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Child Abuse and Neglect in American Indian/ Alaska Native Communities and the Role of the Indian Health Service

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National Indian Justice Center

PHASE II
FINAL REPORT

Child Abuse and Neglect in American Indian/Alaska Native Communities and the Role of the Indian Health Service

NATIONAL INDIAN JUSTICE CENTER

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A non-profit corporation

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The National Indian Justice Center, Inc. (the Center) is an Indian owned and operated non- profit corporation with principal offices in Petaluma, California, (707) 762-8113. The Center was created through the combined efforts of those concerned with the improvement of tribal court systems and the administration of justice in Indian country. Its goals are to design and deliver legal education, research, and technical assistance which promote this improvement.

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- **Advanced Criminal Law**
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PHASE II
FINAL REPORT

Child Abuse and Neglect in American Indian/Alaska Native Communities and the Role of the Indian Health Service

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PHASE II
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In response to Department of Health and Human Services, Indian Health Service Request for Proposal (RFP) No. IHS 236-OP-0003(0) to study the "Role of the Indian Health Service (IHS) in the child Protection/Abuse Arena," the National Indian Justice Center submitted a research proposal and was awarded contract #282-90-0036 in accordance with IHS guidelines and regulations. The National Indian Justice Center is a 100% Indian owned and controlled non-profit corporation with offices in Petaluma, California, and Albuquerque, New Mexico. The goals of the Center are to design and deliver research, technical assistance, education, and training programs which promote the improvement of justice in Indian country.

TABLE OF CONTENTS

PAGE

LIST OF TABLES

LIST OF FIGURES

Executive Summary

NATIONAL INDIAN JUSTICE CENTER

EXECUTIVE SUMMARY

INTRODUCTION

The focus of Phases I and II of this project was threefold: 1) to design a method to assess the systemic response to child abuse; 2) to examine the role of the Indian Health Service (IHS) in child protection and child maltreatment; and 3) to develop a model intervention program. The ultimate objective was to provide the IHS with a comprehensive assessment of current programs, viable alternatives, and a systematic approach to addressing the problems of child maltreatment among Native American people.

There were many questions and concerns to be addressed by this project. In general, while it is agreed that the problem of child abuse is a concern for all tribes, there is wide inter-tribal variation in estimates of the prevalence, availability and acceptability of and quality of prevention and intervention programs. One aspect of this project was to attempt to define the parameters of child maltreatment, including the variations of such definitions that exist in American Indian/Alaska Native (AI/AN) communities. This project also examined current IHS policies and procedures that address the needs of abused and neglected children and their families. To fully explore these issues, it was also necessary to understand the extent of state, tribal, and Bureau of Indian Affairs (BIA) services that exist independently and/or conjointly with IHS services, as these entities are integral components of any child protection effort.

Several versions of federal, state, and local definitions of child abuse exist. Not surprisingly, different professions viewed child maltreatment from different perspectives, e.g., law enforcement personnel viewed abuse as criminal behavior. This makes it necessary for individuals working in a multidisciplinary arena to be aware of varying perspectives and the kinds of interventions that stem from different approaches.

PHASE I

PROGRAM EVALUATION

The project design for Phase I (Melton, Chino, and Fullerton 1991) integrated four main components: 1) a multilevel review of IHS policy and procedure; 2) a series of surveys regarding IHS program objectives, protocols, and coordination of efforts with other federal, tribal, and state agencies; 3) database research; and 4) background and support research. During Phase II researchers evaluated Phase I results, provided additional research and on-site assessments, and developed a model intervention program.

To fully comprehend and evaluate the issues that accompany research on child abuse and neglect among AI/AN tribes, it was necessary to understand the background of Indian law, culture, and political systems. These are the structures which are impacted when the breakdown of Indian family relationships results in maltreatment. Considerable variation exists in the intergovernmental relationships that tribes have with federal, state, and local governments with whom they may share jurisdiction over child protection and child maltreatment issues. Defining the nature of AI/AN child maltreatment required a broad based understanding of the unique social, behavioral, and political dynamics of Indian communities. These issues directly impact strategies for child abuse and child neglect (CA/CN) prevention and intervention.

Program evaluation entailed the specific examination of: identification, reporting and follow-up techniques and procedures for suspected cases of abuse and neglect; treatment protocols; variations in treatment of neglect, physical abuse, and sexual abuse cases; training programs and preparedness for intervention; and the involvement of, and interaction among, the IHS administrative staff, the service units, and the support teams. IHS policies, procedures, and stated goals and objectives regarding CA/CN were analyzed and compared with those of tribal, local, and state institutions or agencies. Current

documented IHS policy and procedures were compared with other regional and local programs. In addition to general policy and procedure comparisons, the following specific areas were examined through a detailed comparative analysis: 1) the variance in training needs of health teams in different communities, and 2) the type of training available in different areas.

SURVEYS

An effective, systematic, and impartial means of collecting information was needed because of the wide geographic dispersion of the IHS system throughout the country. Information regarding incidence of and response to CA/CN is not available as part of service systems within the IHS system. Therefore, these data had to be gathered from field research. Surveys were determined to be the most appropriate format for this data collection (See Phase I Report for description of survey development). The surveys provide an overview of the problem and the affected population. Sample selection was determined following preliminary discussions with key IHS representatives. A statistical analysis was used, taking into account the relevant statistical variables (e.g. expected effect size, the variability of the measure, and the significance criteria). The sample was designed to represent the Native American population, from within the IHS system, and individuals from external agencies and institutions that interact with IHS.

DATABASE RESEARCH

Database research focused on patient registration and inpatient data to assess actual implementation of IHS policy regarding identification, reporting, and intervention in suspected and confirmed cases of abuse and/or neglect. Examinations were conducted of rates, usage, and consistency of identification and reporting policies, type of information obtained, adherence to reporting guidelines, and the intervention chain of command. This analysis provided insight into the various aspects of program implementation and the conditions under which intervention takes place.

SUPPORT RESEARCH

The research and analysis served as the indicator for additional support projects providing essential information in areas reaching beyond the scope of the policy, database research, and surveys. This support research can also be used as a foundation for future, more detailed research in identified areas, which the IHS may wish to undertake, such as: 1) an analysis of IHS mental health programs through a description of services and a review of program goals and objectives; 2) an assessment of training programs within IHS and joint programs with other community agencies; 3) a comprehensive bibliography of current child maltreatment literature including a focus on Indian specific issues; 4) an analysis of the special problems of children affected by Fetal Alcohol Syndrome in relationship to child maltreatment; 5) the role and scope of the IHS Special Initiatives Team; 6) the role and scope of Child Protection Teams; and 7) contracting under the PL 93-"638" (Indian Self Determination Act) amendments.

PHASE II
SURVEY RESULTS

CASELOADS

Perhaps the most important result of the caseload investigation is the consensus between the IHS and BIA estimates of the number of children at risk for maltreatment in Indian communities. Both agencies estimated that 34.4% of Indian children are at risk of becoming victims of abuse and/or neglect. These estimates will help guide future decisions for all agencies involved in the protection of Indian children and the welfare of Indian families and communities. Respondents also estimated that only one in five reported cases is ever substantiated. The number of substantiated cases is a conservative estimation of actual abuse. While abuse may be strongly suspected by professionals, without independent confirmation, many cases are considered unsubstantiated.

REPORTING

Although reporting is mandatory for federal employees, there is still some reluctance to report abuse. The most commonly cited causes for failure to report were a fear of reprisal for reporting the case, the belief that nothing would come of the report, lack of clear directives, and a lack of training concerning where to report suspected cases. These themes must be addressed through training, administrative leadership, and implementation of reporting procedures and protocols to protect the employee suspecting abuse. The common reasons for child abuse and neglect cases to go unreported and/or unsubstantiated are a lack of reporting, poor interagency communication, lack of sufficient expert personnel to investigate, and lack of corroborative evidence for substantiation.

TRAINING

The lack of adequately trained staff was repeatedly mentioned as a problem by both IHS and BIA personnel, and was considered to be the biggest hindrance to effective interagency coordination of services. The type of training, its adequacy, and the means by which it was administered varied among IHS and BIA personnel. IHS professionals were more likely to receive training in prevention, detection of abuse and neglect, and case reporting. BIA personnel were more likely to receive training in technical skills such as detection and diagnosis, forensics, interviewing, investigation, and criminal justice activities such as testifying and prosecution. While these differences reflect the differing missions of each agency, the results suggest that a core curriculum, including some level of cross training, should be developed with ongoing training provided to both IHS and BIA staff.

MANAGEMENT INFORMATION SYSTEMS

Only 25% of respondents had computerized records. This creates limitations in obtaining baseline information, case management information, and obstructs information retrieval for service and policy planning. Without adequate and accessible case information, tracking AI/AN child abuse cases is

problematic due to the number of agencies at local, state, tribal, and federal agencies that may be involved. Case tracking is an essential tool for coordination of services for victims, to promote justice for offenders, and for the development of comprehensive interagency policies and agreements. The need for a centralized system of data collection was reflected in IHS (71.3%) and BIA (86.2%) support for the establishment of a national AI/AN central registry for child abuse and neglect. Such a registry could be a valuable resource if additional funding could be provided for this purpose.

SUBSTANCE ABUSE AND CHILD MALTREATMENT

Respondents agreed that child maltreatment is not an isolated issue, rather it is associated with the myriad problems families face (e.g. poverty, isolation, and substance abuse). Almost all respondents cited alcohol abuse as a contributing factor to maltreatment. However, few programs combined victim treatment or services with specific family or individual alcohol treatment. The data from this research indicated that substance abuse was a factor in nearly three quarters (70.3%) of cases in which such data were collected (n=2,035). The prevalence of substance abuse varied with offender sex, offender relationship to victim, offender age, and type of abuse. Incidents with male offenders were significantly less likely to involve substance abuse (60% of incidents) than incidents with female offenders (70.4% of incidents).

When examined by offender relationship, incidents with offenders who were mothers or fathers were approximately equally likely to involve substance abuse (76.0% and 73.4%, respectively). Cases in which both parents were involved had the highest proportion of substance abuse (83. 1%). Other offenders had lower rates of substance abuse; approximately half of cases involving social fathers (56.9%) or biologic relatives (42.0%) included substance abuse as a factor in the incidents.

An analysis of the association of substance abuse and abuse type revealed that incidents of sexual abuse were significantly less likely to be associated with substance abuse (47.0%) than either incidents

of physical abuse (69.4%) or neglect (78.2%). The difference between incidents of neglect and other abuse types was also statistically significant. Substance abuse was least frequently reported in incidents involving the youngest,(younger than 20 years old), and oldest, (older than 40 years old), offenders. In the interim age categories, ages 20-40, substance abuse was a factor in approximately three quarters of reported incidents. The differences in substance use among different age groups were statistically significant.

In future studies of child abuse and neglect involving AI/AN children, it will be important to assess what interrelationships exist between substance abuse and child maltreatment, and what types of programs directed at the specific problems and needs of Indian people exist or need to be instituted in order to address these issues.

ON-SITE COMMUNITY ASSESSMENTS

Six service units were selected for an in-depth, on-site community health and risk assessment. In order to select a location to pilot the proposed intervention program, the current availability of intervention programs within each of the individual service units and between the IHS and other agencies in each community was assessed. The sites were selected to include information in both urban and reservation settings, and in communities with varying types of facilities, services, interagency agreements, and levels of interaction with the IHS on CA/CN issues. Each field visit averaged three days and included an in-depth CA/CN records review and personal interviews with IHS, BIA, and tribal service providers involved in child maltreatment and child protection services and issues.

ANALYSIS OF CASE STATISTICS

Case statistics were collected from Federal agencies through the mail survey format. The variables included non-identifying demographic and incident-specific information. The goal was to develop a profile of maltreatment cases, the victim population, and the offender population. There were

four primary data sets included in the data analysis: 1) a national data set of over 2000 incidents of child maltreatment reported from 17 states and 10 of the 12 IHS service units; 2) a data set of over 300 incidents reported by BIA school personnel; 3) a comprehensive data set of over 1300 reports from the state of Alaska reflecting the caseload for Anchorage and 70 other Alaskan cities and villages in the surrounding area; and 4) a data set with case information from several communities in New Mexico. This analysis has provided the first, extensive, national American Indian and Alaska Native CA/CN data set.

CASE STATISTICS

Case specific information was gathered nationwide for 2035 reported cases of Indian child abuse and neglect. The analysis of these data has provided the first national profile of Indian child maltreatment. This information has important implications for Indian-specific prevention and intervention efforts. The data represent 17 states and 10 of the 12 regional IHS service areas. As with trends for the general population, neglect cases outnumber those of physical and sexual abuse. The greatest proportion of reported cases were of neglect (48.9%). Sexual abuse (28. 1 %) and physical abuse (20.8%) cases comprised most of the remainder of the reports. Considerable variation exists within individual service areas, with some reporting a preponderance of neglect cases and few physical and sexual abuse cases, and other Areas reporting relatively high numbers of physical and sexual abuse cases in proportion to neglect cases. One of the most important findings is that almost 80% (79.4%) of all cases occur in the child's home (Figure 1E). Less frequently, incidents of abuse and neglect occurred at school (3.9%), a friend's home (3.0%), or other locations (8.0%).

A disproportionate number of victims are under the age of five with a substantial number under one year of age. While boys and girls were about equally likely to be victims of physical abuse (52.8% boys) and neglect (51.1 % boys), sexual abuse victims were primarily girls (79.8%).

Overall, offenders were equally likely to be male or female (48.9% male, 51.1% female), but

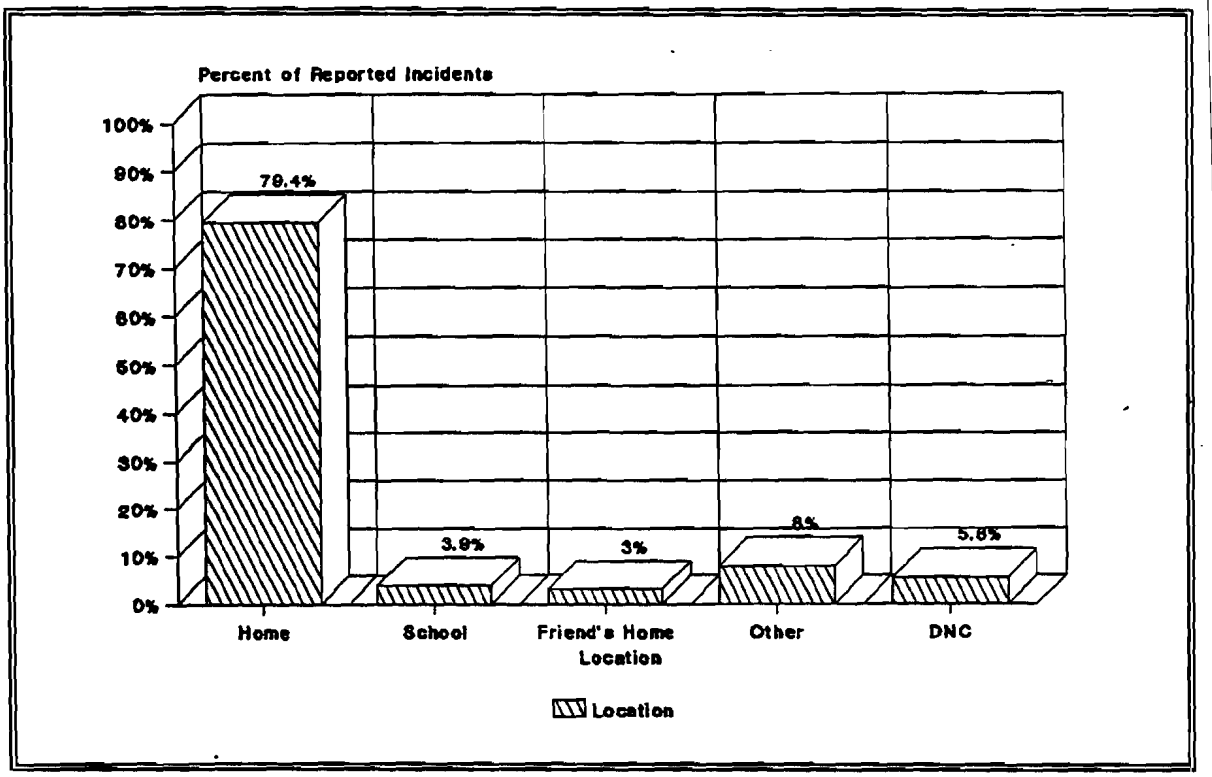

Figure 1E. Location At Which Reported Incident Occurred

a sex bias is evident when cases are further distinguished by type of abuse. Offenders are significantly more likely to be male in cases of sexual abuse (90.2% male) and physical abuse (59.3% male), and most often female (74.7% female) in cases of neglect. The most frequently reported offenders (69.3%) were victims' parents (mothers, fathers, social fathers, or both parents together, Figure 2E). Step-fathers, mothers' boyfriends, and other "social fathers" comprised only a small percentage of that total (5.4%) and the remaining percent were mostly other biological relatives (12.7%) or others (3.6%).

Relationship information from Figure 2E, in combination with age information from Figure 3E, provide a profile of offenders and CA/CN incidents. When abuse type is examined by victim-offender relationship and by offender age (Figure 3E), significant differences exist. Mothers over the age of 20 (as opposed to teenage mothers) were the primary offenders in cases of neglect (62.9% of neglect cases) and fathers were the primary offenders in cases of physical abuse (36.3% of cases). Step-fathers

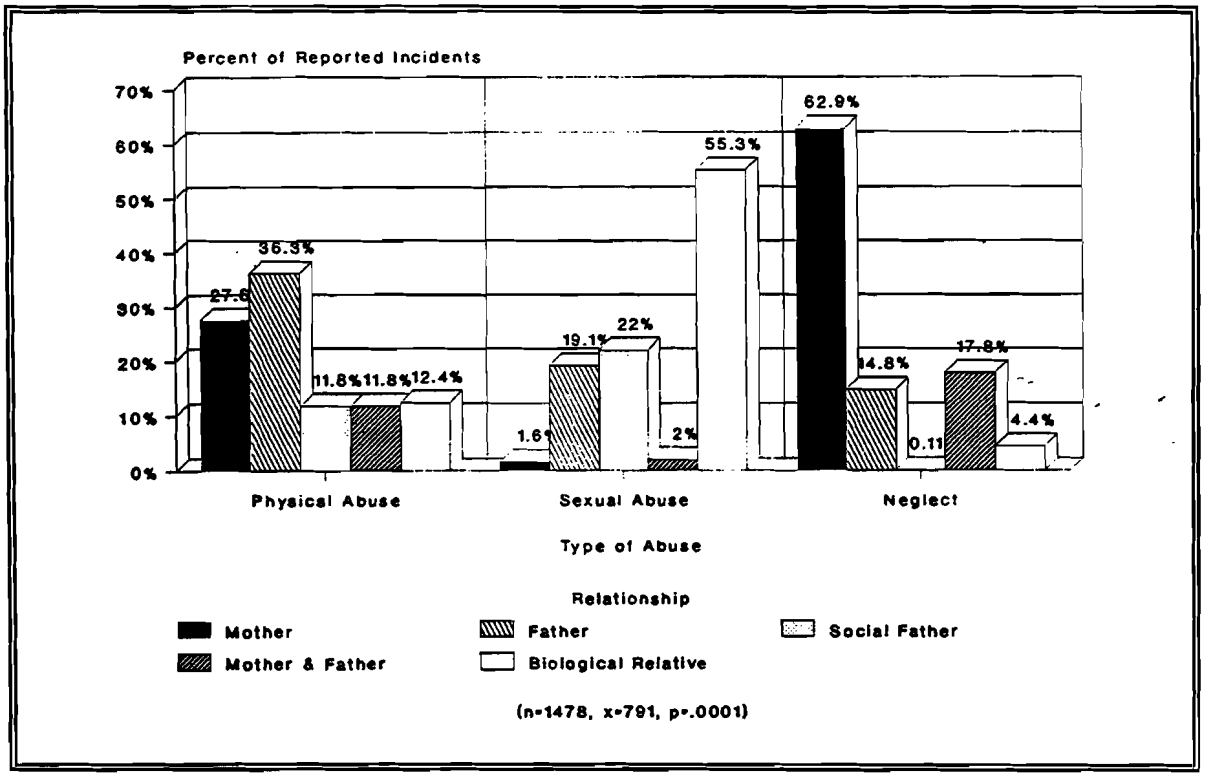

Figure 2E. Victim-Offender Relationship, by Abuse Type

and other social fathers were over-represented in cases of both physical (11.8%) and sexual abuse (22.0%). Other biological relatives, primarily those under the age of 20 and over the age of 50 were the primary perpetrators of sexual abuse (55.3% of cases). Thus the greatest threat of sexual abuse may come from individuals such as siblings, cousins, older uncles, and grandparents, that is, members of the extended family network. The implications of these data are far reaching.

MODEL INTERVENTION PROGRAM

A model for prevention and intervention was identified based on the totality of information available to the research team. This model, based on the Hawaii Healthy Start program, will be known as New Beginnings in Indian Country (hereafter, New Beginnings). The most appropriate and effective type of intervention program for the IHS to implement was determined to be a program targeting families at risk (secondary prevention). As the primary health agency for Indian people, the IHS has a primary

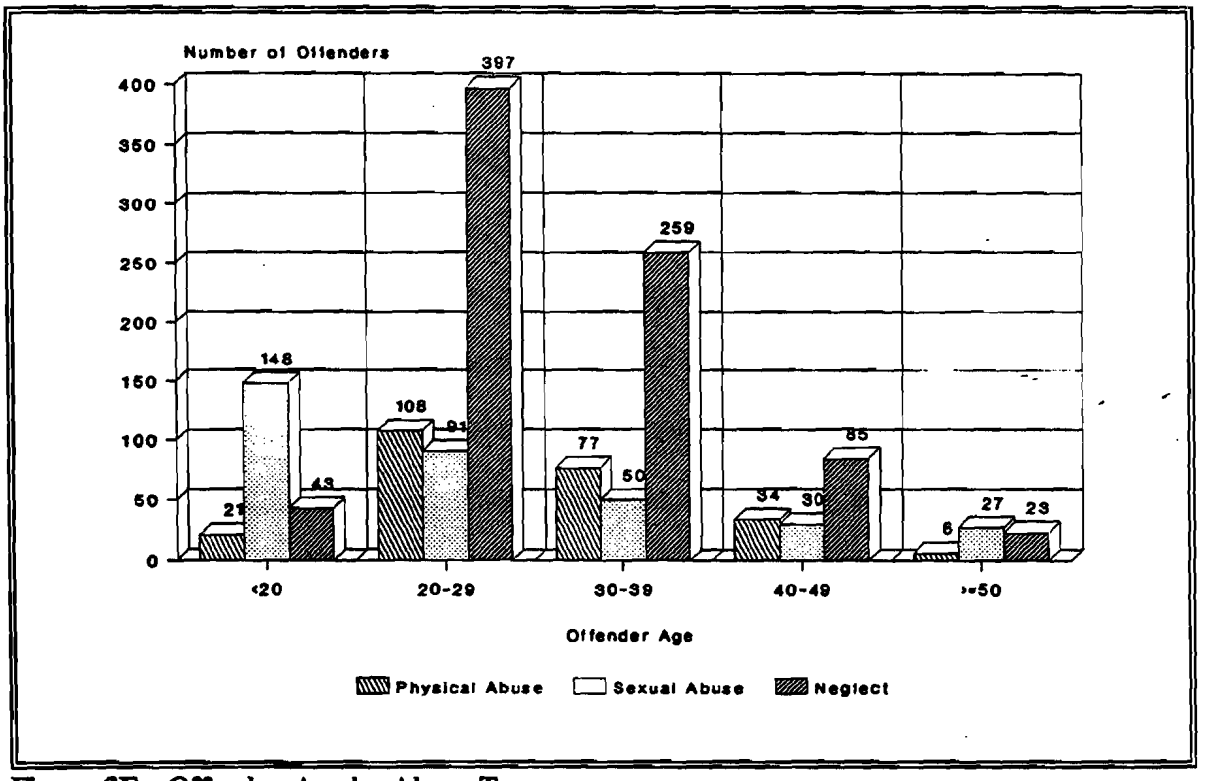

Figure 3E. Offender Age by Abuse Type

role in secondary prevention and is the most appropriate agency to identify families at risk, provide health services, and link families to additional services.

Research has indicated that the essential components of a secondary prevention program include home visitor services, the promotion of healthy child growth and development, and a series of key program elements. Home visitor services for new mothers have been studied worldwide and are repeatedly cited as the most effective CA/CN prevention effort known to date. The use of locally recruited and locally trained paraprofessionals may be an effective means of providing home based services, when supported and monitored by key professionals. The basic requirements of healthy growth and development include: 1) adequate and continuous prenatal care; 2) health promotion and primary health care; 3) parental competency; 4) quality child care; and 5) home visitor services and linkage to agencies. These components are critical to any prevention program. The key elements that contribute

to program success include: 1) systematic screening; 2) timing of intervention; 3) intensity of intervention; 4) length of follow-up; 5) comprehensive services; 6) commitment and quality of staff; 7) standardized training; 8) linkage to state child health programs; 9) a tribal/public/private partnership; and 10) family focused intervention.

The goals of New Beginnings are to identify all at-risk families, provide home-based services, promote family functioning, promote healthy child development, link families to a medical services (known as a "medical home") and community services and, in doing so, prevent child abuse and neglect. It is also designed to address the specific social and cultural needs of clients and the community. This program presents an opportunity to: increase services and support to families in need; reverse the rising incidence of child maltreatment; and reduce the physical, emotional, and societal costs of maltreatment.

Public Law 101-630, the "Indian Child Protection and Family Violence Prevention Act" of 1990 was designed to address the problems associated with the maltreatment of Indian children, citing under-reporting, background checks, and inadequate funding as areas for reform. The Act recognized the value of protecting Indian children from abuse and the need for treatment for victims and provides for the treatment, prevention, and the establishment of tribally operated programs to protect Indian children. Section 411, subsection (d) states that "Funds provided pursuant to this section may be used for ... (7) innovative and culturally relevant programs and projects as the Secretary may approve, including program and projects for ... (C) home health visitor programs." The program designed through this research, New Beginnings, follows the intent of this Act. Federal recognition and support is a powerful force for program development, but more important the New Beginnings program is appropriate to the needs of AI/AN families and the realities of service provision in AI/AN communities.

CHILD PROTECTION TEAMS

The IHS and BIA have been mandated to develop and participate in multidisciplinary Child Protection Teams (CPTs). The variation that exists between local CPTs makes it difficult to generalize about team functioning and effectiveness. Results of the surveys indicate that strong membership and clearly outlined goals and responsibilities seem to maximize team effectiveness, while length of existence had minimal effect. National research on CPTs indicates that written policies, procedures, mission statements and interagency agreements are important to formalize the CPT, standardize its operation, make its activities more consistent, and protect its stability and operation against changes in membership. Another way to strengthen CPTs is to fund a coordinator who maintains a neutral position and has primary allegiance to the interests of victims and their families, members of the CPT, participating agencies, and the community.

THE ROLE AND RESPONSIBILITY OF THE INDIAN HEALTH SERVICE

The primary responsibility of the IHS is widely perceived to be to provide quality prevention and intervention health care services to all Indian people. The responsibility of the IHS in addressing issues of child maltreatment are to: 1) promote individual, family, and community wellness; 2) identify families at risk and provide needed services and links to community services; and 3) provide adequate treatment and services for identified cases. The role of the IHS should be one of service provider with the extent of services provided a function of the needs of the community and the availability of alternatives. The IHS has an important *supportive* role in primary prevention. That is, the IHS should support and promote community efforts to increase public awareness of CA/CN through educational activities and other methods. The IHS has the *primary* role in secondary prevention. That is, they have the responsibility for identifying families at risk, providing needed services, and linking these families to

community services. However, inadequate funding has made providing these services adequately extremely difficult. The IHS is in a strategic position to reduce the flow of new cases of CA/CN and make it possible for tertiary efforts to be effective. In tertiary prevention, the IHS has a *shared* role with the BIA, tribal, state, and other agencies in providing services in cases of CA/CN. As part of the response group, the IHS shares the ability for funding programs and providing staff and training to handle the needs of victims, offenders, and their families.

The IHS has the potential to profoundly impact the prevalence of child abuse and provide treatment programs for the victims, the perpetrators, and their families, effectively increasing the physical and social health and well-being of Indian people. The mission statements of the IHS and its branch divisions indicate a federal level understanding of the responsibilities outlined above. How this mission is reflected in local communities, however, is an indication of the inconsistencies that exist in the delivery of services and the prioritization for use of available funding resources.

CONCLUSIONS AND RECOMMENDATIONS

The results of Phases I and II have highlighted ways in which the Indian Health Service performs in an exemplary manner, ways it can function adequately under current policy and procedures, and areas where change is implicated. The Indian Health Service, the tribal communities served, and the nation itself have changed markedly in the past 40 years. In order to adequately address the current needs of Indian families and promote healthy family and child development in the next decade and prepare for the future, it is recommended that:

- The IHS should increasingly incorporate a public health model into the existing medical model.
- The IHS must make a commitment to providing secondary prevention services to victims of child abuse and neglect and their families, including the provision of extended services

to "at-risk" children and their families.

- The IHS should designate one branch (e.g. Maternal and Child Health) to have primary responsibility for coordinating programs, treatment, and other services regarding child abuse and neglect.

- The IHS should work with tribes to develop a centralized reporting/referral resource office within each Service Unit. This resource would provide a direct link between a referral and available intervention resources, provide coordination between services and agencies, provide information to the general public, assist medical personnel in following the correct referral process, and provide an array of treatment options along with centralized case tracking, case management, and follow-up.

- The IHS should standardize and integrate data collection procedures at local, service unit, area and national levels. Data must be accessible at both operational and clinical levels for effective administration, program planning, evaluation, and research.

- The IHS should train and utilize more local paraprofessionals for specialized CA/CN services for "at-risk" families such as home visitors, early identification workers, and case managers, in order to support and assist the limited number of professionals available. Professional oversight for the paraprofessional staff should be available from IHS staff.

- The IHS should increasingly incorporate the use of AI/AN traditional cultural and healing in treatment according to the needs of individual communities.

- The IHS should provide services for offenders.

- The IHS should coordinate mental health and social services with alcohol abuse programs.

- The IHS should promote community awareness programs and public relations campaigns for new and existing services in coordination with tribal, state and BIA agencies.

NEW BEGINNINGS IN INDIAN HEALTH: A PROGRAM FOR PREVENTION AND INTERVENTION

NEED FOR PREVENTIVE ACTION

Efforts to reduce the incidence of child maltreatment includes promoting healthy child growth and development. The basic requirements for healthy growth and development include adequate and regular

prenatal care, primary health care and health promotion, parental competency and social support networks, quality child care, home visitor services, and linkages to agencies. The nature of the home environment influences the treatment of children. Services for vulnerable families must support healthy child development, enhance family coping skills, expand referrals to services (intensive, comprehensive, and continuous services), and foster self-sufficiency. As societal demands often reduce a family's ability to cope, families also need to learn to mitigate social stressors.

A comprehensive response to CA/CN was developed in the state of Hawaii in 1985. This program, called "Healthy Start," provides home visitor services to new mothers, ensures continuity and consistency of medical care for children, and links families to a variety of needed services. The ultimate goal is to reduce the incidence of CA/CN by building healthy families. This program attempts to meet this goal by directly addressing the basic needs of children and families at-risk or in need, individualized according to the specific needs and level of risk of each child and family. The highly successful Healthy Start program model has now expanded to communities across the country and is strongly supported and recommended by the National Committee for Prevention of Child Abuse (NCPCA). This is the model that was used to develop the proposed intervention model for the IHS, entitled: *New Beginnings in Indian Health.*

The Healthy People 2000: National Health Promotion and Disease Prevention Objectives (1990) states that violent and abusive behavior exacts a large toll on the physical and mental health of Americans: AI/AN are no exception. The years of potential life lost (YPLL) due to premature violent death is a cause for great concern among AI/AN people. *The Healthy People 2000* objectives state the need for multidisciplinary cooperation and integration, quality data, and effective services that address substance abuse, education and training, and are sensitive to cultural differences. The report states that much remains unknown about effective means for reducing violent and abusive behavior. However, current

studies attest to the positive effects of home visitor programs and the well-documented success of the Healthy Start Program implemented in Hawaii provide evidence for potential solutions to the problems of family violence and child maltreatment. The New Beginnings program is a multidisciplinary approach with built in data management, training, and evaluation components. The program is designed to incorporate the social and cultural values of clients and communities. The program provides the communities the opportunity to increase public awareness, provide services and support to families in need, reverse the rising incidence of child maltreatment, and reduce the physical, emotional, and societal costs of maltreatment.

PROGRAM OVERVIEW

New Beginnings is a systematic approach to the prevention of child abuse among families with children from birth to age five (most child abuse-related deaths are children under five years of age). The program's goals are to identify all at-risk families, provide these families with home based services, promote family functioning, promote healthy child development, prevent child abuse and neglect, and link families to a medical home and community services. The basic components include early identification of at-risk families, home visitor services, and linkages to medical care and social services. The program relies on locally recruited paraprofessionals, utilizing specialists when needed. Professional staff are recruited to develop group services in conjunction with other community and family activities (e.g. recreation, celebrations, activities around child play, etc.). The New Beginnings staff also includes a nurse, a child development specialist, and a child health specialist. Professional and paraprofessional staff work together as a team to provide quality services.

The program provides an assessment of parent-child interaction, a model for parent-child activities, and parenting techniques. These activities reduce parent stress and promote parent-infant bonding. The Family Stress Checklist, Nursing Child Assessment Training (NCAST) home, feeding, and

teaching scales, and Revised Denver Prescreening Developmental Questionnaire (RPDQ) tests provide early identification for referrals to needed services. New Beginnings also provides developmental screening and links families with a medical home (well-child care), as well as training and technical assistance for staff members.

One problem faced by CA/CN prevention and other family service programs is that it is sometimes difficult to get those in need to utilize the services offered. Families often do not use programs because: they are unaware of services, they lack transportation or child care, or they feel overwhelmed by the process. New Beginnings facilitates the utilization of services by providing access to insurance, transportation, referrals to Public Health Nurses and the Women, Infants, and Children's (WIC) program, as well as promoting dental health care and special needs programs. The Family Service Worker (FSW) introduces the family to the team nurse, who comes in at 2-4, 12, and 18 months. The team child health specialist monitors the family's medical care (i.e., documentation of well visits, sick visits, immunizations, and developmental milestones) and provides this information to the family upon their graduation from New Beginnings.

Upon referral to the program, the New Beginnings team discusses potential risk factors and family issues. The supervisor assigns a worker to the family and reviews the case, strategies, and safety concerns with the FSW. The goals of the initial contact phase are to: 1) reduce family stress through support, resources, etc.; 2) promote positive parenting through skills-building and changing behaviors; 3) promote child health; and 4) help families learn to help themselves. Children are followed to age five, after which time the educational system becomes the link between the family and the community.

A system of client levels provides a method to determine the intensity of service required for each client family and to mark a family's progress from "high" to "low" risk status. The families' progress is assessed based on the workers' observations of family coping skills, resources, and potential risk

factors and also serves to move families safely and efficiently through the program. All clients enter the program at Level 1 which provides for a minimum of one hour-long home visit per week. Level I involves close observations and data collection by the home visitor and careful scrutiny by the supervisor to assess the level of risk to the infant and to determine service needs. Level 2 provides a minimum of one home visit every other week, with a phone call on alternate weeks. Level 3 provides a monthly home visit with phone calls on non-visit weeks. Level 4 provides quarterly follow-up for families no longer perceived to be at-risk. The family will then be seen on a quarterly basis until the target child is five years old.

Intensive services over a long period of time ensure effectiveness. Critical elements include: starting at the time of birth, universal reaching-out, voluntary services, screening for high risk families, long-term commitment, intensive services, home visits, flexible services, emphasis of social support and ties to other services, and training.

Each New Beginnings program can be modified to suit the particular needs of its community. The New Beginnings staff participate in community functions to promote acceptance. Collaborative efforts make the program work. Using community members as workers increases staff retention rates and provides more sensitivity to the needs of individual families and local customs (e.g. language, dress, behavior, etc.). FSWs need to understand the community strengths and existing resources.

PROGRAM COMPONENTS

EARLY IDENTIFICATION

The two goals of the early identification (EID) program are to: identify all families of newborns who are at-risk for child abuse and neglect in the target area and to successfully refer these families to the New Beginnings Programs and other resources as appropriate. Early identification requires an agreement with local hospitals to conduct screenings, to access medical charts, and to obtain consent forms for participation in the program. The identification of families at-risk is done through hospital-based case-finding at the time of birth. This provides a systematic approach to finding at-risk families and offering them services. Such families often do not seek services and may be resistant to services offered, may lack trust, and are often socially isolated. Professionals and service providers are often too busy to go beyond their own area of focus to make appropriate and necessary referrals. New Beginnings addresses these concerns.

SCREENING

Screening information comes from the hospital chart and an interview with the mother. Information regarding the family's social environment, stressors, domestic violence, expectations, discipline, perceptions of the infant, and level of bonding is included in the screening. A positive screen indicates that more information is needed. The next step is to prepare an intake summary. Families are not told that the program is a CA/CN program-with most it does not become an issue, rather support is the focus of the services available through this program. Whether CA/CN later occurs is only one of the outcomes reviewed. Only about 10% of the families cannot or will not accept services. If the mother wants services, but her partner objects, New Beginnings can provide visits/services at alternative locations and in alternative ways.

FAMILY SUPPORT

Provision of home-based family support has become recognized as a most effective intervention

with families at risk for child abuse and neglect. The need to provide services on a home outreach basis is related to the characteristics of these families, including their social isolation and inability to trust. These families are unlikely to seek services, to come to an office for services, or to attend classes or groups designed to assist new mothers. Home visits provide an opportunity to work within the family's own environment and family context.

It is important to define the role of the FSW. Home visitor development involves getting to know the family, identifying the needs of the client, defining roles within the family, and attention to the needs of the baby. FSWs provide sustained family contact while respecting the family's right to privacy. Sometimes a child's needs compete with urgent family problems which may delay attention to the child's problems. Infancy is a critical developmental period such postponements must be minimized. Workers must be able to help families immediately alleviate acute needs. FSWs maximize professional involvement where necessary and mobilize clients to act on their own behalf.

Family Service Workers have a critical role and need to have several important skills. Workers must be empathetic, objective listeners and must be able to build enduring personal relationships. Workers focus on issues pertinent to the family with an emphasis on nurturing both mother and baby to help foster a positive connection. FSWs focus on observable behaviors to evaluate a mother's competence and suggest improvements where necessary. They focus on the baby's behavior in response to the mother's actions and must affirm mother as the most important person to the baby while mitigating the mother's life stressors. The approach of the home visitor is to provide a trusting, supportive, nurturing relationship with clients and to maintain that relationship while facilitating development of a positive parent-child interaction and the parenting and coping skills.

THE MEDICAL HOME

The multiple and pervasive nature of risk factors challenging today's families requires comprehensive and integrated solutions. The "New Morbidity" has been used to describe the multitude

of risk factors impacting child health, including environmental risk, biological risk, developmental delay, and behavioral problems. The New Beginnings program has developed the "Child Health Care Plan" to address problems related to infant vulnerability. A child is vulnerable and has specific needs which, if not met, can lead to future problems. Because of rapid growth in infancy and childhood, early attention to prevention and a plan for optimal early development are critical. The medical home is a comprehensive health care concept addressing the needs of the whole child. Health care providers must reach the child early on. They need to detect environmental problems, support the family, and get the child involved in health care maintenance in order to tie family and infant growth together. Health professionals are also in the best position to detect early medical, developmental, and social problems. The responsibilities of the medical home component include periodic screening, well child care, medical management, continuity of care, coordination of care, and family support. The medical resources available for Indian families through the Indian Health Service can be utilized to provide the medical home component and interface with the New Beginnings program.

The expected success of the New Beginnings program is attributed to systematic screening, the timing of intervention (birth), the intensity of intervention, the length of follow-up (up to 5 years), the provision of comprehensive services, the commitment and quality of the staff, standardized training, linkage to other programs, a focus on the family, and partnership. Basically, New Beginnings provides a focus on long-term change with attention to immediate needs. Success for Indian communities will come from a commitment to a state/tribal-wide program, a commitment to collaboration with other agencies, persistence in educating legislators, data gathering and evaluation, persistent lobbying with key legislators, effective public-private partnerships, standardized training and technical assistance, and program standards. The opportunity for a state of-the-art, cost-effective, comprehensive, short- and long-term solution to the problems of child abuse and neglect among Indian people now exists.

Research Activities

NATIONAL INDIAN JUSTICE CENTER

RESEARCH ACTIVITIES

INTRODUCTION

This study was designed to research the issue of child abuse in American Indian/Alaska Native (AI/AN) communities and how these problems are addressed by the Indian Health Service (IHS). The specific goals of this research were: 1) to provide a comprehensive assessment of the effectiveness of IHS policy, procedure, and personnel in the recognition and treatment of child abuse and child neglect (CA/CN); and 2) to facilitate the design of an intervention program flexible enough to be used by AI/AN communities across the country. To meet these goals, it was necessary to: 1) assess the incidence of CA/CN among AI/AN people; 2) understand the variation among tribal and urban Indian communities in their response to, and acceptance of, the existence of CA/CN; 3) review resources available within the IHS and through other agencies, for the support of prevention and intervention programs; and, 4) determine the most appropriate type of intervention for the IHS to implement.

This research integrated administrative, medical, and legal aspects with social and epidemiological perspectives on human behavior to comprehensively address the problem of child abuse. This comprehensive perspective offered insight into the dynamics of family systems wherein cultural beliefs, traditions, and values are transmitted through generations. In addition, understanding similarities and differences in patterns of abuse and neglect between Indian and non-Indian cultures can serve to highlight the differences that exist and lead to unique and effective solutions for addressing CA/CN in AI/AN communities. This information, in combination with an understanding of the network of resources and limitations in Indian communities, provided the means necessary to develop an appropriate and effective model for prevention and intervention.

In assessing the role of the IHS, specific internal IHS programs, policies, and procedures were examined through policy review and surveys. Survey research consisted of both internal and external

surveys. Internal surveys focused on the IHS network at both the administrative and program staff levels, i.e. medical, social services, and mental health personnel and health teams. External program and policy research and the surveys focused on community support institutions such as the Bureau of Indian Affairs (BIA), local and tribal courts, schools, social workers, and law enforcement. The analysis of indicators of CA/CN focused on medical records, case reports, and referrals.

Concomitant research on issues of child protection, CA/CN as they apply to victims, offenders, families, and communities, also needed to be addressed within the body of the research. These issues included:

- the variance in effectiveness of child protection services;
- the effective utilization of state and public mental health systems, including increased emphasis on third party revenues, such as Medicaid, to expand health services;
- the use of Native healers and Native healing ceremonies and concepts, considered an important physical and mental health resource by AI/AN communities;
- services and programs that address the needs of urban Indians, who comprise about one-half the total AI/AN population;
- the current IHS definition of CA/CN and the diversity in definitions between facilities and between the IHS and external support agencies;
- screening mechanisms, the identification process, and identification of abuse (e.g. cases of child abuse incorrectly identified as "not abuse," and cases that are not abuse incorrectly labeled "child abuse");
- morbidity, mortality, and risk of injury for AI/AN children resulting from CA/CN;
- the inherent costs and benefits of epidemiologic factors (health care, sanitation, crowding, immunizations, nutrition, the environment) and demographic factors (increasing acculturation, shifting economics, the availability and control of resources, the structure of families, parenting patterns) that tribes must deal with;
- variables that consistently correlate with CA/CN including family structure, household composition, and child characteristics;
- the risk of maltreatment for disabled, low birth weight, premature, and unplanned children;

- the correlations between physical abuse of children and other forms of family violence; and
- the relationship between CA/CN and the use and abuse of drugs and alcohol.

PHASE I ACTIVITIES

Phase I of the research project gathered information on the extent of child maltreatment in Native American communities, studied the role of the IHS in CA/CN, and designed a method for future research. The research design integrated policy analysis, database analysis, and survey research and analysis as they apply to the policy, procedures, protocols, and coordinated components of the project.

Current, documented IHS policy and procedure were compared with other regional and local programs. Internal surveys at both the administrative and line staff levels examined the interpretation, level of compliance, and effectiveness of current policy. External surveys identified community awareness of the inherent problems associated with: 1) issues of child maltreatment; 2) issues specific to Native Americans; 3) perceptions, attitudes, and use of available IHS resources; 4) the politics of reporting; and 5) perceived levels of communication between social services, law enforcement agencies, schools, and health teams.

The data collection phase of this project was designed to obtain background and support information and to obtain both quantitative and qualitative data through mail and telephone surveys. Background research focused on a review of available literature, existing prevention and intervention programs, and census data.

SURVEYS

More detailed and site-specific data were collected through surveys and fact finding. Surveys were administered within the 12 IHS Areas and, where possible, related BIA agencies. Tribal agencies were not included due to restrictions and limitations on surveys of non-Federal agencies by the Office of Management and Budget.

Quantitative data were obtained primarily from administrative personnel through self-administered mail questionnaires. Quantitative measurements included total agency budgets and the proportion spent toward CA/CN prevention and intervention services, CA/CN policy and procedure, the number and position of relevant personnel and retention rates of these individuals, information regarding staff training and background checks, and the types of treatment and services available. The gathering of individual case statistics was a critical component of the data collection.

The mail questionnaires were developed as a cost effective means for gathering secondary data that would provide information about funding, interagency agreements, staffing and personnel issues and records management including available case statistics. Two versions of a self-administered mail survey were designed. One was directed toward the 12 IHS Area directors, 229 IHS Service Unit and facility directors, the 12 BIA Area directors, and the 89 BIA Agency superintendents. The second version was modified to address BIA Education administrators from 215 BIA schools.

There were 90 IHS service units within the 12 regional areas eligible for inclusion. They were defined as: 1) being the central administrative unit (or facility when the service unit contained more than one facility); 2) not a tribally run facility; and 3) providing direct services. We received 85 valid responses yielding a 94% response rate (85/90). There were ultimately 58 potential respondents within the 12 BIA regional areas included in the mail survey. We received 46 valid responses yielding a 79% response rate (46/58).

More qualitative types of data were obtained from program staff through a series of telephone interviews. Qualitative measures included questions about perspectives on issues regarding jurisdiction, interagency cooperation, provision of services, attitudes about child maltreatment, treatment needs, awareness of the issues, the community within which the individual functions, and the types of cases seen. The telephone questionnaires were developed as a means of assessing qualitative data and getting feedback on issues that impact the quality of services caregivers are able to provide. The target population

consisted of 160 individuals representing medical, social services, and mental health personnel from a preselected cluster of 40 IHS service units and a comparable number from related BIA agency law enforcement and social services, and the National Oversight Committee on Child Protection.

METHOD - SAMPLE DESIGN

RESPONDENTS

There were several respondents appropriate for inclusion in the survey research. All were individuals who would have either a broad knowledge base regarding issues of CA/CN or direct experience with children and families. Administrative personnel included IHS and BIA Area level administrators. Program staff included medical personnel such as physicians and nurses, social services personnel (primarily social workers), and mental health personnel such as psychologists and therapists. In addition, while not directly comparable to IHS service units, administrative and program staff from BIA social services, law enforcement, judicial services, and education, were an important part of the sample population as these individuals are integral to child protection efforts.

SAMPLE STRUCTURE

Unequal size cluster sampling with stratification was the most appropriate sample design to address the objectives outlined above. As with any sample design, the availability of funds and the respondents were necessary considerations. Since no single sample design was optimal for meeting all of the research objectives, it was necessary to refine the overall design objectives to develop a priority ordering and a range of tolerable sampling errors. The final sample design evolved by evaluating the tradeoffs among the research design objectives. The complexity of the sample within the context of the research design necessitated stratification of the sample and the application of cluster sampling in order to ensure continuity within communities and cooperating agencies.

Stratified sampling was selected because stratification increases sample efficiency by lowering the sampling variance. First, by dividing the population into strata, sampling error became a function of within-stratum variability, which, if less than the overall variation, would result in decreased sampling errors. Stratification assured that certain key subgroups would have sufficient sample size for separate analysis. This was particularly the case with our 12 Area level administrators. By creating separate strata consisting of particular subgroups of interest, we were free to increase or decrease the relative distribution of these subgroups in the sample. Stratification permitted the use of different sample designs for different portions of the population. More quantitative information from administrative personnel by means of a self-administered mail questionnaire and more qualitative information from line staff by way of telephone interviews was collected. Stratified design enabled use of separate population groups in different forms, which were then pieced together to cover the entire population. This provided a mechanism for dealing with partial population frames that overlapped one another.

Our levels of stratification included both administrative and program staff. The National Oversight Committee on Child Protection, IHS and BIA Area level administrators, and IHS service unit and BIA agency administrators comprised the administrative strata. Program staff from the IHS included medical, social services and mental health personnel. Line staff from the BIA included social services, law enforcement, judicial, and education personnel.

CLUSTER SAMPLING

Unequal size cluster sampling with one or more stages is often used within the framework of a stratified design. It enables different selection techniques to be applied within each of the strata that comprise the total population. Cluster sampling enabled this research to address local interagency interaction and service unit functioning within a particular community. It was felt that this would give a more realistic picture of the issues involved in child protection and a means for verifying information

and comparing the continuity of similar data sets and records kept by different agencies. The clusters consisted of a random sample of 40 IHS service units selected from within the 12 IHS areas. Within the clusters were IHS hospitals, health centers, health stations, BIA and tribal agencies and education services. Our census data provided information that gave us a complete assessment of each communities resources, needs, and limitations.

LITERATURE REVIEWS

Several hundred publications on a variety of issues that relate to child maltreatment were reviewed. While the focus was primarily on Indian-specific publications, it was important to include articles addressing these same issues for the general population. The literature review enabled an assessment of a range of perspectives, activities, and research projects addressing child maltreatment worldwide and their applicability to issues in Indian country. Also collected were a series of case laws, which provide a view of legal perspectives and judicial decisions. Articles addressing the complexities of the Indian Child Welfare Act and its implications for cases of child maltreatment were also collected. Literature reviewed included: Program Reports, Conference Reports, Resource Materials, Research, Legal Issues, the Indian Child Welfare Act, Theory and Perspective, Cross-cultural Research, Child Sexual Abuse-specific, and Related Papers. One major result of the intensive review was identifying the gaps in current research and knowledge.

PROGRAM REVIEWS

An important component of Phase I research included a review of existing child abuse prevention and intervention programs. Of these programs, there were 17 that provided services only to AI/AN people. These programs represented 10 states, both urban and reservation based services, and a program duration ranging from less than one year to more than 20 years. These programs provide a variety of services and approaches to child abuse interventions. This review provided information regarding

resources available to AI/AN people, the essential components of an intervention program, including risk assessment forms, and information about the extent of coordination between these programs and the communities they serve. By identifying components that are consistent throughout these programs, the IHS can better understand ideas that seem to be working in Indian country, and enhance their own programs by incorporating these elements.

Included in the program reviews was a series of projects funded through the Office of Victims of Crime. These projects were specifically designed to improve the investigation and prosecution of CA/CN in AI/AN communities. Some of the important and consistent components of these programs included: 1) the development of child abuse protocols, 2) the revision of tribal juvenile and children's codes, and 3) interagency service provider training. These reviews provided examples of the types of projects tribes were able to develop and define areas where the IHS can work together with tribes to expand services.

An example of some of the current, non-Indian specific, programs nationwide that were reviewed is the Healthy Start program in Hawaii. Secondary prevention is a key component of this comprehensive program; and the program has been very successful since its inception in 1985. Many of the components of this program are easily incorporated within the current IHS structure. For example, the program provides home-based support services to all at-risk families with newborns, using personnel who function in a capacity similar to IHS community health representatives. In addition, program personnel coordinate with child protective services (which may include being part of the local child protection team), and they assist families in the use of community resources such as referrals to social services and mental health services.

CENSUS DATA REVIEWS

A variety of information was available through national census data. Relevant variables were useful in developing a profile of the variation that exists in Indian country and a sense of community and population structure of Indian communities in comparison with the U.S. general population. For example, the data showed relatively high proportions of Indian families with children under age six and high intertribal variance in the proportion of female-headed households. The positive association that exists between single parenting and CA/CN suggests a large group of families potentially at risk. The data also provided information regarding the use of health care facilities. The percentage of the Indian population that utilizes IHS facilities varies from less than 30% in states like California to more than 70% in states like Montana. This fact has implications for using IHS records as a database and will impact the expected efficacy of IHS-implemented programs.

In addition, more detailed county and tribal census data were used to create community profiles of the service unit locations included in the telephone surveys and the site visits. The profiles included information on location, population, birth rates, death rates, physician rates, hospital bed ratios, income, and employment.

PHASE II ACTIVITIES

The research focus of Phase II was to expand on, refine, and test the information obtained during Phase I through extensive data analysis and site-visits to six selected AI/AN communities. The ultimate goal of Phase II was the development of an appropriate and effective model CA/CN prevention program standardized for national implementation, yet flexible enough for individual communities. The data from Phase I clearly identified essential goals and important components for the model program. Site-specific information identified the challenges to IHS as well as the determination of local service providers to

aggressively address the issues of child maltreatment.

DATA ANALYSIS

The myriad of information collected provided a base from which profiles of AI/AN child maltreatment could be developed. The surveys and questionnaires outlined the similarities and the differences between service units and service areas in the awareness of CA/CN issues and their ability to respond effectively. The variation that exists within and between service locations highlighted the relationships between CA/CN and local economies, government structure, resource availability, knowledge of the issues, and sophistication of multi-agency response. Current methods of data collection, data management, case tracking, and sharing of information between administrative levels also emerged as important parts of the analysis.

The primary focus of the data analysis was on the case-specific information gathered on a national level via the mail questionnaires and on local levels via on-site case reviews. Due to the limited range of case-specific information readily available, the number of variables was limited to what was deemed essential information. This included the date of the report, the age and sex of the victim, the age and sex of the offender, the relationship between the victim and the offender, correlations between CA/CN and substance abuse, and the availability and utilization of prevention and intervention resources. All the information obtained was non-identifying, that is, the identity of victims and perpetrators was not included. Further, it is important to note that the incidents in our database reflect IHS caseloads rather than the totality of maltreatment cases in any given location.

While the availability of information was generally limited and inconsistent between locations, sufficient data were available to make some definitive statements about the manifestations of CA/CN in Indian communities, the family and community dynamics of maltreatment, and the response of local service providers. In general the data strongly supported the efficacy of secondary prevention and the

need to focus on the family.

SITE-VISITS

Six service units were selected for an in-depth, on-site assessment. In order to select a location to pilot the proposed intervention program, the current state of intervention dynamics within individual service units and between the IHS and other agencies was explored. The sites were selected to provide information about both urban and reservation settings, communities with varying types of facilities, services, interagency agreements, and levels of interaction with the IHS on CA/CN issues. Each site visit averaged three days and included an in-depth CA/CN records review and personal interviews with IHS, BIA, and tribal service providers involved in child maltreatment and child protection services.

The service units selected for this part of the research were: the Acoma-Laguna-Canoncito Service Unit in San Fidel, New Mexico; the Anchorage Service Unit in Anchorage, Alaska; the Wind River Service Unit in Fort Washakie, Wyoming; the Crow Creek Service Unit in Fort Thompson, South Dakota; the Warm Springs Service Unit in Warm Springs, Oregon; and the Kayenta Service Unit in Kayenta, Arizona. Time and budget constraints limited the number of sites; however, it is felt that these six were fairly representative of the range of IHS responses to CA/CN.

These six service units were evaluated to determine which would be the location at which the pilot program would be tested. The selected location had to offer the best chance for implementing and evaluating the model. The availability of at least minimal services and staff as well as the availability of personnel to provide additional staffing and training, were considered prerequisites. The current management information system (MIS) needed to be amenable to the model and the site needed to reflect issues that were fairly representative of issues faced by communities and service agencies throughout AI/AN communities.

Of the six sites, two of the Service Units have the potential for immediate implementation of the

New Beginnings program: the Wind River Service Unit in Fort Washakie, WY, and the Anchorage Service Unit in Anchorage, Alaska. While each of the six sites have indicated dire need for assistance and strongly support the implementation of the New Beginnings program in their communities, the realities of funding a cost-effective model, including implementation and program development, placed limits on the number of proposed pilot programs. It is sincerely hoped that if a site is selected for a pilot program, the results will provide the impetus for the IHS to assist in the development of similar programs in all AI/AN communities.

DEVELOPMENT OF A MODEL FOR INTERVENTION

Development of an appropriate and effective model for intervention was based on a synthesis of the collected information, of model goals and objectives, and standardized, yet flexible program planning. The data continually pointed to the need for IHS prevention efforts focused on families at risk, as the IHS is in an excellent position to reduce the incidence of maltreatment and increase the health and well-being of AI/AN children and families.

The goals of the model program are to: 1) promote healthy child growth and development; 2) promote positive parenting; 3) assure that all families have a primary medical care provider and a medical home; 4) assure appropriate use of community resources; and 5) prevent CA/CN. Implicit in the model is the provision of basic elements of healthy growth and development, effective strategies for intervention, and a commitment to the reduction of the incidence of child maltreatment. Key elements include: 1) prenatal risk assessment and early identification of families at-risk; 2) home-based intervention services; 3) linkage between medical care and human services; 4) referral and coordination with community services and agencies; and 5) continuous follow-up with families until the child reaches age five. The model provides for the localized needs of individual communities where the IHS can: 1) adjust the intensity of services based on the family's need and level of risk; 2) make an aggressive commitment to

the needs of sexual abuse victims and their families; 3) incorporate AI/AN culture in treatment; 4) provide services for offenders; and 5) coordinate family services with alcoholism programs.

There are several long-term benefits of this program model. First and most important is the substantial reduction of CA/CN. Other benefits include: the systematic and early involvement of health, social services, and educational agencies, reduction in the costs of CA/CN related services, and reduction of the subsequent individual, family and community costs correlated to CA/CN and dysfunctional families.

Child Abuse and Neglect in Indian Country

NATIONAL INDIAN JUSTICE CENTER

CHILD ABUSE AND NEGLECT IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

GENERAL ISSUES

Research on child abuse and child neglect in American Indian and Alaska Native (AI/AN) communities is a challenge. The diversity of cultures, languages, customs, and traditions among tribes makes it difficult for systematic studies to be conducted among AI/AN people. There is no universal standard for optimal child care. Culturally determined attitudes, values, and beliefs strongly influence the way parents interact with their children. Even whether an issue (e.g. corporal punishment) is considered a problem or not, subsequent decisions regarding action or intervention, are made within the context of a specific group's attitudes. Child abuse occurs within a context of community standards, e.g. that which is acceptable or unacceptable in the way of impulse control, punishment, or retaliation. What one group considers abusive may be an accepted standard of behavior for another group, and parents should be expected to be strongly influenced by the standards of their particular social group.

At present, there is no uniformly accepted definition of child abuse. Congress has provided a standard with the recently amended definition of abuse in the Federal Child Abuse Prevention and Treatment Act (1974). Child abuse is defined federally, as the physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of eighteen under circumstances which indicate that the child's health or welfare is harmed or threatened. Definitions, and the processes by which cases are identified and labeled "child abuse," also varies by professional group and between agencies. A study by Gelles found considerable variance within and between groups as to what constitutes child abuse (Starr 1982). Two major characteristics were common to situations defined as abuse. First, there must be some clear identifiable harm or injury, and second, there must be evidence of clear intent on the part of the perpetrator. The problem is that, whether or not there is agreement on

these two characteristics, there is still a continuum of judgment across individuals and between groups.

Such variation in definition can create problems with the implementation of a treatment program, and can also result in two types of errors in case identification. Some cases of child abuse will be incorrectly identified as "not abuse," while cases that are not abuse may be incorrectly labeled "child abuse." Part of the problem is that the decision making process is a social process involving factors other than those that cause maltreatment.

Due in a large part to a very high rate of injury mortality, AI/AN children have one of the highest post-neonatal mortality rates in the country (Epidemiology Reports 1989). Morbidity, mortality, and risk of injury are linked to many different sources, such as automobile crashes, lack of parental supervision, and abuse. Studies have also shown that AI/AN children and adolescents are at high risk for mental health problems including depression, suicide, and drug and alcohol abuse (Belser & Attneave 1982; Tuma 1989), which are often directly correlated with physical and sexual abuse and neglect.

As Chair of the Committee on Child Welfare of the Advisory Boards to the National Center on Child Abuse and Neglect, Judge Skekette (1986) reported the Committee's findings regarding its investigation of issues surrounding the problem of Indian child maltreatment. Among the committee's findings was a "desperate need" for the coordination of the activities of tribes, local, state, and federal governments, and the private sector in identifying, preventing, and treating child abuse and neglect within this special population.

IMPORTANCE OF STUDYING INDIAN CHILD MALTREATMENT

Most, if not all, tribal groups are in some stage of transition and must deal with the inherent challenges. This is reflected, in part, by the changing causes of morbidity and mortality among AI/AN communities, which now closely mirror those of other American communities. Low density tribal communities are expanding and becoming increasingly acculturated by white American society. This has

been accompanied by shifts in economics, the availability and control of resources, the value of people within the society, the structure of families, and patterns of parenting (Levine & White 1987). Cross-cultural studies have shown that societies in transition are especially susceptible to problems such as child abuse. How does the cultural/tribal context and the seemingly inevitable culture change affect the incidence of child maltreatment among Indian people? An understanding of AI/AN culture and how it is changing to meet the demands of the dominant society will provide an important understanding of how best to deal with some of these problems. The cultural context will determine what constitutes abuse, define situations that excuse or mitigate abuse, and the types of appropriate intervention that can be applied. The assessment should take into account the individual strengths and personal resources that exist within individuals of any given community.

While, to date, no definitive research has been done, it might be expected that the physical abuse of children would correlate with other forms of family violence. According to the National Plan for Native American Health Services (1989), violence is considered a serious problem in many AI/AN communities, with the majority of police calls on reservations involving domestic quarrels.

The diversity of culture and language makes it difficult for systematic studies to be conducted among both urban and reservation Indians. Tribes vary in their use of custom and tradition: some rely more on traditional justice systems, such as family gatherings, and mediation by tribal officials, while others rely more on formal systems such as social services, police, courts, and corrections. Many tribes have vastly different relationships with federal, state, and local governments. The type of intergovernmental relationships that tribes have also affects the extent to which services from these governments will be made available and used by the tribes.

Prior to 1978, generations of AI/AN children were systematically removed from their homes into foster care placement or at off-reservation boarding schools. This historical removal of children from their homes impacted the extended family network system. Children were essentially deprived of their

cultural heritage by forces that overlooked and/or disregarded the importance of maintaining the integrity of Indian tribes, cultures, and families. Standards for removal and placement of Indian children were predicated on a value system that ignored the equally valid value systems of Indian people. Actions premised on the "best interests" of Indian children often inflicted irreparable harm on these children by depriving them of their unique identities and forcing them to adopt identities imposed by non-Indians. Studies have shown that Indian children were placed in foster care at a rate estimated at five times higher than for the general population (Younes 1986). These foster care placements were frequently in non-Indian homes and away from the child's reservation. The Final Report to the American Indian Policy Review Commission (1976) stated that approximately 25 to 35 percent of all Indian children were raised in non-Indians homes and institutions during some period of their lives due to non-Indian perceptions that Indian families were incapable of child-rearing.

BREAKING DOWN THE BARRIERS

The national incidence of child abuse and child neglect is staggering. According to the National Center on Child Abuse and Neglect, there are more than 200,000 children abused and more than 800,000 neglected every year. Of these, about 4,000 die as a result of their maltreatment.

National estimates of CA/CN rates among AI/AN are relatively imprecise when compared to rates among non-Indians, due to the incomplete data available. Several studies have reported statistics which appear to indicate rates of abuse among American Indians that are lower than rates among black and white children. For example, an article in the *White Cloud Journal* entitled "Child Epidemiology," it was stated that American Indians "may well neglect their children less frequently than the majority culture." Another report cited statistics from the state of Florida, i.e. 9.2 cases of abuse per 1000 Indian children in comparison with a rate of 13.5/1000 for blacks and 15.5/1000 for white children. However, these numbers may be dangerously misleading, as they are likely due to reporting bias and the nature of the

agencies and communities involved rather than lower rates among Indians. The problem with this perspective is that it minimizes the seriousness of abuse among AI/AN families. Lujan et al., (1986) noted in their research on abused and neglected Indian children in the Southwest that cross-cultural studies tend to place violent or neglectful acts toward children in a cultural context in which the behavior is assumed to be more understandable, and, therefore, more acceptable. They contend that such studies are reluctant to refer to abuse as abuse, or to label abuse as deviant behavior. Child abuse and neglect appears to be as much a problem for Indian families as it is nationwide. Until the problems are faced openly, agencies charged with the protection of AI/AN children cannot expect to effectively prevent child abuse and neglect, intervene with existing cases, or help heal the children, families, and communities.

Cross-cultural studies point out an important factor regarding the treatment of abused and neglected children. These studies as well as the various congressional reports and evaluations of tribal programs contend that child abuse and neglect and other problems confronting the Indian family must be viewed through the lenses of the particular culture in which they occur. While this is important in understanding behavior, it is too often used to minimize or excuse maltreatment as being "cultural." There is a pervasive attitude among families, tribal leaders, and service providers that "culture and tradition" are critical elements in defining what constitutes abuse and neglect which make it sound like abuse is cultural. The problems of child maltreatment and child protection should be approached within the context of the cultural and social environment of individual tribes in order to understand their respective child-rearing practices, kinship systems, and traditional family values.

Traditional ways of life defined complex relationships and acceptable behavior in both public and private. Expectations, education, discipline, and retribution were inexorably linked. Culture is a complete way of life for AI/AN people and, not made up of isolated acts. Thus it is a mistake to support the existence of cultural "sanctions" without the other elements of cultural support and guidance. There is a balance between the positive and negative forces that structure behavior in any community. Children

must witness both to develop a sense of self, pride, and personal integrity and to become productive members of their community. The manifestations of poverty and family dysfunction must be separated from traditional culture, and those who suggest that maltreatment is "cultural" need to be reminded that rape, sodomy, beatings, burning, breaking bones, starvation, degradation, and humiliation are not traditional in any Indian culture.

Service delivery systems and programs must draw on the strengths that exist within families and communities and the spectrum of cultural traditions, rather than focusing solely on the deficits and the problems. As tribes increasingly reassume jurisdiction over their children in child welfare cases, set up children's courts, and develop or expand tribal resources, there is the need for agencies such as the IHS to help. Tribes need to acquire the tools that are necessary for development of local standards that reflect cultural differences, support access to formal and informal networks of support, and that support and strengthen the integrity of the extended family network.

INDIAN-SPECIFIC ISSUES

The demographic and socioeconomic profile of AI/AN may be similar to other minority groups within the U.S., but AI/AN people differ from all these other groups in the unique relationship tribes have with the U.S. government. These factors directly impact issues of child maltreatment. The concept of sovereignty gives tribes the right to exercise basic governmental powers. For example, tribes are not required to comply with any particular standards with respect to child abuse and neglect laws. In contrast, states must comply with specific federal requirements. Second, most tribes have a trust relationship with the federal government as a result of treaties - that is, the exchange of land for food, clothing, shelter, health care and education. The IHS and the BIA are mandated to provide such assistance, and as such are primary foci of any prevention and intervention program. The IHS has the potential to profoundly reduce the incidence of CA/CN and provide treatment programs for the victims,

the perpetrators, and their families, effectively increasing the physical and social health and well-being of AI/AN people.

Professionals and paraprofessionals addressing child maltreatment in AI/AN communities are often confronted with many complex issues, including: 1) the unique strengths and diversity of Indian cultures; 2) the complicated relationships that exist between federal, state, and tribal agencies; 3) the vast distances between communities; 4) lack of services in rural areas; 5) extremely limited human and financial resources; 6) overlapping and often conflicting legal and jurisdictional authorities; and 7) an array of social issues including poverty, substance abuse, modernization and assimilation, the structure and size of the community, extended families, and Native culture and tradition. Depending on the context of a particular case, these issues may be either an asset or an obstacle to the intervention process.

Social issues affect all AI/AN people. Poverty is an issue for most AI/AN people as the median AI/AN income is below the poverty level. Poverty and unemployment exist at very high rates in AI/AN communities and can severely stress a family. Substance abuse is a major factor in many CA/CN cases. It not only disrupts the ability of parents to provide children with proper care, but it can also disrupt the intervention process by making communication with and cooperation by the family very difficult.

Cross-cultural studies have shown that in a variety of cultures, rates of CA/CN increase as a society becomes increasingly modernized. Traditional ways of life offered support systems and coping mechanisms. As AI/AN people become more and more removed from these traditions, families are increasingly prone to abuse. Modernization has also meant that generations of children have lived and are living in institutional settings, isolated from their families, support networks, and models for parenting. Most tribal governments do not have adequate resources to provide the kind of intervention and treatment victims and their families need. The few qualified individuals and programs that do exist are often overworked and under-funded. Networking with other county, state and federal agencies and programs, and finding creative alternatives, are often the only means of providing effective intervention

and treatment.

The small, closely related communities that exist in Indian country can be both an asset and a problem. In a small community where everyone knows everyone else there are few secrets. This can affect confidentiality and the ability of community members involved with child protection to do their jobs. However the closeness of community members and extended families can also increase support for the child and the family.

Extended families can also be both an asset and liability or a problem. The extended family has traditionally played an important role in AI/AN society. Families can provide support, foster care, shared responsibility for children, and the passing on of traditional values and ways of life. However, entire families may be rendered dysfunctional due to the inter-generational effects of maltreatment, substance abuse, and poverty. This can place a child at high risk for abuse, and may also interfere with successful intervention and treatment. Family members may protect a perpetrator and impede an investigation.

Every tribe is unique in its customs and traditions. What is socially correct in one tribal setting may be inappropriate in another. Each tribe has its own ceremonies, medicine, methods of conflict resolution, and ways of healing. These can be valuable tools for the intervention process and a source of great strength for victims and their families. Service providers must make a commitment to be aware of tribal history, traditional sanctions, myths, language, and medicine. This can help facilitate trust and communication between service providers and families. These tribal elements can also be incorporated into a culturally sensitive intervention and treatment program. Culturally sensitive means that the investigation and intervention process takes into account readily identifiable cultural and tribal traditions that may impact a person's way of life and the way he or she will respond to treatment. It is important to remember, however, that dysfunctional families are often alienated from their tribal customs and traditions. They may not be able to positively identify with being Indian so they may have difficulty responding to and accepting traditional methods.

CURRENT STATE OF AFFAIRS

PERSPECTIVES

Problems of definition regarding what constitutes child maltreatment, while an issue for both the IHS and BIA, did not appear to interfere with the provision of treatment or services on the local level. While there were a variety of federal, state, and local definitions, the vast majority were specific enough to differentiate between different types of abuse and general enough to encompass viewpoints of individuals. Respondents were more concerned with actual detection and identification than with definition. There appeared to be substantial consensus on which cases were abuse and which were not, despite a variety of different opinions on the causes of CA/CN and how a case should be handled.

On a personal level, respondents had a variety of perspectives on what causes CA/CN and whether it is a matter of individual pathology, social dysfunction, or criminal intent. It should not be surprising that different professions view the issue from different perspectives, e.g. law enforcement views abuse as a criminal act, social services as a child protection issue, etc. This suggests that people's responses are guided by their viewpoints, and individuals working in a multidisciplinary arena should be aware of these different perspectives and that different types of interventions will result from these different perspectives. Conflict over case dispensation was a frequent issue. What people consistently agreed on was that maltreatment was not an isolated issue. Families in which maltreatment occurs face multiple problems including poverty, isolation, and in some, alcohol abuse. Almost all of the respondents cited alcohol as a contributing factor to maltreatment, noting that alcohol both exacerbates the problems that contribute to abuse (e.g. poverty) and directly impacts parents ability to care for their children. However, few facilities combined victim treatment or services with specific family or individual alcohol treatment.

REPORTING

All 50 states have mandatory reporting laws. Moreover, PL 93-247, the Federal Child Abuse Prevention and Treatment act of 1974, establishes mandatory guidelines for state reporting laws and mandatory procedures for handling reports of abuse or neglect. However, this act does not directly apply to AI/AN tribes since they do not receive funding under its provisions and many AI/AN communities lack laws that require reporting. In addition, many AI/AN communities have not established which agency has primary responsibility to receive reports and conduct immediate investigations. Responsibilities are often shared by at least five disciplines - education, social services, health care, law enforcement and the courts - and by a number of governmental bodies and agencies. Consequently, lack of a clearly defined authority to act, aggravated by overwhelming caseloads and inadequate funding, often causes one agency to pass responsibility to another. The frequent lack of case management can lead to cases "falling through the cracks" as they are passed from one agency to the next.

Reluctance to diagnose and report CA/CN is a problem nationwide and may be particularly serious in Indian communities. Obstacles to reporting include: 1) fear of civil or criminal liability for reporting, 2) belief that reporting is not part of professional responsibilities, 3) difficulty in identifying possible CA/CN, 4) fear of making an unjustified report, 5) objection to time and effort involved, 6) unwillingness to testify in court, 7) belief that child abuse and neglect do not exist in the community, 8) belief by some professionals that they can handle CA/CN problems themselves, 9) fear that reporting will destroy a professional relationship with client or patient, 10) belief that reported family or individuals will be unjustly stigmatized, 11) fear that reporting breaches professional confidentiality, 12) unwillingness to report high status families, 13) belief that reporting will not result in any helpful social or protective services for families and may in fact, cause greater harm, 14) belief that community response to reports is too punitive, 15) uncertainty as to the nature of community response to reports, 16) unwillingness to

accept sole responsibility for making reports, 17) ignorance of child abuse and neglect reporting laws, and 18) fear of personal safety.

Child abuse and neglect case reporting procedures and policies were an important theme cited by service providers. Although reporting is mandatory for federal employees, there is still reluctance to report abuse. The most commonly cited causes for failure to report were a fear of reprisal for reporting the case, the belief that nothing will come of the report, and a lack of training concerning where to report suspected cases. These themes must be addressed through training, administrative leadership, and construction of reporting procedures and protocols which include protection of the employee reporting suspected abuse. Although the vast majority of reporting procedures cited by service professionals include protection clauses, such as confidentiality and immunity to civil and criminal prosecution for reporting of suspected abuse cases, this does not seem to be sufficient in itself to overcome reluctance to report.

A number of positive steps have been taken in recent years to address these problems. Many, if not most, tribes have recently enacted child protection codes which include mandatory reporting laws. Many tribes have assumed greater responsibility for social services to Indian families and children under PL 93-638, the Indian Self Determination Act, contracts with the BIA. There has also been increased emphasis and training in AI/AN communities concerning the problem of child abuse and neglect in general.

Each IHS service unit and BIA agency had some type of reporting protocol and case management criteria in place but there was substantial variation in definition, structure, and implementation of these protocols. Protocols should be clearly defined both within and between local agencies, because after cases are assessed and screened by individuals in one agency, they are often referred to other agencies for further investigation and intervention. Due to the close-knit nature of many Indian communities, it is suggested that victim response protocols include actions involving the offender (e.g. mandatory no

contact orders), while offender protocols include actions involving the victim (e.g. separation or emergency shelter). These types of protocol decisions were not part of local policies, but their implementation might provide an important connection between agencies, improving the provision of treatment and services.

It was also noted that once a case had been referred to another agency, IHS professionals were more likely than their BIA counterparts to have follow-up contact with clients. Higher levels of client contact by IHS could be attributed to the nature of the service provision, i.e. that the IHS is more likely to refer clients out for contracted services but retain overall case monitoring than the BIA, which would refer out cases and close them from their files. This makes IHS the logical choice for primary responsibility for case tracking and case monitoring.

TRAINING

Although personnel involved with child abuse cases were nearly unanimous in reporting that they had received CA/CN training, the type of training, its adequacy, and the means by which it was administered varied greatly. IHS professionals were most likely to have received training in prevention, detection, identification and case reporting of abuse and neglect. This should not be surprising, as these themes have been stressed nationally by governmental agencies and advocacy groups. More technical skills, such as interviewing and investigation of cases, were reported less often by IHS respondents, as was training in the criminal justice and court processing aspects of child abuse cases (e.g. forensic evaluation of evidence, investigation procedures, testifying in court and criminal prosecution of cases). Child abuse and neglect cases necessarily involve professionals from many disciplines (e.g. social service, medical, law enforcement, judicial, mental health, and education) who need to be involved in case investigation and intervention. In addition, both civil and criminal responses to child abuse and neglect cases are mandated, thus causing professionals with differing orientations, training, and goals to deal with

the same case, and with each other. Awareness of all aspects of the system, ideally provided in multidisciplinary training sessions, can promote understanding, enhance communication, and help to develop mutual respect among professionals.

Training may be either voluntary or mandatory. While voluntary training may enhance the willingness of professionals to participate, it may also allow for the perpetuation of gaps in the knowledge of professionals within and between service units. With all training sessions there is a tradeoff between the quantity of individual participants and the quality of the information obtained and retained. The majority of respondents felt that training should be professionally administered and mandatory but reserved for appropriate personnel. Some of the core curricula, tailored to local needs and statutes, should be promoted for professionals. In addition, the results suggest that core training should be provided by experts in the field, or that experts should be contracted to develop a core curriculum and provide ongoing training to IHS staff to develop their skills as instructors. In comparing the responses of IHS and BIA respondents, it is clear that training in more areas was offered to BIA than IHS professionals. Much of this difference was in areas of technical skills (detection and identification, forensics, interviewing, investigation) and criminal justice activities (i.e. testifying and prosecution). But, as mentioned earlier, the awareness of all phases of intervention, and the roles and responsibilities of all involved, is an important component of any training program.

The topics of training for IHS professionals covered all types of abuse, but child sexual abuse was noted most often as a focus of training. This is consistent with broad national concerns that have arisen in recent years concerning this form of child abuse. Training was provided to these professionals usually by a trainer external to the service unit, and training was generally voluntary in nature. Training on case reporting was most often mandatory, reflecting the mandatory reporting laws mentioned earlier, but training of IHS professionals on all aspects of case prevention, investigation and intervention was usually voluntary.

MANAGEMENT INFORMATION SYSTEMS

The collection and maintenance of data and case record information was also cited as a frequent problem. Only about one fourth of the respondents indicated that their records were automated, which creates severe limitations in case information entry, management, and retrieval, both for service delivery and policy planning needs. In addition, the need for some type of centralized, accessible data resource such as a national registry was frequently cited as an issue. The tracking of child abuse cases involving AI/AN children is currently problematic, due to the broad number of agencies at local, state, tribal and federal levels throughout the country that may be involved in such cases. Case tracking is useful to promote justice for offenders, coordination of long-term services for victims, and development of comprehensive interagency policies for coordination and cooperation. Such systems have been successful in some states (e.g. Virginia), and are being contemplated in other states. A more immediate need, however, may be the computerization and standardization of case records and local data. Localized, usable, computerized data management systems provide service professionals and administrators with a valuable tool for assessment, planning, and coordination of services.

CHILD PROTECTION TEAMS

The IHS and BIA have been formally mandated to develop and participate in multidisciplinary Child Protective Teams (CPTS) for a number of years. The variation that exists between local child protection teams makes it difficult to generalize about team functioning and effectiveness. It would seem that areas that have a functioning CPT have a forum for increased communication and coordination of services. However, individual personalities, excessive work demands, and lack of structure makes communication difficult and diminishes team effectiveness. The length of time a CPT has been functioning does not seem to influence its effectiveness as much as a strong membership and clearly outlined goals and responsibilities.

National research on CPTs indicates that written policies, procedures, mission statements and interagency agreements are important to formalize the CPT, standardize its operation, make it's activities more consistent, and protect its stability and operation against changes in membership. Another way to stabilize and institutionalize CPT operation is to fund a coordinator who has no direct affiliation with any participating agency, but maintains a neutral position and has primary allegiance to the interests of child victims and their families, as well as members of the CPT, participating agencies, and the community as a whole. Most non-Indian multidisciplinary teams lack direct authority, but include members of agencies that have statutorial mandate and executive authority to implement the team's decisions.

Since child abuse and neglect are complex social issues, many professional groups and agencies are involved in efforts to prevent and intervene in detected cases. For this reason, IHS and BIA professionals are involved in ongoing relations with other agencies to address their mission and goals.

JURISDICTION

In criminal, civil, and juvenile matters in AI/AN communities, including CA/CN, the first question that needs to resolved is which level of government assumes jurisdiction: federal, state, or tribal governments. The question of tribal jurisdiction involves the interrelationship of three factors: personal jurisdiction - what persons are subject to the authority of tribal courts (Indian/non-Indian), territorial jurisdiction - over what land area may tribal courts exercise authority, and subject matter jurisdiction - the particular statute violated, i.e. what conduct may be punished by tribal courts. Crimes can be classified in many ways, including four classifications of defendant/victim crimes, and two classifications of defendant/victimless crimes. Table 1. (following page) illustrates the classifications, jurisdictions, and criminal statutes involved.

TABLE 1. SUMMARY TABLE OF CRIMINAL JURISDICTION IN INDIAN COUNTRY

Persons Involved	Federal Jurisdiction	Tribal Jurisdiction	State Jurisdiction
Indian Offender v. Indian Victim	Major Crimes Act, the United States can prosecute 16 listed offenses. Among these, burglary, involuntary sodomy, and incest are defined and punished in accordance with the State law, all others are defined by federal statute.	Tribal courts may have concurrent jurisdiction over crimes under the Major Crimes Act. All other offenses, tribal courts have *sole* jurisdiction (except where federal statute specifically provides otherwise).	None, except under P.L. 280 as amended, or other federal statute or by tribal vote pursuant to 25 U.S.C. §1321. The tribe *may* retain concurrent jurisdiction.
Indian Offender v. Non-indian Victim	Major Crimes Act General Crimes Act Assimilative Crimes Act	Tribal courts may have concurrent jurisdiction over crimes under the Major Crimes Act. They do have concurrent jurisdiction over offenses which can be prosecuted by the United States under the General crimes Act. Except for major crimes, tribes may preempt federal prosecution. For any other offenses, (as defined by tribal codes) tribal courts have exclusive jurisdiction.	Same as above
Indian Offender Victimless Crime	The United States probably can prosecute under the General Crimes Act as explained above or Assimilative Crimes Act.	Same as above	Same as above
Non-Indian Offender v. Indian Victim	General Crimes Act, plus a substantive offense defined by federal statute or a substantive offense defined by state law incorporated by the Assimilative Crimes Act.	Tribal courts have no jurisdiction to prosecute non-Indians, unless Congress delegates such power to them.	Probably no state jurisdiction except under P.L. 280, as amended or with tribal consent pursuant to 25 U.S.C. §1321.
Non-Indian Offender v. Non-Indian Victim	No federal jurisdiction except for distinctly federal offenses.	Same as above	State courts have jurisdiction over all offense defined by state law and involving only non-Indians.
Non-Indian Offender Victimless Crime	General Crimes Act, plus a substantive offense defined by federal statute or a substantive offense defined by state law incorporated by the Assimilative Crimes Act. The law is still questionable whether federal jurisdiction is exclusive or concurrent with the state.	Same as above	State courts probably have concurrent jurisdiction with the United States, although the law is unclear.

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CHILD ABUSE AND NEGLECT AND THE ICWA

The Indian Child Welfare Act (ICWA) of 1978 was enacted in recognition of the need to stem the "removal, often unwarranted" of Indian children from their families and to establish "minimum Federal standards" to insure that the values of Indian people are reflected in the foster care and adoptive placements of Indian children, and to insure the preservation of Indian family units. Historically the removal of Indian children from their homes and parents has provided a means to destroy AI/AN cultures and traditions.

When the law was enacted, congressional findings included the following: 1) that there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children, and that the United States has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in an Indian tribe; 2) that an alarmingly high percentage of Indian families are broken up by the removal, often unwarranted, of their children from them by non-tribal public and private agencies and that an alarmingly high percentage of such children are placed in non-Indian foster and adoptive homes and institutions, and; 3) that the States, exercising their recognized jurisdiction over Indian child custody proceedings through administrative and judicial bodies, have often failed to recognize the essential tribal relations of Indian people and the cultural and social standards prevailing in Indian communities and families.

This law permits tribal assumption of jurisdiction over cases involving the care and protection of Indian children residing on reservations and permits tribal intervention in state court proceedings regarding placement of Indian children residing on and off the reservation. These placements may include voluntary or involuntary foster care or pre-adoptive placements, removals, termination of parental rights, and adoption of Indian children. The Act mandates that if placement is necessary, it must be within the extended Indian family, tribal or Indian community. There is a severe shortage of foster and

adoptive care in Indian communities, and issues regarding the mandates of the ICWA come into play in many cases of Indian child abuse and neglect.

To achieve its objectives, the ICWA: 1) confirms that tribes possess exclusive jurisdiction over AI/AN children residing or domiciled on reservations; 2) provides, when appropriate, for transfer of jurisdiction over proceedings involving AI/AN children from state to tribal courts; 3) establishes a right of intervention in state child welfare proceedings by AI/AN custodians and tribes; 4) accords full faith and credit to tribal laws and public acts involving Indian child welfare; 5) authorizes tribal-initiated retrocession from state jurisdiction; 6) requires state compliance with federal and tribal standards for placement of AI/AN children; and 7) provides for intergovernmental agreements between tribes and states in Indian child welfare matters. Most tribal courts are responsible for handling ICWA cases and child custody cases involving child abuse and neglect. The ICWA implementation process has been an important factor in the development of tribal juvenile justice systems. The ICWA applies to Indian children in state court proceedings, in foster care placement, termination of parental rights, pre-adoptive placement, adoptive placement, and actions arising as a result of abuse or neglect. This law is applicable unless other Federal law is invoked.

Since the enactment of the Indian Child Welfare Act (ICWA), Indian tribes have taken a more active role in protecting their children. However, the ICWA was not a cure-all for the problem of child abuse and neglect in AI/AN communities, which continue to be serious problems. The ICWA simply provides a tribal forum for handling child abuse and neglect incidents.

RECENT LEGISLATION AFFECTING AMERICAN INDIAN YOUTH

Seven years ago, P.L. 99-570, the Indian Alcohol and Substance Abuse Prevention and Treatment Act (1986) 25 U.S.C.S § 2411, was passed. The findings in the Act noted that "... alcoholism and alcohol and substance abuse is [sic] the most severe health and social problem facing Indian tribes and

people today and nothing is more costly to Indian people than the consequences of alcohol and substance abuse measured in physical, mental, social, and economic terms; alcohol and substance abuse is the leading generic risk factor among Indians. Indians die from alcoholism at over four times the age-adjusted rates for the United States population and alcohol and substance misuse results in a rate of years of potential life lost nearly five times that of the United States; four of the top ten causes of death among Indians are alcohol and drug-related injuries (18% of all deaths), chronic liver disease and cirrhosis (5%), suicide (3%), and homicide (3%); primarily, because deaths from unintentional injuries and violence occur disproportionately among young people, the age-specific death rate for Indians is approximately double the United States rate for the 15 to 45 age group; Indians between the ages of 15 and 24 years of age are more than two times as likely to commit suicide as the general population and approximately 80% of those suicides are alcohol related. The Act authorizes use of federal facilities and property for juvenile treatment centers, construction or renovation of juvenile detention centers, establishment of youth shelters and halfway houses, training for BIA law enforcement and judicial training, and development of a Memorandum of Agreement (MOA) between the Secretary of the Interior and Secretary of Health and Human Services outlining their cooperative efforts to develop and deliver needed services to Indian youth, families and community members.

The Children's Justice Act (CJA) was signed into law in 1986 to provide funding for states to establish programs to improve the investigation and prosecution of child sexual abuse cases. In 1988, the Anti-Drug Act, which amended the Victims of Crime Act of 1984 (VOCA) 42 U.S.C.S. § 10601 (g), was passed authorizing a portion of the CJA funds to be used to assist Indian tribes to improve the handling of serious child abuse cases on Indian reservations. This legislation made available a limited amount of funds to: 1) assist Indian tribes to implement programs and to improve the handling of child abuse cases, especially child sexual abuse cases, in a manner which limits additional trauma to child victims; and 2) to improve the investigation and prosecution of such cases.

Beginning in February 1990, the Office of Victims of Crime (OVC) of the U.S. Department of Justice awarded a series of grants to Indian tribes under OVC's Children's Justice Act Discretionary Grant Program for Native Americans. As of January 1993, 23 tribes have received funding under the first three cycles of this program. The grant awards were designed to address a range of systemic improvements that included: training for multidisciplinary teams, revision of tribal codes to address child abuse, child advocacy services for children involved in the court process, protocols for reporting, investigating, prosecuting, and treating child abuse cases, and improved case management and treatment services. These grants are designed to fund short-term (one or two year) proposals with emphasis placed on projects that establish a systemic or permanent change in the way that child sexual abuse cases are investigated or prosecuted.

Public Law 101-630, the Indian Child Protection and Family Violence Prevention Act of 1990, was enacted to address findings that: "... A) incidents of abuse of children on Indian reservations are grossly underreported; B) such under reporting is often a result of the lack of a mandatory Federal reporting law; C) multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by persons employed or funded by the Federal Government; D) Federal Government investigations of the background of Federal employees who care for, or teach, Indian children are often deficient; E) funds spent by the United States on Indian reservations or otherwise spent for the benefit of Indians who are victims of child abuse or family violence are inadequate to meet the growing needs for mental health treatment and counseling for victims of child abuse or family violence and their families." The goals outlined in the Act are: "A) to identify the scope of incidents of abuse of children and family violence in Indian country and to reduce such incidents; and B) to provide funds for mental health treatment for Indian victims of child abuse and family violence on Indian reservations." This Act requires: 1) that reports of abused Indian children are made to the appropriate authorities in an effort to prevent further abuse; 2) that a reliable data base be established for statistical purposes and a study be

conducted to determine the need for a central registry for reported incidents of abuse; 3) that other actions be taken as are necessary to ensure effective child protection in Indian country; 4) that the Indian Child Abuse Prevention and Treatment Grant Program be established to provide funds for the establishment on Indian reservations of treatment programs for victims of child sexual abuse; 5) that technical assistance and training related to the investigation and treatment of cases of child abuse and neglect be provided; 6) that an Indian Child Resource and Family Services Center be established in each BIA Area Office which will consist of multi-disciplinary teams of personnel with experience and training in the prevention, identification, investigation, and treatment of child abuse and neglect; 7) that treatment be provided for victims of incidents of family violence and programs aimed at prevention be implemented; 8) that tribally operated programs be established to protect Indian children and reduce the incidents of family violence in Indian country; and 9) that other actions necessary to ensure effective child protection on Indian reservations be taken. This Act contains critically important and appropriate legislation which needs to be accessible and acted upon for changes to come about for Indian people. Unfortunately, appropriations for the prevention and treatment provisions of the Act have been virtually non-existent.