ALPHA Resolution

2009-05 Support for an Institute of Medicine Report Regarding Mental and Behavioral Health Issues in Alaska and Other Parts of the Arctic

WHEREAS the Institute of Medicine of the National Academies (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public;[i] and

WHEREAS the IOM provides advice on a wide range of topics from the quality of medical care to conflicts of interest in medical research, from malaria treatment to environmental hazards, and from vaccine safety to childhood obesity;[ii] and

WHEREAS, since 1970, when Congress established the IOM as the health arm of the National Academy of Sciences, the IOM's recommendations have shaped health policies to improve the lives of millions of people around the world;[iii] and

WHEREAS the IOM applies the National Academies' rigorous research process, aimed at providing objective and straightforward answers to difficult questions of national importance using committees of leading national, international scientists, stakeholders and those with special knowledge of the topic all of whom serve pro bono in the development of IOM's consensus reports; [iv]and

WHEREAS the committee's task is developed in collaboration with the study's sponsor, which may be a government agency, a foundation, or an independent organization;[v] and

WHEREAS once the statement of task and budget are finalized, the committee works independently to come to consensus on the questions raised;[vi] and

WHEREAS as a final check for quality and objectivity, all IOM reports undergo an independent external review by a second, independent group of experts whose comments are provided anonymously to the committee members.[vii]

WHEREAS a consensus report which may include findings, conclusions, and recommendations based on available scientific evidence, reflects a committee's agreement following deliberations;[viii] and

WHEREAS investigations have been conducted on a variety of populations in other Arctic regions including Canada, Finland, Norway, and Russia and some studies indicate high rates of depression, anxiety, and alcohol abuse and seasonal shifts in mood for adults as well as children; [ix] and

WHEREAS mental and behavioral health indicators reveal rates of obesity, smoking, alcohol use and suicide in Alaska that are above national averages[x]; and

WHEREAS the Alaska Suicide Follow-back Study Final Report provides data collected on 426 suicides from September 1, 2004 – August 31, 2006,[xi]

WHEREAS the average annual suicide rate for Alaska for the three year study period was 21.4/100,000 (U.S. Census, 2005 estimated population) and in 2004, there were 155 suicides in Alaska, giving Alaska the highest rate in the U.S. The suicide rate for Alaska was 23.4/100,000 population, more than double the U.S. rate of 11 per 100,000.[xii] and

WHEREAS amongst those having committed suicide, males out-numbered females 4 to 1 in the study[xiii]; and

WHEREAS Alaska Natives had a significantly higher average rate of suicide than the non-Native population (51.4/100,000 compared to 16.9/100,000)[xiv]; and

WHEREAS during the three year reporting period suicides in 20-29 year olds in Alaska had the highest rate at 46.4/100,000,followed by 30-39 at 27.8/100,000. Nationally, suicide rates in the 20-29 age group is ranked in seventh place[xv]; and

WHEREAS although Alaska Natives comprise 16% of the population, they accounted for 39% of the suicides. The ethnic disparity is even greater for Alaskan youth 19 and younger, where, over the past 15 years, Alaska Natives accounted for 19% of the youth population and 60% of the suicide deaths in that age group[xvi]; and

WHEREAS a collaborative effort by the Alaska Department of Health and Social Services, the Centers for Disease Control and Prevention, and the Indian Health Service in the early 1990s to ascertain cases of Fetal Alcohol Syndrome and determine the prevalence in Alaska Natives resulted in a synthesis of various research efforts on the topic leading to other studies and state and federal funding for fetal alcohol syndrome prevention efforts and services; and

WHEREAS the Alaska Public Health Association is committed to promoting sound health policy, reducing health disparities and improving health outcomes for Alaskans, and

WHEREAS the Alaska Public Health Association recognizes the potential benefits of an Institute of Medicine consensus report on mental and behavioral health issues in Alaska and the Arctic that would examine the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations people living at high northern latitudes[xvii];

NOW THEREFORE BE IT RESOLVED that the Alaska Public Health Association is in support of efforts to secure funding ($1.2 million minimum) from state, federal and local sources for an Institute of Medicine report of mental and behavioral health issues, including suicide, in the Arctic with a special emphasis on Alaska:

AND BE IT FURTHER RESOLVED that the Alaska Public Health Association will promote and advocate support for the study through:

- Posting of ALPHA resolutions on the Alaska Public Health Associations's website and/or making this resolution available
- Distribution of this resolution statement to policy makers, key decision makers and funders in the Alaska Native community, State of Alaska, Alaska legislature, University of Alaska, and the Alaska federal legislators.

Fiscal and Public Health Impact Statement: This action will result in minor costs associated with sending this resolution and accompanying cover letter to the Governor and key political leaders. This action will benefit public health by promoting an examination of the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations in Arctic regions, with a focus on Alaska.

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[i] Institute of Medicine Webpage, October 19, 2009. http://www.iom.edu/About-IOM.aspx.
[ii] Institute of Medicine Webpage, October 19, 2009. http://www.iom.edu/About-IOM/Making-a-Difference.aspx.
[iii] Ibid.
[iv] Institute of Medicine Webpage, Occtober 19, 2009. http://www.iom.edu/About-IOM/Study-Process.aspx.
[v] Ibid.
[vi] Ibid.
[vii] Institute of Medicine Webpage, October 19, 2009. http://www.iom.edu/About-IOM/Study-Process.aspx.
[viii] Ibid.
[ix] Draft Developing Project: Mental and Behavioral Health Issues in the Arctic. The National Academies Polar Research Board and Institute of Medicine Board on Health Sciences Policy.
[x] Centers for Disease Control and Prevention, National center for Chronic Disease Prevention and Health Promotion (2003). *Trends Data.* Behavioral Risk Factor Surveillance System. Accessed 1/5/2004 at http://apps.nccd.cdc.gov/brfss/Trends/TrendData.asp?state=US&qkey=10110&state_c=AK&grouping=1.
[xi] Alaska Suicide Follow-back Study Final Report, February 2007. Alaska Injury Prevention Center, the Critical Illness and Trauma Foundation, Inc., and the American Association of Suicidology. http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/sspcfollowback2-07.pdf

[xiii] Ibid.
[xiv] Ibid.
[xv] Ibid.
[xvi] Ibid.
[xvii] Draft Developing Project: Mental and Behavioral Health Issues in the Arctic. The National Academies Polar Research Board and Institute of Medicine Board on Health Sciences Policy.

About the Institute of Medicine

WHO WE ARE

The Institute of Medicine (IOM) is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public. Established in 1970, the IOM is the health arm of the National Academy of Sciences, which was chartered under President Abraham Lincoln in 1863.

Nearly 150 years later, the National Academy of Sciences has expanded into what is collectively known as The National Academies, which comprises the National Academy of Sciences, the National Academy of Engineering, the National Research Council, and the IOM.

OUR MISSION

The Institute of Medicine serves as adviser to the nation to improve health.

OUR WORK

The IOM asks and answers the nation's most pressing questions about health and health care. Our aim is to help those in government and the private sector make informed health decisions by providing evidence upon which they can rely. The IOM applies a distinct research process to provide objective and straightforward answers to difficult questions of national importance. Committees who conduct these studies are carefully composed to ensure the requisite expertise and to avoid conflicts of interest. These leading national and international scientists, all of whom serve as volunteers, are asked to set aside preconceptions and to rely on evidence in their pursuit of knowledge and truth.

Many of the studies that the IOM undertakes begin as specific mandates from Congress; still others are requested by federal agencies and independent organizations. While our expert, consensus committees are vital to our advisory role, the IOM also convenes a series of forums, roundtables, and standing committees, as well as other activities, to facilitate discussion, discovery, and critical, cross-disciplinary thinking.

Each year, more than 2,000 individuals, members, and nonmembers volunteer their time, knowledge, and expertise to advance the nation's health through the work of the IOM. Membership in the IOM is offered to 65 individuals each year, elected by the current membership, and drawn from a range of health care professions; the natural, social, and behavioral sciences; and fields such as law, economics, administration, engineering, and the humanities. For those at the top of their field, membership in the IOM reflects the height of professional achievement and commitment to service.

"In a world full of complex and conflicting health information, the Institute of Medicine is a beacon to those seeking objective, evidence-based guidance."

—Harvey V. Fineberg
President, Institute of Medicine

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the Nation. Improving Health.

Mental and Behavioral Health Issues in the Arctic

Institute of Medicine

Board on the Health of Select Populations

Board on Health Sciences Policy

Division of Earth and Life Sciences
Polar Research Board
National Academies

SUMMARY

In recent years there has been significant improvement in the general health of the Arctic resident populations, but significant health disparities remain, especially between native populations and populations on the whole. These health disparities, in part, account for a shorter life expectancy and increased mortality related to suicide and accidents in Arctic residents, compared to residents in more temperate climates. Although Alaskans face many of the same behavioral and mental health issues faced by communities in other states, the severity of many of the problems is often greater and there are special challenges posed by the remoteness of many communities. Some of the health problems of greatest concern include, but are not limited to elevated suicide prevalence, child abuse/neglect, and sexual assault, abusive alcohol use, high prevalence levels of Fetal Alcohol Spectrum Disorder, high incidence of diabetes, high blood pressure, and high rates of unintentional injuries. As described in the Arctic Monitoring and Assessment Program's 2002 assessment of human health in the Arctic, the younger age structure of the Alaskan population makes the State's communities particularly vulnerable; however, it also provides an opportunity for establishing treatment programs that emphasize resiliency and preventive measures for behavioral and mental health promotion. Many agencies and organizations have recognized the need to invest in further research and improve current services. There is also increased attention to the issue of appropriate training of health care providers. Coordination of these efforts will provide a maximal benefit to the effected communities.

POLICY CONTEXT

The indigenous populations and other residents of the high northern latitudes face a variety of mental and behavioral health and health-related social issues. Although many of these issues parallel those faced by residents of other rural areas, and are similar to those faced by other Native American populations in the lower 48 states, the problems in Alaska are compounded by the challenging physical environment (including extreme cold and photoperiod changes) and limited availability of and access to health services in the region, and aggravated by the rapid social changes of the past few decades.

The Arctic Research and Policy Act, passed in 1984 (PL 98-373) and amended in 1990 (PL 101-609) was enacted to establish national policy, goals, and priorities for Arctic research. The act established the Arctic Research Commission and an Interagency Arctic Research Policy Committee (IARPC). The Commission publishes a report on goals and objectives every two years to help guide the activity of the IARPC and its member federal agencies. In its 2009 report the commission outlined several research program recommendations. In addition to studies of the Arctic Region, Bering Sea Region, and research on resource evaluation and civil infrastructure, the commission called for studies on the health of Arctic residents (USARC, 2009).

The Commission's recommendation for a program of research on Arctic health calls for a focus on mental health in the Arctic since behavioral problems such as alcoholism, drug use, suicide and accidents are among the most frequent causes of ill health and death in Arctic populations (USARC, 2009). The commission recommended that the IARPC begin planning an interagency program to coordinate and emphasize research on mental health concerns in the Arctic, with the National Institutes of Health as the focal point for the effort.

TECHNICAL CONTEXT

The eight nations with territory and populations in the Arctic are Canada, Denmark, Finland, Iceland, Norway, the Russian Federation, Sweden and the United States of America. In the United States, the health of our northern residents in Alaska depends on many factors. Essential infrastructures, such as housing, water, waste, energy, and transportation systems, are far more difficult to design and provide than in temperate regions, bringing a variety of health implications. Providing adequate health care in rural areas of the Arctic is equally challenging.

The issue of mental health care for northern residents has been called a "neglected disparity." Certain behavioral health indicators in Alaska such as binge drinking, and alcohol induced deaths are considerably higher than the national norm. (DHSS Alaska 2008). Sexually transmitted diseases are increasing dramatically (Wooley, 2008). Rates of obesity and diabetes among Alaskans are increasing as well (CDC, BRFSS).

Rates of suicide in Alaska are also among the highest in the nation. The state ranked 3rd in death rates by suicide in 2006, at 19.9 deaths per 100,000 people (Centers for Disease Control and Prevention, National Center for Health Statistics, 2006). Within the state of Alaska, rates of suicide by Alaska Natives were much higher than rates for non-Native Alaskans. Since 2005 the suicide rate has been increasing despite the best efforts of the State of Alaska, the Alaska Mental Health Trust and private groups. The suicide rate is much higher among the Native Alaskan Population. The Native Alaskans comprise 16% of the population but had 39% of the suicides during the study period 2003-2006. The suicide deaths per 100,000 for Alaska Natives was 51.4 per 100,000 compared to 16.9 per 100,000 for non Natives. (Alaska Suicide Prevention Council, 2006). A story from the Anchorage Daily News quoting Alaska's Bureau of Vital Statistics indicated that the suicide rate had increased 4 years in a row in Alaska and that

the current rate is 24.6 per 100,000, the highest rate in a decade, and a 25% increase since 2005 (Hopkins 2009).

The suicide incidence in Alaska natives is highest among their youth. In replies to a recent survey questionnaire of Alaska, an astonishing 35% of both native Alaskan boys and girls stated they had "made serious plans to take their lives in the prior year" (CDC, Alaska Youth Survey 2007). Alaska Native youth less that age 19 year old comprise 19% of Alaska's population in that age range yet 60% of the suicides during the past 15 years (Alaska Suicide Prevention Council, 2006). The Alaskan native males aged 15-25 years seem to be at especially high risk.

It is estimated that 10 percent of Alaska's children and youth have severe emotional disturbances and 6.2 percent of the adult population under age 55 have severe mental illness (Alaska Department of Health and Social Services, 2001). Access to care is limited by financing shortages of both the mental health systems and its clients, and by shortages in mental health personnel in rural areas. Lack of services lead many to have contact with the criminal and legal systems. The Department of Corrections is the largest provider of mental health care in the state (Alaska Department of Health and Social Services, 2001). While Alaskans have a higher incidence of mental and behavioral health disorders, a 2000 study by the Substance Abuse and Mental Health Services Administration places Alaska as the state with the third highest unmet need for substance abuse treatment (University of Alaska, 2004).

The international literature shows similar problems for northern residents more broadly. Suicide incidence data for Canadian and Greenland native residents are similarly excessive.(Haggerty 2008; Bjerregaard 2006). Investigations have been conducted on a variety of populations in other Arctic regions including Canada, Greenland, Finland, Norway, and Russia and studies indicate high rates of depression, anxiety, and alcohol abuse (Haggarty et al., 2000) and seasonal shifts in mood for adults (Haggag et al., 1990; Haggarty et al., 2002;; Bjerregaard 2004; Nayha, Vaisanen, and Hassi, 1994) as well as children (Sourander et al., 1999).

Although a great number of Northern Residents are at risk and experience mental and behavioral health complications there is also a portion of inhabitants who are resilient to these risk factors. These differences can be seen not only between individuals but between communities or villages suggesting an important socio-cultural component to the resilience. It is unclear what makes some individuals or villages more resilient to the same factors that put so many others at risk. With few exceptions, there is no current, compelling framework that guides development of a primary prevention approach for mental illness or addictive disorders. That is, it is not known which societal strategies should be pursued to fundamentally lower incidence and prevalence of these disorders. These might include modifications in housing, socioeconomic status, education, environmental hazards, behavior and violence.

In Alaska, multiple Federal, State and Local agencies and in some cases in collaboration with international agencies, such as the Canadian Ministry of Health, are

involved in promoting, preventing and treating mental and behavioral health disorders. Each one of these agencies comprises a critical piece of the infrastructure that supports and maintains the health of Alaskans'. For example, within the Federal government there at least five agencies active in providing assistance, including the Indian Health Service, Centers for Disease Control, National Institutes of Health, National Science Foundation, and the Health Resources and Services Administration. In addition there are well over 20 non-federal agencies involved in behavioral health services in Alaska. Therefore a coordinated effort among the various agencies and organization will be needed.

Researchers in the behavioral and social sciences are exploring resilience factors that allow better coping and recovery from social and physical trauma. Research in neuroscience is identifying mediators and mechanisms of altered brain functioning and behavior. Community based researchers are employing educational programs that center teaching cultural values and traditions within the context of the modern society. Medical research is finding new approaches to diagnose and pharmacologically treat depression.

Focused research is desperately needed to identify more effective and comprehensive strategies for promoting resilience and recovery in individuals who live in the Northern communities. Despite many trials of intervention or "pilot programs" there is little effectiveness testing of interventions and no interventions have been scaled up to a statewide level The mental health research agenda for Northern residents is much broader than can be accommodated by a single funding agency. Despite the enormity of the problem a minuscule amount of funds are devoted to mental health research in Alaska. Need data here if possible; NIMH less than $50,000/yr; perhaps the Mohatt group can give an estimate of total mental health Research funding.

PLAN OF ACTION

Statement of Task

This study will examine the science base, gaps in knowledge, and strategies for the prevention and treatment of mental and behavioral health problems faced by populations in Arctic regions, with a focus on Alaska. Specifically, the committee would:

1. Summarize the scope and nature of mental and behavioral health problems among residents of Arctic regions, with special emphasis on Alaska and Alaska Natives.

2. Assess the infrastructure for research into the mental and behavioral health issues in Alaska to determine if current mechanisms and resources are appropriate to facilitate progress in the field. This should include an analysis of which federal agencies are funding research programs and the mechanisms used for recruitment and selection of proposals and assessment of their value?

3. Describe factors that contribute to promoting resilience and recovery in Northern residents. Learn if any of these have been robustly tested for effectiveness. Learn if any of these have been scaled up beyond a single village to regions and states. Have any scaled up programs been tested?

4. Provide recommendations for strategies of implementation and testing of programs designed to increase resilience in the affected populations and reduce health disparities.

5. Describe and assess the infrastructure for prevention and treatment of mental and behavioral health in Alaska; including federal, state and community based programs. Special emphasis will be given to suicide prevention programs and in examining the usefulness and effectiveness of native health workers in rural communities using technologic assistance in making psychiatric diagnoses, and instituting surveillance using telepsychiatry in arctic rural areas. This should include examination of collaborative efforts and discussion of ways to improve coordination between the multiple public and private agencies involved in promoting improved mental and behavioral health. The testing of pilot programs for effectiveness will be emphasized, and the scaling potential of pilot therapeutic efforts will be examined.

6. Identify steps that could be taken in the short- , medium-, and long-term to improve the mental and behavioral health of northern US residents, including research needed to understand the impact of abrupt Arctic climate change and rapid social changes on mental and behavioral health, improvements in community infrastructure directly related to health, changes in prevention and treatment programs, and mechanisms to improve selection and training of personnel for mental and behavioral health care services. Special emphasis will be made on the use of telepsychiatry to augment these efforts.

EXPERTISE REQUIRED

Expertise required includes mental and behavioral health, suicidology, community- based health research, Alaska Native culture, medical care delivery in the arctic (including IHS and the ANTHC), sociology, academic, health promotion and prevention, substance abuse, family violence, epidemiology and biostatistics, information technology and telepsychiatry, academic training and health policy. This study will also include international perspectives from other Arctic nations grappling with these problems.

CONSIDERATION OF BALANCE

The committee will be selected to ensure the presence of native Alaskans and individuals with expertise in a variety of fields, with knowledge of mental and behavioral health in Arctic regions including Alaska.

PRELIMINARY WORK PLAN

The IOM (BSP/HSP) and NRC (BPR) proposes to assemble a study committee of 12 to 14 experts knowledgeable in the fields of mental and behavioral health, suicidology, community- based health practice and research, Alaska Natives, medical care (IHS and ANTHC, CDC, etc), sociology, academic, health promotion and prevention, substance abuse, family violence, epidemiology and biostatistics, academic training and health policy. Committee nominations will be solicited from the Academies membership, relevant organizations and associations, federal and Native agencies, and other experts and stakeholders. Special efforts will be made to consider experts familiar with the Native American social and cultural attributes. The committee will meet over an 18 to 24 month to period in order to assess the scope and nature of mental and behavioral health problems among residents of Alaska and Arctic regions of other nations, and make recommendations to improve the mental and behavioral health of northern US residents through research, education and training, and practice as well as advanced technology including telepsychiatry.

The committee will hold five meetings throughout the course of the study. The first full committee meeting will be held in Alaska and will involve the required bias and conflict of interest discussion as well as clarifying the important tasks of the study. In addition the committee and staff will break up into small 2-3 person teams and visit selected arctic communities to speak with the local Native Alaskans and observe first-hand the environmental context of the complex and difficult issues under study. Their observations will be reported back to the committee as a whole. Each of the next two meetings will be held in conjunction with a workshop; each workshop will be dedicated to data gathering and identification of current knowledge and information gaps. At least one of the two workshops will be held at a location in the northwest, such as Seattle, where it would be easier for relevant experts from Canada, Alaska, and other arctic areas to converge. The specific topics to address in the workshops will be determined at the first meeting of the committee. The final two meetings will be devoted to formulating the recommendations, writing, and reviewing the report.

As part of the study process, the committee will: a) critically review published literature, b) convene public workshops at which leading mental and behavioral health professionals and scientists will summarize current knowledge and identify critical questions and possible solutions, and c) interview the leaders of community, state and federal programs regarding the infrastructure needs required for improved research, education and training, and medical treatment. d) make site visits to selected Alaskan communities to obtain first hand knowledge and understanding of the behavioral and mental health issues, assess barriers to their mitigation, and to receive feedback from local residents. The committee also will commission international leaders in Arctic mental and behavioral health to supply in-depth analyses on specific aspects of the study charge. The committee will produce a report of value to the State of Alaska and the Alaska Mental Health Trust as a blueprint for future research and change. During the review phase IOM will be select some reviewers from Alaska intimately familiar with local values and programs. Public release will take place in Alaska with representatives of Alaskan native community present.

Month 1	**Project Start (NOTE: Projects cannot begin until receipt of funds)**
Month 1 - 3	**Committee Nominations and Selection Process** **Plan meeting 1 and first workshop** • Advance meeting with Chair of Committee • Chair and staff to develop preliminary draft report outline with input from committee • Assemble background materials and distribute agenda book
Month 3	**1st meeting, 4 days (Alaska)**: • Committee will meet for 4 full days, split between open and closed session • Workshop on the Public Health Impact of Arctic Mental and Behavioral Health, and State and Community Based Programs • Charge to the committee • Orientation to IOM and NRC process • Briefings from sponsor regarding expectations and needs. • Discussion of statement of task, study plan, timeline • Discussion of data needs and methods • Develop a report outline and work assignments • Organize working/writing groups • Plan meeting 2, including 2nd workshop • Site visits to selected communities 2.5 days.
Month 4	• One or more committee teleconferences will be used to expedite progress. • Information gathering and writing assignments. • Follow-up on assignments from meeting #1 • Prepare site visit reports • Commission additional background papers? • Collect, review, and distribute background materials • Data collection and analysis • Assemble and distribute agenda books for meeting #2
Month 5	**2nd meeting, 3 days (Northwest Regional Area- like Seattle)** • Committee will meet for 3 full days, split between open and closed session • Workshop on Federal and International based Mental and Behavioral Health Programs • Begin drafting report, identify information needed, writing assignments, draft preliminary findings • Plan meeting 3
Month 6	• Committee prepares draft sections • Teleconference calls with working groups • Reference verification • Assemble and distribute agenda books (first draft)
Month 7	**3rd meeting, 2 days (Washington, DC):** • Review commission paper • Review draft sections and finalize report outline

Month 8	• Committee prepares first draft • Teleconference calls with working groups • Draft Executive Summary and Preface, laying out themes • Reference verification • Assemble and distribute agenda books (first draft)
Month 9	**4th meeting, 2 days (Washington, DC)**: • Committee reviews first draft • Review conclusions and recommendations • Complete information gathering • Outline Executive summary
Month 10 - 11	• Committee prepares second draft • Draft Executive Summary and Preface • Finalize data analysis • Reference verification • Prepare graphics for report • Assemble and distribute agenda books (second draft)
Month 12 - 13	**5th meeting, 2 days (Washington, DC)**: • Plenary review and discussion of final draft • Committee sign-off for review
Month 14	Final Report compiled. Committee review finalize findings. Committee sign-off that report is ready for review.
Month 15 - 16	**External Review:** Final Report prepared, cleared by NAS, and sent to external review (2 weeks).
Month 16	**Response to Review:** Committee response to review comments (email and teleconferences). Final editing. Academy RRC approval that final report is acceptable for release. Preparation of prepublication copies.
Month 17	Release Final Report at a Native Community of Alaska site with distribution to Alaskan state government, other Alaskan agencies (Mental Health Trust, ANTHC, etc); USARC; relevant federal agencies; and the general public. Further dissemination activities as needed.
Month 21	Published volume available. Additional dissemination as needed.

PRODUCT AND DISSEMINATION PLAN

All reports will be prepared subject to the standard NRC and IOM review procedures. Reports resulting from this effort shall be prepared in sufficient quantity to ensure their distribution to the sponsor and to other relevant parties, in accordance with Academy policy. Project staff will coordinate with the NRC Office of News and Public Information to produce materials appropriate for dissemination to interested audiences. The report will be made available to the public without restriction and will be posted on the NAS World Wide Web site.

FEDERAL ADVISORY COMMITTEE ACT

The Academy has developed interim policies and procedures to implement Section 15 of the Federal Advisory Committee Act, 5 U.S.C. App. § 15. Section 15 includes certain requirements regarding public access and conflicts of interest that are applicable to agreements under which the Academy, using a committee, provides advice or recommendations to a Federal agency. In accordance with Section 15 of FACA, the Academy shall submit to the government sponsor(s) following delivery of each applicable report a certification that the policies and procedures of the Academy that implement Section 15 of FACA have been substantially complied with in the performance of the grant with respect to the applicable report.

PUBLIC INFORMATION ABOUT THE PROJECT

In order to afford the public greater knowledge of Academy activities and an opportunity to provide comments on those activities, the Academy may post on its website (http://www.national-academies.org.) the following information as appropriate under its procedures: (1) notices of meetings open to the public, (2) brief descriptions of projects, (3) committee appointments, if any (including biographies of committee members), (4) report information, and (5) any other pertinent information.

ESTIMATED COSTS

The total estimated cost of this study is $XXXX for 21 months. The period of performance is expected to be 4/1/10 to 12/30/11

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