and the support and assistance of the Policy Consortium and key stakeholder champions at those Tribes, individual communities will have had a starting point from which to conduct more in-depth reviews of what is working and not working in terms of coordination of their systems related to prevention. This will allow them to consider changes that can then be presented as recommendations to Tribal Administration for improvement in both their data and coordination systems. An opportunity will then be made for them to reassess those system changes at the close of SPE Strategic Plan implementation.

Leveraging of Resources

As stated in our original application for the SPE grant, GLITC is unique. The organization is *not* a state, and as an inter-tribal agency, GLITC has absolutely no control over any federal or state resources other than those grants that GLITC receives. It is important to note again that grants received by GLITC rarely allow for services to all twelve member Tribes. Based upon this knowledge, the only thing GLITC can do is work closely with our state, local IHS Bemidji Area Office, and other federal contacts to advocate for improvements in the systems that Tribes attempt to leverage for resources. The Affordable Care Act implementation will certainly have potential effects on both services and reimbursement issues related to ATODA/BH. The manner in which SAMHSA distributes block grants (either directly to Tribes or through the states) has the potential to and will likely change. Continued austerity measures to bring federal and state budgets out of the red will certainly impact leverage of resources. As the political and funding scenes change, GLITC will continue, along with the Policy Consortium, to identify and/or advocate for ways in which the Tribes might access/leverage limited resources.

Culturally Appropriate Tools/Models

It is well know that most assessment, screening, and service models have been developed for mainstream use; many times this provides challenges for use in AI/AN communities. If only certain approved screenings/assessments are eligible for reimbursement, this creates challenges for programs that are

attempting to provide culturally appropriate and responsive services. One distinct example of this is the use of traditional healers. The services of traditional healers are not currently reimbursable, yet they provide a more holistic, medicine wheel based approach to care that is extremely valuable to tribal members and supports the basic premise of this plan: "C*ulture is Prevention*." GLITC and the Policy Consortium will continue to work with IHS, SAMHSA, and others to help identify appropriate screening and assessment tools as well as reimbursement systems to improve compensation for culturally appropriate services.

Coordination of Services

Coordinated Prevention Systems Effectively Address Needs *(Capacity)*

Goal 1: GLITC will encourage local tribes and other partners to enhance collaboration so that they can share information and lessons learned to make changes that will benefit the system as a whole to promote behavioral health, prevent alcohol, tobacco, and other drug abuse (ATODA) including prescription drugs, and suicide.

Objective 1: Increase the linkages between community-based coalitions, prevention practitioners, treatment providers, other service providers, law enforcement, and other community partners.

	Action Steps	Responsibility	Timeline	Completion
1.1.1	Share the results of key stakeholder interviews with the Policy Consortium.	EPI	Prior to implementation period	5/31/12
1.1.2	Make recommendations to enhance linkages.	Policy Consortium	Short-term (12 months or less)	
1.1.3	Analyze the coordination efforts for effectiveness via repeated systems survey or other means.	EPI, GLITEC, participating Tribes	Intermediate-term (12 to 36 months)	
1.1.4	Analyze the coordination efforts for effectiveness via repeated systems survey or other means.	EPI, GLITEC, participating Tribes	Long-term (36 months or more)	

Goal 2: GLITC will work with individual Tribes and local tribal coalitions to increase community capacity to implement, increase, and sustain the use of the SPF process.

Objective 1: GLITC and participating Tribes will understand the importance and adopt the use of the SPF process.

	Action Steps	Responsibility	Timeline	Completion
2.1.1	Analyze the systems survey to determine: 1) stakeholders knowledge of the SPF process, 2) gaps in the utilization of the SPF, 3) perceptions on the effectiveness of SPF in conducting prevention efforts.	EPI	Prior to implementation period	5/13/12
2.1.2	Educate Tribal key stakeholders, service providers, and community partners on the SPF process and its usefulness as a means to enhance prevention efforts.	EPI, GLITEC and trained Tribal staff	Short-term (12 months or less)	
2.1.3	Develop and improve the strength of community coalitions.	GLITC, Policy Consortium, participating Tribes	Intermediate-term (12 to 36 months)	
2.1.4	Continue to use the SPF process to drive prevention efforts.	Participating Tribes	Intermediate-term (12 to 36 months)	

2.1.5	Reassess the number of Tribes using SPF process.	GLITEC	Long-term (36 months or more)	

Goal 3: Increase ability to leverage assets through the coordination of resources to promote behavioral health, prevent alcohol, tobacco, and other drug abuse (ATODA) including prescription drugs, and suicide.

Objective 1: GLITC will examine the coordination of its resources.

	Action Steps	Responsibility	Timeline	Completion
3.1.1	Review and/or assess the current internal processes and protocols for coordinating resources through an initial systems-level assessment of coordination of resources.	Project staff, GLITC	Intermediate-term (12 to 36 months)	
3.1.2	Present recommendations to improve protocols and coordination of resources to GLITC administration.	GLITC administration and program staff	Intermediate-term (12 to 36 months)	
3.1.3	As a result of doing an internal assessment, model coordination with programs that will include coordination of prevention services as well that of resources, both human and financial.	GLITC administration and program staff	Long-term (36 months or more)	

Objective 2: Participating tribes will examine the coordination of resources.

	Action Steps	Responsibility	Timeline	Completion
3.2.1	Meet on a regularly scheduled basis to coordinate programming.	Individual Tribal programs	Short-term (12 months or less) and on-going	
3.2.2	Come together to identify their work and create a directory of programs/services.	Participating Tribes	Intermediate-term (12 to 36 months) and on-going	
3.2.3	Assess the support needed for prevention infrastructure at the Tribal level.	Participating Tribes with assistance from GLITEC and the EPI	Intermediate-term (12 to 36 months)	
3.2.4	Review and/or assess the current internal processes and protocols for coordinating resources through an initial assessment of coordination of resources.	Participating Tribes	Long-term (36 months or more)	
3.2.5	Present recommendations to improve protocols and coordination of resources to Tribal administration.	Participating Tribes	Long-term (36 months or more)	

Objective 3: Increase the capacity of individual Tribes to assess, screen, and provide services in such a way as to improve billing and funding resources through mainstream and Native traditional methods.

	Action Steps	Responsibility	Timeline	Completion
3.3.1	Work with other agencies serving tribes to identify ways to improve leverage of resources for individual Tribes.	GLITC with elicited assistance of BAO and Center for Medicare & Medicaid Services (CMS)	Intermediate-term (12 to 36 months)	
3.3.2	Work with participating tribes to identify areas where resources can be leveraged more effectively.	Participating tribes, BAO, and appropriate TA providers	Intermediate-term (12 to 36 months)	

3.3.3	Work with the PC to identify ways to improve both GLITC and the local level coordination of services.	GLITC, project staff, PC	Long-term (36 months or more)	
3.3.4	Work with the PC and tribes to identify culturally appropriate assessment, screening and service models that will improve the implementation and reimbursement of services.	GLITC, PC, and participating Tribes	Long-term (36 months or more)	

Southern Further Considerations

- Some loss of capacity may occur because of lapse of funding between SPF SIG and SPE implementation grant funding, so there may be increased needs for TA and other services to help ramp up coalition building and the use of the SPF process.

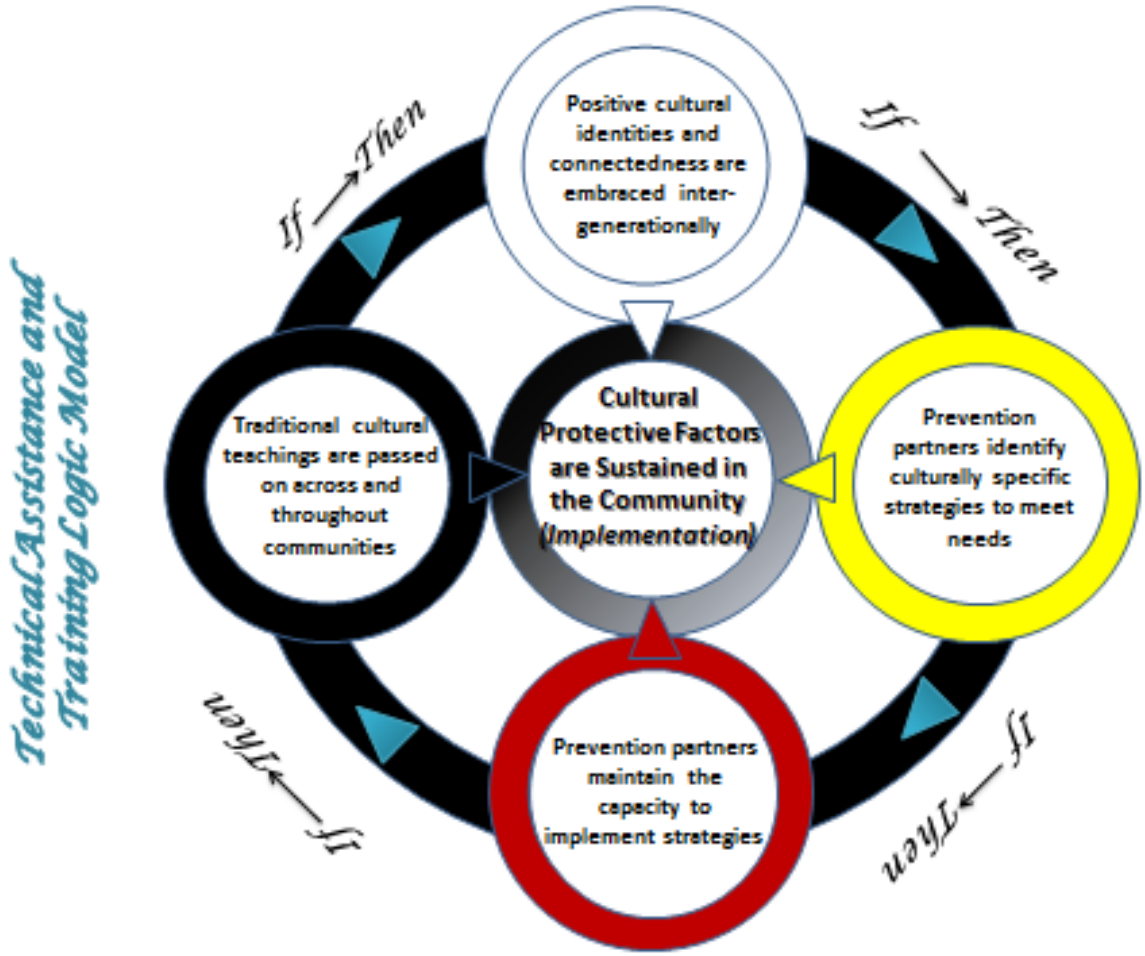
- The situation regarding the Affordable Care Act and other funding issues has not yet been determined. Tribes will need to continue to develop relationships and communication with the State regarding prevention funding.

- It will be crucial to continue dialog with the State and develop a system for assessing and approving culturally responsive PBEs as the State of Wisconsin moves toward a requirement for use of EBPs in order to receive block grant funding

THE WEST: TECHNICAL ASSISTANCE AND TRAINING

With adulthood comes the skills and responsibility to take action and apply the learning that has been gathered from infancy and adolescence. In this case it refers to moving from data-driven decisions and capacity development to implementation. It is the responsibility of the West and adults to implement those activities, policies, or protocols that are necessary to see the completion of the goals. Like an adult raising a family, it is the task of the South to insure that appropriate action is taken in a timely manner to achieve success. So, too, is the goal of this Western logic model.

Western Logic Model



Western Narrative

Although Native communities have participated in providing AODA prevention programs for many years, there remains a paucity of Native-specific EBP programming options and culturally appropriate screening tools. Tribes have frequently had to try to use approaches that are "evidence-based" but not culturally appropriate. "Culture *is* prevention" in Indian communities and credence needs be held for practice-based evidence with roots in that culture and the attendant protective factors that accompany cultural practices. Indian communities also have some distinctive risk factors related to historical and generational trauma[1] that require unique approaches. "Cookie cutter" mainstream programs, practices, and policies tend to be ineffective. GLITC proposes to be guided by the medicine wheel in its approach to prevention. This provides a culturally based and holistic methodology. GLITC and participating Tribes will pursue technical assistance and training plans that will foster the use of holistic, culturally appropriate programs, policies, practices, and tools that can be adequately evaluated and proven effective for the Tribes.

Risk and Protective Factors and Holistic and Culturally Appropriate Approaches

Research has shown that addressing risk and protective factors (Hawkins, Catalano, & Miller, 1992) is an effective approach to preventing substance abuse and other related high-risk behaviors. Those risk factors include such things as a family history of drug abuse, low perception of risk (for substances), and attitudes favorable to substance abuse. Like the population in general, Native Americans are impacted by these risk factors. Natives, however, are also impacted by additional factors that elevate the risk of substance abuse: cultural disenfranchisement, poverty and disempowerment (Emshoff, Erickson, and Thompson, 1992). Historical and generational trauma is an additional factor that is also pervasive within Tribal communities. Service providers, particularly those that are non-Native, must understand how these risk factors impact tribal communities. Practitioners and agencies need effective tools, methodologies, and skill sets to address these unique issues. Understanding and being able to utilize such tools as the Adverse Childhood Events (ACE), trauma informed care, and current research on historical trauma as it pertains to Native culture is critical to working with Native populations.

Also critical to the provision of services, and reimbursement of those services, is the recognition that if "culture is prevention," then attention must be given to the unique ways in which the issues of substance abuse prevention and treatment, behavioral health, and suicide prevention are approached in a tribal setting. In a truly culturally responsive system of care, traditional practices and methodologies must be seen as legitimate areas of service and must be reimbursable. Often in tribal communities a traditional healer or "medicine person" might be called in to address certain issues. Although these practices may not be common outside of Native communities, they are quite often part of the holistic way in which Indian people approach both healing and behavioral change. Western medicine and evidence-based programs may not utilize the same methodologies as these traditional approaches. Nevertheless, there is generations worth of practice-based evidence showing that these holistic systems of care are effective in working with Native American populations. It is vital to prevention and treatment in Indian Country that this holistic and culturally based approach be respected and funded for reimbursement along with more Westernized methods of prevention and treatment.

[1] "Historical trauma (HT) is defined as cumulative emotional and psychological wounding across generations, including the lifespan, which emanates from massive group trauma. To our knowledge, the concept of historical trauma among American Indians first appeared in the clinical literature in 1995." Brave Heart, Yellow Horse, M., Chase, J., Elkins, J. & Altschul, D. (2011). Historical Trauma among Indigenous Peoples of the Americas: Concepts, Research, and Clinical Considerations. *Journal of Psychoactive Drugs*, 43(4), 282-290.

Workforce Development

There is a significant identified need to bring prevention work at the Tribes to the next level so the implementation of prevention activities is driven by the usage of appropriate data and analyzed for effectiveness. Becoming certified by the state as a prevention specialist is an avenue to help assure this. In addition, those working in the prevention field in Indian Country must be cognizant of the extremely important role that culture plays. Understanding of the SPF process and institutionalizing its inclusion in position descriptions and actualization in activities is also important. GLITC, working with the PC, will work toward recognition of these elements and provide for/assist in arranging for appropriate technical assistance. GLITC will also evaluate the extent to which these recommendations have been incorporated at the Tribes during the final year of strategic plan implementation.

Current tools/techniques and strategies

IHS has developed strategic plans for behavioral health and for suicide prevention. As these areas have not been previously addressed in the SPF SIG, we will refer to their plans to help guide the implementation of this plan. The IHS strategic plans have identified tools, techniques, and strategies to assist in addressing these issues. In consultation with the IHS Bemidji Area Office, GLITC will review and assess these tools and strategies and assist with any needed training.

Prevention Specialist Certification

Few state "certified" prevention specialists are employed by the Tribes. Although there are increasing numbers of staff "in-training," more remains to be done to ensure quality prevention efforts that are based upon appropriate assessment data. As part of the SPF SIG grant, GLITC was able to offer a Native American specific Substance Abuse Prevention Specialist (SAPST) training. In March of 2011, GLITC was informed that a revised version of the regular SAPST training was in process and a Native American adaptation was high on the list for development. However, who will be working on this and when and whether an adaptation is or could be appropriate is not yet known. GLITC strongly supports the general concept of SAPST training but wants to ensure that what becomes available is culturally responsive and appropriate before including it in the Technical Assistance plan for implementation with the member tribes. GLITC will also strive for inclusion of prevention certification and use of the SPF process in GLITC and Tribal position descriptions for those working in the prevention field. In addition to SAPST training, which is an excellent foundation, GLITC will look for and/or provide opportunities for training in the core areas needed for certification, increasing epidemiological capacity, learning opportunities, culturally appropriate primary care screening tools, and training on reimbursement for those tools when appropriate. GLITC has developed a number of relationships with outside providers of TA and will use them when and if our own internal resources cannot provide what is needed.

In addition, approaches to certification testing with Native Americans should be investigated. Often standardized tests do not fit the cultural perspective of Native providers. The Addiction Counselor Certification Board of Oregon has developed a portfolio style of testing that is an alternative to the standardized test; however, in Oregon a candidate must first fail the standard test to be eligible for the alternative test. GLITC and the Policy Consortium recommend creating a testing protocol that would permit those of Native descent and those practitioners working in Native American settings to choose the method of testing that best reflects their learning style, world view, and cultural perspective.

Appropriate Training

GLITC, with the help of other technical assistance providers such as Indian Health Service and the Native American Center for Excellence will assess and meet the training needs of the participating Tribes throughout

the five-year strategic plan implementation. Staff turn-over tends to be frequent, so when possible, trainings will be recorded. For some tribes the distance to GLITC, which is centrally located, ranges from 70-200 miles one way. Because of this we will consider trainings at multiple sites or the use of technology for remote sites.

Evaluation Plan

Understanding of culture, tribal communities, and cross-tribal differences is a key area in which evaluators must be skilled (see the Northern Further Considerations for specifics). GLITC, GLITEC, and the evaluator will work with the participating Tribes to develop appropriate evaluation plans and the analysis for those plans. GLITC, GLITEC, and the evaluator will provide technical assistance as identified and needed to increase the capacity of both the Tribes and the tribal-level evaluators.

Technical Assistance and Training

Cultural Protective Factors are Sustained in the Community (Implementation)				
Goal 1: GLITC will work with key stakeholders, Board of Directors, member tribes, and the Policy Consortium to increase their understanding and use of current information and evidence-based approaches/ practice-based evidence to implement culturally responsive and appropriate prevention programs, policies, and practices.				
Objective 1: GLITC will provide TA and training to the Policy Consortium, member tribes, and other key stakeholders on evidence-based prevention and practice-based evidence theories, programs, practices, and policies.				
	Action Steps	Responsibility	Timeline	Completion
1.1.1	Provide TA and training to assess and increase the overall community readiness to develop, implement, and sustain current and culturally responsive prevention programs, practices, and policies.	GLITEC, GLITC, and Consultants	Short-term and ongoing	
1.1.2	Provide TA and training to the Policy Consortium to increase their understanding of the need for a holistic and culturally appropriate approach to prevention efforts.	GLITC, EPI, Consultants with input from the Evidence Based Practices/Practice Based Evidence (EBP/PBE) workgroup	Prior to implementation period	7/26/12
1.1.3	Provide TA and training to the Policy Consortium to develop culturally appropriate recommendations that identify and prioritize community and individual risk and protective factors.	Policy Consortium with assistance from GLITC/Consultants	Intermediate-term (12 to 36 months)	
1.1.4	Provide TA and training to develop a method, structure, and protocol for determining what is "evidence-based" for programs, polices, and practices using existing models, including the Oregon Evidence-Based Program Selection in Indian Country as a guide.	GLITC, Consultants with input from the EBP/PBE workgroup and the PC	Intermediate-term (12 to 36 months)	
1.1.5	Develop a menu of culturally responsive programs, activities, strategies, and policies that will be listed on the GLITC website.	GLITC, Consultants with input from the EBP/PBE workgroup and recommendations from the PC	Intermediate-term (12 to 36 months)	
1.1.6	Develop program, practice, and policy implementation plans that will include a preliminary plan to systematically provide for any TA needs of GLITC and member Tribes.	PC with assistance from GLITC, Consultants and other local, state and federal TA providers	Intermediate-term (12 to 36 months)	

Objective 2: GLITC will provide TA and training to the Policy Consortium, member tribes, and other key stakeholders to build capacity to collect and analyze data to support practice-based tribal practices and programs.

	Action Steps	Responsibility	Timeline	Completion
1.2.1	Continue to provide technical assistance and work with GLITC member Tribes and other key stakeholders to develop to epidemiological capacity to collect and evaluate behavioral health, AODA including prescription drugs, and suicide data.	GLITEC, GLITC	Short-term (12 months or less) and on-going	
1.2.2	Provide an EPI 101 training to GLITC member Tribes, including topics such methodology review and simple data analysis using descriptive statistics.	GLITEC, GLITC, and Consultants	Short term (12 months or less) and on-going	
1.2.3	Provide TA and training that will include how to use data to tell a story about the community and its needs.	GLITEC, GLITC, and Consultants	Short-term (12 months or less) and on-going	
1.2.4	Provide TA and training to promote and increase the capacity to share data and move toward standardizing data sets for collective use and reporting.	Tribes, GLITC/ GLITEC, consultants and evaluator	Long-term (36 months or more) and ongoing	
1.2.5	Provide TA and training to increase the capacity of key stakeholders, PC, and member tribes to use data to prioritize needs and drive decision making on programming, policy development, planning, and infrastructure design.	GLITEC, GLITC project staff, and Consultants	Short-term (12 months or less) and on-going	
1.2.6	Work with staff to develop evaluation capacity related to the approaches that are implemented.	PC, individual participating Tribes with the assistance of GLITEC and/or Evaluator	Intermediate (12 to 36 months) and on-going	
1.2.7	Work with staff to analyze the evaluation plan and make appropriate changes if needed.	PC, individual participating Tribes with the assistance of GLITEC and/or Evaluator	Intermediate (12 to 36 months) and on-going	
1.2.8	Routinely update Chairs and Councils regarding their tribal-specific data to assist them in prioritizing needs and decision making for programming, policy development, planning, and infrastructure design.	Participating Tribes with assistance from GLITEC, as needed	Intermediate (12 to 36 months) and on-going	

Objective 3: All partners will have an increased understanding of the current evidence, research, unique and current risk, and protective factors that should be addressed when working with Native Americans to promote behavioral health and prevent suicide and alcohol and other drug abuse including prescription drugs.

	Action Steps	Responsibility	Timeline	Completion
1.3.1	Service providers, key stakeholders, and communities will increase their understanding of the need for holistic and culturally appropriate approaches to prevention efforts through TA and Training.	PC, project staff, consultants, individual Tribes , elicit assistance from IHS BAO (based upon their strategic	Intermediate-term (12 to 36 months)	

		plans)		
1.3.2	GLITC and tribes are able to identify GLITC service area and local traditional practices, activities, skills, policies that increase protective factors and support healthy living	GLITC staff, Policy Consortium, and local tribes	Intermediate-term (12 to 36 months) and on-going	
1.3.3	Service providers, key stakeholders, and communities will increase their capacity to develop culturally appropriate approaches to addressing risk and protective factors for Native Americans.	Individual participating Tribes with assistance of GLITC, appropriate TA providers, and elicit assistance of IHS BAO	Intermediate-term (12 to 36 months)	
1.3.4	EPI workgroup and EBP/PBE workgroup will increase their capacity to understand and develop culturally appropriate measures, methods, and tools for assessing work in prevention field.	EPI, Evaluator, Consultants, EBP/PBE workgroup	Intermediate-term (12 to 36 months)	

Goal 2: GLITC will encourage individual tribes to increase the number of certified prevention specialists.

Objective 1: Tribes will increase their recognition of the need for prevention certification for those involved in promoting behavioral health and preventing alcohol and other drug abuse (AODA) including prescription drugs, and suicide.

	Action Steps	Responsibility	Timeline	Completion
2.1.1	Consider and develop recommendations to incorporate prevention certification and understanding of the SPF process at Tribal sites.	PC with support from project staff and consultants	Short-term (12 months or less)	
2.1.2	Examine barriers to getting individuals certified to become tribal prevention specialists.	GLITC, PC with support from project staff and consultants	Short-term (12 months or less)	
2.1.3	Develop action plans to reduce/remove barriers to certification and certified staff.	PC with support from project staff and consultants; elicit cooperation and coordination with State	Intermediate-term (12 to 36 months)	
2.1.4	Encourage all tribes to provide the opportunity for new tribal prevention specialists to participate in the Native American SAPST Training.	GLITC, PC, Individual participating Tribes	Intermediate-term (12 to 36 months)	
2.1.5	Analyze the extent to which participating Tribes have included prevention certification and knowledge of the SPF process in their position descriptions.	Participating Tribes and GLITEC	Long-term (36 months or more)	

Goal 3: Participating Tribes will increase their knowledge of culturally responsive prevention and behavioral health-related assessment, screening, evaluation, and other tools as appropriate.

Objective 1: Provide training to increase participating Tribes' knowledge of culturally responsive tools and techniques.

	Action Steps	Responsibility	Timeline	Completion
3.1.1	Provide TA and training to develop an assessment of readiness, tools, and techniques currently being used by the participating Tribes.	GLITC staff/and with consultation elicited from IHS BAO (according to their strategic plan)	Short-term (12 months or less)	

3.1.2	Provide TA and training to assess the appropriateness of tools for Tribal use.	PC with assistance from project staff and consultants	Intermediate-term (12 to 36 months)	
3.1.3	Routinely use tools in primary care with both adolescent and adult populations after appropriate TA and training.	Participating Tribes with elicited assistance from IHS (National and BAO)	Intermediate-term (12 to 36 months)	

Objective 2: Using a quality improvement approach, provide technical assistance and training to primary care providers to increase referrals for services and utilization of culturally appropriate and responsive prevention, treatment, and behavioral health care.

	Action Steps	Responsibility	Timeline	Completion
3.2.1	Provide TA to GLITC and participating tribes to assess current utilization referral systems and existing standards and protocols for referrals.	Consultants, GLITC, PC, and local tribes	Short-term (12 months or less) and ongoing	
3.2.2	Provide TA and training to increase awareness of culturally appropriate tools, programs, and practices.	GLITC staff, PC, and local tribes	Short-term (12 months or less) and ongoing	
3.2.3	Provide TA and training to service providers on effective utilization of referrals to culturally based systems of care.	GLITC staff, PC, and local tribes	Intermediate-term (12 to 36 months)	
3.2.4	Disseminate information on local best practice primary care referral systems.	GLITC staff, PC and local tribes	Intermediate-term (12 to 36 months)	
3.2.5	Provide TA and training to create guidelines and protocols for culturally responsive referral systems that can be used as models/prototypes.	GLITC staff, PC, and local tribes	Intermediate-term (12 to 36 months)	

Goal 4: Foster prevention programming, practices, and strategies that are culturally responsive and appropriate.

Objective 1: Identify and implement culturally appropriate prevention programming, practices, and strategies.

	Action Steps	Responsibility	Timeline	Completion
4.1.1	Conduct an assessment of prevention programs, practices, and strategies for AODA/BH/Suicide/Prescription drug currently being used by the Tribes.	GLITC staff, EBP/ PBE workgroup	Short-term (12 months or less)	
4.1.2	Present results the Policy Consortium for consideration/recommendation.	GLITC staff, EBP/ PBE workgroup	Short-term (12 months or less)	
4.1.3	Conduct appropriate training for prevention programming, practices, and strategies that addresses all areas at each of the participating Tribes based upon needs/preferences.	Individual participating Tribes with assistance from GLITC, and elicited assistance from Native American Center for Excellence, IHS BAO and others	Intermediate-term (12 to 36 months)	
4.1.4	Assess and meet on-going training needs.	Individual participating Tribes	Long-term (36 months or more)	
4.1.5	Provide TA and training to review existing models of reimbursement of services across ATODA and behavioral health so that	Tribes, GLITC, GLITEC, consultants and evaluator	Long-term (36 months or more) and	

	traditional practices and approaches to prevention can be reimbursed.		ongoing	

Goal 5: Continue to work with the Policy Consortium, key stakeholders, GLITC Board of Directors, member Tribes, and others to advocate for the implementation of the SPE Strategic Plan.

Objective 1: Provide technical assistance and training to Policy Consortium and other key stakeholders to increase their capacity to advocate for the implementation of the strategic plan.

	Action Step	Responsibility	Timeline	Completion
5.1.1	Create a bullet point summary of the concepts and outlines of the SPE Strategic Plan to share with key stakeholders at the local, state, and regional levels for dissemination representation in the SPE project.	GLITC project staff and consultants	Prior to Implementation	6/12/2012
5.1.2	Identify "champions" to advocate for the adoption and implementation of the strategic plan to the Board of Directors.	PC and GLITC project staff	Prior to Implementation and ongoing	5/31/2012
5.1.3	Provide TA and training to member tribes to increase awareness of both the overall plan and how to implement the entire plan or its components.	GLITC project staff, consultants, and PC	Short-term (12 months or less) and ongoing	
5.1.4	Disseminate the SPE Strategic Plan to key stakeholders in member tribes, service organizations, the BOD, and others and provide TA and training to increase adoption of the plan and capacity for implementation.	GLITC project staff and PC	Short-term (12 months or less) and ongoing	

Western Further Considerations

- Continue to increase capacity and commitment to secure ongoing funding and resources to sustain a functional and effective state-of-the-art prevention system throughout the GLITC service area and locally, including the possibility of a tobacco tax. Create opportunities to discuss increasing taxes to benefit prevention work.

- Continue the commitment to the education and support of a cadre of local and regional prevention specialists, allowing GLITC and member tribes to move toward goals that have been established to increase cultural protective factors and sustain health generations into the future for Native people.

- Recognize Prevention Specialist certification in the development of the system and as a necessity for the ongoing quality improvement of prevention activities.
    - Plans cannot be implemented with integrity if there are not credible trained staff and systems in place to support the adoption of state-of-the-art prevention theories, practices, and policies.
    - Ongoing training and staffing of prevention positions at the GLITC service area and local levels must be considered a priority. Prevention specialists must:
        - Be knowledgeable in current trends in ATODA within tribal communities
        - Understand information-gathering techniques
        - Be well versed in historical trauma and cultural identity issues
        - Possess strength-based skill sets
        - Be well organized and have good communication skills
        - Have the ability to teach
    - Preference should be given to local tribal members or others of Native enrollment.

- Require TA and training at many levels including state, GLITC service area, and local to ensure that the various aspects of developing and maintaining culturally appropriate skilled systems and personnel are achieved and sustained over time. employ

- Continue to increase the capacity to understand and utilize the SPE Strategic Plan as a prototype for ATODA, including prescription drug abuse, as well as behavioral health promotion and the decrease in suicide attempts.

- Disseminate the SPE Strategic Plan to leadership and policy making groups at the state, GLITC service area level, and local levels.

- Disseminate the SPE Strategic Plan to the GLITC Board of Directors.

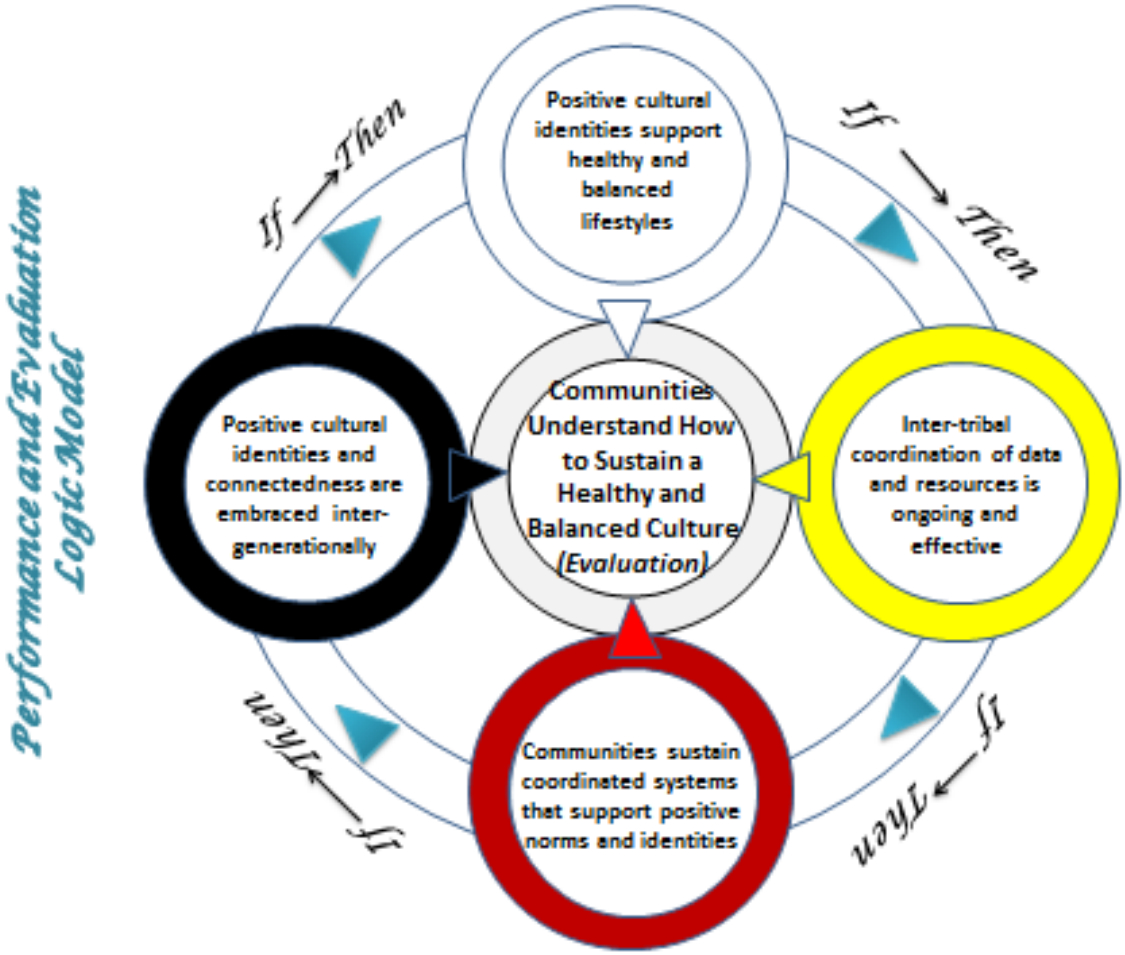
- Provide TA and training to state, GLITC service area, and local tribal leadership on the SPE and GLITC Strategic Plan.

- Develop and advocate for a commitment of an effective proactive and coordinated referral system that can be implemented by primary care providers and behavioral health and substance abuse providers within local and GLITC service area agencies.

THE NORTH: PERFORMANCE AND EVALUATION

When moving to the North there is the acknowledgement of the time for hind sight. It is when as elders we are able to look back objectively and evaluate what has come before and apply the wisdom that we have gained to further the next generation's ability to be successful. It is when we look beyond ourselves and our preferences to objectively see what has worked and what hasn't and to pass that on to the next generation. The Northern logic model then refers to the evaluation of the plan and its activities to provide wisdom on what has worked and what must be improved. To evaluate brings with it the ability to adapt what has been done to protect the health and balance of generations to come and to provide for them a better approach to live a healthy life, as is the way for many Native cultures.

Northern Logic Model



Northern Narrative

A definitive list of measures to be used in assessing implementation and outcomes of the Strategic Plan has not yet been identified, but it is assumed that GPRA and other measures determined by SAMHSA or measures developed by IHS from their strategic plans for behavioral health/suicide will be used. Several methods of data collection (specifics to be determined) will be used to demonstrate progress toward strategic plan implementation. The evaluation team, working with implementers, will put into place whatever evaluation plans are necessary to adequately respond to implementation funding requirements and the expressed needs of the Tribes. The evaluator, GLITC, and GLITEC will assist participating Tribes in building their capacity to do evaluation by working with participating Tribes to develop a system that has standardized measures. An actual "system" for inputting data into a central repository will be developed and institutionalized.

Many evaluators who have not worked with Native communities often lack the cultural competency to perform evaluation that both satisfies grant requirements and is meaningful to the community. Due to historical trauma and unethical research projects throughout history, tribal communities, understandably, may have initial trust issues with new evaluators until they demonstrate their genuineness. Often this is compounded by the evaluator's lack of knowledge on cultural and legal issues in Indian Country. Tribal communities may then have to spend considerable time and effort to educate evaluators to bring them to a competent level of cultural understanding. This creates a burden on the project as time and energies are diverted to a period of trust building and educating. Evaluators who will be effective working with tribal communities should be "bilingual" in translating a funder's grant requirements and the work of evaluation to the tribal communities and at the same time advocate for Native communities and indigenous ways to the grantors. Unfortunately, due to staff turnover both internally and externally, this process is often repeated regularly. We will address this issue first at the GLITC level by developing core competencies for evaluators and then share what has been developed with GLITC member Tribes for their potential use.

Measures

Any required GPRA, NOMS, or other measures will be reviewed and adopted as appropriate. These measures will be implemented and collected at the participating Tribal sites according to guidelines developed by funding agencies. The Epidemiology Center will do an analysis of that data and will be able to produce aggregate results. They will also store this data by Tribe for their own use, if desired and according to protocols that will be developed as part of the implementation of the SPE plan.

Tribal Capacity to Collect/Evaluate Data

Two GLITC member Tribes have not previously collected prevention data as part of the SPF SIG grant. Those Tribes, if participating, will be assisted to increase their capacity to bring them up to date with SPF SIG Tribes. As mentioned previously, GLITC member Tribes who have participated in the SPF SIG have some capacity to collect, analyze, and store data across a wide continuum. Many have little experience or do not have adequate resources to determine what constitutes good, quality data and how to collect it, much less analyze or store it. Those Tribes desiring to increase their capacity will be assisted by the BH epidemiologist, evaluator and the Epidemiology Center, dependent upon funding for those services. As a result, capacity to report into a central repository and/or a Tribal specific warehouse will provide an enhanced system.

Standardization of Measures

Because there is not currently a mechanism in place to collect and report aggregate data from the Tribes at GLITC, several things must occur. After securing commitment to participation, it will be necessary to determine what gaps exist and work on standardization of measures. It will also be necessary to develop agreements regarding reporting and access into a central repository over the long term.

Core Competencies for Evaluators (Workforce Development)

As mentioned in the background, Tribes frequently do not have access to culturally competent evaluators, especially when partnering with universities or other non-Indian entities. While there are some qualified Native evaluators, to our knowledge no vetting process or core competency recommendations have been developed for evaluators working in Indian Country. The development of core competencies for these positions is critical, especially because funders need continued education to help them understand that standard "cookie cutter" approaches to evaluation often do not work with Native communities. GLITC will begin this process by reviewing and developing qualifications for those they contract with for evaluation of projects. GLITC administration will be given recommendations to consider and put forth to Human Resources and Program Coordinators/Directors for inclusion in hiring and/or contracting policies. The guidelines developed will be shared with GLITC member Tribes for their consideration when hiring/contracting evaluators, thus helping to insure that culturally competent evaluators are used throughout the GLITC service area.

Progress Toward Goals and Objectives

A number of both quantitative and qualitative methods will be used to measure progress towards strategic plan goals throughout the five-year term of the plan. As these assessments are completed, reviews will be done and recommendations for any needed adaptations to the plan made. This will be done at the GLITC level as well as the Tribal level of those who choose to participate in the five-year plan.

Performance and Evaluation

Communities Understand How to Sustain a Healthy and Balanced Culture (Evaluation)				
Goal 1: Identify benchmarks and outcome measures to assess and improve strategies that enhance evaluation systems to collect process and outcome data that address promotion of behavioral health, prevent alcohol, tobacco, and other drug abuse including prescription drugs, and suicide.				
Objective 1: Identify existing GPRA indicators.				
	Action Steps	Responsibility	Timeline	Completion
1.1.1	Research current measures identified by IHS and/or SAMHSA.	EPI, Evaluator, Project Director	Short-term (12 months or less)	
1.1.2	Present measures to the SPE Policy Consortium.	Evaluator, EPI, EBP & PBE workgroups	Short-term (12 months or less)	
1.1.3	Adopt appropriate measures.	Participating Tribes	Intermediate term (12 to 36 months)	
1.1.4	Evaluate measures.	Participating Tribes, Evaluator, EPI, EBP/PBE workgroups	Long term (36 months or more)	
Objective 2: Building upon previous SPF SIG efforts, increase Tribal communities capacity to collect and evaluate data.				
	Action Steps	Responsibility	Timeline	Completion
1.2.1	Reach out to Tribes that were not part of the SPF SIG and assess their current capabilities.	EPI, Evaluator	Short-term (12 months or less)	
1.2.2	Assist Tribes that show interest in growing greater capacity.	EPI, Evaluator, GLITEC	Intermediate term (12 to 36 months)	
1.2.3	Put in place an enhanced system at participating Tribes.	Individual participating Tribes with assistance from EPI, Evaluator, GLITEC	Long-term (36 months or more)	
Objective 3: Identify and implement evaluation measures of cultural identity and social connectedness.				
	Action Steps	Responsibility	Timeline	Completion
1.3.1	Research existing measures of cultural identity and social connectedness.	EPI, Evaluator, EPI Workgroup, EBP/PBE Workgroup	Short-term (12 months or less)	
1.3.2	Determine appropriateness of existing measures, modify if needed, and develop new if needed.	EPI, Evaluator, EPI Workgroup, EBP/PBE Workgroup	Short-term (12 months or less)	
1.3.3	Present recommended measures to the SPE Policy Consortium.	EPI, Evaluator, EPI Workgroup, EBP/PBE Workgroup	Intermediate term (12 to 36 months)	
1.3.4	Adopt appropriate measures.	GLITEC, Participating Tribes	Intermediate term (12 to 36 months)	
1.3.5	Evaluate measures for effectiveness	Participating Tribes, Evaluator, EPI, EPI Workgroup, EBP/PBE Workgroup	Long term (36 months or more)	

Goal 2: Promote and foster a culture of purposeful evaluation within and across Tribal entities.

Objective 1: Develop and implement policies and practices to instill a culture of ongoing evaluation of programs and practices.

	Action Steps	Responsibility	Timeline	Completion
2.1.1	Develop a greater understanding of the value and utility of evaluation beyond just meeting funder requirements.	Participating Tribes, Evaluator, EPI, EPI Workgroup, EBP/PBE Workgroup	Short-term (12 months or less)	
2.1.2	Explore protocols and procedures to input, analyze, and share data.	Evaluator, EPI, EPI Workgroup, EBP/PBE Workgroup	Short-term (12 months or less)	
2.1.3	Develop and present to the Policy Consortium a recommendation for protocol and procedures for data input, analyzing, and sharing data.	Evaluator, EPI, EPI Workgroup, EBP/PBE Workgroup, PC	Intermediate term (12 to 36 months)	
2.1.4	Upon development and implementation of a central repository, analyze and develop reports on an ongoing basis.	GLITEC	Long term (36 months or more)	
2.1.5	Present and explain to tribal entities generated data report results to foster data-driven decision making.	Participating Tribes, Evaluator, EPI, GLITEC	Long term (36 months or more)	

Goal 3: Standardize data collection measures and methods across service area Tribal Nations to allow for more useable data.

Objective 1: Create a central repository for evaluation data to be submitted with the goal of institutionalizing the process within GLITC or through agreements with an external provider.

	Action Steps	Responsibility	Timeline	Completion
3.1.1	Engage Tribal entities in discussion regarding the benefits of a central data repository.	SPE staff, PC members	Prior to plan implementation period	
3.1.2	Determine what data are currently being collected at the participating Tribal sites for program evaluation purposes.	SPE staff, EPI workgroup, EBP workgroup	Short-term (12 months or less)	
3.1.3	Develop a system for reporting data to a central data repository.	Evaluator, SPE staff, EPI workgroup, EBP workgroup	Short-term (12 months or less)	
3.1.4	Determine what gaps should be addressed at Tribal sites.	Participating Tribal Entities, evaluator, GLITEC, and GLITC	Intermediate term (12 to 36 months)	
3.1.5	Develop a long-term system for reporting data to a central repository.	GLITEC and participating Tribes	Intermediate term (12 to 36 months)	

Objective 2: Develop core competency requirements for evaluators working with American Indian prevention programming.

	Action Steps	Responsibility	Timeline	Completion
3.2.1	Engage PC in discussions about the core competency requirements for evaluators working with prevention programming.	Evaluator with assistance from Project Director	Prior to plan implementation period	5/31/2012

3.2.2	Draft a recommendation of core competencies.	Evaluator with assistance from Project Director and Administrative Assistant	Short-term (12 months or less)	
3.2.3	Present recommendation to Deputy Directors (DD) for consideration.	Project Director	Intermediate term (12 to 36 months)	
3.2.4	Work with Human Resources to incorporate standard language in position descriptions or contracts used with evaluators.	DDs with assistance from Substance Abuse Program directors	Intermediate term (12 to 36 months)	
3.2.5	Share the core competencies with member Tribes for their consideration.	GLITC, SA Program Directors	Intermediate term (12 to 36 months)	

Goal 4: *The process of strategic plan development and implementation will demonstrate progress toward goals and objectives based upon timelines developed.*

Objective 1: Accomplish an ongoing assessment of the implementation of the strategic plan.

	Action Steps	Responsibility	Timeline	Completion
4.1.1	Utilizing document review and participant observation, conduct and review a quantitative assessment of goal and objective progress.	Evaluator(s)	Short-term (12 months or less) and on-going	
4.1.2	Utilizing focus groups and participant interviews conduct and review a qualitative assessment of goal and objective progress and rationale behind deviations.	Evaluator(s) with input from PC and assistance of SPE staff	Short-term (12 months or less) and on-going	

Northern Further Considerations

- At the conclusion of the five-year implementation, another strategic plan should be developed utilizing knowledge gained through the implementation and evaluation of this strategic plan.

- The Policy Consortium and key stakeholders recommend these core competencies for an evaluator:
    - The ability to enter and leave communities in a good way
    - The ability to communicate effectively and build effective relationships
    - An understanding of American Indian communities and related issues
    - The ability to culturally translate and then advocate to others on both the tribal side and the grantor side
    - Technical and organizations skills needed to do the work; a demonstrated ability to collect, analyze, and interpret data and create useful reports
    - An understanding of issues of sovereignty and cultural awareness and respect
    - Strong communication skills and patience
    - Knowledge of the prevention field
    - Native preference

REFERENCES

American Indian/Alaska Native National Behavioral Health Strategic Plan 2011-2015 (August 2011). IHS National Tribal Advisory Committee on Behavioral Health, IHS Behavioral Health Work Group, and IHS. Retrieved July 9, 2012 from http://www.ihs.gov/medicalprograms/Behavioral/documents/AIANNationalBHStrategicPlan.pdf

American Indian/Alaska Native National Suicide Prevention Strategic Plan 2011-2015 (August 2011). National Tribal Advisory Committee on Behavioral Health, IHS Behavioral Health Work Group, and IHS. Retrieved July 9, 2012 from http://www.ihs.gov/medicalprograms/Behavioral/documents/AIANNationalSPStrategicPlan.pdf

Bartgis, J. & Subia BigFoot, D. (2010). *Healthy Indian Country Initiative Promising Prevention Practices Resource Guide: Promoting Innovative Tribal Prevention Programs*. National Indian Health Board, Washington DC. Retrieved July 12, 2012 from http://www.nihb.org/docs/04072010/2398_NIHB%20HICI%20Book_web.pdf

Blood, N. & Heavy Head, R.A. (Beaver Bundle Transfer). 2011. *Naamitapiikoan: Blackfoot Influences on Abraham Maslow's Developmental and Organizational Psychology*. Presented at Privileging Indigenous Voices: Hearing the Wisdom of Generations, Winter Roundtable, Teachers College Columbia University, New York. Feb 25, 2011.

Community Health Data Profile: Michigan, Minnesota, and Wisconsin Tribal Communities. (2010). Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council, Inc. 2011. Retrieved July 3, 2012 from http://www.glitc.org/epicenter/publications/pdf/Final%202010%20CHP.pdf

Echo-Hawk, H. 2011. *Compendium of Best Practices for Indigenous American Indian/Alaska Native and Pacific Island Populations: A Description of Selected Best Practices and Cultural Analysis of Local Evidence Building*. Portland, OR: First Nations Behavioral Health Association.

Emshoff, J., Erickson, S., & Thompson, M. (1992, unpublished manuscript). *Community factors and strategies for substance abuse*. Center for Substance Abuse Prevention. Sited in: Understanding Substance Abuse Prevention Toward the 21st Century: *A Primer on Effective Programs*. Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention Division of Knowledge Development and Evaluation. DHHS Publication No. (SMA) 99-3301.

First Nations Centre. (2007). OCAP: Ownership, Control, Access and Possession. Sanctioned by the First Nations Information Governance Committee, Assembly of First Nations. Ottawa: National Aboriginal Health Organization. Retrieved July 9, 2012 from http://cahr.uvic.ca/nearbc/documents/2009/FNC-OCAP.pdf

Great Lakes Inter-Tribal Epidemiology Center, Great Lakes Inter-Tribal Council, Inc. (2011). *Great Lakes Inter-Tribal Epidemiology Center's Data Source Inventory for Tribal Programs*. Unpublished manuscript. If you are interested in reviewing *Great Lakes Inter-Tribal Epidemiology Center's Data Source Inventory for Tribal Programs* please contact Kristin Hill, Director of Great Lakes Inter-Tribal Epidemiology Center at 715-588-3324 or khill@glitc.org.

Hawkins, J. D., Catalano, R. F., & Associates. (1992). *Communities that care: Action for drug abuse prevention*. San Francisco, CA: Jossey-Bass Publishers.

ICF Macro. 2011. *Closing the Space In-Between, Integrating Evidence and Practice: Developing an Inclusive Framework for Effective Mental Health Services for Children and Families* (Final Summary Report, March 29).

Indian Health Service. (1996). Adjusting for miscoding of Indian race on state death certificates. U.S. Department of Health and Human Services, Public Health Service, Indian Health Service, Office of Planning, Evaluation, and Legislation, Division of Program Statistics.

Isaacs, M.; Huang, L.; Hernandez, M. & Echo-Hawk, H. 2005. *The Road to Evidence: The Intersection of Evidence Based Practices and Cultural Competence in Children's Mental Health*. Washington, DC: Annie E. Casey Foundation, National Alliance of Multi-Ethnic Behavioral Health Associations.

National Prevention Council. (2011). *The National Prevention Strategy*. Washington, DC: U.S. Department of Health and Human Services, Office of Surgeon General. Retrieved July 3, 2012 from http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf

Nebelkopf, E. (2011). Editors Introduction: Growing Roots: Native American Evidence-Based Practices. *Journal of Psychoactive Drugs,* 43(4), 263-268.

Schnarch, B., (n.d.). *Ownership, Control, Access, and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities*. First Nations Centre National Aboriginal Health Organization. Retrieved July 3, 2012 from http://www.research.utoronto.ca/ethics/pdf/human/nonspecific/OCAP%20principles.pdf

Shiva, Vandana (1997). *Biopiracy: The Plunder of Nature and Knowledge*. South End Press.

Sondik, E. Director of the National Center for Health Statistics of the Centers for Disease Control and Prevention. (1999). Proceedings from the Intercultural Cancer Council. Washington, DC.

Walker, R. Dale, M.D., and Douglas A. Bigelow, PhD.: *Journal for Psychoactive Drugs* (Volume 43, Number 4, October-December 2011) *A Constructive Indian Country Response to the Evidence-Based Program Mandate*.

Yarholar, C., Rogers, P., BigFoot, D. (2012). *Combining Evidence-Based Practices and Practice-Based Evidence for American Indian and Alaska Native Youth Suicide Prevention*. Presentation at the Annual National Indian Health Service Behavioral Health Conference, DoubleTree by Hilton, Bloomington, MN. June 27, 2012 Conference dates June 25-28, 2012.

APPENDIX A: SPE SYSTEMS SURVEY SUMMARY

Planning for a systems analysis began in mid-October 2011 with the intent of conducting phone interviews with key informants. In December the Policy Consortium participated in a pilot, providing important feedback to further modify the survey. On April 4, 2012, the final draft of the survey was created and posted online. Key informants were determined based on current contact information for Tribal Health Directors, Prevention Specialists, AODA Directors and Behavioral Health Directors. A completion rate of greater than 66% was achieved with 44 of 66 eligible participants completing a survey. Some key findings from the report include:

- 61.4% of survey responders indicated their Tribe's prevention coalition(s)/ group(s)/ organization(s) currently collect prevention data and/or behavioral health data.
    - 100% of AODA coalition member survey responders indicated this
    - 60% of AODA director survey responders were unaware of whether or not this was true.
- 72.7% of survey responders indicated that they were more than "somewhat interested" in developing a local level tribal specific data warehouse.
    - 100% of AODA coalition member responders indicated they were "very interested."
    - 80% of AODA director survey responders indicated they were "very interested."
- 61.3% of survey responders indicated they were more than "somewhat interested" in developing a central data repository for Tribal and Inter-Tribal use.
    - 75% of AODA coalition member responders indicated they were "very interested."
    - 60% of Tribal Health Director survey responders indicated they were "very interested."
- Only 2.3% of survey responders indicated their tribe's AODA, behavioral health, and primary healthcare systems share data with prevention staff to make data-driven decisions to guide prevention programming.
- 31.8% of survey responders indicated that their Tribe has more than one AODA prevention coalition/group/organization, 29.5% indicated their Tribe does not, and 34.1% did not know.
- Only 4.5% of survey responders indicated that the communication between the different AODA prevention coalitions/groups/organizations in their Tribe was "very effective."
- Only 2.3% of survey responders indicated they are "very informed" of their Tribe's AODA, behavioral health, and primary healthcare systems on updates, accomplishments, and/or difficulties with prevention grants and programs.
- Only 6.8% of survey responders indicated their Tribe's AODA prevention efforts are "very coordinated" with the Tribe's AODA, behavioral health, and primary healthcare systems.
- 43.2% of survey responders indicated that their Tribe has a training plan in place for staff to help support their efforts to obtain and/or maintain AODA prevention specialist certification, while 22.7% indicated their Tribe did not and 31.8% did not know.

The above findings indicate that there are assets in the tribal communities in regard to prevention work, but that many areas need improvement. Collaboration and coordination between organizations is a critical area that should be improved.

*The complete Systems Survey Report is available for download at https://sites.google.com/site/winapc10/additional-resources click on "SPE_Systems_Survey_Report.pdf"

APPENDIX B: DATA "WISH" LIST

Strategic Prevention Enhancement (SPE) Prevention System
EPI and Evidenced-Based/Practice-Based Evidence Workgroup
DATA WISH LIST

In January, 2012, the SPE Policy Consortium conferred and created the following list of data resources that Tribes in the GLITC service area would collect and have access to in an ideal world.

Data Desired:

- NOMS
- Childhood trauma data
- What beverages are being consumed
- Assess "cultural social connectedness"
- Data that will address policy/environmental changes
- Data that is not just numbers it tells people's stories
- Data that is not just keeping score/record keeping, but preventative action

Data System Desired:

- Standardized survey instruments
- Standardize methodologies, coordination
- Individual Tribes should be able to collect, analyze, use data in order for us to have a data repository
- Increase systems level assessment

Data Collection Methods Desired:

- Utilize oral traditional story telling as a method for data gathering

Data Analysis Needs:

- Capacity to analyze data changes
- There are groups at Tribes that collect and analyze data *(i.e. grants department, enrollment department, community college, school);* need to coordinate with these groups, so not every department has to collect and analyze data
- Want to create a system where you give demographics and with appropriate releases – this department can give information to another department to help coordinate services for individuals – without repeating story to 18 different people.
- This system already exists through RPMS user classes and health data repository, can be expanded, although not every Tribe uses RPMS or will give user classes to all individuals.
- Want to collect data on prescription drug abuse and bath salts
- Literature is years behind – need to collect data on current issues
- Expand data collection methods to include more than just surveys
- Look at morbidity and mortality data (vital statistics) that is collected by states
- Talk to health directors or clinicians – focus groups – this will identify latest trends
- Talk to law enforcement – focus groups – this will capture latest trends

Data Storage/Retrieval System Desired:

- All agree that a data repository is a good idea....need to put that in the plan.
- Tribes (would) have all data in one place – marvelous
- Process to have all data in one place – what types of data (non-identifiable data) - MOUs
- Data could be identifiable, but only certain individuals would have access to it through their server – not everyone has access to everything
- Currently data are stored in all the different Tribal departments – there is no one place where data is stored in the Tribes.
- What about a directory of data in each Tribe?
- Knowledge of who is collecting what
- Sell this as disaster recovery (what happens if each department loses their data) – back up all at one site.

Challenges:

- Currently data is stored in all the different Tribal departments – there is no one place where data is stored in the Tribes
- Currently there is no knowledge of who is collecting what
- IT
- Individuals working in prevention are supposed to be collecting and entering – not sure of their capacity
- Tribes have trust and confidentiality (small communities) issues
- How are data used and shared with others?
- National Native Network group – to include everyone's names and what everyone is doing, aggregate report which shows what Tribes are doing – gave out information on what they are doing what about issues of sustainability
- Doing surveys with people – how do you code surveys so they are not identifiable (birthdays, bar codes, etc.) and match them up
- Evidenced-based practices and practice-based evidence – issues with pre and post-tests
- Individual pre and post-test survey vs. group pre and post-test
- How do we code surveys and make sure that they are confidential?
- Where is hard copy of data kept?
- How secure are these data?
- Survey gluttony – do we really need to do all these surveys, what about data collecting data in other ways – arrest records, census data, enrollment, public health data, morbidity and mortality data, etc.

Assets to be used:

- Culture is prevention
- Use native students to implement research in communities
- Will in SPE policy consortium to collect and analyze data and spread to other communities
- Tribes partnering with counties? – Ideally, yes, but remember there has been negative experiences in the past.
- How did Tribe X and County X work well together? – developed a relationship – frank discussions about how county steals Tribes data and how Tribe shoves responsibilities onto County – strength based – developed a philosophical model – multi-generations of poverty – that agreed on – timing was right – lots of people on similar coalitions – cut down on these – collaborating and coordinating

Results to be realized:

- Shared data sets implemented
- YRBS in every school 6-12 grades
- Improve academic success
- Improve education and awareness of Native Cultural History & Curriculum
- Increase protective factors for native youth – Wisconsin's ACT 31
- Improve Respect for Cultural Diversity
- Increase Developmental assets for native youth
- Native Communities aren't afraid to collect and talk about data
- Data Repository that is functioning
- Data are not used to beat each other down
- Decrease in shame-based reactions to substance abuse

Other:

- Review "GLITC" Organization – through systems level assessment
- There are fewer alcoholics per-capita in the Native Americans populations than in any other sub culture in the US.--- source unknown, person on workgroup heard at a meeting.
- Reviewing prevention programs and grants over-time at GLITC and the Tribes – which were successful? What failed? Why did this happen?- sometimes we were not able to sustain over to know they did work
- YRBS – can add two questions – maybe Tribes should think about and agree on these questions to get common measures – should talk to local schools to add questions – all the Tribes using the same two questions help coordinate services
- Gambling – first cousin to addiction
- Data collected on how much time kids are using electronic devices (i.e. TVs, Ipads, video games, computer) --- cocooning behavior – changes brain – may lead to addiction
- Nature deceit disorder – more game time, less time outside

Additional Information Fact Sheets for the Strategic Prevention Enhancement (SPE) Strategic Plan

July 2012

Information Fact Sheet

The Strategic Prevention Framework (SPF) Steps and Overarching Principles

The SPE takes the basic framework and theory of change of the SPF "to scale" through the inclusion of behavioral health promotion, suicide prevention, and a focus on prescription drug abuse as well as alcohol and other drug abuse in general. The steps of the SPF are:

- **Assessment** Profile population needs, resources, and readiness to address problems and gaps in service delivery. A substance abuse issue must be assessed correctly through the collection and analysis of data that show the extent and location of a problem, risk and protective factors associated with it, community assets and resources, gaps in services and capacity, and readiness to act.
- **Capacity** Mobilize and build capacity to address needs. Key tasks include convening leaders and stakeholders, building coalitions, and training community stakeholders to help keep activities going.
- **Planning** Develop a prevention plan. The strategic plan expresses a vision for prevention activities and a roadmap for conducting them. It describes policies and relationships, incentives for groups to work together, and evidence-based actions that will be taken. The plan also identified milestones and outcomes for gauging performance.
- **Implementation** Conduct prevention activities. Supported by training and technical assistance, local stakeholders select programs, policies, and practices proven to be effective in research settings and in communities. Culturally competent revisions are made without sacrificing core elements of the program.
- **Evaluation** Monitor and evaluate results and the ability to continue. Ongoing monitoring and evaluation are vital to determining whether the desired outcomes are achieved, to assessing the quality of service delivery, and to identifying needed improvements. Sustaining what has worked well should be an ongoing process.

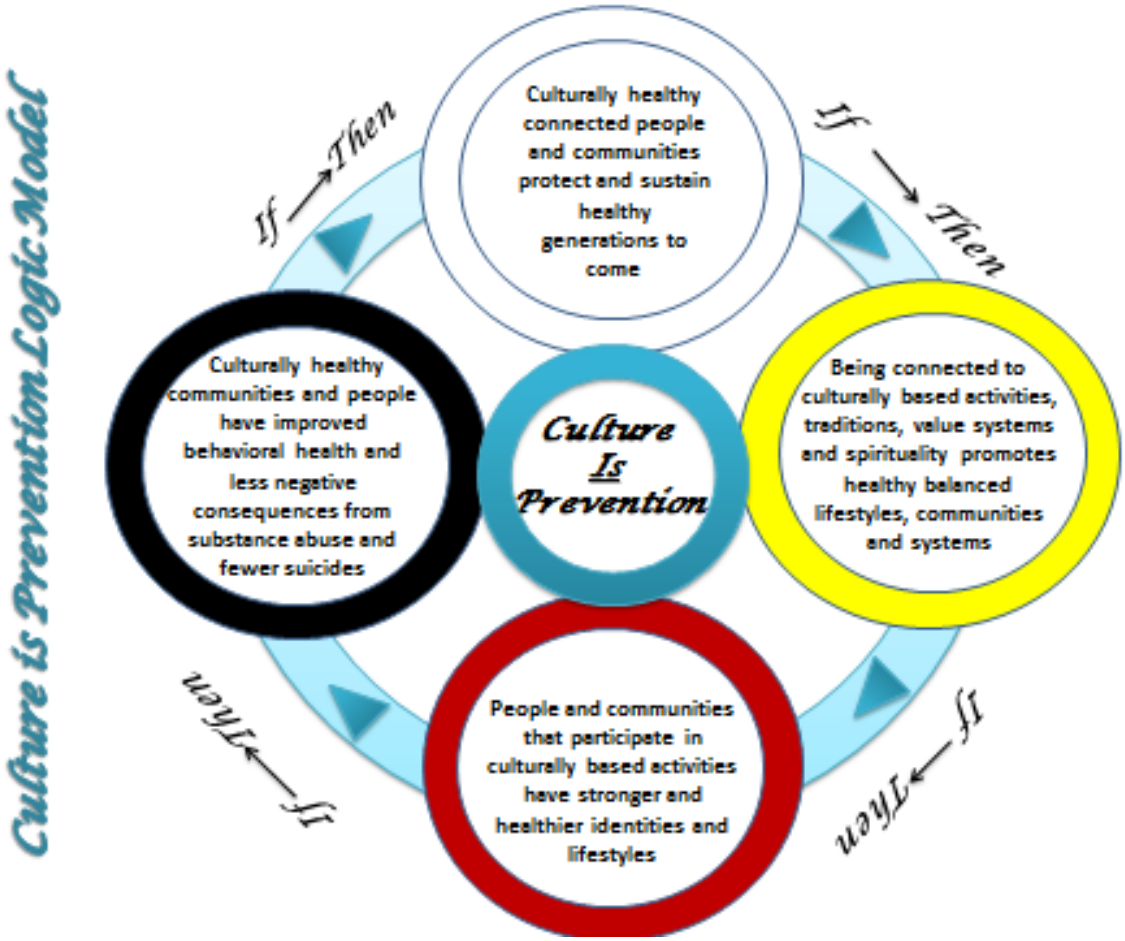
Overarching Principles/Guides

Plans are required to address

- **Cultural Responsiveness (competence)**
- **Sustainability**

Information Fact Sheet

"Culture Is Prevention" and the Evidence-Based Program Mandate



Another key area to be addressed is the development of a process, system, and infrastructure at the regional level and within member tribes to actively understand and pursue evidence-based/informed and culturally relevant prevention programs, activities, symbols, practices, and policies. The means by which practice-based evidence is reviewed and approved for implementation and funding should be well thought out and constructed if the work being done is to be effective for the people served and acceptable to funders and policy makers as viable and credible means by which to implement prevention in Native communities.

The Policy Consortium, after reviewing literature and models by which to establish a list of approved culturally based interventions, tools, programs, and practices, has recommended that a formalized

process be established that will include review criteria, peer-reviewed approval processes, and policies to govern how these are managed and by whom.

It has become common practice in the field of substance abuse prevention that funders require states, tribes, and communities to use "evidence-based" practices and programs. This has been a difficult issue for many tribes and tribal organizations across the country because there has been such limited understanding of and research available regarding what works in Indian Country. Until relatively recently there was not a focus on producing evidence-based research for prevention with Native Americans; the prevailing belief was that if a program or practice worked in one group or sample, then it could be duplicated (with fidelity) in most or all other environments and be equally successful. There are clearly some problems with that simplistic framework for approaching the complex issues of more than 567 federally recognized tribal nations, each with its own form of government, culture, history, environment, and problems. Nor was there a place for some of the basic tenets of many tribal belief systems for the role of more culturally traditional means of effectively addressing these types of problems. The reality for many tribes when it comes to what works in Indian Country is rooted in practice-based evidence as opposed to evidence-based practice. It is an important distinction that greatly impacts the ways in which cultural competency and, more importantly, cultural responsiveness is to be addressed when designing and implementing prevention programs within tribes and tribal organizations.

In a recent article in the *Journal for Psychoactive Drugs* (Volume 43, Number 4, October-December 2011), Drs. Walker and Bigelow summarize the Tribal Best Practices (TBP) process in Oregon with the foundational idea that this is a model that other tribes and tribal agencies could promote as a prototype to begin the process of effectively translating culturally responsive and evidence-informed programs, policies, and practices in other tribal settings.

Walker and Bigelow went on to describe three important aspects that such programs must be aware of and replicate if they are to be culturally responsive.

- Credible program personnel and/or practitioners
- Culturally based prevention activities that include participation in traditional ceremonies and rituals, sharing stories, oral instruction and modeling, and fun
- Materials that include culturally relevant and specific aspects such as setting, dress and ornamentation, symbols and graphics, sensory substances, and food

Information Fact Sheet

The Four SPE Directions

- East: Data Collection, Analysis and Reporting
  - Develop or enhancing current tribal and state data systems to collect, analyze, and report aggregated community-level data up through the tribal and state governance level

- South: Coordination of Services
  - Coordinating, leveraging, and/or redirecting, as appropriate, all substance abuse prevention resources—including funding streams and programs—within the tribes and states that are the directed at communities. "Communities," in the broadest sense, should include community coalitions, which play a vital role in creating and enhancing successful State and Tribal prevention systems for behavioral health promotion, suicide prevention, and all types of alcohol and other drug abuse, including prescription medication.

- West: Technical Assistance and Training
  - Restructuring current technical assistance and training programs for behavioral health, prevention, and primary care professionals throughout the tribes and states in order to provide greater responsiveness to the needs of the community. Tribes and states are encouraged to create commonalities in these training programs that can be used universally.

- North: Evaluation and Performance
  - Focus on revitalizing current performance management and evaluation systems with an eye to accommodating SAMHSA performance goals, measures, and cost savings. Tribes and states must include strategies to enhance their evaluation systems to collect both process and outcomes data using both formative and summative methods.

Information Fact Sheet

Medicine Wheel Logic Model Concept

Explanation of Logic Model Concept

Although logic models are typically created based on the deficit model, our Policy Consortium felt it was important to create a strength-based logic model. They also felt that a unique way to do this–a way that would have meaning to the Native American Tribes that we work with–would to be to design that logic model based on the traditional medicine wheel.

The process of change and growth using the medicine wheel as a basis has been developed over time from traditional Native belief systems. Currently the medicine wheel is often recognized as an inter-tribal symbol across contemporary Indian Country. While not all tribes draw, interpret, or use the medicine wheel in the same way, it is a shared approach to life and the world in general and functions as a holistic model for many tribes. It stems from the belief that all things in life and on earth must be in balance and harmony to grow in a healthy way; each quadrant of the medicine wheel is both unique and equal to the other aspects of the wheel. Each direction is given unique developmental aspects so that following the circle will allow a person/process/task/community to move through growth in a productive, effective, and culturally responsive way. It is not uncommon for people/processes/tasks/or communities to be in different directions on multiple things at any given time.

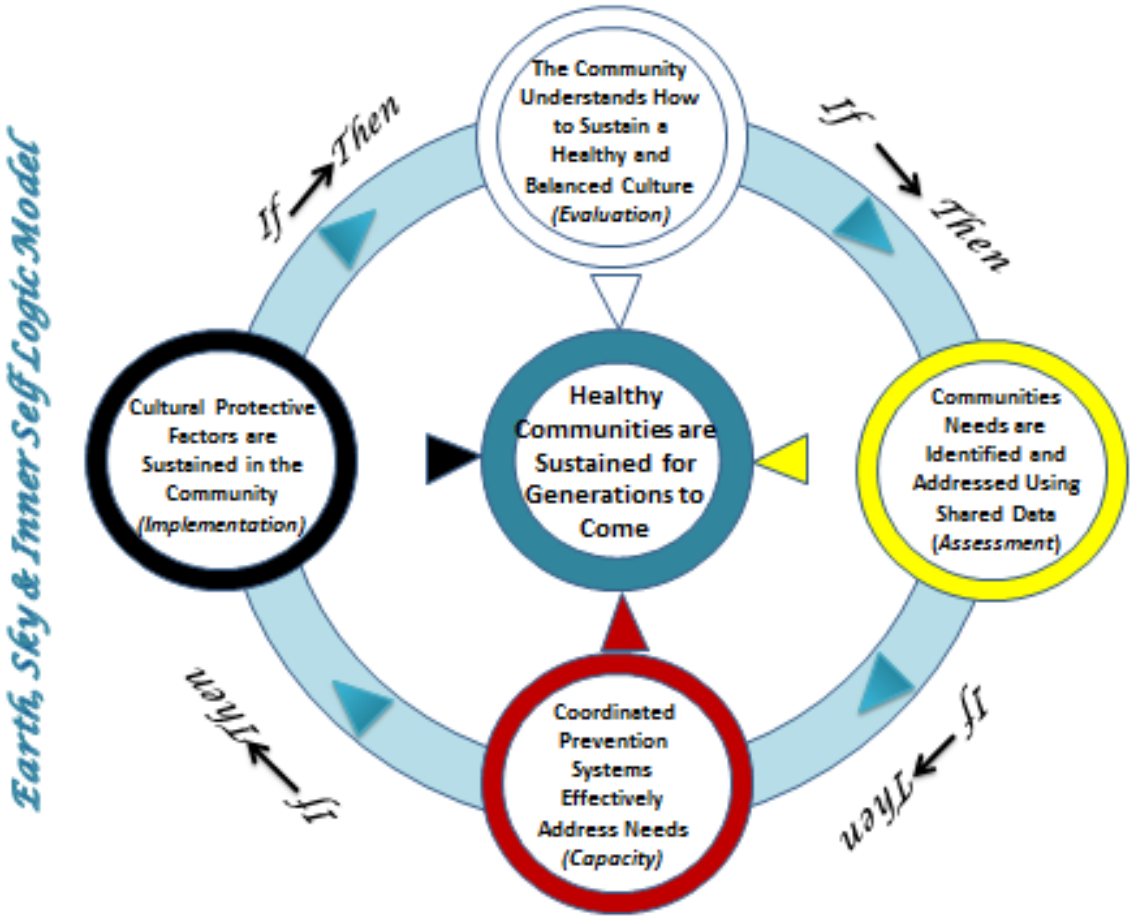
While the overall description and use of medicine wheel model provided for the purposes of the strategic plan may not be identical with any specific tribal model, it was developed with respect to the tribes involved and the collective definition of the medicine wheel as an inter-tribal cultural icon. The definitions and descriptions given here are for the purposes of this plan and based on the feedback of both tribal members and the Policy Consortia that participated in its development.

Any differences to specific tribal models are not meant to be disrespectful. This model is an attempt to integrate many approaches to the medicine wheel in order to provide a culturally responsive way to bring logic to the requirements of the SPE grant requirements. The GLITC staff and consultants have worked to develop a model that is respectful of many tribal approaches, while also meeting the requirements of the federal funders. For the purposes of this plan and logic models, each direction has been given a general description/definition from both the traditional perspective and from the Strategic Prevention Framework model that is used by the funders. This is a story of translation meant to serve as the guide for the approach and structure of this plan and not as an exclusive definition of the tribal meaning or approaches to the medicine wheel in general or particular.

Information Fact Sheet

SPE Four Directions Logic Models
GOALS AND OBJECTIVES

Overall Goal of the SPE



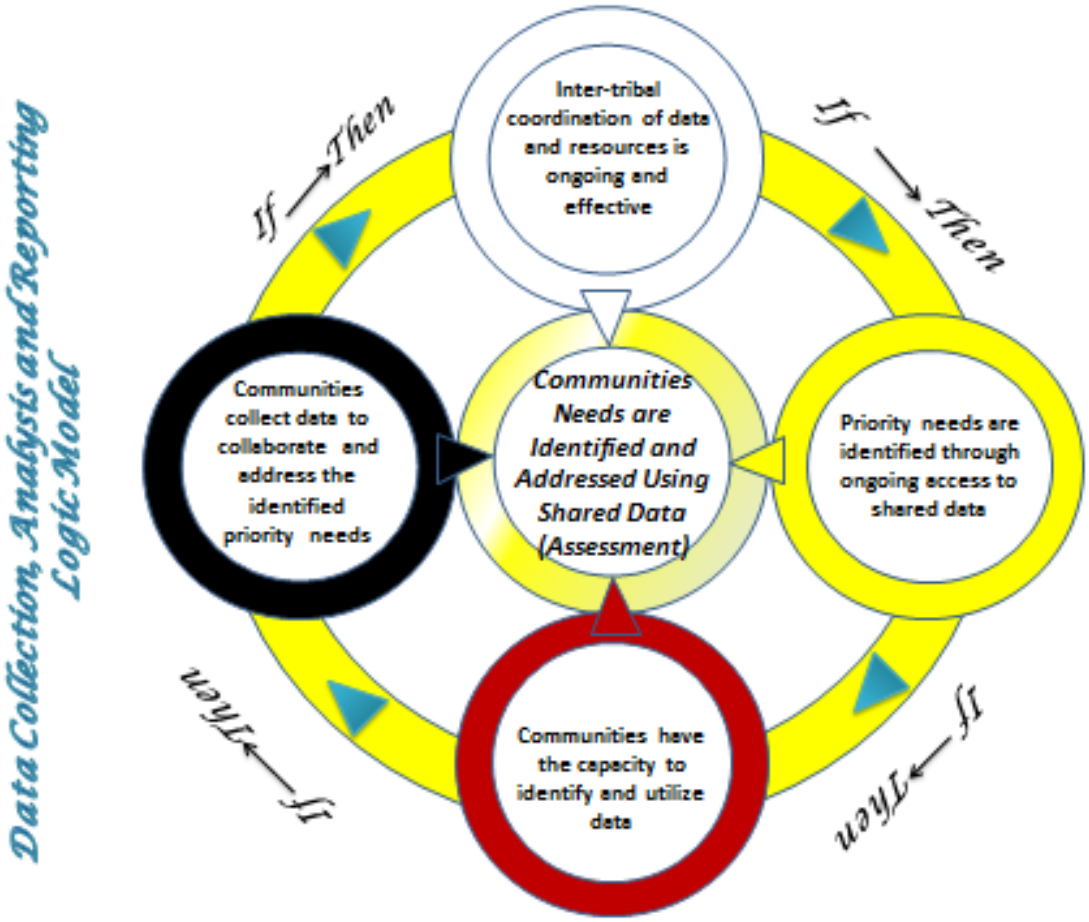
Overall Goal: Healthy Communities are Sustained for Generations to Come

- East: Data Collection, Analysis, and Reporting
  - **Community needs are identified and addressed using shared data (*assessment*)**
- South: Coordination of Services
  - **Coordinated prevention systems effectively address needs (capacity)**
- West: Technical Assistance and Training
  - **Cultural protective factors are sustained in the community *(implementation)***
- North: Evaluation and Performance
  - **Culture connects communities that are healthy and balanced *(evaluation)***

Recommendations from SPE Policy Consortium, Consultants, and SPE Staff

- Use the medicine wheel as a basic approach
- Develop a logic model that is strength-based
- Incorporate "Culture is Prevention" and Tribal culture as protective factors and approaches to strategies and planning
- Support "cross pollination" and replication of tribal best practices at the local, regional, state, and national levels to develop a body of evidence that reflects culturally based programs, policies, strategies, and practices

Eastern Goal: Community Needs are Identified and Addressed Using Shared Data (*assessment*)



East: Data Collection, Analysis, and Reporting

Goal 1: Standardize data collection measures and methods across service area Tribal Nations to allow for more useable data.

Recommendations from SPE Policy Consortium, Consultants, and SPE Staff

- Develop data collection and analysis capacity
- Develop a data repository/warehouse
- Develop individual tribal capacity to store data

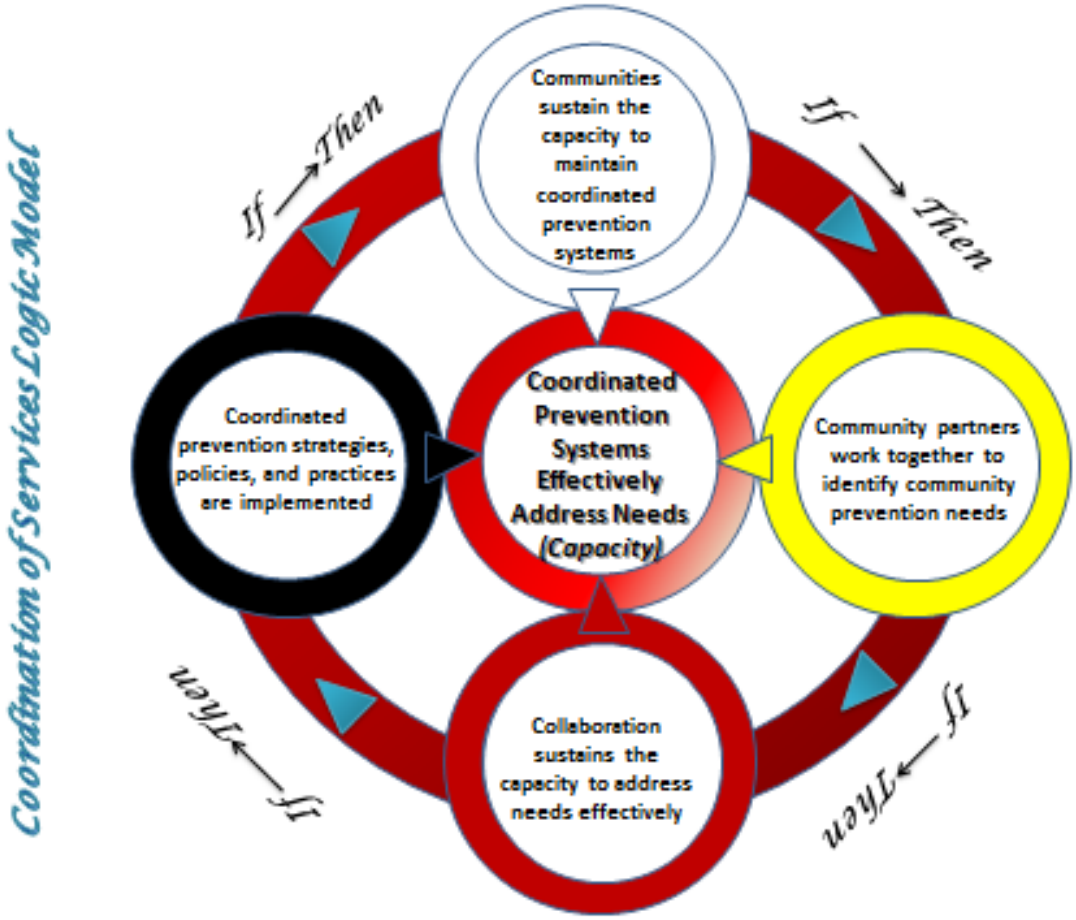
Individual Tribes

- Develop capacity to collect, evaluate, and use data
- Provide training and technical assistance to build epidemiological capacity

GLITC Level

- House, store, and analyze data for individual tribes
- Produce aggregate reports, identify issues, increase awareness, write grant proposals, etc.

Southern Goal: Coordinated Prevention Systems Effectively Address Needs (Capacity)



South: <u>Coordination of Services</u>

Goal 1: GLITC will encourage local tribes and other partners to enhance collaboration so that they can share information and lessons learned to make changes that will benefit the system as a whole to promote behavioral health, prevent alcohol, tobacco, and other drug abuse (including prescription drugs), and suicide.

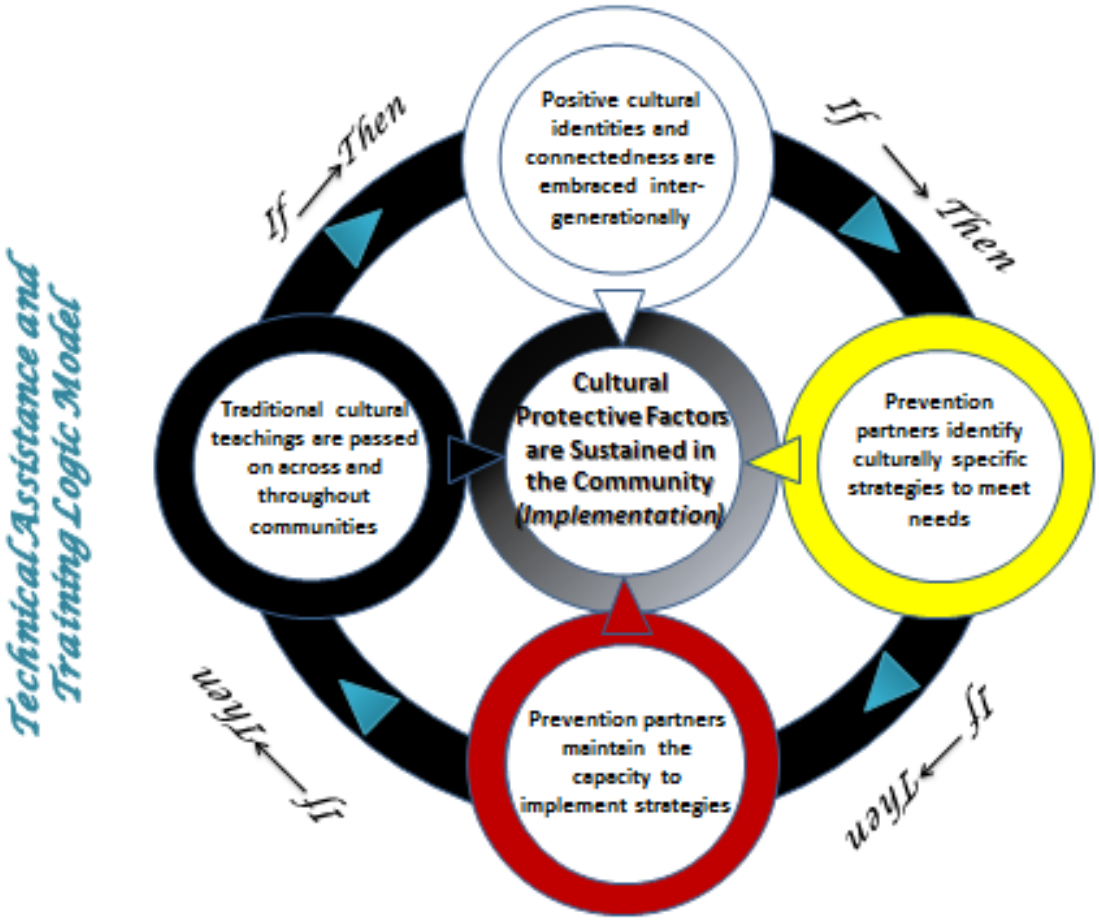
Goal 2: GLITC will work with individual Tribes and local tribal coalitions to increase community capacity to implement, increase, and sustain the use of the SPF process.

Goal 3: Increase ability to leverage assets through the coordination of resources to promote behavioral health, prevent alcohol, tobacco, and other drug abuse (including prescription drugs), and suicide.

Recommendations from SPE Policy Consortium, Consultants and SPE Staff

- Increase linkages at the Tribal and Inter-Tribal levels
- Increase community capacity to implement, increase, and sustain the use of the SPF process
- Increase the ability to leverage assets through coordination of resources at both the Tribal and Inter-Tribal levels
- Look at ways to increase reimbursement for screening/assessments and for Traditional Healers, etc.

Western Goal: Cultural Protective Factors are Sustained in the Community *(Implementation)*



West: Technical Assistance and Training

Goal 1: GLITC will work with key stakeholders, Board of Directors, member tribes, and the Policy Consortium to increase their understanding and use of current information and evidence-based approaches to implementing culturally responsive and appropriate prevention programs, policies, and practices.

Goal 2: GLITC will encourage individual tribes to increase the number of certified prevention specialists.

Goal 3: Participating Tribes will become aware of culturally responsive prevention and behavioral health related assessment, screening, evaluation, and other tools as appropriate.

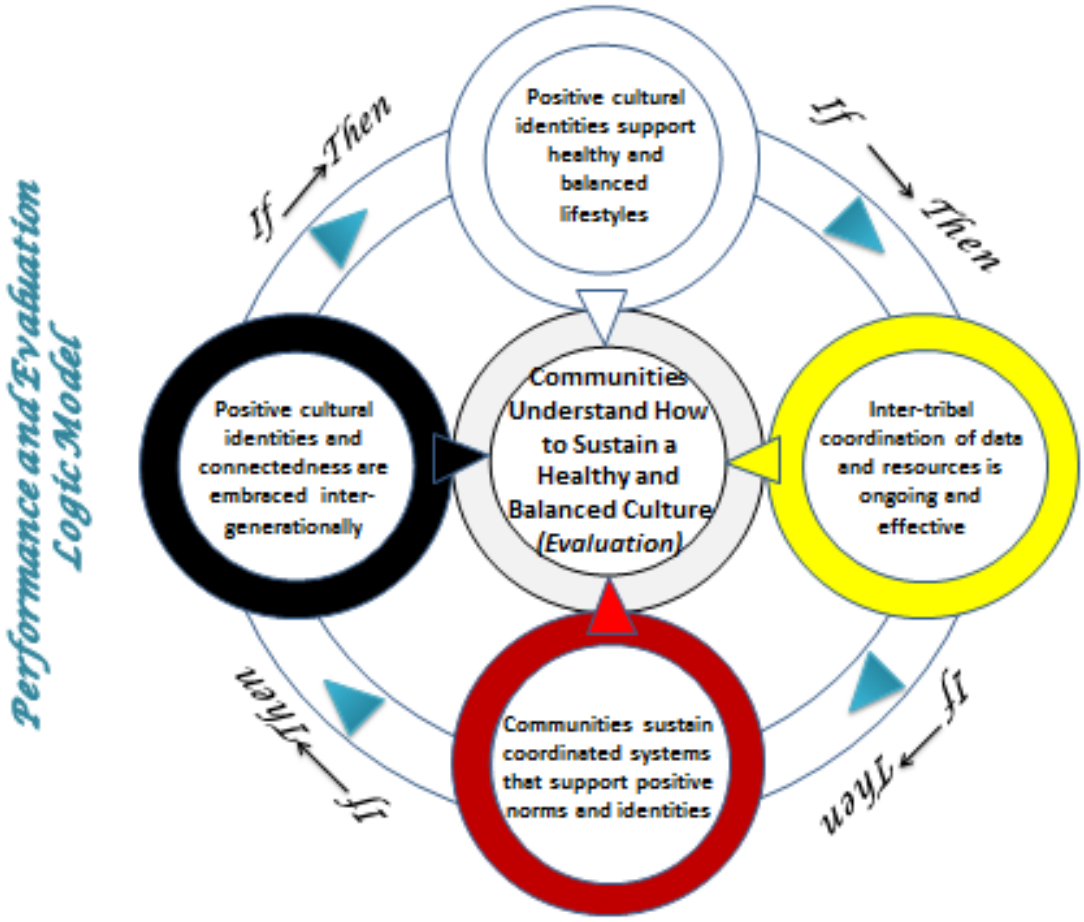
Goal 4: Prevention programming, practices, and strategies that are culturally responsive and appropriate will be fostered.

Goal 5: Continue to work with the Policy Consortium, key stakeholders, GLITC Board of Directors, member Tribes, and others to advocate for the implementation of the SPE Strategic Plan.

Recommendations from SPE Policy Consortium, Consultants, and SPE Staff

- Create a technical assistance and training system that supports:
    - Developing local, regional, state, and national capacity to collect, retain, house, analyze, and share data in Indian Country
    - Work with the GLITC Board, the Policy Consortium, Behavioral Health, the state, nationally, and with other key stakeholders to develop a commitment and process by which tribal best practices and cultural programs become recognized as evidence-based
    - Work with GLITC Board, regionally, locally, and with the state to develop culturally based prevention of AODA, suicide and behavioral health promotion systems in Wisconsin and nationally

Northern Goal: Culture Connects Communities that are Healthy and Balanced *(Evaluation)*



North: <u>Performance and Evaluation</u>

Goal 1: Identify benchmarks and outcome measures to assess and improve strategies that enhance evaluation systems to collect process and outcome data that address promotion of behavioral health, prevent alcohol, tobacco, and other drug abuse (including prescription drugs), and suicide.

Goal 2: Promote and foster a culture of purposeful evaluation within and across Tribal entities

Goal 3: Standardize data collection measures and methods across service area Tribal Nations to allow for more useable data.

Goal 4: The process of strategic plan development and implementation will demonstrate progress toward goals and objectives based upon timelines developed.

Recommendations from SPE Policy Consortium, Consultants and SPE Staff

- Develop data collection and analysis capacity
- Develop a data repository/warehouse
    - GLITC Level
        - House, store, and analyze data for individual tribes
        - Produce reports, recommendations, proposals at the regional level
        - Provide inter-tribal coordination, training, and technical assistance to individual tribes
    - Individual Tribes
        - Develop capacity to collect and use data
        - Provide GLITC with data while retaining ownership

APPENDIX D: ONE WITH ALL PROJECT

One With All Project
Strategic Prevention Framework State Incentive Grant
Native American Health Center
3124 International Blvd., Oakland, CA 94601 510.434.5421
Contact: Serena Wright or Esther Lucero
Summary Author: Stevie S. Burden

The Native American Health Center, Inc., is a nonprofit, community-based organization with multiple locations in the Bay Area and regionally in northern California. The Native American Health Center assists American Indians and Alaska Natives to improve and maintain their physical, mental, emotional, social, and spiritual well-being with respect for cultural traditions and advocates for the needs of all Indian people, especially the most vulnerable members of our community.

In 2006 the NAHC received a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Center for Substance Abuse Prevention. The goals of the SPF SIG were to: prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; reduce substance abuse-related problems in communities, and; build prevention capacity and infrastructure at the State/Tribal/Territory and community levels.

The purpose of One With All was to expand the capacity of AI/AN agencies to provide culturally appropriate, evidence-based substance abuse prevention programs for AI/AN/NHs in Northern California based on the Strategic Prevention Framework, and in collaboration with urban tribal organizations, local behavioral health departments, and state agencies addressing substance abuse and its related problems. To accomplish the goals, the NAHC staff worked with local agencies that addressed substance abuse prevention topics and used culturally appropriate and responsive activities and methods of delivery. An evaluation of the project was conducted to measure the effect of the interventions on participants. Expected individual-level outcomes of positive behavioral change among clients and community participants included abstinence from substance abuse, decreased criminal and juvenile justice involvement, and increased social supports and social connectedness. Outcomes on the systems and community level included increased use of evidence-based practices and increased community capacity for services to AI/AN families.

The local evaluation incorporated the outcome measures with factors associated with cultural identity, family strengths, trauma history, and cultural notions of healing. A local question set focusing on cultural issues was developed to measure factors pertinent to client functioning in an urban Indian environment. NAHC also selected some Native American Addiction Severity Index questions to be added to the local instrument; the ASI has been used nationally and is valid and reliable. These instruments are sensitive to age, race/ethnicity, culture, language, sexual orientation, disability status, literacy, and gender.
All data collected have been cleaned and are being analyzed. Some of the most statistically significant findings between exit and follow up were as follows:

- Among those participants who reported drinking in the past 30 days, there was a 66% reduction number of drinking days.
- Among all AIANNH participants, there was a 50% reduction in number of days in which participants drank four drinks or more on drinking days.
- Among those participants who reported binge drinking (having five drinks or more) in the past 30 days, there was a 73% reduction in the number of days of binge drinking.

APPENDIX E: ABBREVIATIONS AND ACRONYMS

Plan Abbreviations and Acronyms

ACE	Adverse Childhood Experiences
AI/AN	American Indian and Alaska Native
AODA	Alcohol and Other Drug Abuse
ATODA	Alcohol Tobacco and Other Drug Abuse
BAO	Bemidji Area Office
BH	Behavioral Health
BOD	Board of Directors
BPTR	Bureau of Prevention Treatment and Recovery
BRFSS	Behavioral Risk Factor Surveillance System
CAC	Clinical Application Coordinator
CMS	Center for Medicare and Medicaid Services
DHS	Department of Health Services
DMHSAS	Division of Mental Health Substance Abuse Services
DOT	Department of Transportation
EBP	Evidence Based Practice
EBP/PBE	Evidence Based Practice/Practice Based Evidence
EHS	Education and Human Services
EPI	Epidemiological/Epidemiology
FHS	Family Health Services
GLITC	Great Lakes Inter-Tribal Council, Inc.
GLITEC	Great Lakes Inter-Tribal Epidemiology Center
GPRA	Government Performance and Results Act
HIV/STD's	Human Immunodeficiency Virus/ Sexually Transmitted Disease
IHS	Indian Health Service
IT	Information Technology
MA	Medical Assistance
MIS	Management Information Systems
MOU	Memorandum of Understanding
NARCH	Native American Research Center for Health
NREPP	National Registry of Evidence-based Programs and Practices
OCAP	Ownership, Control, Access and Protection
PBE	Practice Based Evidence
PC	Policy Consortium
PCHC	Peter Christiansen Health Center
PD	Project Director
RPMS	Resource Patient Management System
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPST	Substance Abuse Prevention Specialist
SPE	Strategic Prevention Enhancement Grant
SPF	Strategic Prevention Framework
SPF SIG	Strategic Prevention Framework State Incentive Grant
TA	Technical Assistance
TBP	Tribal Best Practices
WI	Wisconsin
WIEA	Wisconsin Indian Education Association
WNATN	Wisconsin Native American Tobacco Network
YRBS	Youth Risk Behavior Survey

Tribal Abbreviations

BR	Bad River Band of Lake Superior Tribe of Chippewa Indians
FCP	Forest County Potawatomi Community
HCN	Ho-Chunk Nation
LCO	Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wisconsin
LDF	Lac du Flambeau Band of Lake Superior Chippewa Indians
LVD	Lac Vieux Desert Band of Lake Superior Chippewa Indians
Men	Menominee Indian Tribe of Wisconsin
ML	Mole Lake, Sokaogon Chippewa Community
Oneida	Oneida Tribe of Indians of Wisconsin
RC	Red Cliff Band of Lake Superior Chippewa Indians
SBM	Stockbridge-Munsee Community
St. Croix	Saint Croix Chippewa Indians of Wisconsin