Tribal Law and Order Act -- Indian Alcohol and Substance Abuse Memorandum of Agreement and Tribal Action Plan | *Webinar Summary*

This summary was compiled by Sarah S. Pearson, Tribal Youth Justice Fellow, OJJDP.
View webinar here: http://edc.adobeconnect.com/p8whj71czm9/

The webinar, held on September 12, 2012, was organized by the Office of Juvenile Justice and Delinquency Prevention at the Office of Justice Programs, U.S. Department of Justice in collaboration with federal partners from the Office of Indian Alcohol and Substance Abuse (OIASA) at the Substance Abuse Mental Health Services Administration (SAMHSA), the Indian Health Service, the Bureau of Indian Education and the Bureau of Justice Assistance.

Overview

The purpose of this webinar is to familiarize audiences with the Tribal Action Plan (TAP), a component within the Tribal Law and Order Act (TLOA), under the Indian Alcohol and Substance Abuse Memorandum of Agreement (MOA). The MOA was signed by three federal agencies and, among other responsibilities, outlines how agencies should support tribal development of a TAP.

The first panel features federal agency representatives who describe the purpose of the TAP and provide an update on interagency efforts to assist tribes in their development of a TAP. The second panel features tribal practitioners, first a tribal consortium and then an individual tribe, who share their TAP development experience.

Federal Agency Panel

Virginia Mackay-Smith, Director (Acting), Office of Indian Alcohol and Substance Abuse, SAMHSA

Experience suggests that effective prevention and treatment in Indian country takes a holistic and integrated approach. This approach reflects the strength of tribal culture and matches the federal approach to substance abuse issues. Taking this into account and with broad support from Indian country, Congress passed and the President signed the TLOA of 2010.

The TLOA places an emphasis on federal coordination in support of tribes. It directs federal agencies to coordinate existing federal resources and programs to serve the needs of Indian tribes working to achieve their goals in the prevention, intervention and treatment of alcohol and other drug abuse.

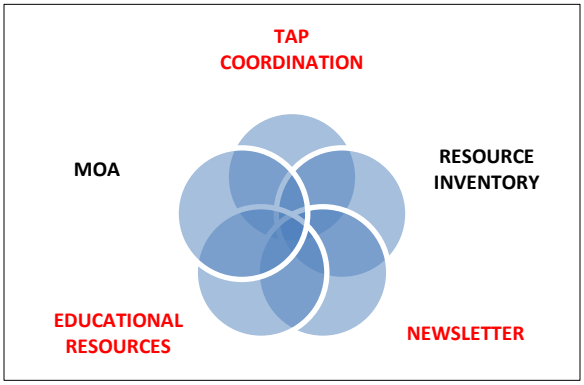
The Act identifies three federal departments: The Department of Health and Human Services, the Department of the Interior and the Department of Justice to form the core of this new coordinated effort. And recently, the Department of Education, Department of Agriculture and White House Office of National Drug Control Policy have become involved.

There are three goals identified to guide the agencies' work. The first is to determine the scope of the problem—to describe the nature and extent of the alcohol and substance abuse problems faced by the tribe. The second goal is to identify the resources and programs of each agency that would be helpful to tribes making a coordinated effort to combat substance abuse. And, third, to coordinate existing agency programs within those established unto the Act.

The identified federal agencies bring different strengths and programs that make up the universe of assistance that contributes to strong communities. For instance, within the Department of Health and Human Services, SAMHSA brings a focus on preventing substance abuse and promoting behavioral health. And the Indian Health Service brings treatment and rehabilitation expertise. Within the Department of the Interior, the Bureau of Indian Affairs and the Bureau of Indian Education support programs in education, social services and law enforcement functions. And the Department of Justice offers a broad range of programs and resources that focus on public safety issues critical to tribal communities. These roles are only the federal agency roles; the most important player in these activities is the tribe whose wellbeing is the focus of the TLOA.

TLOA provides a new opportunity for tribes to take a bold step forward in addressing substance abuse issues by developing a TAP. This component of TLOA recognizes tribal sovereignty and that Indian tribes are in the best position and have the primary responsibility for protecting and insuring the wellbeing of their members.

The Office of Indian Alcohol and Substance Abuse (OIASA) was created within SAMHSA to coordinate the work of the federal partners. The MOA guides the work and allows for broad participation of agencies and their components within the Indian Alcohol and Substance Abuse Interdepartmental Coordinating Committee (IASA Committee).



The IASA Committee established workgroups to manage the various responsibilities under the MOA. The workgroups overlap like the spheres shown. This echoes the way different parts of the community overlap or the way different aspects of a well-planned program affect and support each other.

The IASA Committee developed three channels of outreach to Indian country: 1) "Prevention and Recovery," a quarterly newsletter posted on the IASA website, 2) tribal leaders letters to convey information about the TLOA resources, and 3) a dedicated website **http://www.samhsa.gov/tloa/** that outlines work under TLOA, and how the federal partners have organized to carry out activities.

Juanita Mendoza, Bureau of Indian Education, DOI and Education Workgroup Chair

The Educational Services Workgroup represents members working across five federal agencies that directly or indirectly work with American Indians and Alaska Natives. It serves as a multiagency collaborative to garner information critical to the fight against alcohol and substance abuse. The Workgroup's primary charge is to gather, maintain and update a list of federal programs and resources providing educational services. The comprehensive list of current federal programs is available on the OIASA website.

While the Workgroup primarily concentrates on alcohol and substance abuse matters, it also focuses on identifying general educational services and includes programs that encompass family and community. Because reaching out to Native youth who are at risk for engaging in alcohol and substance abuse is so critical, special attention is given to programs that aid that population.

Four issues of the "Prevention and Recovery" newsletter have been produced by the Newsletter Workgroup to date and they are posted on the OIASA website. The newsletter is meant to inform Indian country about tribal achievements, program successes, and updates of IASA Committee activities. It is disseminated to schools, tribal offices, Indian Health Service offices and others. We want the newsletter to represent what is working in Indian country. It's important that we receive your contributions, so please send us articles, information about programs and resources, personal stories, and any relevant material you want to share.

Rose Weahkee, Indian Health Service representative to the TAP Workgroup and TAP Workgroup Chair

The OIASA serves as a point of contact for tribes and their **Tribal Coordinating Committees** (TCC), answering questions and coordinating tribal requests for training or technical assistance related to the development and implementation of the TAP.

A sub-group of the IASA Committee, the TAP Workgroup is made up of federal partners including Indian Health Service, Bureau of Indian Affairs, Department of Justice and others. One of the primary roles for the TAP Workgroup is to provide TAP guidelines to tribes consistent with the requirements of available federal resources.

The TAP Workgroup works with federal partners within the IASA Committee to manage the overall coordination of a tribe's request for assistance in the development of their TAP. The TAP Workgroup also works closely with other IASA workgroups, in particular the Inventory Workgroup, in responding to tribes seeking assistance with training or technical assistance regarding their TAP.

The TAP Workgroup developed **TAP Guidelines** which can be found on the OIASA website. The guidelines offer a roadmap to develop a TAP and provide samples of model frameworks for developing a TAP, including a community readiness model, a strategic prevention framework model, a spectrum of prevention model and a comprehensive assessment process for planning strategies. Also included is a sample tribal resolution and examples of resources and technical assistance that can be provided by federal partners.

A significant component of a TAP is the TCC, which is formed at the local level. The TCC holds the primary responsibility for implementing, reviewing and evaluating the TAP, and for making recommendations to the tribe regarding the TAP. The TCC is comprised of a tribal representative serving as the chair and, as the tribe chooses, the Bureau of Indian Affairs Agency and Bureau of Indian Education Superintendents, where appropriate, and the Indian Health Service Chief Executive Officer, or their representative. Beyond those just mentioned, members of the TCC may include tribal leaders, elders, youth, school staff, law enforcement, business owners, spiritual leaders and other interested community members as well as other federal partners.

The IASA Committee helps to provide guidance and coordination of all appropriate federal efforts and resources to help tribes in the implementation of their TAPs. All of this information is included in the TAP Guidelines, available on OIASA website.

The TAP is a tribally driven process where the community builds their plan from the ground up. Tribes should update their TAP every two years to be sure it accurately addresses emerging issues that may be impacting the community. The tribe, its staff and the tribe's partners should use the TAP as an ongoing framework for addressing issues of alcohol and substance abuse.

Tribes are encouraged to submit their tribal resolutions to the OIASA when they submit their TAPs. Doing this helps OIASA to identify helpful training and technical assistance and to coordinate with other federal partners in meeting tribal requests for assistance. With the tribe's permission, their TAP will serve as an example to other tribes who are thinking of developing their own tribal resolutions and TAPs.

Federal Panel Q&A

Q: When students need treatment for alcohol and substance abuse, who is the contact person in BIE?
A: The first point of contact would be a counselor in the school. If there isn't information available from the counselor, then we can, if the parent wants, contact the principal. The principal could then reach out to the safety school specialist. It really depends on the school. The BIE has different schools and they have different administrative systems set up. (Juanita Mendoza, BIE)

Q: Once it's determined that a student needs treatment services for alcohol and substance abuse, where does that request (referral) go from there?
A: The referral would go to the counselor at the school. If the school has a counselor, the counselor would then work with the substance abuse or treatment center. If the school does not have a counselor, then they could work with the leadership at the school, the principal. It would be contained within the school system and not come to the federal level. Referrals are also made to the Indian Health Service and tribal programs that run their alcohol and substance abuse treatment programs. The Indian Health Service also runs 11 Youth Regional Treatment Centers throughout Indian country. This is another resource. (Juanita Mendoza, BIE and Rose Weahkee, IHS)

Q: Is there tribal representation on the TAP?
A: The workgroups are made up of federal partners to help coordinate the federal resources in response to tribal requests for assistance. Where the tribal membership comes in is in terms of the local Tribal Coordinating Committees. That is where the tribal representatives within the tribe would be represented to help develop an action plan and to assist in implementing it. Tribal Coordinating Committees may include federal partners such as IHS, BIA and BIE. (Juanita Mendoza, BIE and Rose Weahkee, IHS)

Q: Where can we access that information? Is it on the website?
A: The list of promising practices can be found in a number of different places. Right now, the IASA Committee is putting together a list of general resources that are available, and that should be in an appropriate format for web posting shortly, OIASA website. In addition, the different federal departments have lists of promising practices that their programs have found work well in Indian country. Finally, there are a couple of programs that are listed on the National Registry of Effective Programs and Practices that are particularly effective in Indian Country. (Rose Weahkee, IHS)

Q: Will the inventory of strategy practice-based models information be available?
A: Yes. The Office on Indian Alcohol and Substance Abuse is working now to post that information online. On the Indian Health Service website, we share the best promising practices for alcohol abuse, suicide and other issues that impact Indian country. If someone has a specific question and is looking for promising practices to address multiple issues, they can contact the OIASA or IHS. (Rose Weahkee, IHS)

Q: Does the health curriculum include aspects identified in the childhood experience study? How early does it incorporate it?
A: The health curriculum isn't universal. All the schools do not follow one specific health curriculum. Because BIE has BIE-operated contract and grants that are different systems that the schools will employ to provide health programs or health education, I cannot say that the health curriculum would include that information. (Juanita Mendoza, BIE)

Q: How many Tribal Coordinating Committees are there?
A: The Tribal Coordinating Committees that we know of are, at this point, under a dozen, and they are primarily in the southwestern regions. Not every tribe that is working on a resolution or setting up a Tribal Coordinating Committee has let us know. The first we may hear of that is when the resolution is complete or when a tribe is far along in the development of their TAP and they have a question or need resources to help in the development. There may be far more tribes working on a Tribal Coordinating Committee than we know. Tribes are not required to let us know. I think as Dr. Weahkee pointed out, if we do know that a tribe is working on a resolution or a TAP, this can help us ensure that we have resources available and arranged in a way that would be most helpful to them. (Virginia Mackay-Smith, OIASA)

Q: Are regional and/or multiple Tribal Coordinating Committees allowable for the TAPs and I'm assuming that the Tribal Action Plans are a specific plan?

A: Yes. The guiding rule is that the tribe should make a decision about what works best for their community. And we have found in our separate agency work that many tribes will have partnerships or collaborations with their neighbors, sharing resources and so on. The next panel will describe working with multiple tribes so we'll get to hear a little bit more about that. (Virginia Mackay-Smith, OIASA)

Q: All grantees must complete the TAP in collaboration with the technical assistance provided to the granting agency. Is this correct?

A: That's a complicated question. The TLOA is not a grant program per se. So, under TLOA, there is no requirement like that. However, there are grant programs that are authored by different agencies and of course those programs will have their own terms and conditions for the grants and their own technical assistance providers as well. Tribes can contact the Indian Alcohol and Substance Abuse Coordinating Committee and we can work with them to find technical assistance providers that might be appropriate for their work and available to them. The best place to ask whether TAP activities are allowable would be to go to their specific tribal government project officer for clarification and guidance regarding their specific grant. (Virginia Mackay-Smith, OIASA and Rose Weahkee, IHS)

Q: What are the due dates for resolutions, tribal resolutions and TAPs? Is there a place that tribes or groups of tribes can access a sample tribal resolution?

A: The TLOA does give a series of dates for tribes to look at. However, if you read the whole statute, it's clear that Congress intends the tribes to be the ones who are the driving force in deciding whether to develop a TAP, how, and along what timetable. So, although there are statements in the Act that say, for example, "within a year of that date," a tribe should not consider that if that date has passed, that they are no longer eligible to proceed in developing a TAP. They are, and at whatever stage their plan is in, that's the stage at which the OIASA is prepared to work with them. There is a sample tribal resolution in the TAP guidelines under appendix A. The TAP Guidelines are on the OIASA website. We don't have a sample TAP yet posted to the website, but we hope to make that available in the future. Northwest Portland Area Indian Health Board has their TAP available on their website. (Virginia Mackay-Smith, OIASA and Rose Weahkee, IHS)

Q: Do the TAPs generally involve tribal law enforcement in the development of relevant strategies?

A: Yes. They very often do. Tribal law enforcement people have a lot of information, resources, knowledge and experience and can be very helpful in putting together a TAP. But again, it depends on the individual community. In some communities, that's a very effective approach and in other communities, they might involve tribal law enforcement in other ways. Again, it's up to the tribe to determine the most effective partnership there. In the TAP Guidelines, there is a list of the various systems that a Tribal Coordinating Committee or tribe may want to consider to serve on their coordinating committee—law enforcement, child welfare, youth services, health services—depending on the tribe's focus and who they think is an appropriate partner to have at the table. (Virginia Mackay-Smith, OIASA and Rose Weahkee, IHS)

Tribal Practitioners Panel

Stephanie Craig Rushing, Northwest Portland Area Indian Health Board

I work at the Northwest Portland Area Indian Health Board with the 43 federally recognized tribes in Oregon Washington and Idaho, and we also have one of the tribal epidemiology centers. We have worked with our tribes over the last ten years on a number of different health action plans using a TAP model, focusing on everything from cancer, STDs, HIV, suicide, and substance abuse.

In general, we go through a five-step action planning process. We use the same process for all of our action plans. They usually take four to six meetings over the course of a year to develop. We spend the first meeting looking at the epidemiology data, and our second and third meetings gathering information from our tribe, health professionals and technical experts around regional capacity, readiness, and director activities that align to our region's capacity and readiness. Once our action plan has been reviewed by our tribes and tribal delegates, we'll pass a resolution supporting the plan at a quarterly board meeting of all of our tribal delegates. Then we spend the next three to five years implementing and evaluating the strategies outlined in the plan so as to create community change.

These meetings are open to anyone to attend. We invited our Northwest delegates, tribal health educators, parents, community members, and state and county health department personnel that are focusing on the substance abuse and treatment plan. We also reached out to our youth treatment sites and prevention personnel in the three states region. It is a mixed group at each meeting because we rotate our meetings throughout the region to get the perspectives from different fields at the table as we develop our plan.

Looking at our first step, we pulled data and worked with our tribes to gather information on substance use in the region. We looked at trends and age distribution, gender distribution, and different types of drug and alcohol use to prioritize our interventions in the action plan. We also identified risk factors that we're interested in modifying.

Then we spent the next few meetings talking about causal factors and that included community norms, what things were going on in our community, informal rules and acceptable behavior around drug use, the social availability of drugs and alcohol, where people were accessing it, what community perceptions are of getting access from family members and friends, and the like.

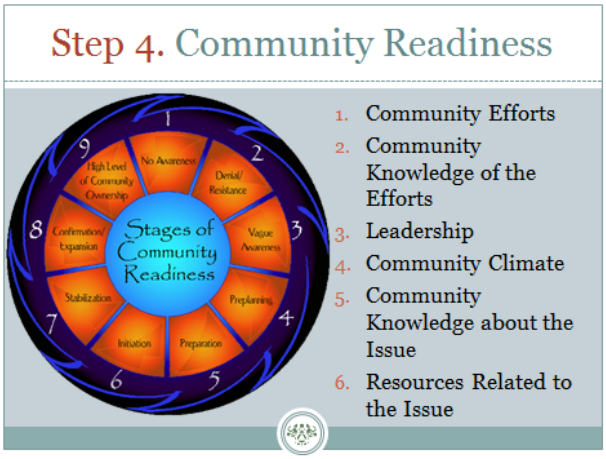
Then we also discussed the related consequences of different drug and alcohol use, so arrests, employment…. Having those conversations helped us identify elements that would be most critical to address in developing our action plan.

We also thought about our regional capacity and we know that in our region we have a wide variety of tribes from very small to much larger communities, and so our capacity around prevention, treatment recovery, enforcement can range widely throughout the region. These kinds of conversations help us get a sense of the common denominators and resources that exist as we put together an action plan.

We used the community readiness model to help guide us through this process. As we had our meetings, we used automated response systems, those little clickers, to provide data from participants while we have the conversation. So, we have questions that rank readiness and each of the six domains along the right-hand side of the slide from community efforts, knowledge of effort, leadership, and we rank each of those on a nine point scale—ranging from no awareness to high levels of community ownership. Going through that process allowed us to rank areas most in need of assistance and to align our activities to the existing level of readiness.

We found that activities that are beyond the readiness of the community can make them ineffective.

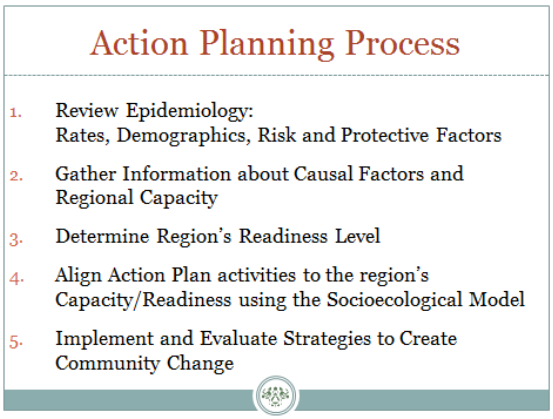
Our use of the readiness model is somewhat unique in that, generally, it's used for a single tribe—and we're using it across the region. We have to merge and find common denominators, even though our tribes are diverse and might have different levels of readiness.



Then we take those activities and try to make sure we're focusing on changing individual knowledge, attitudes and behaviors, but also including activities that focus on the physical environment, organizational systems and community norms and values.

We are almost two years into our action plan. Our action plan includes five different goal areas, two of which are focused on knowledge and awareness, increasing our tribal members' and tribal decision makers' knowledge and awareness of drug and alcohol and prevention opportunities. We included goals focusing on tribal capacity to prevent and screen for and treat substance use in culturally appropriate ways, developing interventions and having access to interventions, improving intertribal and interagency communications as a regional coalition around these topics, and helping support our tribal policy.

This is an example of what one page of our action plan looks like. We identified three to four strategies for each goal area. Some will take a lead on that activity and then try to set a course for five year strategies. Then as we move forward, we use the plan to secure funding. This shows our intention in this area and ability to work collaboratively. We continue to use regional quarterly board meetings to focus on the action plan, and it has guided our promotion disease prevention activities in the region.



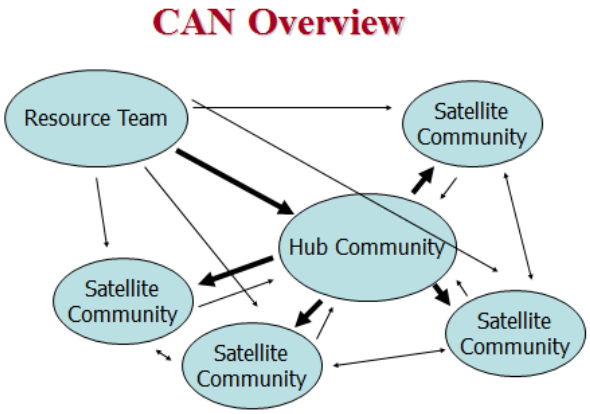
One of the challenges that we've had implementing our action plan is that, often times, for the topics that we have action plans for, we find the same people sitting at the table. For example, the health educator in one community is doing STDs, suicide, drugs and alcohol, and so we're asking the same folks to come to the table to focus on five or six different action plans. We're asking them to come to a lot of meetings and they are not able to do so and focus on those topics separately. So our next step down the road is to focus on creating a holistic adolescent health action plan that will integrate some of these topics and, hopefully, lead us to a more holistic framework for improving the health of the young people in our communities and regions. We've secured funding for some elements but not the entire action plan. So those are still things to get to down the road.

One example of a strategy to come out of our action plan is that we have recently worked with Indian Health Service to develop a campaign called, *I Strengthen My Nation*. There's an order form on the behavioral health website to order all of these materials. We have a text messaging service and young people across Indian country use this resource to get information about drug and alcohol use and prevention. Our final step is to evaluate these strategies and we look forward to doing that down the road.

B.J. Boyd and Levi Keehler, The Cherokee Nation

Levi and I work with the Cherokee Nation in Northeastern Oklahoma. We're going to talk about a project developed under a strategic prevention framework, state incentive grant from SAMHSA. This predates the TLOA but it is the kind of work that lends itself to what the TLOA was designed to help tribes do.

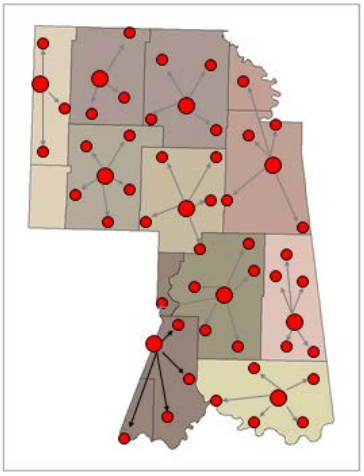
We developed Project CAN. CAN stands for Community Anti-Drug Network, a network of neighboring coalitions that collaborate on common goals and shared resources. Community Anti-Drug Coalitions of America (CADCA) refers to this as a coalition of coalitions. We are not only a coalition of one community but of several communities that work as a larger organization.



At Cherokee Nation, we have a philosophy of mutual contribution. Communities provide participation; they contribute their time, resources and knowledge of their own community. The Cherokee Nation, as a tribal government, works with communities to provide our resources in terms of access to funding, to the things the tribal government can do, to information and technical assistance, and to our professionals for addressing whatever the topic may be. In this case we're talking about substance abuse prevention. We have a resource team, our behavioral health staff in our prevention program that works with Levi Keehler.

Our initial approach was to develop the hub community, the larger population centers that follow The Cherokee Nation. These are the communities most everyone in the surrounding communities passes through frequently. Once we established a good relationship in the hub community, we then worked with that hub community to branch out to the smaller neighboring communities. Eventually you have all the communities working together in this network. So you can imagine replicating this slide ten times and linking them altogether. That's what we're going for.

This map shows the boundaries of The Cherokee Nation in Northeastern Oklahoma and this is an example of what we have if we add more communities to each location. Something to keep in mind is we're not a reservation; we're a tribal jurisdictional service area. A big part of this is data and assessment.



We focus our prevention on outcomes based prevention. From that standpoint we want to know if people are abusing alcohol or drugs, but we don't just want to know that they are, we want to know how and when and where, as far as consumption. And then we want to know the consequences—domestic violence, suicide, vehicle accidents, dropouts, unemployment, things like that. We want to use measurable data to understand the nature and extent of consumption and of the consequences.

This is a model we got from SAMHSA, the working model for this grant. We established a Tribal Epidemiology and Outcomes Workgroup that includes a chairperson from our staff along with the statistician we hired for the project, our project evaluator, and our medical director from Cherokee Nation. This group helped the coalitions analyze and make sense of the data they use for planning and how to do prevention in each community. We did not have the two-year planning grant that the states got before receiving the funding, so we really did this on the fly. We created a strategic plan which I think would look like part of what you'd want in a TAP with the TLOA.

One of the barriers we encountered… There are some national data sources that, for example, states could go to and create a profile of what was going on in their state—US Census data, the National Surveys on Drug Use and Health on Drug Abuse, the Center for Disease Control, Behavioral Risk Factors Surveillance Systems for both youths and adults, and more. We found that these data aren't available for the county or community level. We couldn't profile anything from the State of Oklahoma, so we couldn't break this data down to our region of Oklahoma or even the county, the community or the zip codes that fall within our region.

We also went to some state data sources trying to find information, and we encountered some of the same Issues. Substance abuse treatment admissions in the state system, prevention needs assessment in the schools is hard to break that down to the boundaries of our community. We had to rely on community-level data sources, such as local law enforcement and local school data. We had to enlist the help of communities and community members to find sources of data to measure what was going on in each community in terms of substance abuse. This prepopulated data from national databases was not available for us. We had to focus on local data as the key to our assessments for needs and resources. And local state holders are really the key to that. We had to engage these coalitions very early in the process so they could help us collect data.

We have sustained the tribal work group. This past year they received a contract from SAMHSA that we have an option to renew for this year to continue the work. We also have committed departmental resources to maintain the work even without grants or contract funding. As far as developing the coalitions themselves, again Cherokee Nation is not a reservation. We don't have any form of governmental authority over the public schools, the county sheriffs, the local police forces, or the town government. This is all done by diplomacy and mutual goodwill. Cherokee citizens are part of a larger demographic. They work, go to school, socialize, they live next door and go to church with non-native people. When we think of a population based or community-based way of improving things, we have to reach out to the entire community. These coalitions even though we're sponsoring them and trying to supported them, they're not just coalitions of Cherokee Citizens or American people, and they include all kinds of diverse people.

We had some preexisting Infrastructure on these ten initial hub communities. Ten already had drug free community grants from the drug control policy so they were already working on a coalition model. And there were other grants in there as well. About four of them didn't have any organization to build upon. We thought that it would be easy to build and we found that it was a little more challenging.

Community mobilization is key early on. If you don't have existing organizations to partner with within a community you have to go out and mobilize the community before you can start to work on any kind of assessment and planning. Our coalitions have sustained

themselves. They're still active now. We meet monthly and continue to work together. We did have to add some staff to do this—a project coordinator. We also hired a statistician and some prevention specialists. Each coalition was to higher staff to work on the problem.

I want to quickly acknowledge that we had lots of partnerships and technical assistance from CADCA, and developed a great working relationship with the Department of Mental Health here in Oklahoma. They are now the grantee and we've contracted in one of the counties, all within The Cherokee Nation, to manage their grant process. The Southwest Center for Applied Prevention Technologies is located at the University of Oklahoma and the Muskogee Non-profit Resource Center.

It's not something you can do alone. It's good to see in the TLOA there appear to be options to seek help from SAMHSA, Department of Justice, Indian Health Service and other federal partners that can give us ideas on what we need to be doing. We learned valuable lessons that tribes and states can work together when they have a common purpose. Use your TA providers. When you're offered any kind of assistance from the outside, don't be afraid to ask, and don't be afraid to listen. I found that our providers are very open about learning about our tribe and the nuances of our tribe and other tribes.

Tribal Practitioner Panel Q&A

Q: Do you use a software solution to track each member and their drug and alcohol abuse? If you do, what software do you use?

A: Currently, many. We have the RPMS which is what most tribes use working with the Indian Health Service where we can run reports in RPMS to see how many substance abusers we have and which patients have been diagnosed with substance abuse and what kind of services they're receiving.

Q: Where you can access resources or training materials on community readiness and community mobilization?

A: The community readiness model was originally developed by prevention folks. They are at the Colorado State University, and It was developed in Indian Country and it's now been used all over the world to develop action plans with communities around a wide variety of different health topics. They provide training and technical assistance free of charge to communities interested in using their models. You can download the model and get technical assistance.

A: There are also resources listed within the TAP Guidelines including the community readiness model that Stephanie was sharing. So there is a brief description about four model frameworks and where to get additional information or resources.

Q: If a tribe has completed a strategic plan that has been in process for a number of years, how is this different from the TAP? Is the TAP more chemical dependency focused?

A: Well, in this case, we're talking about TAPs that are addressing the area of alcohol and substance abuse. But basically a TAP *is* a strategic plan, so a tribe may already have a strategic plan or TAP that's currently in process and that can be modified to address alcohol and substance abuse to meet those needs of tribal communities. So if there are already models or processes the tribe has gone through, certainly a strategic plan is a living document that can be updated as emerging Issues come up including substance abuse. But TAPs are basically that--they're strategic plans. ★

SPEAKER BIOGRAPHY

Virginia (Ginger) Mackay-Smith is the acting director of the OIASA (OIASA) in the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Ms. Mackay-Smith has also directed activities supporting SAMHSA's substance abuse prevention grant programs with resources and technical assistance in planning, implementing, evaluating, and promoting effective, data-driven prevention programs at the community and State/Tribal levels. Before joining SAMHSA, Ms. Mackay-Smith directed a national resource center for campus-based substance abuse and violence prevention, and prior to that served in a variety of positions in higher education, non-profit, and research organizations.

Juanita M. Mendoza is a member of the Pascua Yaqui Tribe of Arizona. She currently works as a program analyst at the Bureau of Indian Education where she focuses on policy development and assists with multiple federal partnerships. She has extensive experience working with Native American leaders, administrators, and citizens on a wide array of issues. Juanita has focused on Native language preservation, Indian education, gaming, and legislation and policy development during her career. Juanita attended the University of Maryland where she received a bachelor of arts in anthropology. She also completed a master's degree in management with an emphasis in health care administration and policy at the University of Maryland University College.

Rose Weahkee is a member of the Navajo Nation from Crownpoint, New Mexico. She is of the Tangle Clan born for the Mexican People. Dr. Weahkee received her Doctorate in Clinical Psychology with an emphasis in multicultural community clinical issues from the California School of Professional Psychology. She is currently the Director for the Indian Health Service Division of Behavioral Health. She has also served as the Behavioral Health Consultant for the IHS California Area Office and the Administrative Clinical Director for United American Indian Involvement. Dr. Weahkee has served on numerous boards at the local, state, and federal level advocating on behalf of American Indian and Alaska Native issues.

Stephanie Craig Rushing is a Project Director at the Northwest Portland Area Indian Health Board. Dr. Rushing contributes to community-based participatory research activities at the regional and national level, focusing on adolescent health. She and her team have developed several InterTAPs, which she will share with you today. She completed her Master of Public Health degree with a concentration in international health development at Boston University, and her doctorate in public administration and policy at the Hatfield School of Government at Portland State University, focusing on community health and social change.

B. J. Boyd is an enrolled citizen of the Cherokee Nation and is the Director of Behavioral Health Services for the Cherokee Nation, where he oversees both clinical operations and community-based prevention programs. He also currently serves on the Oklahoma Commissioner of Mental Health and Substance Abuse Services' Planning & Advisory Council. As an adjunct professor of psychology at Oklahoma State University, he serves as a member of the advisory council for the American Indians into Psychology program. Dr. Boyd received his Ph.D. in clinical psychology from Oklahoma State University in 2003.

Levi Keehler is an enrolled member of the Cherokee Nation and is the Associate Director, Director of Prevention, and Substance Abuse Treatment Advisor for Cherokee Nation Behavioral Health. He earned his Master's Degree from Northeastern State University in Tahlequah, Oklahoma and is a Licensed Professional Counselor, Licensed Alcohol and Drug Counselor, and Certified Prevention Specialist in the State of Oklahoma. He is an adjunct professor in the Counseling and Psychology Department and a guest lecturer for the School of Social Work at his alma mater. He has presented internationally on drug abuse and Native American issues.