

**Intentional Injuries in American Indian
Communities: A Report with Recommendations**

Submitted to:

The National Injury Prevention Tribal Steering Committee

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EXECUTIVE SUMMARY

Approximately 1.5% of the U.S. population—4.1 million Americans—claim American Indian or Alaska Native heritage. Many Native American communities demonstrate significant strength by maintaining much of their traditional culture including language, social and religious functions, structures and ceremonies. However, many Native communities also face enormous challenges to their health and social well-being. American Indians and Alaska Natives die at an earlier age and at a higher rate proportionately compared to the rest of the US population. Many of these deaths are considered excess death--deaths that would not have occurred if American Indian/Alaskan Native death rates were comparable to those of the total population. The Indian Health Service has identified seven causes of death that result in excess mortality for American Indians including homicide, suicide, and alcohol¹.

In this report, we address some of the micro and macro issues related to the excess deaths among American Indians by examining suicide, intimate partner violence, sexual assault, and child abuse and neglect among Native Americans. Being aware of some disagreement over the terminology used to identify the aboriginal people of North America, we have chosen to use American Indians, Indian people, Native Americans and native populations interchangeably throughout the report. One of the challenges for the

¹Andrew, M.M., & Krouse, S.A. (1995). Research on excess deaths among American Indians and Alaska Natives: A critical review. *Journal of Cultural Diversity*, 2(1), 8-15.

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intervention and prevention of family violence and suicide prevention among American Indians is the need to be aware of and integrate cultural relevance and social sensitivity of diverse tribal groups. We recognize that American Indians represent a heterogeneous population with more than 500 tribes and 200 different spoken languages. Rates of suicide and family violence, as well as risk factors and prevention and intervention programs, will vary widely between tribal groups as well as individuals within a tribal group.

General recommendations

- Intentional violence in American Indian communities is an issue that needs to be addressed by examination and reflection of a tribal community's core values, strengths and weaknesses.
- Recognition and attention to differences across tribal communities and inclusion of tribal leaders and members in the development of effective prevention programs is needed.
- General socioeconomic development is needed to improve the income, education and social opportunities for American Indians, which will in turn, enhance the ability of individuals and communities to cope with social and cultural challenges and lower the rate of intentional violence.
- Increased funding is warranted for quantitative and qualitative studies related to intentional violence among American Indians. Programs for the prevention and intervention of intentional injury among American Indian populations should be developed, tested, expanded, implemented and disseminated through funding from appropriate federal, state, tribal, and private agencies.

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- Improve accessibility and acceptance of clinical and preventative services, by increasing access to both Western and traditional services needs to American Indians on and off the reservation.
- Programs aimed at intervening and preventing intentional violence in tribal communities must recognize that these issues are interrelated; as a result, these efforts should not be fragmented but integrated with efforts to ameliorate substance abuse as well as efforts to alleviate poverty.

Suicide in American Indians

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SUICIDE IN AMERICAN INDIANS

Introduction

Suicide is a major public health problem in the United States. Every year, approximately 30,000 people die by suicide and 650,000 people receive emergency treatment for a suicide attempt (Moscicki, 1999). Suicide is the third leading cause of death among youth, aged 15 to 18 years, and the 11th for people of all ages (Moscicki, 1999). Suicide is defined as a “fatal self-inflicted destructive act with explicit or inferred intent to die.”(Institute of Medicine, 2002; pg.27). In the past century, the number of reported suicides has been higher than the number of reported homicides (Institute of Medicine, 2002). Biological, psychological and social/cultural factors all have a significant impact on the risk of suicide.

The rates of suicide among some populations are exceedingly high; for example, American Indian and Alaska Natives² experience the highest suicide rates of all ethnic groups in the US. The rate of suicide among Native Americans in the United States is approximately 1.7 times higher than the rate of the nation as a whole (Indian Health Service, 1999). Suicide is the sixth leading cause of death among American Indians (Andrew & Krouse, 1995). Clearly, self-destructive behavior, including suicide and suicide attempts, are a significant health and social problem in many Native American communities. This section of the report synthesizes the epidemiological patterns and risk factors associated with suicide among American Indians, barriers to research and mental

² Native Americans, American Indians, indigenous peoples and Native populations are used interchangeably throughout this document to refer to the Native peoples of continental US and Alaska.

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health services and recommendations for research and practice. Our recommendations arise from the current literature as well as interviews with practitioners and academics in the field of suicide prevention.

Epidemiological Patterns

The Indian Health Service serves approximately two-thirds of all Indians living on and near reservations and provides the most complete records of completed suicides for American Indians (Andrew & Krouse, 1995; Middlebrook, LeMaster, Beals, Novins & Manson, 2001). Most studies among Native Americans have been reservation based. Unfortunately, data for American Indians living in urban environments is not readily available due to difficulties in correctly identifying race and ethnicity on death certificates (Middlebrook et al., 2001). In addition, data on suicide attempts is scarce for the nation as a whole and in particular for American Indians. Recent Indian Health Service data (1998 and 1999) shows that the overall age-adjusted suicide rate for the American Indian population was 19.3/100,000, approximately one and half times higher than the rate of 11.2/100,000 for the US general population. The overall rate of suicide for American Indians hides a disturbing trend, the excess of suicide deaths among adolescent and young adults; especially males aged 15-24 years. The adjusted rates of suicide death for that age group (37.1/100,000) is 2.5 times higher than the rate for those same-aged individuals in the general population (Wissow, 2000).

Tribes vary widely in reported suicide rates, with some tribes reporting an annual suicide rate as high as 150 per 100,000 and others reporting a rate as low as zero per 100,000 (Range et al., 1999). Some of the fluctuation or differences is due to suicide “clusters”, in which one completed suicide appears to act as a trigger for others over a

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relatively short time interval; it appears that in many American Indian communities, there is a tendency for suicides to occur in clusters that can be considered an epidemic particularly among youth (Bechtold, 1994; Keith et al., 1996; May, 1990). Information on suicide clusters among American Indians is scarce but appears to be related to imitative or suggestible behavior where one suicide might trigger one or more additional suicides among friends, relatives or others in a small relatively closed community (May, 1987). Three important factors have been put forth related to the phenomena of suicide clustering in Native communities; 1) suicide clusters appear to be largely limited to youth; 2) females appear more susceptible to the effects of clustering than do males; and 3) females are more likely than males to successfully commit suicide in the midst of a cluster (Bechtold, 1994). While suicide clusters have been reported among adolescents in geographically and socioculturally diverse locales across the United States, the magnitude (both in terms of the suicide rate and of the perspective of the small Native community) of impact is greater in American Indian communities compared to non-Indian communities (May, 1987).

While acknowledging tribal diversity in American Indian suicide patterns, May (1987), identified several general characteristics of American Indian suicides from more than 40 studies on suicide among various Indian groups. May noted that suicide among American Indians; (a) occurs primarily among young males; (b) Indian males tend to use highly violent or lethal methods such as firearms or hanging to commit suicide; (c) tribes with loose social integration which emphasize a high degree of individuality generally have higher suicide rates than those with tight integration that emphasizes conformity;

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and (d) tribes undergoing rapid change in their social and economic conditions and acculturation stress experience higher suicide rates than those who are not.

Generally, the risk factors for suicide among Native Americans are the same as for other populations. These include mental and addictive disorders, access to firearms or other lethal means, previous suicide attempt(s), physical or sexual abuse, recent and severe stressful life events, and intoxication (Moscicki, 1999). However, some risk factors are different and others differ in their importance for American Indian communities. For example, several studies have shown that previous suicide attempts, family disruption; loss of ethnic identity, and lack of identification of themselves as a religious or spiritual person places American Indian adolescents at risk for suicide, and that a more frequent relationship between alcohol and suicidal deaths occurs in American Indians compared to the general population (Borowsky, Resnick, Ireland & Blum, 1999; Middlebrook et al., 2001; May et al., 2002; Johnson & Tomren, 1999; Range et al., 1999). In addition, it has been shown that Indian youth exhibit more serious problems than other US ethnic groups in such areas as depression, anxiety, and general health (Cameron, 1999; Johnson & Tomren, 1999).

Acculturation and social change has been widespread in American Indian cultures, disrupting tribal unity and creating a challenge to the traditional way of life, values, and relational systems (Johnson & Tomren, 1999). For some tribal communities, acculturation has led to conflict resulting in chaotic families, child neglect, divorce, and alcoholism (Range et al., 1999). Several studies have found that in less traditional tribes where pressures to acculturate have been great and tribal conflict exists concerning traditional religion, governmental structure, clans and the importance of extended

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families, the suicide rate in the adolescent and young adult population is high (Johnson & Tomren, 1999; Range et al., 1999). The increase in chaotic families among American Indians is unfortunate as a recent study by Borowsky and colleagues (1999) found a protective effort of family connectedness and cohesion, and emotional health on suicidal behavior among American Indian youth. Interestingly, these authors also found that the probability of attempting suicide increased dramatically as the number of risk factors to which an adolescent was exposed to increased; however, increasing protective factors were more effective at reducing the probability of a suicide attempt than was decreasing risk factors. This has implications for prevention programs.

Suicide and Alcohol

Alcohol misuse is the leading and perhaps most costly risk factor among Native Americans today, especially in Indian populations. Indian populations experience a more frequent relationship between alcohol use and suicidal death (May et al., 2002). Surveys of Indian youth have found that they use alcohol as frequently as or more frequently than other youths in the U.S. (May and Moran, 1995). What may be the biggest difference between Indian youth and other youth is the age of first involvement with alcohol. For example, when compared with other youth, Indian youth's age of first involvement with alcohol is younger, the frequency and the amount of drinking is greater, and the negative consequences are more common (May & Moran, 1995). Similar to all youth, Indian youth who abuse alcohol report close ties to alcohol and drug abusing peers, poor school grades and attendance, weak identification with the Indian culture, a family history of alcohol abuse and little hope for the future (May and Moran, 1995).

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The body of literature on American Indians use of alcohol suggests that the continued use and harm of American Indians' use of alcohol is shaped by a number of factors, including cultural values, federal policies, the drinking styles of neighboring populations, socioeconomic differences within tribes and alcohol availability. Of these factors, controlling the supply or prohibition has been the most widely used and studied policy with mixed results reported. For example, Landen and colleagues (1997) found alcohol prohibition to be associated with lower rates of suicide in several Alaskan villages, while May (1986) reported higher rates of suicide associated with prohibition in reservations located in the lower 48 states.

Suicide and Mental Health

From the viewpoint of contemporary psychiatric research, suicide is largely explained as a complication of mental illness, personality and substance abuse (Wissow, 2000). While some studies suggest that American Indians, especially youth, appear to be at higher risk than other US ethnic groups for mental health problems, there have been relatively few published studies of the prevalence of mood disorders among Indian populations and the data have been contradictory. To date, no large-scale epidemiological studies of American Indians and mental health prevalence have been published (Cameron, 1999; Wissow, 2000; Manson, 2000).

Several small-scale mental health studies have been conducted among Cherokee children in the Great Smoky Mountains and among Northern Plain adolescents. These studies indicated that while the rates of mental health problems were similar to non-Indian children, the behavioral health service use patterns for Indian youth differed from non-Indian youth. For example, Cherokee youth were more likely to receive mental

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health treatment through the juvenile justice system and inpatient facilities compared to non-Indian children, despite the fact that free mental health services were available to Cherokee children through the Indian Health Services (Manson, 2000). Almost 60% of the Indian children in the Northern Plains study who met criteria for a psychiatric disorder never used treatment services during their lifetime (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Some investigators suggest that these differential service use patterns reflect funding emphases, programmatic biases, and organizational barriers, while others argue that cultural differences in beliefs about behavioral health services are more significant determinants of help-seeking behavior (Hoberman, 1992; Wallen, 1992). One model of youth suicide among American Indians involves children developing problems with conduct disorders early in life, gradually associating with more deviant members of their peer group, adopting the use of alcohol and or other drugs, and ultimately succumbing to stresses that result in suicide (Wissow, 2000).

Generally Native Americans, both adults and children, appear to suffer most from the most common risk factors for suicide--depression complicated by anxiety and the use of alcohol and other drugs. Other common mental health problems experienced by American Indians are major anxiety, including panic disorders, psychosomatic symptoms, and emotional problems resulting from disturbed interpersonal and family relationships (Nelson, McCoy, Stetter, & Vanderwagen, 1992). Mental health problems, including depression, among American Indians may arise from the difficult life circumstances many native families experience including poverty, inadequate employment, and minimal education opportunities. The relationship between ill health and socioeconomic status has been well documented and the disadvantaged

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socioeconomic conditions of American Indians may be an important contributing factor to their high death rates from suicide. In terms of income, education, and labor force activities, American Indians fare worse than their national counterparts. Approximately 30% of American Indians live below the poverty level in contrast to 13% for the US population while the median household income of American Indians families is two-thirds of the US population (IHS, 1997). Over three quarters of the US population obtains a high school degree compared to 65% of the American Indian population. Unemployment statistics show the same trend; 16% of American Indian males and 13% of American Indian females are unemployed compared to 6.5 for the US. In some parts of the IHS service units the unemployment rate is as high as 25% (IHS, 1997).

In addition, Native American individuals and communities face racial discrimination, geographic isolation, and cultural identity conflicts, which may lead to depression and other mental health problems. Some of these factors have historical roots including personal and group rejection in many forms, disenfranchisement, and relocation of entire communities from traditional lands to distant and often- barren reservation sites. Environmental circumstances, coupled with low self-esteem, substance abuse and life frustrations increase vulnerability to impulsive self-destruction acts among many American Indian individuals and families.

Prevention Efforts

Suicide Prevention Programs

Many tribes in partnership with Indian Health Service and other federal and private agencies have implemented programs related to suicide prevention and intervention and related problems but relatively few have been reported in the literature

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(Middlebrook, LeMaster, Beals, Novins & Manson, 2001). As a result, the effectiveness of most programs is unknown. Middlebrook and colleagues (2001) conducted a review of nine selected suicide prevention programs identified in the published literature. Five of the programs were developed and implemented specifically to address suicide rates in an American Indian community, while the other programs were part of broader spectrum efforts to address problem behaviors such as alcohol or other drug use and teen pregnancy.

None of the nine programs offered epidemiological evidence that the risk or protective factors targeted are statistically correlated with, precede, or mediate suicide. All programs provided some information regarding the risk status of the target population but few provided sufficient detail regarding how individuals were determined to be at risk. Only one program reported detailed information about the content intervention and none of the programs employed a random design; only two programs identified any type of research design (pre and post tests, and quasi experimental with intervention and no intervention). Four of the programs reported that process evaluation was being conducted and only one included any outcome data (changes in risk and protective factors). In summary, the authors found that information on the effectiveness of suicide programs among Native American communities is scarce. There are few descriptions of the programs in the literature, and even fewer with any type of evaluation effort or a specific research design. In addition, the generalizability of the results are limited, however the authors felt that core program components can be tailored to other Indian communities because many of the basic risk factors cross cut among Indian communities. The majority of programs identified in the review supported two themes; the need for

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cultural relevance in all aspects of program development, and implementation and the importance of community involvement. The authors cited the need for American Indian communities to be comprehensive when identifying ways of addressing the problem of suicide, considering suicide relationship with other life events. It is likely that other suicide prevention programs and interventions are conducted by and for American Indians but the results are not available in the published literature.

A conversation with Pat Serna, MSW, (personal communication, March, 24, 2003), Director of the Behavioral Health Unit for the Jicarilla Apache Nation, provided information on the Native American Community Suicide Center and Prevention Network, a five year project which ended in September of 2002. The Network, administered by the Jicarilla Apache Tribe, was formed so that Indian communities could help each other by providing suicide crisis and prevention assistance to Tribes throughout the US. Funded primarily by the Centers for Disease Control and supported by the Indian Health Service, the Network employed one full time staff person and trained 12 adults and 5 youth from geographically diverse Indian communities to provide crisis, prevention, and education assistance to Tribes throughout the US. These 17 community members were available at no costs to tribes who requested technical assistance from the Network. No clinical interventions were included in the program. In addition, a quarterly newsletter was sent to all tribes and area offices. Serna reports that the most valuable part of the program was the training of 17 community members and that many of the members are still offering assistance to their communities even though the Network is no longer receiving external funds. Funding from the Centers for Disease Control was approximately \$100,000/year for five years. The Indian Health Service

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contributed some funding for the first two years of the Network. The Jicarilla Apache Nation Behavioral Health Unit paid for the salary for Ms. Serna, who worked full time on the Network. Ms. Serna stated that the external funding was not sufficient to cover the costs of running the Network and that the Behavioral Health Unit at Jicarilla Apache Nation supported the network by not only funding her salary but also paying rent and utilities for the Network offices. Ms. Serna estimates that the Network probably needed \$350,000/yr to adequately address all the program objectives. Evaluation of the network consisted of process measures including the number of technical assistance calls received per month and number of on-site visits; no outcome evaluation was conducted. Ms. Serna reports that all tribes received a quarterly newsletter and that approximately 75 tribes received on-site technical assistance.

Alcohol Prevention Programs

In regards to alcohol prevention programs, May and Moran (1995) conducted an extensive review of health promotion efforts (both treatment and prevention) regarding alcohol misuse among American Indians. Their review found several protective factors that could be used to shape health promotion programs related to alcohol prevention. Among Indian youth, protective factors included a strong attachment to families where culture and school are valued and abusive drinking is neither common nor positively valued, and the ability to function well in both tribal society and the modern western world. Those youth who were able to move between Indian and western culture with little tension tended to have lower substance abuse rates compared with youth who identified only with one culture or with neither. This last factor was also found to be an important factor for adult chronic alcoholics in a treatment program on the Navajo

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reservation. The authors report that the more successful programs recognized the heterogeneity of American Indians; were relevant to local norms and values; were either led or included local leaders and advocates in the planning and implementation; used more than one strategy or approach; and were community based. Unfortunately, many of these programs examined lacked good documentation of their success. The authors stress the need for substance abuse programs to begin early in American youth's life to be the most effective.

Mental Health Prevention Programs

Ambulatory mental health services programs have been developed at more than 130 services units operated by either IHS or a tribal entity. Each service unit is responsible for a defined geographic area that may be a reservation or a population concentration. The most common model used by the service units is a crisis-oriented outpatient service staffed by one or more mental health professionals with the assistance of a local tribal mental health technician (Nelson, McCoy & Vanderwagen, 1992). At present, approximately 70 percent of the IHS Behavioral Health Unit's efforts and funds are geared to treatment rather than prevention of mental health problems (John Perez, personal communication, April 7, 2003). However, the Mental Health and Social Services program at IHS is transitioning to a community oriented clinical and preventive service program whose activities are part of a broader, multidisciplinary behavioral health approach where the behavioral health teams at IHS units are composed of psychologists, mental health counselors, psychiatrists, social workers, substance abuse counselors and traditional healers (<http://info.his.gov>, accessed February 10, 2003). Inpatient mental health services are still generally provided under contract with psychiatric units local

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general hospitals. There are few, if any, transitional living, or child residential mental health programs within IHS or tribal organizations; therefore these services must be obtained from local or state resources when available. Native healers are active in most Native American communities. Utilization of native healers is usually a private matter, although in many communities traditional medicine is coordinated with other health and mental health services (John Perez, personal communication, April 7, 2003).

Barriers

Recognition

Recognition of the impact of suicide in American Indian populations among federal agencies appears to be limited. For example, the multi-agency document, the *National Strategy for Suicide Prevention* (U.S. Department of Health and Human Services, 2001) contains only one graph and one paragraph on American Indians and suicide. Increased recognition is found in the Institute of Medicine Report-*Reducing Suicide: A National Imperative* (2002) where there are two pages devoted to the epidemiology of American Indian suicide and several pages on suicide prevention programs for rural American Indian communities. Compared to the magnitude of the problem among Indian populations, the lack of information in these national documents is concerning

Another barrier related to recognition is what program within the Indian Health Service is responsible for the prevention and treatment of suicide. The IHS is the principal federal health care provider and health advocate for Indian people, and currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states. Within the

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IHS, there are two divisions that are primarily responsible for reducing injuries-the Injury Prevention Unit and the Behavioral Health Services Unit. Historically, the role of the Injury Prevention Unit was to study and reduce unintentional injuries while the Behavioral Health unit was responsible for injuries related to alcohol and intentional injuries (Allan Dellapenna, personal communication, March, 25, 2003). These roles were confirmed by the Government Evaluation Performance Results Act (GEPR) that states the Behavioral Health Unit is responsible for and evaluated on their work with alcohol and intentional injuries while the Injury Prevention Unit is responsible for unintentional injuries. In addition, Dellapenna, acting Program Manager for the IHS Injury Prevention Program and John Perez, Director of the IHS Behavioral Health Unit (who has been the director for less than 6 months), who work for the same federal agency and in the same building in Rockville Maryland have not met to discuss how their two programs could work together to improve suicide prevention/intervention programs. These artificial separations cause turf issues not only at the headquarters level of IHS but also among the practitioners working in Indian country.

There appears to be better recognition of suicide among Native populations among two federally funded resources centers for suicide prevention. The Centers for Disease Control funded Suicide Prevention Research Center (SPRC) at the University of Nevada, is surveying suicide prevention activities in the intermountain states using a survey instrument that specifically asks about activities related to American Indians. In addition, surveillance activities in the Intermountain region conducted under SPRC includes information on American Indians (Lynne Fullerton-Gleason, SPRC Center Director, personal communication, March 20, 2003).

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The mission of the National Suicide Prevention Resource Center (NSPRC) funded by the Substance Abuse and Mental Health Services Administration is to further the implementation of the National Strategy for Suicide Prevention at national, state, and local levels (Lloyd Potter, NSPRC Principal Investigator, personal communication, March 26, 2003). In our discussion, Dr. Potter stated that the Center proposal was based on the epidemiology of suicide and what segments of the population are at risk and so consequently the Center has plans to work with tribal agencies and individuals as well as encouraging state agencies to work with tribal agencies in development of state suicide plans.

Funding

Decreased recognition of the problem among American Indians also affects funding. Overall, in the US, there has been in the past and is currently a mismatch in terms of the federal dollars devoted to the understanding and prevention of suicide contrasted with other diseases of less public health impact (Institute of Medicine, 2002). For example, national funding and efforts have been devoted to the problem of homicide in contrast to suicide, yet suicides in the US and among American Indians in particular, outnumber homicides by at least a third (Institute of Medicine, 2002).

How funds are allocated can be problematic. For example, tribal agencies often negotiate yearly for scarce resources, taking much time and effort to do so. Other times funding is not released until late in the fiscal year, limiting programs and operations. As a result, basic operating costs are constantly at peril, which can result in loss of trained staff and program momentum. This continuous battle for scarce and limited resources leaves American Indian communities at risk. In other areas of funding, such as the

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federal block grant monies, allocated for substance abuse and mental health services, Indian communities have always been included among populations that states enumerate as the basis for their respective allocations. However, the American Indian communities often have not shared proportionately in the services supported by the allocated funds. Recognition of the funding inequity led to a change in the authorizing language with the result that tribes could now apply directly to the Substance Abuse and Mental Health Agency (SAMSHA) for block grant funds to support substance abuse prevention and treatment services independent of the programs offered by the states in which they reside. No such provision is available with respect to mental health block grants.

Mental Health Treatment

There are significant barriers to receiving effective mental health services for American Indians living off and on the reservation. One of the barriers relates to funding--greater than one third of the demands on health facilities in Indian country involve mental health and social service related concerns yet the Indian Health Service line item mental health budget has hardly increased in last 20 years (Nelson, McCoy, Stetter & Vanderwagen, 1992). The Indian self-determination act (Public Law 93-638) provides tribes with opportunities to manage and operate own health and mental health programs which has improved sensitivity and responsiveness of mental health programs to local concerns. However issues of adequacy and accountability for mental health funds have been raised since the enactment of the public law. In addition, an increased emphasis is being placed on collection of third party revenues (e.g., private insurance, Medicaid, Medicare) by IHS mental health service programs. The third party revenues collected for mental health services are sometimes used to expand these services.

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However, more commonly, service units pool these collections with other funds and allocate them to areas of greatest perceived overall health needs, which may or may not include mental health services.

Many of the barriers around service accessibility relate to availability of mental health professionals (e.g., psychiatrists, doctoral level psychologists, psychiatric nurses, and social workers). For example, there are approximately 101 American Indian mental health professionals available per 100,000 American Indian population compared to 173 per 100,00 for the general population (<http://www.surgeongeneral.gov/library/mentalhealth/cre/fact4.asp>, accessed January 31, 2003).

Recruitment and retention of mental health treatment staff, particularly professionals, is often difficult. Salary levels for many professional disciplines in IHS programs are lower than those in the private sector. Many tribal programs pay considerably less than IHS and are therefore unable to attract or retain high-quality staff. The geographic isolation and harsh climatic conditions of some reservation and tribal locations can create problems of adaptation for some professional staff, particularly those who are non-native and who have little or no experience with Native Americans. The high demand for services in many mental health programs, combined with the complexity and seriousness of mental health needs, frequently results in high rates of burnout and turnover among mental health professionals. As a result, staffing of mental health professionals remains at less than 50 percent of what is needed to provide minimally adequate ambulatory mental health services to American Indians (Nelson, McCoy, Stetter & Vanderwagen, 1992).

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Availability of services does not mean that the services will be utilized. Several studies show that Native Americans tend to underutilize mental health services, experience higher therapy dropout rates than other ethnic groups, and have negative opinions about non-native mental health providers (<http://info.his.gov>, accessed February 10, 2003). At present, only 20% of American Indians report access to IHS clinics located primarily on reservations (<http://www.surgeongeneral.gov/library/mentalhealth/cre/fact4.asp>, accessed January 31, 2003). Affordability is also an issue. Medicaid is the primary insurer for 25% of American Indians. Only about 50% of American Indians have employer based insurance coverage, compared to 72% of whites and almost a quarter of American Indians do not have any health care insurance, compared to 16% of the U.S. population (<http://www.surgeongeneral.gov/library/mentalhealth/cre/fact4.asp>, accessed January 31, 2003). In addition, the majority of mental health care for American Indians is crisis orientated very few specialized mental health services for populations such as children and elderly. A recent report found that there were only 17 child-prepared mental health professionals within the entire IHS system and in 4 of the 12 IHS service units, there are not child or adolescent-trained mental health care providers (Manson, 2000).

Research

Despite consistent epidemiological evidence that indicates American Indians are at an elevated risk for suicide, the lack of research in this area makes it difficult to understand and explain the higher rate in this population. Research efforts have generally been descriptive and limited in both scope (mostly mortality and on reservation samples) and sample size. One of the most important correlates for youth suicide is a previous

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suicide attempt, yet very little information on suicide attempts among American Indian youth is collected systematically. In addition, the majority of suicide studies lack any kind of cultural contextual information-lifestyle, belief systems, and socioeconomic and education levels- that could illuminate risk factors. The lack of information in turn affects the development of effective suicide intervention programs.

Problems with categorization of race, ethnicity and population also hamper suicide studies among Indian populations. American Indians are viewed homogeneously by many researchers despite cultural, geographic and environmental diversity among Indian populations. Definitions of ethnicity are often arbitrarily assigned or based on death certificates only with no cross checking or corroboration from Indian Health Service records or other population databases. Jurisdictional issues also arise when studies focus on Indian populations in specific states, as these boundaries do not necessarily correlate with tribal boundaries. Valuable information may be lost about tribal specific suicide rates when tribal boundaries are obscured by state geography.

Lastly, barriers exist on who is conducting the research. Many of the studies examined for this report were conducted by epidemiologists and were primarily statistical or numerical. Very few studies included contextual information or were conducted by social scientists and Native researchers or practitioners conducted even fewer studies.

RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

Despite the public health significance of suicide among Native populations, progress has been slow in developing a scientific understanding of the incidence, prevalence, nature, and consequences of suicide and in measuring the efficacy of interventions to prevent or reduce the effects of suicide, among American Indians. In

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addition, a number of methodological issues and constraints as well as lack of funding have hampered research in this area.

The recommendations in this section are based on available information from journal articles and book reviews and interviews with practitioners and academics in the field of suicide prevention and intervention. The recommendations are organized into four categories: Research Efforts, Mental Health Services, Collaboration among Tribal, State and Federal Agencies, and Funding and Public Education.

Research Efforts

Data Collection

The paucity of research regarding completed suicide and suicide attempts, contextual background, and mental health problems among Native populations demonstrates the need for accurate, timely, and valid qualitative and quantitative data on suicidal behavior among American Indians. Specifically there is a need for the following;

- Evaluate the current record keeping systems for suicide and suicide attempts at Indian Health Services and tribal operated clinics and hospitals for accuracy and timeliness of information. Based on findings from the evaluation, develop recommendations for standardized recording and monitoring of suicide and suicide attempts.
- Expand information on American Indian suicide deaths by conducting psychological autopsies and in depth case studies among Native populations.

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- Conduct studies of suicide attempts to supplement data from death certificates and psychological autopsies.
- Examine the social and cultural factors that shape and form suicidal behavior among Native populations, especially youth, including descriptions of victims' motivations, interrelationships, mental health, and histories of help seeking behavior.
- Expand the scope of suicide and suicide attempts to include off reservation and urban Indian populations.
- Prevention and intervention trials in Native communities must be carefully designed with appropriate controls and evaluated with long term follow up in order to know what works.
- Conduct qualitative studies on cross-cultural and cross ethnic definitions of suicide and self-destructive behaviors.

Program Implementation and Evaluation

The lack of published research on the suicide programs among Indian populations indicates that research on the development, delivery and evaluation of suicide preventive interventions in reducing suicidal behavior among Indian populations needs to be better supported.

- In general, programs for suicide prevention and alcohol abuse among American Indian populations should be developed, tested, expanded, implemented, and published through funding from appropriate agencies including Indian Health Service, National Institute of Mental Health,

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Centers for Disease Control and Prevention, and Substance Abuse and Mental Health Services Administration.

- Comprehensive and community-based programs to address multiple risk factors are needed in Indian communities for both the prevention of suicide and alcohol abuse.
- More information is needed on what is generally effective for suicide and alcohol prevention in American Indian communities. As a result, program evaluations need to gather and analyze information on what program components are generally needed to make a prevention/intervention program work.
- Programs conducted and evaluated within one tribal group or native population must be assessed to determine if they are generalizable to other native populations.
- Programs that limit access to the means of suicide (e.g., firearm and drugs) and alcohol should be considered for many American Indian communities.

Other Research Concerns

- The how and why of suicide studies among Indian populations need to be reconsidered. At the very least studies of suicide should be multidisciplinary and multi-perspective, including Native and non-Native views and use broadly applied and culturally specific instruments and measures. Future research needs to be meaningful from a Native perspective, not just for the reporting of mortality statistics. Studies should involve tribal leaders and members in the planning, implementing

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and evaluation of the studies, using multiple research methods, applying expertise from multiple disciplines, and learning from past successes and failures.

- The Institute of Medicine report, *Reducing Suicide: a National Imperative* (2002) recommends that the National Institute of Mental Health (in collaboration with other federal agencies) develop and support a national network of suicide research population laboratories to investigate the suicidal process. Tribal, state, and federal agencies need to advocate that at least one of the member networks concentrate on the American Indian population.
- Injury morbidity and mortality rates among populations are often examined when allocating funds for prevention and intervention efforts. Therefore, the data used to calculate such rates should be reliable and valid. The classification of American Indians is a complex issue related to identity and enumeration and is beyond the scope of this report. A consensus meeting with national experts including tribal leaders is needed to make recommendations on how to compensate for the biases in identity and reporting.
- Based on future research which takes into account the recommendations listed above, the development of specific intervention/prevention protocols for suicidal behavior for use in an Indian community in crisis needs to be formulated and adopted that would dictate the process and direct a plan of action for both intervention and prevention.

Mental Health Services

It is clear that programs that offer mental health treatment and suicide prevention and intervention to American Indian populations are fewer in number than what is actually needed and that funding for mental health services are woefully inadequate. In addition, limited information is available on epidemiology of mental health problems among Native populations.

- Overall, the general enhancement of self-esteem among tribal groups are needed to revitalize tribal and individual perceptions of tribal cultures and put traditional strengths to work on solutions to the prevention of suicide and alcohol abuse. In addition, these efforts need to be approached from both traditional and western perspectives.
- Conduct descriptive epidemiological studies of suicide and related psychiatric disorders among Native populations. This need was echoed by John Perez, Director of IHS Behavioral Health Unit (personal communication, April 7, 2003) who stated there was an urgent need for timely and accurate data on mental health needs among Native populations to educate legislators and policy makers on importance of the problem and the need for increased and consistent funding for mental health programs among Native populations.
- Develop standardized record keeping and monitoring systems for mental health problems in IHS and tribal clinics.
- Evaluate the efficacy of broadly applied clinical instruments as to their sensitivity and reliability in Indian communities. As needed, develop

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culturally sensitive tools for assessing suicidal behavior among Native populations.

- Increase the availability and access of both traditional and Western treatments and practitioners to reservation and off reservation Native populations.
- Determine the most effective means of recruiting and training mental health clinicians to work in tribal areas.
- Develop culturally meaningful ways of training mental health providers who work with Indian populations to recognize, assess, treat, and manage the spectrum of psychiatric disorders.
- Develop a culturally sensitive diagnostic manual and casebook for mental problems among Indian populations.
- Increase the number of child prepared psychiatrists who are available to treat American Indian adolescents.
- Conduct studies to collect in-depth information on mental health problems and the relationship to suicide among both reservation and off-reservation populations.
- Conduct studies on help seeking behavior of Native populations so that culturally appropriate strategies to increase access and utilization of mental health services can be employed.
- Increase the recruitment of American Indians in the controlled clinical trials used to develop treatment guidelines for the major mental disorders in the U.S.

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- Examine the role of alcohol policies and their effect on suicide among native populations.

Collaboration among tribal, state and federal entities

Too often services and funding for suicide prevention/intervention and mental health services and programs for American Indians are fragmented among local, state and federal agencies. There is a strong need to increase and improve collaboration among agencies and personnel concerned with Native Americans' mental health. As a result, we make the following recommendations;

- Conduct organizational research on successful interagency approaches and barriers to effective delivery of mental health services. It was clear from personal communications with both Allen Dellapenna of IHS Injury Prevention Unit and John Perez, of IHS Behavioral Health, that governmental organizational restriction, such as GEPR, hinders their respective agency's ability to collaborate on the prevention of suicide in American Indian communities.
- Collaboration must begin at the federal level. The directors of the two lead agencies at IHS tasked with suicide prevention/intervention and mental health services need to meet on a regular basis to promote collaboration at the federal, state, and local tribal level. Ideas for the agenda could include but are not limited to the following;
 - Establishment of an advisory committee of tribal and federal representatives, program staff, and topical experts (from academia, CDC, other agencies);

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- Consideration of funding a comprehensive review of the literature on suicide prevention for AI/AN communities;
 - A review past initiatives in Indian country (e.g., Special Initiatives Team, Jicarilla Suicide Center) to identify helpful and ineffective strategies;
 - Identification of funding sources;
 - Preparation of a strategic plan for research and action regarding suicide and violence in American Indian communities.
- Establish mechanisms for federal, regional, and state interagency public health collaboration toward improving monitoring systems for suicide and suicidal behaviors and develop and promote standard terminology in the systems.
 - Suicide does not occur in a vacuum. As a result it is important to integrate a variety of mental health and social services in communities, including mental health and substance abuse/alcohol abuse treatment, treatment and prevention of suicide, treatment and prevention of intimate partner violence and child abuse, and legal assistance (for divorce, educational entitlements, financial, and housing assistance).

Funding and Recognition

A lack of funding, as well as recognition, of the suicide problem among Native communities was identified as a barrier for both research and services related to suicide prevention. As a result, we make the following recommendations;

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- Use timely and accurate data that can be used to broaden federal agencies awareness regarding the sequelae of suicide among American Indian populations and use this information to advocate for increased and consistent financial support for suicide prevention programs and mental health services for both on and off reservation American Indian populations.
- Conduct a case study on the process for how the authorizing language for the SAMSHA block grant monies was changed so that tribes could apply directly to SAMSHA for programs to support substance abuse and prevention treatment services. Use the case study to advocate for changes in the authorizing language of other funding sources so that tribes can apply directly to federal agencies for block grant funds to support substance abuse prevention and treatment services independent of the programs offered by the states in which they reside.
- Explore novel approaches to funding since current funding mechanisms are not adequate.

CONCLUSION

Suicide remains a serious mental health concern among American Indian populations. In native communities that experience high levels of self-destructive behavior, the effects may be as devastating as the effects of war or acts of terrorism. Overall a formulation of a broad set of policies and recommendations are needed to reduce suicide among American Indians. These policies and recommendations should include the current state of knowledge, describe general and specific priorities for

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research, and mental health services, as well as funding that are needed to reduce suicide among American Indian populations.

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**Intimate Partner Violence and Sexual Assault in
Native American Communities:**

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June 6, 2003

INTIMATE PARTNER VIOLENCE AND SEXUAL ASSAULT IN NATIVE AMERICAN COMMUNITIES

Introduction

Intimate partner violence (IPV) and sexual assault against women are pervasive occurrences in the United States (National Institute of Justice, 2000). Perhaps the most exhaustive survey of (IPV) to date in the United States is the National Violence Against Women Survey (NVAWS), a national telephone survey jointly sponsored by the National Institute of Justice and the Centers for Disease Control and Prevention. The survey, conducted from November 1995 to May 1996, consisted of interviews with a representative sample of 8,000 women and 8,000 men. Tjaden & Thoennes (2000) report that, “nearly 25 percent of surveyed women and 7.5 percent of surveyed men said they were raped and/or physically assaulted by a current or former spouse, cohabitating partner, or date at some time in their lifetime” (p. 2). The percentage breaks down to approximately 1.5 million women and 834,732 men respectively.

Tjaden & Thoennes (2000) report that rates of IPV vary significantly among women of diverse racial backgrounds. Various studies indicate that Native American³ women experience the highest rate of violence of any group in the United States. This section of the report addresses the prevalence of violence and sexual assault among Native Americans according to the most recent literature. This section also addresses significant issues that inform research on violence in the lives of Native Americans, as

¹ Native Americans, American Indians, indigenous peoples and Native populations are used interchangeably throughout this document to refer to the Native peoples of continental US and Alaska.

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well as contemporary interventions to address IPV and sexual assault in Native American communities. We have found three major categories of interventions, those that are community based, those grounded in the public health and health care systems, and those grounded in federal and/or national organizations. This report provides examples of interventions from each of these three levels of direct service. Following, we discuss barriers, noted in the literature, to service accessibility. We conclude with recommendation for research and practice grounded in both the literature and practice arenas.

Prevalence

According to the NVAWS, and Greenfeld & Smith (1999)⁴, American Indians⁵ (AI) experience violent victimization at a rate greater than other U.S. racial or ethnic subgroups. Between 1992-1996, the average annual violent crime rate among AIs was 124 per 1,000 persons age 12 or older, which translates into approximately 1 violent crime per year for every 8 residents age 12 or older. The average annual violent crime rate per 1,000 persons age 12 or older during that period was 49 for whites and 61 for blacks (Greenfeld & Smith, 1999). This per capita rate of violence is more than twice that of the national rate. In addition, rates of violent victimization for both men **and** women are higher among American Indians than for all races. The Department of Justice (Greenfeld & Smith, 1999) reports that, at least seventy percent of the violent victimizations experienced by American Indians are committed by persons of non AI

⁴ Greenfeld & Smith's report used data from statistical series maintained by the Bureau of Justice Statistics (BJS), the FBI, and the Bureau of the Census.

⁵ *American Indians* in the DOJ report include Alaska Natives and Aleuts.

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racess. Sixty percent of the AI victims of violent crime described the offender as white, while thirty percent of the offenders were likely to have been other American Indians, and ten percent were described as black. While the statistics above include crimes of aggravated assaults, murder, robberies, rapes and/or sexual assaults, this section of the report will specifically address the prevalence⁶ of intimate partner violence and sexual assault among Native Americans.

Sexual Assault

While much of the information on IPV and sexual assault in Native American communities is anecdotal and/or experiential (Koss, Goodman, Browne, Fitzgerald, Keita, & Russo, 1994; National Sexual Violence Resource Center, 2000), limited studies documenting its prevalence do exist. Information on sexual assault, specifically, is much more limited than information on IPV. Greenfeld & Smith (1999) report that, the average annual rate of rape and sexual assault among American Indians is 3.5 times higher than for all races. According to the *American Indians and Crime* report (Greenfeld & Smith, 1999), over 70% of sexual assaults are not reported. Gonzales (1999) supports the notion that most Native Americans do not report sexual trauma. Mistrust of white agencies and helpers, fear of being ostracized by families, shame & guilt (Gonzales, 1999), concerns with confidentiality, and jurisdictional confusion have been reported as factors informing the low rates of reporting (National Sexual Violence Resource Center, 2000).

⁶ Prevalence refers to the percentage of persons within a demographic group who are victimized during a specific period (NIJ, 2000).

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Jurisdictional confusion caused by the multiple realities of tribal political sovereignty and two hundred years of tribal-U.S. government contact, challenges victims' abilities to attain legal recourse that are accessible, fair and timely (National Sexual Violence Resource Center, 2000).

Ultimately, jurisdiction has to do with the type of crime, the race of the perpetrator and victim, and location of crime. The issue of race exemplifies the problem; if both victim and perpetrator are Indian, major crimes may fall under federal and/or tribal jurisdiction; if a non-Indian perpetrator and Indian victim, the jurisdiction is federal; if both the victim and perpetrator are non-Indians, the jurisdiction belongs to the state. Generally, most major crimes fall within the federal scope and misdemeanors are tribal. Tribal courts have no criminal jurisdiction over non-Indians (National Sexual Violence Resource Center, 2000, p. 12).

Consequently, low levels of reporting inform record keeping in a way that obscures our ability to assess the true prevalence of sexual assault in the various Native American communities and tribes. Low levels of reporting may contribute to feelings of isolation and helplessness among victims, as well as send a message to perpetrators that, even if they are caught/arrested, prosecution may not occur due to the gaps caused by jurisdictional confusions.

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Tjaden & Thoennes (2000) report that rates of IPV vary significantly across racial groups, and that different types of racial groups report significantly different rates of IPV. The NVAWS found that African-American and American Indian/Alaska Native women and men report higher rates of IPV than other groups. Specifically, they found that

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American Indian/Alaskan Native women report “significantly higher rates of IPV than do women of other racial backgrounds” (p, 18).

The NVAWS findings are consistent with other findings of IPV in Native American communities. In Bachman’s 1992 study of violent episodes within Native American communities, a greater percent of AI couples than white couples reported serious physical abuse. Norton & Manson (1995) conducted a study in the Rocky Mountain region of women who had sought assistance from social programs. They found that 46% of the women reported a history of domestic violence. Robin, Chester, & Rasmussen (1998) investigated the prevalence and characteristics of IPV among 104 members of a Southwestern American Indian tribe. Men and women reported high rates of lifetime (91%) and recent (31%) IPV. Female victims were more likely than male victims to require medical attention due to sustained injuries. Fairchild & Fairchild (1998) conducted a study of 371 women on a Navajo reservation in the southwest to determine the prevalence of domestic violence. Among the 341 respondents, 179 (52%) reported a history of at least 1 episode of domestic violence. Fifty-six (16%) reported violence within the previous 12 months. Finally, a qualitative study of three communities in Alaska found that informants believed domestic violence to be occurring in 15-36% of the homes in their community (Shinkwin & Pete, 1983). The prevalence of IPV in Native American communities reported in the studies above, for the most part, exceed those of the NVAWS’ random sample.

Research Issues

Despite research findings that indicate a consistently greater prevalence of IPV and sexual assault among Native American communities, the paucity of research in this

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area makes it difficult, if not impossible, to understand and explain why Native Americans report more IPV (and perhaps sexual assault). In addition, it is useful to keep in mind that most of the research in this area is primarily descriptive and numerical rather than inferential. Different methods of data collection constitute inform another concern, both in terms of numerators (which episodes get reported to DOJ) and denominators (variation among Census, HIS, tribal enrollment figures). Tjaden & Thoennes (2000) recommend additional inquiry to determine how much of the difference in reporting of IPV across different racial groups can be attributed to differences in willingness to disclose abuse to interviewers (i.e. reporting practices), and/or how much is due to actual differences in abuse (victimization) experiences. They also note that future research should explore how much of the differences in IPV reported across different racial and ethnic groups has to do with demographics, social and environmental factors. Thus, more research is needed to establish the degree of variance in the prevalence of intimate partner violence among women (and men) of diverse racial and ethnic groups and to determine how much of the variance may be explained by differences in such factors as cultural attitudes, community services, and income.(Greenfeld & Smith, 1999, p. 31)

In addition to understanding the reasons for differential prevalence rates of IPV and sexual assault among Native Americans, researchers must pay attention to the differences across these indigenous groups. Despite the fact that there are 512 recognized native groups and 365 state-recognized Indian tribes, who speak 200 different languages in the U.S. (Chester, Robin, Koss, Lopez, & Goldman, 1994), Native Americans are subject to similar oversimplifications and ethnic essentializing, as are other racial and ethnic groups. Hamby (2000) provides a comprehensive analysis of inter-tribal

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differences that could be acknowledged when attempting to explore and understand IPV in Native American communities. Specifically, she suggests that researchers pay attention to tribal differences concerning; (1) the role of dominance in domestic violence, (2) the intersection of gender and dominance, (3) the intersection of gender and authority, (4), gender and disparagement, (5) gender and restrictiveness, and (6) the role of socioeconomic organization and domestic violence. It has been suggested that the necessity to explore and consider such differences may contribute to researcher's reluctance to tackle the problem in the first place.

Research methodologies play a significant role in our ability to explore and understand IPV and sexual assault. Most research on Native Americans is limited in terms of sample size and design. Hamby (2000) challenges the use of telephone or mail surveys with Native Americans, a method "appropriate for middle-class suburban homes, but do not include homes that are too poor or isolated to have telephones, or communities whose members have relatively low levels of English fluency" (p. 653). Another critique includes the widely systematic gathering of data from "captive populations" found in hospitals, medical clinics and educational institutions (Chester et. al, 1994; Manson & Shore, 1981). In addition, research frequently utilizes interviewers who are unfamiliar with the community they are interviewing which contributes to mistrust and misinterpretation of the actual realities of the participants' lives (McShane, 1987). Ultimately, there is a lack of IPV research with Native Americans that explores the complex role of culture (LaFramboise, Choney, James, & Running Wolf, 1995b), fluid identities, oppression, and socio-economic issues in their experiences of IPV.

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Risk Factors

Sexual Assault

Despite the lack of empirical inquiry regarding risk factors that render Native Americans vulnerable to sexual assault, the literature does contain speculation and some discussion of likely factors. Institutional oppression (in the forms of racism, classism, sexism) and internalized oppression have been named as possible risk factors for sexual assault. It is believed that the treatment of Native Americans by colonizers, racism (Allen, 1985), exploitation of resources, seizure of lands, introduction of alcohol (Allen, 1985) and disease, coupled with oppressive policies such as the boarding school and land allotment programs have profoundly negatively affected the values and lives of indigenous peoples (Gonzales, 1999; National Sexual Violence Resource Center, 2000). Consequently, some argue that Native Americans, through the process of internalizing oppression, have moved from being mostly peaceful cultures to having high rates of violence and self-destructive behaviors (National Sexual Violence Resource Center, 2000). Allen (1985) argues that, the conquest of Native tribes by the colonizers was accompanied by the “conquests and degradation of Indian women by men, Indian and otherwise”.

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While the IPV literature is replete with studies that have explored risk factors associated with IPV, researchers have yet to specifically explore risk factors associated with IPV among Native Americans. Some authors assert that domestic violence has been present in indigenous communities for some time (Durst, 1991), while others allege that domestic violence is a new occurrence (Allen, 1985; McEachern, Van Winkle & Steiner,

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1998; Wolk, 1982). Those who argue that IPV is a relatively new phenomenon, point to the introduction of alcohol as a potential contributing factor. Although alcohol abuse has been identified as a significant contributor to domestic violence situations for non-Native Americans, some believe that it may constitute an even greater force in IPV among Native Americans (Chester et. al, 1994; McEachern, Van Winkle & Steiner, 1998; Wolk, 1982), perhaps because alcohol is considered to be the single most widespread and critical health problem in today's Native American communities (National Institute on Alcohol Abuse and Alcoholism, 1980). Powers (1988) found that all incidents of abuse studied in a Public Health Service study on Pine Ridge in 1979, occurred under the influence of alcohol (77%) or drugs (23%). A consistent theory of battering and alcohol remains lacking due to "heterogeneity of behaviors connoting both domestic violence and alcohol abuse among Indian people" (Chester et. al, 1994, p. 254).

Other factors that may place individuals at risk for IPV include the same issues (mentioned earlier) that are believed to place Native Americans at risk for sexual assault, including; oppression, internalized oppression, racism, oppressive practices such as the removal of Indian people from ancestral lands, the removal of children into foster homes and boarding schools (McEachern, Van Winkle & Steiner, 1998; May, 1987), and the prohibition against religious and spiritual practices (Chester et. al, 1994). A conversation with Karen Artichoker (Artichoker, 2003), Management Director with Cangleska Inc., and leading activist in IPV issues concerning Native American women, provided information that supports some of the literature concerning IPV and sexual assault against Native American women. Cangleska, Inc. is a nonprofit, nongovernmental victim services agency serving Oglala Lakota women on the Pine Ridge reservation. Artichoker

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(Artichoker, personal communication, February 7, 2003) believes that a combination of a lack of resources, a history of oppression and genocide, the introduction of alcohol (“as a weapon of war”), the destruction of Native families, a lack of employment opportunities and, the sexual abuse of Native children in boarding schools by priests, have contributed to the comparatively higher rates of IPV and sexual assault rates in Native communities.

Interventions

Despite significant national attention and resources directed towards addressing the prevention and remediation of IPV, limited efforts specifically targeting IPV and sexual assault in Native American communities exists. Documentation of such programs is limited and evaluations are virtually non-existent at this point in time. Our exploration of IPV and sexual assault interventions and programs specifically targeting Native Americans indicates that such efforts fall under three main categories, with some overlap and intersections. These categories include, community (local & regional) based interventions, health care interventions, and federal/national organizations. The following section provides a brief description and summary of the different IPV and sexual assault efforts and services currently in operation.

Community Based Interventions

The resources and services that fall into this category include those that serve individuals and groups at the local and regional (state) levels. These efforts typically have agendas and objectives that address micro and mezzo (systems that affect individuals) change and issues, with some occasional focus on macro issues. Many of these projects stem from grass roots efforts, including shelters for battered women and children, crisis hotlines, and support groups. The first shelter on an Indian reservation was opened in

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1977 by the White Buffalo Calf Women's Society of the Rosebud Reservation (DeBruyn, Wilkins, & Artichoker, 1990). Since then, few shelters specifically for Native American communities, including Native American Connections in Phoenix, have emerged including *Dabinoo'Igan*, in Duluth Minnesota. *Dabinoo'Igan* provides mainstream battered women's shelter programs like crisis intervention and advocacy for victims, legal advice, counseling and information and referral services. Providing culturally specific and sensitive programs to its client population is one element that makes shelters like *Dabinoo'Igan* unique. Talking circles, naming ceremonies, and other traditional practices are included in the shelter activities. Similarly, the Minnesota Indian Women's Resource Center (presented below), developed a handbook for sexual assault advocates that encourages programs to develop tribally specific materials that consider language, ceremonies and histories. For many community based shelters and support services (individual & group counseling, crisis intervention), focusing on the consequences of IPV and sexual assault consume their resources. That is not to say that community based efforts do not engage prevention efforts because they do, as evidenced by outreach efforts, community presentations, and coalition work. However, the focus of their efforts tend to address IPV and sexual assault remediation. Examples of such community-based interventions include:

(1)The Minnesota Indian Women's Resource Center.

They have developed a curriculum, "Songidee Biimadaziwin"⁷, which is Ojibwe influenced, to address sexual assault in Native women. The curriculum involves a

⁷ Means "Strong hearts living life to the fullest".

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handbook for Native advocates who work with sexual assault victims. Native women survivors of sexual assault were involved in the development of some of the chapters.

Minnesota Indian Women's Resource Center

2300 15th Ave. S, Minneapolis, MN 55404 Phone: 612-728-2000

(2) Minnesota Indian Women's Sexual Assault Coalition.

Created by the Minnesota Indian Women's Resource Center. The coalition is one of 8 tribal coalitions around the country formed to address domestic violence and sexual assault in American Indian communities. "The coalition will work to create supportive systems response and promote social change for communities". Also, they aim to unite American Indian Sexual Assault Advocates throughout the State of Minnesota in their efforts to create awareness, influence social change, and reclaim the traditional values that honor the sovereignty of Indian women and children".

www.fdlrez.com/newspaper/newcoalition.html

Minnesota Indian Women's Resource Center

2300 15th Avenue South, Minneapolis, MN 55404 Phone: 612-728-2027

(3) Native American Women's Health Education Resource Center

Opened a shelter on the Yankton Sioux Reservation in South Dakota for battered women in 1991. The shelter provides women and their children with a safe place to escape domestic violence and sexual assault.

P.O Box 572, Lake Andes, SD 57356-7072; Phone: (605) 487-7072

(4) The Albuquerque Indian Center

The Center focuses on treatment services for Native American victims and perpetrators of domestic violence and sexual assault in New Mexico. Their services

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include group counseling and traditional healing. Languages spoken at the Center are English and Navajo.

105 Texas SE, Albuquerque, NM 87108 Phone: (505) 263-4418

(5) The Jicarilla Apache-Mental Health & Social Services, Domestic Violence Prevention Program

The Program provides services to victims of sexual assault, domestic violence and stalking in New Mexico. They provide 24 hours a day emergency victim advocacy, legal support and advocacy, batterers education, and women's groups and support services.

P.O. Box 546, Dulce, NM 87528 Phone: (505) 759-3162

(6) The Alaska Network on Domestic Violence and Sexual Assault

“The Network is a non-profit, membership corporation composed of 21 programs statewide that provide services to victims of domestic violence and sexual assault, offender services, and adult crisis intervention services. The purposes of the Network are to promote linkage and communication between the programs, facilitate information sharing, secure funding in a cooperative and non-competitive manner, and to expose the roots of violence against women and children in this culture.”(

<http://www.andvsa.org/informat.htm>)

130 Seward Street, Rm. 209

Juneau, AK 99801 (907) 463-4493 fax

(7) The Governor's Office of Criminal Justice Planning, Native American Sexual Assault/ Domestic Violence Program

“This program targets Native American Indian women in California by funding grantees to develop projects aimed at addressing and impacting the issues of sexual

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assault and domestic violence affecting Native American women. Projects are to provide outreach services and training regarding the dynamics of assault and domestic violence perpetrated against Indian women, and provide linkages to available resources including legal options.” (http://www.ocjp.ca.gov/programs/pro_sa_nasa.htm)

Empowerment

Among several of the concepts (i.e. healing, safety, traditional, change) that consistently appear in these programs’ informational materials, is the concept of empowerment, particularly, empowerment of the whole individual as a Native American. Paying attention to specific cultural and tribal values and ways appears to be one of the main strategies these programs utilize to work towards empowerment of the whole individual, as well as the healing and support of survivors of IPV and sexual assault. Despite the fact that almost all of the programs listed above mention “social change” as one of their objectives and/or services, how these projects both regard and operationalize the connection between individual and institutional change is rarely clearly or explicitly stated.

Health Care Based Interventions

Interventions occurring in health care settings that address IPV and sexual assault within Native American communities almost uniquely revolve around screening and referral practices (i.e. identifying IPV and sexual assault). Many of the health care setting interventions are designed to educate and support health care professionals to identify the occurrence of IPV and sexual assault in the lives of their patients, as well as,

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how to provide resources and referrals when appropriate.⁸ A study by Clark (2001) found that screening for domestic violence in Indian Health Service (IHS) hospitals and clinics is promoted by the presence of relevant policies and procedures. Clark found that screening is more likely to occur in facilities with policies and procedures for handling domestic violence. Examples of IPV interventions within health care settings include:

(1) U.S. Department of Health and Human Services, Indian Health Service (IHS), Slide Set on IPV During Pregnancy: A guide for Clinicians

A training tool developed for clinicians designed by the American College of Obstetricians and Gynecologists (ACOG) and the Center for Disease Control (CDC). The tool is designed to help clinicians' understanding of the important role they can play in identifying, preventing and reducing IPV.

http://www.cdc.gov/nccdphp/drh/violence/ipvdp_download.htm

(2) IHS-Administration for Children and Families Domestic Violence Pilot Project.

“The purpose of this initiative is to develop up to 6 pilot programs within the American Indian/Alaskan Native health care system that can serve as a model to other AI/AN clinics and hospitals. The intent is to develop and increase the role of health care

⁸ See Rhodes & Levinson (2003) for a review of the limited scientific literature, which has evaluated medical interventions for IPV, as well as a list of medical resources for IPV interventions in health care settings. Also, see Wathen & MacMillan (2003) for a review of the available evidence on interventions aimed at preventing the abuse of women in medical settings. Neither of these studies address specific populations such as Native Americans.

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providers in the recognition and response to domestic violence” (IHS, <http://endabuse.org/programs/display.phpd?>)

Unlike community based interventions, health care setting interventions typically do not engage in remediation and victim counseling services and advocacy beyond making referrals to appropriate services. While community based interventions almost solely target the individual and their immediate families (perhaps the perpetrator as well), health care interventions also target clinicians (rather than just survivors and perpetrators).

Federal/National Organizations

Federal and National Organizations tend to create and provide interventions and services that address macro issues including sexism, institutionalized oppression, intersections between individual and state violence, and federal and tribal policy concerning IPV and sexual assault. While these types of projects may fund smaller community and/or health care projects that do address micro and mezzo issues, federal and national organizations tend to be a bit more focused and concerned with systemic and institutional forces that both contribute to and prevent IPV and sexual assault, evidenced by their efforts to inform policy, create comprehensive educational programs and materials, work with government systems, and provide funding.

Our review of existing national and federal services for Native Americans who have experienced IPV and/or sexual assault, indicate that these efforts often embrace traditional and holistic approaches to healing, social change and prevention. Examples of such projects include:

(1) Mending the Sacred Hoop Technical Assistance Project

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The project works towards the elimination of violence in the lives of women and their children, by providing training and technical assistance to Alaskan Native and Tribal Nations. They work with villages, reservations, rancherias, and pueblos across the U.S. to improve the response of the justice system, law enforcement, and services providers to address IPV, stalking and sexual assault issues. The project organizers argue that in order to address IPV against women, we must also understand oppression in its many forms (racism, classism, sexism etc.). One of their objectives is to, recreate “a natural world that supports leadership, strategies and tangible responses to tribal communities in their efforts to stop violence against Native women”.

<http://www.msh.ta.org>

202 East Superior Street, Duluth, MN 55802 Phone: (218) 722-2781

(2) The Native Healing Connection

A hotline for Native American survivors of IPV and/or sexual assault in the U.S. and Canada. The project offers a confidential call for those needing support and referrals. The hotline provides both Native and non-Native counselors. Phone: 1-888-600-5463

(3) Tribal Court Clearinghouse

A web resource that provides hyperlinks to tribal court personnel, tribal law enforcement personnel, domestic violence victim service agency personnel, social services personnel, and others who work with survivors of IPV. Links included in the Clearinghouse include:

Tribal Court Bench Book for Domestic Violence Cases

The Michigan Judicial Institute’s Sexual Assault Handbook

Mending the Sacred Hoop

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End Violence Against American Indian, Alaskan Native, and First Nations
Women

Justice Department's Violence Against Women Office

<http://www.tribal-institute.org/lists/domestic.htm>

8235 Santa Monica Blvd. Suite 211, West Hollywood, CA 90046 Phone: 323-
650-5467

(4) Native American Circle, Ltd

“A non-profit, tax exempt victim advocacy organization. Its programs are available to tribes operating batter intervention and victim services programs to aid survivors of domestic violence, sexual assault, and stalking crimes, as well as to non-Indian programs desiring to offer culturally competent victim services.”

“NAC’s programs are designed to foster admiration of indigenous cultures and pride in cultural-connectedness, while fueling interests in recovering non-violent, traditional lifestyles in today’s American Indian/Alaskan Native communities”.

<http://www.vaw.umn.edu/FinalDocuments/namain.asp>

Their services include:

1. Training programs and resources that are culturally sensitive to Native American people and their customs and traditions;
2. Development of community-based responses and tribal legal codes that effectively and appropriately address stalking crimes against Native women;

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3. Development of domestic violence fatality review process to generate demographic-specific statistics for the Native American population nationally;
4. Development of links to local service providers and tribal resources which urban Indian women are typically unable to access due to geographic restrictions.

P.O. Box 227, Elgin, OK 73538 Phone: (866)-622-2872

Much like community based interventions, some of the national interventions also embrace Native American traditional ways of being, healing and values, as they operationalize their efforts.

The Violence Against Women Office, created in 1995, is the government branch of the Department of Justice that addresses legal and policy issues regarding violence against women. The Office also administers the Department of Justice's formula and discretionary grant programs authorized by the Violence Against Women Act of 1994. In 2000, the percentage of VOWA funds, specifically for Native Americans, increased from 4% to 5% of the VOWA budget, totaling \$9.5 million. As of 2001, in addition to \$9.5 million, VOWA also allocates \$3.42 million to the Tribal Coalitions Grant Program, and five percent of the following budgets; 1) *Grants to Encourage Arrest Policies and Enforcement of Protection Orders*, 2) *Rural Domestic Violence and Child Victimization Enforcement Grants*, 3) *Legal Assistance for Victims Grant Program*, yearly for Native American specific programs.

Accessibility of Services

The creation of services for Native Americans does not guarantee their utilization. In fact, numerous barriers have been cited as contributing to the challenges Native Americans face when seeking assistance for IPV and/or sexual assault. Bhungalia (2001) notes that racism, fear of losing child custody, mistrust of white dominated agencies, fear of familial alienation, a history of inactivity by the state, and confusion around jurisdiction, all create barriers to attaining services. Other issues, referenced in the literature, that may prevent Native Americans from accessing services include language barriers, cultural and value differences (Debruyn, 1990; Hamby, 2000), confidentiality (Anderson & Ellis, 1988), lack of flexibility and trust (Trimble & Fleming, 1899), and the type of service delivery design (i.e. group vs. individual counseling) The following section provides recommendations to address such barriers.

RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

Although the lack of documentation and evaluation of IPV and sexual assault programs specifically for Native Americans does not allow for the creation and/or referencing of “best practices” with these communities, the literature does suggest significant research and practice strategies. Recommendations below are both substantive and methodological.

Contextualize research

Due to the sheer number of different Native American tribes, research should not aggregate data across diverse groups (Hamby, 2000). Rather, research and practice should consider exploring IPV & sexual abuse contextually across the different tribes,

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particularly since gender, class, and power relations differ across tribes (Hamby, 2000).

Contextualizing research will have significant implications for interventions. For instance, IPV advocates and counselors who frequently recommend divorcing and/or leaving the abuser as an appropriate intervention, may have to rethink this strategy.

Hamby (2000) notes:

The choice of marriage partners from one's own tribe may be quite limited. Although many interracial marriages occur, some women may be reluctant to marry outside their tribe and especially to marry a non-Indian. The dilution of bloodlines is a sensitive issue in some communities (Spratt, 1994)

Study design

Other recommendations come from Chester et. al's (1994) who suggest we consider and pay attention to; using local interviewers for research, maintaining a sensitivity to issues of confidentiality, the need to integrate current treatment efforts (i.e. substance abuse and mental health services), and the importance of framing specific research questions. The authors argue that researchers (and practitioners) must "establish culturally appropriate operational definitions of domestic violence or family violence and point and lifetime prevalence rates of these behaviors in different tribal groups" (p. 256).

Include variables from the general population

Coupled with more extensive research on prevalence rates, antecedents, and outcomes of IPV, future research on risk factors for IPV specific to Native Americans may consider exploring some of the factors identified in the literature for the population at large, as identified by Tjaden & Thoennes (2000): (1) unmarried, cohabitating couples have higher rates of IPV than do married couples (Klaus & Rand, 1984; Stark & Flitcraft,

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1988; Zwait, 1994); (2) women with lower incomes have higher rates of IPV than do women with higher incomes (Yllo & Straus, 1981; Stets & Straus, 1989); (3) less educated women have higher rates of IPV than do more educated women (Bachman & Saltzman, 1995; Zawit, 1994; Hornung, McCullough, & Sugimoto, 1981); (4) couples with income, educational, or occupational status disparities have higher rates of IPV than do couples with no status disparity (Horung, McCullough & Sugimoto, 1981); (5) wife assault is more common in families where power is concentrated in the hands of the husband or male partner and the husband makes most of the decisions regarding family finances and freedom of movement (Frieze & Browne, 1989; Levinson, 1989).

Samples

Diversifying sample pools by conducting inquiries that extend recruitment designs beyond medical and health care settings may contribute to more contextualized, as well as generalizable data. In so doing, researchers may consider including samples from reservations, urban areas, cultural centers, educational institutions, and various social service venues.

Variables and substantive issues in research and practice

Due to the fact that evaluations of the programs referenced in this report are either non-existent or unavailable, we recommend that researchers strongly consider evaluating, through research, current, existing programs. Future research and service efforts may also consider and explore variables such as; cultural differences and similarities in language, values, and traditions, across tribes; the different contexts in which services are provided (reservation, urban, rural), jurisdiction, socio-economic class, as well as the intersections of different forms of oppression experienced by Native Americans in the

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U.S. Hamby (2000) reminds us that; “[I]nterventions in American Indian communities need to be sensitive to the history of oppression and domination by outsiders. Using materials and resources developed for the majority culture can raise issues of domination” (p.666). Culturally sensitive and appropriate programs might consider paying attention to; home visits (Norton & Manson, 1997; Sue, Allen & Conway, 1978), flexibility and trust (Trimble & Fleming, 1899), group vs. individual counseling, confidentiality (Anderson & Ellis, 1988), and intertribal variations (Debruyne, 1990; Hamby, 2000).

Identity

Finally, Artichoker (Artichoker, personal communication, February 7, 2003) believes that interventions to prevent and address IPV and sexual assault in Native American communities must be grounded in (and a part of) efforts to “rebuild a nation” that was ravaged by war. Her recommendations call for macro interventions that will support the rebuilding of institutions in Native American communities, provide employment and training opportunities, support self-determination, empowerment and pride. While Artichoker does not speak, by any means, for all Native Americans, she does provide an interesting and provocative perspective regarding identity and “organizing” around IPV and sexual assault issues. When asked if she was familiar with national organizations of “women of color” who work with IPV and sexual assault issues, she adamantly negated the construction of Native American women as “women of color”. She stated, “Native women have a political, historical, and legal relationship with the United States government that is not a color issue”. She added that there are “Indians with blond hair, blue eyes and fair skin”. While some Native Americans may identify

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themselves as and/or with communities of color (i.e. non-white communities), Karen's comment reminds us of the complex relationships we have with the social constructions of race and ethnicity. Consequently, existing IPV and sexual assault efforts that focus on "marginalized and/or underserved" communities, may think twice about lumping Native Americans with "non-white communities" in their efforts, specifically to keep the focus on "political, historical and legal issues", which rest at the heart of the contemporary self-determination and empowerment of diverse Native American communities.

McEachern, et. al. (1998) remind us that "[w]orking with Native Americans requires the ability to collapse the past and present into a current reality. Time often takes on a different meaning, with the past feelings like a part of the present" (p. 34). Given the current socio-economic and political realities of the diverse Native American tribes, it is impossible to work with/in the present without maintaining a space for their past and history.

In conclusion, we provide a summary list of practical recommendations from the literature and practice arena.

- Evaluate existing programs.
- Contextualize research.
- Attention to issues of identity.
- Attention to differences and similarities across tribes.
- Explore variables that related to IPV and sexual assault that are represented in the literature on the general population.
- Diversify samples beyond medical and health care settings.
- Involved those who are being studied in the inquiry process.

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- Use culturally relevant language, definitions and constructs.
- Utilize empowerment theories to guide research.
- Utilize empowerment models to ground interventions.
- Utilize culturally relevant and specific interventions.
- Advocacy for increased program and research funding.
- Utilize interventions that address the empowerment and healing of the whole individual, rather than simply focus on the IPV and sexual assault wounds and trauma.
- Incorporate substance use counseling and resources in interventions.
- Incorporate analyses of oppression, as they affect individual and collective experiences, when addressing prevalence rates, antecedents, and outcomes of IPV and sexual assault.
- Support and learn from existing IPV and sexual assault programs run by Native Americans for Native Americans.

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**Child Abuse and Neglect in Indian Country: A Review
with Recommendations**

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June 6, 2003

CHILD ABUSE AND NEGLECT IN INDIAN COUNTRY

Introduction

Collecting information on child abuse and neglect (CAN) among American Indians and Alaska Natives is a challenge because there is no central report center and therefore no complete data. The government agency responsible for upholding the Federal Government's obligation to promote healthy AIAN people, communities, and cultures is the Indian Health Service (IHS). IHS is an HHS agency with a goal "to assure that comprehensive, culturally acceptable, personal and public health services are available and accessible to American Indians and Alaska Natives" (Available <http://www.ihs.gov/IHSprofile>). IHS is responsible for providing health services to more than 550 federally recognized nations/tribes. However, IHS has facilities in only 35 of the 50 states and provides services to only 55% of the estimated 2.4 million Indian people (ibid). Injury prevention is among the list of services IHS provides to Indian communities.

Knowing about the AIAN population is a critical issue. A general rule of thumb is that one-third of AIAN people live on the reservation, one-third live in urban settings, and one-third transition between the reservation and urban areas. The transitory group are, of course, the most difficult to follow for research and/or data collection. It behooves the researcher and practitioner to determine how the client child/family defines their home base.

The Literature

The 2000 census data identifies four different geographic areas where AI children live: reservations, states, counties, and cities (Snipp, 2002, p. 11). In 2000, about 29% of all AIAN children lived on 619 reservations and Alaska Native villages (p. 12). Of particular note, nearly

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70% of all AIAN children live west of the Mississippi River (p. 14). Cities with the highest number of AIAN children were New York City with 27,000 and Los Angeles with 16,000 (p. 19). Additionally, there are higher concentrations of AIAN families in metropolitan areas because of the 1950s relocation program. During the Eisenhower era, the Bureau of Indian Affairs relocated AIAN families from reservations to urban settings as an assimilation effort. The objective was that the families would “blend” into society and no longer identify as an Indian or Native. Cities with the highest concentration of AIAN families were areas that were booming in the post-World War II industrialism: Seattle, San Francisco, Phoenix, Oklahoma City, Tulsa, and Minneapolis-St. Paul (Snipp, 2002, p. 19).

American Indians/Alaska Natives have the poorest health of any minority population in the U.S., according to Healthy People 2000 (Available <http://www.ihs.gov/health2>). The general American public knows little about the Indian/Native health care system, and often relies on stereotypes and/or erroneous information (ibid). Low education levels, high poverty rates, high rates of unemployment, discrimination, reservations in remote areas, and cultural differences are contributing factors to poor health. Often, these same factors lead to child abuse and neglect.

Policy barriers that prevented Indian peoples’ ability to protect their children is evidenced in struggles for over a century. It started with the broken treaties in the 1800s and continued through the 1900s with the boarding schools and relocation programs. During this time, the Federal government removed children from their homes and families leaving tribes helpless and without judicial control over their children. Problems in Indian communities became compounded with oppression, disease, poverty, and alcoholism. The policies and problems prevented Indian/Native people from maintaining their culture, beliefs, values and customs that

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had “child protection mechanisms” built into their life ways. The policies and problems created an environment “where child abuse and neglect could develop and continue to exist” (Earle, 2000, pp. 7-17).

It is important to acknowledge that world views, issues of trust and historical mistrust, policies and problems, background and training are all critical components of data collection in Indian Country.

Understanding the status of child abuse and neglect in Indian Country means reviewing the national data in order to place it in perspective. Data were compiled on 59 health status indicators in this twelfth annual report on the health status and service needs of America’s children by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB) “Child Health USA 2001” report (2001). As a result of the report, the MCHB created a strategic plan that includes a goal to eliminate barriers and health disparities, to assure quality of care, and to improve the health infrastructure and system (p. 5). The national data indicates that, in 1999, an “estimated 826,000 children were victims of abuse or neglect, equivalent to a rate of 11.8 per 1,000 children under 18 years of age” and 87% of the perpetrators were the parents of the victim (p. 28). Of the 826,000 victims: 58% suffered neglect, 21% physical abuse, 11% sexual abuse, 8% psychological maltreatment, and 28% other maltreatment. The Children’s Bureau of the U.S. Department of Human Services works with States to gather annual statistics on child abuse and neglect from the State child protective services agencies. The national data for the calendar year 2000, indicates **three million referrals** [emphasis added] “... concerning the welfare of approximately *five million children* [emphasis added]”. Their investigations show that 32% of

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the cases resulted in finding that the children were either maltreated or at risk of maltreatment. There were about 879,000 children nation-wide who were victims of child maltreatment – an increase of 53,000 children when compared to the 1999 data above. The victimization rate increased from 11.8 per thousand children in 1999 to 12.2 per thousand children in 2000. The age group with the highest rate of victimization is the birth to 3 years old at 15.7 victims per 1,000 children of the same age. The racial composition of the victims was: 51% White; 25% African American; 15% Hispanic; 2% American Indian/Alaska Native; and 1% Asian/Pacific Islanders. A quick calculation of the 2% AIAN children who were abused and/or neglected in calendar year 2000 totals **17,580!**

Risk Factors

The degree to which a community, whether reservation or rural or urban, is characterized by a fragmented health and social service structure, isolation from jobs or other communities and frequent gang/drug activity can create a milieu conducive to child maltreatment. Although the causal relationships remain unclear, neighborhoods such as these impair parenting and inhibit healthy child development (Hay & Jones, 1994). Researchers have established nine socioeconomic and demographic variables that distinguish neighborhoods with high levels of child abuse:

1. The percentage of families living in poverty.
2. The percentage of minority families.
3. The percentage of single-parent, female-headed families.
4. The unemployment rate.
5. The percentage of affluent families in the neighborhood.

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6. The percentage of overcrowded housing.
7. The percentage of residents that have lived there less than five years.
8. The economic, social and health outcomes of the neighborhood.
9. The number of crimes committed.

Hay and Jones (1994) indicate that perhaps the most crucial component of societal change regarding violence in general and violence toward children in particular, is education including:

- Traditional, school-based education of children and adolescents
- Public education
- Education of professionals
- Educational activities intended for parents, either in general or for particular targeted audiences.

Within the educational format are several approaches that can help prevent violence toward children. These include education in family relations, parenting, and child development. Likewise, a community can be facilitative in prevention and treatment of child abuse and neglect by creating programs, collaborating with agencies, and developing policies that protect children.

Research Issues

An example of informative data is the report funded by the Annie E. Casey Foundation and the Population Reference Bureau and published in April 2002 entitled, *A KIDS COUNT/PRB Report on Census 2000: American Indian and Alaska Native Children in the 2000 census*. This report presented the first data for American Indians from the 2000 census and brought to light the complex issue of identity and enumeration. For instance, there are three

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primary areas of confusion around the question of who is an American Indian: (1) blood quantum is a rule of descent used by the federal government; (2) tribal enrollment; and (3) some tribes are federally recognized, some are state recognized but not federally recognized, and some have neither state nor federal recognition (pp. 6-7). The author summarizes, “Suffice it to say that not everyone who might have a valid claim to being an American Indian is recognized as such by federal authorities, or even by other American Indians” (ibid, p. 8). Snipp adds that comparing the numbers of American Indians in the 2000 census with other census years is more problematic because there are now two sets of numbers to compare – AI “alone” or AI “alone/in combination” – resulting in a total of about 1.4 million AIAN children (p. 11).

Establishing identity becomes even more challenging when AIAN children do not “look” like they are Indian or Native and the worker wrongly assumes they “fit” some other classification or fails to ask the vital questions. In defense of the worker, however, there are times when adults fear identification because of the historical trauma associated with governmental agencies and a genuine lack of trust. In these instances, adults may lie about their heritage for two common reasons: (1) they fear retribution; and (2) they believe services will not be provided if they identify themselves or their children as being AIAN. A possible solution to this problem is provided by NICWA to explain how non-Indian workers with Indian clients can overcome historic distrust:

- Historic distrust is a reality in almost all cross-cultural interviewing situations.
- The dynamics of historic distrust are best handled when accepted as a given and not taken personally by the worker.

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- Respect for the distrust will enhance the worker's ability to establish a relationship that moves the helping process along (NICWA, 1996, p. 30).

In addition, establishing trust in the community is a primary issue, which becomes nearly insurmountable and highly sensitive when researching family violence. For instance, the Child Welfare League of America has a history of condoning and facilitating adoption of Indian children by non-Indians who lived far away from the child's home area or reservation. In some Indian communities, this history may chronologically date to pre-1978, the year when the Indian Child Welfare Act was passed. However, the community may have experienced such a high level of intergenerational grief and pain that the effects are physically and emotionally experienced today.

One solution is to use action-based research methodology. Workers enter the community prepared to listen rather than offer canned and "expert" solutions. The community identifies the "issues that hurt" and the "things that help" to capitalize on the community's strengths and to build a solid foundation for advocacy. For instance, one "hurt" may be the removal of children from the elementary school by child protection team members when child abuse/neglect is reported. The "help" may be a faculty or staff member employed by the school who knows the family and is willing to help the child protection worker. Another avenue for "help" may be an active foster grandparent organization in the school where elders will care for the child while the protection workers investigate. There are more answers intrinsic to the community but these answers can only come from that specific community. Establishing community trust and overcoming barriers can slowly but surely be accomplished by applying the community strengths identified by/for/with the community.

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Another issue that informs research in this area pertains to differing world views. Cross (1998) points out that, “Today, the linear model dominates delivery of family services, yet almost half the clients nationwide hold a relational world view” (p. 155). Non-Indian workers with Indian/Native families who come into a therapeutic setting will have different problem indicators and different solutions, which result from their different world views. One solution to this problem requires that the non-Indian worker deliberately and purposefully learn about the community in which they work by attending tribal council meetings or volunteering to help elders or asking Indian/Native people how they may help. By becoming a part of the community, the non-Indian worker will learn more about the differences in culture and traditions and hopefully get a better perspective of the relational world view.

The issue of abused/neglected children’s co-occurring needs found in the literature includes:

- Protection for safety sake while investigation is in progress.
- Aid for the families and children, especially community based agencies.
- Education and training to focus on prevention, public awareness, and advocacy.

Examples models for responding to these common co-occurring needs may include:

- The individual (the micro level) who may act as the child’s advocate by becoming a Court Appointed Special Advocate (CASA) volunteer.
- The neighborhood (the mezzo level) where “safe homes” are identified with signs in their front windows indicating a home where children will be protected.
- The community or city or reservation or village (the macro level) that includes parent/foster parent training to reduce intentional injuries among their children.

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Studies with abused and neglected children have identified four themes for understanding the traumatic impact of sexual abuse on children:

- **Traumatic Sexualization:** refers to the process in which the child's sexuality is shaped in a dysfunctional manner because of the incidence of child sexual abuse. Children who have been sexually abused experience sexual stimulation, which they do not have the emotional, cognitive or social capacity to handle. As a result, they often display inappropriate sexual behaviors.
- **Powerlessness:** is the process in which the child's will, desires and sense of efficacy are continually contravened. This results in the child feeling trapped, fearful and unable to protect himself-herself against harm.
- **Betrayal:** is the process in which the child feels betrayed because a trusted person has harmed or failed to protect him. The emotional responses to betrayal include grief, depression, extreme dependency, mistrust, and anger. Behavioral manifestations range from attachment disturbances such as clinging or withdrawal from intimacy to aggressive behaviors.
- **Stigmatization:** this process results from negative messages about the child's "badness" either communicated by others or construed by the child because of the emphasis on secrecy and the strong societal taboos relating to incest and sexual misbehavior. The psychological impact is manifested in low self-esteem, self-destructive behavior, feelings of guilt and shame, isolation and body image problems.

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In addition to these indices, researchers have found there are societal costs and symptoms, i.e., juvenile delinquents, adolescent runaways, violent crimes, sexual perpetration, prostitution, substance abuse.

- Child abuse is rarely reported after the first incidents occur.
- Children may attempt to protect an abusive parent.
- A child may indirectly disclose by talking about a “friend” who has been abused.
- Sometimes the outcry may not be verbal but portrayed in a drawing left for the teacher, the counselor or trusted relative to see.
- A child may go repeatedly to the school nurse to complain of vague symptoms, often without organic basis, hoping that the nurse will guess what has happened.

Interventions

Family services in urban areas vary depending on how organized the AIAN population has been since the relocation era. For instance, Minneapolis-St. Paul is highly organized with a number of federal and state agencies collaborating with the inter-tribal community to provide an array of services. However, in other urban areas AIAN family services may range from a few programs to none. Indian Health Service may or may not have contracted health care with urban nonprofit organizations since fiscal resources are distributed to reservation areas first.

The Denver Indian Family Resource Center (DIFRC) is an excellent example of partnerships in an urban community. The Casey Family Program joined with the Denver Indian Center, Denver Indian Health and Family Services, Native American Counseling, and members of the Denver community to construct this agency. It provides culturally appropriate services using a strengths-based and empowerment-oriented approach. Services are coordinated with

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active stakeholder participation. For instance, the DIFRC 2002 service delivery report indicates: 47 tribes served; 7 county departments of human services cooperated; Title VII programs and parent groups participated; Catholic Charities, a private agency, were involved; and two departments from the University of Denver (Graduate School of Social Work and Law School) contributed to meeting their annual goals. Families served has steadily increased from under 50 in January 2001 to over 125 in December 2002. Youth served has also had a steady increase from about 85 in January 2001 to almost 350 in December 2002 (Esquibel-Hunt, DIFRC, 2002).

The Indian Walk-In Center (IWIC) in Salt Lake City is another example of partnerships in urban Indian Country. The IWIC is one of the 214 health centers funded by IHS. Mental health services, as well as health and dental referrals, are contracted with IHS for a service area described as the “wasatch front,” from Brigham City to Spanish Fork, Utah, a distance of about 150 miles.

Practice Recommendations

We believe there are seven basic principles that govern practice in this area: individualization, acceptance, non-judgmental attitude, and purposeful expression of feelings, controlled emotional involvement, client self-determination, and confidentiality.

Holding fast to culture and tradition are strengths most Indian/Native communities possess. Researchers have found that the resilience of Indian/Native people is strong and viable. Working toward ending child abuse and neglect in Indian Country, consequently, is considered best practice when the culture and traditions are infused in the treatment methods. The following websites may provide practitioners with literature and guidance:

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- U.S. National Library and the National Institute of Health, child abuse topic:
<http://www.nlm.nih.gov/medlineplus/childabuse.html>
- Center for Disease Control, National Center for Injury Prevention and Control:
<http://www.cdec.gov/ncipc/factsheets/dvcan.htm>
- National Indian Child Welfare Association at <http://www.nicwa.org>
- Child Abuse Prevention Network at <http://child-abuse.com>
- National Data Archive on Child Abuse and Neglect at <http://www.ndacan.cornell.edu>
- National Clearinghouse on Child Abuse and Neglect (NCCAN) at
<http://www.calib.com/nccanch/>

Becoming culturally competent (responsive), knowing more about the population served, and being an active member of the community are three important ways community helpers can best serve the needs of AIAN people who are trying to overcome the devastation of child abuse/neglect. Like so many other skills sought and learned, becoming culturally competent to work with/for American Indian/Alaska Native families and children can be an exercise in becoming a better person. Consider the Sky Woman story told by Ojibwe people; she gave birth to all of the humans and their skin colors are yellow, red, black, and white. We all need each other to overcome the pain and agony associated with CAN.

Blended "...Indian and non-Indian approaches to child welfare issues" instill hope for the future of Native children (Hunt, Gooden & Barkdull, 2000, p. 165). Promising community-based interventions to reduce child abuse and neglect include home visitation programs, alcohol and substance abuse treatment programs, and programs to prevent unplanned pregnancies. Where previous research has resulted in a version of care known as "cultural competence," Hunt

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et.al. encourage going beyond cultural competence to “a broader definition of *culturally responsive* practice that goes *beyond* learning history, valuing diversity, and complying with policy”[italics in text] (ibid, p. 166). Hunt et.al. advocate that educators, workers, agencies and policy makers “... consciously choose a *change of heart* and deliberately put on a pair of *moccasins*” so the individual adapts more readily to the Native collective and becomes “re-dedicated to serve Indian children, families, communities, and nations ...”.

The leading organization in the United States and Canada is the National Indian Child Welfare Association (NICWA) in Portland, OR. Brochures and information from their website are highly encouraged, as they are reasonably priced, and come from the very heart of Indian Country. One booklet is specifically recommended, “Watchful eyes: Community involvement in preventing child abuse and neglect of Indian children” (NICWA, 1990). This booklet provides information that will help prevent abuse and neglect and, moreover, aid AIAN communities in returning “to the old ways of community involvement and family responsibility in the protection and care of [Indian] children” (p. 1). Using modern methods to prevent child abuse and neglect are blended with traditional AIAN values. An integral part of this booklet is the recommendation to the AIAN people to develop and implement a “Children’s Rights” document (p. 7). By taking a community approach, IHS and other organizations would have a formula, of sorts, to work with the community to be unified in their prevention programs.

Casey Family Programs (CFP) has joined with NICWA to form the National Indian Child Alliance (NICA). Briefly, CFP joined with NICWA in 1999 to increase permanency options for AIAN children in three areas: (1) conducting research to contribute to policy development on issues that pertain to AIAN children; (2) providing on-site training and technical assistance to

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tribes to enhance service options for their AIAN children and families; and (3) developing tribal adoption codes which incorporate cultural and historical practices that will result in a campaign to recruit and train more foster, kinship, and/or adoptive homes. Overall, NICA strives to provide AIAN children with a stronger foundation for achieving the permanency that all children deserve.

IHS and other DHHS agencies would bode well in following the Casey Family Programs' example by pooling resources, establishing common goals, and ultimately helping more children in Indian Country. For instance, goal 14 (of 18) from the original CFP Strategic Plan addresses services for AIAN children:

.... each Casey office serving Native American populations will be actively engaged in a collaborative initiative with other providers and leaders on and off reservations to expand existing services for Native American youth and to create new economic opportunities for Casey youth and others in the community (NICWA, 2001, p. i).

As a guide for best practice, we can take heed in the words of Sitting Bull, the Hunkpapa Lakota spiritual leader who said, "Let us put our minds together to see what we can build for our children."

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