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Abstract
This article informs social workers about sexual violence against American Indian and Alaskan Native (AI/AN) women and the policy reforms in the 2010 Tribal Law and Order Act (TLOA). It describes the unmet needs of AI/AN survivors, reviews the TLOA reforms on sexual assault in relation to social work and public health principles, discusses the complementary roles for social workers and public health practitioners in reform efforts, and offers guidance for professional participation that emphasizes tribal sovereignty, indigenous capacity, and cultural competence.

Keywords: public health, sexual assault, trauma, Tribal Law and Order Act, social work

A number of issues have recently emerged that are salient to the problem of sexual assault against American Indian and Alaskan Native (AI/AN) women and the need for effective programs and services.

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(Following the literature on this topic, although distinctions exist, the terms *rape* and *sexual assault* and *survivor* and *victim* are used interchangeably). Given the severity of the problem, its human consequences, and the difficult challenges it presents, social workers need up-to-date information to act on their commitment to assist this oppressed ethnic group. The extremely high rates of sexual assault against AI/AN women have established this problem as a public health issue (Bachman, Zaykowski, Lanier, Poteyeva, & Kallmyer, 2010; Tjaden & Thoennes, 2000). Beyond the epidemiological facts, there are serious consequences for individuals and society. At the individual level, the survivors' needs for emergency care, justice, and mental health treatment are not being met (Johnson & Cameron, 2001). With larger systems, researchers have noted the failures of the law enforcement and the criminal justice systems in Indian country and have called for the effective prevention of sexual violence against Native women (Dobie, 2011). The most hopeful opportunity lies with a new policy, the Federal Tribal Law and Order Act of 2010 (TLOA, 2010), which, among other reforms, mandates improvement in the systems that deal with the sexual assault of tribal women. (TLOA, the common name for the new P.L. 111-211, officially the H. R. Indian Arts and Crafts Amendments 725: Act of 2010, is used throughout this article.) As a social justice issue, the law authorizes reforms in prosecution and services for victims that are modeled on existing programs that are available to the general population.

This article aims to inform social workers about the challenges and opportunities surrounding this problem, so they can be effective participants in solutions. Social workers' understanding must include the public health aspects of the problem and cultural competence that acknowledges the leadership of tribal governance and the strengths of indigenous traditions. Specifically, we (1) describe the unmet needs of AI/AN survivors and the risk of severe physical and mental disorders from the trauma; (2) analyze the sexual abuse policy reforms in the TLOA in relation to public health and social work principles; (3) discuss the complementary roles for social work and public health in the TLOA reform efforts; and (4) offer guidance for professional participation that emphasizes tribal sovereignty and leadership, indigenous capacity, and cultural competence as the means to collaborate effectively and engage in partnerships with tribal communities.

The Unmet Needs of AI/AN Survivors of Sexual Assault

Although research has documented that sexual violence against AI/AN women is a serious problem with multisystem causes and consequences, the immediate and long-term needs of survivors are largely unmet. Various factors contribute to the failure to provide effective emergency care and services for AI/AN women in the aftermath of the trauma.

Severity of the Problem

The literature in the past decade has documented the high level of sexual assault against AI/AN women, the complex facets that are involved, and the challenges in addressing it effectively through programs and services. In the National Violence against Women Survey, Tjaden and Thoennes (2000) found that 33% of all women had been physically and/or sexually assaulted since age 18; however, AI/AN women were twice as likely to experience a rape or sexual assault as were women of all other races. Another study found even higher rates based on a multiple wave, targeted sampling approach that was designed to yield a representative sample of AI/AN women living in the New York City metropolitan statistical area. Of the 112 women in the sample, 48% had experienced rape, with 40% reporting multiple victimizations. In the study by Evans-Campbell, et al. (2006), of 112 AI/AN women. Additional confirmation of these early research results has come from a recent methodological review of the national and local epidemiological research on rape and sexual assault against AI/AN women; the conclusion was that the prevalence and incidence are higher for Native women than for white or African American women (Bachman et al., 2010).

Barriers to Effective Services for AI/AN Survivors

Complexity of Mental Health Assessment

Since the 1990s, the literature has reported the damaging effects of rape on women's psychological and physical health: posttraumatic stress, depression, anxiety, gynecological symptoms, sexually

transmitted diseases, general health problems, and increased sexual risk behaviors (Campbell, Sefl, & Ahrens, 2004). Although similar effects are likely to occur with AI/AN survivors, the lack of research on this group's specific response to rape makes assessment a challenge. What further complicates assessment is the difficulty of sorting out immediate responses to rape from chronic health and mental health symptoms (Gone & Alcantara, 2007).

An important assessment factor in the response to sexual assault is the individual's psychosocial and health/mental health history. With AI/AN survivors, no research has clearly identified the *immediate* psychological distress or symptoms experienced at the time of the traumatic event; however, information based on the recollection of past assault is available. In Evans-Campbell, Lindhorst, Huang, and Walters' (2006) study of 112 AI/AN women in New York City, the survivors *recalled* high levels of emotional trauma, rating it at the time of the incident as 6.43 on a 7-point scale.

The general literature on rape emphasizes that symptoms of posttraumatic stress disorder (PTSD) such as intrusion or reexperiencing the trauma, numbing, fear or anxiety, and avoiding cues that are associated with the assault are a common response. Although such PTSD symptoms have not been documented for AI/AN survivors immediately following assaults, what is known is that AI/AN victims experience other symptoms that may correlate with PTSD as experienced by nonminority women. Bryant-Davis, Chung, and Tillman (2009) reported that sexual and physical assault was the most significant predictor of lifetime PTSD among AI/AN women. In another retrospective study, Bohn (2003) found that AI/AN victims of sexual assault were more likely to report substance abuse; she also found a significant relationship among victimization and depression, PTSD, and suicide attempts. Bubar (2010) reported from multiple sources that AI/AN women who have experienced violence may present with these previously mentioned conditions, as well as ''attempted or completed suicide, alienation, or unhealthy diet-related diseases'' (p. 63). It is also important to note that with depression, AI/AN women may make little distinction between emotional and somatic complaints (Pole, Gone, & Kulkarni, 2008).

Separating out symptoms that are *immediately* associated with sexual assault is further complicated by the overall high prevalence of mental health problems in general among AI/AN individuals. Several

studies have found a higher lifetime prevalence of PTSD and higher levels of alcoholism, suicide, and mental distress than for the general population (Gone & Alcantara, 2007; Pole et al., 2008). The AI/AN survivor who seeks help may not identify the immediate sexual assault as the problem but present other issues, such as those noted earlier. It appears that victimization, in general, and sexual assault, in particular, are "associated with a substantial increase in sexual risk behaviors" (Evans-Campbell et al., 2006, p. 1420). In summary, although AI/AN women experience higher rates of sexual assault than do women of any other race, research is lacking on the specific immediate and long-term psychological and physical effects that individuals experience from such violence.

Another factor that complicates assessment and survivors' response is the nature of the assault itself, for example, the relationship with the offender, injuries, and reporting the crime. Bachman, Zaykowski, Lanier, Poteyeva, and Kallmyer's (2010) review of epidemiological research also included a contextual analysis of the characteristics associated with the sexual abuse from the National Crime Victimization Survey. Compared to white and African American victims, Native American women were more likely to sustain injuries that require medical attention and to face an interracial attack and/or an armed offender who is under the influence of alcohol or drugs. Reporting sexual abuse to the police was higher for AI/AN women, with the reports being made primarily by others, not the victims; however, charges or arrests of the offenders were much less likely than for either comparison group.

Who the offender is likely has an impact not only on health and mental health but on whether the crime is reported. If the offender is white, AI/AN women expect to be disbelieved or devalued; if a perpetrator is an AI, the offender could potentially be banished, resulting in the loss of a member of the tribal community (Deer, Flies-Away, Garrow, Naswood, & Payne, 2004). Dobie (2011) noted that victims feel hopeless about reporting and getting justice: There are almost no tribal police, they are not responsive to victims or willing to investigate, the federal prosecutors have a high rate of rejecting cases for prosecution, and victims are often intimidated or slandered when offenders are known and have family members who are employed by the police and the courts.

Historical Trauma

The most important large-system factor that affects the health or mental health effects of rape for AI/AN women is that of historical trauma. An assessment issue is how the experience of historical trauma interfaces with the trauma that survivors experience from sexual assault. Historical trauma, also referred to as intergenerational trauma, societal trauma, and oppression, is an ongoing reality for the AI/AN population and is relevant to the high rates of mental health concerns. Historical trauma refers to the damaging conditions endured by Native Americans in the context of the many conflicts with the dominant U.S. government. Historical trauma can be viewed as ''interpersonal and systemic emotional, verbal, and physical assaults by those with power and privilege against members of marginalized groups'' (Bryant-Davis, Chung, & Tillman, 2009, p. 331). The historical trauma facing Native American peoples has been said to be of greater severity than the Holocaust because the trauma is still ongoing and present. The negative consequences include a loss of trust, PTSD, and substance abuse (Whitbeck, Adams, Hoyt, & Chen, 2004).

Understanding the impact of historical trauma on survivors of rape is important, since symptoms from this type of cultural assault may exist prior to any immediate negative effects from the sexual violence. There are also likely differences that are due to women's personal history of trauma. Consequently, assessing the effects of sexual assault will involve several layers of a survivor's history of trauma. The lack of research-based information on this complexity has significant implications for assessment and treatment. However, Pole, Gone, and Kulkarni, (2008) stated that Native Americans' high levels of exposure to violence that are associated with a history of multigenerational trauma may affect their risk of PTSD. It is essential to encompass the reality of historical trauma and other cultural issues in any community planning to address sexual violence against AI/AN women and before proceeding with any mental health services (Bryant-Davis et al., 2009).

Other Barriers to Effective Services

Aside from the complexity of assessment and the role of historical trauma, other barriers contribute to the lack of care for survivors.

Trust is a major issue, and victims simply may distrust the offer of help from a program that is affiliated with the dominant culture (Johnson & Cameron, 2001). Social isolation is an environmental barrier, since some tribal communities may lack access to transportation and telephones. A study of AI/AN communities in four states found that only 43% to 72% of the homes had telephones (Hamby, 2004). Another issue is confidentiality. Many AI/AN women may refuse to participate in support groups or seek help for fear that their situation will become known among the small and close-knit tribal community (Bachman, Zaykowski, Kallmyer, Poteyeva, & Lanier, 2008). Although the community can offer support, the lack of privacy can bring stigma for issues like rape. Accessing services can also be hindered by language barriers, cultural and value differences, and the location and types of services that are offered (Wahab & Olson, 2004). These environmental and cultural constraints may play a role in why AI/AN survivors get so little emergency health care.

In summary, AI/AN women who experience the trauma of sexual assault are at a high risk of immediate disabling symptoms and the development of depression, anxiety, substance abuse, and PTSD. Effective response services are critical for meeting their immediate needs and for preventing severe physical, behavioral, and mental health disorders.

TLOA Policy Reforms and Public Health and Social Work Principles

The TLOA overall addresses the high crime rate in Indian country, expands law enforcement and crime-fighting resources, and gives special attention to sex crimes and domestic violence against AI/AN women. Violence against women and its impact on their health and mental health have been designated a ‘‘significant public health problem’’ (Evans-Campbell et al., 2006, p. 1416). The new policy offers a much-needed opportunity to meet the needs of survivors and to address the larger system factors that are associated with sexual violence. Specifically, Subtitle F—Domestic Violence and Sexual Assault Prosecution and Prevention—mandates a new approach to sexual assault. Relevant sections from Subtitle F are briefly summarized next. We subsequently discuss how these reform efforts are congruent with public

health and social work principles. This perspective may help the diverse players who work on implementing the TLOA reforms find a common ground to improve services.

TLOA Mandates Relevant to Sexual Assault

Overall, the mandates authorize improvements in law enforcement and criminal justice procedures as well as in services to victims. Section 261 provides tribal governments with specific methods to improve correctional systems and to track federal prisoners, especially the release of convicted sex offenders, better. Section 262 has two goals. The first goal is to increase the conviction rate by training tribal police to improve their interviewing of victims and collecting evidence and by requiring written action on any request or subpoena for documents that are needed in criminal proceedings, such as for a deposition or trial. The second goal is to improve response services for victims by requiring the use of a standardized sexual assault protocol and policies in tribal health facilities, such as the U.S. Department of Justice (DOJ, 2004) protocol. Section 264 requires accountability for the development of services for Native American victims and training programs for advocates for victims and calls for recommendations to prevent the sex trafficking of AI/AN women. Section 266 requires accountability and means for improving the capability of the Indian Health Service in remote Indian areas to collect, maintain, and secure evidence for the prosecution of incidents of sexual assault and domestic violence (TLOA, 2010). The brief wording of the mandates encompasses much change. A primary intention is to provide AI/AN women with the same quality of rape crisis services that are typically available in most communities in the dominant culture.

Public Health and Social Work Principles

The reforms in the TLOA are congruent with the principles of the public health and social work professions, both of which share similar philosophical and theoretical perspectives, while emphasizing different practice roles. The values of both professions focus on the public's well-being, social justice, respect for diversity, and culturally sensitive practice (American Public Health Association, 2002;

National Association of Social Workers, 2009). Theoretically, both professions draw on the broad ecological and social systems frameworks to conceptualize and intervene in social problems. Consequently, solutions for problems involve various systems (Ashford, Lecroy, & Lortie, 2010; Turnock, 2009). Next, we analyze further how the public health and social work perspectives are aligned with the TLOA initiatives on sexual violence.

Public Health Perspective

The public health profession explains the state of health or mental health as a product of the interaction of the environment, agent, and host, with information on these areas gained from epidemiological research (McLeroy, Bibeau, Steckler, & Glanz, 1988). This explanation is the basis for identifying a public health problem and "patterns and interpretations that can suggest hypotheses for intervention and prevention" (Bloom, 1981, p. 170). The major framework posits three levels of prevention—primary, secondary, and tertiary—that are linked to the course of the "disease" or to social/psychological problems in populations (Bloom, 1981), although the boundaries among these levels are not clear-cut and may not readily fit with mental health conditions (Blair, 1992). The Institute of Medicine (IOM) has offered different terminology for the three levels: prevention, treatment, and maintenance, based on Gordon's (1987) classification, and these terms seem more applicable to medical or clinical contexts. Whether labeled primary prevention (the IOM term is prevention), the goal is to prevent the occurrence of the disease or problem, and the targets can range from universal (applicable to everyone) to known subgroups who are at risk. Secondary prevention (the IOM term is treatment) operates at the clinical level; it can target persons with underlying risks or incipient symptoms and those who manifest early acute symptoms so as to arrest, eliminate, or reduce the duration of the disorder. Tertiary prevention (the IOM term is maintenance) takes place when symptoms are such that the disease or problem is diagnosed, with the goal being to prevent complications and limit disability (Agency for Healthcare Research and Quality, 2010; Blair, 1992).

It is important to this analysis that prevention includes both person-centered and system-level approaches, with the latter based on the view that environmental, social, and organizational conditions

contribute to mental health problems. For example, programs have centered on policy in a community for the prevention of lead poisoning (Rabito, White, & Shorter, 2004). Blair (1992, p. 87) argued that primary prevention too often ignores ''changing the systems and structures of organizations, communities, and societies.'' The societal and policy aspect of public health has been seen as important to preventing various types of violence against women that result in physical and psychological trauma and other mental health conditions (Fitzgerald, 1993).

The TLOA's mandates aim to cut through the convoluted, uncoordinated, nonresponsive systems that are charged with addressing sexual assault, pursuing its prosecution, and assisting its victims. Specific targets include federal policy and departments, tribal correctional systems and governments, law enforcement, the courts, and medical providers and other service systems. Change is called for in the procedures and organization of these systems; this is the first but essential aspect of the primary prevention of mental and behavioral disorders in survivors. The systems changes, however, also encompass improved person-centered services, which fit under secondary prevention, that is, emergency care for victims of sexual trauma so as to address acute symptoms and mitigate the risk of damaging physical and psychological consequences.

Social Work Perspective

As we noted earlier, social work principles also explain that individual and social problems result from interaction among various systems. Moniz (2010) noted that social work's biopsychosocial approach fits well with public health initiatives. In addition, the social work concepts of empowerment, respect for cultural diversity, and identifying strengths and resources are relevant to all levels of systems. More specifically, social workers who work in services to individuals and families apply ecological theories of human development. These theories explain how the individual's activities, roles, and interpersonal relationships are influenced by the external environment, from the immediate family, peers, and schools to the more distant systems, such as community groups, organizations, government, and societal values and attitudes.

These social work principles are useful for understanding the actual reforms for services to victims: training for police who interview victims, the development of Indian victim services and victim advocate training programs, and the use of existing standardized sexual assault policies and protocols in rape crisis programs that serve AI/AN victims. Historically, social workers participated in early rape crisis services during the shift from the volunteer, collaborative structure of programs created by the feminist movement to a more organized agency-type structure (Gornick, Burt, & Pittman, 1985). Although the mission of rape crisis services was aligned with social work values, programs in the 1980s were initially wary of professionalization and feared the loss of the feminist philosophy. Social workers, however, typically did not replace volunteer roles but provided crisis intervention, counseling, and training; moreover, one more recent small study showed MSWs in a rape crisis program clearly supporting feminist views (Clemans, 2004). Today, many social workers have worked on interdisciplinary coordinated sexual assault response teams (SARTs) that provide services for survivors of sexual assault. Given this relevant practice experience and the profession's values and knowledge base, the social work perspective has much to contribute to the rape crisis services that are mandated in the reforms. In a sense, the mandates promote for AI/AN victims the goals of the 1970s feminist programs: to empower women by changing the patriarchal society and its understanding of rape and to provide victim services and advocacy for survivors of sexual assault.

Both social work and public health principles support the value of these long-overdue reforms. Social work is dedicated to serving oppressed groups; in this case, victims of sexual violence deserve timely, efficient, just, and effective services that address their immediate trauma and ongoing needs. Social work principles are also inherent in the components that are prescribed for the services, such as training for the police, developing victim services that include training programs of advocates for victims, and the use of existing standardized policies and protocols for sexual assault. Social work principles of direct practice would be relevant to crisis services, treatment to mitigate the impact of immediate symptoms of trauma and to prevent damaging sequelae, and ongoing counseling to restore functioning and limit disability for survivors with severe conditions (Campbell,

2008). These direct services can also have an impact on broader public health prevention goals. The presence of effective services may lead to community-wide changes in attitudes and behavior. For example, improved investigation and evidence collection and the tracking, prosecution, and incarceration of offenders can raise the status of women and prevent further crimes and victims. With more effective police investigation and prosecution, women and the community can gain a sense that justice is possible. In addition, attitudes may shift toward the support of survivors and the service systems that help them.

Complementary Roles for Social Work and Public Health

The practice roles of social work and public health intersect in many ways, but each profession has its unique competencies to offer in community efforts to implement the TLOA reforms; moreover, added benefits could come from collaborative practice. Here, we briefly discuss potential roles, since the actual involvement of professionals will depend on local tribal processes and preferences. Furthermore, it is important to note that workers from these two professions should expect to be a part of multidisciplinary coalitions and teams with indigenous leaders at the helm. Social workers possess macro- and micro-skills that could be beneficial. At the macro level, practitioners who have experience in community coalitions that developed coordinated, multidisciplinary rape crisis programs could help identify and engage key stakeholders to participate in an implementation task force. Social work skills in group processes, especially task groups, could support positive coalition processes. Planning skills could be helpful, as coalitions move to develop the mandated victim service programs or improve existing ones. All personnel in these programs need knowledge and skills for working with victims, and, in this context, social workers could participate in training the police, victims advocates, and members of medical and legal teams about the trauma of rape and effective communication with survivors. In addition, social workers who are already familiar with the SART model and standardized crisis protocols that are used in rape crisis services could help integrate these mandated components into programs.

Social workers' most important competence, as distinct from public health workers, is in direct practice. The day-to-day work of victim

service programs fits well with such social work competencies as case management, advocacy, and brokering. For the critical services of crisis intervention and ongoing counseling with survivors, social workers can draw on their specialized knowledge of behavioral and mental health conditions and interventions. Added benefits that are consistent with the intent of the TLOA could come as social workers integrate into their various service roles the principles of empowerment, respect for cultural diversity, and the strengths perspective (Bletzer & Koss, 2006; Evans-Campbell et al., 2006). In addition to practice in mandated TLOA rape crisis services, social workers who see survivors in general mental health settings could offer comprehensive, culturally sensitive assessments and individual counseling for specific disorders, such as PTSD, as well as family and group treatment. Clearly, social work professionals can be key team members in meeting the needs of AI/AN victims of sexual assault.

The competencies that are the most unique to public health and distinct from social work center on prevention and its theoretical base. A number of practice activities and related skills support prevention, specifically monitoring a community's health status, conducting research on health hazards, informing and educating the public, developing policies to support health goals, building community partnerships, and providing links to health services (Stover & Bassett, 2003). Some of the literature on the sexual assault of AI/AN women includes public health research on risks and the need for various levels of prevention, as well as recommendations for direct and indirect services for survivors.

Several public health practice roles are highly relevant to the implementation of the TLOA reforms. Public health workers could access and present the research that has identified the risks associated with sexual assault against AI/AN women (especially within the local area). They could also identify local health services that are available to support the victim service programs and the quality of the workforce. A major role would be to lead the initiative to design and evaluate a variety of educational programs to support the goal of preventing severe health and mental health consequences for traumatized survivors of sexual assault. Drawing on prevention science, public health workers can develop programs with different types of targets, including community-wide information or media campaigns and educational programs for organizations like schools or informal Native groups.

Advantages of Collaborative Efforts

Benefits for the victim programs can come as the two different types of professionals learn from each other and jointly engage in comprehensive problem solving. For example, one reform is use of the SART model, with the DOJ protocol (U.S. DOJ, 2004) cited as a resource that explains and provides the goals, standards, and procedures for this coordinated service. Both social workers and public health practitioners have skills that would apply to the many steps needed to develop a SART. First, they could engage existing key stakeholders and members of the community during the process of organizing a community coalition that is charged with adopting the SART model (Clairmont, 2008). Once a coalition is under way, social workers with established links to community resources and public health workers who are armed with research data could jointly inform diverse members of the coalition about the theory, value, and procedures of the SART model. The combined skills of these workers can help with the central task of building a consensus and commitment among essential members of the SART team, that is, advocates for victims of sexual assault, law enforcement officers, medical personnel, and prosecuting attorneys, as the first responders who see a victim soon after the assault. Further collaboration could enrich the critical task of training that is also inherent in the reforms.

When it comes to specific prevention programs mentioned in the AI/AN literature on sexual assault, the synergy from collaboration would be essential. For example, Yuan, Koss, Polacca, and Goldman (2006) suggested providing prevention materials, community resources, and programs targeting "women that are separated, divorced, or who are in cohabitating relationships," since these characteristics are linked to the high risk of sexual assault; they also recommended psychoeducational programs for men that "focus on gender-role definitions, the negative effects of colonialism, and traditions that discourage male violence" (p. 1585). Another prevention idea is to educate elders and religious leaders about sexual assault to develop a layperson triage network that could provide informal support for victims (Bletzer & Koss, 2006; Bryant-Davis et al., 2009).

With these types of programs, collaborative planning at every stage could enhance the potential for success. Public health specialists could

readily access informational materials, identify outreach methods and delivery settings, and build community partnerships to make such programs a reality. Social workers could contribute to program planning by including cultural values and traditions, identifying indigenous persons as participants or leaders, and addressing ways to minimize stigma. They could also serve as cofacilitators of group programs and incorporate the principles of empowerment and strengths. Similar joint planning and delivery, using the competencies noted earlier, are needed to develop recommended screening programs (Masho & Ahmed, 2007; Roy-Byrne et al., 2004).

Guidance for Effective Professional Participation in TLOA Implementation Efforts

Once informed about the issues surrounding sexual violence against AI/AN women, professionals can play a critical role in this social justice issue. They must understand, however, that implementation resides with Native community leaders, a point noted earlier. Now we offer guidance on the principles for effective participation. Native people have encountered ''experts'' who have overreached to usurp power or decision making, and they are wary of trusting the dominant culture (Pole et al., 2008). The discussion here aims to sensitize practitioners to the principles for working respectfully with tribal communities.

A central principle is that of tribal sovereignty. Because each community has the right to govern itself, each will determine its response to the reforms, drawing on unique tribal values and traditions. First, professionals need to understand the local tribe's values about health and health care. Moreover, they should accept that they are learners and collaborators in ways that are consistent with Native American values of patience, listening, cooperation, and humility. In addition, seeking and maintaining personal contacts are important for successful interactions with representatives of tribal governance or services. Finally, professionals need to be sincerely committed to assisting with the broad needs of the community, such as support for employment and training, self-determination, empowerment, and pride (Limb, Hodge, & Panos, 2008; Wahab & Olson, 2004). The avenue for

nonnative workers to join any TLOA initiative will depend on the local community. Indigenous colleagues in local health services could be a source of learning about any implementation effort and participating in it. An existing personal or professional relationship with tribal members may be another avenue for participation. Professionals and community stakeholders should stay aware of tribal activities and pursue their involvement in announced TLOA efforts—with the understanding that tribal leaders and councils are responsible for managing the reform initiatives.

The second principle, as task forces or coalitions come together, is to support and build the capacity of indigenous people. Building a true community capacity calls for frameworks that are ''designed by tribal people for tribal people''—that is, a ''ground-up'' process with Native leaders and elders, not a top-down process led by nonnative experts (Chino & DeBruyn, 2006). Nonnative participants should recognize that building trust and partnerships depends on communication and finding common ground. It is important to respect the interdependence of the community with its history, culture, and environment. Task force participants should not assume a Western model that immediately starts with planning for action. They should show a sincere commitment to serve the community for the long term by helping develop the team's skills for engaging in future tasks. Although professionals may be used to taking charge, assuming the role of an assistant conveys respect for the community's ability to lead and decide for its own people.

The third principle of cultural competence is broad and complex, and professionals should always be open to learning. The first step is to gain knowledge about Native values and history, remain aware of one's own values and biases, and adapt one's practice to the uniquely diverse needs of clients (Weaver, 1999). It is important to know that the U.S. DOJ (2004) protocol was developed with input from national, local, and tribal experts throughout the country. In addition, Clairmont's (2008) guide on SARTs was developed by the Tribal Law and Policy Institute (www.tlpi.org). Nonnative social workers and public health specialists who may work with these documents on implementation can gain specific guidance on culturally sensitive practices. In work on developing service or prevention programs, professionals must always integrate the reality of historical trauma. They should

also be open to traditional avenues of help: working with native healers or elders, spirituality interventions like sweat lodges and talking circles, tribal justice forums, and the free Indian Health Service's Western-style medical and mental health programs (Bubar, 2010; Deer et al., 2004; Gone & Alcantara, 2007; Hamby, 2004; Johnson & Cameron, 2001; Oetzel & Duran, 2004; Sheehan,Walrath-Greene, Fisher, Crossbear, & Walker, 2007). For social workers who provide casework or counseling, the principle of empowerment means accepting the client's account of the problem, exploring power issues in the problems, and working with strengths. Several types of culturally sensitive interactions that could apply to work with Native clients, as well as task groups, include the following: accept a broad definition of family, use casual indirect conversation, let others take the lead, avoid probing and eye contact, and keep a low voice tone and distance that is comfortable to others (Wahab & Olson, 2004).

Perhaps, a major barrier for nonnative professionals to integrate these principles for effective participation is the attitude that they already possess cultural competence. Changing this attitude and others, such as overvaluing one's position as a leader and expert, is one way to move toward sincere and effective collaboration with Native leaders and communities. If social work and public health practitioners can internalize the principles just discussed, they have much to contribute to the reform efforts to address sexual assault against AI/AN women. With cultural competence and a systemic understanding of the problem and tasks, their complementary roles and skills can contribute to partnerships with Native leaders and others who are committed to a coordinated response to sexual assault that fits the unique community.

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