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**PHASE III  
FINAL REPORT  
Child Abuse And Neglect  
In American Indian And Alaska Native Communities  
And The Role Of The Indian Health Service**



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**CHILD ABUSE AND NEGLECT**  
**IN AMERICAN INDIAN**  
**AND ALASKA NATIVE COMMUNITIES**  
**AND THE ROLE OF**  
**THE INDIAN HEALTH SERVICE**

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## **ACKNOWLEDGMENTS**

There are several key individuals who contributed their time and talents to completing this project, which examines the role of the Indian Health Service (**IHS**) in child protection and child maltreatment and the development of a model child abuse intervention program. I commend their collective efforts and dedication to attaining the goals of this project.

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Joseph Myers  
Executive Director  
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## **PREFACE**

In 1990, the Department of Health and Human Services identified the need to examine the Indian Health Services (**IHS**) response to child abuse and child neglect (**CA/CN**) in Indian communities to gain accurate data on the incidence of **CA/CN** in Indian country and to develop a model intervention program to address this problem. Based upon the findings from the study, the IHS intended to develop standardized responses to cases of abuse and neglect, emphasizing coordination among federal, state, private, and tribal agencies involved in child protection.

The National Indian Justice Center (**NIJC**) undertook this study to provide a critical assessment of the effectiveness and impact of MS policies and to evaluate the capacity of II-IS personnel to competently recognize and treat the abuse and neglect of Indian children. The **NIJC** also recommended and implemented a culturally sensitive intervention **program** to address the issues of **CA/CN**.

Indian child and adolescent abuse and neglect are issues of widespread concern; however, no reliable statistics exist regarding the prevalence of abuse or neglect in Indian country. The **NIJC** study provides critical measurements of the **IHS** and tribal policies, procedures, and personnel in the recognition and treatment of **CA/CN**. The study also facilitates the design of an intervention program, which is flexible enough to be used by American Indian and Alaska Native communities across the country.

This project was conducted in three phases. Phase I included both a review of MS policies and procedures on **CA/CN**, and a survey and on-site data collection investigating **CA/CN**-related issues. Phase II involved the evaluation of the data obtained in Phase I, additional research and on-site assessments, and the development of a model intervention program. Phase III involved surveying tribal service providers, implementing the New Beginnings Program at a pilot site, and disseminating information about this project to Indian communities throughout the country.

This project provides both important insights into the current response to **CA/CN** cases in Indian country and comprehensive data regarding the incidence of such events. The model intervention project, which was developed and implemented, highlights both the need for such programs and the blueprint for implementing them in Indian communities throughout the nation. We hope that the information provided in this report will lead to significant improvements in the response to **CA/CN** cases and the national implementation of an effective intervention program.

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## EXECUTIVE SUMMARY

### INTRODUCTION

In 1990, the Department of Health and Human Services, Public Health Service, Indian Health Service (II-IS), issued a request for proposals for a "Study of the Role of the Indian Health Service in the Child Protection/Abuse Arena." The purpose of this project was to:

- (1) determine whether the **IHS** has adequate policies, procedures, and protocols in place to address child protection/abuse/neglect (**CP/A/N**) in Indian communities;
- (2) determine whether the **IHS** staff receive adequate/appropriate training to implement the policies, procedures, and protocols;
- (3) determine what type and to what extent **IHS** mental health treatment is available to victims (and their families) and alleged offenders (and their families);
- (4) determine whether the present reporting system accurately reflects the scope of the problem and, if not, how it can be improved to do so;
- (5) develop a model intervention program to address **CP/A/N**; and
- (6) provide recommendations for improvements in **IHS** policies, procedures, protocols, and coordination efforts.

Based upon the findings from this study, the **IHS** should: (1) develop a standard agency policy addressing **CP/A/N** which will be implemented nationwide; (2) develop standard **medical-social welfare and data collection procedures and protocols** addressing **CP/A/N** that will be employed nationwide; (3) develop or initiate better **coordination** between all agencies (federal, state, private, and tribal) involved in **CP/A/N**; and (4) identify gaps in mental health services in Areas where the **IHS** is the primary mental health treatment provider.

The National Indian Justice Center (**NIJC**) project proposed to address several key issues of Indian child abuse, its prevention, recognition, and treatment. The project seeks to provide a comprehensive assessment of the effectiveness and impact of the MS polices and to evaluate the capacity of **IHS** personnel to competently recognize and treat the abuse and neglect of **Indian children**. The **NIJC** also proposed to design and implement a culturally sensitive intervention program to address the issues of **CP/A/N**.

Indian child and adolescent abuse and neglect are issues of widespread concern; however, no reliable statistics exist regarding the prevalence of abuse or neglect. Recent data have indicated that more than 6,500 referrals for suspected child abuse **and neglect** were made to the Bureau of Indian Affairs (**BIA**) in 1988, reflecting a minimum of 1 percent of Indian children in the BIA service area. According to the Indian Adolescent Mental Health Bulletin (**OTA-H-446, 1990**), this is considered an underestimate of the actual extent of the problem for several reasons: (1) referrals do not represent all cases, as, in some states, social service agencies, rather than the BIA, handle suspected cases; (2) there is a lack of formal systems for reporting cases; and (3) the data do not include urban Indians. The **NIJC** study is the first to provide national information regarding the incidence of child abuse and neglect (**CA/CN**). This study provided comprehensive assessments of the effectiveness of MS and tribal policies, procedures, and personnel in the recognition and treatment of **CA/CN**, and facilitated the

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design of an intervention program flexible enough to be used by American Indian and Alaska Native (AI/AN) communities across the country.

The project took place in three phases. Phase I included a review of **IHS** policy and procedures on child abuse and neglect, and a survey and on-site data collection regarding issues concerning the incidence of **CA/CN**. Phase **II** involved the evaluation of the data obtained in Phase I, additional research and on-site assessments, and the development of a model intervention program. Phase **III** involved surveying tribal service providers, implementing the “New Beginnings Program” (hereafter, New Beginnings) at a pilot site, and disseminating information about this project to Indian communities throughout Indian country.

## **PHASE I**

### **PROGRAM EVALUATION**

The project design for Phase I integrated four main components: (1) a multilevel review of MS policy and procedure; (2) a series of surveys regarding IHS program objectives and protocols, and the possibility of coordinating efforts with other federal, tribal, and state agencies; (3) database research; and (4) background and support research.

### **SURVEYS**

An effective, systematic, and impartial means of collecting information was needed because of the wide geographic dispersion of the **IHS** system throughout the nation. Information regarding incidence of and response to child abuse and neglect is not available from service systems within the MS system. Therefore, this 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.

### **DATABASE RESEARCH**

Database research focused on in-patient data to assess actual implementation of the MS policy aimed at identifying, reporting, and intervening in suspected and confirmed cases of **CA/CN**. The research examines the rate, usage, and consistency of identification and reporting policies, the type of information obtained, the 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.

## **PHASE II**

### **CASELOADS**

The most important result of the caseload investigation is, perhaps, the consistency between the MS and the BIA estimates of the number of children at-risk for maltreatment in Indian communities. Both agencies estimated that 34.4 percent of Indian children are at-risk of

becoming victims of abuse and/or neglect. Respondents also estimated that only one in five reported cases is ever substantiated; the number of substantiated cases is a conservative estimate of actual abuse. Without independent confirmation, many cases are considered unsubstantiated, even if they are strongly suspected by professionals.

## 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, the 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 the 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, a lack of sufficient expert personnel to investigate the case, and a lack of corroborative evidence for substantiation.

## TRAINING

The lack of adequately trained staff was repeatedly mentioned as a problem by both the MS and the BIA personnel and was considered to be a major hindrance to effective interagency coordination of services. The type of training, its adequacy, and the means by which it was administered varied among MS and BIA personnel. 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 the IHS and the BIA staff.

## MANAGEMENT INFORMATION SYSTEMS

Only 25 percent of the respondents had computerized records. This creates limitations in obtaining baseline and 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 local, state, tribal, and federal agencies that may be involved.

## SUBSTANCE ABUSE AND CHILD MALTREATMENT

Respondents agreed that child maltreatment is not an isolated issue; rather, it is associated with the problems Indians 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 percent) of the cases in which such data were collected. The prevalence of substance abuse varied with the offender's sex, relationship to victim, age, and type of abuse. Incidents with male offenders were significantly less likely to involve substance abuse (60 percent of incidents) than incidents with female offenders (70.4 percent of incidents).

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In future studies of CA\CN involving AI/AN children, it will be important to assess what interrelationships exist between substance abuse and child maltreatment, and what programs directed at the specific problems and needs of Indian people should be instituted.

### **ON-SITE COMMUNITY ASSESSMENTS**

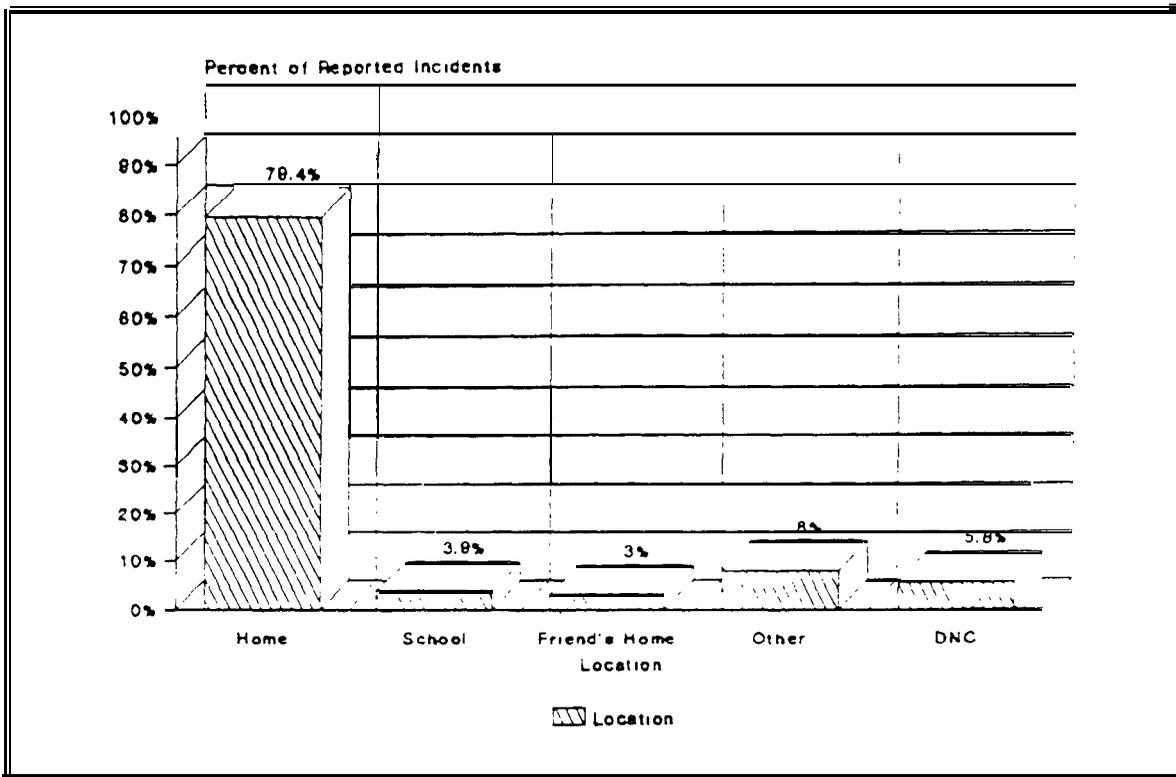
Six service units were selected for an in-depth, on-site community health and risk assessment. In order to select a location to pilot the proposed intervention program, the availability of intervention programs within each service unit and between the IHS and other agencies in the community was assessed. The Wind River Service Unit was eventually selected as the site for the pilot program, and a successful program was established there.

### **ANALYSIS OF CASE STATISTICS**

Case statistics were collected from Federal agencies through the mail survey format. 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 IHS service areas; (2) a data set of over 300 incidents reported by the 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 AI/AN CA\CN data set.

### **CASE STATISTICS**

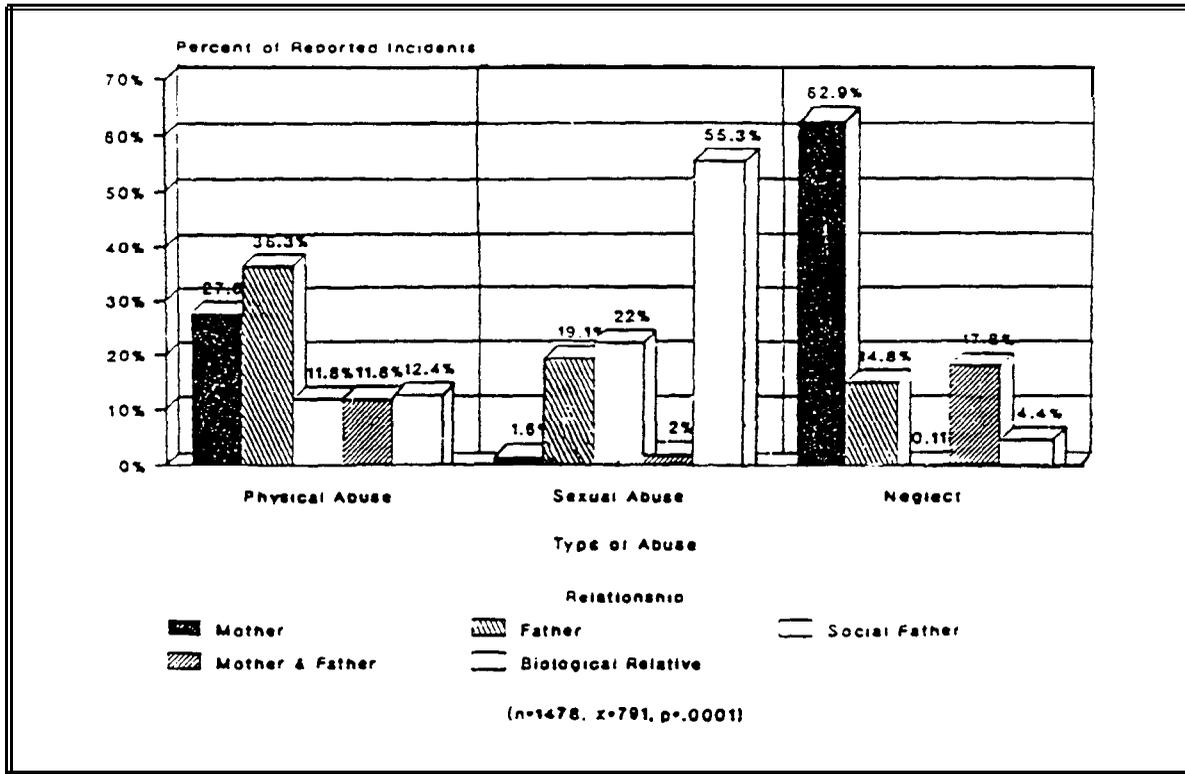
Case specific information was gathered nationwide for 2035 reported cases of Indian child abuse and neglect. The analysis of these data has provided the first national profile of Indian child maltreatment. This information has important implications for Indian-specific prevention and intervention efforts. The data represents 17 states and 10 regional MS 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 percent), sexual abuse (28.1 percent) and physical abuse (20.8 percent) cases comprised most of the remainder of the reports. Considerable variation exists within individual service areas. An important finding was that almost 80 percent of all cases occurred in the child's home (Figure 1E - next page). Less frequently, incidents of abuse and neglect occurred at school (3.9 percent), a friend's home (3.0 percent), or other locations (8.0 percent).



**Figure 1E. Location At Which Reported Incident Occurred**

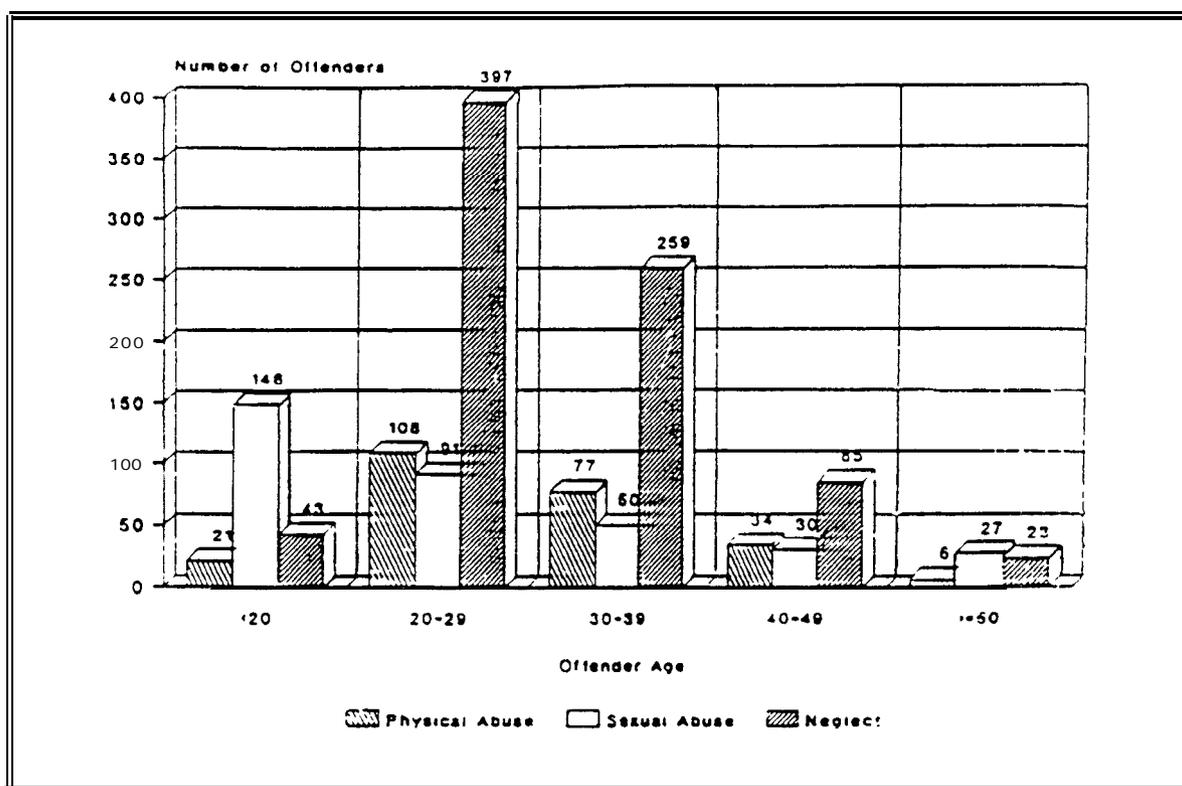
A disproportionate number of victims are under the age of five with a substantial number under one year of age. While boys and girls were about equally likely to be victims of physical abuse (52.8 percent boys) and neglect (51.1 percent boys), sexual abuse victims were primarily girls (79.8 percent).

Overall, offenders were equally likely to be male or female (48.9 percent male, 51.1 percent female), but 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 percent male) and physical abuse (59.3 percent male), and most often female (74.7 percent female) in cases of neglect. The most frequently reported offenders (69.3 percent) were victims' parents (mothers, fathers, social fathers, or both parents together). Step-fathers, mothers' boyfriends, and other "social fathers" comprised only a small percentage of that total (5.4 percent) and the remaining were mostly non-parent biological relatives (12.7 percent) or others (3.6 percent).



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

Relationship information from Figure 2E, in combination with age information from Figure 3E (next page), provides a profile of offenders and CA/CN incidents. Mothers over the age of 20 (as opposed to teenage mothers) were the primary offenders in cases of neglect (62.9 percent of neglect cases) and fathers were the primary offenders in cases of physical abuse (36.3 percent of cases). Step-fathers and other social fathers were over-represented in cases of both physical (11.8 percent) and sexual abuse (22.0 percent). 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 percent of cases). The greatest threat of sexual abuse may come from members of the extended family network, such as siblings, cousins, older uncles, and grandparents.



**Figure 3E. Offender Age by Abuse Type**

### MODEL INTERVENTION PROGRAM

A model for prevention and intervention was identified based on the information available to the research team. This model, based on the Hawaii Healthy Start program, will be known as New Beginnings in Indian Country. The most appropriate and effective type of intervention program for the MS 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 role in secondary prevention and is the most appropriate agency to identify families at-risk, provide health services to those families and link them 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 is 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.

## CHILD PROTECTION TEAMS

The IHS and the BIA have been mandated to develop and participate in multi-disciplinary 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. CPTs can be further strengthened with the funding of 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.

## PHASE III

There were three major activities undertaken during Phase III: (1) surveys of tribal service providers (2) implementation of the New Beginnings Program at a pilot site; and (3) dissemination of information about this project to Indian communities throughout the country.

Direct service providers were surveyed regarding their perceptions of existing tribal policies and procedures regarding CA/CN, staffing and personnel issues, jurisdiction and interagency issues, treatment of CA/CN, access to services, CPTs, and staff background information. Program administrators were surveyed regarding budget, child protection programs, staffing and personnel issues, interagency relationships, the CPT and Family Violence Prevention Team, the treatment of CA/CN, case statistics, policy and procedure, and case history information.

## SURVEYS

As in Phase II, quantitative data were obtained primarily from the self-administered mail questionnaires sent to administrative personnel. 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 mail questionnaires were modified from Phase II in accordance with concerns from the Office of Management and Budget (OMB). Obtaining OMB approval caused a delay that spanned over an entire year and proved to be extremely detrimental to the project.

The mail questionnaires were utilized as a means for gathering secondary data that would provide information about funding, interagency agreements, staffing and personnel issues and

records management including available case statistics. The mail surveys were sent to 140 direct service providers representing mental health, medical, judicial, and law enforcement personnel. These 140 people represented all identified tribal direct service providers. The response rate to the survey was quite small, with only five surveys completed and returned (response rate 5/ 140).

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 utilized were identical to the survey used in Phase II. The target population consisted of 112 individuals representing medical, social services, and mental health personnel from tribal programs of tribes surveyed in Phase II.

### **RESPONDENTS**

There were several respondents appropriate for inclusion in the survey research. All were individuals who have had either a broad knowledge base regarding issues of CA/CN or direct experience with children and families. Administrative personnel included tribal administrators, such as department heads or program directors. Direct service providers included social services personnel (case workers and Indian Child Welfare staff), mental health personnel (such as psychologists and therapists), law enforcement officials, and providers of judicial services.

### **SAMPLE STRUCTURE**

Due to the small response size, there was no specific sample design utilized. It was not possible to statistically analyze the data obtained or to compare the data obtained in Phase II with that obtained in Phase III. There are many possible reasons why there were such low survey response rates (5/140 mail surveys and 24/112 telephone), including, but not limited to, the following: little incentive to complete either telephone or mail survey, insufficient funding and staff to carry out the project, lack of availability to complete telephone surveys, limited potential respondents, and lack of any "pressure" to comply.

The delay in OMB approval for the survey also contributed to the low response rate. The NIJC staff who carried out the initial research were no longer employed during this Phase. The lack of continuity of staff and the time lapse between the initial surveys and the secondary, tribal surveys added to the difficulties in obtaining responses.

### **NEW BEGINNINGS PILOT PROJECT**

The Wind River Service Unit, located in Fort Washakie, Wyoming, was chosen as the pilot site for the New Beginnings Program. The program, which coordinated services with a variety of on- and off-reservation agencies, was quite successful during its short duration. Members of the local community were recruited and trained to provide services to at-risk

families. Families referred for service were receptive to participation in the program. Unfortunately, the program was only funded for 10 months. Despite many efforts to secure additional funding, the program ran out of money and had to shut down. The life cycle of this program is typical of many Indian country programs: funding is provided for only a short time, the program begins offering services, then, clients are left in the lurch when the funding ends.

During the 13 months of the program's existence, eighteen families received intensive in-home services. Significant improvement was measured in several areas. None of the parents in the New Beginnings Program were referred for CA\CN during their participation in the program; and no subsequent pregnancies occurred during the program. Fifteen of the families showed improvement in the use of both formal and informal social support networks, eleven of the families attended parenting classes, and all of the families showed improvement in the quality of parent-child interactions. Four participants passed their GED examinations, with one couple making plans to attend college.

All of the infants in the program were up to date on well-baby visits and **immunizations**. In addition, all of the babies were within normal limits of growth and development. All 18 client families received ten months of home visitation.

By comparison, one of the two families identified as at-risk who declined services from the New Beginnings Program, was subsequently referred for suspected child abuse and neglect. While the sample size is small and the program short, it appears to have significantly benefitted the families that participated.

#### DISSEMINATION OF INFORMATION ABOUT THE NEW BEGINNINGS PROGRAM

Project staff members were able to provide information regarding the concept of an early intervention program to tribal communities nationally. The NIJC staff made numerous presentations at local and national meetings regarding the development and implementation of the New Beginnings Program and provided technical assistance to other Indian communities interested in developing such programs. These efforts were coordinated with the **IHS** to provide maximum information and resources to communities exploring the potential for developing child abuse/neglect prevention programs.

Each New Beginnings Program can be modified to suit the community's particular needs. The success of the New Beginnings Program in Wind River is attributable to systematic screening, the timing of intervention (birth), the intensity of intervention, the provision of comprehensive services, the commitment and quality of the staff, the linkage to other programs, a focus on the family, and unique public-private partnership. The ultimate goal of New Beginnings is to provide a focus on long-term change with attention to immediate needs. Success for the program in Indian communities will come from a commitment to a state/tribal-wide program, a commitment to collaboration with other agencies, persistence in educating legislators, attention to data gathering and evaluation techniques, persistence in lobbying with key

legislators, effective public-private partnerships, standardized training and technical assistance, and high 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.

These programs must be nurtured and supported. The benefits of prevention of child abuse and neglect are obvious, the costs minimal. There must be a strong commitment to long-term funding and support of New Beginnings in Indian country.

### THE ROLE AND RESPONSIBILITY OF THE INDIAN HEALTH SERVICE

The primary responsibility of the **IHS** is 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 **IHS** has an important supportive role in primary prevention; the organization should support and promote community efforts to increase public awareness of **CA/CN** through educational activities and other methods. Just as important, however, is the primary role the **MS** plays in secondary prevention. It has the responsibility of identifying families at-risk, providing needed services, and linking these families to community services. Unfortunately, inadequate funding has made providing these services extremely difficult.

### CONCLUSIONS AND RECOMMENDATIONS

The results of this study have highlighted ways in which the **MS** performs in an exemplary manner, ways it can function adequately under current policy and procedures, and areas where change is implicated. In order to adequately address the current needs of Indian families by promoting healthy family and **child** development and preparing for the future, it is recommended that:

- The **MS** increasingly incorporate a public health model into the existing medical model.
- The **IHS** make a commitment to providing secondary prevention services to victims of **CA/CN** and their families, including the provision of extended services to “at-risk” children and their families.
- The New Beginnings Program be implemented in other reservation communities with a minimum of five years guaranteed funding per program.

- 
- The II-IS 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 MS work with tribes to develop a centralized reporting/referral resource office within each service unit.
  - The MS standardize and integrate data collection procedures at local, service unit, Area, and national levels.
  - The II-IS 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 MS increasingly incorporate the use of AI/AN traditional cultural and healing in treatment according to the needs of individual communities.
  - The II-IS provide services for offenders.
  - The II-IS coordinate mental health and social services with alcohol abuse programs.
  - The **IHS** promote community awareness programs and public relations campaigns for new and existing services in coordination with tribal, state and BIA agencies.

The II-IS 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 everywhere.

## **CHILD ABUSE AND NEGLECT IN AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES**

### **INTRODUCTION**

In 1990, the Department of Health and Human Services, through the Public Health Service and the Indian Health Service (MS), issued a request for proposals for a study of "The Role of the Indian Health Service in the Child Protection/Abuse Arena and the Design of a Model Intervention Program." The purpose of this project was to: (1) determine whether the MS has adequate policies, procedures, and protocols in place to address child protection/abuse/neglect (CP/A/N) in Indian communities; (2) determine whether the MS staff receive adequate and appropriate training to implement the policies, procedures, and protocols; (3) determine what type and to what extent MS mental health treatment is available to victims (and their families) and alleged offenders (and their families); (4) determine whether the present reporting system accurately reflects the scope of the problem and, if not, how it can be improved to do so; (5) develop a model intervention program to address CP/A/N; and (6) provide recommendations for improvements in IHS policies, procedures, protocols, and coordination efforts.

Based upon the findings from the study, the MS intended to: (1) develop a standard agency *policy* that addresses CP/A/N, and that can be implemented nationwide; (2) develop standard medical and social welfare and data collection *procedures* and *protocols* addressing CP/A/N to be employed nationwide; (3) develop or initiate better *coordination* between all agencies (federal, state, private, and tribal) involved in CP/A/N; and (4) identify gaps in mental health services in areas where the IHS is the primary mental health treatment provider.

The National Indian Justice Center (NIJC) project proposed to address several key issues of Indian child abuse: its prevention, recognition, and treatment. The NIJC proposed to provide a comprehensive assessment of the effectiveness and impact of the MS policies and to evaluate the capacity of the II-IS personnel to competently recognize and treat the abuse and neglect of Indian children. The NIJC also proposed to design and implement a culturally sensitive intervention program to address the issues of CP/A/N.

Indian child and adolescent abuse and neglect are issues of widespread concern; however, no reliable statistics exist regarding the prevalence of abuse or neglect. Recent data have indicated that more than 6,500 referrals for suspected child abuse and neglect were made to the Bureau of Indian Affairs (BIA) in 1988, reflecting a minimum of one percent of Indian children in the BIA Service Area. According to the Indian Adolescent Mental Health Bulletin (OTA-H-446, 1990), this is considered an underestimate of the actual extent of the problem for several reasons: (1) referrals do not represent all cases (in some states, social service agencies, rather than the BIA, handle cases); (2) there is a lack of formal systems for reporting cases; and (3) the data do not include urban Indians. The NIJC study provided the first national information regarding the incidence of Indian child abuse and neglect. This study provided comprehensive assessments of the effectiveness of the II-IS and tribal policies, procedures, and personnel in the recognition and treatment of child abuse and child neglect (CA/CN), and facilitated the design of an intervention

program flexible enough to be used by the American Indian and Alaska Native (AI/AN) communities across the country.

## GENERAL ISSUES

Researching child abuse and neglect in AI/AN communities is extremely challenging. 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 Native parents interact with their children. Even with issues (e.g., corporal punishment) that may or may not be considered a problem, depending on the group, subsequent decisions regarding action or intervention are made within the set 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, another accepts as standard behavior. Parents, like all members of a group, are strongly influenced by the standards that their particular social group provides.

At present, there is no uniformly accepted definition of child abuse. The Congress provides a federal standard within the recently amended Federal Child Abuse Prevention and Treatment Act (1974). This Act defines child abuse 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. Yet, definitions and the processes by which cases are identified and labeled as "child abuse" vary by professional groups and between agencies. A study by Gelles, for example, found considerable variance within and between groups as to what constitutes child abuse (Starr 1982). Two major characteristics are found to be 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, even if agreement exists on these two characteristics, a continuum of judgment across individuals and between groups still exists.

Such variation in definition creates problems with the implementation of a treatment program and often results in two types of errors in case identification; cases of child abuse may be incorrectly identified as "not abuse," while cases that are not abuse may be incorrectly labeled as "child abuse." Because the decision making process is a social process involving factors other than those that cause maltreatment, the problem is extremely complex.

Largely due to a very high rate of injury mortality, the AI/AN children have one of the highest post neonatal-natal 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 a 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.

The chair of the Committee on Child Welfare of the Advisory Boards to the National Center on Child Abuse and Neglect, Judge Skekette, reported the Committee's findings regarding its investigation of issues surrounding the problem of Indian child maltreatment (1986). The Committee found a "desperate need" for the coordination of the activities of both the private sector and the tribal, local, state, and Federal governments 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 increasingly acculturating into White American society. This has been accompanied by shifts in economics, resource control and **availability**, values that exist within society, familial structure, and parenting patterns (Levine & White 1987). Cross-cultural studies have shown that societies in transition are especially susceptible to such social ills as child abuse. How does the seemingly inevitable transition from one culture to, another 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 to deal best with some of these questions. The cultural context will determine what constitutes abuse, define situations that excuse or mitigate abuse, and determine the types of appropriate intervention techniques. 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 inter-governmental relationships that a tribe has affects the extent to which it will be able to access and use government services.

Prior to 1978, generations of AI/AN children were systematically removed from their homes into foster care placement or 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 availability. Several studies have reported statistics which appear to indicate rates of abuse among American Indians that are lower than rates among African-American or Caucasian children. For example, an article in the *White Cloud Journal* entitled “Child Epidemiology” stated that American Indians “may well neglect their children less frequently than the majority culture.” Another report cited statistics from Florida (i.e., 9.2 cases of abuse per 1000 Indian children in comparison with a rate of 13.5/1000 for black children and 15.5/1000 for white children) in order to demonstrate the existence of low CA/CN rates among AI/AN. However, these numbers may be dangerously misleading, since they may include reporting biases due to 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 appear to be as much a problem for Indian families as it is for non-Indians. Until the problems are faced openly, agencies charged with the protection of AI/AN children can expect to neither effectively prevent child abuse and neglect, intervene with existing cases, nor 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 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.” The pervasive attitude among families, tribal leaders, and service providers that

“culture and tradition” are critical elements in defining what constitutes abuse and neglect make it seem as if abuse is cultural. While the problems of child maltreatment and child protection cannot be considered cultural, they must be approached within the context of the cultural and social environment of individual tribes in order to understand the groups respective child-rearing practices, kinship systems, and traditional family values.

Traditional ways of life define complex relationships and acceptable behavior, both publicly and privately. Expectations, education, discipline, and retribution are inexorably linked. Culture is a complete way of life for AI/AN people; it is not made up of isolated acts. Thus, it may be a mistake to support the existence of cultural “sanctions” without the other elements of cultural support and guidance. There is a balance between positive and negative forces that structure behavior in any community. Children should witness this balance so they can develop self, pride, and personal integrity, and so they can become productive members of their community. The manifestations of poverty and family dysfunction must be separated from traditional culture. 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 should draw on the strengths that exist within families and communities and the spectrum of cultural traditions, rather than focusing on deficiencies and problems. As tribes reassume jurisdiction over their children in child welfare cases, set up children’s courts, and develop or expand tribal resources, they need the help that federal agencies can provide. Tribes need to acquire the tools necessary for development of local standards that reflect cultural differences, that support access to formal and informal networks, and that strengthen the integrity of the extended family.

#### INDIAN-SPECIFIC ISSUES

The demographic and socioeconomic profile of AI/AN may be similar to that of other minority groups within the U.S., but AI/AN communities differ from 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. States, on the other hand, must comply with specific federal guidelines. Second, most tribes have a trust-based relationship with the Federal Government as a result of numerous treaties - that is, the exchange of land for food, clothing, shelter, health care, and education. The IHS and the BIA are mandated to provide assistance and, as such, are primary foci of any prevention and intervention program. The MS has the potential to profoundly reduce the incidence of CA/CN by providing treatment programs for the victims, the perpetrators, and their families. This, in turn, would effectively increase the physical and social health and well-being of AI/AN communities.

Service providers who try to address child maltreatment in AI/AN communities are often confronted with an array of 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) the lack of services in rural areas; (5) the extremely limited human and financial resources; (6) the overlapping and often conflicting legal and jurisdictional authorities; and (7) the array of social issues, including poverty, substance abuse, modernization and assimilation, extended families, Native culture and tradition, and the structure and size of the community. 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 communities, as the median AI/AN income is below the U.S. poverty level. Poverty and unemployment exist at very high rates in AI/AN communities and can cause severe strains on 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 complicating communication with and cooperation by the family.

Cross-cultural studies have shown that, in a variety of cultures, rates of CA/CN increase as society becomes increasingly modernized. The AI/AN families are increasingly prone to abuse as they become more and more removed from their traditional ways of life embedded with support systems and coping mechanisms. Modernization has also meant that generations of children have lived and are living in institutional settings, isolated from their families, support networks, and parenting models. Most tribal governments do not have adequate resources to provide the intervention and treatment that victims and their families need. The few qualified individuals and programs that do exist are often overworked and under-funded. Networking with 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 either an asset or a problem. In a small community where everyone knows each other, there are few secrets. This can affect confidentiality, and thus the ability of community members involved with child protection to do their jobs. At the same time, however, the closeness of community members and extended families can also increase support for the child and the family.

Extended families can also be either an asset or a problem. The extended family has traditionally played an important role in AI/AN communities. 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 differences, and alternative 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. A culturally-sensitive 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 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 in defining what constitutes child maltreatment, while an issue for the MS and the BIA, did not appear to interfere with the provision of treatment or services at 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 individual viewpoints. 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 on the correct manner in which cases should be handled.

On a personal level, respondents had a variety of perspectives on the causes of 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 individual responses are guided by personal viewpoints, and individuals working in a multi-disciplinary arena should be aware of diverse perspectives and the different types of interventions that may result. Although people consistently agreed that maltreatment was not an isolated issue, conflict frequently arose over case dispensation. Families in which maltreatment occurs face multiple problems, including poverty, isolation, and, in some cases, 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 the 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, Public Law (P.L.) 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 communities, since they do not receive funding under its provisions, and since many AI/AN communities lack laws that require reporting P. L. 10 1-

630, the Indian Child Protection and Family Violence Prevention Act of 1990, includes a federal mandatory reporting law. Neither the MS nor the BIA, however, has adopted regulations implementing the Act or requested significant funding under the Act.

In addition, many AI/AN communities have not established which agency has primary responsibility to receive reports and to conduct immediate investigations. Responsibilities are often shared by at least five disciplines - education, social services, health care, law enforcement, and the courts. A lack of clearly defined authority to act, aggravated by overwhelming caseloads and inadequate funding, often causes one agency to pass responsibility onto another. This mismanagement provides the setting for cases to “fall 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 AI/AN 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 by themselves; (9) fear that reporting will destroy the professional relationship with a 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 higher-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 policies and procedures 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 for the employee reporting the suspected abuse(s). 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 to overcome the reluctance to report.

A number of positive steps have been taken in recent years to address these problems. Many tribes have recently enacted child protection codes, which include mandatory reporting laws. Others have assumed greater responsibility for social services to Indian families and children under P.L. 93-638, the Indian Self Determination Act. There has also been increased emphasis and training in AI/AN communities concerning child abuse and neglect.

Each IHS service unit and BIA agency had some type of reporting protocol and case management criteria in place, but they showed substantial variation in definition, structure, and implementation. 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, victim response protocols should include actions involving the offender (e.g., mandatory no contact orders), while offender protocols should 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, the IHS professionals were more likely than their BIA counterparts to have follow-up contact(s) with clients. Higher levels of client contact by the IHS could be attributed to the nature of the service (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 remove them from their files). This makes the MS 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. The MS 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 those geared toward interviewing and investigating cases, were reported less often by the 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 involves 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 backgrounds, and goals to deal with the same case and with each other. Awareness of all aspects of the system, ideally provided in multi-disciplinary training sessions, can promote understanding, enhance communication, and help develop mutual respect.

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 the IHS and the BIA respondents, it is clear that training in more areas was offered to the BIA than to the IHS professionals. Much of this difference was in areas of technical skills (detection and identification, forensics, interviewing, investigation) and criminal justice activities (testifying and prosecution). As mentioned earlier, however, 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 the MS 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 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 often mandatory, reflecting the mandatory reporting laws mentioned earlier, but training of the MS 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 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, to coordinate long-term services for victims, and to develop comprehensive interagency policies for coordination and cooperation. Such systems have been successful in some states (e.g., Virginia) and are being contemplated in others. 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 assessing, planning, and coordinating services.

### **CHILD PROTECTION TEAMS**

The IHS and the BIA have been formally mandated to develop and participate in multi-disciplinary Child Protection Teams (CPTs) for several 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, personalities, excessive work demands, and lack of structure makes communication **difficult** and diminishes team effectiveness. The length of time that a CPT has been functioning seems to influence its effectiveness, less than does 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 its activities more consistent, and protect its stability and operation against changes in membership. Another way to stabilize CPT operation is to fund a coordinator who has no direct affiliation with any participating agency, but who maintains a neutral position and has primary allegiance to the interests of child victims and their families, as well as to members of the CPT, participating agencies, and the community as a whole. Most non-Indian multi-disciplinary teams lack direct authority, but include members of agencies that have statutable mandates 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, the MS and the BIA professionals are involved in ongoing relations with other agencies.

### **JURISDICTION**

In criminal, civil, and juvenile matters in AI/AN communities, including CA/CN, the first question to be resolved is which level of government - federal, state, or tribal - assumes jurisdiction. 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 - what land area may tribal courts exercise authority; and subject matter jurisdiction - 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**

State Jurisdiction	Federal Jurisdiction	Tribal Jurisdiction	
Indian Offender v. Indian Victim	Major Crimes Act. <b>the United States</b> can prosecute 16 <b>listed</b> offenses. <b>Among these</b> , burglary, involuntary sodomy, and <b>incest</b> are <b>defined</b> and <b>punished in accordance with the State law</b> , all others are <b>defined</b> by federal statute.	Tribal courts may <b>have</b> concurrent jurisdiction over <b>crimes</b> under the Major Crimes Act. All other offenses, tribal courts <b>have sole jurisdiction</b> (except where federal statute <b>specifically provides otherwise</b> ).	None, <b>except</b> under P.L. 280 as <b>amended</b> , or <b>other federal statute</b> or by tribal law pursuant to 25 U.S.C. 51321. The <b>tribe may</b> retain concurrent jurisdiction.
Indian Offender v. Non-Indian Victim	Major Crimes Act General Crimes Act <b>Assimilative Crimes Act</b>	<b>Tribal courts</b> may have concurrent jurisdiction over <b>crimes</b> under the Major Crimes Act. They <b>do have concurrent jurisdiction</b> over offenses which can <b>be prosecuted</b> by the United States under the <b>General Crimes Act</b> . Except for major crimes, tribes may preempt <b>federal prosecution</b> . For any other offenses, (as defined by tribal codes) tribal courts <b>have exclusive jurisdiction</b> .	Same as above
<b>Indian Offender</b> <b>Victimless Crime</b>	The <b>United States</b> probably can prosecute under the <b>General Crimes Act</b> as <b>explained</b> above or <b>Assimilative Crimes Act</b> .	Same as above	Same as above
Non-Indian Offender v. Indian Victim	<b>General Crimes Act</b> , plus a substantive <b>offense defined</b> by federal statute or a substantive offense defined by <b>state law incorporated</b> by the <b>Assimilative Crimes Act</b>	Tribal courts have no <b>jurisdiction</b> to prosecute non-Indians, unless <b>Congress</b> delegates such power to them.	Probably no state jurisdiction <b>except</b> under P.L. 280, as amended or <b>with tribal consent</b> pursuant to 25 U.S.C. 91321.
Non-Indian Offender v. Non-Indian Victim	No <b>federal jurisdiction</b> except for <b>distinctly federal offenses</b> .	Same as above	<b>State courts</b> have jurisdiction over <b>all offense</b> defined by <b>state law</b> and <b>involving</b> only non-Indians.
Non-Indian Offender <b>Victimless Crime</b>	<b>General Crimes Act</b> , plus a <b>substantive offense defined</b> by federal statute or a substantive offense <b>defined</b> by state <b>law</b> incorporated by the <b>Assimilative Crimes Act</b> . The law is still <b>questionable whether</b> federal jurisdiction <b>is exclusive</b> or concurrent with the <b>state</b> .	Same as above	<b>State courts</b> probably <b>have</b> concurrent jurisdiction <b>with the United States</b> , although the law is <b>unclear</b> .

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## CHILD ABUSE AND NEGLECT AND THE INDIAN CHILD WELFARE ACT

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 ensure that the values of Indian people are reflected in the foster care and adoptive placements of Indian children, thus ensuring 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.

Congressional findings regarding the Act included the following: (1) no resource is more vital to the continued existence and integrity of Indian tribes than their children, and the U.S. has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in a federally-recognized Indian tribe; (2) an alarmingly high percentage of Indian families are destroyed by the removal, often unwarranted, of their children from them by non-tribal public and private agencies, and a high percentage of such children are placed in non-Indian foster and adoptive homes and institutions; and (3) the states, exercising 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 first be sought within the extended Indian family, the tribal/Indian community. There is a severe shortage of foster and adoptive care in Indian communities, and issues regarding the mandates of the ICWA are often triggered in 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 the transfer of jurisdiction over proceedings involving AI/AN children from state to tribal courts; (3) establishes the 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 a tribal juvenile justice system, for the Act applies to Indian children in state court proceedings, foster care placement, the 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 ICWA, Indian tribes have taken a more active role in protecting their children. However, the ICWA is not a cure-all for child abuse and neglect in AI/AN communities; it simply promotes 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. § 24 11, 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 general U.S. population, and alcohol and substance misuse results in a rate of years of potential life lost nearly five times that of the general U.S. population; four of the top ten causes of death among Indians are: alcohol and drug-related injuries (18 percent of all deaths), chronic liver disease and cirrhosis (5 percent), suicide (3 percent), and homicide (3 percent). Because deaths from unintentional injuries and violence occur disproportionately among young people, the age-specific death rate for Indians is approximately double the U.S. rate for people between 15 and 45 years of age. Indians between the ages of 15 and 24 are more than two times as likely to commit suicide as those in the general population; and approximately 80 percent of those suicides are alcohol-related.

The Act authorizes the use of federal facilities and property for juvenile treatment centers, the construction or renovation of juvenile detention centers, the establishment of youth shelters and halfway houses, the training for the BIA law enforcement and judicial training, and the 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 Congress passed the Anti-Drug Act, which amended the Victims of Crime Act of 1984 (VOCA) 42 U.S.C.S. § 10601 (g), authorizing a portion of the CJA funds to be used in assisting Indian tribes with improving the handling of serious child abuse cases on Indian reservations. This legislation made available a limited amount of funds to: (1) assist Indian tribes with the implementation of programs and with the handling of child abuse cases, especially those that deal with sexual abuse, 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 (DOJ) awarded a series of grants to Indian tribes under its Children's Justice Act Discretionary Grant Program for Native Americans. More than 35 tribes have already received funding under the first three cycles of this program. The grant awards were designed to address a range of systemic improvements, such as: training for multi-disciplinary teams; the 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, designed to fund short-term (one to two year) proposals, emphasize projects that establish a systemic or permanent change in the way child sexual abuse cases are investigated or prosecuted.

The Indian Child Protection and Family Violence Prevention Act of 1990, P.L. 101-630, was enacted to address findings that: "...(1) incidents of abuse of children on Indian reservations are grossly under-reported; (2) such under reporting is often a result of the lack of a mandatory federal reporting law; (3) multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by persons employed or **funded** by the Federal Government; (4) Federal Government investigations of the background of federal employees who care for, or teach, Indian children are often deficient; (5) funds spent by the U.S. 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: ".( 1) to identify the scope of incidents of abuse of children and family violence in Indian country and to reduce such incidents; and (2) to provide funds for mental health treatment for Indian victims of child abuse and family violence on Indian reservations." This Act requires that: (1) reports of abused Indian children be made to the appropriate authorities in an effort to prevent further abuse; (2) 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) other actions be taken, as necessary, to ensure effective child protection in Indian country; (4) 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) technical assistance and training related to the investigation and treatment of cases of child abuse and neglect be provided; (6) an Indian Child Resource and Family Services Center consisting of multi-disciplinary teams of personnel with experience and training in the prevention, identification, investigation, and treatment of child abuse and neglect be established in each BIA Area Office; (7) treatment be provided for victims of incidents of family violence, and programs aimed at prevention be implemented; (8) **tribally-**operated programs be established to protect Indian children and to reduce the incidents of family violence in Indian country; and (9) 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 occur. Unfortunately, appropriations for the prevention and treatment provisions of the Act have been virtually non-existent.

# RESEARCH ACTIVITIES

## INTRODUCTION

This study was designed to research the issue of child abuse in American Indian and Alaska Native (AI/AN) communities and how these problems are addressed by the Indian Health Service (MS). The specific goals of this research were: (1) to provide a comprehensive assessment of the effectiveness of IHS policies, procedures, and personnel in the recognition and treatment of child abuse and child neglect (CA/CN); (2) to provide a comprehensive assessment of the effectiveness of tribal policies, procedures, and personnel in the recognition and treatment of CA/CN; and (3) 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: (1) to assess the incidence of CA/CN among AI/AN people; (2) to understand the variation among tribal and urban Indian communities in their responses to, and acceptance of, the existence of CA/CN; (3) to review resources available within the IHS and through other agencies for the support of prevention and intervention programs; and (4) to 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 child abuse and neglect. This comprehensive perspective offered insight into the dynamics of family systems wherein cultural beliefs, traditions, and values are transmitted through generations. An understanding of the similarities and differences in patterns of abuse and neglect between Indian and non-Indian cultures helped serve to highlight the differences that exist and led 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 MS, specific internal MS programs, policies, and procedures were examined through policy review and surveys. Survey research consisted of both internal and external surveys. The former focused on the MS network at both the administrative and program staff levels (i.e., medical, social services, and mental health personnel and health teams), while the latter focused on community support institutions, such as the BIA, local and tribal courts, schools, social services, and law enforcement agencies. The analysis of indicators of CA/CN focused on medical records, case reports, and referrals.

Survey research was also conducted in assessing the role of the tribal programs. The research elicited information on administrative and direct service program levels and community support institutions. Concomitant research on issues of child protection and 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 MS definition of CA/CN and the diversity in definitions both between different facilities and between the MS 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 where there is no abuse incorrectly labeled as “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, and 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 MS 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 policies, procedures, protocols, and coordinated components of the project.

Current IHS policies and procedures were compared with other regional and local programs. Internal surveys at both the administrative and the line staff levels examined the interpretation, the level of compliance, and the 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 both background and support information and 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

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 because of the OMB restrictions on surveys of non-federal agencies.

Quantitative data were obtained primarily from administrative personnel through self-administered mail questionnaires. These measurements included total agency budgets and the proportion spent toward CA/CN prevention and intervention services, CA/CN policies and procedures, 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 process.

The mail questionnaires were developed as a cost effective means for collecting 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 MS Service Unit and Facility Directors, 12 BIA Area Directors, and 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. These units were: (1) the central administrative unit (or facility when the service unit contained more than one facility); (2) not a tribally-run facility; and (3) providers of direct services. Eighty-five valid responses were received, yielding a 94 percent response rate (85/90). There were ultimately 58 potential respondents within the 12 BIA regional Areas included in the mail survey. Forty-six valid responses were received, yielding a 79 percent 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 interagency cooperation, treatment needs, attitudes regarding child maltreatment, the perspectives on issues regarding jurisdiction, the provision of services, the 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 care-givers 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 MS 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 with either a broad knowledge base regarding issues of CA/CN or direct experience with children and families. Administrative personnel included the MS and the 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 the MS service units, administrative and program staff from the BIA social services, law enforcement, judicial services, and education, were an important part of the sample population, as these are key roles in child protection,

### **SAMPLE STRUCTURE**

Unequal size cluster sampling with stratification was the most appropriate sample design for addressing the objectives outlined above. As with any sample design, the availability of funds and 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 the stratification of the sample and the application of cluster sampling in order to ensure continuity within communities and cooperating agencies.

Stratified sampling was selected, as this technique 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 sizes for separate analysis. This was particularly the case with the 12 Area level administrators. By creating separate strata consisting of particular subgroups of interest, the research was free to increase or decrease the relative distribution of these subgroups in the sample. Stratification also 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. The stratified design enabled the 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.

The levels of stratification included both administrative and program staff. The National Oversight Committee on Child Protection, the MS and the BIA Area level administrators, and the MS service unit and the BIA agency administrators comprised the administrative strata. Program staff from the MS 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 allows 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 MS service units selected from within the 12 MS Areas. Within the clusters were IHS hospitals, health centers, health stations, the BIA and tribal agencies and education services. The census data provided information that gave a complete assessment of each community's 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 provided a view of legal perspectives and judicial decisions. Articles addressing the complexities of the ICWA and its implications for cases of child maltreatment were also collected. Literature reviewed included program reports, conference reports, resource materials, research, legal issues, the ICWA, theory and perspective, articles, cross-cultural research, child sexual abuse-specific materials, and related papers. The intensive review resulted in the identification of 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, only 17 provided services 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. The programs provided a variety of services and approaches to child abuse interventions. By reviewing these programs, information was obtained regarding resources available to AI/AN people, the essential components of an intervention program, including risk assessment forms, and the extent of coordination between these programs and the communities they serve. The identification of components that are consistent throughout these programs provides the MS with a better

understanding of the ideas that seem to be working in Indian country and enhances their own programs by incorporating these elements.

Included in the program reviews was a series of projects funded through the OVC. 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 projects tribes were able to develop and defined areas where the IHS can work with tribes to expand the services provided.

Current, non-Indian specific programs, such as the Healthy Start Program in Hawaii, were also reviewed. Secondary prevention is a key component of this comprehensive program, which has been very successful since its inception in 1985. Many of the components of Healthy Start are easily incorporated within the current MS 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 the 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 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 the 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 six years of age 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 potentially at-risk families. The data also provided information regarding the use of health care facilities. The percentage of the Indian population that utilizes the IHS facilities varies from less than 30 percent in states like California to more than 70 percent in states like Montana. This fact has implications for using the II-IS records as a database and will impact the expected efficacy of MS-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 focus of Phase II research 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 the MS, 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 information sharing between administrative levels also emerged from the analysis.

The primary focus of the data analysis was on the case-specific information collected via the mail questionnaires for the national level and via on-site case reviews for the local levels. 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. Furthermore, it is important to note that the incidents in the program database reflect the MS 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 and communities with varying types of facilities, services, interagency agreements, and levels of MS interaction regarding CA/CN issues. Each site visit averaged three days; the visits included an in-depth CA/CN records review and personal interviews with the MS, the 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. Although time and budget constraints limited the number of sites, these six service units were fairly representative of the range of the MS responses to CA/CN.

The selected units were evaluated to determine 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. It was also important for the pilot site to have at least minimal services and staff as well as the availability of personnel to provide additional staffing and training. 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 were determined to have the potential for immediate implementation of the New Beginnings Program: the Wind River Service Unit in Fort Washakie, Wyoming, and the Anchorage Service Unit in Anchorage, Alaska. While each of the sites indicated dire need for assistance and strongly supported 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. Budget constraints allowed the funding of only one site; the Wind River Service Unit became the pilot site for the New Beginnings Program.

#### DEVELOPMENT OF A MODEL FOR INTERVENTION

Development of an appropriate and effective model for intervention was based on a synthesis of the collected information, model goals and objectives, and standardized, yet flexible, program planning. The data continually pointed to the need for the **IHS** prevention efforts focused on at-risk families, since 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 attempt 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) pre-natal risk assessment and early identification (EID) of families at-risk; (2) home-based intervention services; (3) linkage between medical care and human services; (4) referral **from** and coordination with community services and agencies; and (5) continuous follow-up activities 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, the most important being the substantial reduction of CA/CN. Other benefits include the systematic and early involvement of health, social services, and educational agencies; the reduction in the costs of CA/CN related services; and the reduction of the subsequent individual, family, and community costs correlated to CA/CN and dysfunctional families.

### **PHASE III ACTIVITIES**

The major research activity undertaken in Phase III involved surveying tribal service providers in order to obtain comparative data to the data collected from Federal Employees in Phase II of the study. Direct service providers were surveyed regarding their perceptions of existing tribal policies and procedures regarding CA/CN, staffing and personnel issues, jurisdiction and interagency issues, treatment of CA/CN, access to services, CPTs, and staff background information. Program Administrators were surveyed regarding budget, child protection programs, staffing and personnel: interagency relationships, CPT and Family Violence Prevention Teams, the treatment of CA/CN, case statistics, policies and procedures, and case history information. Because of the enormous time lapse between Phases II and III, the effectiveness of Phase III fell far short of original expectations. The OMB involvement during this phase compromised the study.

### **SURVEYS**

As in Phase II, 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, the retention rates of these individuals, information regarding staff training and background checks, and the types of treatment and services available.

The mail questionnaires were modified from Phase II in accordance with concerns from the OMB. The process of obtaining the OMB approval was extremely time-consuming, causing a detrimental one-year delay in the project.

This significant time delay between Phases II and III led to a lack of consistency in interviewers and contributed to a lower response rate. During the initial phase of the study, staff were hired and trained solely for the purpose of this project. Because these workers were laid off when funds were expended, it was necessary to reassign existing staff to perform the Phase III survey. The new workers were expected to administer the survey, plus continue performing their core job responsibilities (before the survey could be used, they had to ensure that the instruments had received OMB approval).

The mail questionnaires were utilized as a means of gathering secondary data that would provide information about funding, interagency agreements, staffing and personnel issues, and records management, including available case statistics. The mail surveys were sent to 140 direct service providers representing mental health, medical, judicial, and law enforcement personnel. These 140 people represented all identified tribal direct service providers. The response rate to the survey was extremely small, with only five surveys completed and returned (response rate 5/140: 4 percent).

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, the 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 utilized were identical to the survey used in Phase II. The target population consisted of 112 individuals representing medical, social services, and mental health personnel from tribal programs of the tribes surveyed in Phase II.

The telephone survey aspect of this study was very burdensome. Because the list of original tribes surveyed for this project did not include telephone numbers, it was necessary to locate these numbers for all 116 tribes on the original list. Once telephone numbers were located, it often took several calls to locate appropriate service providers for the survey. It was not known whether the service providers were federal or tribal employees until the actual staff members were available for discussion. This process led to numerous calls in an attempt to locate tribal service providers. For example, it was not unusual to call a tribal administrative office only to be referred to another department. Oftentimes, the referred individual was not the person or agency that needed to be located. Thus, a third telephone call had to be made.

The NIJC staff made a total of 550 calls, attempting to locate tribal employees in order to complete the survey. These 550 calls resulted in 112 messages being left with requests for the recipient to return a call to a specified NIJC staff member. Of these 112 messages, only 23 people returned the NIJC's calls. The simple act of identifying appropriate potential telephone survey participants was burdensome in terms of both the extraordinary amount of time expended in locating participants and the expense of long distance telephone calls and staff time to carry out this task.

An additional difficulty involved the actual completion of the surveys. Of the 82 surveys scheduled, only 24 useable surveys were completed. Many of these scheduled surveys were not completed because the participants were not available at the time the survey was scheduled.

## METHOD - SAMPLE DESIGN

### RESPONDENTS

Several respondents were appropriate for inclusion in the survey research. All were individuals with either a broad knowledge base regarding issues of CA/CN or direct experience with children and families. Administrative personnel included tribal administrators, such as department heads or program directors. Direct service providers included social services personnel (case workers and ICW staff), mental health personnel (psychologists and therapists), law enforcement, and judicial services.

### SAMPLE STRUCTURE

Due to the small response size, there was no specific sample design utilized. All survey results are reported as anecdotal data. It is not possible to statistically analyze the data obtained or to compare the data obtained in Phase II with that obtained in Phase III. There are many possible reasons why there were such low survey response rates (5/140 for the mail surveys and 24/112 telephone). For example, tribal programs had little incentive to complete either telephone or mail surveys, the NIJC had insufficient funding and staff to carry out the project, few complete telephone surveys were available, the number of potential respondents was limited, and those who qualified as potential respondents felt little "pressure" to complete the surveys.

Tribal program staff had little incentive to complete either the telephone or mail survey. There was no obvious benefit for staff to take the time necessary to complete the surveys, as the telephone surveys required that direct service providers, already overburdened by demands on their time, set aside a block of time to participate in the survey. Even those who agreed to participate were often forced to cancel at the last minute due to job demands. Others were unavailable because of emergencies or prior commitments (meetings, court appearances, investigations, client crises, etc.) The NIJC staff identified four reasons why potential telephone survey participants were unable or unwilling to participate: respondents were too busy; the survey was at the bottom of their priorities; they didn't feel comfortable talking about any faults in their programs; and they didn't feel qualified to participate and deferred to their supervisors.

When NIJC staff had scheduled a survey for a specific time and the person being surveyed was unavailable, the time allotted for the survey was wasted. Only one survey could be scheduled for a given time-frame. If the scheduled participant was unavailable, the staff could not substitute another participant, as the surveys needed to be scheduled in advance.

The main problem with Phase III data collection was the tremendous gap in time between the federal surveys and the tribal surveys. It is anticipated that the response rate to the tribal surveys would have been much higher if the staff hired for the federal surveys could have also administered the tribal surveys. The vast experience in survey administration that these staff members had was lost when new staff had to be trained to administer the telephone surveys. The original staff also had personal contacts at each of the tribes which would have facilitated identifying appropriate contacts for the tribal survey. As previously noted, considerable time and

energy was spent in attempting to locate suitable participants for the tribal survey. If future projects of this type are undertaken, all data collection instruments for the entire project should be approved prior to any data collection. The piecemeal nature of approval for the instruments was a major impediment to the timely completion of this project.

Another problem arose due to the finite number of tribally administered programs. Many tribes continue to receive medical services from the MS and law enforcement **from** the BIA. In those situations, there were no tribal programs to be surveyed. For this reason, the potential sample population in Phase III was much more limited than in Phase II. The projections of the number of responses possible during this Phase failed to take these facts into account.

In Phase II, the MS and the BIA staff were encouraged by their superiors to complete the surveys. In tribal structures, there may not have been such “pressure.” Tribal Governments may not have been as committed to the survey process as were the BIA and the MS personnel. While it only required one person within the MS and the BIA to inform their respective staffs to cooperate with the surveys, it would have taken over 100 different tribal leaders to make such a commitment. Tribes lacked the intimate involvement that the MS staff had for the survey project. Without “pressure” from superiors, service providers and administrators had little motivation to actively participate in this process.

## HEALTHY START PROGRAM OVERVIEW

### SITE SELECTION AND PROGRAM DESCRIPTION

Phase III included the implementation of the New Beginnings intervention program on the Wind River Reservation. An on-site health assessment of the Wind River Reservation conducted by the NIJC research team aided in defining local resources and constraints in dealing with CA/CN. The study profiled the Shoshone and Arapahoe Tribes, both of which reside on this Reservation. A profile of the types of cases Wind River service providers handle was developed. The caseload profiles were designed to provide descriptive information about the types of cases existing in the community. However, because the profile information was not population-based, it was not complete in terms of the number of cases or the extent of the CA/CN problem in this community. Information on CA/CN was collected only for two years; data from previous and subsequent years need to be collected for further analysis.

The 1991 profile of CA/CN included: an IHSCA/CN caseload of 65, representing primarily those cases needing medical attention, and 157 cases reported by the BIA, which included some overlap with the cases reported by the MS. Reported cases of physical abuse, sexual abuse, and neglect appear to be equally distributed. In contrast to the national sample of Indian CA/CN cases, neglect was not the predominant type of reported maltreatment. Also unlike the national sample, the profile showed that girls were over-represented in all forms of abuse. The average age of child victims was 9 years old for physical abuse, 10 years old for sexual abuse, and 3 years old for neglect victims. There were interesting differences between the two tribes, Shoshone and Arapahoe, and a higher rate than expected of victims from other tribes, all of which require further investigation. Review of the MS CA/CN caseload indicated an increase in reported cases over time. Other sources for obtaining existing data on CA/CN still need to be accessed from the Wind River Tribal Court, the Tribal Social Services Program, and the Police Department. Once all the extant data are collected and analyzed, a more accurate picture of CA/CN in this community can be drawn.

Respondents who were interviewed on the site-visit included administrative and line staff employed by the Tribes, the II-IS, the BIA, and members of the tribal councils. These people were asked to identify social problems that existed on the Reservation. Child maltreatment, domestic violence, and high rates of suicide (particularly among adolescents) were repeatedly cited as major problems. Inhalant abuse and truancy among young people were also cited as major problems. Motor vehicle crashes, suicide, and cirrhosis of the liver were among the five leading causes of death reported for these two tribes. Moreover, the Reservation has an unemployment rate of 75 percent, which is blamed, in part, on the lack of local industries and businesses. Although this is a close-knit community of large extended families, there appeared to be minimal awareness of the existing problems. Yet, avenues for positive change do exist. The proposed program will significantly reduce the incidence of child maltreatment and enhance the quality of life for Wind River families.

## OPERATIONAL OBJECTIVES

The New Beginnings Program has the following goals: (1) the improvement of family functioning; (2) the promotion of positive parenting and parent-child interaction; and (3) the promotion of healthy child development. The ultimate goal is to reduce the incidence of CA/CN by building healthy families. To reach these goals, the following objectives need to be achieved: (1) systematic hospital-based screening to **identify** high-risk families of newborns within the geographic service unit area; (2) incorporation of community-based home visiting by a paraprofessional; (3) linkage of identified families to appropriate medical care and social services; (4) provision of intensive, long-term and flexible services; (5) case management and coordination of a wide range of community services with human service agencies or programs, including those who handle children with special needs; (6) development of a management information system; and (7) intensive training and supervision of locally recruited professionals and paraprofessionals to administer and provide direct services.

## DEVELOPING THE INTERVENTION MODEL

The New Beginnings Program is a modification of the Healthy Start Program developed in the State of Hawaii in 1985. It is now a statewide CA/CN prevention program in Hawaii and has expanded to communities across the U.S. This program provides home visitor services to new mothers, ensures the continuity and consistency of medical care for children, and links families to the services they need. It also recruits professionals and paraprofessionals **from** within the community and, when needed, seeks the help of specialists. The professional staff assist and develop group services that involve other community and family activities.

A proactive search for at-risk families will begin with hospital-based screening to **identify** newborns in the service unit geographical area. The program will provide an assessment of parent-child interaction, a model for parent-child activities, and lessons regarding parenting techniques. In order to facilitate the early identification and referrals for needed services, several data collection instruments and tools will be used for assessment and testing. These instruments include: the Family Stress Checklist; Nursing Child Assessment Scales Training (NCAST) home, feeding and teaching scales; and the Revised Denver Pre-screening Developmental Questionnaire (RPDQ). The testing will be used periodically to determine client progress and changes needed in intervention. New Beginnings will provide developmental screening, link families with a medical home (well-child care), and offer training and technical assistance for staff members.

New Beginnings is a proactive program that will help identify families who do not use programs either because they are unaware of them, lack transportation or child care, or feel overwhelmed by the process. Establishment of trust early in the intervention phase is crucial and is accomplished by facilitating access to services and by providing such services as transportation, referrals to community services and programs for special needs children, crisis intervention, and assistance with the paperwork involved in getting aide from public service agencies or programs. The program's primary focus is to provide emotional support to parents and to teach effective ways of dealing with the daily problems and the stress of being a parent.

To ensure the program's effectiveness, it is important that intensive services be provided over a long period of time. These long-term intensive services, which start at the time of birth, include: universal outreaching, voluntary services, high-risk screening, home visits, flexible services, a social support system, ties to other services, and staff training. Each family remains in the program until the targeted child is five years old.

A client classification system provides a method for determining the level or intensity of services required at various stages of the intervention process and aids in tracking a family's progress from high- to low-risk status. The classification system assists in case planning, identifying family coping skills and potential risk factors, matching available resources to client needs, and moving families safely and efficiently through the program.

New Beginnings promotes acceptance through the facilitation of staff participation in community functions. Converting community members into staff members will increase staff retention rates and cultural sensitivity to the needs of individual families and the community. Collaborative efforts help make the program work.

### **DEFINING THE EXTENT AND DISTRIBUTION OF THE TARGET POPULATION**

It is often desirable to distinguish between the group that will immediately receive the intervention (the direct targets) and the total population that will eventually benefit from the program (the indirect targets). The direct targets in the New Beginnings Model are new mothers and infants, while the indirect targets include their partners, other family members, and the community. The choice of a target population is a strategic decision, for the program's focus must shift dramatically if characteristics of the target population are not what they were originally thought to be (Rossi and Freeman 1989).

In selecting the area for implementing the New Beginnings Program, six service units were selected for an in-depth, on-site community health and risk assessment by the NIJC research team. These assessments were done during the three month period from April 1992 to June 1992. In order to select a location to pilot the proposed intervention program, the current state of interventions used within individual service units and other agencies needed to be understood. The sites were selected to provide information to the research team 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 field visit averaged three days and involved several weeks of pre-visit planning, in-depth CA/CN records reviews, and personal interviews with the IHS, the BIA, and tribal service providers involved in child maltreatment and child protection services and issues.

Two sites were identified as having the best chance of implementing and evaluating the New Beginnings Program. Both Anchorage Service Unit in Anchorage, Alaska, and the Wind River Reservation in Fort Washakie, Wyoming expressed a dire need for assistance in the prevention of CA/CN and strongly supported the implementation of the New Beginnings Program in their communities. Both sites had at least minimal services and staff and opportunities for additional

staffing and training, two prerequisites for the chosen program site. Moreover, the existing management information systems were amenable to the model, and the sites were fairly representative of issues faced by communities and service agencies throughout Indian country. Of the two possible service units, the Wind River Reservation was chosen for the pilot.

The Wind River Reservation, located in west central Wyoming, covers approximately 3,500 miles of land. The Reservation is home to the Shoshone and Arapahoe Tribes, the primary recipients of local health and social services. All federal contracts under P.L. 93-638, the Indian Self-Determination Act, and business interactions with the II-IS and the BIA are joint ventures between the agencies and a joint council comprised of the Shoshone and Arapaho Tribes. Policies and procedures apply equally to both tribes, making it a strong, interactive government system.

The combined tribal population is estimated at 6,500 persons, of whom almost half are under twenty years of age. There are an estimated 200 births per year, a birth rate of about 32.7 per 1,000 population. Per capita distribution from oil and mineral resources is available to families, but the amount is subject to the health of the oil and mining economy. The lack of local industries or businesses contributes to a 75 percent unemployment rate. Most families are on public assistance, and few incentives for education, self improvement, or family planning exist. The lack of telephones and the large distances between families and nearby services inhibit the linkage of services to families.

The early identification component of the New Beginnings Program will provide systematic identification of at-risk newborns from the target area. The proactive case finding approach precludes the "hit and miss" approach of programs that depend on referrals before providing services. This type of outreach will enable the program to reach the majority of high-risk families in the target area.

#### **SPECIFYING THE DELIVERY SYSTEM**

To maximize the effectiveness and efficiency of the New Beginnings Program, the delivery was carefully planned by an established planning group. The program monitored the following: (1) the appropriateness of the target population served; (2) the treatments and services provided; (3) the qualifications and competencies of **staff**; (4) the mechanisms for recruiting and obtaining cooperation of the targets; (5) the means of optimizing access to the intervention, including location and physical facilities at the service delivery sites; and (6) the referral and follow-up efforts. In addition to assessment of the various elements of the delivery system, provisions were made for collecting data on costs in order to evaluate efficiency. The New Beginnings Program included: early identification of families at-risk; home visitor services; medical home; a system based on referral and coordination; a Management Information System (MIS); the training and development of personnel; and quality assurance.

## **EARLY IDENTIFICATION**

The two goals of the early identification program are to **identify** all families of newborns who are at-risk for CA/CN in the target area and to successfully refer these families to the New Beginnings Programs and other resources, as appropriate. The early identification process involves five essential activities:

- (1) identification of the eligible target group for intervention among all births;
- (2) review or screening of medical records of all eligible families residing in the Wind River Service Unit Area;
- (3) assessment of all identified families through interviews, using a family stress checklist to assess risk status. Time limitations for completing paperwork on interviewed families will be established and will include an intake summary, response forms, a client tracking sheet, a psycho-social summary, and follow-up forms;
- (4) documented referral of all high-risk families to the New Beginnings Program and for other appropriate services;
- (5) quality assurance provided through the development of a quality assurance plan that includes the following components: (A) daily review of records and all interview results of new clients by the supervisor to ensure completeness and appropriate dispositions; (B) review of the tracking system which will log all newborns and screen eligible families to ensure that these families are seen and offered services; © quarterly review of client progress and service plans between the supervisor and family service worker (FSW); and (D) an annual random review of 20 percent of the cases, conducted by the Wind River Service Unit Director or his designee.

## **HOME VISITOR SERVICES**

The primary goal of home visitor services is to provide early intervention through home-based support to the family, particularly to the mother and her infant. The initial objectives of the FSW will be to develop and maintain a trusting, supportive, nurturing relationship with his/her clients. This will facilitate the development of positive parent-child interaction and improvements in parental competence and positive coping skills. It will also help parents develop positive relationships with people outside their family or social network. Home outreach services will be used to reach those families who are at-risk or in-need but do not trust outsiders and/or are socially isolated. These families are usually the least likely to seek services, to come to an **office** for services, or to attend classes or groups designed to assist new parents (Breakey 1989). Because home visits will provide an opportunity for the FSW to work within the family's environment, they will enable problem-solving based on the family's needs and using the family's strengths.

Home-based family support services will include crisis intervention; emotional support to parents; informal counseling; role modeling of family relationships, communication skills, and life coping skills; and links to other services. The goal of the FSW is to provide support to parents during the early years of parenthood. This may involve various levels of dependence by the family, beginning with complete dependence on the worker and gradually working toward independence and family self-sufficiency.

A classification system with four levels will be used to determine the intensity of services that need to be provided by the FSW. Family progress will be based on such criteria as frequency of family crises, quality of parent-child interactions, and the family's ability to use other community resources. All clients enter the program at Level 1, the level at which maximum visitation and services occur. This level requires weekly (or more) visits, each a minimum duration of one hour. On this level, close observations and data collection by the home visitor are essential, as is careful scrutiny by the supervisor in an attempt to assess the level of risk to the infant and to determine family service needs. Levels 2 and 3 involve fewer visitations, but services from other sources may remain the same. Level 2 requires bi-weekly visits of one or more hours with telephone contact (if possible) on alternate weeks. Level 3 requires monthly home visits with telephone calls (if possible) on non-visit weeks. Level 4 involves minimum visitation and possibly fewer services from other sources. This level requires quarterly follow-ups with families no longer at-risk; visitations continue until the target child is five years old. At that point, the family will graduate from the New Beginnings Program,

The FSW aims to facilitate positive parent-child interaction as early as possible in order to assure strong initial bonding between the mother and infant. This will involve teaching the mother how to recognize the infant's cues for attention and supporting the mother as she learns appropriate responses through role modeling techniques. Specific activities may include feeding, diaper changing, bathing, playing, consoling a crying infant, and lessons related to different infant stages and child development. The NCAST will be conducted by the FSW and used to assess the quality of the parent-child interaction by pointing out its strengths and weakness.

The most critical stages of human development occur during the first few years of life, which coincide with rapid child growth. For this reason, it is essential to monitor key child health and growth indices to make sure that the infant receives all needed services (Murphy, Orkow, & Nicola 1985). The FSW will use the RPDQ on all infants at different key stages of growth and will identify those infants who may need further developmental assessment. Monitoring child health will be a shared responsibility of the FSW, the New Beginnings Supervisor, and the pediatrician or primary health care provider.

One focus of the New Beginnings Program will be to develop clients' interest in group and community functions. Many at-risk families are inhibited by distrust, poor self-esteem, poor communication skills, and social isolation, all of which may initially impede their willingness to participate in such activities. They may also have multiple problems that need to be addressed before they are comfortable with people outside their family unit. Once some of the urgent

problems and major stresses are reduced, the FSW will begin helping the clients as they develop socialization skills through group-focused interventions and participation in community activities.

### **THE MEDICAL HOME**

The multiple and pervasive nature of risk factors challenging today's families requires comprehensive and integrated solutions. The New Beginnings Program will use the "Child Health Care Plan" developed by Hawaii's Healthy Start Program to address problems related to infant vulnerability. Rapid growth in childhood necessitates a plan for optimal early development to prevent or reduce future problems. Prevention is the key to positive child development.

The goal of the medical home is to provide comprehensive health care addressing all of the needs of the child. Early intervention by health care providers is crucial. Providers need to detect environmental problems, offer support for the family, and involve the child in health maintenance in order to link family and infant growth. The contact that health professionals establish with pre-natal mothers and with newborns places them in an advantageous position to detect problems early and to intervene, if necessary. The medical home component will 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 Wind River Service Unit will be used to provide the available medical home component of the New Beginnings Program.

### **REFERRAL AND COORDINATION**

The main goals of this component are to develop a coordinated service delivery system and to track referrals. Prior to FSW referrals, a review of the disposition will be conducted with the supervisor to ensure that all appropriate services and referral sources are identified. Documented referrals will be completed using a standard form within a specified time period. The FSW will be responsible for coordinating the referrals to different agencies or programs and monitoring the services provided. Agencies or programs accepting referrals will have a specified amount of time to provide documented feedback outlining the assistance or services that they will provide. Part of this coordination will involve monitoring both the client and the service provider in order to assure that the client is accessing the services and that services are being provided by the referral agency or program. A monthly review of referrals for needed services will be conducted by the FSW for each case. A system for regular case consultations with various service providers will be developed and implemented.

### **DATA COLLECTION AND MANAGEMENT INFORMATION SYSTEM**

This component aims to collect baseline data that will be used for various information and evaluation purposes. For instance, an important part of program evaluation includes development of a MIS that can be used to aid administrators and line staff in conducting continuous program and summarization evaluations. Although effective program management is critical for public administrators, most administrators are inundated by daily tasks. A well developed MIS will provide program administrators with the ability to assess the results of the program on an ongoing basis. The system will be developed to record individualized

information, such as the services provided, the staff providing the services, the diagnosis or reasons for program participation, the socio-demographic data, the outcomes, and the costs. The system will then allow for regular collection and maintenance of information on the characteristics of clients, their problems or reasons for seeking treatment, their history of treatment and current participation in other programs, and their outcomes. The MIS will have two basic functions: information management-storing, retrieving, and reporting information in a convenient format; and massive data quantification-condensing and analyzation into a few indicators that extract relevant information about impact. The MIS will also **function** to provide data for research.

Careful planning will be necessary to determine the type of data collected, methods for collection, and those individuals internal to the program responsible for data collection and entry. The process will include identifying the various sources - both primary and secondary - of data. Quantitative and qualitative data collected on the site-visits will be used as pre-intervention information on CA/CN rates.<sup>1</sup> Several sources for data collection have been identified, but others may be added. The types of data collected will be expanded to fulfill the data needs of the New Beginnings Program. Case information for the 1992 CA/CN profile for Wind River was collected primarily from the Service Unit.

The New Beginnings Program MIS will be linked to the various program objectives and will serve as the foundation for providing evaluation data. The system will capture information to document. This information will include screening and assessment; classification or intensity of service need; profile of risk and family demographics; incidence of CA/CN; reduction of stress and improved coping; improved bonding and child development; and linkage to medical care and other community services. Collection of baseline data from the first year of operation will provide information for future cost projections.

Different groups will use the various standardized Data Collection Instruments (DCIs) and forms in order to record information that will later be entered into the system. The DCIs will include standardized tests used for client assessment and evaluation, such as the NCAST, RPDQ, and the Family Stress Checklist. These particular testing instruments have been tested and used by several early child intervention programs in a variety of settings and with different ethnic groups (Hawaii Healthy Start; and Murphy, Orkow and Nicola, 1985). The techniques for DCI administration will also be discussed (e.g., personal interviews, mail questionnaires, secondary sources, chart reviews, or observations). The data collected will provide a comprehensive picture of the program.

Training will be provided to all the different user groups, particularly those who will be responsible for data collection and entry. The Wind River Service Unit has a computerized data

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<sup>1</sup>. **The data collected during the site visit may or may not provide valid rates.**

management system in place. Extensive planning will be done to expand the existing MIS to incorporate any new data requirements for the New Beginnings Program.

Data analysis will focus on reducing and describing large volumes of data to produce information that is useful and meaningful in the decision-making process. Interpretation will involve the process of combining the results of a data analysis with goals, objectives, and standards to produce conclusions, judgements, and recommendations. Interpretation of the data analyses will give meaning to the information and permit the evaluator to draw valid conclusions and make educated judgments.

#### TRAINING AND DEVELOPMENT OF PERSONNEL

The goals of this component are to develop a competent professional and paraprofessional staff and to provide that staff with quality training that develops their knowledge, skills, and abilities. The composition of the staff depends on the size of the target population, but usually a team consists of a manager, a supervisor, several paraprofessionals, and a secretary. The New Beginnings Program will be incubated by an existing program within the Wind River Service Unit until the program develops to its full capacity. Some positions could not be filled due to budgetary restraints, but the Service Unit will offset the staff shortage by overseeing the administrative functions of the program and by assisting in the program's implementation. The New Beginnings staff will include a supervisor and two family service workers who will record, enter, and analyze the results.

The Service Unit already screens new mothers pre-natally for a variety of high-risk behaviors. This will simplify the implementation of the early identification component, as it can be incorporated into the existing system. It is recommended that no more than three family service workers be assigned to one supervisor and that FSWs begin with a caseload of 15 families, not to exceed 25. Based on the experiences of current programs in Hawaii, it is expected that approximately 20 percent of the total population screened will be identified as at-risk and in-need of intervention services. It is further expected that 85 percent of those families identified as at-risk for CA/CN who are offered services will actually receive the intervention services. In 1992, there were an estimated 200 births reported in the Wind River Service Unit, which identified 40 at-risk families (20 percent). Thirty-four of these 40 at-risk families (85 percent) would eventually receive services, thus comprising a caseload for two family service workers.

Employing paraprofessionals from the community is extremely valuable, as they have the ability to relate to client families in a supportive, non-threatening way. Recruitment of quality staff will be essential, and the personal qualities of candidates will need to be evaluated closely. Since paraprofessionals are not expected to have degrees in early childhood development, it will be crucial to provide them with extensive orientation and training. Job descriptions and a training curriculum, which includes classroom and on-the-job training, will be finalized in the first quarter of the program. A salary and a competency-based system for promotion will be developed.

## QUALITY ASSURANCE

The goals of the quality assurance component will be to ensure continuity in service delivery for clients and consistent progress toward achieving program goals and objectives. Quality control activities will occur at several levels of the service delivery system, and will be the primary responsibility of the supervisor with input from the FSW's. This will involve monthly, quarterly, and annual reviews of the cases; disposition of client services; and workers' application of knowledge and skills gained through training. It will also include monthly diagnostic reviews of the methods and procedures used in each of the service delivery components.

An advisory committee composed of people from the community will be established to support and guide the development of the new program. Its function will be to provide input from various professions and disciplines in the community regarding program implementation, development of a coordinated service delivery system for responding to CA/CN cases, and advocacy for the New Beginnings Program. Policies and procedures for membership, and responsibilities will be developed by the initial planning group who may then be replaced by this committee.

## IDENTIFICATION OF THE ELIGIBLE TARGET GROUP

The early identification process will be used to identify clients (families). The target group is comprised of parents of newborns who are eligible for services under the IHS Wind River Service Unit. The most reliable way of finding all families of newborns is through the Wind River Service Unit and county hospitals.

## SITE SPECIFIC IMPLEMENTATION PLAN

Implementation of the New Beginnings Program will require the full support of the Wind River Service Unit Director, the Maternal and Child Health (MCH) staff, and the staffs of Public Health Nursing and Mental Health/Social Services. Since the New Beginnings Program is a dependent program, it will need to be incubated by an existing program within the Service Unit. Once the sponsoring program has been identified, implementation of the various components will take place. The primary implementation goal will be to put into motion the various service delivery components. Implementation will involve program management activities, such as personnel management-staffing patterns, selection, supervision and training; case management; team building; record keeping and data management; contract compliance and reporting; formative program evaluation; and quality assurance.

The plan for the first year involves tasks relevant to program set-up, including the selection and training of program staff; the identification of local resources; the development of memoranda of agreement with local hospitals for the early identification and screening components; the development of site-specific policies and procedures; the development of the data management system and evaluation component; the modification of site-specific assessment tools; and community awareness and outreach. The first year will provide an estimated nine months of full program operation.

## **CASE STATISTICS**

### **NATIONAL STATISTICS - FEDERAL LEVEL**

The case statistics were collected as part of a federal child abuse and neglect mail survey administered to the IHS Service Unit Directors and the BIA Agency Superintendents nationwide. The response rate for the mail questionnaire was 94 percent for the IHS and 79 percent for the BIA. There were several reasons for non-responses. First, the type of services an agency provides varies greatly. Agencies that did not respond and could not be contacted through follow-up activities may have felt unable to respond because they did not provide CA/CN related services. Those who indicated that they were not federally run or did not provide direct services were eliminated. Second, some agencies that refused to complete the survey noted personnel and time constraints. Third, CA/CN is a sensitive issue and intervention activities are under intense tribal scrutiny in some locations. Some employees felt their jobs would be threatened and thus declined to respond. Finally, several people who refused participation were in denial regarding CA/CN; they claimed that “these problems do not exist” in their communities. Of all the responding agencies, 37 were able to return some or all of the information requested for our analysis of case statistics.

Sample sizes for individual questions varied, as some responding organizations either did not collect or had no access to certain types of data included in the questionnaire. However, the minimum sample size exceeded 900 statistical incidents, so all of the analyses had sufficient power to detect small differences in the variables tested. Analyses were conducted to determine frequencies and to test associations between variables,

The smallest unit of analysis in this data set is a reported incident, of which there were a total of 2,037 during the calendar years 1989 and 1990. These 2,037 incidents involved 1,800 child victims, some of whom were the victims of two or more abuse incidents in any given year. Unless otherwise indicated, columns headed “number” refer to numbers of reported incidents rather than numbers of abused or neglected children.

### **GEOGRAPHIC LOCATION**

The data were collected from 10 of the 12 national MS service Areas and 17 states within those Areas. As indicated in Table 2A, the Navajo, Aberdeen, Albuquerque, and Oklahoma service Areas had the most reported incidents during the two years surveyed. When examined by state (Table 2B), New Mexico, Arizona, and North Dakota reported the most incidents. However, it is important to emphasize that, due to the varying populations of AI/AN in responding areas, combined with the low response rate, it is not possible to compare rates of CA/CN between various geographic areas. Such analyses require population-based data, which are not available at this time.

<u>SERVICE AREA</u>	<u>NUMBER</u>	<u>PERCENT</u>
Albuquerque	305	15.0%
Navajo	501	24.6%
Portland	155	7.6%
Aberdeen	332	16.3%
Phoenix	144	7.1%
Bemidji	73	3.6%
Nashville	61	3.0%
Alaska	49	2.4%
Oklahoma	263	13.0%
Billings	152	7.5%

**Table 2A. Reports of Child Abuse and Neglect Incidents, By Area**

<u>STATE</u>	<u>NUMBER</u>	<u>PERCENT</u>
Alaska	49	2.4%
Arizona	293	14.4%
Idaho	68	3.3%
Kansas	134	6.6%
Louisiana	9	.4%
Michigan	24	1.2%
Minnesota	4	.2%
Montana	152	7.5%
Nebraska	14	.7%
New Mexico	513	25.2%
New York	52	2.6%
North Dakota	215	10.6%
Oklahoma	129	6.3%
Oregon	87	4.3%
South Dakota	103	5.1%
Utah	144	7.1%
Wisconsin	45	2.2%

**Table 2B. Reports of Child Abuse and Neglect Incidents, By State**

## YEAR

Approximately half (54.0 percent) of the case reports included information concerning the year in which the incident occurred, either 1989 or 1990 (Figure 1). Of those, over half (57.1 percent) were 1990 cases, suggesting an increase in reported cases over time. However, the large proportion of cases missing this information, combined with the low response rate, make such an interpretation tentative, at best. The apparent increase may be the result of an increase in incidents of maltreatment, but it may also result from improved recognition and reporting of such incidences, including recent legislation that requires mandatory reporting. Current research suggests that, while the incidence of child abuse may be on the rise, training and improved data management systems have contributed to an increase in agencies' abilities to detect, diagnose, report, and track cases of child maltreatment.

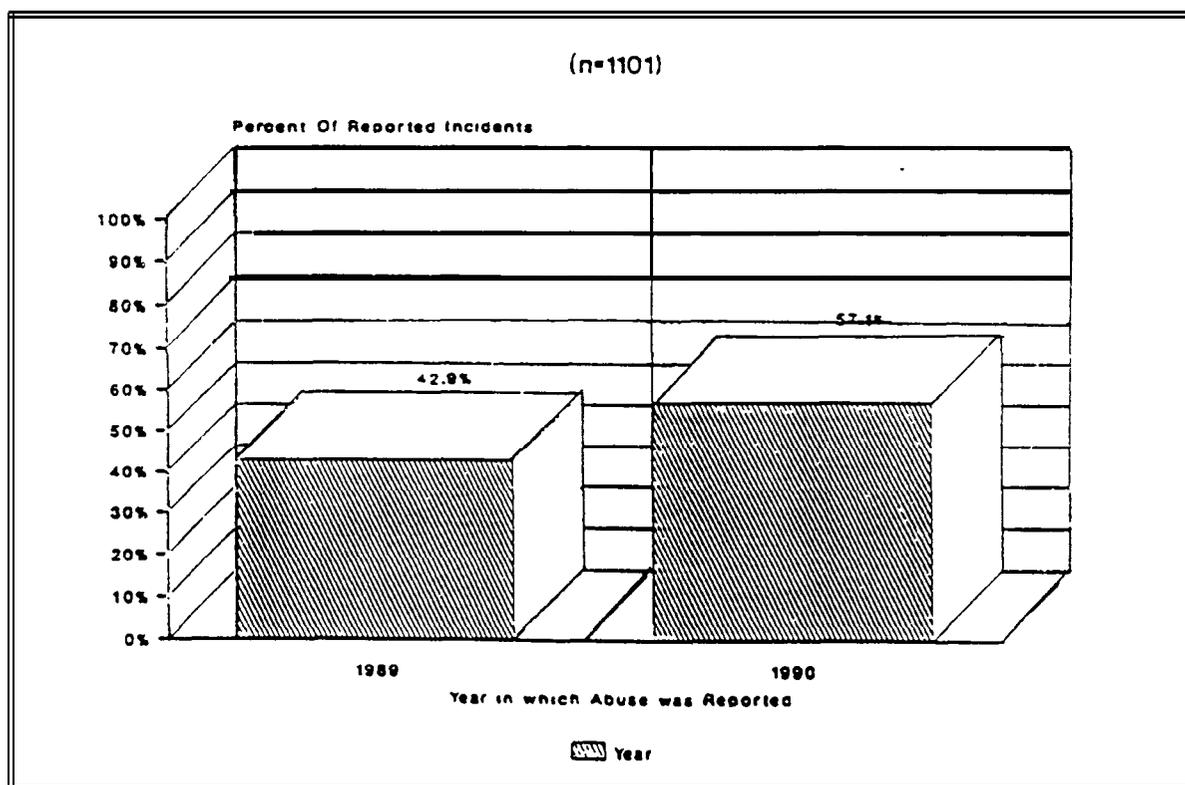
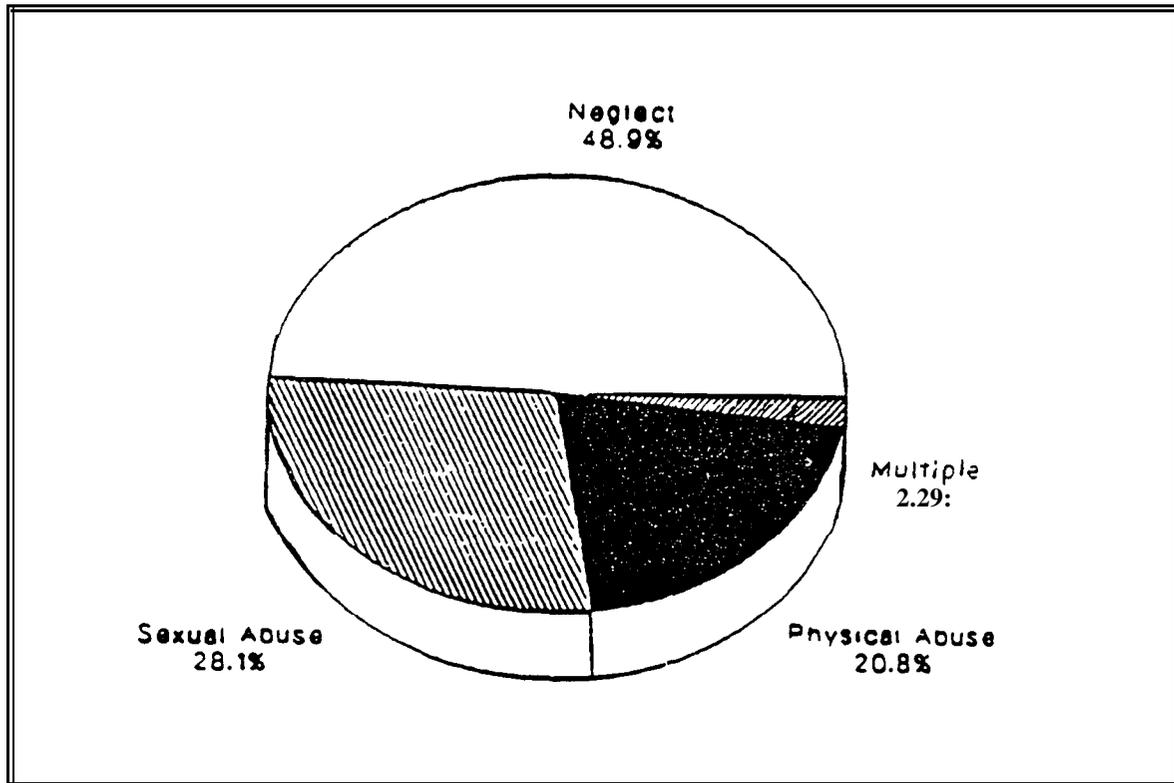


Figure 1. Year In Which Incident Was Reported

## ABUSE TYPE

As indicated by Figure 2, the greatest proportion of reported cases were of neglect (48.9 percent). Sexual abuse (28.1 percent) and physical abuse (20.8 percent) cases comprised most of the remainder of the reports. A few (2.3 percent) cases involved more than one type of abuse (e.g., physical abuse and neglect in the same report). Data collection formats within many agencies provide for only one type of abuse per incident reported, potentially leading to the under-reporting of multiple-abuse type incidences. The differing circumstances surrounding various types of maltreatment warrants further study.



**Figure 2. Proportion of Incidents by Type of Abuse**

<u>Abuse Type</u>	<u>IHS</u>	<u>BIA</u>
Physical Abuse	23.2%	19.8%
Sexual Abuse	31.5%	26.7%
<b>Neglect</b>	<b>45.3%</b>	<b>53.5%</b>

**Table 3. Proportions of Physical Abuse, Sexual Abuse, and Neglect Incidents, by Agency (N=1975)**

The IHS respondents reported higher proportions of physical abuse (23.2 percent) than the BIA respondents (19.8 percent), though these differences were not statistically significant (Table 3). However, the IHS incidents involved a significantly higher proportion of sexual abuse than the BIA incidents (IHS = 31.5 percent; BIA = 26.7 percent), while the BIA respondents reported relatively more incidents of neglect (BIA = 53.5 percent; IHS = 45.3 percent;  $\chi^2 = 13.1$ ;  $p < .002$ ). These inter-agency differences clearly have implications regarding the types of services provided by each agency to child victims of abuse and neglect.

As noted earlier, the number of incidents reported varies considerably between states and service units. Thus, the contribution of each Area to the total sample of incidents reported is biased by the total number of incident reports for that Area. It is, therefore, not surprising that the Navajo service Area reported the greatest number of incidents of physical abuse and of neglect and that the Aberdeen service Area reported the greatest number of incidents of sexual abuse; these two service Areas submitted over 40 percent of the reported incidents in our data set. An analysis of the association between location and abuse type allows a more critical evaluation of the relative proportions of physical abuse, sexual abuse, and neglect in each service Area.

As indicated in Table 4, the Phoenix service Area was the only area to have a significantly higher proportion of incidents of physical abuse than expected; the Aberdeen, Nashville, and Oklahoma service Areas all had significantly fewer incidents than expected. Sexual abuse was higher than expected in the Portland, Aberdeen, and Phoenix service Areas, and lower than expected in the Albuquerque, Bemidji, and Nashville service Areas. Finally, there were more incidents of neglect than expected in the Bemidji, Nashville, and Oklahoma service Areas, and a lower than expected proportion in the Portland and Phoenix service Areas

<u>Abuse Type</u>	<u>Higher Than Expected</u>	<u>Lower Than Expected</u>
<u>Physical Abuse</u> Average . 21.2%	Phoenix (36.6%)	Aberdeen (9.1%) Nashville (8.5%)
<u>Sexual Abuse</u> Average . 50.1%	Portland (40.4%) Aberdeen (44.1%) Phoenix (40.7%)	Albuquerque (21.2%) Bemidji (9.0%) Nashville (8.5%)
<u>Neglect</u> Average . 50.1%	Bemidji (68.7%) Nashville (83.0%) Oklahoma (67.2%)	Portland (31.4%) Phoenix (23.2%)

Table 4. Proportions of Physical Abuse, Sexual Abuse, and Neglect Incidents, by Service Area (N=1973)

## NUMBER OF INCIDENTS

Respondents were asked to indicate whether each report represented the first incident for a child or one of multiple incidents involving the same victim in a given year. Surprisingly, this was the most frequently misunderstood question of any included in the questionnaire. Several respondents included more than one incident for the "same victim," when, in fact, the cases included victims that experienced more than one age or sex. Also, it should be noted that the incident number refers only to a particular year, and the same children may have been victims in reports of previous years not included in the survey.

With these qualifications in mind, analysis of the incident field showed the following (Table 5). For the years 1989 and 1990, as far as could be determined from the data, 1,800 child victims experienced at least one incident of neglect, physical abuse, or sexual abuse. Of these, 1,626 (90.3 percent) victims had one report only, 127 (7.0 percent) had two reports, 37 (2.0 percent) had three reported incidents, 7 (0.4 percent) had four, and three (0.2 percent) were the victims of five or more reported incidents.

<u>Number of Incidents</u>	<u>Number of Cases</u>	<u>Percent</u>
One incident only	1626	90.3%
Two incidents	127	7.0%
Three incidents	37	2.0%
Four or > incidents	10	.7%
TOTAL	1800	100.0%

Table 5. Number of Incidents Reported for Each Child Victim in Any One Year (N=2037)

### DURATION

The duration of abuse for reported cases was evenly distributed among the given options (Figure 3). The options included one incident of abuse (27.1 percent), a duration of less than 6 months (28.8 percent), 6-12 months of abuse (17.2 percent), and 1-5 years of abuse (21.4 percent), and few reported cases (5.6 percent) exceeded five years in duration. It is noteworthy that victim age is not uniformly distributed; rather, it is skewed toward younger ages, particularly those under 5 years old. Thus, for a substantial proportion of the sample (40 percent), a duration of abuse exceeding five years would not be possible, for they are not yet five years old.

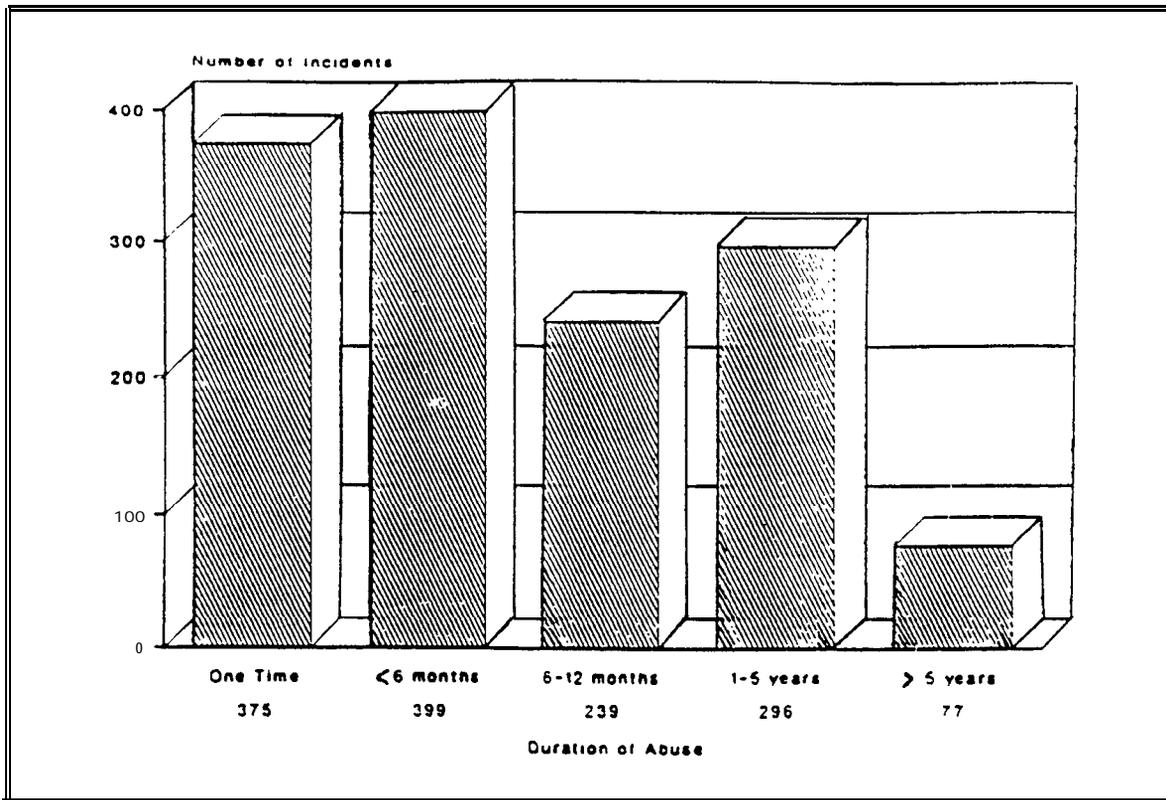


Figure 3. Duration of Abuse

## LOCATION

By far, the greatest proportion of reported cases (79.4 percent) occurred in the victims' homes (Figure 4). Less frequently, incidents of abuse and neglect occurred at school (3.9 percent), a friend's home (3.0 percent), or other locations (8.0 percent). This type of data was not collected by 5.6 percent of respondents.

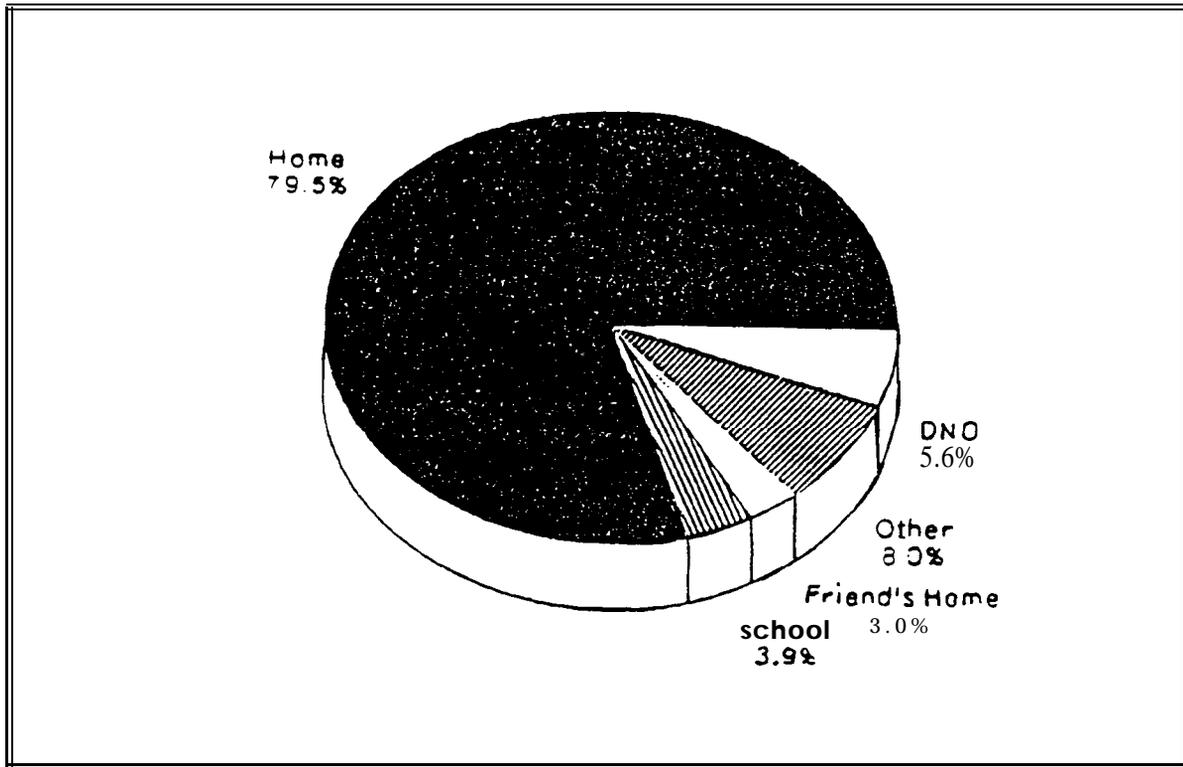


Figure 4. Location At Which Reported Incident Occurred

## VICTIM AGE

Within the given age ranges, the reported victims' ages appear to be a normal distribution (Figure 5), with the mode at 5-10 years (30.6 percent of cases). When examined more closely,, it is clear that a disproportionate number of victims are less than one year old (9.6 percent vs. 5.6, percent assuming uniform distribution), with a particular concentration of victims less than one month old (1.2 percent vs. 46 percent, assuming uniform distribution) When victim age is examined by type of abuse, it is clear that sexual abuse victims were older than victims of neglect or physical abuse ( $\chi^2 = 146.9$ ;  $p = 0001$ ). Sexual abuse generally increases as a proportion of total cases with increasing victim age, and is most common in the 10-15 year victim age category, comprising over 40 percent of incidents in that age range (41.6 percent) Conversely, neglect was most common in the youngest victim age group, and decreased as a proportion of total incidents with increasing victim age; over 80 percent (82.6 percent) of incidents with victims under one month old reported neglect, contrasting with 32.3 percent of incidents with victims aged 10-15 years Physical abuse varied little with victim age, consistently accounting for 17-26 percent of cases in all victim age groups

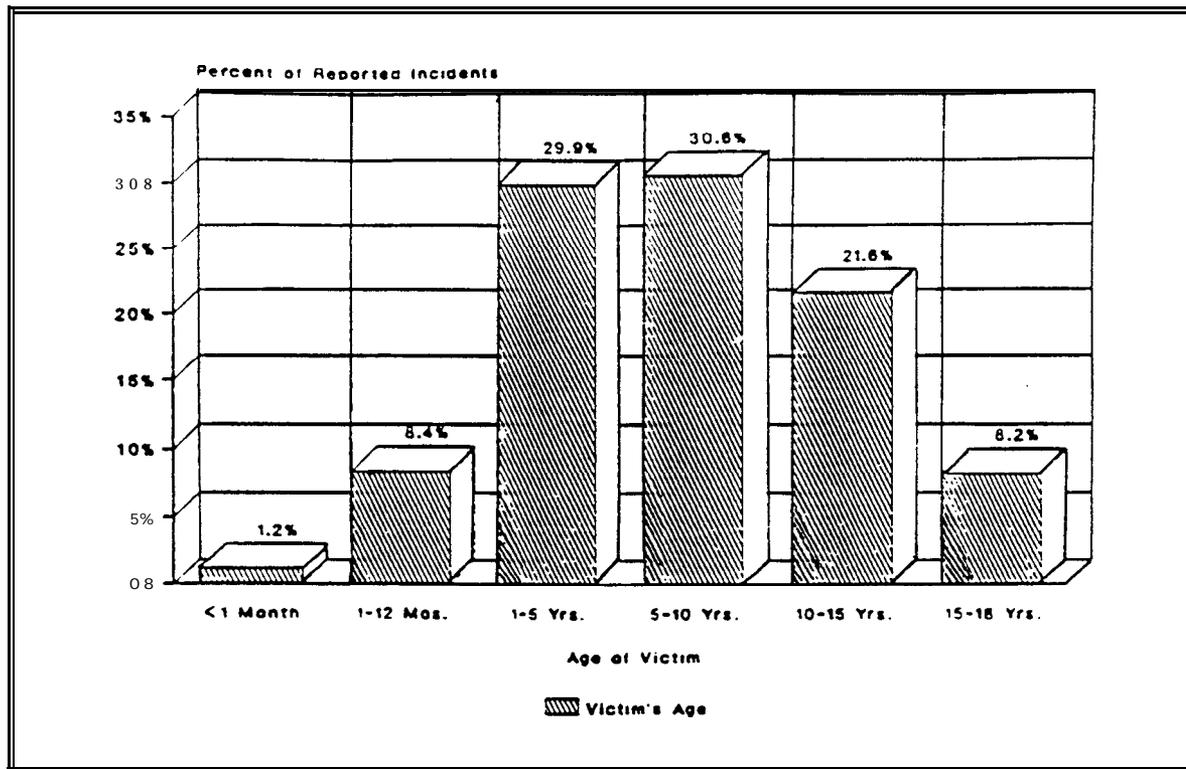


Figure 5. Distribution of Victim Ages For All Reported Incidents

**VICTIM SEX**

Table 6 shows the proportion of male and female victims in all reports by abuse type. As indicated in this table, over half (57.1 percent) of victims were female. Male and female victims were approximately equally represented in cases of physical abuse (52.8 percent male) and neglect (51.1 percent male), while sexual abuse cases involved primarily female victims (79.0 percent). These differences were statistically significant ( $\chi^2 = 162$ ;  $p < .0001$ ).

	<u>VICTIM SEX</u>			
	<u>MALE</u>		<u>FEMALE</u>	
	<u>number</u>	<u>percent</u>	<u>number</u>	<u>percent</u>
<b>Total</b>	<b>227</b>	<b>42.9%</b>	<b>1155</b>	<b>57.1%</b>
<b>Physical Abuse</b>	<b>197</b>	<b>52.8%</b>	<b>177</b>	<b>47.2%</b>
<b>Sexual Abuse</b>	<b>102</b>	<b>20.2%</b>	<b>450</b>	<b>79.0%</b>
<b>Neglect</b>	<b>102</b>	<b>51.1%</b>	<b>481</b>	<b>48.9%</b>

**Table 6. Proportion of Male and Female Victims in All Reports, and by Abuse Type (N=2022)**

## OFFENDER AGE

The greatest proportion of offenders fell into two age categories: 20-29 years of age (42.5 percent of cases) and 30-39 years of age (37.7 percent). When examined by abuse type, physical abuse cases were fairly evenly distributed over all age groups (Figure 6). Offenders in sexual abuse cases were significantly more likely to be younger (<20) or older (>50) than average, while offenders in neglect cases were more likely to be between 20 and 40 years old. These differences are statistically significant ( $\chi^2 = 352, p < .0001$ )

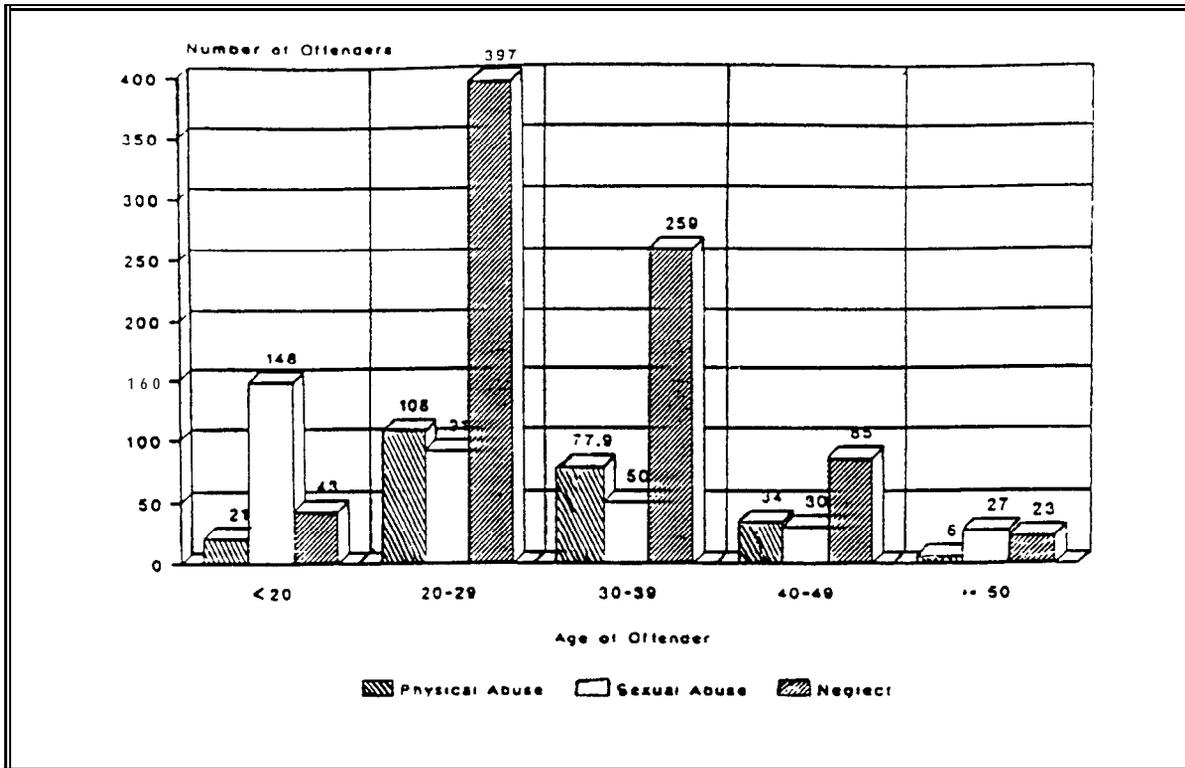


Figure 6. Offender Age by Abuse Type

## OFFENDER SEX

While it appeared that offenders of different sexes were nearly equal (43.9 percent male, 51.1 percent female), a sex bias was evident when cases were further distinguished by type of abuse (Table 7). Offenders were more likely to be male in cases of sexual abuse (90.2 percent male) and physical abuse (59.3 percent male), and female (74.7 percent female) in cases of neglect ( $\chi^2 = 566; p < .0001$ )

	OFFENDER SEX			
	MALE		FEMALE	
	number	percent	number	percent
Total	757	46.9%	796	51.1%
Physical Abuse	191	60.4%	125	39.6%
Sexual Abuse	390	90.3%	42	9.7%
Neglect	150	20.0%	613	79.8%

**Table 7. Proportion of Male and Female Offenders in All Reports and By Abuse Type (N=1553)**

As indicated by Figure 7, male offenders were over-represented in both the youngest (<20 years old) and oldest (>40 years old) age groups, while the interim categories had significantly more female than male offenders ( $\chi^2 = 82.0$ ;  $p < .0001$ ).

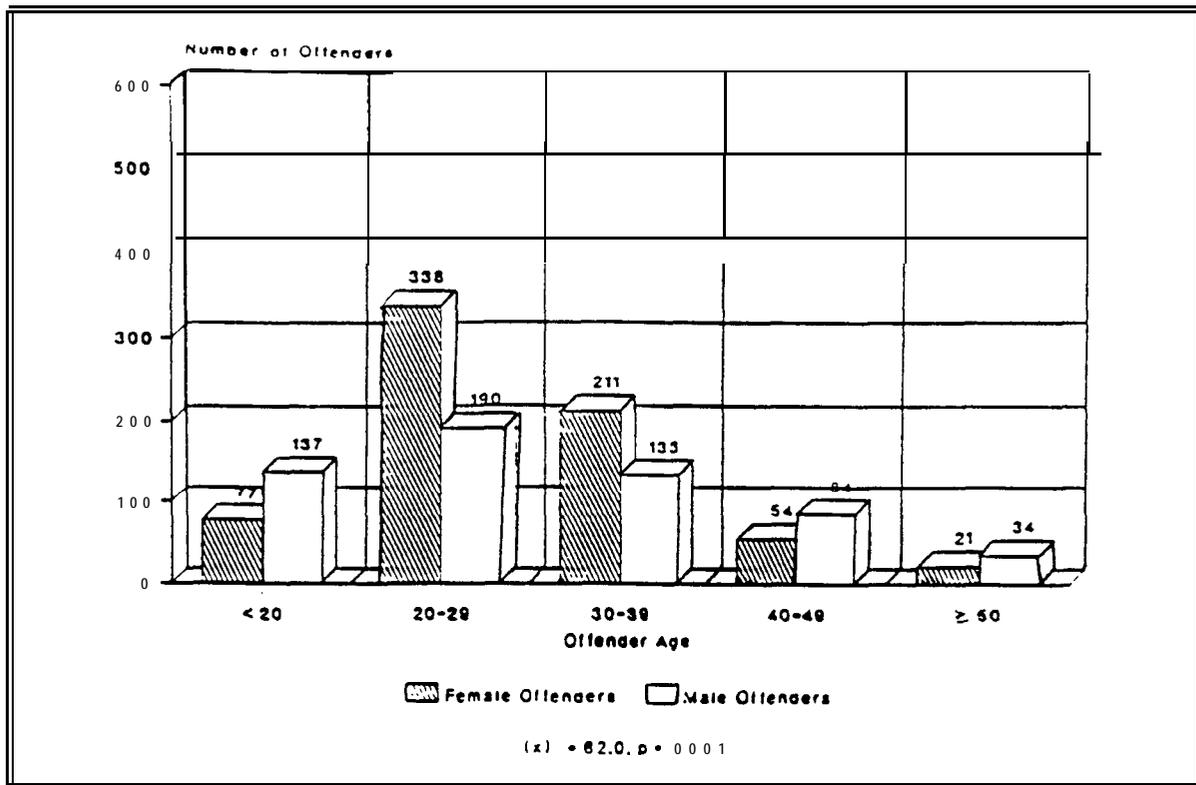


Figure 7. Number of Offenders by Sex and Age Category

## VICTIM-OFFENDER RELATIONSHIP

The most frequently reported offenders in the data set (Figure 8) were victims' mothers (39.4 percent). Other reported offenders include the victims' fathers (17.8 percent), mothers and fathers combined (12.0 percent), and other biological relatives (12.7 percent). Step-fathers, mothers' boyfriends, and other "social fathers" comprised a small percentage of the total offender population (5.4 percent).

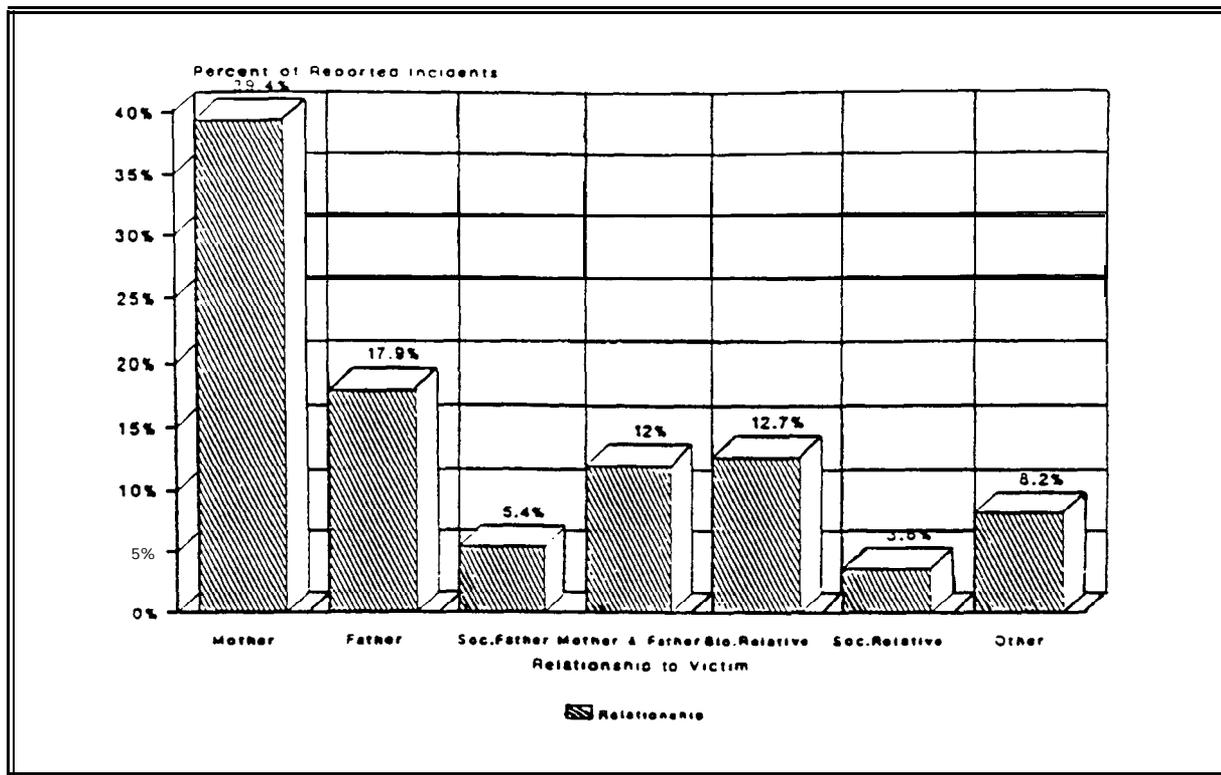


Figure 8. Relationship of Offender to Victim in Reported Incidents

When examined by specific type of abuse (Figure 9). significant differences exist in associations between offender categories and the three abuse types ( $\chi^2=791, p < 0001$ ) Mothers were the primary offenders in cases of neglect (62.9 percent of neglect cases). fathers in cases of physical abuse (36.3 percent of cases), step-fathers and other social fathers in cases of both physical (11.8 percent) and sexual abuse (22.0 percent), and other biological relatives in cases of sexual abuse (55.3 percent).

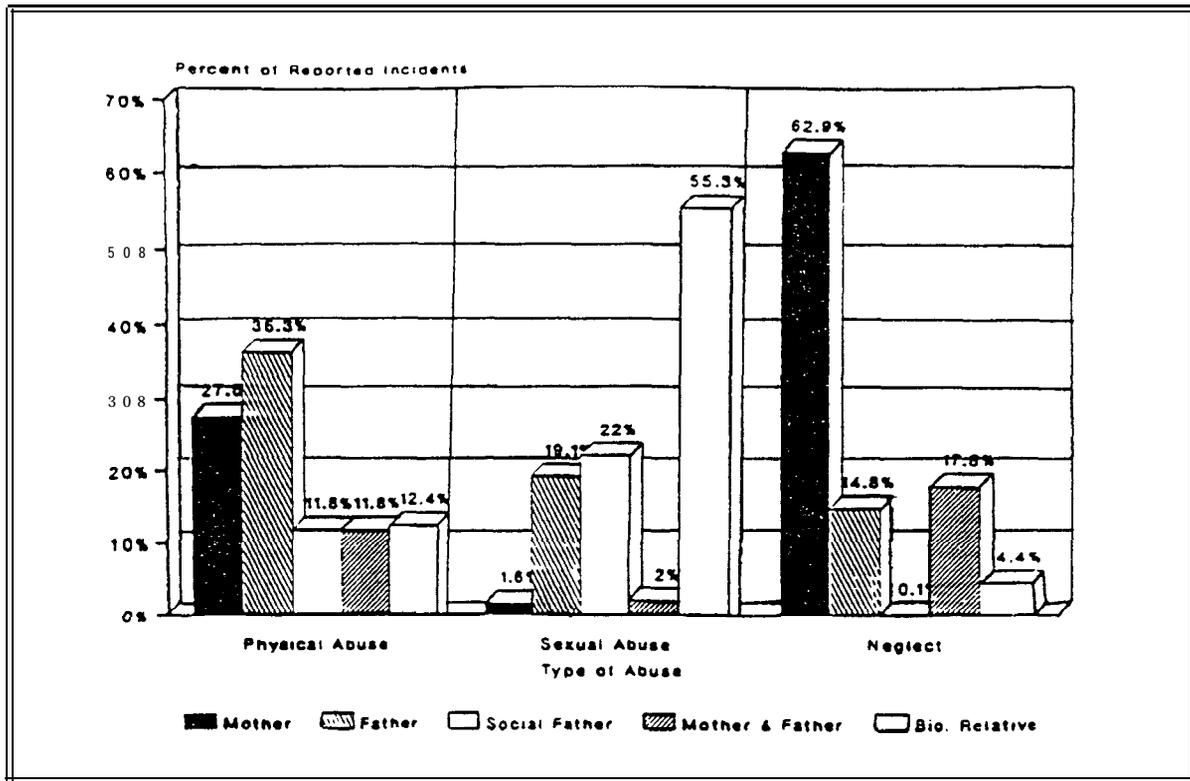


Figure 9. Relationship Between Offender and Victim, By Abuse Type

## SUBSTANCE ABUSE

Substance abuse was a factor in nearly three quarters (70.3 percent) of the cases in which such data were collected (Figure 10). The prevalence of substance abuse varied with offender sex, relationship to victim, age, and type of abuse inflicted on victim. The association of substance abuse and abuse type was examined. Analyses showed that incidents of sexual abuse were significantly less likely to be associated with substance abuse (47.0 percent) than either incidents of physical abuse (69.4 percent) or neglect (78.2 percent)

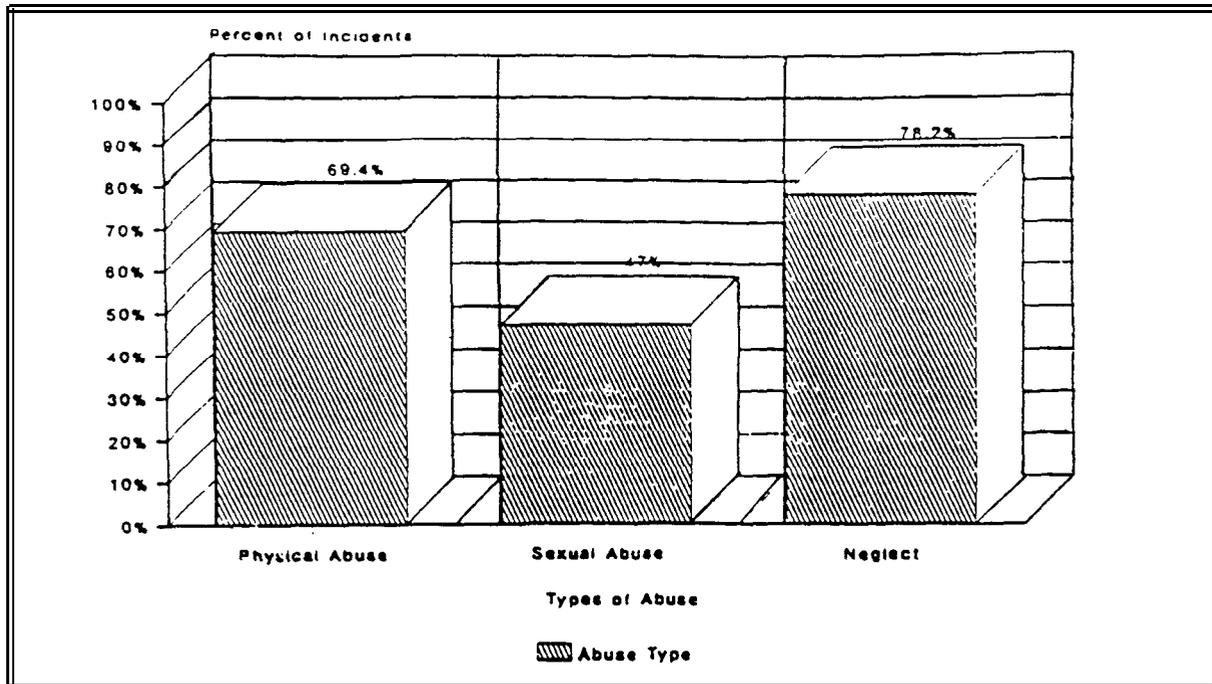


Figure 10. Percent of Incidents Involving Substance Abuse by Abuse Type

When substance abuse by offender sex was examined (Figure 11), significant differences became apparent. Incidents with male offenders were less likely to involve substance abuse (60 percent of incidents) than incidents with female offenders (70.4 percent of incidents;  $\chi^2=13.8, p < 0002$ ).

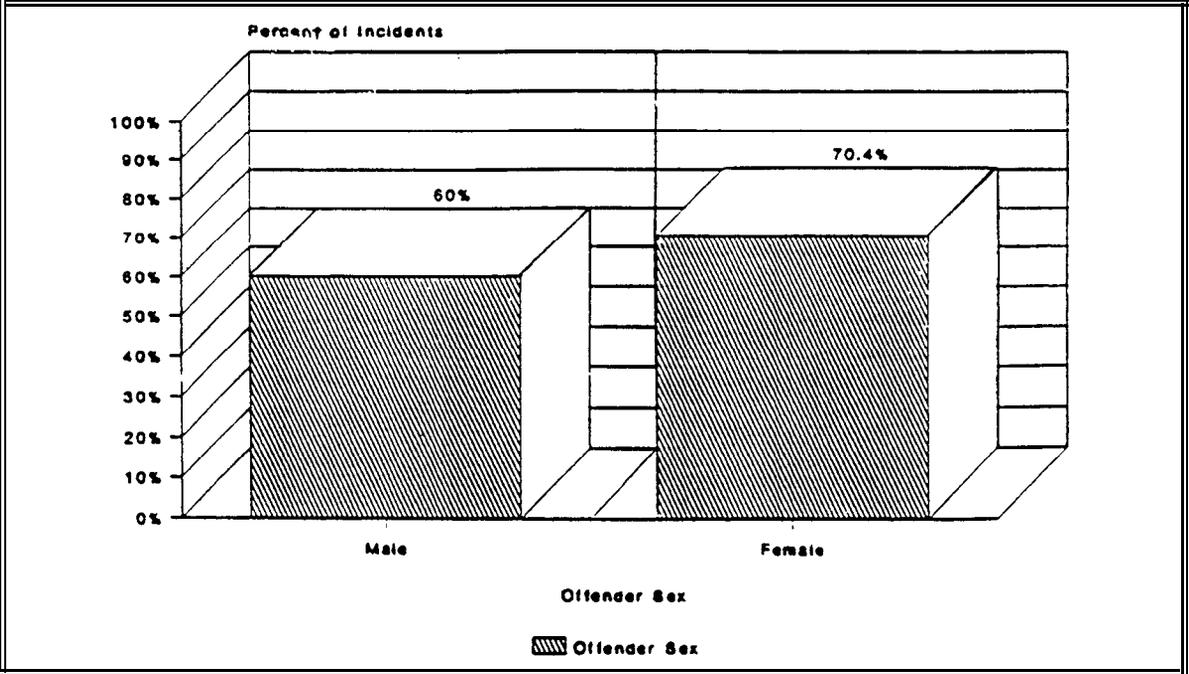


Figure 11. Percent of Incidents Involving Substance Abuse, by Offender Sex

Substance abuse was least frequently reported in incidents involving the youngest (< 20 years old) and oldest (> 40 years old) offenders (Figure 12). In the interim age categories, ages 20-40, substance abuse was a factor in nearly three quarters of reported incidents. The differences in substance use among different age groups were statistically significant ( $\chi^2 = 171, p < .0001$ ).

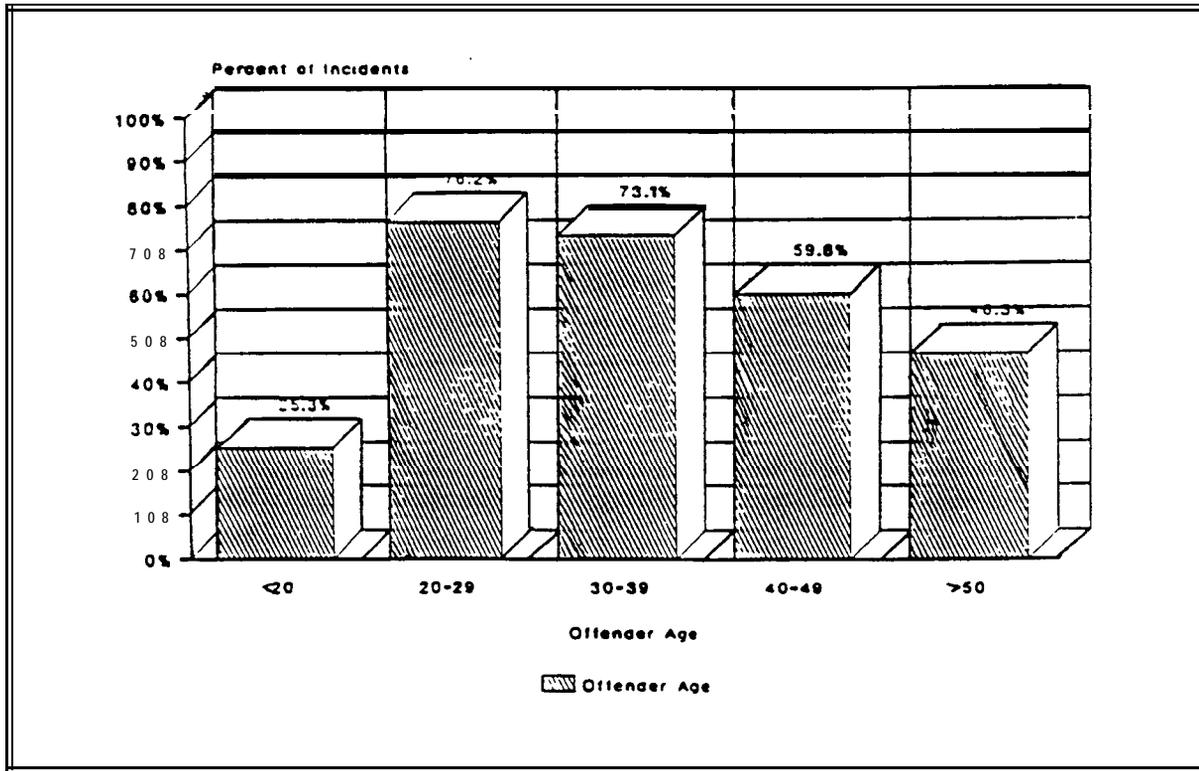
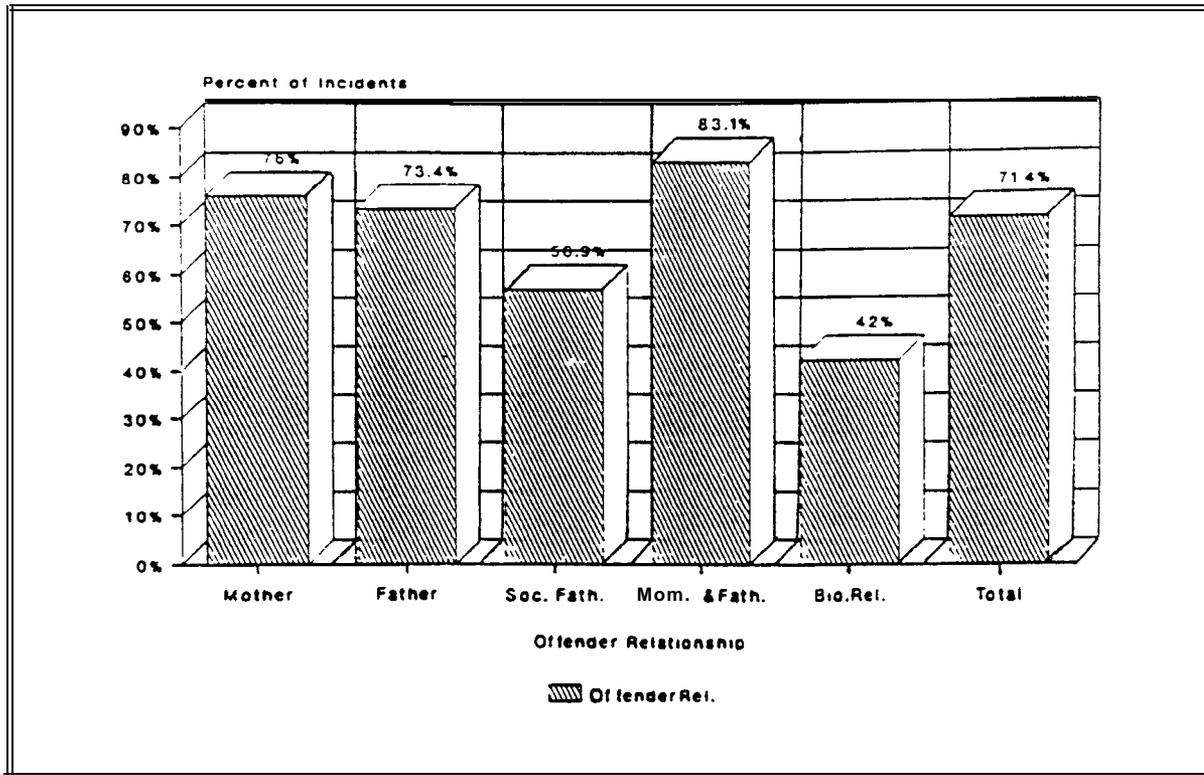


Figure 12. Percent of Incidents Involving Substance Abuse, by Offender Age

When examined by offender relationship (Figure 13). incidents with offenders who were mothers or fathers were equally likely to involve substance abuse (76.0 percent and 73.4 percent, respectively). Cases in which both parents were involved had the highest proportion of substance abuse (83.1 percent). Other offenders had lower rates of substance abuse; in approximately half of the cases involving social fathers (56.9 percent) or other biologic relatives (42.0 percent), substance abuse was a factor ( $\chi^2 = 87.5$ ;  $p < .0001$ )



**Figure 13. Percent of Incidents Involving Substance Abuse, by Offender Relationship**

Few multi-variate statistics were used in the analyses of the case statistics due to the categorical nature of the data. The one exception was an analysis of the association between substance abuse and duration of abuse, controlling for victim age, offender age, abuse type, and offender relationship (Figure 14). To utilize multiple regression, a dummy variable was substituted for the dichotomous substance abuse variable. The resulting multiple regression indicated that substance abuse was positively correlated to the duration of abuse; this relationship persisted when victim age, offender age, abuse type, and offender relationship were controlled ( $B = .2$ ;  $p < .0001$ )

<u>CONTROL VARIABLES</u>	<u>REGRESSION STATISTICS</u>
Victim Age	$B = .20$
Offender Age	$r^2 = .084$
Victim-Offender Relationship	$p < .0001$

**Figure 14. Substance Abuse as a Predictor of Abuse Duration in Incidents of Abuse and Neglect (N=970)**

The substance abuse variable, however, explained only four percent of the variance in duration of abuse, and the addition of the other four controlling variables increased this to only eight percent. Thus, many other factors influence the duration of abuse observed in this sample.

It should be emphasized that the association between substance abuse and duration of abuse is not necessarily causal; a third factor (e.g., family history, unemployment, lack of family support) may influence both duration of abuse and substance abuse. Although this information was not available for offenders in this data set, such associations may suggest the type of information which would be usefully included in child abuse and neglect records collected in the future.

## AGENCY

Of the incidents included in our data set, 57.5 percent were from the BIA agencies and 42.5 percent were from the MS service providers. Such information needs to be interpreted cautiously because of the different roles of the MS and the BIA agencies in cases of child maltreatment. Further, direct comparison of reported incidents by the two agencies is complicated by the differences in absolute numbers of potential responding organizations, as well as different response rates for mail surveys. A more useful approach is to examine the relative proportion of incidents of physical abuse, sexual abuse, and neglect reported by the IHS and the BIA respondents.

## NATIONAL STATISTICS - BUREAU OF INDIAN AFFAIRS EDUCATION

These case statistics were collected as part of the mail survey process. A specialized set of mail questionnaires were sent to the BIA administrators of day and boarding schools. The sample size for this part of the study was 314 incident reports, received from a total of 44 school agencies across the country.

### RATES AND REPORTING TRENDS (N = 194)

Over half (61.8 percent) of the case reports included information on the year in which the incident occurred, either 1989 or 1990. Of these, only 29 percent were reported in 1989 (71 percent in 1990). This may reflect either an increase in the numbers of cases over time or an increase in reporting rates. However, the low response rate for this question and the short period of time for which data are available make any interpretation tentative.

### ABUSE TYPE (N = 309)

Approximately half (49.5 percent) of the case reports were of neglect. Sexual abuse incidents comprised nearly one-fourth (25.9 percent) of the reports, and physical abuse incidents nearly one-fifth (19.4 percent) of the total. A few reported incidents were of multiple abuse types (i.e., neglect and physical abuse, 3.6 percent; sexual and physical abuse, 1.6 percent).

### LOCATION (N = 290)

The greatest proportion of reported incidents (82.1 percent) occurred in the victims' homes. The remaining incidents occurred at school (7.6 percent), friends' homes (1.7 percent), or other unspecified locations (8.6 percent). These results are particularly interesting given the fact that a series of sexual abuse incidents occurring in boarding schools helped catalyze attention and response to the problem of child abuse among AI/AN groups. The proportion of incidents occurring at school was greater (by 3.7 percent) than in the national data set, not surprising given the source of these data. The proportion of incidents occurring in **friends'** homes was slightly less (by 1.3 percent) than in the previously reported data set.

When abuse location was examined in relation to specific categories of abuse, significant differences emerged ( $\chi^2 = 47.4$ ;  $p < .0001$ ). Over 95 percent of neglect incidents occurred in victims' homes, while only three fourths (77.6 percent) of physical abuse and approximately two

thirds (63.0 percent) of sexual abuse incidents occurred in the homes. The remaining physical abuse cases occurred primarily at schools (15.5 percent). A substantial proportion of sexual abuse incidents (12.3 percent) occurred at school; sexual abuse (21.9 percent) was also more likely than physical abuse (6.9 percent) or neglect (2.1 percent) to occur in “other” locations.

#### ABUSE DURATION (N = 264)

Duration of abuse was divided into categories ranging from one incident of abuse to a duration exceeding five years. Approximately 63 percent of incidents lasted a year or less in duration: 22.0 percent of the cases reported one-time occurrences, 27.3 percent reported a duration of less than 6 months, and 13.6 percent lasted between 6-11 months. Nearly a third (31.2 percent) reported a duration of 1-5 years, and a few cases (5.3 percent) exceeded 5 years in duration. These values differ from the national case statistics. The proportion of incidents reported as one time occurrences in this data set was less than the national statistics (by 6 percent); the proportion of a 6-11 month duration was also lower (by 3.6 percent), while the proportion of 1-5 years was higher (by 10 percent).

#### VICTIM PROFILE (N = 314)

Nearly all of the victims (99.0 percent) were between 5 and 18 years old, as expected, given the survey population (these data are from school reports). Approximately half (50.6 percent) of the victims were in the 5-9 year age category, and most of the remaining victims (43.3 percent) were in the 10-14 years of age. A few victims (3.8 percent) were 15 years old or older. When victim age was examined by abuse type, no statistically significant differences were observed. There was a slight trend for the proportion of neglect cases to decrease with increasing age. The greatest proportion of sexual abuse cases occurred in the 10-14 year age category, while the greatest proportion of both neglect and physical abuse incidents reported victims in the 5-9 year age category.

Slightly over half (54.4 percent) of the victims were female. Female victims were slightly over-represented (52.9 percent) in neglect incidents, and comprised the greatest proportion (75.0 percent) of sexual abuse victims. Conversely, physical abuse victims were more commonly male (63.3 percent) than female. These differences in victim sex within the three abuse categories were statistically significant ( $\chi^2 = 21.4$ ;  $p < .0001$ ).

#### OFFENDER PROFILE (N = 284)

In our sample, male offenders outnumbered female offenders. Nearly half (47.9 percent) of the incidents involved only male offenders, 32.7 percent only female offenders, and 19.4 percent involved both male and female offenders in the same incident.

When offender sex was examined by type of abuse, the differences were statistically significant ( $\chi^2 = 147$ ;  $p < .0001$ ). Male offenders were significantly over-represented in both physical (69 percent) and sexual abuse (95.8 percent) incidents. In reports of neglect, offender sex was

significantly less likely to be male (13.5 percent); the offender(s) was more likely to be either female (48.9 percent) or both female and male (37.6 percent).

#### OFFENDER AGE (N = 160)

The majority of offenders in this data set (85.6 percent) was under 40 years old. Few offenders fell into the 40-50 year age category (8.1 percent) or the over 50 year age group (6.2 percent). When compared with the national data set, two notable differences existed. In this data set, there were fewer offenders in both the 20-29 year age group (15 percent) and the 30-39 year age group (5 percent). This may be due, in part, to the fact that the average victim is older than the average victim in the national data set (their parents were older).

Offender sex was examined for a relationship with offender age. Males and females comprised approximately equal proportions of the offenders in the age category that ranged from 20-39 years old. However, male offenders substantially outnumbered females in the oldest ( $\geq 40$ ) and youngest ( $< 20$ ) age categories. Of the 41 offenders less than 20 years old, 40 (97.6 percent) were male; males also comprised 22 of 23 (95.6 percent) offenders over 40 years old. The offender sex differences observed in offender age categories were statistically significant ( $\chi^2 = 37.3$ ;  $p < .0001$ ).

When offender age was examined by abuse type, the differences that emerged were statistically significant ( $\chi^2 = 52.7$ ;  $p < .0001$ ). Over 95 percent of neglect cases had offenders in the 30-39 (49.0 percent) or the 20-29 (46.9 percent) year age categories. Conversely, offenders in the incidents of physical and sexual abuse cases were most likely to be less than 20 years old (38.5 percent and 36.4 percent, respectively).

When patterns were examined within age groups, offenders in the youngest age categories ( $< 25$ ) most often perpetrated sexual abuse, offenders 40 years old and older were most often involved in physical or sexual abuse, and offenders in intermediate age categories (25-39 years old) were most likely to be involved in cases of neglect.

#### VICTIM - OFFENDER RELATIONSHIP (N = 279)

The offenders involved in the greatest proportion of the reported incidents were victims' mothers (30.1 percent). Other common offenders included victims' fathers (9.7 percent), mothers and fathers together (19.3 percent), biological relatives (19.7 percent). Social fathers (5.7 percent), other social relatives (7.9 percent), students (4.6 percent), and "others" (2.9 percent) comprised groups of less common offenders. These results need to be interpreted with consideration for opportunity for abuse. While it appears that social fathers are less likely to be offenders than biological fathers, it is also likely that in most populations the proportion of children who live with biological fathers exceeds the proportion who live with social fathers. Similarly, strangers comprised less than 3 percent of the offenders in this sample, yet many child abuse prevention programs focus on educating children about the risks of interactions with strangers.

There were several differences between this sample and the case statistics from the national data set. In this sample, the proportion of offenders who were the victim's mothers was 9 percent lower than the national average, as was the proportion of fathers (8 percent). Both the proportion of biological relatives and the proportion of mothers and fathers, together, were 7 percent higher than the national average.

When offender relationship is further examined by abuse type, significant differences emerge ( $\chi^2 = 197$ ;  $p < .0001$ ). Mothers and parents together were over-represented in cases of neglect. Fathers and students comprised a disproportionate group of offenders in physical abuse incidents. Sexual abuse incidents were most likely to report social fathers, social relatives, and non-parental biological relatives as offenders. Focusing on the primary offender type in each abuse category, mothers were the primary perpetrators of neglect (47.1 percent of neglect incidents); biological relatives were the likely perpetrators of sexual abuse (43.3 percent of sexual abuse reports); and fathers (20 percent), biological relatives (20 percent), and mothers (18.2 percent) were the primary perpetrators of physical abuse.

Non-parental biological relatives were significantly over-represented in the youngest ( $\leq 20$ ) and oldest ( $> 50$ ) age groups. Over 60 percent of offenders who were non-parental biological relatives were 20 years old or younger; and offenders in this category comprised 65 percent of the teenage offenders in the sample. Offenders who were social relatives were the only offender type to be represented in each age category. Their distribution did not differ significantly from the age distribution of the whole sample except that they were over-represented in the 40-50 year age category.

### **SUBSTANCE ABUSE (N = 249)**

Over half (59.8 percent) of the reports noted substance abuse as a factor in the incident of abuse or neglect. The prevalence of substance abuse in reported incidents varied by offender sex, relationship to victim, age, and type of abuse inflicted upon the victim. Substance abuse was frequent in cases involving both male and female offenders (83.7 percent) and in those involving only female offenders (73.5 percent). Less than half (39.7 percent) of the incidents reporting only male offenders involved substance abuse. It was also likely to be a factor in incidents in which the offenders were victims' mothers (77.3 percent), fathers (65 percent), social fathers (83.3 percent), or both parents (82.0 percent). Substance abuse was less often a factor in incidents involving non-parental biological relative offenders (37.0 percent). More than half the incidents involving offenders in the 20-29 (54.8 percent) and 30-39 (66.7 percent) year age categories also involved substance abuse. Conversely, substance abuse was rarely a factor in incidents in which offenders were in the youngest ( $< 20$ ; 11.4 percent) or the oldest, ( $\geq 40$ ; 31.6 percent) year age categories. Differences in the prevalence of substance abuse within abuse types were significant for all three abuse categories ( $\chi^2 = 61.6$ ;  $p < .0001$ ). Substance abuse was a factor in over three quarters (84.1 percent) of neglect cases, but in less than 40 percent of physical abuse (30.0 percent) and sexual abuse (37.5 percent) incidents.

The involvement of substance abuse was examined with respect to the reported period of abuse. The proportion of incidents involving substance abuse increased consistently **with** increasing duration of abuse categories, **from** 24 percent in incidents with one-time occurrences, to 83.3 percent in cases in which the duration of abuse exceeded five years. This difference between the involvement of substance abuse in a one-time occurrence and in incidents which take place for over five years is significant ( $\chi^2 = 44.8$ ;  $p < .0001$ ).

#### VICTIM DISABILITY (N = 294)

This data set was unique among the four analyzed in that it included information on victim disability. The presence of a physical or mental disability may result in increased victim vulnerability. It may also be a constraint to offender treatment when the offender has a disability. It is an important issue in child maltreatment that is not being adequately addressed within the MS.

Among the victims in this data set, over 10 percent had either mental (9.9 percent) or physical (.7 percent) disabilities. Due to the small percentage of victims reporting either type of disability, subsequent analyses combined mental and physical disabilities into one category, "physical or mental disability."

When victim disability was examined with respect to the duration of abuse, most categories had small proportions of disabled victims (0-6.1 percent). However, 14.1 percent of incidents with a reported period of 1-5 years involved victims with some disability, a difference that is statistically significant ( $\chi^2 = 12.1$ ;  $p < .02$ ). This result may suggest: (1) disabled victims are more likely to experience abuse for a prolonged period before it is reported; (2) disabled victims are more likely to suffer abuse types that tend to have longer duration; or (3) cases involving a longer period of abuse are more likely to result in victim disability. A combination of any or all of these factors may explain the observed differences.

Victim disability was examined to determine whether victim sex was associated with victim disability. Although a slightly greater proportion of male (11.9 percent) than female (9.4 percent) victims reportedly had some type of disability, this difference was too small to reach statistical significance ( $\chi^2 = .45$ ;  $p < .5$ ). Similarly, victim disability was examined with respect to victim age, and no statistically significant differences were observed ( $\chi^2 = 1.8$ ;  $p < .6$ ). There was a slightly greater tendency for victims with reported disabilities to be in younger age groups (5-9 years; 12.2 percent) than in older ones (10-14 years; 9.5 percent).

Victim disability was further examined to determine if abuse type had any association with victim disability. The proportion of disabled victims was lowest among sexual abuse victims (7.1 percent), intermediate among physical abuse victims (9.1 percent), and highest among victims of neglect (12.0 percent). However, these differences were not statistically significant.

The offender's relationship to the victim was significantly associated with the victim disability variable ( $\chi^2 = 9.9$ ;  $p < .02$ ). Incidents involving non-parental biological relatives had the smallest proportion of disabled victims (2.0 percent), while incidents whose offenders were social fathers had the highest proportion (25.0 percent). This result is confounded by associations between offender relationship and abuse type and must be considered in that light.

## CASE STATISTICS - ALASKA AREA

These data were made available by Anchorage, Alaska. It was deemed important to address the Alaska area as a separate entity due to vastly different structures of community life and service delivery. The total data set included 1,708 reports, but incomplete data and analysis restrictions limited most analyses to subsets of this total. However, none of the analyses involved fewer than 1,400 incidents, so results of these analyses have considerable statistical power.

### RATES AND REPORTING TRENDS

Complete data were available for the years 1990 and 1991; data for 1992 were complete through part of May. At first, the incidents appear to increase over time, with 36.2 percent of the total data set reported in 1990 and 44.0 percent reported in 1991. However, the number of reports in 1992 was slightly less for the completed months than for the same months in 1991. This, combined with the possibility of confounding externalities due to changes in reporting rates over time, makes it impossible to state whether rates of abuse and neglect are increasing, decreasing, or staying constant.

Despite changes in the number of incidents reported for each of the three years, there was no significant change in the proportions of the various abuse types. Looking only at the three major types of abuse, the proportion of the total cases attributed to physical abuse remained nearly constant from 1990 to 1992, varying from 24.0 percent to 27.8 percent. Incidents of neglect were similarly stable, comprising from 55.6 percent to 57.8 percent of the sample. The only substantial change over time was noted in incidents of sexual abuse, which increased from 14.7 percent of the sample in 1990 to 20.4 percent of the sample in 1992. Whether this change is an artifact of improved rates of reporting of sexual abuse or whether it reflects an actual trend cannot be discerned from these data. However, this result highlights the need for continued scrutiny of these variables as more data became available.

### NATIVE GROUP

A variety of Native groups were represented among victims in this data set. Nearly one third (30.6 percent) of the victims in this data set were reported to be "Eskimo," nearly a fifth (19.7 percent) were Aleut, 11.9 percent were Athabascan, 10.3 percent were Yupik, and 12.9 percent

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The term "Eskimo" likely refers to Inupiaq people. However, since the database includes categories for both Inupiaq and "Eskimo;" we did not combine the two groups.

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were “other Alaska Natives.”<sup>3</sup> Smaller percentages of victims were Inupiaq (6.5 percent), Tlingit (5.6 percent), Tsimshian (0.18 percent), Haida (0.06 percent), and non-Alaska Indians (2.2 percent)

#### ABUSE TYPE

The reports in this data set included sixteen categories of abuse types, ten of which comprised less than one percent of the total reports. The majority of reports were of neglect (50.1 percent), physical abuse (23.3 percent) or sexual abuse (14.0 percent). Smaller proportions of the incidents reported abandonment (1.4 percent), request for services (1.9 percent), and “other” abuse types (6.4 percent).

The variable abuse type was further examined for associations with several of the other variables in this data set. The analysis of Native group by abuse type was restricted to the eight groups for which at least five reports were made (Haida and Tsimshian were excluded). It was further restricted to the three primary types of abuse (neglect, physical abuse, and sexual abuse).<sup>4</sup> Nearly all groups reported more neglect than other types of abuse; the exception was non-Alaskan Indian victims, among whom only 29.2 percent of reports were neglect. Physical abuse comprised from 20-30 percent of the reports among most groups; the exception was, again, non-Alaskan Indians, for whom 45.8 percent of reports were of physical abuse. The proportion of incidents involving sexual abuse ranged considerably, from a low of 5.7 percent among Inupiaq victims, to a high of 30.1 percent among “other Alaska Natives.” Differences in reports of abuse types between these Native groups were statistically significant ( $\chi^2 = 58.5$ ;  $p < .0001$ ).

#### VICTIM PROFILE

Victims were more likely to be in younger age groups than in older ones; nearly two thirds of the victims (64.1 percent) were younger than 10 years old. Reported incidents were slightly more likely to involve female (53.0 percent) than male (47.0 percent) victims. Analysis of victim age by victim sex showed that female victims were significantly older (mean = 8.3 years) than male victims (mean = 7.3 years) (t-test value = -4.2;  $p < .0001$ ).

When abuse type was examined with respect to victim sex, significant differences were apparent ( $\chi^2 = 43.2$ ;  $p < .0001$ ). While male and female victims were closely represented in incidents of neglect (50.2 percent male) and physical abuse (52.8 percent male), females make for a disproportionate number (72 percent) of sexually abused victims. Abuse type was further analyzed for an association with victim age, and, again, significant differences emerged (ANOVA

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<sup>3</sup> For each victim, each type of abuse was reported as a separate incident, thus none of the individual reports involved multiple abuse types.

<sup>4</sup> Such restrictions are necessary in order to ensure that there are no empty cells in the  $\chi^2$  analysis. Restricting the number of categories also reduces the possibility of type I errors, i.e., incorrectly concluding that a relationship exists due to the increased probability of finding significance with increasing numbers of comparisons.

F-test = 37.6;  $p < .0001$ ). Victims of neglect were the youngest (mean = 6.8 years), followed by victims of physical abuse (mean = 8.3 years). Sexual abuse victims were the oldest (mean 9.7 years).

The use of multiple regression was necessary to determine whether the confounding variables had an affect on the preceding observations. The analysis was limited to victim age (under 19) and abuse type (neglect, physical abuse, or sexual abuse). The resulting multiple regression included victim sex, Native group, and abuse type as independent variables, with year of reference included as a control variable. Two of the three variables (victim sex and abuse type) were significantly associated with the victim age variable (with p-values of .0002 and .0001, respectively), and the third (Native group) was nearly significant ( $p < .06$ ). However, it is of interest to note that these three variables accounted for only 3.6 percent of the variance seen in victim age. Considerably larger amounts of information are necessary before a more complete model of child abuse and neglect in this population can be constructed.

#### REFERENCE SOURCE

Incidents of abuse, neglect, and other types of child maltreatment in this data set were reported from 18 different sources. While no one source referred a majority of incidents, nine combined to provide over 88 percent of the total. Referral sources contributing to at least 5 percent of the incidents include schools (17.3 percent), the police (16.6 percent), relatives (12.2 percent), medical sources (9.8 percent), Human Services Agencies (8.6 percent), the client (6.6 percent), the Department of Family and Youth Services (5.1 percent), neighbors (5.0 percent), and anonymous **sources** (7.3 percent).

#### CASE STATISTICS - ALBUQUERQUE AREA

The IHS Albuquerque Area, in collaboration with the Albuquerque BIA Social Services, conducted an intensive CA/CN data collection effort. The data collection instrument used was modeled after the questionnaire utilized in the national survey. The results of this data collection provided the Albuquerque Area with local level CA/CN information and development of a system for interagency coordination and data management.

#### RATES AND REPORTING TRENDS

Thirteen communities were represented in the Albuquerque Area data base, for a total of 379 cases reflecting eight months of incident reports. The data indicate that CA/CN reporting varies considerably from month to month. Including only the eight months for which complete data are available, the number of cases reported per month ranged from 28 to 75, with a mean of 45 and standard deviation of 16. The greatest number of reports occurred in the months October through January, an average of 57.8 per month. The maximum number of reports, 75, occurred in December of 199 1.

## ABUSE TYPE

Information was collected on four types of child abuse and neglect, emotional abuse, physical abuse, sexual abuse, and neglect. Neglect was the most frequently reported (61.4 percent of incidents), followed by physical abuse (14.9 percent), emotional abuse (10.5 percent), and sexual abuse (9.1 percent). The remaining incidents (4.1 percent) involved two types of abuse/neglect in the same report (physical abuse in combination with neglect - 1.6 percent, with sexual abuse - 1.4 percent, or with emotional abuse - .3 percent; emotional abuse combined with neglect - .8 percent). Albuquerque and Alaska are unusual in their efforts to detect and report emotional abuse that is distinct from other abuse types. This is a positive reflection on the child protection efforts in these two areas. Due to the need to restrict the number of comparisons in **chi-squared** analyses, subsequent two-way comparisons involving the abuse type variable were restricted to neglect, physical abuse, and sexual abuse.

## LOCATION

Of the 379 reported incidents, 92.1 percent included information on the location where the incident occurred. Of these, 84.0 percent occurred in the victim's home, 6.6 percent occurred in a friend's home, 3.7 percent occurred at school, and 5.7 percent reported "other" locations. Despite the national attention focused on the potential for child sexual abuse at schools, over three fourths of all incidents reported the victim's home as the location of abuse. When location of abuse was further examined by abuse type, significant differences emerged ( $\chi^2 = 23.4$ ;  $p < .0007$ ). Over 80 percent of physical abuse (82.0 percent) and neglect (88.4 percent) incidents occurred in the victims' homes, but only about two thirds (64.3 percent) of sexual abuse incidents occurred in their homes. A very small proportion of physical abuse (6.0 percent) and neglect (3.7 percent) incidents occurred at "other" locations; in contrast, 25.0 percent of sexual abuse incidents occurred at "other" locations (relatives' homes, public buildings, vehicles, and outdoors).

## VICTIM PROFILE

The majority of victims (58.5 percent) were female. Examination of victim sex within abuse types showed that the sex ratio of sexual abuse incidents differed from the pooled sample. Over three fourths (81.8 percent) of sexual abuse victims were female. The proportion of female victims exceeded males for every abuse category. These differences were statistically significant ( $\chi^2 = 8.8$ ;  $p < .02$ ).

## VICTIM AGE

Victims ranged from under 1 month to 18 years in age, with a median age category of 5 - 9.9 years, and the modal age category at 10-14.9 years. Over 40 percent of victims in the Albuquerque Area data set were 10 years or older. However, the age distribution was somewhat skewed toward younger victims; 8.5 percent of victims were younger than one year old.

When victim age was analyzed within specific types of abuse, the overall **chi-squared** analysis was not statistically significant ( $\chi^2 = 12.6$ ;  $p > .2$ ). However, three of the eighteen cells in the analysis were significantly different than expected. Incidents of neglect were significantly over-

represented among victims aged 1-4 and under-represented among those aged 10-14 years. Moreover, sexual abuse incidents were more frequent than expected among those 10-14 years old. Incidents of physical abuse were concentrated among older victims, with nearly 60 percent in the 5-14 year age categories and over 35 percent between 10 and 14 years old. Conversely, neglect incidents were more frequent among younger victims: over 30 percent were 1-4 years old, and nearly 55 percent were 1-9 years old. Sexual abuse victims were the oldest, as 50.0 percent of these victims were 10-14 years old.

The rate of neglect reported among adolescents was higher here than in national samples, and this may reflect Albuquerque's effort to detect and report neglect of adolescents. This is a positive reflection on Albuquerque's efforts to protect children of all ages from health risks and other problems that result from neglect.

### OFFENDER PROFILE

Incidents were categorized as involving only male perpetrators, only female perpetrators, or both males and females together in the same incident. Nearly one quarter (22.6 percent) of the CA/CN incidents in this sample involved both male and female perpetrators. Approximately half (51.0 percent) involved exclusively female offenders. The remaining 26.4 percent involved only male offenders.

A significant sex bias became apparent when offender sex was examined by abuse type. While only about a quarter of all incidents involved exclusively male offenders, over half of the physical abuse incidents (56.6 percent) and nearly all of the sexual abuse incidents (90.9 percent) involved exclusively male perpetrators. In contrast, nearly two thirds (62.6 percent) of neglect incidents involved exclusively female perpetrators. Cases-involving both female and male perpetrators were primarily (98.5 percent) incidents of neglect. These differences were statistically significant (140.9 percent;  $p < .0001$ ).

### OFFENDER AGE

The greatest proportion of offenders were between 20 and 29 years of age (40.2 percent). A high proportion of perpetrators were also in the 30-39 year group (38.5 percent), with smaller percentages in the 40-50 (10.6 percent), over 50 (2.6 percent), and under 20 (8.1 percent) year age categories.

An analysis of abuse type and offender age showed a significant association between these two variables ( $\chi^2 = 35.9$ ;  $p < .0003$ ). Most physical abuse (65.3 percent) and neglect (74.4 percent) incidents involved offenders in the 25-39 year old age categories. Incidents of sexual abuse were less concentrated within specific age categories; however, it was clear that sexual abusers were younger than perpetrators of other abuse types.

Looking at proportions of abuse types in the various offender age categories uncovers other interesting associations. For example, 42.9 percent of incidents involved offenders under 15 years old, and 35.0 percent of incidents with offenders aged 15-19, were incidents of sexual

abuse. This contrasts markedly with the overall percent of incidents reporting sexual abuse (10.6 percent).

#### VICTIM - OFFENDER RELATIONSHIP

Of the 379 reported incidents, 364 (96.0 percent) identified the relationship between the victim and offender(s) involved in the case. At least 447 offenders were involved in the 364 incidents (83 reports indicated more than one offender). The greatest proportion of reported incidents involved mothers (43.9 percent of all offenders), biological fathers (14.8 percent), and mothers and fathers together (20.6 percent). Smaller proportions of incidents involved social fathers (5.8 percent), non-parental biologic relatives (6.3 percent), professionals (.3 percent), and others (4.5 percent). What is revealing about these results is that, among cases whose offenders were identified, over 95 percent of offenders were biological or social relatives of the victims.

When relationship to offender was examined by abuse type, differences were statistically significant in all but two of fifteen cells ( $\chi^2 = 123.5$ ;  $p < .0001$ ). Most incidents of physical abuse involved biological fathers (36.0 percent), mothers (30.0 percent), and social fathers (22.0 percent). The primary offenders in sexual abuse incidents were biological fathers (50.0 percent), social fathers (27.8 percent), and biological relatives (16.7 percent). Finally, most incidents of neglect involved either mothers (58.6 percent) or mothers and fathers together (29.6 percent).

The same data regarding offender relationship can be analyzed by abuse type, as well. Physical abuse was the most frequently reported abuse type for social and biological fathers (57.9 percent and 43.9 percent, respectively), while neglect was the primary abuse type among non-parental biological relatives (50.0 percent), mothers (89.0 percent), and mothers and fathers together (100 percent).

Offender relationship was also examined for an association with offender age, and the resulting relationship was found to be statistically significant ( $\chi^2 = 68.4$ ;  $p < .0001$ ). Analysis showed that non-parental biological relatives were disproportionately represented in the youngest and oldest offender age categories. Mothers were also over-represented among offenders under 15, and were more frequent than expected among offenders in the 30-39 year age group (mothers were involved in 71.9 percent of incidents overall but comprised approximately 80 percent of the offenders in the under 15 and 30-39 year age categories). Biologic fathers were over-represented in the oldest age group (over 50), and social fathers were more frequent than expected in the 20-24 and 40-49 year age groups.

#### SUBSTANCE ABUSE

Most of the reports (77.6 percent) included information about substance abuse. Nearly two thirds (67.0 percent) noted that substance abuse was involved in the reported incidents. Substance abuse was most common in incidents involving both male and female offenders in the same incident (77.8 percent of those incidents) and least common in incidents involving only female offenders (60.0 percent). These differences were statistically significant ( $\chi^2 = 7.2$ ;  $p < .03$ ).

When substance abuse was examined with respect to victim-offender relationship, the association was significant for incidents involving non-parental biological relatives and for those involving both mothers and fathers (overall  $\chi^2 = 32.1$ ;  $p < .0001$ ). While the overall rate of substance abuse was 67.0 percent for this sample, only 14.3 percent of incidents whose offenders were non-parental biological relatives also involved substance abuse. In contrast, over three fourths of incidents involving biological fathers (78.3 percent) or mothers and fathers (76.5 percent) involved substance abuse.

When substance abuse was examined by offender age, the overall association between these two variables was not significant ( $\chi^2 = 8.7$ ;  $p > .18$ ). However, it is interesting to note that substance abuse was most common in incidents involving offenders aged 30-39 years (72.8 percent), and least common in incidents involving offenders aged 15-19 years (37.5 percent). These associations are clearly influenced by the victim-offender relationships.

Substance abuse was examined within the three abuse types. In this sample, sexual abuse incidents had the highest level of substance abuse involvement (73.7 percent) and substance abuse was unlikely in incidents of physical abuse (47.2 percent). The association between abuse type and substance abuse was significant ( $\chi^2 = 7.5$ ;  $p < .03$ ).

#### REFERRAL SOURCE

Child abuse and neglect cases were referred by a myriad of agencies, including tribal law enforcement (8.3 percent), tribal social services (9.6 percent), public schools (9.1 percent), and II-IS-PHS (8.6 percent). The greatest proportion of reports (47.1 percent) listed “other” as the referral agency (the eleven choices listed in the questionnaire combined to provide just over half the referrals). It is apparent that referrals come from a variety of sources; no single agency contributes over 10 percent of the CA/CN referrals in the Albuquerque Area. Respondents who identified the “other” referral source indicated primarily family members.

The Albuquerque data also included information on the type of services provided to victims, the number of court prosecutions that resulted, and the type of court system, whether or not there was an out-of-home placement of the victim, and whether the case was substantiated at the time of the report. This information was extremely useful to the Albuquerque Area and should be included in case record management in every location.

#### SUMMARY OF CASE STATISTICS

The databases described above were collected from many sources. As a result, each database differed with respect to the combination of variables available for analysis. However, several of the variables were available in two or more of the databases, and it is of interest to compare and contrast the results discussed above. Due to the great number of possible comparisons, the analyses were restricted to descriptive statistics.

## YEAR

Three of the databases included incident reports for more than one year of reporting. Although the years differed between databases, the number of reports in each appeared to be increasing over time. However, the limited number of years for which data were available (two consecutive years in each database) and other confounders make it impossible to determine whether CA/CN, itself is increasing, whether reported incidents of CA/CN is increasing, or whether the apparent increases are an artifact of the limited period of time for which data were available.

## ABUSE LOCATION

Information concerning the location of abuse was included in three of the four data sets. The most salient observation emerging from the comparison is that, in each case, the home was the reported location of abuse in over three fourths of incidents. Slight differences exist in the proportion of reports occurring at school (ranging from 3.6-7.6 percent), a friend's home (1.7 percent-6.6 percent), and "other" locations (5.7-8.6 percent), but these differences are not substantial and are unlikely to be important.

## ABUSE TYPE

Each of the databases analyzed above included information concerning the type of child maltreatment in incident reports, although some variations existed in the categories of abuse that were included. For example, only two of the four data sets (Albuquerque, Alaska), included reports of emotional abuse, and it was not possible to examine reports of "multiple abuse types" in one data set (Alaska). Thus, to compare the four data sets, all proportions were recalculated using only the three most commonly reported abuse types (neglect, sexual abuse, and physical abuse).

Neglect was the most frequently reported abuse type in each data set, ranging from 50.0 percent in the national data set to 71.9 percent in the Albuquerque Area data. Sexual abuse was the second most frequently reported abuse type in the national and BIA data sets, comprising between 27 percent and 29 percent of the reports. In the Albuquerque and Alaska Area data, sexual abuse comprised smaller proportions of the incidents (between 10 percent and 16 percent of case reports). The proportion of incidents reporting physical abuse ranged from 17.4 percent of the Albuquerque Area reports to 26.6 percent of the incidents in the Alaska Area data base. While it is clear that neglect is consistently the most frequently reported type of abuse, it is also clear that regional differences exist in the proportions of each abuse type reported. The greatest variation is seen in the percent of incidents involving sexual abuse.

## ABUSE DURATION

Abuse duration was recorded in three of the four data sets (national, BIA, and Albuquerque Area), and considerable overlap was seen between these databases. Nearly 25 percent of the incidents in all three data sets reported a one-time occurrence (range 22.0-27.1 percent); another 25 percent reported an abuse period of under 6 months (23.9-28.8 percent). Slightly greater variation was seen in the proportion of incidents with a duration of 6-12 months (13.6-20.8 percent) and 1-5 years (21.4-31.2 percent), but all indicated that about 5 percent of reported

incidents occur for durations of over 5 years (4.8-5.6 percent). This suggests that the duration of abuse variable is not very affected by differences in the sources of these databases. The observed differences are most likely due to variations in proportions of abuse type between data sets and the significant association between abuse type and duration of abuse.

#### VICTIM AGE

Victim age was recorded in all data bases, and this variable showed more differences than any other for which comparative data were available. Differences in this variable are primarily attributable to the data source (since all the incidents in the BIA database attended school, virtually all the victims were at least 5 years old). Such factors make it difficult to compare data from these sets. It is interesting to observe that all of the data sets indicated a disproportionate amount of victims in younger ages, though some of the databases were more skewed than others. For example, in the national and Albuquerque Area data sets, the youngest victims (under 1 year old) were the most over-represented age group. In the Alaska Area data set, victims under 1 were under-represented, but victims aged 1-9 were over-represented. Part of the difference in victim age between data sets may be associated with differences in the proportions of incidents involving the various abuse types, but it appears that some of the variation can only be explained by incomplete information.

#### VICTIM SEX

All of the databases recorded the victim's sex in incident reports. There was a striking correspondence in the victim sex ratios within the four data sets. Female victims outnumbered males in each database, but only slightly, with the percent of female victims ranging from 53.0 percent to 58.5 percent.

#### OFFENDER SEX

Three of the data sets included information on the sex of the offender in child maltreatment reports, and substantial differences were noted in the offender sex ratios. In the national data set, offenders were almost equal (48.9 percent male). The proportion of male perpetrators in the BIA data set was noticeably greater than half (57.6 percent male), while the reverse was true in the Albuquerque Area data set (37.7 percent male).

#### OFFENDER AGE

Offender age was collected for three of the four data sets (national, BIA, and Albuquerque Area databases). The greatest differences exist in the proportion of offenders who are under 20 years old (range: 8.1-25.6 percent). The BIA database had the highest proportion of offenders in this youngest age category, likely influenced by the fact that they reported a higher number of offenders who were students than did either of the other two data bases. While offenders in the BIA database were nearly balanced between 20 (25.6 percent), 20-29 (27.5 percent), or 30-39 (32.5 percent) year age groups, offenders in the national and Albuquerque Area data sets fell predominantly in the 20-29 year age group (42.5 percent and 40.2 percent, respectively). In each of the data sets, almost half of the offenders were under 30 years old, and over 85 percent were under 40 years old.

## **OF-FENDER RELATIONSHIP**

The relationship between the offender and the victim was recorded for all but the Alaska database. Some of the differences that do exist in the proportions of incidents attributed to the various perpetrator categories are due to the sources of the data. For example, the category of students as perpetrators was negligible in all but the BIA data set. Yet, this is expected because all the victims in the BIA data set were attending school. Most notable is the fact that, in each of the data sets, mothers were the most frequently reported offenders, with the proportion ranging from **30.1** percent to 43.9 percent of reported incidents. Mothers, fathers, and mothers and fathers together (in the same incident) combined to account for almost three fourths of all incidents in each data set (range: 73 .0 percent - 81.9 percent), with social fathers comprising another 5 percent (5.4 percent - 5.8 percent). Most of the remaining incidents were perpetrated by non-parental biological relatives (6.3 percent - 19.7 percent). **All** data sets showed strangers to be offenders in few of the incidents. These results combine to indicate that close family members are the primary perpetrators of abuse and neglect. For this reason, attention needs to be focused on the family by CA/CN prevention or intervention programs.

## **SUBSTANCE ABUSE**

Three of the data sets (national, BIA, and Albuquerque Area) incorporated information concerning whether or not substance abuse was a factor in the reported incidents of child maltreatment. While the proportions of incidents involving substance abuse varied somewhat (range: 59.8 percent - 70.3 percent), substance abuse was a factor in well over half the reported incidents in each database. Analysis of the combined data sets shows that over two thirds of the incidents involved substance abuse, indicating that this variable is one of the most important and most tangible predictors of child maltreatment. Substance abuse is a likely target for CA/CN prevention efforts as it is more amenable to intervention than many of the other factors associated with this problem (e.g., poverty). However, it must be stressed that substance abuse is as much an indicator of other problems and **stressors** as it is an individual problem; it must be treated as a proximate, rather than an ultimate, cause of child abuse and neglect.

## **CHILD MALTREATMENT AND SUBSTANCE ABUSE**

A primary consideration for Indian people is the relationship between drugs and alcohol and CA/CN. Researchers have found consistent relationships between a caretaker's use of these substances and the abuse and neglect inflicted upon children (Gelles 1987). Behavior and patterns of drinking vary considerably between groups and may have different implications in the protection of children. A Navajo child abuse study found that 50 percent of abuse cases and 50-80 percent of neglect cases were alcohol-related (White 1977, White & Comely 1981).

The results of this research also supported a highly significant correlation between substance abuse and child maltreatment. In the national data set, substance abuse was involved in over 70 percent of all cases in which this information was collected, and in approximately 75 percent of those in which parents were the perpetrators. Incidents involving male offenders were significantly less likely to involve substance abuse (60 percent of incidents) than incidents with

female offenders (70.4 percent). In addition, an analysis of the association of substance abuse by abuse type and age of perpetrator revealed statistically significant differences. Sexual abuse was less likely to be associated with substance abuse than were neglect or physical abuse. These results imply that substance abuse severely impacts parental competency, the parent-child relationship, and healthy child growth and development.

Substance abuse adds a myriad of complications to the intervention process. Two issues of primary concern for the MS are to address the correlation between family substance abuse, fetal alcohol effect (FAE)/fetal alcohol syndrome (FAS), and child maltreatment; and the possible intervention techniques that include treatment for substance abuse. The leading cause of disabilities among AI/AN newborns is pre-natal exposure to alcohol and/or drugs. This exposure can result in FAS or FAE, patterns of malformation found in children whose mothers consumed alcohol during pregnancy. FAE is more difficult to diagnose than FAS because children may look normal, and obvious signs of FAE tend to manifest later than FAS (usually when children are in elementary or middle school). Systematic research has not been conducted with FAE, but it is essential to understand the long-term effects, the prevalence rates, and the treatment needs of these children.

The reported prevalence of FAS varies between tribes, ranging from 1.3 to 10.3/1,000 births. Alaska MS Area data from 1981 to 1989 indicate a high rate of alcohol-related birth defects among infants born to AI/AN women. The rate of FAE infants is an estimated 10 to 15 times the rate of FAS infants.

Women in Alaska, including AI/AN women, have similar drinking patterns to women in the general population, particularly binge drinking. An estimated 25 to 75 percent of AI/AN women are at-risk of having an FAE baby. In general, the rates of FAS among Alaska Native tribes range from 2.2 -16.7/1,000 live births, considerably higher than the 1.3-1.7/1,000 range of the U.S. general population.

Most FAS/FAE children remain with their parents, which may place these children at higher risk for child abuse and neglect by their care-giver(s). To minimize these potential problems, the implemented program must conduct long-term follow-ups with FAS/FAE children and their mothers. Follow-ups would ideally begin no more than two weeks after birth and would continue through adolescence.

It is essential to have an early identification system in order to begin providing immediately for both mother and child. Prevention strategies should include routine evaluation and risk assessments of new mothers and babies through diagnostic clinics and pre-natal programs; training in behavior management; for parents, pre-conception counseling whenever possible; and early pre-natal care.

Effective intervention in cases in which child maltreatment coexists with substance abuse address both of these problems. Substance abuse can exist at several levels: the perpetrator, the victim, or both may be involved with alcohol and/or drugs.

### **PHASE III**

#### **RESPONSES TO TRIBAL PHONE AND MAIL SURVEYS**

It was extremely difficult to identify, locate, and survey tribal service providers. These difficulties resulted in a low response rate. There were 23 usable telephone surveys and five completed mail surveys. The telephone survey respondents represented 21 tribes from Nebraska, Arizona, Washington, Oklahoma, South Dakota, Wisconsin, Montana, Michigan, Nevada, Alaska, and Oregon. The 24 usable surveys included 13 responses from social service agencies, three from mental health providers, two from law enforcement officials and six from judicial services. There were no responses from tribal medical agencies.

The mail surveys that were returned represented five diverse geographic areas: Wyoming, Alaska, Washington, Idaho, and Oregon. Respondents included representatives from the judicial (2), medical (1), other (1; child protection agency), and social service (1) fields.

Given the small response rate, there is no appropriate statistical analysis that can be applied to compare data gathered in Phase III with those gathered in Phase II. The differences in sample size from Phase II to Phase III renders such scientific analysis inappropriate. However, the responses to surveys in Phase III are illustrative of the problems encountered by various programs. It can be argued that the responses received were from those service providers who are most interested and motivated in regard to child abuse and neglect. These responses might be the most meaningful responses available.

#### **TELEPHONE SURVEYS**

Telephone surveys were administered to tribal employees who are direct service providers. The first aspect of the telephone survey was to **identify** appropriate participants. Administrating employees were requested to fill out the mail survey.

#### **PARTICIPANTS**

The telephone survey of this study was extremely burdensome. Because the list of original tribes surveyed for this project did not include telephone numbers, it was necessary to locate telephone numbers for all 116 tribes on the original list. Once telephone numbers were located, it often took several calls to locate appropriate service providers for the survey. Staff could not discern whether service providers were federal or tribal employees until they actually spoke with them. This process led to numerous calls to locate tribal service providers. Oftentimes, calls to the tribal administrative office were referred to departments which did not employ the person or agency the staff was attempting to locate. In these cases, a third telephone call ensued. As a result, staff made 550 calls attempting to locate tribal employees to complete the survey. Of the 550 calls, 112 resulted in messages being **left** with requests for the recipient to return a call to a

specified NIJC staff member. Only 23 of the 112 recipients with messages returned the NIJC's staff call. The simple act of identifying appropriate potential telephone survey participants was burdensome, both in terms of the extraordinary amount of time expended in locating participants and the expense of long-distance telephone calls and staff time to carry out this task.

An additional difficulty involved the actual completion of the surveys. Of the 82 surveys scheduled, only 24 **useable** surveys were completed. Many of the scheduled surveys remained incomplete because the participants were not available at the time the survey was scheduled. These people were usually unavailable due to emergencies or other commitments (meetings, court appearances, investigations, client crises, etc.) The NIJC staff identified four reasons why potential telephone survey participants were unable or unwilling to participate: respondents were too busy; the survey was at the bottom of their priorities; they didn't feel comfortable talking about faults of their programs; and they didn't feel qualified to participate and, thus, deferred to their supervisors.

Once the NIJC staff had scheduled a survey for a specific time and the person was not available at that time, the time allotted for the survey was wasted. Because surveys needed to be scheduled in advance, and because only one survey could be scheduled for a given time-frame, the staff could not substitute another participant when the scheduled participant was unavailable

## RESULTS

The small number of respondents allows for the presentation of only anecdotal presentation of information to be presented. Although this data cannot be generalized, the information can guide future research and suggest possible priorities for funding allocations. For the purpose of this report, all data will be reported in aggregate form, with responses **from** four types of providers (social services, mental health, law enforcement, and judicial) reported in composite form. The small number of responses from mental health, law enforcement, and judicial representatives precludes reporting their data separately.

Section I of the telephone survey deals with policies and procedures regarding CA/CN cases and ways in which information is collected and exchanged between agencies. Overall, most respondents felt that their organizational policies and procedures are adequate. Eighteen respondents rated their organizations' policies regarding CA/CN as adequate, while only six rated them inadequate. Similarly, 20 rated their organization's procedures as adequate, while four described them as inadequate.

The questions exploring the sharing of CA\CN information with other programs was enlightening. Sixteen responses indicate that there is CA\CN information which is not shared with other programs, and seven reported that there was no unshared information. The reasons for unshared information focused on confidentiality and a need-to-know basis (information that should be available to only those people who have a legitimate use for it, such as in the course of doing their job(s)). Some responses indicated specific types of unavailable information, such as the name of the person making the report or confidential counseling files. However, the majority

of programs reported no major obstacles for sharing CA\CN with other tribal or external agencies and programs (15 programs reported no major obstacles, while seven reported obstacles). When obstacles were identified, they included a lack of procedures for releasing information, a lack of confidentiality, a need to protect individual reputations, and changes in personnel, politics, and jurisdictional issues.

There was overwhelming support for the idea of a central registry (20 in favor, 2 opposed). Those in favor of the registry felt that such an instrument would help them know their community, track child abusers who move from one Reservation to another, assist in performing background checks, and provide for better tracking of offenders. Five respondents felt the registry should be inter-tribal, three statewide, and 16 nation-wide (some respondents had more than one reply). The main concern of those opposed to a central registry regarded how the information would be utilized.

Section II of the survey involved specific staffing and personnel issues that occur in dealing with CA\CN. The majority of respondents felt that the size of the professional staff was inadequate for dealing with CA\CN (eight rated this item as completely inadequate; six as somewhat adequate). The level of paraprofessional staff was also noted as inadequate (seven rated this item as completely inadequate; eight as somewhat inadequate). Only two programs reported that they had no problems, due to professional or paraprofessional staff size in their organization.

The majority (15) of the programs reported that they never denied needed services to clients due to lack of available staff, while only two agencies reported that they frequently denied needed services to clients for this reason. All agencies do their best to provide some level of service, despite the lack of available resources that many experience.

The question regarding the two major staff-power needs for dealing with CA\CN drew a number of responses, most of which focused on funding for additional staff. Programs voiced a need for increased staff in all areas, which includes law enforcement, social services, mental health, case workers, specially trained child sexual abuse investigators, crisis response teams, and support staff. Other identified needs included minority service providers, inter-tribal conferences, the employment of tribal members with degrees, the inclusion of cultural healing, prevention activities, the interaction with the state, and the updating of the CA\CN System.

Major training needs included specialized training for mental health workers, social workers, and foster parents. Specifically, responses reported the need for training in using traditional culture, interviewing, developing codes and ordinances, detecting abuse, dealing with parents, working with Indian law, understanding the court system and the impact(s) of violence. It was also noted that the CPT needed better training and that all employees needed training in legal research and writing.

Section III of the survey involves jurisdiction and interagency issues. The primary provider of medical services is the MS (20 responses), followed by the tribe (3 responses), and private

facilities (1 response). Because the IHS acts as the primary health care provider explains, the majority of tribes still receive their health care from the MS. This explains why no surveys were received from tribal health care providers.

As expected, there was both criticism and praise for the MS role in CA/CN cases. The criticisms included concerns that the IHS staff were not accessible, not thorough with their findings, not culturally sensitive, and not successful in providing psychological treatment. Additional concerns were that the agency is under-staffed, especially in regard to Indian staff, and that the staff turn-over rate is high. The praise for the MS staff involved their participation in multi-disciplinary teams (Sexual Child Abuse and Neglect (SCAN) or CPT), willingness to testify in court, speed in dealing with referrals, provision of good reports, and referrals of suspected CA\CN.

Tribal programs were lauded for being close by, having good staff, and providing immediate referrals to appropriate agencies. Criticisms of the tribal programs included lack of necessary equipment and adequate training.

Social services were reported to be provided by the IHS(4), the BIA (7), the tribe (10), the county (1) and the state (5). The one criticism of the MS social services was that they do not provide psychological evaluations. Concerns regarding the lack of funding exists for all agencies. Other concerns included the lack of Indian staff, lack of training, and lack of cooperation.

Respondents also reported that the MS social services are in touch with people and offer support. The BIA caseworkers were seen as excellently-trained people who know the community and who help with intervention. Tribal programs were seen as helpful in reporting, providing financial assistance, responding quickly with CPT, and using sensitivity in dealing with potential abuse situations.

In law enforcement, the BIA (3), tribe (9), the Federal Bureau of Investigation (FBI) (1), and county (6) were reported as providers of police services. These agencies were also reported to hinder tribes abilities to handle CA/CN cases by lack of staff. The BIA responds slowly with too few and inadequately trained staff. Reports also complained about the BIA's disinterest in testifying. Tribal law enforcement was cited for not being available in crisis situations, partly because of a lack of staff. In addition, the staff is in need of technical training and must begin providing appropriate documentation, resisting case investigation, and working with other agencies. Other agencies, such as the FBI and county, were faulted for being over-worked, located far away, disinterested in cultural issues, and inadequately trained. These agencies also demonstrated large amounts of distrust. In addition, there were racial problems, which interfered with their investigation of important issues.

On the positive side, the BIA law enforcement was seen to be helpful in handling CA/CN cases by removing children, being thorough, and working with the tribal court counselor. Tribal police were commended because they know the cultural issues, listen attentively, and conduct prompt

investigations. They are cooperative and accessible, and “they do a good job.” The county was identified as providing good referrals, a willingness to assist the tribe, participating in joint training, providing on-scene response, increasing efforts to get involved, and having a special officer assigned to the tribe.

The primary provider of judicial services is the tribal court (17 responses), followed by the federal (5), state (4), Code of Federal Regulations (CFR) (2), and traditional (1) courts. Judicial services were identified as hindering the tribe’s ability to handle CA/CN cases; the providers mix abuse cases with juvenile delinquency cases, lack follow-up procedures (the most frequently mentioned problem), lack adequate knowledge, take too long to make prosecutorial determinations (federal), are unable to handle all cases, lack constancy, lack cooperation/coordination, use prosecutors that are unfamiliar with issues, and take too long to issue orders. The judicial services were also criticized because the court docket is too full; therefore, they do not spend enough time pursuing the needs of CA/CN victims. Moreover, tribal courts are still needed where none exist.

When asked how judicial services can better assist in handling CA/CN cases, three replied that “they don’t.” However, other respondents replied that judicial services are adequate: judicial employees recognize the need for counseling, respond in a timely manner, increase public awareness of perpetrators, place strict conditions on perpetrators, cooperatively work with the Reservation, provide alternatives to incarceration, obtain convictions, are open to learning, and are accessible.

Respondents listed several jurisdictional or interagency issues that need to be addressed in handling CA/CN cases. The most commonly named issues were limited numbers of counselors, lack of tribal jurisdiction, and the need for improved communication. Other comments included the need for tribal law enforcement, public information, ICWA understanding, cultural sensitivity, and increased networking and cross-deputization. Problems also include a lack of decision-making, poor coordinating of state/county/tribal procedures, a lack of respect/understanding of tribal sovereignty, and the existence of multiple investigations, due to a lack of inter-agency coordination.

Section IV focused on the treatment of CA/CN. Respondents were asked to approximate the percentage of children in their tribe who may be victims of abuse or neglect. Estimates ranged from 5 percent to 80 percent. The specific responses are as follows: 5 percent (3 respondents), 10 - 15 percent (1), 20 percent (2), 25 percent (4), 30 percent (3), 40 percent (1), 45 percent (1), 50 - 60 percent (4), 70 percent (1), 75 percent (1), and 80 percent (1). Once again, it is impossible to evaluate the data based on this limited sample. In future research, however, it would be useful to correlate estimates of CA/CN with respondent’s role. Direct service providers may estimate higher levels of abuse based on their exposure to reported cases, while a judge only sees those cases which appear before the court.

Respondents were then asked to offer their opinion as to why cases are not reported more often. They had the following five options to choose from: lack of training, fear of reprisal, not knowing who to report to, feeling that nothing will be done, and people are indifferent. The most common reason was a fear of reprisal (16), followed by indifference (11), feelings that nothing will be done (11), confusion regarding who to report to (8), inadequate training (8), the fact that families try to resolve issues on their own (1), and denial (1). Respondents were allowed to agree with as many responses as they believed applied, so the total number of reasons given the number of respondents (26).

Once again, the results are suggestive of future activities. Because the fear of reprisal exists to such a large extent, agencies (including the MS) may need to look into better ways of protecting the confidentiality of a reporter. Clearly issues such as a “lack of training” and “not knowing who to report to,” can be addressed through mandatory training programs and clear procedures. The IHS should explore their role in providing such education, not only to their own employees, but to tribal, state, and county employees as well. The “feeling that nothing will be done” is more difficult to address. However, the MS has a role here, as well. An active CPT can be a force for action. The MS support of and active participation in the local CPT may provide an avenue to improve the system response to CA/CN.

The final issue, “people are indifferent,” is the most difficult to address. The MS could assert its leadership role by increasing public awareness. Past experience shows that what appears to be public indifference is actually a complex mixture of personal confusion and fear. Substance abuse can impede a person or a community from taking direct action. Lack of education and understanding regarding the impact of child sexual abuse can also impair people from taking action. The MS can set a clear direction by providing community education.

Respondents had several ideas regarding the types of services most needed or required in the community to deal with CA/CN. The most commonly mentioned services were mental health services, shelters, community education, drug/alcohol counseling, parenting classes, prevention activities, on-reservation residential treatment facilities, CPT, and group counseling. Other suggestions included more educational materials, a juvenile protection team, the BIA social services (for a tribe that does not currently have such services), foster parents, Indian professionals, increased use of tradition, family therapy, employment services, case workers, child abuse clinic, drivers, crisis unit, investigation, tribal court council, staff training, and treatment services of sexually aggressive youth.

Programs reported that they rarely (6) or never (8) had to deny needed services due to lack of adequate funding. Only three programs reported that they frequently denied services, and only four programs reported that they sometimes denied services. These results are consistent with other reports from the surveys; service providers do the best that they can with the limited resources they have. While they may not be able to provide clients with all of the services they know the clients need, they will provide whatever they can. This approach is consistent with traditional values of sharing whatever resources are available.

The most frequently mentioned types of services that the program is unable to provide due to inadequate funding are counseling, training for families, and follow-up procedures. Other needs included treatment for sexually aggressive youth, psychological evaluations, truancy, community education, direct service, specialized technical assistance, emergency funding, inpatient treatment, and foster homes.

Service providers were asked: "If a client needs services which your program cannot provide, do you frequently, sometimes, or rarely refer cases to the following agencies: the MS (medical), the BIA (social service/law enforcement), tribal agencies, municipal agencies, county agencies, state and human service, school systems, and private agency care?" Respondents indicated that they were frequently willing to make referrals to the IHS (15 respondents) and tribal agencies (18) but rarely referred patients to the BIA (9), municipal agencies (13), and private agencies (10). Importantly, two respondents stated that they rarely make referrals to the IHS, and two replied that they never make such referrals. These responses may indicate a cause for concern. While the numbers are small, the sample is limited. Almost 20 percent of the sample indicated a negative view toward the MS.

The vast majority of programs involve Native American culture in their treatment program (19), with only two programs reporting that they do not use cultural treatments. The types of cultural interventions mentioned most often included the use of traditional values/beliefs/practices, and language. Other frequently mentioned interventions included the use of traditional healing, sweat lodges, ceremonies, story telling of the experience of elders, talking circles, **crafts**, and Native American staff.

In response to the question, "Do you frequently, sometimes, rarely, or never involve Native healing care-givers?" four programs responded that they frequently used such care-givers, 11 responded "sometimes," one responded "rarely," and six responded "never." In terms of the involvement of Native healing ceremonies, four responded that they "frequently" used such ceremonies, seven responded "sometimes," two responded "rarely," and seven responded "never."

The majority of respondents (14) stated that legal action is "usually" taken in CA/CN cases, and that counseling or treatment is usually undertaken (13). Thirteen programs responded that their tribe has mandatory arrest provisions for offenses involving child abuse and another 13 stated that they thought mandatory arrest is a good idea. Those who agreed with the concept of mandatory arrest most often cited the importance of separating the perpetrator from the victim and other children, and identified arrest as a means for the abuser to receive treatment. Those who disagreed with mandatory arrest were concerned that the child would be left alone, that it does not allow investigation of mitigating circumstances, that it does more harm than good, and that officers refuse to implement the provisions.

The respondents were unanimous in their support of a secondary prevention program. This support from diverse agencies (social services, law enforcement, social services, mental

health, etc.) suggests that communities throughout the country desire a home-visitor program targeted towards providing services to pre-natal mothers and parents of newborns.

Section V of the survey addresses client access to services. The survey identified eight reasons why clients have problems accessing services and asked respondents to rate whether the reasons are a major concern, somewhat a concern, or not at all a concern. Most respondents rated lack of transportation by clients as either a major barrier (11) or somewhat of a problem (10). Eight respondents stated that large distances between the program and the client was a major problem, and another 8 noted it as somewhat problematic. Seven respondents rated this issue as “not at all a problem.” Lack of awareness of programs or services was rated as a major barrier by six respondents, somewhat problematic by 10 respondents, and not problematic at all by eight people.

Too much red tape, a lack of needed services, and a lack of staff also appeared to be barriers. For each of these areas, 10 or more respondents rated these difficulties as “major” problems. Lack of outreach services was perceived as a major problem by 15 respondents. In contrast to these problems, language barriers did not appear to be much of a problem (15 respondents rated this issue “not at all” a problem).

When asked to describe the most consistent problems faced by their program in accessing services from external agencies, respondents listed the following **difficulties**: clients don’t want to go outside the community, rejection, money, transportation, access, cultural differences, recognition of court orders, obtaining reports, isolation, scheduling, workers don’t want to work with the tribe, availability of services, jurisdiction, and the **BIA/FBI** being slow to respond.

Section VI dealt with questions concerning the CPT. The majority of communities (17) reported the existence of a local CPT, while only seven reported that they did not have a CPT. The primary purpose of the CPT was most often described as protecting children (8), coordinating services (3), providing a multi-disciplinary perspective (2), providing education (2), identifying potential abuse situations, making resources available, providing prevention services, following/ updating cases, influencing custody decisions, and sharing information.

Survey respondents were offered a list of eight ways a CPT can hinder the ability to provide services to clients and asked to rate whether these were a major concern, somewhat a concern, or not at all a concern. The list included non-action, mismanagement of cases, direct services to clients not provided, limited technical and advisory assistance provided, a lack of coordination for services, a lack of a coordinated referral system, a lack of a clear authority structure and conflicting perspectives by different disciplines on the team regarding the role of the CPT. Of these issues, all were rated as somewhat of a problem or a major problem by seven to 11 of the respondents.

The next survey question involved identifying ways in which a CPT can best provide services to its clients. Respondents were provided with a list of six methods in which a CPT can provide

services and asked to rate their level of agreement with each statement. The six methods included high quality of service, better caseload distribution, efficient response, variety of services, clear policies and procedures, and strong leadership. The majority of respondents replied that they strongly or somewhat agreed that all six methods represented ways in which a CPT can best provide services to its clients.

In response to the question, “what are the two major areas of development that your CPT needs to address?” there were a variety of comments. These comments included increased funding, increased personnel, training, overall family service, health service, alcohol treatment, tribal counselors, politics, jurisdiction/sovereignty, lack of reports, classes for kids, increased client contact, accountability, status of cases, development of procedures, child sexual abuse treatment, family treatment, and commitment to the team.

The final section of the survey covered personal background information on the survey respondents. Respondents represented a variety of educational levels. Four respondents have completed high school or GED, two have completed technical/vocational school, two have completed “some college,” three have associate degrees, eight have college degrees, and six have graduate degrees. Respondents had majored in a variety of fields of study including psychology, social work, teaching, office techniques, public administration, counseling, medicine, law, accounting, criminal justice, nursing, community service, and law enforcement.

Years of experience among respondents ranged from one to 21 years, with half of the respondents having 12 years or less of experience and 12 having more than 12 years. Respondents have worked for the agency between one month and 15 years. Half of the respondents had worked for their agency for three years or less. Only three reported working for over six years.

## CONCLUSIONS

Any conclusions drawn from such a limited data set are suggestive, at best. Some possible trends in the telephone survey data bear further elaboration. For example, responses to the telephone survey indicate basic satisfaction with organizational CA/CN policies and procedures. These results suggest that workable frameworks exist within tribal programs for handling CA/CN cases. However, barriers to the sharing of information do exist. The major barrier involves concerns regarding confidentiality. While such concerns are quite appropriate, it is important for programs to recognize the various ways that information can be shared among those with a need to know and still protect a client’s privacy. For instance, case data can be maintained by using only identification numbers, rather than actual case names. Agency personnel need to be aware of provisions within federal law, such as P.L. 101-630, **which** explicitly sanctions the sharing of information among those with a legitimate need-to-know (information that should be available to only those people who have a legitimate use for it, such as in the course of doing their job(s)). This Law allows for the possibility of a central registry which would pool information from contributing agencies in order to track the offender. There was strong support

for this type of central registry. It is hoped that the IHS would support the efforts underway to initiate such a registry on the federal level.

The clear consensus of responses to the questions in Section II (staffing and personnel issues) show the needs for more training and for more staff in all areas, mental health, social service, law enforcement, judiciary, etc. These widespread needs will be difficult to meet with impending budget cuts. The MS must work with tribal programs to develop a strategy for meeting the staffing needs in the medical, social services, and mental health arenas. It may be possible to **identify** alternative means of staff deployment to fill existing gaps. The MS should also work with tribal programs to meet staffing shortages in other areas such as law enforcement and the judiciary. The MS could, for example, support cross-training programs, multi-disciplinary approaches, and funding requests by tribal programs seeking support for such endeavors.

In the area of training, the MS must work with local, regional, and national organizations to fully utilize available training resources. In recent years, there has been a proliferation of opportunities for training in CA/CN and for the coordination between different groups and agencies. The MS could “piggy-back” their training sessions with other training activities so that participants could participate in both.

The MS has funded a number of training initiatives related to child sexual abuse in the recent past, including “Project Making Medicine,” a project aimed at training mental health providers to provide effective services to victims of child sexual abuse, and the juvenile sexual perpetrator program, training mental health workers to provide on-reservation treatment to juvenile sexual offenders. In the DOJ, the OVC administers funding for the discretionary grant program for Victim Assistance Programs in Indian Country (VAIC), a program which provides victim assistance services to victims of child abuse, and the discretionary grant program for the CJA to improve the investigation and prosecution of child sexual abuse cases. Both of these OVC-funded programs deal with child sexual abuse victims.

Each of these four programs, two by the MS and two by the OVC, includes a training component. Training sessions are offered on a regional or national basis solely to participants in each of the specific programs. With only a little bit of coordination, it could be possible to provide a wide range of training opportunities to participants in all four programs. For example, participants could take part in a full week of training at little additional cost to the training they currently receive. The OVC could sponsor a two-day training focusing on victim advocacy and improving systemic responses to child sexual abuse (CJA and VAIC programs), followed by an IHS-sponsored event of treatment for victims of child abuse (Project Making Medicine), and a final day of MS-sponsored training on juvenile sexual offender treatment issues (Juvenile Sex Offender Treatment Program). Such an arrangement would provide a holistic training experience for participants of all four programs at little additional expense to each program and would provide a demonstration of cooperation and resource-sharing between government agencies.

Section III of the survey concerning jurisdiction and interagency issues showed strong support for tribal programs. These programs received broadly favorable ratings. Survey respondents voiced several common concerns, including the lack of adequate funding, Indian staff, cultural sensitivity, the use of traditional healing, and interracial unity. Many of these concerns reflect a lack of cultural understanding by non-tribal service providers. The IHS can take a lead in this realm by developing cultural sensitivity training, providing training to both IHS employees and non-Indian service providers working with Indian people.

The responses to questions in this section of the survey highlight the need for interagency cooperation. The most positive responses to working with external agencies included comments about the non-tribal programs' willingness to cooperate and to participate in joint training and activities with tribal programs. Once again, the MS can take a leadership role through the inclusion of non-tribal program staff in training and other activities.

Treatment issues form the focus of Section IV. Once again, a consistent theme is the need for increased mental health services. These include general counseling, substance abuse, parenting skills, prevention, residential treatment, group therapy, family counseling, and crisis intervention. While there is a need for increased mental health services, few programs deny services to people. Service providers appear to do their best to supply some assistance, despite limited resources.

An important area for future exploration involves some respondents' unfavorable reactions to referring clients to the BIA, municipal agencies, and private agencies. Another area of potential concern involves some strong negative comments regarding the MS. It is important to explore the nature of these negative feelings. There may be actions that the IHS can take to improve the relationships between the community and MS personnel.

Survey respondents indicated that they frequently use traditional approaches to treatment and interventions. However, they reported utilizing actual traditional healing/ceremonies less often. This situation may be the result of a separation of traditional healing ceremonies from the "western" version of therapy. Not all clients are receptive to culturally-based interventions. A future area of investigation would be to explore how programs successfully integrate traditional healing ceremonies and healers into their programs.

The only area of unanimous assent involved the support for a secondary prevention program. This support represents a basis for implementing secondary prevention programs, such as the New Beginnings Program, in Indian communities. The success of the NIJC New Beginnings Program on the Wind River Reservation offers a replicable model for other Reservation communities.

Section V addressed client access to services. There were several major barriers identified, including lack of transportation, programs situated too far away, a lack of awareness of programs, too much red tape, a lack of needed services, a lack of **staff**, and a lack of outreach to tribal communities. The next section, Section VI, dealt with **CPTs**. Most communities reported

having CPTs. The existence of these teams offers vehicles for multi-disciplinary training and advocacy for child abuse victims.

The final section of the survey reveals that the majority of those people filling out the survey have a college education. There appears to be a high level of staff turnover; over half of the respondents had worked for their agency for three years or less. Staff turnover is a major problem for tribal programs. Enormous time and energy is expended in hiring, recruiting, and training staff. This results in a lack of continuity of care for clients who may have two or three different therapists in the course of treatment.

For the non-Indian working in Indian country, it may take a year or two to become familiar with the community and for the community to build trust in her/him. Just as people begin to feel comfortable with non-Indian staff, they leave the community. It was determined that the IHS policy that has encouraged Commission Corp staff to rotate assignments after a two year period has contributed to continuous staff turnover.

### **MAIL SURVEYS**

Due to the small mail survey response rate, it is not possible to report the aggregate data. This data can only be considered as anecdotal and illustrative. The data provides some direction for future investigations. Selected items from the survey are presented to suggest areas of future exploration.

The first section of the mail survey requests information concerning funding. Each of the 4 diverse programs is represented by only one or two responses, which makes it impossible to assess funding aspects of these programs. Three of the programs (including both judicial programs) responded that they frequently had problems providing needed services to clients due to a lack of funding. In specifying the types of services the program was unable to provide, the following responses were received: "Cannot fill position of juvenile officer who monitors offender cases and oversees diversion program which is dysfunctional;" "cannot fill probation officer position who coordinates community service program, work release program and supervises probation for adults and juveniles;" "unable to secure appropriate housing for needy clients;" "shelter home, foster care, transportation, long-term foster care, routine respite care, prevention programs, safe house, recreational programs, runaway hotline;" "psychiatric evaluations, treatment/counseling, family preservation." These responses show the variety of unmet needs. Not only are there personnel considerations, but all types of services, ranging from transportation and shelter to psychological counseling, are in short supply.

Section II requested information regarding child protection teams. Four of the five respondents stated that their tribe has a program that specifically addresses child protection and/or child abuse and neglect. When asked to provide a description of the child abuse and neglect program, each of the respondents provided a short description of their own role in child abuse cases.

Section III involved staffing and personnel. Each of the programs reported that the majority of their staff is American Indian or Alaska Native. All five respondents indicated that pre-employment background checks are carried out on staff members who have direct contact with children. Background checks include the verification of credentials, reference checks, criminal record checks, and personal interviews. None of the programs utilized written reference checks from past employers or drug testing in their pre-employment investigations. In order to deal with child abuse and neglect, programs claimed to need additional experienced staff, funds for contract services, an interview room, investigators, shelter/foster care, vehicles, and a guardian ad litem for representation of the child.

In terms of training, three programs reported that they had not provided any training in prevention, detection or diagnosis, forensic exams, interviewing, reporting, investigating, testifying, or prosecuting child abuse cases. Two programs reported that they had provided some types of training. The two major training needs identified were regarding community awareness, professional staff directly involved in child abuse/neglect cases, investigation, mental health issues, court procedures, detection, diagnosis, and the scientific aspects - including the effects on a child - of abuse and neglect.

In the area of interagency relationships, the consistent finding was that no formal written protocols exist between the various health care, social service, law enforcement, and judicial agencies. Regarding mandatory arrest, two of the five respondents indicated that the tribe has mandatory arrest provisions. In four of the areas, child abuse and neglect cases are usually processed in tribal courts. Two tribal courts have a separate juvenile justice division and two do not. Three of the four tribal courts have written statutory provisions or ordinances addressing child abuse and neglect. Only in Alaska did the state have jurisdiction over tribal courts. There are no written protocols or MOAs governing the interaction between educational systems and tribal programs.

Four of the five respondents reported the existence of a CPT. The meeting frequency of the teams varies from once a week to once a month. The primary function of these teams is case management and follow-up. Three of the teams have written policies and procedures, but none has a funded coordinators position. None of the respondents was aware of the MS Family Violence Prevention Team.

Section VI of the survey involved the treatment or services in child abuse and neglect cases. Two respondents replied that their organization does not provide any type of treatment services. Of those that did provide services, the average duration of services treatment ranged from one to two years.

Section VII queried clients' access to services. The four organizations which responded to this section indicated that clients have problems in accessing all types of services. The most consistent problems in accessing services from external agencies were finding correct services and the money to pay for them, transportation to and from the sites and child care, proving a

client's need, and networking and coordinating existing services so that information is readily available to the court when the need arises in a case. Only two of the organizations, the two tribal courts that responded to the survey, reported numerical case data. All of the four agencies that reported data on referral sources reported that the majority of their referrals come from law enforcement, social services, and schools.

Section IX refers to the policies and procedures regarding definitions, records management, case reporting, and central registry for child abuse and neglect cases. All programs, except Alaska, reported that tribal statutes provide the primary basis of their organization's definition of child abuse and neglect and that there is a differentiation between emotional, physical, and sexual abuse. These four programs utilize individual personal computers which cannot communicate with other computers. Only the program in Alaska reported a computer networking system.

Only one agency stated that it collects data on all 10 Areas listed in the survey: type of abuse, location of abuse, information on the victim, information on the offender, information on the victim's family, information on the offender's family, type of **offence**, prosecutions, conviction, and substance use.

In regard to information sharing, all agencies reported that information regarding child abuse and neglect is shared with other agencies on a need-to-know basis (information that should be available to only those people who have a legitimate use for it, such as in the course of doing their job(s)) through written request and approval or a court order. The most common obstacle in sharing child abuse and neglect information with other tribal agencies concerned confidentiality.

Three of the agencies use written protocols for reporting child abuse and neglect (one of these agencies stated that the written protocol is state law), but only one includes all six elements listed in the question: procedures for prioritizing cases, procedures for reporting time frames, procedures for prioritizing contacts with other agencies, interviews with the victim, interviews with the offender, and medical exams or referrals for exams. The penalties for failing to report child abuse and neglect varied among programs. Two programs reported that there were no immunity provisions for protecting an employee who reports abuse.

The final set of questions in this section deals with the need for a central registry. Four of the programs were in favor of a national central registry for child abuse and neglect. Agencies responded that they would appreciate the ability to track offenders and to collect data on the incidence of child abuse and neglect. None of the communities represented in the sample had a central registry. All five of the organization's responding stated that they would support a secondary prevention program in their community.

#### SUGGESTIONS FOR FUTURE RESEARCH

The small response rate to the mail and telephone surveys of tribal programs suggests that an alternative form of research design should be used with this population. One possible problem in

the current survey effort may have been the extraordinary commitment of time to complete this instrument. It may be possible to utilize telephone surveys that are less ambitious in the nature of the data collected. A brief survey that could be completed in under 10 minutes might have allowed people to be surveyed "on the spot," rather than during a scheduled appointment. When an appointment was scheduled, respondents were **often** unavailable at that time.

Similarly, a shorter mail survey may have elicited a larger response. Although Section X was voluntary, people may have noticed the survey's extreme length (29 pages) and immediately disregarded it because it would be too time-consuming. An abbreviated version of the mail survey may have been more **successful**. An all-together alternative method of data collection might have been more effective because of the nature of the mail surveys; mail survey research has an expected return rate of under 30 percent. The effort and expense involved in the current survey would have been better utilized in an alternative type of data collection. One alternative would be to collect the data in person. It may be possible, for example, to collect data at an area meeting attended by tribal department heads by surveying participants at the meeting (e.g., after the conclusion of the day's business meeting or schedule time into the meeting day). For example, the MS hosts a yearly mental health conference. This conference is attended by both the MS and tribal employees. With MS support, it would be possible to survey participants as part of the conference activities. Follow-up data could be collected by telephone to supplement information collected at the conference.

Another alternative would be to collect on-site data. The participation rate is likely to improve with personal contact. Yet, this alternative would take considerable costs and time. If certain geographic regions were selected for data gathering, it would be possible to have a staff member travel to those agencies and collect data in person. Some states, such as Arizona, New Mexico, California, and South Dakota, have large numbers of tribes within their borders, thus enabling research staff to gather data from numerous tribes with only one visit.

The main difficulty with Phase III data collection was the tremendous time-gap between the federal surveys and the tribal surveys. It is anticipated that the response rate to the tribal surveys would have been much higher if the staff hired for the federal surveys could have also administered the tribal surveys. These staff members had vast experience(s) in survey administration that was lost when other staff had to be trained to administer the telephone surveys. The original staff also had personal contacts with each of the tribes which would have facilitated **identifying** appropriate contacts for the tribal survey. Considerable time and energy was spent in attempting to locate suitable participants for the tribal survey. If future projects of this type are undertaken, all data collection instruments for the entire project should be approved prior to any data collection. The piecemeal nature of the **OMB** approval for the instruments was a major impediment to the completion of this project.

#### POTENTIAL AREAS OF INVESTIGATION

The small response rate precludes any type of generalization from the results. There are some items which suggest areas for future research. Programs seem to experience an inability to

provide needed services due to the lack of funding as well as an inability to recruit and hire appropriate staff. The lack of accessible services also seems to be a common problem. There is a need to assess current gaps-in-service. In order to ensure that all types of these gaps are identified, information must be gathered from representatives of a variety of agencies and disciplines. Programmatic and community needs can only be effectively addressed by policy-makers if the needs are comprehensively and systematically documented.

It appears that communities have existing CPTs. The IHS should explore ways of bolstering existing teams through an evaluation of team needs (training, equipment, resource materials, etc.). It can be helpful for tribal CPTs to meet with other teams and share information about their policies, procedures, and common concerns. Current training opportunities rarely address CPTs as teams; rather, they focus on each team member's individual affiliation. Social workers attend social work training, law enforcement attends law enforcement training, physicians attend medical training, and prosecutors attend judicial training. Cross-discipline training for all CPT members as a team could allow teams to function more effectively.

While tribes may be performing background checks on employees working with children (as mandated by P.L. 101-630), the types of checks that are performed vary. It may be useful to develop a model policy for conducting background investigations for prospective employees in positions dealing with children. Tribes may be encouraged to solicit written reference checks from past employers as an additional step to strengthen the investigative procedure.

There appeared to be concern about a lack of manpower to provide needed services for dealing with child abuse and neglect. Vital services, including experienced investigators and a representative for children in the court, were mentioned. Once again, the MS should investigate the exact needs of tribal programs which are currently unmet due to personnel constraints.

It is unclear what levels and types of training are being provided to tribal programs. There were a number of areas in which respondents requested training. There needs to be an effective mechanism for providing on-going training to tribal employees. Rather than expending scarce resources on future surveys in this area, it would be useful for the MS to develop an effective plan for ensuring that tribal employees receive appropriate training in all areas of dealing with child abuse and neglect cases. It is suggested that any training activities undertaken by the IHS involve cross-training of representatives of various agencies.

With regard to interagency relationships, the fact that none of the respondents reported the existence of formal written protocols between agencies is suggestive that the protocol development may be an area for future attention. The MS may want to explore their role in facilitating the development of interagency protocols. The lack of interagency relationships is partly due to the variation within the separate agencies. For example, there appears to be variability in how child abuse cases are handled in tribal court. Such variability is not unexpected, given the many jurisdictional issues in Indian country and the differing stages of

development of tribal courts. The existence of a separate juvenile justice division within tribal courts may be a reflection of a lack of funding, rather than a lack of interest.

The issue of the existence and role of the child protection teams remains unclear. It seems that many tribal communities do have CPTs, but their roles vary from community to community. Such variance may reflect differing community needs or a lack of exposure to the variety of activities that a CPT can engage in.

The fact that none of the organizations surveyed were aware of the MS Family Violence Prevention Team suggests that tribal workers may be unaware of an excellent and important resource. The IHS must engage in a wide-spread public relations campaign to increase tribal awareness of this team. This apparent lack of resource knowledge suggests that there may be other resources in existence that tribes are unaware of. In this age of budget restrictions and cuts, tribes must be able to access all possible resources. There must be a more effective way of disseminating information.

The survey provides little information on the availability of treatment services but does suggest that, when treatment services are available, these services are provided on a long-term basis. There was clear sentiment that additional mental health services are needed in virtually every area. It is worthwhile to look at successful programs and to document the creative means which some tribes have developed to utilize limited resources.

# **NEW BEGINNINGS IN INDIAN HEALTH A MODEL FOR PREVENTION AND INTERVENTION**

## **INTRODUCTION**

Recent investigation in the CA/CN field shows that the single, most effective strategy for preventing CA/CN is to provide parents with education and support from the time a child is born. An early opportunity for prevention and intervention begins at birth, when new parents have a heightened interest in developing good parenting skills. The first year of life is usually the time when abuse or neglect is most likely to occur and is a time to ensure the development of positive parent-child bonding.

Home-based early intervention programs, such as Hawaii's Healthy Start Program, have solid evaluative and theoretical bases on which to build and replicate (Breakey 1991). This is the model that was chosen for the prevention of CA/CN in Indian communities. The program developed for the Indian Health Service (MS), entitled "New Beginnings in Indian Health" (hereafter referred to as "New Beginnings"), was funded at the rural Wind River Service Unit in Fort Washakie, Wyoming. The program development protocols initially included an implementation plan for an urban Indian setting (Alaska Native Medical Center in Anchorage, Alaska), as well, but funding constraints allowed for only the one program at Fort Washakie.

Data from early intervention programs indicate that the risk of CA/CN is significantly reduced if a continuum of support, education, and therapeutic services are made available to families. Recent data from Hawaii's Healthy Start Program (1985-1988 and 1987-1990) show that no CA/CN was reported in 99.8 percent of families participating in the program who were identified as "high-risk." Control group studies showed that incidents of CA/CN were reported in approximately 20 percent of high-risk families who did not receive services. Moreover, there was a 99.8 percent accuracy rate in correctly identifying families as "not-at-risk." Families who fell below the cut-off for services on the assessment tool did not move into the at-risk category within the five year follow-up period. Hence, services appear to have been offered to the families most in-need of those services.

Reducing the incidence of child maltreatment includes promoting healthy child growth and development. The basic requirements for healthy growth and development include adequate and continuous pre-natal care, primary health care and health promotion, proper and adequate nutrition, parental competency and social support networks, quality child care, home visitor services, and linkages to agencies. Services for vulnerable families should fulfill these developmental requirements by enhancing family coping skills, improving referrals to services, and fostering self-sufficiency. The nature of the home environment influences the treatment of children (Hamburg n.d.).

P.L. 10 I-630 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 innovative and culturally-relevant programs and

projects as the Secretary may approve, including program and projects for home health visitor programs.” The program designed through this research follows the intent of this Act. While federal recognition and support is a powerful force for program development, the knowledge that the New Beginnings Program is appropriate for the needs of AI/AN families and the realities of service provisions in AI/AN communities are the primary considerations for the implementation of this program.

The New Beginnings Program incorporates a multi-disciplinary approach and was designed to address the specific social and cultural needs of clients and the Fort Washakie community. This Program presented an opportunity to increase services and support for families in-need, reverse the rising incidence of child maltreatment, and reduce the physical, emotional, and social costs of maltreatment. This Program directly addressed the basic needs of children and families and was individualized according to the specific needs and risk level of each family.

### THE HOME VISITOR APPROACH

The impetus for the development of home visitor programs in the U.S. grew from the work of Dr. Henry Kempe. Dr. Kempe gained national attention in the early 1960’s with the definition of child maltreatment as a medical phenomenon. Kempe proposed that every mother-to-be have a paraprofessional home visitor who could work with the family from pregnancy until the child reaches school age.

Home visitors, either professional or paraprofessional, provide a wide range of social, health, and/or educational support services in the home to individual children and/or families. Past program experience suggests that paraprofessionals are preferred to professionals as home visitors. Locally recruited paraprofessionals are felt to be: (1) more culturally compatible; (2) better able to focus on an array of issues of importance to the child and the family; and (3) better able to help families connect with a variety of other needed services, including professional services, as appropriate.

Home visitors can provide several important services, including: (1) services that are difficult to provide in clinic settings; (2) outreach and liaison between the family and health and social service provision agencies; (3) attention to socio-economic issues that directly affect the child and the family; (4) reinforcement and follow-up of preventive care; and (5) peer support and encouragement in a less-threatening environment (the family’s own home). Home visitor services can augment clinic-based services, thus effectively reducing the time and effort that medical providers must now spend addressing the “new morbidity” (the psychosocial, behavioral, and environmental influences on a child’s well being).

For a home visitation program to be effective, home visitors must visit frequently enough to establish rapport with families, identify family strengths, use a structured, yet flexible curriculum, and summon available formal and informal community support for families.

Home visitors are particularly appropriate for rural settings (Chapman, et al. 1990). In these areas, particularly on Indian Reservations, problems of isolation and transportation make it difficult for families to participate consistently in center-based programs. Even when urban and rural families can access programs, family members may be uncomfortable with standard health programs such as group programs or clinic settings.

Studies of home visitor programs have found them to be very effective in reducing child abuse and neglect. In studies of high risk mothers (mothers identified as being at high-risk of abusing their children), there were fewer cases of verified CA/CN perpetrated by mothers who received home visitor services than by those who did not receive such services. Support for these findings also exists in comparisons with control groups. In one study's support group, the incidence of CA/CN increased with the risk for maternal dysfunction, a trend that did not exist in the group visited at home by nurses. Overall, home visitation proved to be a powerful means of preventing child maltreatment.

In the past two decades, home visitor programs across the country have been studied and evaluated. The most successful programs had several things in common. They all provide parent education regarding infant and child development, involve family and friends in child care, thus strengthening the mother's informal social support system, and link the family with other health and human services.

The most successful models also integrate health education and social support. This combination serves to influence the behavioral, psychological, physical, social, and economic environment of the mother and child. To be optimally effective, home visitor programs must simultaneously address parental behavior, child development, situational stressors, and social supports that can either interfere with or promote a healthy pregnancy, positive birth outcomes, and successful child rearing.

The optimal situation is one in which all children and families will benefit from home visitor programs and other services. However, where resources are limited, the program must focus on high-risk families. By focusing services where they are most needed, the program has the highest probability of preventing CA/CN, thus avoiding the problems that arise when interventions are offered only after maltreatment has occurred. Furthermore, high-risk clients are more responsive to health care interventions and more receptive to project services than are low-risk clients, (Olds et al., 1990). These at-highest-risk may show the greatest benefit from an intervention.

Important considerations for new programs are the immediate and long-term financial costs. Costs of home visitor programs can be kept low with the use of both locally available resources and paraprofessionals. Preliminary cost-benefit analyses suggest that a major portion of the cost for home visitation can be offset by avoiding foster care placements, hospitalizations, emergency room visits, costs associated with the time of child protective services staff, court costs, costs of incarceration, the concomitant of substance abuse, and the costs of tertiary prevention services .

Over the long-term, communities who invest in CA/CN prevention will benefit both financially and in terms of reducing human suffering.

## THE NEW BEGINNINGS MODEL

### PROGRAM GOALS

The immediate and long-term goals of this Program include: (1) enhancing child physical and emotional development; (2) promoting positive parenting; (3) enhancing parent-child interaction; (4) assuring that all families have a primary medical care provider and a medical home; (5) assuring the appropriate use of community resources; and, ultimately, (6) preventing child abuse and neglect.

### PROGRAM COMPONENTS

The Program is comprised of components designed to maximize Program effectiveness while providing flexible and personalized services to at-risk families. These components include the early identification of families at-risk home-based intervention services; the intensity of services based on family's need and level of risk; a linkage with a medical home; the referral and coordination with other community service agencies; the coordination with child protective service agencies; and the continuous follow up with the family until the child is five years old.

### PROGRAM BENEFITS

The benefits of this Program vary and will promote long-term positive change(s) for individual families, service agencies, and communities. The benefits include, above all, the substantial prevention of child abuse. The Program also allows for the systematic and early involvement of health, social services, and educational agencies. Reductions in the incidence of CA/CN and costs of abuse-related services, coupled with increases in the number of healthy children and families, will inevitably reduce the costs correlated to child abuse.

### ADDITIONAL CONSIDERATIONS FOR THE INDIAN HEALTH SERVICE

The Program designed for the MS goes beyond the basic Hawaii model. The IHS is in the position to screen and identify families pre-natally. This implies that it need not wait until birth to begin the process of early identification and home visitor contact. The MS must also make an aggressive commitment to the needs of sexually abused victims and their families. The needs of child sexual abuse victims, families, and offenders can no longer be minimized or ignored. The physical, emotional, and spiritual needs of AI/AN people are essential parts of health care. The incorporation of American Indian culture in treatment according to the needs of individual communities is an important consideration for the MS. The MS must also make some provision for services and/or treatment for offenders, for it does not make sense to treat only the victim. The research has shown that offenders include parents and family members and that substance abuse is a major factor in a majority of CA/CN incidents. The MS must coordinate services with alcoholism programs when such a need is indicated. The focus of any CA/CN intervention should be comprehensive and family-oriented.

## IMPLEMENTATION OF THE NEW BEGINNINGS PROGRAM

The implementation of the New Beginnings Program required significant modification from the ideal Healthy Start model. Many of these modifications involved changing the Program to meet the resources and needs of the Wind River community. Some of the changes reflect the cultural considerations which are addressed in the next section of this report.

The New Beginnings staff began work on June 21, 1993. The staff consisted of a full-time Program Manager and three part-time FSWs. The Program's goal was "to prevent child abuse/neglect by having family service workers provide intensive outreach and liaison services to pregnant women, newborn infants (up to three months of age), and their at-risk families." The New Beginnings Program illustrates a cooperative tribal/federal coordination. The MS provided many in-kind services to the New Beginnings Program, including staff supervision, training, use of a vehicle, telephone usage, office supplies, and office space. The Arapahoe Tribe provided in-kind contributions in the form of office space and training.

The Program staff reviewed the materials used by the Hawaii Healthy Start Program, local agencies and the IHS. This information was then modified to reflect the needs of clients in the Fort Washakie community. Materials used in the Program include the NCAST, genograms, and a specific curriculum.

The biggest barrier to the implementation of the New Beginnings Program was the lack of certainty regarding funding. Concerns about the Program's future impacted the ability to retain staff and to provide **effective services**. Although the New Beginnings Program was established to provide services to families over a five-year period, the Program only existed for 13 months. The Program never had the opportunity to impact families as was intended. While the Program was successful with the clients who participated, it is not possible to evaluate the New Beginnings Program because it never had the chance to fully develop. The New Beginnings Program is designed to promote interagency and interdisciplinary interaction and coordination of services. While the Program is flexible with regard to local needs and the availability of local resources, there are three primary components of program structure, administration, medical, and human services.

### ADMINISTRATION

In the Wind River Program, a community member was hired as the New Beginnings Program Manager. This person undertook the Program's administrative functions, providing oversight, planning, and administration. Additionally, she set local Program goals, standards, objectives, priorities, and developed evaluation components and quality assurance. Due to funding constraints, the ideal computer-based data management system was not implemented.

The Program Manager and FSWs gathered and recorded data in client records on an on-going basis. Since the Program was housed in the MS, project **staff utilized** the MS record keeping system (Patient Care Component (PCC) forms). The original PCC forms were placed into the

clients' medical charts, documenting their participation in the New Beginnings Program. No additional documentation was kept in Program files in order to maintain confidentiality. The Program Manager provided weekly narrative progress reports to the NIJC and the on-site project supervisor.

The Program Manager also had responsibility for personnel recruitment, training, retention, and oversight; she promoted interagency coordination and developed memorandums of interagency agreements. The Manager was able to recruit and train a total of three staff members. Staff retention proved to be somewhat of a problem, in part due to the uncertainty of funding. Moreover, the Program Manager supervised and organized the training of the New Beginnings FSWs in providing intensive outreach and liaison services to pregnant women, newborn infants (up to 3 months of age at intake), and at-risk families.

The New Beginnings Program was able to work well with both on and off-reservation agencies. The external agencies provided training to Program staff and referred families to the Program. They utilized the New Beginnings Program during its existence, indicating a definite need for this type of service. The interagency cooperation was a strong component of the New Beginnings Program.

### **MEDICAL**

The IHS is the local primary provider of medical care to treat and document maltreatment. It provides needed exams and medical services for cases reported to tribal agencies or the BIA Law Enforcement. Within the context of the New Beginnings Program, the primary function of these medical services is to act as the medical home to Program children. This required coordination between all medical staff working with the child, including the pediatrician, the child health specialist, and the child development specialist. The physician care coordinator is the link between the medical and human services branch and can also serve as a community liaison. The location of the New Beginnings Program within the Service Unit helped to facilitate interaction between the Program and medical staff.

### **HUMAN SERVICES**

In an ideal program, the human services branch is the primary service provider to program families. This branch houses both the early identification team, which provides assessments, screening, and testing, and the home visitor team. Human services also controls the services of the psychologist/master social worker (MSW) for crisis intervention, short-term counseling, therapeutic intervention, and referrals for more intensive services. The responsibility for resource networking with community, tribal, state, and federal agencies lies within the structure of the human services branch. The New Beginnings Program was not able to develop this part of the Program due to the limited life of the Program. The human services Program should facilitate and support programs such as parents anonymous, parenting classes, short-term counseling, emergency services, and crisis intervention. It should be a cultural/community liaison that links CA/CN services with substance abuse and domestic violence services, when needed.

Staffing should include a professional level social worker, a psychologist or psychiatrist, and a team of paraprofessionals. Our data indicate that the II-IS has significantly higher proportions of sexual abuse and physical abuse cases than does the BIA. These interagency differences clearly have implications regarding the types of services provided by each agency to child victims of abuse and neglect. The MS must be prepared to recognize, report, treat, and document cases of abuse. Training in these areas must be provided to the IHS staff.

Treatment of child abuse extends beyond a single branch of service provision. It is not solely a medical problem, a mental health problem, a legal problem, or a social problem. It is an issue that impacts every facet of a victim's life and therefore requires a multi-disciplinary approach. Nor is it the only problem that should be viewed this way. The majority of the social ills that plague Indian communities are complex phenomena that exacerbate existing problems and are perpetuated by the cycle of poverty and a myriad of social problems. Human services should become an essential component of the MS health care provision.

### **COMMUNITY/TRIBE**

The New Beginnings Program works with the community, as it accesses and utilizes locally available resources and expertise. Community-Program interaction is especially important in terms of the local child protection team; this multi-disciplinary team supports all three levels of prevention and intervention. The Fort Washakie MS actively participates in the tribal CPT. Communities should look seriously at the New Beginnings Program and at the IHS for support in developing programs, such as parents anonymous and appropriate parent education programs. These programs will be most successful if they include community awareness and promote interagency involvement, two important features of the New Beginnings Program.

Cooperation between different agencies, programs, and organizations is especially important to the New Beginnings Program. Throughout the year, this Program networked with a number of tribal and community programs, including all local high schools, tribal health, Best Beginnings, Wyoming Parent Information Center, Early Intervention, CHILD Project, Circle of Respect, Sho-Rap Rehabilitation, OMNIBUS adolescent after-care, Pine Ridge Drug and Alcohol Treatment Center, Lander Valley Medical Center, Riverton Memorial Hospital, Wind River Obstetrical and Gynecological Clinic; Fremont Counseling, WIC offices, BIA Criminal Investigations, Wind River Health Promotion, Tribal Social Services, Breast Feeding Promotion Task Force, FAS\FAE Prevention Task Force, BIA Social Services, Shoshone and Arapaho Indian Child Welfare Advocates, and the University of Wyoming extension office.

### **TRAINING**

The Program Manager organized training on an on-going basis for the Program staff. Other tribal agencies, as well as the MS, provided training for the New Beginnings staff. The FSWs were trained to screen and interview prospective clients. The II-IS Behavioral Health Director provided the basic Hawaii Healthy Start curriculum materials which were purchased through his department. New Beginnings staff members were trained in these curriculum materials during staff meetings. Additional training was provided by Dr. Sue Brown in the IHS Central Office

West. Dr. Brown addressed infant development, learning, infant developmental pre-screening, infant sleeping and feeding behaviors, and the use of the genogram in working with at-risk families.

The Program provided extensive staff training. Training topics included basic infant care, the dynamics of child abuse and neglect, child management techniques, safety in the home, FAS and FAE, bonding and attachment, child protection, domestic violence, sexual harassment, pre-natal care, blood-borne pathogens, breast feeding promotion, nutrition, child management techniques, behavior management, teen pregnancy, parenting, creative outreach, child management techniques, pre-natal labor and delivery class, self-defense, developmental disabilities, health issues of minority-women, Hanta Virus, healthy communities, traditional parenting, healthy mothers/healthy babies, child abuse detection, and advocacy for victims of crime.

The Program Manager took part in the NIJC training sessions, including a session in Hawaii in 1993. During this session, the Program Manager presented the New Beginnings project to workshop participants. Such presentations served to inform other tribes about the Program and to disseminate information.

#### **CLIENT SERVICES**

During the course of the New Beginnings Program, home visiting services were provided to a total of 18 clients. Due to limited funding, the Program Manager limited referrals to the Program. The limitation on the number of clients accepted into the Program allowed the FSWs to provide intense supportive services to families in their caseload.

New Beginnings utilized a level system for client service provision very similar to the level system used in the Healthy Start Program. The client level system was used as a case management tool to monitor the progress of client families. All 18 clients entered the Program at level one (requiring the greatest level of service) and remained at this level throughout the Program.

One FSW was based at each of the two health centers serving the Reservation. The Program Manager completed all intake summaries and at-risk assessments of clients. The Program received 35 referrals. Of these referrals, 20 were assessed as at-risk and 14 as not-at-risk. Eighteen of the 20 at-risk families accepted services and actively participated in the Program.

No family that participated in the New Beginnings Program was referred to the local child protection team. One of the two at-risk families that declined to participate in the New Beginnings Program was referred to the CPT. These numbers suggest that the New Beginnings Program was effective in preventing families from being referred for child protective services. When families were assessed as requiring additional assistance, they were referred to the MS Behavioral Health Department for follow-up services. The families participating in the New Beginnings Program were carefully assessed for child abuse or neglect on an on-going basis by Program staff.

## **PROGRAM OUTCOMES**

The Program was unable to secure an accurate data summary prior to the end of the operation. The data that was available showed that no parents were referred for child abuse or neglect during their participation in the Program. Fifteen of the client families showed improvement in the use of both formal and informal social support (well-baby visits, life lines to relieve stress, parenting classes, etc.) All clients improved their quality of parent-child interactions. There were no subsequent pregnancies in any of the participating families. Four Program participants passed their GED examinations, and one couple made plans to go to college.

All of the infants in the Program were up to date on their well-baby clinic visits and immunizations; they were also normal in growth and development. In addition, these 18 clients received 10 full months of home visiting services. Overall, New Beginnings had a significant and positive impact on the lives of all participants.

## **ATTEMPTS TO SECURE FUNDING**

The main handicap for the New Beginnings Program was the limited nature of the funding. From the Program's start to finish, services were overshadowed by the knowledge that funds would last only one year. A promising, successful program is no longer available due to this lack of funding.

The Program Manager sought alternative funding sources throughout the year. The NIJC staff assisted by revising funding proposals and provided other technical assistance in this area. Early in the Program, the Manager presented the proposal to the local BIA Agency Superintendent. The BIA funding constraints prevented the BIA from offering financial assistance. The BIA staff who were assigned to assist in the Program's funding efforts had their own job demands; they were unable to offer any assistance.

During the Program's implementation, the Shoshone and Arapaho Joint Business Council was expected to become the grantee for New Beginnings. However, this Council concluded that it would be in the project's best interest to have the MS as the grantee. The search for an appropriate agency to hold this position consumed significant amounts of time, thus contributing to the Program's short 13 month existence.

The Program Manager sought funds from a number of sources, including the State of Wyoming Family Preservation Program, Ronald McDonald charities, Charles Stewart Mott Foundation, AL Mailman Family Foundation, Robert Wood Johnson Foundation, and five unsolicited groups. Although the Program Manager researched possible funding opportunities, many potential funding sources were unavailable due to the lack of 501(c)(3) (non-profit) status. Most granting agencies required the Program to provide some matching funds, but New Beginnings had none to offer.

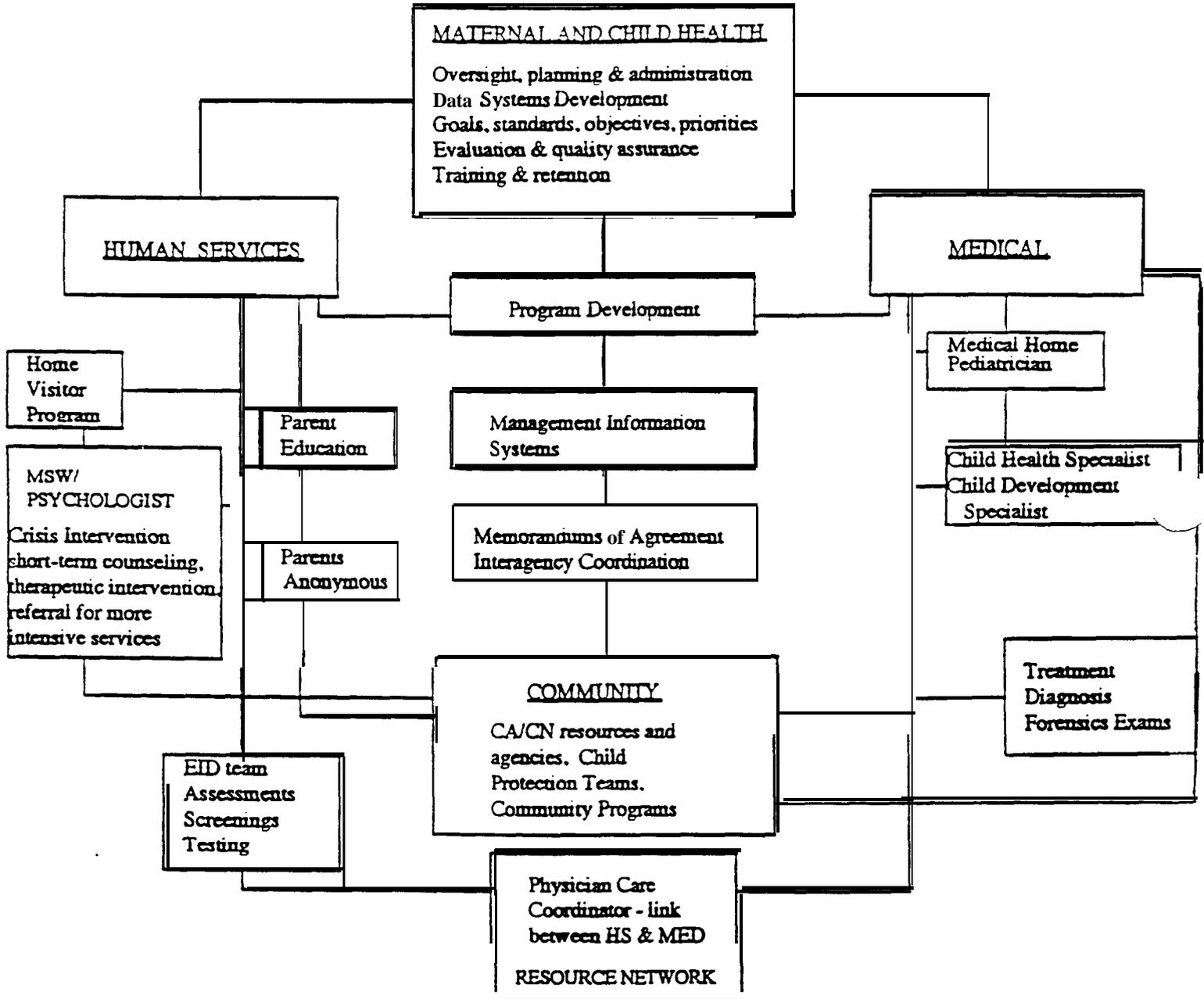
Significant time, energy, and money was invested in implementing the New Beginnings Program and training the staff. With the termination of the Program, all of these resources were lost. It is

imperative that any such program funded in the future be provided with a **full** five years of funding to enable the Program to show its efficacy.

### **DISSEMINATION OF PROGRAM INFORMATION**

Both New Beginnings and the NIJC program staff participated in local and national training events to discuss the implementation of the New Beginnings Program. Staff made presentations at the national conference on child maltreatment and at several **IHS** conferences. Information on New Beginnings has appeared in the NIJC Tribal Court Record, which is distributed to over 1,500 subscribers. Participants in the NIJC training sessions, including training for tribal leaders, have also been indoctrinated into the New Beginnings Program. The Program has been received with enthusiasm; there is a great deal of interest in implementing the Program throughout Indian country. Unfortunately, the lack of stable funding continues to be a major barrier.

## NEW BEGINNINGS IN INDIAN HEALTH



**Figure 15. Intervention Model Component Chart**

## NEW BEGINNINGS PROGRAM -CULTURAL FACTORS

The New Beginnings Program was designed to be culturally appropriate, community-based, family-centered, and comprehensive. It addresses the social and cultural identity of each community it serves and incorporates local beliefs and value systems into service delivery protocols. Support and preservation of American Indian and Alaska Native cultures are crucial for the survival of the indigenous peoples of this nation. The use of cultural references, along with human and maternal resources, provides an opportunity for tribes to enhance their indigenous methods for handling social problems and intra-familial conflicts; perpetuate their culture by engaging both members and non-members in culturally appropriate activities; apply approaches and techniques that are meaningful to the people being served; and enhance the cultural perspective of members by using and drawing upon cultural strengths. Only the tribe itself, is in the position to transfer, teach, or pass on the nuances of culture to an Indian child. This provides an opportunity for the Indian child to be culturally identified to the tribe and to become a tribal person who knows about the culture, language, history, traditions, ceremonies, rituals and community standards that make that tribe unique.

### Cultural Competence and Cultural Sensitivity

The inherent differences in world view, the role of family, and the social interaction within and outside one's Indian community environment, mandate awareness of culture as a factor in administering programs for Indian people. New Beginnings focuses on individuals and on their families. A successful program requires the integration of individual level and community level factors, as both levels are inherent in culture.

To limit the trauma of Indian children, youth, parents, and families involved in health, social services, justice and correctional systems, it is critical for these systems to be sensitive to the environment in which the individuals have been raised. Culture must be taken into account in at least three areas: (1) agency or program professionals and paraprofessionals need to be culturally sensitive; (2) the individual and family's level of cultural competency needs to be assessed; and (3) intervention programs must both address the needs of the Indian child, youth, or family, and determine the most appropriate course of action.

Striving toward cultural sensitivity implies that individuals working with Indian children, youth, and families must become aware of the cultural differences and must view these differences as additional resources, rather than as constraints to effective intervention. Cultural sensitivity requires the recruitment of Indian professionals and paraprofessionals whenever possible; it requires language interpreters when needed; it requires creative and assertive outreach to promote programs, and include an array of options and support systems that may exist from within the family and the tribal community.

Recruitment of professionals and paraprofessionals from within the community is essential to assist and develop services that interface with other community and family activities. In the New Beginnings Program, the home liaison workers are community residents who know the needs and

abilities of local Indian families. With training and experience, they can assist non-Indian providers to better understand and appreciate the differences between Indian and non-Indian societies. Staff selected from the community will know and understand the local demographics, manifestations of poverty, social problems, economic difficulties, and will know where to find available resources.

A major value in employing professionals and paraprofessionals from the community is their ability to relate to children and families in a supportive, non-threatening way. Recruitment of quality staff will be essential; therefore, the personal qualities of candidates need to be scrutinized. Since paraprofessionals are not expected to have degrees in health, social work, or mental health, it is essential that they be provided extensive orientation and training in order to improve their knowledge, skills, and abilities. The development training curriculum should include both classroom and on-the-job training. Using community members as workers is especially beneficial because it increases staff retention rates. If non-Indian professionals or paraprofessionals are hired, it is important for them to understand the difference between Indian and non-Indian society. Non-Indian staff should be acculturated to the community's economic, historical, governmental, geographic, socio-demographics, and relationships with local, state, and federal agencies before they begin serving clients.

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 will help facilitate trust and communication between service providers and families.

Cultural sensitivity also implies that the investigation and intervention processes take 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, and, thus, they may have difficulty responding to and accepting traditional methods.

Cultural competency/proficiency refers to the level of knowledge and use of cultural ideals and practices within the daily life of each child or family. For an individual to become culturally competent or proficient, it is necessary for tribes to take responsibility in making opportunities for learning about the culture available and accessible to members. Likewise, the individual, through his or her family, must take the responsibility of learning and acquiring the knowledge, skills, and abilities necessary to become proficient in his or her culture. Service programs in Indian communities must take into consideration both the micro-level social structure of Indian families and the macro-level social structure of Indian communities. Family dynamics reflect individual factors that support either family conflict or compromise. The age, gender, family history, education level, employment level, learning styles and role expectations of each family

member are key factors in developing family intervention. Many at-risk Indian families are vulnerable because they are young, socially isolated, under-employed, under-educated and overwhelmed by changing societal and family roles.

It is often the case that at-risk or in-need Indian families are extremely sensitive to discrimination and have had few positive experiences as Indians in a non-Indian world. As a result, they may lack knowledge about their culture and may view their heritage as a detrimental scar, thereby lacking the ability to integrate tribal traditions into their daily lives. This impairs the ability to effectively compete both in their tribal community and in mainstream society.

These factors and resultant family dynamics must be understood when conducting home visits. Positive factors can be supported, and negative factors modified. Indian families have many capabilities that can be accessed. When people, especially children, learn about and understand their culture, they often develop a sense of pride. This pride greatly enhances positive results with treatment or interventions and **future** behavior patterns. The New Beginnings Program strives to promote an individual level of understanding, encourage child development, address the needs of each family member, and enhance the existing strengths of parents who are constants in their **childrens'** lives.

The macro-level social structure of the community includes the extended family, clan systems, tribal political systems, and centuries of tribal customs, traditions, and practices. The community provides a framework within which families develop their value systems and cultural identity. Service programs must be in sync with the community in order to understand group dynamics, family allegiance, social support systems, the role of elders, and the use of rituals, customs, and traditions. In Indian communities, the existing human resources may be more important than the economic and programmatic ones. A program needs baseline macro-level information to be able to understand family dynamics in a community context.

### Culture and Society

The demographic and socioeconomic profile of American Indians and Alaska Natives may be similar to that of other minority groups within the U.S., but Indians distinguish themselves from these groups through their unique relationships with the U.S. Government. The concept of sovereignty gives federally-recognized 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. Tribes also have a trust relationship with the Federal Government as a result of these treaties. The MS and the BIA are mandated to provide assistance, and, as such, are primary foci of any prevention or intervention program. The MS has the potential to profoundly reduce the incidence of child abuse and to provide treatment programs for the victims, the perpetrators, and their families, effectively increasing the physical and social health and well-being of Indian people.

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

Social issues affect all AI/AN. Poverty is an issue for most AI/AN, as the median income is well below the poverty level. Poverty and unemployment exist at very high rates in Indian communities and can severely stress a family. Substance abuse, another major difficulty today's Indians must face, plays a role 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 child abuse increase as a society becomes increasingly modernized. Traditional ways of life offered support systems and coping mechanisms. As Indian people become more and more removed from these traditions, families are increasingly prone to abuse. With modernization comes the fact 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.

There is a severe shortage of foster and adoptive care in Indian communities, and issues regarding the mandates of the ICWA play a role in virtually every case of Indian child abuse. It has been estimated that 60 percent of misplaced Indian children relate to child abuse and neglect. However, the licensing of foster care homes by state agencies has often been a barrier for tribes because of the conflicting regulations and values between state agencies and the structure of most Indian homes. Because the New Beginnings Program focuses on early intervention with families, the need to remove children from their homes is greatly decreased. Thus, it keeps the family intact while they are receiving the necessary services and support they need to become a stable, strong family.

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 proximity of community members and extended families can also increase support for the child and the family.

Extended family can also be both an asset or a problem. The extended family has traditionally played an important role in Indian 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 interfere with successful intervention and treatment. Oftentimes, family members will protect a perpetrator, thus impeding an investigation.

Here again, home visitors play an important role. As community residents with a shared understanding of the local community, they can ensure that the program is flexible, accessible, and responsive to the needs and realities of individual families. The program uses local languages, customs, and traditions. It relies on community-defined modes of communication, community sanctions, community support systems, and locally available resources. As a community-based program, New Beginnings offers the benefits of maintaining ties with the family and the tribe and ensures an open path for the child and family to strengthen their relationship. It also provides an opportunity for the tribe to maintain a sense of responsibility for the child's benefits and to offer a welcoming attitude towards the family. It allows the extended family to remain a resource to the child and his or her family; and it provides an opportunity for the culture, language, knowledge, history, beliefs, values, etc., to be passed on to the child. A key component of the New Beginnings Program is that it address the issues of child abuse and family violence in the need to integrate an alienated family back into a community and a positive social support system. Tribal culture provides the means to develop and strengthen the link between family and community.

# THE ROLE AND THE RESPONSIBILITY OF THE INDIAN HEALTH SERVICE

## INTRODUCTION

The task of selecting the most appropriate intervention for the MS can be clarified by understanding the role of the MS in CA/CN. The MS has an important supportive role in primary prevention; the IHS should support and promote community prevention efforts to increase public awareness of CA/CN through educational activities and other methods. In tertiary prevention, the IHS has a shared role and responsibility with the BIA, tribe, state, and other agencies in providing services for CA/CN cases. As part of the response group, the IHS shares the responsibility for **funding** programs, providing staff with training to handle the needs of victims, offenders, and their families. While these are important roles, the IHS has the primary role and responsibility in secondary prevention. It has the responsibility for identifying at-risk families, providing needed services, and linking these families to community services. In doing so, the MS will be in a strategic position to reduce the incidence of CA/CN among AI/AN people.

The need for a national prevention effort is indicated by frustrating and **often** difficult tertiary intervention efforts (U.S. Advisory Board 1991), by the rising CA/CN report rates (U.S. Advisory Board 1991), and by the continuing and **often** expanding problems within local communities. The direct costs of CA/CN are seen in law enforcement, the judicial system, foster care placement, medical care, social services, victim/offender treatment programs, and the adult and juvenile correctional centers. Indirect costs of child maltreatment include substance abuse, depression, teenage pregnancy, juvenile delinquency, suicide, violent crime, and school failure.

## THE MISSION OF THE INDIAN HEALTH SERVICE

Although the demographic and socioeconomic profile of AI/AN may be similar to that of other minority groups within the U.S., the AI/AN differ **from** these other groups in the unique relationship tribes have with the U.S. Government. These factors directly impact issues of child maltreatment. Sovereignty gives federally-recognized tribes basic governmental powers. For example, tribes need not comply with the standards required of states regarding child abuse and neglect laws. Tribes also have a trust relationship with the Federal Government. Two federal agencies, the IHS and the BIA, are mandated to provide assistance and are the primary foci of prevention and intervention programs.

The primary responsibility of the IHS is to provide quality preventive and **intervention** services to Indian people. The MS has the potential to profoundly reduce the incidence of CA/CN, as well as to provide treatment programs for victims, perpetrators, and their families. The mission statements of the IHS and its branch services indicate a federal level understanding of this responsibility. How this mission is reflected in local communities, however, is an indication of the inconsistencies that exist in the delivery of services.

The MS policy and procedure regarding CA/CN indicate that: (1) the MS will provide prompt, comprehensive health services to the abused or neglected child and the family, assure a safe environment for the welfare of the child, and work towards the ultimate rehabilitation of the child and the family; (2) the MS will coordinate its activities with other community agencies towards the prevention of abuse and neglect; and (3) the IHS will provide appropriate health care to any AI/AN identified as, or suspected of, being a victim of sexual abuse.

- The MS Mission Statement - The mission of the MS is to ensure the equity, availability, and accessibility of a comprehensive, high quality health care delivery system providing maximum involvement of AI/AN in defining provisions for their health needs, setting priorities for their local areas, and managing and controlling their health program.
- Maternal and Child Health (MCH) Mission Statement - MCH is a coordinated multi-disciplinary approach being promoted in the MS service delivery areas to address the comprehensive health needs of AI/AN children, youth, and the family, emphasizing services to infants, children, and women in child-bearing years. Recognizing the importance of the family as the most basic unit of our society, an important objective for the 1980's was to promote family-centered care in all the IHS facilities providing MCH services. Sensitivity to cultural beliefs and practices relating to MCH is an important component of supporting the family structure. The goal of health care activities for women is to provide health promotion maintenance services relating to childbearing and the reproductive cycle, including prevention, intervention, and rehabilitation. Family planning services are important components of the comprehensive program to protect the health of women and promote a healthy and happy family environment.
- Mental Health Mission Statement - The mission of the mental health system for AI/AN is: (1) to ensure that mental health services are available to all AI/AN persons who need them, are appropriate to the nature and severity of their mental health needs, are of high quality, and are sensitive and responsive to the cultural values of the individual, family, and community; and (2) to promote the mental health of individuals, families, and communities.
- Social Services Mission Statement - The policy of MS social services is to: (1) assure that individuals, families, and groups will have access to needed social work services; (2) identify community and other public and private providers of health and welfare services for which AI/AN are eligible; and (3) evaluate MS-supported social work service programs against the standards contained in the IHS Social Work Policy and Procedure Manual.
- Community Health Representatives (CHR) Mission Statement - The mission of the CHR program is to provide quality outreach health care services and health

promotion/disease prevention services to AI/AN within their communities through the use of well-trained **CHRs** as mandated by section 107 of the Indian Health Care Improvement Act Amendments, P.L. 100-7 13 (November 23, 1988.)

### THE NEED FOR PREVENTIVE ACTION

This study noted that child maltreatment is a persistent, but inadequately addressed, problem in AI/AN communities. Problems with current intervention efforts include the lack of both substance abuse treatment programs for offenders and other offender-directed interventions, and attention directed toward primary and secondary prevention strategies. The mental and social health of AI/AN families are at serious risk of disintegration. Existing victim-oriented intervention programs and agencies, such as shelters and foster care, and offender interventions, such as incarceration, are not adequate to address the scope of **CA/CN-related** problems. The lack of a systematic approach to secondary prevention becomes particularly important in light of studies which suggest that those most in-need of services are most likely not to receive them.

The need for a national prevention effort is indicated by the difficulty of tertiary intervention efforts, by the rates of CA/CN reports, and by the continuing and often expanding related social problems within local communities. The focus of prevention and early intervention should begin at birth, when new parents show strong interest in developing good parenting skills. Birth is a time at which the development of positive parent-child bonding occurs and a time at which abuse is most likely. Families at-risk for maltreatment may also be at-risk for substance abuse, suicide, and poor health. The proposed program directly addresses the basic needs of children and families, individualized according to the specific needs and level of risk of each child and family.

Reducing the incidence of child maltreatment includes promoting healthy child growth and development. The basic requirements for healthy growth and development include adequate and continuous pre-natal care, primary health care and promotion, parental competency and social support networks, quality child care, home visitor services, and linkages to agencies. Services for vulnerable families should support healthy child development, enhance family coping skills, improve referrals to services (intensive, comprehensive, and continuous services) and foster self-sufficiency.

### PRIMARY PREVENTION

Primary prevention refers to activities that are aimed at the general population. Primary prevention efforts must come from within the community and must reflect sensitivity to attitudes, local power structures, and cultural norms. Such prevention should be mainly the responsibility of local, tribal, and state agencies, whose responsibility extends to the general public. The goal of primary prevention is to increase the community's awareness of child abuse and neglect, access local resources, and improve local laws and reporting procedures for all individuals and families within the community. Schools, social services, and law enforcement can all be involved in primary prevention. The role of the MS in primary prevention should be to encourage and facilitate community programs, provide expertise and support when requested, make literature available, and host parenting workshops.

## **SECONDARY PREVENTION**

Secondary prevention, activities aimed at families at-risk, should be the responsibility of the MS. The MS, as the primary provider of medical and, oftentimes, mental health and social services, is in the unique position to have access to families on a regular basis. Secondary prevention, more than either primary or tertiary prevention, is the best level for the MS to impact multi-problem families and effect positive change for both the short- and long-terms.

## **TERTIARY PREVENTION**

Tertiary prevention (medical and other types of clinical interventions) should be a shared liability between the MS and existing local and state agencies. As the primary provider of response services, the MS holds the burden of providing all needed services. However, existing cases require the kind of intervention not readily available within the MS. Treatment for the psychological effects of severe abuse for victims, offenders, and families requires a long-term, intensive, and continuous commitment to the patient. The reluctance of the IHS to commit to and provide long-term care requires restructuring of mental health goals. Until a commitment to the provision of long-term, intensive, family-centered, therapeutic services is made and implemented within the MS, some other provision for the needs of abuse victims must be made. This is where the IHS can use contract services, MOAs, and informal agreements with available local, tribal, and state agencies. Many Indian people are eligible for an array of services through Medicaid-type programs. These resources, services, and benefits are not being used sufficiently. In situations for which the MS is the primary provider of mental health and/or social services, the MS must evaluate the ability of their own programs to provide this type of long-term therapeutic intervention. Where tribal, local, or state mental health services are available, the MS should work to network with these services, serving as an information base for Indian patients.

## **WHY FOCUS ON THE FAMILY?**

Results from this study indicate that the overwhelming majority of reported cases (79.4 percent in the national data set) occurred in the victims' homes. While much attention has been focused on boarding schools and forces outside the family, these data show that CA/CN is primarily a problem that exists within the family; offenders in this data set were primarily nuclear and extended family members. National data indicate that over 90 percent of reported offenders were mothers, fathers, social fathers, and other biological and social relatives. The data also show that, in almost three fourths of the cases, abuse has been going on for months and even years. This indicates that abuse may be part of the regular pattern of family interaction for some victims. For this reason, a focus on the family is not only appropriate, it is essential in understanding, and thus preventing CA/CN.

## **WHY FOCUS ON PREVENTION RATHER THAN INTERVENTION?**

There are many studies which identify the high cost of intervention, as opposed to the relatively low cost of prevention. In addition to the monetary costs, the human costs to generations of individuals and families impacted by CA/CN are immeasurable and cannot be mitigated by any level of intervention. The effects of CA/CN last a lifetime and will frequently be transmitted

across generations and within and between families. The number of reported incidents is increasing each year. Regardless of whether increased rates are due to better reporting, more cases, or extraneous factors, there are many AI/AN families in crisis and at high-risk for CA/CN and other problems.

Data supporting the cycle of violence theory are substantial. Adults who mistreat their children and spouses frequently have histories of child maltreatment themselves. Abusive parents typically rely on coercive patterns of family interaction, indicating interpersonal incompetence or a lack of social and parenting skills. Because interpersonal incompetence and social skill deficits may predict abuse, they may also be a factor in the observed “inter-generational transmission” phenomenon. In one abuse study, relentless brutality, often condoned by other family members, characterized the backgrounds of children who committed murder. In another study, researchers found that nearly 82 percent of husbands who witnessed marital violence as children were also victims of child abuse by their parents. These men were also much more likely to be physically violent toward their wives. Children who are abused are more likely to become coercive with siblings and peers, and thus more likely to be rejected by those groups.

The association between CA/CN and suicide, juvenile delinquency, substance abuse, domestic violence, and the continuing cycle of family dysfunction, has long been known. The social and monetary costs to communities are staggering. Studies that have directly addressed the association between child abuse and later suicidal behavior show that those who attempt suicide are three to six times more likely to have been reported as victims of abuse or neglect. In addition, studies show that abused children have a significantly higher incidence of self-destructive behavior. There is also considerable evidence that abused children are more likely to become juvenile delinquents and/or adult criminals; they also abuse their own children, spouses, and siblings more often than children who have not been abused. Other studies have shown that, among delinquent youths, those committing violent acts were more likely than non-violent delinquents to have been abused. As many as 90 percent of juveniles arrested for delinquent acts report a history of abuse or neglect.

There are enormous economic costs associated with child maltreatment. A conservative estimate of the immediate costs of placement and medical and therapeutic services for victims is \$500 million a year; another \$600 million may be required for the foster care of each year’s victims or the juvenile detention of those abused children who themselves commit violent or criminal acts. This does not begin to address the costs for related issues, mentioned above, that tax the health, social services, law enforcement, and judicial services in every community. CA/CN also costs the community in terms of years of productive life lost; in 1980, child homicides accounted for an estimated 93,000 years of productive life lost. Thus, the stability of the social and economic structure of every community is threatened by the drain on public resources, due to CA/CN and related issues.

### **WHY COORDINATE CA/CN SERVICES WITH OTHER AGENCIES?**

The coordination of services, whether in a rural or urban area, seeks to develop a more effective network or system for identifying and serving families where abuse and neglect occur. The purpose of such coordination is: (1) to develop a service network in which the various agencies' roles, responsibilities, and relationships are clear, and (2) to avoid overlapping functions and to ensure that essential services are available to the community in order to provide the best system for helping families respond to their problems. It is also critical to coordinate with substance abuse prevention and treatment programs. Substance abuse was a factor in nearly three quarters (70.3 percent) of the national data set cases in which such data were collected. The prevalence of substance abuse varied somewhat with offender sex, relationship to victim, age, and type of abuse inflicted, but it was a consistent issue throughout the study.

The responsibilities of the MS in addressing issues of child maltreatment are to: (1) promote individual, family, and community wellness; (2) identify at-risk families 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 within a community context, with the extent of services being dependent on the needs of the community and the availability of alternatives.

## CONCLUSIONS AND RECOMMENDATIONS

### INTRODUCTION

The 1991 report of the U.S. Advisory Board on Child Abuse and Neglect, established under the provisions of P.L. 100-294, stated that “Child abuse and neglect in the United States now represents a national emergency.” The Board made a series of recommendations for change in six major areas of reform:

- The development and implementation of a national child protection policy. This policy should be comprehensive, child-centered, and family-focused; it should support multi-disciplinary involvement and encourage concerted community action.
- The prevention and reduction of child maltreatment by strengthening families and communities -- Factors that affect the rate of child maltreatment include the child’s physical and social environment, such as housing, education, social and geographic isolation, and employment opportunities. It is now recognized that local people can solve local problems. Social support from community volunteers, trained paraprofessionals from within the community, and programs and support networks that are localized and accessible are important components for change.
- The provision of a new focus on child abuse and neglect, one that strengthens families in all relevant federal agencies. This means redefining the role and responsibility of federal agencies in providing leadership to the justice system, state, tribal, and county agencies; addressing the connection between substance abuse and child maltreatment; supporting parent education and child health; and **funding** and staffing child protection efforts.
- Enhanced federal efforts related to the generation, application, and **diffusion** of knowledge concerning child protection. This includes the need for more and better data, research, evaluation studies, and skilled professionals. It includes the implementation of standards of practice, the provision of technical assistance to state and tribal child protection efforts, and the diffusion of knowledge. The Board believes that it is particularly important to increase both public and professional sophistication about child abuse and neglect; it calls upon the Federal Government to develop a highly visible entity that takes whatever steps are necessary to ensure that practitioners, policy makers, and the general public (especially parents) have ready and continuous access to comprehensive, state-of-the-art information on child abuse and neglect.
- Improved coordination among federal, state, tribal, and private sector child protection efforts. This includes establishing a structure for the planning and coordination of the federal, state, and tribal levels, thus providing the opportunity for an integrated approach in the child protection programs of states, tribes, and communities.

- The most critical area of reform focuses on the implementation of a dramatic new federal initiative aimed at preventing child maltreatment, piloting universal, voluntary, neonatal-natal home visitation. Decades of research have demonstrated the efficacy and cost-effectiveness of home visitation programs. Not only have these programs been shown to prevent abuse, but, where home visitor programs were implemented, the use of costly emergency health services declined, immunization rates improved, and subsequent pregnancies were delayed for two years longer than in comparison groups. The Board noted that “the best documented preventive efforts are for home visitation sources for families of infants which are universal in many developed countries but are not now widely available in the United States.” Complex problems, like child maltreatment, do not have simple solutions. While not a panacea, the Board believes that no other single intervention has the promise that home visitation has.

In the past 30 years, there has been an exponential growth in the number of research efforts directed towards issues of child abuse and neglect. A variety of methods have been employed to help clarify the cause of maltreatment and its impact on child development and family well-being. Of equal importance is the need for research to increase the understanding of how best to intervene, to both prevent maltreatment and ameliorate its negative consequences. While research must continue, there are effective means of addressing the complex phenomenon of child maltreatment.

The original impetus for addressing child abuse in Indian communities stemmed in part from the development of the Indian Child Welfare Act, whose goal was to promote and maintain the integrity of the Indian family. This goal must be perpetuated by the MS and all agencies charged with the health and well being of Indian people. Interest in child maltreatment issues was furthered by several landmark cases involving abuse within schools and institutions that were responsible for the care of Indian children. While these situations require the implementation of appropriate CA/CN services, the primary focus of prevention and intervention for Indian people must be the family. The profile of maltreatment in AI/AN communities, like that for the general population, is one of abuse within families. Factors contributing to high rates for Indian people involve substance use and abuse, problems related to family disintegration and dysfunction, parents’ and caretakers’ inability to cope with parenting problems, and problems related to income and employment. These are issues that need to be addressed.

## **GENERAL RECOMMENDATIONS**

The recommendations put forth in this section were the result of two years of intensive research on the issue of child maltreatment and the evaluation of the MS treatment and services, caseloads, and interaction with local communities. Finding a balance between the stated needs of local communities and the practical limitations of the IHS service provisions will require some restructuring of current MS service models. These recommendations will provide practical ways to improve service provision, reduce the incidence of child maltreatment, and improve the physical and emotional health and well-being of AI/AN children and families.

In addition, the recommendations address the concerns and intent of P.L. 101-630. The Act was designed to address the problems associated with the maltreatment of Indian children, citing under-reporting, a lack of background checks, and inadequate funding as areas for reform. The Act also sets guidelines for reporting, collecting data, creating multi-disciplinary child protection teams, and treating and preventing abuse. These issues are addressed by the following recommendations.

In order to adequately address the current needs of Indian families and promote healthy family and child development in the next decade, it is recommended that the MS:

- Incorporate a public health model into the existing medical model.
- Make a commitment to secondary prevention and the provision of extended services to “at-risk” children and their families.
- Designate one of its branches to have primary responsibility for overseeing programs, treatment, and other services regarding child abuse and neglect, such as Maternal and Child Health or, possibly, Social Services.
- 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, and research.
- Work with other agencies to secure funding for implementation of the New Beginnings Program in other reservation communities. Programs must be provided with at least five years of stable funding.

## **SPECIFIC RECOMMENDATIONS**

### **POLICIES, PROCEDURES, AND PROGRAM PLANNING**

Effectively applying existing research and information to program planning is a sensitive and difficult task, particularly with respect to child abuse. The literature is replete with examples of programs which have successfully mitigated the risk for, or outcomes of, maltreatment. These program models include traditional methods of psychotherapy, home visiting services, education and support programs, self-help groups, family resource centers, and crisis intervention services. Over and above these direct services lie broader efforts to alter the environmental conditions which contribute to maltreatment. Public and private efforts aimed at reducing poverty, enhancing access to quality medical care, improving the quality of early childhood education and reducing societal violence are all believed to offer more efficient methods to confront child abuse than merely relying upon individual strategies. While each of these service models play an important role in preventing child abuse, the data suggest that the risk of child abuse or neglect can be significantly reduced if a continuum of support, education, and therapeutic services are made available to families.

Before the IHS can provide effective CA/CN prevention and intervention services, it must aggressively review current service provisions. The extreme level of poverty and the rural nature of many IHS service Areas demand some alternative approaches to care and additional types of services. The health of the people in many communities is seriously compromised by their inaccessibility of basic health care services.

#### PREVENTION EFFORTS

Several key elements appear to be critical to the development of a **framework** for prevention and intervention programs. Primary and secondary prevention are essential components, due to the increasing number and severity of reported cases, their associated problems, and the high costs of tertiary intervention. The low relative costs associated with, and the benefits of, prevention aimed at at-risk families make it the best long-term means to mitigate maltreatment. The costs associated with physical and sexual abuse of children are not only the current social and monetary costs for immediate treatment, investigation, and protective services. Also included are the continuing costs of the impact that abuse and neglect may have during the child's adolescence and adulthood. For example, up to 90 percent of convicted felons and 79 percent of adolescent drug abusers report that they were victims of physical and/or sexual abuse as children.

#### MANAGEMENT INFORMATION SYSTEMS AND DATA MANAGEMENT

The need for centralized information sources was identified as a major problem. Effective and efficient service delivery is impeded by the duplication of services, procedures that vary both within and between agencies, and demands on medical and other professional personnel to be aware of a complex referral system. Coordinating directly with medical treatment reduces possible duplication of services and improves case management. Access to information is essential to the development of a case plan. A system whereby case information is centralized and shared between the multitude of professionals often involved in a child abuse case is critical to effective diagnosis and treatment. Computerization simplifies and standardizes this process. The lack of a centralized and computerized data collection system impedes proper case planning and tracking. A system that includes separate case records with information on the status of the case and the child's progress in treatment should be implemented. Information about the offender should also be systematically collected.

Too often, there is a lack of readily available information with which to compile case reports. CPT members and service providers rely on memory and immediate knowledge of local families in preparing reports. This makes it **difficult** to maintain case management continuity if team membership should change. Without the benefits of computerization, as is the case in many service units (even those equipped with computers), implementation of an expanded case information log would be very **useful**.

Medical records, especially sexual assault records, need clear, concise medical reporting. Current records are often unclear and inadequate. A standardized supplemental report form, if used consistently, would effectively address this problem.

## **ACCESS TO SERVICES**

In some communities, the IHS clinic is closed during the times when most incidents are reported. In one community visited by the research team, for example, the MS clinic is the primary source of health care for a community; it is closed one morning per week for paperwork and one afternoon per week for each of the following clinics: diabetic, well-baby, and pre-natal. Provisions need to be made that allow needed services to be available at all times. The standard IHS response to local requests for additional and/or after hours services is to contract out (P.L. 93-638) needed services, but there is a history of problems in obtaining approval and payments for such services in almost every community.

The IHS must make some provisions for after hours care, as it is during this time when the need for services may be the most critical. At best, the MS should provide some after-hours personnel 24 hour, 7-day care. At the very least, a community needs a physician's assistant (PA) or some health care worker to be on call 24 hours/day for both mental and physical health needs. In addition, communities that have EMT programs can reduce the burden on medical staff by utilizing medical staff as consultants. For example, EMTs should rely on the availability of a physician or other health care worker for consultation and support.

Transportation is a major problem on every reservation (and many urban) communities. In many service units, outlying communities, often as far as 60 miles from an MS facility, receive little or no services. There are often no law enforcement or medical/health services readily available to outlying communities, and residents of these communities must wait long hours for help to arrive. As a result, residents must rely heavily on the CHR program to provide transportation. This limits the CHR's ability to provide the types of services, such as home visits, that they are trained, and paid, to do. In addition, many AI/AN people do not have telephones, further isolating them from needed care and services.

## **COMMUNITY RELATIONS**

In many communities, there is very little contact and/or interaction between the IHS and the community. If few CA/CN cases are reported through the MS system, then the IHS has little awareness of the scope of the community's problems. Poor coordination of services and poor documentation may compound the lack of awareness. A community liaison would contribute greatly to a facility's awareness of local needs, problems, and appropriate alternatives to standard care practices. Interaction with local communities can also be achieved through shelter services. Some communities have shelters for child and adult victims of domestic violence that do not have health care providers on staff. The II-IS could improve the health of victims, and thus community relations by allowing a doctor, PA, or RN to make at least one visit to a local shelter per week.

It is believed in some communities that local people will often refuse certain services in fear of losing their children. Even parenting skills classes can be threatening to parents. Building up community outreach and trust relationships are an essential component of service provision.

## RECOMMENDATIONS

Programs and policies should be designed to accomplish three basic objectives: (1) promote prevention; (2) address the specific needs of clients; and (3) continually evaluate, modify, update, and revise program planning. Information must be accessible to promote and maintain program flexibility according to the changing needs of clients.

Because programs should be based on the continually-changing needs of the client, rather than a static service provision model, it is recommended that the MS:

- Develop a centralized reporting/referral resource office within each service unit. This resource office would provide a direct link between a referral and available intervention resources, provide coordination between services and agencies, provide information to the general public, eliminate the need for medical personnel to decide on the correct referral process, and provide an array of treatment options, such as centralized case tracking, case management, and follow-up.
- Improve the coordination between programs, especially social services and mental health. These programs should coordinate and complement, not compete with, each other.
- Standardize and computerize child abuse data at the local level and coordinate information with other local child protective services.
- Incorporate evaluation criteria into program design for measuring effectiveness, efficiency, and quality of service to CA/CN victims and families.
- Incorporate systematic periodic reviews of CA/CN program goals.
- Develop a plan for conducting longitudinal studies of current and proposed child abuse and neglect programs within the MS system.
- Define the roles of its various programs in CA/CN programs, such as medical records, mental health, Family Violence Prevention, etc.
- Provide a transport van or a mobile clinic to link clients in remote areas to medical care. Increasing contact with isolated clients can also serve to increase health care worker awareness of families at-risk. In addition, patients often require services available only in distant cities, yet transportation is not available.
- Provide health care services at local shelters and residential treatment centers on a regular basis.
- Continue to encourage MS staff to participate and take leadership positions in multi-agency, multi-disciplinary training.

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- Undertake explorations to determine how differing agencies can coordinate resources to improve the availability of training opportunities. The MS should take a leadership role in broadening training opportunities to include tribal and state/county employees.
  - Develop a cultural sensitivity training course for implementation with IHS staff and other service providers, particularly state and country personnel.
  - Facilitate training in local communities on reporting procedures in cases of CA/CN
  - Work with other agencies to protect the confidentiality of those who make reports of suspected abuse and neglect.
  - Provide a leadership role in educating the community about the impact(s) of CA/CN
  - Actively survey local community sentiment towards MS services and work to improve negative community views regarding MS services.
  - Make available the use of traditional healing and healers to clients who desire such services.

#### TREATMENT AND SERVICES

Child health problems are changing in AI/AN communities across the nation. The morbidity facing children today includes behavioral and developmental concerns, as well as concerns about illness and disease. This “new morbidity,” defined by Robert Haggerty (AJDC 1974), calls for a more developmental perspective in child health care. Biological risks are now compounded by environmental risks, such as physical, social, and economic factors that may impede and/or limit child health and development. Developmental, behavioral, and psycho-social problems are emerging as issues for health care providers.

Child maltreatment is a family, not an individual problem. Victims, offenders, and families all need treatment. In many areas, the MS is operating in a crisis mode in regard to child abuse intervention. To increase the quality and long-term effectiveness of services, the number of proactive interventions should be increased. Services the MS cannot effectively or consistently provide should be referred and/or contracted out. In general, the MS needs to assess treatment protocols, available personnel, and the short-term and long-term cost effectiveness of services.

Intervention and treatment must be comprehensive and sufficiently long-term to adequately address the trauma of abuse and to enable victims to function effectively. There is no single, short-term prescription to cure the effects of abuse. Treatment includes medical, legal, social services, and clinical intervention. To be effective, it should be aimed at the entire family, not just the victim.

Medical intervention provides not only treatment for specific injuries, but forensic evidence, pregnancy, and venereal disease testing in cases of sexual abuse, and a chance for the victim to discuss physical problems and somatic complaints. Social service intervention may provide links to other agencies or may be the primary provider of an array of social resources to in-need families and individuals. Clinical interventions, such as therapy and counseling, are the most effective means available to provide victims and families with ways to reduce anxiety, identify family problems, define appropriate behaviors, develop effective communication skills, exact offender responsibility, and alleviate the victim's feelings of guilt. Providing counseling to offenders has become increasingly identified as a critical need, particularly when the offender is a juvenile and/or family member.

Legal intervention is also an aspect of treatment. Removing the perpetrator or victim from the home and involving the court should be part of the intervention process. Intervention may take several months or several years, as the long-term effects of abuse on individual and family functioning are well documented. While the MS is primarily a provider of medical intervention, it also needs to take into account, and often take an active role in, social service, clinical, and legal intervention. The provision of medical services does not terminate the IHS's involvement in a case of child abuse.

Traditional medicine is highly valued in some communities; this can be either a positive or negative factor in dealing with CA/CN. Fears of witchcraft and reprisals from community members can inhibit reporting and service provision. Mainstream community awareness campaigns may even increase fear and work against prevention efforts. Community education needs to come from respected leaders. However, it is likely that, in some communities, people in power may be part of the problem.

There have been consistent problems due to the failure of the MS to provide sufficient services to individuals involved in abuse cases. Long-term care is often indicated for CA/CN intervention, but it is not available. The MS often provides only acute care and, thus, cannot effectively deal with severe cases and sexual abuse cases. Treatment does not always mean a long-term commitment, but when provided treatment and/or services are incomplete, the effect on the victim may be as detrimental as the total absence of services. For example, residential treatment and more intensive services are denied to victims and offenders who may in fact present a danger to themselves and/or others.

Another problem occurs when families fail to show up for prescribed treatment (parenting classes, counseling, etc.) In such cases, the MS does not pursue the family for follow-up. There needs to be an impartial and assertive advocate for the needs of the victims who can help ensure that treatment is sufficient and complete. There also needs to be simultaneous intervention with the victims and their families, as well as interventions for offenders.

In some service units, the MS does not have a significant role in CA/CN services other than medical treatment and referrals. Such a limited role does not allow IHS personnel to play a vital

role in certain aspects of CA/CN cases, such as participation in the local CPT, availability to testify in court, etc.

There are also problems for service units that address cases involving children from tribes outside the service unit boundaries. Intervention in these instances may be impeded by severe logistic and geographic problems. Despite the best efforts of service providers, resources are oftentimes unavailable.

The greatest problems occur in situations where the IHS involvement is too limited to allow for the sufficient monitoring and maintenance of child and family health. In areas where IHS intervention in cases of CA/CN is limited, no definitive policies for “in-house” intervention exist. Families who are ineligible for tribal services have no resource to link them to non-tribal services. The IHS can significantly improve access to and utilization of available resources if it becomes more involved in community health issues, such as CA/CN.

### **RECOMMENDATIONS**

While developing an overall format for CA/CN treatment and service provision, the MS can begin to make specific changes in several areas:

- The MS should include a risk factors checklist on medical records for pre-natal or immediate post-partum assessment. Where maternity services are contracted out, the IHS should require the hospital or midwife to obtain information as part of the contract, for such information has been successfully used to identify at-risk families. This information should include marital status, employment status of mother and partner, income level, housing, home telephone, level of education, emergency family contacts, history of substance abuse, timing of pre-natal care, history of abortions, history of psychiatric care, feelings about the pregnancy, adoption(s) attempted, marital/family problems, history of or current depression, history of abuse, domestic violence.
- The IHS should implement early identification, home visitor, and referral services for at-risk families using teams of professionals and paraprofessionals.
- The IHS should directly link medical exams with CA/CN referrals to and from all sources
- Provisions should be made for long-term therapy for abuse victims when indicated, an increase in services to families in which incest has occurred, and counseling for victims and families.
- The MS should increase its focus on neglect cases.
- The MS should increasingly incorporate the use of Native culture in treatment according to the needs of individual communities.

- In cases involving the determination of placement or return of a child to the home after removal, an assessment of the child's physical and/or psychological state and ability to live in the home should be requested. This type of assessment would greatly enhance the ability to protect the best interests of the child.
- Since programs are often short-term and/or subject to modification or cancellation, an updated resource list should be available to service providers.
- The II-IS should provide appropriate services for offenders, including juvenile offenders

### STAFFING AND PERSONNEL

A nation-wide MS program for intervention requires a standard point of reference for decisions regarding child abuse and neglect intervention. Interventions requiring interagency coordination and collaboration, as is often the case with child abuse and neglect, demand a high level of interagency communication.

### TRAINING

Cross-training provides avenues of communication for members of different professions to understand the perspectives of their colleagues. Training needs to be on-going and mandatory for appropriate personnel. Local child protection teams provide an invaluable service when they function effectively. By aiding a team's ability to function through the coordination of efforts and consistent agency participation, the MS can increase team effectiveness. Service providers want more training and more coordination of efforts within and between agencies.

### PERSONNEL MANAGEMENT

Characteristics of IHS staff, such as quality, quantity, experience, and background, can vary markedly between facilities. To create a structure of social support, central to prevention and intervention, many programs employ the services of individuals who come from within the community and share the values and experiences of program participants. Paraprofessionals are utilized to improve program efficiency and effectiveness. In addition, paraprofessionals provide more culturally-relevant services and can assist professionals in communicating in their native language.

It has been suggested that there is some reluctance on the part of the IHS physicians to **identify** and report child abuse, particularly sexual abuse. The reasons for this reluctance are suggested to be lack of training in detection, lack of confidence in the intervention process, community, and judicial repercussions, and time involved in court appearances. Since an appearance in federal court can mean days away from the job, and since there is **often** a severe shortage of IHS doctors on-the-job, a notarized medical statement should be allowed to suffice in many cases. It should be stated that while clinic physicians are overworked and understaffed, they are trying very hard to provide needed services to the communities they serve.

## RECOMMENDATIONS

To increase staff effectiveness and coordination of efforts within the MS and across agencies, it is recommended that the IHS:

- Provide training that facilitates the detection and identification of at-risk children and families, and training in prevention and intervention strategies.
- Provide specialized cross-training in policy and procedure, data collection, and specific intervention issues.
- Mandate training for appropriate personnel.
- Support a funded coordinator's position for local Child Protection Teams.
- Include CPT participation in appropriate job descriptions and employee job evaluations
- Train and utilize more paraprofessionals, such as home visitors, early identification workers, and case managers. Paraprofessionals trained with specialized CA/CN services will be able to support and assist the limited number of available professionals,
- Work with tribal courts and law enforcement in support of mandatory arrest and other procedures which act to protect children.
- Network with off-reservation service providers and facilitate client awareness of the availability of services.
- Increase awareness of existing resources within the MS (e.g., the Family Violence Prevention Team, etc.) and other federal agencies such as OVC (e.g., Trainer's Bureau, Emergency Response Team, etc.)
- Develop and share a comprehensive background investigation questionnaire and share the questionnaire with tribal programs.

## INTERAGENCY AND JURISDICTIONAL ISSUES

Child abuse intervention is an interagency issue. In determining its role within a given community, the MS should access and coordinate with existing, effectual, service providers to expand and support the IHS network of services. As a medical/mental health/social services provider, the IHS is in the unique position to track children from birth to school age, when the education system then becomes the primary link between family and community.

Prevention and intervention programs must be designed not only to prevent and treat individual trauma, but to mitigate the cycle of individual, family, and community dysfunction. The enormity and complexity of problems associated with abuse and neglect cannot be adequately

addressed by a traditional medical model alone, or by the efforts of a single agency. Maltreatment transcends physical injury to long-term emotional and social dysfunction. To move towards effective policies and programs, the focus on the individual victim must be expanded to include the family and the community. This effectively broadens the definition of the problem and divides the responsibility for the prevention and intervention more equitably among the people who have a stake in the solution. Because the problems of prevention and intervention ultimately affect the well-being of the entire community, the cost of addressing them should be borne collectively. The size and complexity of the AI/AN population, coupled with geographic barriers, makes any type of service delivery difficult. Child maltreatment cases, in particular, require specialized attention and treatment coming from a multi-disciplinary approach.

In some communities, the MS may provide only a small proportion of total services; in many areas, the IHS facility may be the primary or even sole resource for prevention and intervention services. Regardless of the proportion of services provided, the MS is part of the total network of service delivery in every community. The II-IS has the ability to be at the forefront of an integrated system of child and family health care in CA/CN cases.

The most inhibitory factors in effective CA/CN service provision are the lack of a centralized resource for information regarding where to report, to whom to report, and what services are available; severe case overloads for medical, social service, judicial, and law enforcement personnel; and inadequate case management. Contract services are only part of the answer for complete intervention services. Although P.L. 96-638 contracting enables tribal empowerment, some administrators and service providers do not believe that it guarantees improved health care. A dilemma for tribes has been balancing the importance of health services (quantity) and health improvement (quality).

Court-ordered treatment can be positive, but there are very few prosecutions. Part of the problem may be due to the feeling that the courts only tend to see the criminal side, and provide no support, treatment, or family preservation. Additional problems occur because the court does not view social workers as expert witnesses.

#### CHILD PROTECTION TEAMS

Although protocols for CPTs often exist, they do not appear to be used effectively. For example, although cases are supposed to have a case manager, they are often not assigned to a specific person. Case information is not readily shared with appropriate agencies or team members. Follow-up services, case monitoring, and team participation need to be consistent. In most communities, personalities interfere with effective team functioning. While a team may have developed a case reporting process, it may lack a solid rehabilitation or case plan that clearly identifies the short- and long-term objectives for each case and provides a time line for reaching these goals. A team also needs to identify who or which department is responsible for ensuring that services are provided. Accountability for service provision appears to be a major

flaw for many teams. Team members are professionals and paraprofessionals with preassigned heavy workloads outside their CPT responsibilities, which often results in time conflicts.

In many locations, there is excessive reliance on memory and personal knowledge for case management. This, therefore, has the potential of undermining case management. An improved structure for collecting and sharing information through written reports, establishing criteria for selecting cases to be reviewed by the team, writing referrals for services, documenting cases, and implementing case follow-up protocols would improve case management. Current case recording and reporting systems do not provide adequate information to determine whether previous interventions have been effective, nor do they document the need for subsequent actions. Because the weakest link is usually in coordination between the various entities, a single administrative entity for child protection would improve coordination. The lack of communication between programs translates into decreased input to the CPT, no accountability, and little consistency with agency participation at meetings. The team's role, power, and responsibility need to be clearly defined and routinely updated. This would help increase communication and cooperation within and between different teams.

### **RECOMMENDATIONS**

To improve communication and coordination with other agencies, to attain concordance with Presidential guidelines regarding school readiness, to deal with the correlation between substance abuse and child maltreatment, and to provide access to services for individuals, families, and communities, the IHS should promote healthy lifestyles, positive parenting, and maximum child growth and development. It is recommended that the MS:

- Coordinate services with local schools.
- Coordinate family services with alcoholism programs.
- Promote community awareness programs and public relations campaigns for new and existing services.
- Improve reporting through better coordination, employee confidence, and mandatory employee training support.
- Play a significant unifying role in linking people to services and centralizing case information, giving priority to filling all vacant social worker positions within service units
- Provide training regarding the Privacy Act, P.L. 101-630, Freedom of Information, and other regulations regarding the sharing of confidential information in cases of CA/CN.

### **RESEARCH**

Research needs to be an on-going process that provides both short- and long-term information. The MS should be commended for their efforts in employing AI/AN professionals to conduct

research. The commitment to research must remain part of the IHS's overall goals and objectives, To promote quality research, it is recommended that:

- The MS continue to support research by Native Americans.
- The MS Project Officers, the MS Reports Clearance Officer, and other appropriate personnel provide orientation for contractors involved in research, outlining:  
(1) regulatory requirements and clearance procedures for proposed data collection instruments for PHS and the Office of Management and Budget; (2) other pertinent information; and (3) descriptions of on-going research within the IHS that would be relevant to the project. This will avoid costly delays.
- Future research efforts be undertaken in a manner that does not interfere with direct service providers' daily schedule. Research instruments could be administered in the context of training events, area meetings, or routine administrative functions.
- Future research efforts be collaborative efforts with tribal organizations, such as the National Indian Court Judges Association, to increase participation.

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**INTERAGENCY AGREEMENT** - A formalized, written agreement between two or more local, tribal, state, or federal agencies, specifying areas of coordination, cooperation, and/or exchange of services.

**INTERVENTION** - Any program or other planned effort designed to produce intended changes in a target population, in child abuse and neglect. It may include treatment directed toward individuals and families where abuse has occurred, to keep it from recurring.

**JURISDICTION** - The power of a particular court to hear cases involving certain categories of persons or allegations. Jurisdiction may depend upon geographical factors, such as the county of a person's residence.

**MANAGEMENT INFORMATION SYSTEM (MIS)** - An ongoing data collection and analysis system, usually computerized, that provides information on a routine basis about the delivery of services to specific clients. MIS often includes information required for case tracking, social and demographic information, treatment results, payment of services, etc.

**MANDATORY ARREST ORDINANCE** - A statutory provision, ordinance, or resolution that requires a police officer to arrest the abusing defendant on probable cause in cases involving family violence.

**MATERNAL AND CHILD HEALTH (MCH)** - MCH is a coordinated multidisciplinary approach being promoted in the IHS service delivery areas to address the comprehensive health needs of AI/AN children, youth, and the family, emphasizing services to infants, children, and women in child-bearing years.

**MEDICAL MODEL** - Conceptualizing problems in terms of diagnosis and treatment of illness. With respect to child abuse and neglect, the medical model focuses on identification and treatment in a medical or other health setting.

**MEMORANDUM OF AGREEMENT (MOA)** - An agreement between the Department of Health and Human Services, IHS, and the Department of the Interior, BIA, specifying child abuse and neglect as a major area of interagency coordination. Specific guidelines for child abuse and neglect reporting and referral procedures have been developed including implementation and operation of child protection teams.

**NURSING CHILD ASSESSMENT SCALES TRAINING (NCAST)** - A data collection instrument and tool used for assessment and testing (home, feeding, and teaching scales) to facilitate the early identification and referral(s) for needed services. The testing will be used periodically to determine client progress and changes needed in intervention.

**OFFICE OF VICTIMS OF CRIME (OVC)** - The OVC is located in the U.S. Department of Justice (DOJ), and was awarded a series of grants to Indian tribes under its Children's Justice Act Discretionary Grant Program for Native Americans.

**PARAPROFESSIONAL** - Agency employee who has not completed a bachelor's degree, but is trained to a limited extent in a particular profession. The role of the paraprofessional in protective service work is usually to provide outreach and/or direct services and advocacy for the family, often as a case aide.

**PATIENT CARE COMPONENT (PCC)** - Indian Health Service record-keeping system forms that the IHS uses to record data in client records on an on-going basis.

**PREVALENCE** - The number of cases of a particular problem or condition present at a particular time in a given population. Distinguished from incidence. it is a measurement of the health of a population at a specified moment in time. where incidence measures the rate of onset of disease.

**PREVENTION** - Efforts to eliminate individual and societal causes of child abuse and neglect

- a. **PRIMARY PREVENTION** - Programs and policies on a societal and **community** level aimed at positive family functioning, to keep child abuse **from** happening before it has ever occurred.
- b. **SECONDARY PREVENTION** - Measures focused on “at-risk” populations to keep child abuse from happening before it has occurred to a serious degree. but after certain warning signals have appeared.

**PRIMARY CARE** - The range of routine medical services that are generally provided in a physician’s office. such as examinations. diagnosis. treatment. immunization. pre-natal. well-child care. first aid. etc

**PRIMARY CARE PROVIDERS** - A specific type of health professional (physician. **community** health medic, physician assistant, nurse practitioner. or nurse mid-wife). who provides preventive. diagnostic. therapeutic or rehabilitative services and has been professionally trained and licensed or certified to provide such service.

**PROFESSIONAL** - Individual employed in an upper level position with at least a bachelor’s degree in a related field. plus professional training applicable to their current area of work.

**PUBLIC LAW (P.L.) 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. The Act provides financial assistance for a demonstration program for the prevention, identification. and treatment of child abuse and neglect, to establish a national center on child abuse and neglect. and for other programs.

**P.L. 93-638 CONTRACT** - Contracts between Indian tribes or tribal organizations and federal agencies (i.e.. IHS and BIA), under which tribes assume planning. operation. and administration of programs and services for Native Americans **from** the Federal Government. Authorized by the Indian Self-Determination and Education Assistance Act of 1975.

**P.L. 99-570** - The Omnibus Drug Act of 1986. Subtitle C of the Act - AI/AN - included \$26.3M authorization per year for IHS drug/substance abuse programs and calls for an interdepartmental MOA between the IHS and the BIA. Indian Alcohol and Substance Abuse Prevention and Treatment Act (1986) 25 U.S.C.S. § 2411.

**P.L. 100-294** - Child Abuse Prevention, Adoption. and Family Services Act of 1988 - Title I - Child Abuse Prevention and Treatment Act of 1988 established to amend the Child Abuse Prevention and Treatment Act. the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 and the **Family** Violence Prevention and Services Act to extend through fiscal year 199 1 the authorities established in such Acts.

## GLOSSARY

**CENTRAL REGISTRY** - Records of child abuse reports collected centrally from various agencies under federal, tribal, or state law or voluntary agreement. Agencies receiving reports of suspected abuse check with the central **registry** to determine whether prior reports have been received by other agencies concerning the same child or parents or perpetrator(s). The purpose of central registries is to alert authorities to families with a prior **history** of abuse, to assist agencies in planning for abusive families, and to provide data for statistical analysis of child abuse.

**CHILD ABUSE AND NEGLECT** - 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, specifically:

- a. **PHYSICAL ABUSE** - Non-accidental **injury**, which may include severe beatings, burns, shaking, strangulation, or human bites.
- b. **SEXUAL ABUSE** - The exploitation of a child for the sexual gratification of the offender, as in rape, incest, fondling of genitals, or exhibitionism.
- c. **EMOTIONAL ABUSE** - A pattern of behavior that attacks a child's emotional development and sense of self worth, e.g.: verbal abuse or placing excessive and/or inappropriate demands on the child's emotional, social, and physiological capabilities, constant criticizing, belittling, insulting, rejecting, and/or providing no love, support, or guidance.
- d. **NEGLECT** - The failure to provide a child with the basic necessities of life, i.e., food, clothing, shelter, medical care, and/or providing adequate supervision and protection.

**CHILD PROTECTION TEAM (CPT)** - A working team of professionals or paraprofessionals representing a variety of disciplines who interact and coordinate their efforts to facilitate diagnosis and treatment of specific cases of child abuse and neglect. Their goal is to pool their respective skills in order to formulate accurate diagnoses and to provide comprehensive coordinated treatment with continuity and follow-up for both parents and child or children.

**CHILD PROTECTIVE SERVICES** - The provision of investigation services, legal proceedings or maintenance at home or foster care services to a child following a referral from any person alleging that the child is being abused or neglected.

**CHILDREN'S JUSTICE ACT (CJA)** - Signed into law in 1986 to provide funding for states to establish programs to improve the investigation and prosecution of child sexual abuse cases.

**CODE OF FEDERAL REGULATIONS (CFR) COURT** - A court that operates under a grant of authority from the Federal Government. It is a Court of Indian Offenses established pursuant to Title 25, Section II of the Code of Federal Regulations.

**COMMUNITY HEALTH REPRESENTATIVE (CHR)** - **Indian** health paraprofessionals who assist in providing health care, health promotion, and disease prevention services. The **CHRs** are selected.

employed, and supervised by their tribes or by the IHS, and trained to provide specific health care services at the community level.

**CONFIDENTIALITY** - Something told in confidence and intended to be kept secret. Many communications from parent to doctor or social worker are “confidential,” made so by statute and/or policy.

**CONTRACT CARE** - Services not available directly from the IHS or tribes that are purchased under contract from community hospitals and practitioners.

**EARLY IDENTIFICATION (EID)** - The early identification component of the New Beginnings Program (proactive case-finding approach) provides systematic early identification of at-risk newborns. This type of outreach will reach the majority of high-risk families in the target area(s).

**FAMILY SERVICE WORKER (FSW)** - The FSW, through home visitor services, provides early intervention through home-based support to the family, particularly to the mother and her infant. The goal of the FSW is to develop and maintain a trusting, supportive, nurturing relationship with clients to facilitate the development of positive parent-child interaction and improvements in parental competence and positive coping skills and helps the parent(s) to develop positive relationships with people outside the family and social network (during the early years of parenthood).

**FETAL ALCOHOL EFFECT (FAE)/FETAL ALCOHOL SYNDROME (FAS)** - Patterns of malformation found in children whose mothers consumed alcohol during pregnancy and is the leading cause of disabilities among AI/AN newborns. FAE is more difficult to diagnose than FAS because children may look normal; obvious signs of FAE tend to manifest later than FAS (usually when children are in elementary or middle school).

**GUARDIAN AD LITEM** - Sometimes known as NEXT OF FRIENDS in child abuse and neglect cases, usually an attorney, but may be a court advocate, probation officer, or child protection worker, appointed by a court to protect a child’s interests.

**HUMAN SERVICES/SOCIAL SERVICES WORKER** - An individual who provides preventive, reunification, therapeutic, habilitative, rehabilitative, remedial, or other support services to individuals and families in stress, through a recognized local, tribal, state, or federal agency.

**INCIDENCE** - The number of new cases of a particular problem or condition that are identified or arise within a defined population in a specified time period.

**INDIAN CHILD WELFARE ACT (ICWA)** - Enacted in 1978 in recognition of the need to stem the “removal, often unwarranted” of Indian children from their families and to establish “minimum federal standards” to ensure that the values of Indian people are reflected in the foster care and adoptive placements of Indian children, thus ensuring the preservation of Indian family units.

**INFORMAL AGREEMENT** - An agreement of convenience between two or more agencies providing mutual coordination, cooperation, and/or exchange of services.

**INTAKE** - Process by which cases are introduced into an agency. Workers are usually assigned to interview persons seeking help in order to determine the nature and extent of the problem(s).

P.L. 100-713 - This Act amends P.L. 94-437, the Indian Health Care Improvement Act. This Act provides reauthorization funding for 4 years and establishes a new nursing program. The Amendment modifies and expands the 1976 provisions. Section 107 of the Indian Health Care Improvement Act Amendments, November 23, 1988, defines the mission of the CHR Program is to provide quality outreach health care services and health promotion/disease prevention services to AI/AN within their communities through the use of well-trained CHRs.

P.L. 101-630 - This Act amends P.L. 94-437, the Health Care Improvement Act, that requires reporting of suspected child abuse. The Indian Child Protection and Family Violence Prevention Act of 1990 explicitly sanctions the sharing of information among those with a legitimate need-to-know (information that should be available to only those people who have a legitimate use for it, such as in the course of doing their job(s)). This Law allows for the possibility of a central registry which would pool information from contributing agencies in order to track the offender and also allows agencies to perform background checks on employees who have to work with children. It also provides for the treatment, prevention, and the establishment of tribally-operated programs to protect Indian children.

**RECIDIVISM** - (1) Recurrence of child abuse and neglect; (2) Further violations of the law by those previously convicted for the same offense or related offense.

**REVISED DENVER PRE-SCREENING DEVELOPMENTAL QUESTIONNAIRE (RPDQ)** - A data collection instrument and tool used for assessment and testing to facilitate the early identification and referral(s) for needed services. The testing will be used periodically to determine client progress and changes needed in intervention.

**SERVICE POPULATION** - (1) Persons identified to be eligible for IHS services and others not eligible for IHS services, but determined eligible by the specific Tribal Health System; (2) the Indian population residing in geographic areas that are served by the IHS; (3) members of federally-recognized tribes and Alaska Natives who live in areas served by the IHS and certain California Indians.

**SOCIAL SERVICES** - A permanently-organized team of persons from appropriate professions who plan and coordinate services to families in which abuse and neglect occur.

**SOFT FUNDING** - Funding from any source that must be solicited, and is temporary or short-term, e.g., development grants, seed money'.

**SUSPECTED CHILD ABUSE AND NEGLECT** - Reason to believe that child abuse or neglect has or is occurring in a given family. Anyone can in good faith report this to the local mandated agency, which will investigate and protect the child, as **necessary**.

**TRIBAL CODES, ORDINANCES, AND RESOLUTIONS** - These are documents enacted by tribal councils that **define** both the territorial and personal jurisdiction that the tribal court may exercise. These documents also define both the offenses that may be prosecuted in tribal courts and the penalties that may be given upon conviction.

**VICTIM ASSISTANCE PROGRAMS IN INDIAN COUNTRY (VAIC)** - In the DOJ, the OVC administers funding for the discretionary grant program for VAIC, a program which provides victim assistance services to victims of child abuse, and the discretion-. grant program for the CJA to improve the investigation and prosecution of child sexual abuse cases. Both of these OVC-funded programs deal with child sexual abuse victims.

**VICTIMS OF CRIME ACT OF 1984 (VOCA) 43 U.S.C.S. § 10601 (G)** - In 1988, the Congress passed the Anti-Drug Act, which amended the VOCA, authorizing a portion of the CJA funds to be used in assisting Indian tribes with improving the handling of serious child abuse cases on Indian reservations.

## ACRONYMS

**AIAN** - American Indians and Alaska Natives

**BIA** - Bureau of Indian Affairs

**CPAN** - Child Protection Abuse Neglect

**DHEW** - Department of Health, Education, and Welfare

**DHHS** - Department of Health and Human Services

**DOJ** - Department of Justice

**IHS** - Indian Health Service

**NIJC** - National Indian Justice Center

**OMB** - Office of Management and Budget

**P.L.** - Public Law

**PHS** - Public Health Service

**SCAN** - Sexual Child Abuse and Neglect