

FINAL REPORT

Profile of the State of Indian Children and Youth

In support of
the Domestic Policy Council Workgroup on Indian Youth

For and on Behalf of:
Indian Health Service
Department of Health and Human Services

November 1997



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FINAL REPORT

Profile of the State of Indian Children and Youth

Synopsis

This study was conducted in support of a proposed Federal initiative to promote the quality of life (QOL) of American Indian and Alaska Native (AI/AN) youth. The goal of the study was to collect and organize existing information and to develop a set of recommendations to assist in the development of coordinated Federal policy.

1.0. Key Concepts

1.1. Definition of American Indian/Alaska Native (AI/AN). AI/ANs are generally defined in terms of membership in Federally recognized tribes. There is a special problem of the AI/AN diaspora and history of forced relocation of AI/AN families from Reservations to cities. AI/ANs do not constitute a single group; there are over 500 Federally recognized tribes and Native villages--different languages and cultures.

1.2. Indian Self-Determination. The principles and policy of Indian self-determination require that tribes actively participate in the definition of quality of life (QOL) and the development and application of policies to promote the QOL of AI/AN youth.

2.0. Dimensions of Quality of Life (QOL). This study examined five interrelated dimensions of QOL: 1) health, 2) education 3) justice/security, 4) employment-poverty, and 5) environment.

2.1. Health

2.1.1. Dramatic reductions in maternal and infant mortality have been achieved. In the 1950's the AI/AN rates were twice those of the general population. Over the next 20 years, parity achieved—these achievements demonstrate that problems in Indian country are not intractable.

2.1.2. Accidents/unintentional injuries are the biggest threat to the health and survival of AI/AN youth—depending on age, accidents cause 3 to 7 times more deaths than any other cause. Most accidents are car crashes. Interventions needed include: 1) increase use of infant car seats and seat belts, and 2) decrease use of alcohol and other drugs by drivers and pedestrians.

2.1.3. Alcohol and tobacco use plays key roles in 1) fetal alcohol syndrome (FAS), 2) accidents, 3) school problems and dropout, and 4) family violence.

2.2. Education. AI/AN youth have the highest dropout rate and the lowest academic achievement in the United States. The views and recommendations of the tribes have been expressed in two major initiatives: 1) the Indian Nations at Risk Task Force in 1990, and 2) the White House Conference on Indian Education in 1992.

2.3. Employment-Economic Development-Poverty. Forty nine percent are unemployed on Reservations. If those not actively looking for employment are eliminated, the unemployment rate drops to 35 percent—people stop looking for work when there are no jobs. Chronic unemployment affects poverty, mental health, school dropout, and substance abuse.

2.4. Environment.

2.4.1. Housing—28 percent AI/ANs reside in inadequate, overcrowded facilities.

2.4.2. **Transportation**—there is virtually no public transportation except to schools. Lack of transportation impedes ability to secure employment and training and access health care.

2.4.3. Major pollution **problems**—there is a lack of waste water treatment and safe solid waste disposal in many AI/AN communities.

2.4.4. Justice-Security-violence represents the greatest threat to AI/AN adolescents: 40 percent involved in violence. Fifteen percent of AI/AN adolescents have some level of gang affiliation. Sexual assault/abuse is 5 times greater on Reservations than in nearby rural counties. Treaty rights of AI/AN individuals and tribes are violated by Federal agencies, states, counties, and other groups. Civil rights of AI/AN youth and their families are violated by denial of access to health care and employment. Finally, there are virtually no detention facilities for AI/AN youth accused or convicted of crimes. AI/AN youth are either released without rehabilitation efforts or incarcerated with adults.

3.0. Methodology. This study was conducted primarily by means of bibliographic and archival research of information maintained by Federal agencies, libraries, and other institutions.

4.0 Conclusions.

4.1. Youth initiative is needed. The AI/AN youth initiative under consideration is needed.

4.2. Federal/tribal initiatives have been successful. Spectacularly successful initiatives have been achieved in “Indian country”—reductions in maternal and infant mortality.

4.3. Important changes occurring in Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA). Any AI/AN initiatives must factor in major changes occurring in IHS and the BIA.

4.4. Lack of accessible data. Most Federal agencies lack coordinated, accessible information about AI/ANs—better information systems are needed.

5.0. Recommendations. AI/AN youth initiative should be conducted in the context of Indian self-determination and include:

- Prevention and treatment of alcohol/substance abuse by youth and their families
- Accident prevention
- Economic development and employment in Indian country
- Education reform
- Crime prevention, gang activity, protection from assaults and crimes of violence
- CI Housing improvement, and
- CI Waste water treatment and solid waste disposal.

5.1. Coordinate efforts. The initiative should involve coordination among Federal agencies and between Federal agencies and the tribes.

5.2. Collect needed data. The initiative should involve the development of data systems that will provide the data needed to evaluate achievements of the AI/AN youth initiative.

1.0. Introduction

“The Indians survived our open intention of wiping them out, and since the tide turned they have even weathered our good intentions toward them, which can be much more deadly.”

JOHN STEINBECK, *America and Americans*

This study was undertaken in support of a proposed Federal initiative to promote the quality of life (QOL) of American Indian and Alaska Native (AI/AN) children and youth. While the impetus for this initiative included knowledge of numerous threats to the QOL of AI/AN youth, the goal of this study was to collect and organize existing information and to develop a set of recommendations to assist in the development of coordinated Federal policy.

1.1. Definitions

To facilitate communication, this section of the report provides working definitions for some of the key concepts in this study. As is often the case with definitions, on close inspection there is sharp disagreement among “experts” regarding the definition of abstract concepts. Thus, the definitions presented below are not meant to be exhaustive, but rather to identify generally agreed upon key components or elements of each concept.

1.1.1. American Indian and Alaska Native (AI/AN). There are two key issues associated with the definition of who is an AI/AN and who is not: 1) there are over 550 Federally recognized American Indian tribes and Alaska Native villages, each with its own language or dialect and culture, and 2) there are special problems associated with the AI/AN diaspora—including AI/ANs who live away from their reservations or tribal lands, whether or not they are members of a particular tribe. Because there are so many tribes and Native villages and because of their diversity, it is often inappropriate or incorrect to make generalizations or statements pertaining to *all* AI/ANs, as if they were a single unitary group.

AI/ANs residing away from their home reservation or Native village (generally in cities) often represent special problems for Federal agencies especially with respect to eligibility for services. Such “urban Indians” are often excluded from services available to AI/ANs residing on or near reservations. Such emigration by AI/ANs from reservations or Native villages would be less of a problem were the emigration voluntary; however, some of the AI/ANs residing in cities were forcibly removed there by the Federal government (or are the descendants of such persons). The numbers of “urban Indians” exceeds the numbers residing on or near reservations and Native Villages.

The definition of who is an AI or AN is complex with political as well as other dimensions. A complete discussion of the definition of AI/AN is beyond the scope of this study-some of the more important aspects of the definition are highlighted in this section. Traditionally, AI/ANs are members of a tribe or Native Village with a common language, culture, and history. Since its inception, the United States has developed formal political relationships with tribes. These political relationships were often expressed in treaties between the United States (and prior to the ratification of the Constitution, between Colonies) and tribes. Consistent with the principle of Indian self-determination, the Federal government has generally deferred to the tribes in the definition of tribal membership. Nevertheless, for a variety of reasons, Federal agencies have found it necessary to distinguish between AI/ANs and others to define AI/AN. Some of the most widely used definitions are presented below.

Many Federal departments and agencies have programs or program components which benefit AI/ANs; however, the program is not restricted to AI/ANs. Examples include Head Start, Women and Infant Children (WIC), and Job Training Partnership Act (JTPA) services. Such programs may have reservation-based facilities or services, but AI/ANs (e.g., urban Indians) are eligible to participate in off-reservation programs as well. On the other hand, there are programs provided by the Interior and Health and Human Services Departments for which only AI/ANs are eligible. The definition of AI/ANs for purposes of eligibility for these programs varies for these Departments.

For the purposes of eligibility for services, the Indian Health Service (IHS) in the Department of Health and Human Services defines American Indians and Alaska Natives as: a person of “Indian or Alaska Native descent and belongs to the Indian/Native community served by local facilities and program.” A different definition based on tribal membership has been developed (42 CFR Part 36) but has not been implemented.

In defining its service population, the Bureau of Indian Affairs (BIA) in the Department of Interior (DoI) defines AI/ANs as persons who “are members of Indian tribes or who are one fourth degree or more of blood quantum of descendants of a member of any tribe, band, nation, rancheria, colony, pueblo, or community including Alaska Native villages or regional village corporations” residing on or near Indian reservations governed by Federally recognized tribes.

Such variation in the definition of AI/ANs suggests that coordination of activities across Federal agencies will have to include agreement on a working definition of who is to be counted as an AI/AN and the role of “urban Indians” with respect to the proposed initiative.

1.1.2. Children and Youth. For the purposes of this study, “children and youth” refers to persons from birth (including the prenatal period) to the attainment of 18 years of age. For the sake of

brevity, in this report the term “youth” will refer to a person at any age from infancy through 18 years (i.e., youth will include all ages from infancy, preschool, school age, and adolescent children).

1.1.3. Quality of Life (QOL). The concept, “quality of life” has been defined in a variety of different ways depending on the context in which it has been used. Four definitions are presented: 1) an AI/AN approach, 2) a social indicator approach, 3) a subjective approach, and 4) a human rights approach; each approach is discussed, in turn, below.

1.1.3.1. AI/AN approach to QOL. There are over 550 Federally recognized tribes representing great diversity in culture, circumstances, values, and world view.¹ Despite this diversity, the Sacred Circle is often used as a conceptual framework for representing the relationship of 1) the person to the family, community, tribe and society, or 2) the four basic components of a person and, by extension, QOL (see Figure 1).

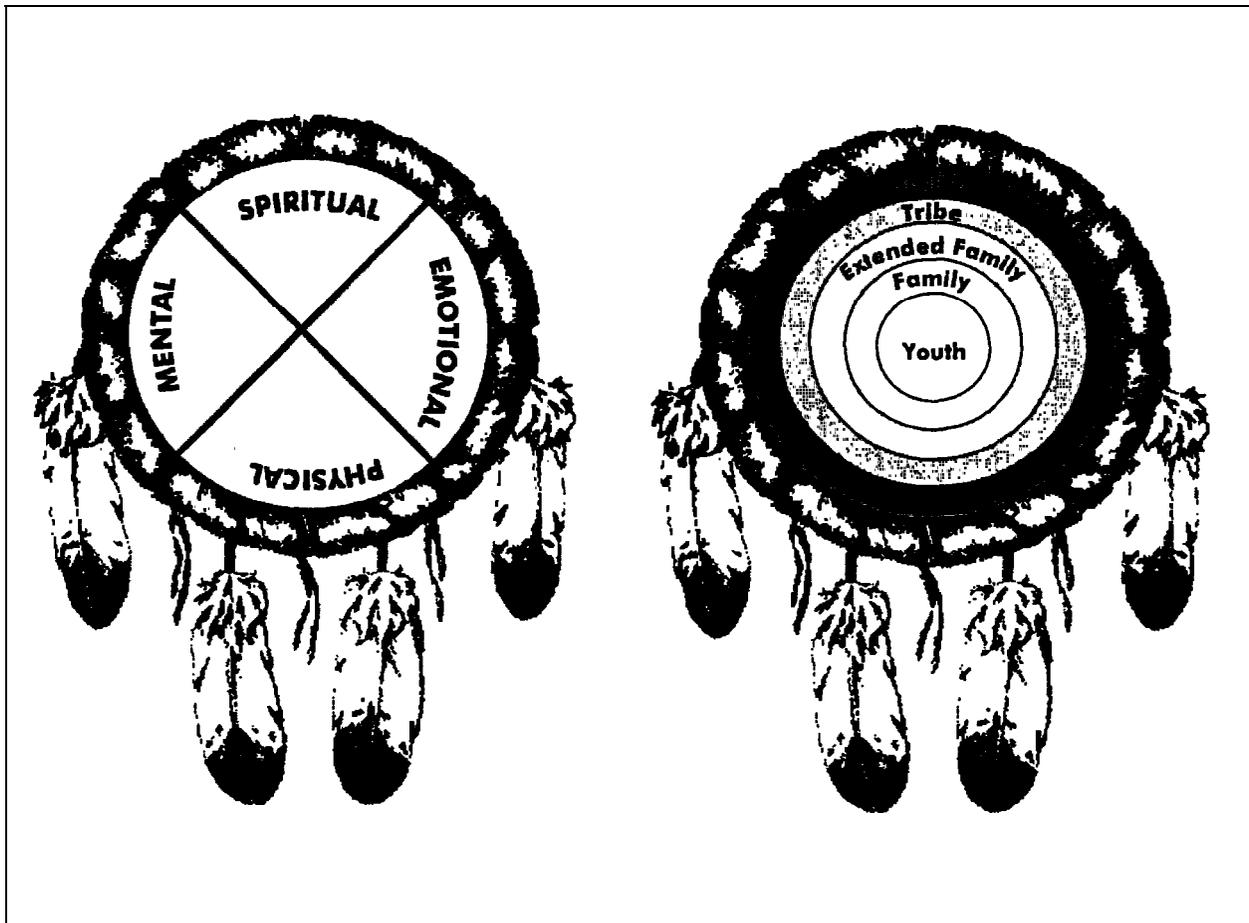


Figure 2. Sacred Circle Illustration

¹ The number of Federally-recognized tribes changes over time as previously unrecognized groups gain recognition. The BIA recognizes 330 tribes and 226 Alaska Native villages. Sometimes the Alaska Native villages are counted as tribes.

The center of the circle represents the individual or youth. The individual is represented in the context of the family which often includes relatives defined as “extended family” by Western writers. What is labeled in the Sacred Circle as “extended family” is often defined by Western observers as the clan, band, or moiety. The family is the center of much AI/AN life, the strength and power that keeps the tribe alive and well. The tribal community is an extension of the primary family. The tribal community is the place where tribal members, particularly elders, take an active role in the strengthening of families and improving the QOL for the individual, family, and community. Society represents the outside influence which impacts on the tribe.

The Sacred Circle can also depict the holistic AI/AN view of the person as the integration of spiritual, physical, social, and mental aspects of life. The QOL for both youth and adults derives from the harmonious balance and integration of the spiritual, physical, social, and mental aspects of being-all in the context of the family, clan, and tribe.

1.1.3.2. Social indicator approach to QOL. QOL has been the focus of the research literature on social indicators. A social indicator may be defined as:

“A statistic . . . which facilitates concise, comprehensive, and balanced judgments about the condition of a major aspect of a society. It is in all cases a direct measure of welfare...if it changes in the ‘right’ direction...things have gotten better or people are ‘better off’ (Department of Health, Education, & Welfare, 1969, p.97).

It is noteworthy that the journal *Social Indicators Research* is subtitled *An International Journal of Quality of Life Measurement*.

1.1.3.3. Subjective definition of QOL. Other lines of research have used a subjective definition of QOL:

“a sense of achievement in one’s work, an appreciation of beauty in nature and the arts, a feeling of identification with one’s community, a sense of fulfillment of one’s potential” (Campbell, Converse, and Rogers, 1976).

A simpler subjective definition is, “...the only defensible definition of quality of life is a general feeling of happiness” (Milbrath 1978, p.36).

1.1.3.4. Human Rights Approach. In 1948, the General Assembly of the United Nations proclaimed the *Universal Declaration of Human Rights* as a “common standard of achievement for all peoples and all nations.” The Declaration contains 30 articles specifying human rights including equality before the law, the presumption of innocence until proved guilty, to a nationality, to own property, peaceful assembly, etc. Articles 25 and 26 are especially pertinent to this study. Article 25

states that every person has the right to “a standard of living adequate for the health and well-being of himself and his **family...and** to security in the event of unemployment . . . or other lack of livelihood in circumstances beyond his control.” Article 25 continues, “Motherhood and childhood are entitled to special care and assistance.” Article 26 states that “everyone has the right to **education...and** education shall be directed to the full development of the human personality....”

1.2. Impetus for the Proposed AI/AN Youth Initiative

The history of duplicity, maltreatment, even genocidal treatment of AI/ANs still reverberates to this day (Nies 1996). There are a number of long-standing threats to the QOL of AI/ANs in general and AI/AN youth in particular. In recent years, some of these threats seem to be growing. These long-standing and growing threats to the QOL of AI/AN has indicated the need for a coordinated, focused initiative on the part of Federal departments and agencies. These threats to the QOL of AI/AN youth include:

- Health-high mortality and morbidity rates for many causes including alcohol and other drugs, sexually transmitted diseases, and diabetes,
- School-high dropout and low academic achievement rates,
- Family-family violence, alcohol and substance abuse,
- Community/Social-youth gangs and crime,
- Employment-chronic unemployment and lack of economic development,
- CI Environmental Quality-pollution and inadequate housing, sanitation, and transportation.

1.3. Related Federal Initiatives and Programs

The proposed initiative to improve the QOL of AT/AN youth should be understood in the context of related Federal initiatives, programs and activities. Rather than a detailed inventory of Federal “Indian programs,” this section summarizes new or planned programs or initiatives which are directly relevant to the proposed AI/AN youth initiative.

1.3.1. President’s Memorandum of 1994. The President’s Memorandum, “*Government-to-Government Relationship with Native American Tribal Governments*” reaffirmed the unique government-to-government relationship between the United States and tribal governments, and directed each executive department and agency to consult with tribal governments prior to taking actions that affect them.

1.3.2. Executive Committee for Indian Country Law Enforcement Improvements.

Working on a government-to-government basis with tribal leaders, the focus of this committee is to develop options for addressing violence and crime in Indian country. The committee is co-chaired

by the BIA Deputy Commissioner of Indian Affairs and the Deputy Assistant Attorney General. A report detailing possible options is planned for the end of October 1997.

1.3.3. Executive Order to Reduce Environmental Health and Safety Risks to Children.

This Executive Order (EO) specifies actions that will strengthen policies and improve research to protect children, and will ensure that new safeguards consider special risks to children. Federal agencies will be required to analyze and explain the effects of their rules on children, and a task force on environmental health risks and safety risks to children will be established. The task force will prepare a biennial report on research, data, or other information that would enhance the ability to understand, analyze, and respond to environmental health and safety risks to children.

1.3.4. Proposed Indian Education EO. Discussions with stakeholders in Indian education indicated that they have been working with tribes for over 2 years to develop an initiative to improve Indian education-this initiative may take the form of an EO independent from the contemplated initiative to improve the QOL of AI/AN youth.

2.0 Methodology

This study involved the collection and evaluation of information on the current QOL of AI/AN youth. Data collection efforts were limited to the study's 2 month period of performance and included bibliographic research, and solicitation of information from Federal agencies and national Indian organizations.

2.1. Bibliographic Research

A variety of automated and non-automated bibliographic resources were searched to identify information pertaining to the QOL and welfare of AI/AN youth. This search included the following resources:

1. **MEDLINE (MEDlars online).** MEDLINE is the National Library of Medicine's (NLM) automated bibliographic database covering the fields of medicine, nursing, dentistry, the health care system, and preclinical sciences. MEDLINE contains almost 9 million records dating back to 1966.

2. **PsycINFO.** PsycINFO is a collection of electronically stored bibliographic references to the psychological literature. The database contains over 1 million records beginning in 1967.

3. Library of Congress Experimental Search System (**ESS**)— The ESS makes cataloging and digital library resources available over the World Wide Web.

4. **ALADIN** (Access to Library and Database Information Network) is the share information system maintained by the Washington Research Library Consortium (**WRLC**). Operational since June 1990, the **ALADIN** system serves the American University, the Catholic University of America, Galludet University, George Mason University, George Washington University, Marymount University, and **the University** of the District of Columbia.

5. Sociological Abstracts. Sociological Abstracts is an index of the sociological literature organized by author and subject with an abstract describing the content of each publication.

6. Bibliographic research at university research centers included:

- Center for American Indian and Alaskan Native Health at John Hopkins University
- . American Indian and Alaska Native Mental Health Research Center, University of Colorado Health Sciences Center
- . Native American Research Information Service, American Indian Institute, University of Oklahoma, Norman, OK
- National Indian Youth Resource Center, University of Oklahoma, Tahlequah, OK
- Adolescent Health Program, University of Minnesota,

7. Internet search engines. Internet-based resources were searched using such engines as Yahoo, Infoseek, Lycos. The terms “American Indian,” “Native American,” “quality of life,” “social conditions,” “economic conditions,” etc. were used to identify and locate relevant resources and publications.

8. University research libraries-bibliographic research was conducted at two universities in the Washington, D.C. area: The Catholic University of American and the American University.

2.2. Federal Agency Data Requests

Most of the Federal executive departments and agencies are represented on the Domestic Policy Council Working Group on Indian Affairs. A subcommittee of this Working Group has been developing information and strategies in support of the proposed **AI/AN** youth initiative. The representatives of each agency on the Working Group were contacted and information pertinent to the AI/AN youth initiative was solicited (see Appendix 2).

2.3. National Indian Organization Data Requests

The major national Indian organizations were contacted and data, resolutions, position papers or other information pertinent to the AI/AN youth initiative were solicited. The organizations are listed below:

1. United National Indian Tribal Youth, Inc. (**UNITY**)—a national, non-profit organization serving American Indian and Alaska Native youth aged 15-24. UNITY was formed to develop leadership, promote self-sufficiency, and instill cultural pride among AI/AN youth. It is based in Oklahoma **City**.²

2. National Congress of American Indians (**NCAI**) is a national organization that advocates for interests of tribes and AI/AN communities. Most Federally recognized tribes are members of NCAI which maintains offices in Washington, D.C.

3. National Indian Health Board (**NIHB**). Based in Denver, Colorado, NIHB advocates for the health-related needs and concerns of tribes and AI/AN communities. NIHB is affiliated with an Area Health Board in each of the **IHS** areas.

4. National Indian Child Welfare Association, Inc. (**NICWA**)-a private, non-profit organization based in Portland, Oregon that promotes the welfare of AI/AN children. **NICWA**'s major activities include community development, public policy development, and information exchange.

5. National Indian Education Association (**NIEA**) is a non-profit organization founded by AI/AN educators in 1969 as a means of improving education for all **AI/ANs** through advocacy, technical assistance, coordination, communications, and, in particular, by holding an annual conference on Indian education. **NIEA**'s mission is to support traditional Native cultures and values, enable Native learners to be contributing members of their communities, promote Native control of educational institutions, and improve educational opportunities and resources for **AI/ANs** throughout the U.S.

6. Native American Rights Fund (**NARF**) is a non-profit legal organization devoted to defending and promoting the legal rights of the AI/AN people. NARF concentrates its legal resources in the following areas: 1) preservation of tribal existence, 2) protection of tribal natural resources, 3) promotion of human rights, 4) accountability of governments, and 5) development of Indian law.

² "Indian country" refers to the land on or near Indian Reservations and Alaska Native Villages and includes the entire state of Oklahoma.

2.4. Data compilation and analysis

Data collected in this review were organized into a matrix which summarizes available data by source. One of the values of the matrix is that it can be used to easily determine knowledge gaps-areas where QOL data are missing. The matrix is presented in Appendix 1 (page 55). The rows of the matrix contain components or correlates of QOL. The columns of the matrix refer to data sources.

Based on review and evaluation of the information collected in this review, a set of fundamental concepts was developed. The status of AI/AN youth is presented on each of five QOL components, and recommendations for development of the proposed initiative are described.

3.0. Key Concepts

Review of the literature suggested that there are a number of concepts that are critical to understanding the threats to and the factors promoting the QOL of AI/AN youth. These concepts are discussed below.

3.1. Indian Self-Determination and Self-Governance

The Indian Self-Determination and Educational Assistance Act, Public Law (PL) 93-638, as amended, allows tribes and Alaska Native villages to assume responsibility for and control of programs formerly operated by Federal agencies for the benefit of AI/ANs. Funding for these programs is provided to the tribes under contracts, grants or compacts between the tribe and the Federal agency. PL 93-638 and its implementing regulations have been reinforced by the President's Memorandum, "Government-to-Government Relationship with Native American Tribal Governments." In the context of the proposed Indian youth initiative, Indian self-determination suggests that the identification of the problems and of the proposed solutions be done in consultation with and collaboration of the tribes. To this end, national Indian organizations were contacted to solicit their input and guidance for this study.

3.2. Culturally Relevant Holistic Approach to QOL

As indicated elsewhere in this report, the "sacred circle" is widely used to represent both the individual's relation to the people and to represent four major components of the whole person (spiritual, mental, physical, and emotional). The point of cultural relevance is that to be effective, Federal efforts to improve the QOL of AI/AN youth must be accomplished at the community level where culturally appropriate adaptations and applications of the initiative are created.

3.3. AI/AN Youth's Approach to QOL

Consistent with the principle of self-determination, this study examined the efforts of AI/AN youth organizations relevant to QOL. One such organization is United National Indian Tribal Youth, Inc. (UNITY)-a national organization designed to develop leadership, promote self-sufficiency, and instill cultural pride among AI/AN youth. UNITY includes 183 youth councils in AI/AN communities. UNITY representatives meet at regional conferences and hold an annual national conference to identify problems and develop solutions for AYAN youth.

In 1990, UNITY published *"The Journey to the Year 2000,"* which includes a set of 12 goals to help AI/AN youth realize their full potential and attain their rightful place in the world community. The 12 goals, or "interrelated paths," include:

- Spirituality*, learning the values of Native American ancestors
- Unity*, working towards healing with those who share a common purpose
- Environment*, developing responsibility and respect for the Earth
- Heritage*, appreciating the unique AI/AN culture and history
- Sovereignty*, discovering tribal/village governments and getting involved
- Family*, strengthening the family-unit and improving communication
- Individual*, recognizing one's own worth and the worth of other people
- Education*, increasing educational attainment of the people
- Health*, promoting the balance between physical, mental and spiritual well-being
- Economy*, building a sound support for tribes and communities
- Sobriety*, adopting lifestyles free of substance abuse
- Service*, establishing community service as a part of life

At the 1997 annual UNITY conference in Phoenix, the participants identified a list of priority issues to be addressed. These issues include:

- Alcohol and substance abuse
- Cultural preservation
- Teen pregnancy
- Discrimination
- Gangs
- Education dropout rate
- Violence.

Each of these issues are addressed later in this report,

definition and can be put in a similar way: Health is the state of physical, mental, social, and spiritual well-being and not necessarily the absence of disease or disability (Cross, Terry 1997).

Health is an undisputed component of QOL. There is a dynamic set of interrelationships between health and other components of QOL such as employment, education, and environment. This section of the report presents the key aspects in the relationship between health and the QOL of AI/AN youth.

4.1. Threats to Life of AI/AN Youth

Without life itself there can be no quality of life. This section reviews **AI/AN** natality and mortality data to identify the greatest threats to the survival of **AI/AN** youth.

4.1.1. Maternal and Infant Mortality. The death of an AI/AN's mother at the child's birth is one of the first threats to the newborn's QOL. In 1958, 3 years after the IHS was established, the **AI/AN** maternal death rate was 82.6 per 100 thousand live births, over twice the rate for the total US population (37.6 per 100 thousand births). Over the next 20 years the **AI/AN** maternal death rate had dropped to 8.5 per 100 thousand births, below the rate for the total population (11.2 per 100 thousand). Since 1977, the maternal death rate for **AI/ANs** has generally remained close to or below that for the total population (6.9 for **AI/AN** in 1992 vs. 7.8 for the general population; **IHS** 1997). This remarkable achievement in Indian health shows that the Federal government, working with the tribes, can make large and lasting contributions to the QOL of all **AI/ANs**.

Not only has there been a dramatic reduction in the maternal death rate, a corresponding decrease in infant mortality has occurred. In 1973 the **AI/AN** infant mortality rate for **AI/ANs** living on or near reservations was 22.2 per thousand live births—significantly higher than the 17.7 rate for the general population. In 10 years the **AI/AN** infant mortality rate had almost halved to 11.5 per thousand. Since 1982 the **AI/AN** infant mortality rate has been close to but slightly greater than that for the general population. When the death rate is computed for neonates (newborns under 28 days of age) the **AI/AN** rate is actually lower than that for the general population.

One of the key variables affecting the survival of newborns is the weight at birth. Low birth weight babies have a far greater chance of dying or having a handicapping condition than babies with a normal birth weight. Many factors contribute to the birth weight including the mother's health, nutrition, smoking and use of other drugs, and age. The most recent data show that the percentage of **AI/AN** births with low birth weight babies (5.8%) was significantly lower than the percentage for the general population (7.1%). This suggests that programs such as the **IHS** Maternal and Child Health Program, and Agriculture Department's Women and Infant Children (**WIC**) and Food

3.4. Research on QOL

This section summarizes the published research focusing on QOL. The concept of quality of life (QOL) is not new; nevertheless, research on QOL began in the 1960s often conducted by sociologists and social psychologists. It was not until 1979 that “quality of life” first became an index entry in *Sociological Abstracts*. In the 1970s, emerging QOL research tended to focus on objective, primarily economic, indicators of well-being. Subsequent research developed subjective or psychological QOL measures. In 1986, *Research on the Quality of Life* (Andrews 1986) included papers comparing QOL across racial/ethnic groups in the United States—however, American Indians were not included in these comparisons (Borgatta and Borgatta 1992).

The 1980s saw increasing attention to QOL in medical research, often with respect to patients with chronic diseases, cancer or elderly patients. Before 1970 cancer research focused almost exclusively on survival. As survival rates of cancer patients increased, research began to examine the QOL of cancer survivors. Similarly, studies began to assess the effects of treatment of chronic diseases on the patient’s QOL (Borgatta and Borgatta 1992).

3.4.1. Measuring QOL. There have been two general types of QOL measures—objective and subjective. The objective measures tend to be used in studies examining changes in the QOL of a group or groups over time or to compare the QOL of different groups, communities, or nations. At the time of this study, no research on the QOL of AI/AN youth had been published. Subjective measures of QOL tend to focus on a person’s happiness or satisfaction with life. The proposed Federal AI/AN youth initiative&likely to focus on objective measures-the goal of the initiative is not to make AI/AN youth into happy or satisfied adults; rather, the goal is to create conditions which enable AI/AN youth to grow, develop, acquire education and skills needed for a productive life, secure employment, and to make positive contributions to their communities.

3.4.2. Objective measures of QOL. Published research has included objective measures such as:

- unemployment,
- per capita income,
- average calorie consumption,
- percent adult illiteracy,
- air quality
- average daily temperature,
- crime rates,
- life expectancy,
- disability,
- level of education.

It is generally recognized that any one objective measure is an inadequate indicator of QOL. Consequently, researchers have developed composite measures such as the Physical Quality of Life Index (Morris 1977). This index includes life expectancy at birth, infant mortality, and literacy. The Index of Social Progress (ISP) consists of 36 objective indicators organized into 10 subgroups: education, health status, status of women, defense effort, economic, demographic, political participation, cultural diversity, and welfare effort (Estes 1988). The ISP was designed to assess the changing capacity of nations to provide the basic social and material needs of their populations as opposed to personal happiness, satisfaction with life or personal fulfillment.

Objective measures have been used to assess the QOL of American cities. The QOL domains used include economic, environmental, health, and education (Borgatta and Borgatta 1992). The present study focuses on five QOL domains: health, education, employment, environment, and justice.

3.4.3. Subjective measures of QOL. Most subjective QOL measures involve happiness or satisfaction with life—either life as a whole (global measures) or with specific aspects of life. Between 1967 and 1984, over 700 studies using subjective measures of QOL were published (Diener 1984). The best predictors of global satisfaction with life include family life, leisure activities, work, finances, housing, the community, and friendships (Campbell, Converse, and Rogers 1976).

3.5. Demographics of AI/AN Youth

Based on 1990 Census data, the age distribution in the AI/AN population residing on or near reservations is very different from that in the general population of the United States—the AI/AN population is much younger (see Figure 2). The percentage of the population that is comprised by infants under 1 year of age is two times greater for **AI/ANs** (2.6%) than for the general population (1.3%). Children aged 1-4 years represent 9.4 percent of **AI/ANs** but only 6.1 percent for the general population. Children under 10 represent over 20 percent of the AI/AN population whereas they represent less **than** 15 percent of the general population (MS, 1997). The predominance of youth in the AI/AN population is likely to have profound impact on many facets of life in Indian country.

Related to the relative youth of the AI/AN population is its high birth rate—the **AI/AN** birth rate in 1991-1993 (26.6 births per 1 thousand population) was 67 percent greater than for the general population (15.9 per 1 thousand population). Given these birth rates, the AI/AN population will continue to grow as will the numbers and percentages of AI/AN youth.

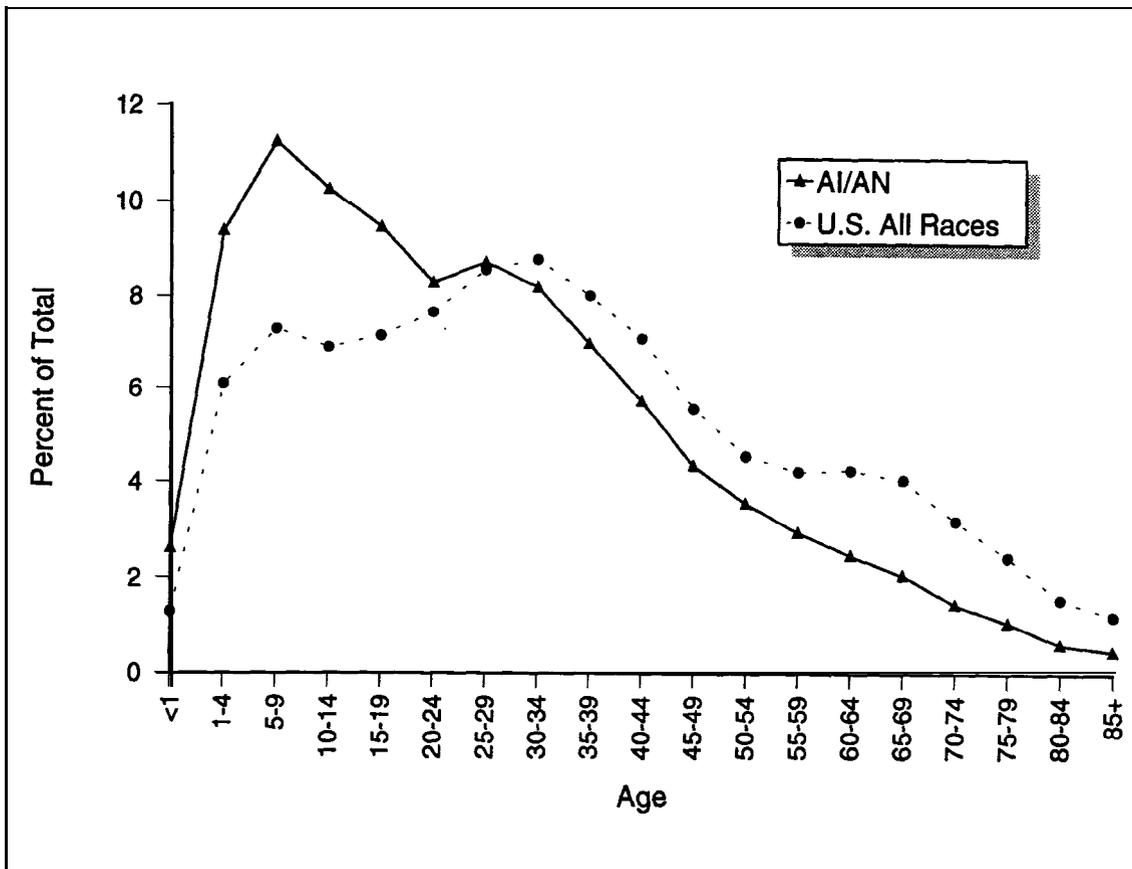


Figure 3. AI/AN Population Based on 1990 Census Data

3.6. Stages of Development

The life span of an individual from birth (from gestation) to death is often divided into periods, stages or phases of development. While the concept of developmental stages is widely used throughout the world, the exact nature of the stages often varies across time and cultures. For example the period “adolescence “ between childhood and adulthood was generally not recognized as separate from adulthood until the late 18th century (Aries 1962). Despite such variation in definitions, the present study distinguishes 4 developmental periods in order to facilitate the definition of threats to QOL at particular periods of development of AI/AN youth-prenatal, infancy, childhood, and adolescence. These developmental periods used in this report are often subdivided into finer categories by researchers; however, such fine discrimination is unnecessary for the purposes of this study.

The resources and conditions needed to sustain life and to maintain a desirable QOL transcend most developmental stages. Regardless of the developmental stage, a person needs adequate food, housing, safety, etc. Likewise, there are few, if any, threats to or resources needed for QOL that are unique to any developmental period. Furthermore, detailed information on the threats to QOL while

probably known, were often not readily available and, thus, are not included in this report. Nevertheless, the distribution of threats to QOL is often very different for different periods. For example, there is a dramatic increase in the incidence of alcohol and substance abuse starting at adolescence. The developmental stages used in this study are presented below.

1. Prenatal period. While the 9 month gestation period is often subdivided into stages, for purposes of this study, only the prenatal period as a whole is addressed. Examples of issues of particular importance in the prenatal period include maternal nutrition and education, and fetal alcohol syndrome (FAS).

2. Infancy. Infancy is the first year of life.

3. Childhood. Childhood is the period from age 1 to 11 years.

4. Adolescence. Adolescence is the period from puberty, generally at 11 or 12 years to adulthood. In this study, the attainment of age 18 is set as the upper boundary for Indian youth.

3.7. Components of the QOL Examined in the Study

While the review of the literature indicated that there is a complex set of relationships among components of QOL as well as the fundamental importance of a holistic approach to QOL, it is necessary to organize the results in some systematic fashion. The approach adopted is to focus on issues in a way that facilitates targeting by existing Federal agencies and departments. Thus the remainder of this report is organized around five aspects of QOL:

1. Health
2. Education
3. Employment
4. Environment, and
5. Justice and Law Enforcement.

4.0. Health

In this report health is construed in its broadest sense and includes public health, wellness as well as disease, and threats to health. The World Health Organization (WHO) defines health as “The state of physical, mental, and social well-being and not necessarily the absence of disease” (Institute of Medicine 1988). The Indian understanding of health adds an important dimension to the WHO

Distribution Programs on Reservations have been successful despite all the problems existing in Indian country such as high unemployment, high school dropout rates, etc.

While the reduction in **AI/AN** maternal and infant mortality rates have been dramatic, there remains great variation in these mortality rates across AI/AN communities-in some **AI/AN** communities the maternal and/or infant mortality rate significantly exceeds that for all races. There is similar variation across these communities on most aspects of QOL. Two points should be kept in mind with respect to this variation: 1) instances of success (e.g., dramatic reductions in maternal and infant mortality, school dropout, and unemployment) should be studied so that the successes can be replicated, and 2) instances of little or no progress should be targeted for renewed.

4.1.2. Natality and Adolescent AI/ANs. Generally, adolescent pregnancy and births are considered to be undesirable from a public health perspective. Pregnancy in an adolescent interferes with social, educational, and economic development and tends to be associated with medical problems for both the mother and baby. Thus, it is of concern that relatively high percentage of AI/AN adolescents are having children. The percentage of AI/AN births to women under 20 years of age (20%) is almost twice that for whites (11%). Almost 2 percent of the AI/AN births were to adolescent mothers less than 15 years old.

Sexually Transmitted Diseases (STDs). Early sexual activity is also associated with **STDs** including HIV infection. In a 1994 survey of students in **BIA-funded** schools, two of every three **BIA** students indicated that they had sexual intercourse. Among male BIA students, 39 percent had four or more sexual partners in their lifetime. Four of every ten students reported sexual intercourse during the previous 3 months. Overall, 12 percent of the students reported that they had been pregnant or had gotten someone pregnant.

4.1.3. Accidents/Unintentional Injuries. The causes of death vary drastically as a function of age and gender. Despite this variation, accidents (unintentional injuries) represent the major cause of death and, thus, the greatest threat to the life and health of AI/AN youth. Depending on the age, AI/AN youth are 3 to 7 times more likely to die in an accident than from any other cause. Among accidents, the greatest single cause is motor vehicle **accidents**.³

After motor vehicle accidents, the most common causes of accidental deaths of AI/AN youth include bicycle accidents, drowning, and fire-related accidents. The data are clear, efforts to improve QOL of AI/AN youth by reducing avoidable deaths should target accidents in general and motor vehicle accidents in particular.

³ The only exception is neonatal deaths which are most often caused by sudden infant death syndrome (SIDS) and congenital abnormalities.

4.1.4. Other Causes of Death. After accidents, the two major killers of AI/AN youth are suicide and homicide. While there is some suicide for youth aged 5 to 14 years (the rate is 1.9 per 100 thousand population), there is a dramatic jump in suicides of AI/ANs 15-24 years of age (the rate is 3 1.7 per 100 thousand population).⁴ The suicide rate for AI/ANs aged 15-24 years is almost 2.5 times greater than that of the general population. The homicide rate for AI/ANs aged 15-24 (20.1 per 100 thousand) is slightly lower than that of the general population (MS 1997). Thus, an initiative to reduce avoidable deaths of AI/AN youth should include suicide prevention as well as prevention of motor vehicle accidents.

4.1.5. Alcoholism and Alcohol Abuse. Alcohol is an important risk factor associated with the top three killers of AI/AN youth—accidents, suicide, and homicide. In addition, there is a direct effect of alcoholism on the mortality of AI/AN youth. Based on 1991 to 1993 data, the rate of mortality due to alcoholism among AI/ANs 15 to 24 years of age was 5.2 per 100 thousand population, which is 17 times the rate in 1992 among U.S. whites of the same age.⁵ An indicator of the gravity of alcoholism among AI/AN youth is the mortality rate for chronic liver disease and cirrhosis. These maladies result from long-term, regular abuse of alcohol and generally appear in middle age or older. Thus, few adolescents die from alcohol-induced liver disease because they have not lived long enough to manifest the injuries. Nevertheless, chronic liver disease and cirrhosis are the eighth leading cause of death among AI/ANs, and the AI/AN mortality rates (1.0 per 100 thousand) for persons 15 to 24 years of age are 10 times greater than the rate for the same age group in the general population (0.1 per 100 thousand).

4.1.6. Gender, Age, and Mortality. Up to age 5, the mortality rates for AI/AN boys are slightly higher than those for girls; however, starting at age 5, boys die at rates generally between 2 and 6 times greater than do girls. For the 5-14 age group, almost 2 boys die for each girl in accidents; in the 15-24 age group, 5 boys commit suicide for each girl who commits suicide, and 6 boys are killed in homicides for each girl killed. Clearly, initiatives to decrease the mortality of AI/AN youth should take gender into account.

4.2. Morbidity

This section examines the non-lethal threats to the health of AI/AN youth and, thus, their QOL-QOL can be impaired by injury, illness, and disability. To identify the major non-lethal threats to Indian health, we examined hospitalization data.

⁴ The age range 15-24 is used here because it was unavailable in finer categories in the source: *Trends in Indian Health-1996*.

⁵ As with the AI/AN suicide data, the age range 15-24 is used because it was unavailable in fine categories in the source: *Trends in Indian Health-1996*.

4.2.1. Hospitalizations. As with the causes of death, the causes of hospitalization vary with age and gender and vary across AI/AN communities. Up to age 15, respiratory diseases account for 46 percent of hospitalizations of infants under 1 year of age, and for those 1 to 4 years old; the percentage falls to 23 percent of hospitalizations of children 5 to 14 years old. For the age group 15-24, complications of pregnancy and childbirth account for the majority (54%) of hospitalizations. Following deliveries and complications of pregnancy, which are for women only, the leading causes of hospitalization are injury and poisoning. Given that injuries are the leading cause of death in this age group, it is not surprising that injuries lead as reasons for hospitalization as well. Examination of data on the reasons for ambulatory doctor and clinic visits confirm the hospitalization data—respiratory diseases, accidents, and prenatal care are the major reasons for such visits among AI/AN youth.

In the 40 years between 1955 and 1995, significant changes occurred in the 10 leading causes of hospitalization of AI/AN youth less than 16 years old. In 1955, tuberculosis, measles, and other infective conditions were among the 10 leading reasons for hospital care of AI/AN and youth. Almost 40 years later, these have been replaced by asthma, appendicitis, and convulsions. The appearance of asthma among the current 10 leading causes points to the growing importance of this disease and is confirmed with anecdotal information from IHS clinicians.

4.2.2. Prenatal Exposures. Of great importance to the health and well-being of AI/AN youth are two prenatal exposures that have potential health effects through life-prenatal exposure to alcohol and diabetes.

Prenatal Alcohol Exposure. In *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (Public Health Service 1991) the baseline rate given for the incidence of FAS in the white population is 0.22 per 1,000 live births. In contrast, 4 cases per 1,000 births among AI/ANs are given as baseline (Pettitt, et al. 1993). From 1981 to 1986, the Centers for Disease Control Births Defects Monitoring Program reported an FAS rate among AI/ANs that was 33 times the rate among whites (Chavez 1988). Retrospective studies among some American Indian groups found FAS rates quite variable ranging from 1.3 to 10.3 per 1,000 births (May 1983; 1991). Apparent high rates among American Indians may, in part, reflect more complete reporting and surveillance on the part of MS health professionals. Furthermore, some clinicians and community workers involved with AI/ANs and general FAS prevention programs, cite clinical evidence that many infants with FAS are not identified or reported.

FAS is a relatively small part of the total impact of prenatal alcohol exposure (Ernhart 1991; American Academy of Pediatrics 1993). Although the findings of FAS are not fully present, and the

child may appear to have less alcohol related damage, the full personal and societal impact may be quite significant.

Prenatal Diabetes Exposure: Type II Diabetes (Adult Onset/Non-insulin Dependent Diabetes) has multiple associated risk factors. It is well known that obesity is one of the most significant of the risk factors. Determinants of obesity in children include an interaction of environmental and hereditary factors (e.g parents and children share diets, lifestyles, and genes).

In addition, it has been found that intrauterine exposure to the metabolic environment of an obese or diabetic mother also may be an important determinant for obesity and onset of diabetes in her child (Byers 1992). Indian preschool children of mothers who were obese during their pregnancy were more than twice as likely to be obese than children whose mothers were not obese (Gallaher 1991). In another study (Pettitt 1987), children, five to 19 years of age whose mothers had maternal diabetes, were heavier than children born to mothers who were not diabetic or who did not develop diabetes after pregnancy. In longitudinal studies done over many years in a southwest Indian population, this relationship of maternal diabetes and obesity in the offspring was again noted as well as the finding that children who were exposed to intrauterine diabetes had higher glucose concentration and more diabetes than children who did not experience this exposure (Pettitt, et al. 1993). This may be the reason clinical observations report an increase in the incidence of Type II Diabetes among AI/AN adolescents.

Diet/Nutrition. Findings from the *State of Native American Youth Health* indicate that the eating habits of many adolescents result in nutritionally inadequate diets. For example:

- Cl Over 67% reported eating junk food daily, with 41% eating such food 2 or more times daily
- 53% reported failing to eat foods from one or more food groups daily
- 13% reported eating fruits and vegetables less than daily
- Cl 39% eat red meat daily
- Cl 37% eat eggs daily.

Given the high rate of teen pregnancy, nutritionally inadequate diets of many AI/AN youth, and the low rate of prenatal care, many infants start life at a disadvantage. Forty percent of females and 21 percent of males reported being overweight.

4.2.3. Specific Physical Health Conditions. Two specific conditions threaten the QOL of AI/AN youth.

Asthma. Older practitioners, who served Indian children and youth 30 and 40 years ago, infrequently treated asthma (Herxheimer 1964; Slocum, Thompson, and Chavez 1975). For example, from 1969 to 1977 only one Indian death due to asthma was recorded in New Mexico (Samet, et al. 1980). Recent data seem to show asthma is an important emerging chronic health problem among AI/AN children. The mortality rate due to asthma among AI/ANs (1.1 per 100 thousand) appears to be near the rate among the general population (1.2 per 100 thousand; Coultas, et al. 1993). Asthma was the fourth leading pediatric discharge diagnosis in 1991 for Indian children under 15 years of age. When asthma-related hospitalizations in MS facilities between 1979 and 1989 were studied, asthma related discharges of Indian children less than 17 years of age increased 2.6 percent. Children under five years of age experienced a 3.7 percent increase in hospitalizations for asthma (Hisnanick, Coddington, and Gergen 1994). Two to three percent of ambulatory care visits in 1991 and 1992 for Indian children under 15 years of age were due to asthma (MS 1994). Asthma in early age can lead to chronic respiratory conditions.

Obesity/Diabetes. Surveys of the nutritional status of American Indians 50 to 70 years ago documented significant malnutrition among some tribes (Jackson 1986). As recent as the 1960s, deficient weight for age, kwashiorkor, and marasmus were not uncommon reasons for pediatric admissions to the Tuba City MS Hospital on the Navajo Reservation (Duzen, Carter, and Vander 1976). Overweight and obesity have replaced this malnutrition. Some populations of AI/AN children now have rates of obesity 2 to 10 times the rate seen in the general US. population. Rates of overweight and obesity among selected age and population groups among AT/AN children and youth appear to have been increasing over the last 10 to 15 years (Broussard, et al. 1991; Sugarman, et al. 1990; Gilbert, et al. 1992; Nelson 1994; Hauck, et al. 1992).

The overall prevalence rate of diagnoses of diabetes for individuals 15 to 44 years of age is three times the general U.S. rate. For Indians less than 15 years of age, the prevalence rate was almost twice the rate for the general U.S. population. Rates, derived from IHS ambulatory care data, show wide regional variation, from less than half among Alaska Natives to more than 7 times the rate among general U.S. population (Valway, et al. 1993) among some Indian groups in Arizona.

4.2.4. **Behavior-Related Conditions.** Value of one life lost is unmeasurable, but cumulative losses of lives to AI/AN communities due to injuries, homicide, and suicides among its youth cannot be fathomed and such loss never heals. One way to express the depth of loss is in years of productive life lost (YPLL). YPLL are calculated on the basis of the years a person who dies would have lived before age 65. Thus a person who dies at age 20 will have 45 YPLL. YPLL adds rapidly when deaths are considered among youth. For the years 1990 to 1992 the average yearly YPLL for AI/ANs due to these three causes of death was 23,289 years (Sack, et al. 1994). The complex constellation of

social, emotional, and behavioral factors associated with these conditions include chronic depression, feelings of loss, family dysfunction, and substance abuse.

Baby-bottle tooth decay (BBTD). Baby bottle tooth decay is a preventable dental disease which affects over 50 percent of pre-school AI/AN children (MS 1992). BBTD results from one of the following practices: leaving a bottle with a child at nap or bedtime, or allowing a child to walk around or sit with a bottle during waking hours. Any liquid (milk, juice, formula) with fermentable sugar can cause BBTD. Problems resulting from BBTD may include many cavities, crooked permanent teeth, ear and speech problems, possible psychosocial problems, and/or orthodontic problems. Surveys indicate that the prevalence of BBTD ranges from 17 percent to 85 percent in some AI/AN communities. The MS has implemented an innovative program to combat BBTD.

Tobacco Use. Two forms of tobacco use-smoking cigarettes, and chewing/dipping smokeless tobacco are significant threats to the health of AI/AN youth. These practices are likely to have long term consequences such as increased morbidity from lung and oral cancer.

Smokeless tobacco. A review of 7 different community based behavioral risk surveys conducted on AI/AN youth populations from grades K-12 indicates the following findings concerning prevalence of smokeless tobacco use (Breud 1990):

- Cl 13% and 21% of the children in 2 separate kindergarten sites
- Cl 18% of students in grades K-6
- Cl 37% of students in grades 7-12
- Cl 56% of the 9-10 graders (at another site).

The overall findings from this review indicate: 1) onset at an early age, 2) fairly similar patterns of use by males and females, 3) duration of 1 to nearly 8 years, 4) average intensity of use at nearly 3.5 dips per day for 30 minutes duration, and 5) higher overall rate of use compared to the non-Indian population.

There appeared to be an understanding by the AI/AN youth survey participants of the health risks associated with use of smokeless tobacco. One study reviewed included a component where junior and senior high school students who use smokeless tobacco volunteered for oral screening. **Thirty-seven** percent of these students receiving the screening showed evidence of leukoplakia in the site where the smokeless tobacco was held. The reasons most frequently given for using smokeless tobacco were peer pressure and enjoyment.

Cigarettes. Illnesses associated with cigarette smoking are acknowledged to be one of the major causes of premature death in adults, and the breathing of secondary cigarette smoke is associated with childhood respiratory and other health problems.

In an evaluation of the effectiveness of the MS-funded adolescent alcohol/substance abuse regional treatment centers (RTCs), the mean age at first use for tobacco by AI/AN youth was 12 years of age, with no significant difference for gender (Hillbrant et al., 1997). The study also showed that there was a relationship between age at first use and a history of physical and sexual abuse—clients who were abused tended to smoke cigarettes and drink alcohol at earlier ages than those who had not been abused.

Risky Behaviors. In 1994 the BIA Office of Indian Education Programs sponsored a youth risk behavior survey (YRBS) of 9th through 12th grade students attending BIA-funded schools (BIA 1994). The survey revealed that the students engaged in a number of behaviors that put “at risk” the health and QOL of AI/AN youth (OIEP 1994):

- Overall, 41% of the BIA students “never” or “rarely” wore a seat belt when riding in a car driven by someone else.
- One-half of the BIA students (50%) rode in a car driven by someone who had been drinking during the previous 30 days.
- Overall, 29% of BIA students seriously considered attempting suicide during the past 12 months. Among female students, 36% seriously considered attempting suicide during the past 12 months.
- Overall, 24% of BIA students were involved in a physical fight on school property during the past 12 months.
- Nearly one-third (31%) of all BIA students smoked on 20 or more days during the past 30 days.
- Over four in every ten BIA students (43%) had five or more drinks in a row in one day during the past 30 days.
- Overall, 68% of BIA students have tried marijuana.
- Overall, 15% of BIA students had tried cocaine.
- Overall, 36% of BIA students had use inhalants.
- Two or every three BIA students have had sexual intercourse. Of those BIA students who had sexual intercourse during the past three months, 64% used contraception and 47% used a condom at last sexual intercourse.

4.3. Alcohol and Substance Abuse

National surveys of adolescent drug use report AI/ANs have higher rates of alcohol and other drug use than any other racial-ethnic group (Beauvais 1992; Oetting, et al. 1988). Despite previous treatment and prevention efforts, A/SA continues to be prevalent among AI/AN youth—82 percent of AI/AN adolescents admitted to having used alcohol, compared with 66 percent of non-Indian youth (Beauvais and LaBoueff 1988). In a school-based study, 39 percent of AI/AN high school seniors reported having “gotten drunk” and 39 percent of AI/AN admitted to using marijuana in the

month prior to the survey (BIA 1994). Utilization of inhalants by AI/AN youth has been reported to be two to five times greater than that of non-Indian youth. An evaluation of MS-funded adolescent regional treatment centers (RTCs) found that 36% of the clients reported using inhalants, a rate 2 to 5 times greater than that of non-Indian youth (Hillabrant, et al. 1996).

Alcohol and substance abuse are believed to be contributors to and the results of other health and social problems including sexually transmitted diseases, physical abuse, sex abuse, poor school achievement and dropout, and suicide. Studies (Beauvais 1992) of A/SA prevalence by AI/AN youth indicate:

- ❑ The age at first involvement with alcohol is younger for AI/AN youths, the frequency and amount of drinking are greater, and the negative consequences are more common.
- ❑ At all ages and grades, a greater percentage of AI/AN youths are more heavily involved with alcohol than non-Indians.
- ❑ AI/AN youth have the highest rate of sexually transmitted diseases found in any ethnic group. This rate is associated with the use of alcohol and other drugs.

The youth most likely to abuse alcohol are those with a parent who abuses alcohol or other drugs, with friends who use and who have problems at school (Hillabrant, et al. 1996).

The RTC study indicated that some AI/AN youth reported using alcohol as early as 2 to 4 years of age; 21 percent reported age of first use at 7-10 years of age. One client record indicated that family members had placed alcohol in his bottle when he was a toddler. These findings on age at first use have implications for A/SA prevention efforts: Efforts that target teenagers and high school students will be “too late” for many adolescents who begin to abuse alcohol by age 11 or younger. If efforts are to impact children before they begin to drink and/or smoke, the efforts have to target children in elementary schools at ages younger than 11 years and even in the Head Start program. These findings also suggest that clients who were abused tended to smoke cigarettes and drink alcohol at earlier ages than those who had not been abused.

4.4. Mental Health

A critical factor in the mental health and well being of AI/AN youth is a well functioning and secure family. However, the severe stresses in many AI/AN communities present special **challenges**—poverty, isolation, alcohol and substance abuse, discrimination, unemployment, and low levels of education individually and collectively cause emotional distress.

Thirty-six percent of adolescents in the *State of Native American Youth Health* survey indicated they worry a great deal about the economic survival of their family. Other findings from the study include:

- ❑ 65 percent of adolescents reported being bored,

- Cl 20-27 percent reported being tense, stressed, and burnt out
- approximately 50 percent reported being worried about future job prospects
- 18 percent report being the victim of sexual or physical abuse; females report being victimized at much higher rates than males (20% of high school girls)
- Cl 22 percent of youth reported they have a family member whom they are aware attempted or completed a suicide.

4.5. Family Violence

Family violence on Indian reservations is devastating for individuals, families, and reservation communities. It has a lasting and detrimental effects on the individuals who directly experience the abuse, on the nuclear family, the extended family, and members of the Indian community. There are many families in AI/AN communities that have experienced violent behaviors, that have coped with violent behaviors positively, and/or wish to learn more about violent behaviors and their prevention (Hillabrant, et al. 1996).

Elected offices or “the man in the street” seldom acknowledge or understand the nature and scope of family violence in many AI/AN communities. Family violence is defined as any of the following: 1) spouse abuse including the beating, battering or sexual abuse of one spouse by the other, 2) child abuse including physical injury or maltreatment of a child under 18 years of age, 3) child neglect, 4) child sexual abuse including persuasion or coercion of a child to engage in sexual activity, and 5) elder abuse including physical or emotional abuse that hinders the life of an elderly person.

Reliable prevalence data on family violence on reservations is generally lacking; however, it is known that gender and age are critical aspects of family violence. Most of the perpetrators are men, and most the victims are women and children; nevertheless, family violence knows no class, income, age, race, ethnicity, or education bounds. Family violence occurs among the wealthy and the poor, among the employed and the unemployed; family violence is perpetrated by people with advanced degrees and people with little formal education. Family violence occurs among Indian tribes and communities throughout the United States.

Increased awareness of family violence prompted the formulation and passage of legislation aimed at putting in place a more effective system of reporting, identifying, and remedying the problem. The *Indian Child Protection and Family Violence Prevention Act of 1990* emanated from a Congressional review of the problem of child abuse on Indian reservations. The findings from this review revealed that:

- Incidents of abuse of children on Indian reservations are grossly underreported;
- Cl Underreporting is often a result of the lack of mandatory Federal reporting law, and a lack of the resources needed to develop a sophisticated tracking and reporting system;

- ❑ Multiple incidents of sexual abuse of children on Indian reservations have been perpetrated by community members and by persons employed or funded by the Federal government;
- ❑ Federal investigations of the background of Federal employees who care for, or teach, Indian children are often deficient;
- ❑ Funds spent by the Federal government 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; and
- ❑ There is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and families, and the United States has a direct interest, as trustee, in protecting Indian children who are members of, or are eligible for membership in, an Indian tribe.

4.6. Reducing Threats to Health of AI/AN Adolescents

Probably no group in the AI/AN community is more in need of consistent and comprehensive health care than its adolescents. Adolescence is the time when physical health is at its peak and the need for curative care is relatively infrequent. This does not diminish the importance of well developed and efficiently implemented adolescent health care programs. The major health conditions that affect the well being of AI/AN require concerted community-based efforts directed toward reduction of behavioral risk factors and toward support of the majority of youth who follow a path of good behavior.

Threats to adolescent health are related to participation in risky behaviors. Reducing adolescent involvements in risky behaviors calls for well organized and focused primary prevention efforts-efforts that will be accessible and acceptable to adolescents. Prevention interventions will likely be more effective when adolescents themselves, along with community involvement and support, become engaged in shaping programs and activities to reduce risk and to promote well-being among adolescents. Approaches to consider in development of adolescent health services and programs include:

1. Community Based Adolescent Education Programs. These programs can develop interaction and communication with parents and community that will promote parents' and community capacities to respond to the health needs of their adolescent children such as:

- ❑ Helping adolescents understand the physical and emotional changes that are occurring in this time of their life.

- Helping adolescents to understand the importance of and adoption of behaviors leading to safety and injury prevention.
 - Helping adolescents understand the importance of adopting good nutrition practices and physical fitness and of avoiding overweight and obesity.
 - Helping adolescents to understand the risks of and to avoid tobacco, alcohol, substance abuse.
- CI In collaboration with the community and supporting organizations and resources, develop and promote programs and activities that will focus on creative prevention interventions in adolescent violence, suicide, and depression.
- In keeping with community values, develop a consistent focus on promoting healthy psychosexual adjustment and preventing the negative consequences of sexual risk behaviors among adolescents.

It is important to recognize that the majority of AI/AN adolescents are well motivated. The adult community and health providers should be careful not to apply adverse stereotypes when discussing and planning around adolescent health issues. Therefore, an adolescent health intervention should help the larger community recognize and reward the majority of adolescents who are engaged in making successes of themselves, their families, and their communities.

2. Coordinated multi-disciplinary, inter-agency, systems approach. Development, implementation, and maintenance of a comprehensive community adolescent health program and services is complex and challenging. To meet this challenge, a multi-disciplinary, interagency systems approach is required in allocating resources and in developing community-based programs that focus on the special health needs of adolescents. The community health facility and school are the primary institutions involved in adolescent health, but other organizations and community activities also have important roles and include at least the following:

- CI Community recreation programs
- CI Religious organizations
- Law enforcement
- The courts
- Social services
- CI Community political leaders.

How to bring these together in creation of a common and cooperative focus on the health needs of adolescents will likely emerge from community wisdom supported by technical assistance and professional knowledge from interested and committed professionals, especially professionals associated with local health and school programs and services.

5.0. Indian Education

Education is a both a key component as well as a key determinant of the QOL of AI/AN youth. Educational achievement is dynamically associated with many other aspects of QOL such as employment, use of alcohol and other drugs, family values and involvement, and health and nutrition.

Over the years, Indian education has experienced major failures and unacceptable practices (e.g., forced separation of children from families, suppression of native language and culture). Consequently, numerous attempts have been made to reform and improve Indian education. One such effort is an on-going initiative lead by the National Indian Education Association (NIEA), many tribes, and other organizations with the aim of securing an Executive Order that will promote Indian education reform. While Indian education is the focus of a separate tribal/Federal initiative under development, education is such a key component of the QOL of AI/AN youth that it must be addressed in this study too,

Among many Indian Education reform initiatives, two key national efforts have occurred in the 1990s—the Indian Nations at Risk Task Force and the White House Conference on Indian Education. Consistent with tribal consultation, these initiatives and their recommendations are summarized in this section of the report. Appreciation of the comprehensive treatment given by these two educational reform efforts requires reference to their respective final reports.

In 1990, the Education Department (ED) chartered the Indian Nations at Risk Task Force to report the status of Indian education and recommend ways to improve it. In 1991, the Task Force issued its final report. This report 1) documents failures and problems in Indian education, 2) lists 10 “national goals” for AI/AN students, and 3) presents an “Indian Student Bill of Rights.”

In 1992, in accordance with PL 100-297, the White House Conference on Indian Education (WHCIE) was convened. The WHCIE was organized to “facilitate solutions [rather than] to revisit and re-debate the problems.” Based on 30 state, regional, and tribal pre-conferences and the resolutions adopted by 234 delegates at the Conference, a set of 11 topic areas were identified along with action plans for implementing improvements.

5.1. Failures and problems in Indian Education

The alarming state of Indian education is amply captured in the October 1991 final report of the Indian Nations at Risk Task Force. The report depicts an education system in need of immediate and drastic improvements. Among the problems with Indian education cited by the report are:

- a) **General Critique.** Schools have failed to nurture the intellectual development and academic performance of many Native children, as is evident from their high dropout rates and negative attitude toward school. Schools have discouraged the use of Native languages in the classroom, thereby contributing to a weakening of American Indians' resolve to retain and continue the development of their original languages and cultures.
- b) **Low Academic Achievement.** The Scores of **AI/ANs** on a standardized college entrance exam (ACT) are lower than for most other minority groups.
- c) **Dropout Rate.** As many as 35 percent, and in some places 50 to 60 percent, of AI/AN students drop out of school. **AI/AN** students have the highest high school dropout rate in the nation. Thirty-six percent (36%) of AI/AN tenth graders in 1980 were reported to have later dropped out of school, a number which represents more than twice the national percentage for white students.
- d) **Math Performance.** The percentage of AI/AN students (32.3%) determined to show a "Below Basic" level of performance in Math, represents twice that for white students (15.5%). Conversely, the percentage of white students (22.4%) determined to show an "Advanced" level of performance in Math is almost five times that for AI/AN students (4.8%).

5.2. Indian Student Bill of Rights

The Indian Nations at Risk Task Force identified 5 rights to which every AI/AN student is entitled:

- Cl A safe and psychologically comfortable environment in school,
- A linguistic and cultural environment in school that offers students opportunities to maintain and develop a firm knowledge base,
- Cl An intellectually challenging program in school that meets community as well as **individual academic needs**,

- ❑ A stimulating early childhood educational environment that is linguistically, culturally, and developmentally appropriate,
- ❑ Equity in school programs, facilities, and finances across Native communities, and in schools run by the Federal government and public schools in general.

5.3. National Education Goals for AI/AN Students

The Indian Nations at Risk Task Force identified 10 educational goals to guide the improvement of all Federal, tribal, public, and private schools serving AI/ANs and their communities. These 10 goals are presented below:

Goal 1: Readiness for School. By the year 2000 all Native children will have access to early childhood education programs that provide the language, social, physical, spiritual, and cultural foundations they need to succeed in school and to reach their full potential as adults.

Goal 2: Maintain Native Languages and Cultures. By the year 2000 all schools will offer Native students the opportunity to maintain and develop their tribal languages and will create a multicultural environment that enhances the many cultures represented in the school.

Goal 3: Literacy. By the year 2000 all Native children will be literate in the language skills appropriate for their individual levels of development. They will be competent in their English oral, reading, listening, and writing skills..

Goal 4: Student Academic Achievement. By the year 2000 every Native student will demonstrate mastery of English, mathematics, science, history, geography, and other challenging academic skills necessary for an educated citizenry.

Goal 5: High School Graduation. By the year 2000 all Native students capable of completing high school will graduate. They will demonstrate civic, social, creative, and critical thinking skills necessary for ethical, moral, and responsible citizenship and important in modern tribal, national, and world societies.

Goal 6: High-Quality Native and non-Native School Personnel. By the year 2000 the numbers of Native educators will double, and the colleges and universities that train the nation's teachers will develop a curriculum that prepares teachers to work effectively with the variety of cultures, including the Native cultures, that are served by schools.

Goal 7: Safe and Alcohol-Free and Drug-Free Schools. By the year 2000 every school responsible for educating Native students will be free of alcohol and drugs and will provide safe facilities and an environment conducive to learning.

Goal 8: Adult Education and Lifelong Learning. By the year 2000 every Native adult will have the opportunity to be literate and to obtain the necessary academic, vocational, and technical skills and knowledge needed to gain meaningful employment and to exercise the rights and responsibilities of tribal and national citizenship.

Goal 9: Restructuring Schools. By the year 2000 schools serving Native children will be restructured to effectively meet the academic, cultural, spiritual, and social needs of students for developing strong, healthy, self-sufficient communities.

Goal 10: Parental, Community, and Tribal Partnerships. By the year 2000 every school responsible for educating Native students will provide opportunities for Native parents and tribal leaders to help plan and evaluate the governance, operation, and performance of their educational programs.

5.4. Eleven Topics Identified by the WHCIE

The results of the WHCIE were published in two volumes that are organized around 11 topics. These topics are summarized below.

Topic 1: Governance of Indian Education Independent Board of Education. Three themes were expressed with respect to this topic: 1) the need for tribal control of Indian education, 2) strengthening and reinforcing tribal capabilities for such control, and 3) the need for an Executive Order reaffirming Federal trust responsibility for Indian education.

Topic 2: Well-Being of Indian Communities/Delivery of Services. This topic includes the need for holistic and comprehensive efforts to protect and ensure the well-being of AI/AN communities. The well-being of the whole community is seen to be intrinsic to improved student educational and social outcomes. Efforts to improve student educational outcomes must be done in a culturally appropriate fashion.

Topic 3: Literacy, Student Academic Achievement and High School Graduation. This topic includes 1) local community control and involvement in all aspects of meeting the educational and cultural needs of the community, 2) the need to enhance and develop educational strategies and curriculum methodologies that are culturally relevant, promote positive student outcomes, and 3) the requirement for program accountability.

Topic 4: Safe, Alcohol/Drug-Free Schools Introduction. This topic includes community-based 1) identification of needed resources, 2) comprehensive health, education and employment services, and 3) sustained prevention and rehabilitation efforts.

Topic 5: Exceptional Education. This topic includes 1) equitable access to funding under existing authorities (e.g., PL 94-142, PL 100-297, and PL 101-477), 2) the need for culturally appropriate research, training, and services, and 3) comprehensive educational planning to meet the needs of exceptional **AI/AN** students.

Topic 6: Readiness for School. This topic includes 1) parent and family training in early childhood education, 2) coordination of multi-agency, comprehensive early childhood services, and 3) research to improve techniques for identifying, teaching, and providing other services to challenged, gifted, talented, and at-risk **AI/AN** children.

Topic 7: Native Language and Culture. This topic includes strengthening and preserving **AI/AN** language and culture by enforcing existing laws (e.g., the Indian Religious Freedom Act and the Bilingual Education Act) and by a Federal policy statement in support of strengthening and preserving the languages and cultures of **AI/ANs**.

Topic 8: Structure for Schools. This topic includes 1) educational restructuring and reform based on locally-determined needs, 2) Federal policy statement of its trust responsibility to protect tribal rights and interests, especially self-determination and governance, and 3) streamline existing systems to provide for a better coordinated and comprehensive approach to educational planning, research, and services.

Topic 9: Higher Education. This topic includes 1) efforts to improve student outcomes should result in social and economic benefits to the tribal community (e.g., better coordination between student graduation and community employment opportunities), 2) Federal and state assistance to tribes to develop histories, undertake research, develop and implement training and curricula, and 3) strengthening the infrastructure of tribally controlled colleges including library, language, and cultural services.

Topic 10: Native/Non-Native Personnel. This topic includes 1) the United States' honoring and maintaining treaties with and trust responsibilities for Indian nations by making Indian education an entitlement, 2) tribal involvement and decision making at all levels of Indian education, and 3) improvement of recruiting and retention of **AI/AN** education **professionals**.

Topic 11: Adult Education and Lifelong Learning/Parental, Community and Tribal Partnerships. This topic includes 1) the definition of tribal, state, and Federal responsibilities for adult education, 2) need for comprehensive assessment of community adult education needs, 3) enhancing adult education services to meet community cultural, vocational, and educational needs,

6.0. Employment, Economic Development, and Poverty

There is an obvious direct association between employment and economic development, and employment is dynamically related to many aspects of QOL including education, health, and housing. Both economic development and employment opportunities are severely limited on most Indian reservations. The most recent published unemployment rate for the potential labor force of AI/ANs living on or near reservations is almost 50 percent (BIA 1996). While the lack of jobs in Indian country means it is difficult for AI/AN youth to secure employment, the indirect effects on their QOL are far more dramatic. Over multiple generations, the inability of parents and other relatives to secure productive, paying jobs has resulted in poverty and an expectation that there is little hope of ever securing employment.

Economic development and employment on Indian reservations and Alaska Native villages is unique. The regulation of commerce between Indian nations and the United States has always been the domain of the Federal government. Article 1, Section 8 of the Constitution states, “the Congress shall have the power...to regulate commerce with foreign nations, and among the several states, and with Indian tribes.” In fact, prior to the ratification of the Constitution, the Northwest Ordinance of 1787 asserted that Indian “land and property shall never be taken from them without their consent...” Subsequent laws such as the “non-intercourse acts” prohibited land deals with Indians without the explicit approval of Congress.

6.1. Obstacles to Indian Economic Development

An Indian reservation is a specific area of land which has been reserved or set aside for the occupancy and use of an Indian tribe. While reservations have been created for several purposes, the area set aside for tribes was seldom selected for its desirability or valuable natural resources. Since Indian commerce, like all commerce, is strongly affected by the presence and availability of natural resources, it is not surprising that the economic development of many tribes is hampered by a lack of a strong resource base. Furthermore, economic development on many reservations is made difficult by the operation of the following six factors:

1. Title to Land. The title to much of the Indian land is held by the Federal government as a trustee for a tribe, an individual Indian or a group of Indians. Land held in trust generally cannot be used as security for a mortgage or other credit financing.

2. Jurisdiction. Jurisdiction on Indian reservations is complex. Different governmental bodies (e.g., tribe, Federal government, state government) may have jurisdiction for various purposes, and sometimes jurisdiction may overlap.

3. Sovereign immunity. Like other political entities, Indian tribes have sovereign immunity. This immunity can discourage corporations and other commercial entities from entering into business ventures with tribes or tribally-owned enterprises.

4. Unskilled workforce. Most Indian reservations have a long history of underdevelopment with chronic unemployment exceeding 35 percent. Little hope of obtaining productive work combined with high school dropout rates and low levels of academic achievement have resulted in unskilled workforces. According to the 1990 census, 65 percent of AI/ANs living in reservation states are high school graduates or higher compared to 75 percent in the general population. The percentage of AI/ANs who are college graduates (9%) is less than half that of the general population (20%).

5. Lack of infrastructure. Many reservations lack sophisticated telecommunications, efficient transportation and other infrastructure that facilitate employment and economic development. For example, many Alaska Native villages can be reached only by air except in the winter when the tundra freezes permitting surface travel by motor vehicle or dog sled.

6. Remote location. Many reservations are located in remote locations subject to harsh environmental conditions such as extreme heat and cold. These locations are often far away from population centers and markets and associated facilities and resources such as airports that can accommodate large passenger and transport aircraft, railroad terminals, factories, etc.

6.2. Unemployment

Approximately every 2 years, the BIA publishes statistical data about its service population and labor force estimates. At the time of this report, the most recent BIA data was for the 1995 calendar year. Of the total 1.9 million AI/ANs counted in the 1990 census, 1.3 million resided on or near Indian reservations governed by Federally-recognized tribes. Of these AI/ANs, the BIA report includes only those who are members of a Federally recognized tribe or who are “one fourth degree or more of blood quantum descendants of a member of a tribe....”

In 1995, the BIA reported a “potential labor force” of 616 thousand-the potential labor force is defined as “all persons 16 years or older, excluding those who are either students or otherwise unable to work.” Of the total potential labor force, 49 percent were unemployed. When persons not seeking work (i.e., those who have no available work opportunities in the immediate area and those lacking transportation to seek work elsewhere) are eliminated from the potential labor force, the unemployment rate falls to 35 percent.

6.2.1. Chronic Unemployment and Education. There is a dynamic interrelationship between unemployment and education. When there is little hope of securing employment the incentive for youth to remain in school and to earn degrees is attenuated and, consequently, the school dropout rate increases. Conversely, when academic achievement decreases and school dropout increases, there are fewer skills in the reservation labor pool. These effects are compounded over the generations as parents do not model being employed and completing high school or college education for their children.

6.2.2. Chronic Unemployment and Mental Health. As with education, there is a dynamic interrelationship between chronic unemployment and mental health in a community. Unemployed persons are less able to provide for their needs as well as the needs of their family and community. This lack of autonomy and power is frustrating, often leads to a sense of **diminished value** or **self-worth**, depression, and despair. These feeling are associated with increased dispositions to substance abuse, displacement of aggression to others, and suicide. Conversely, frustrated, angry, depressed, or substance abusing people are poor employment prospects.

6.3. Poverty

According to the 1990 census, the percentage of **AI/ANs** living below the poverty level (32%) is almost three times that of the general population (13%). An even higher percentage of **AI/AN** children live below the poverty level_“3 percent of **AI/AN** children below the age of 5 years live below the poverty level. The median **AI/AN** household income is \$19,897 while that of the general population is \$30,056.

6.3.1. Poverty and Chronic Unemployment. Poverty combined with chronic unemployment tends to have a transcendental effect of **QOL**. A critical factor in the equation is a sense of hope, purpose, or probability of changing conditions. Individuals with few resources (i.e., are poor) but have a job may have an sense of self-worth; or a person may chose to have few material resources for the sake of a valuable end (e.g., education, religious orientation, war against an invader). In such circumstances, the effects of poverty are often benign. On the other hand, if poverty is experienced in the context of unemployment, with little hope for improved conditions, or is involuntarily (as opposed to a chosen sacrifice for a cherished goal), the effect on **QOL** is often pernicious.

6.4. Federal Employment and Economic Development Programs

A number of Federal programs have been created to generate employment and economic development in Indian country. Seven of these programs are described below.

6.4.1. BIA Economic Development and Employment Programs. The BIA has several programs designed to foster economic development and employment in Indian country. There are several financing programs including a revolving loan fund, a loan guarantee program, and an economic development “seed money” program. In addition, the BIA funds economic development grants. Other BIA programs that contribute to economic development include natural resources development, business enterprise development, construction (e.g., highways, housing), and forestry.

6.4.2. Small Business Administration (SBA). The SBA has several programs designed to promote small and disadvantaged (generally minority-owned) businesses. One of these programs, the Section 8(a) program has been recently adapted to meet the unique needs of tribally-owned businesses. Businesses participating in the 8(a) program can be awarded Federal contracts on a sole source basis (i.e., without having to compete with other firms). A number of tribes and Alaska Native villages have businesses participating in the 8(a) program. Some of these businesses are making sales to the government in excess of \$5 million per year.

6.4.3. Minority Business Development Agency (MBDA). In the Department of Commerce, the MBDA promotes minority business development by funding Minority Business Development Centers and Native American Business Development Centers. These centers help create jobs, and improve the QOL for minority Americans by supporting local businesses and offering them bonding, bidding, estimating, and financing assistance.

6.4.4. Administration for Native Americans (ANA). Part of DHHS, ANA provides a variety of programs and services to Native Hawaiians and other native groups in addition to AI/ANs. One of the ANA programs is the social and economic development strategies (SEDS) program. Through the SEDS program, ANA provides grants to tribes, Alaska Native villages and to AI/AN organizations to develop infrastructure needed for social and economic development. In addition to funding grants, ANA provides training and technical assistance to grantees. Tribes and bands seeking Federal recognition are eligible for and receive ANA grants.

6.4.5. Education Department (ED) Vocational Education Program. The ED funds grants to schools and educational organizations providing vocational education (VocEd). These VocEd programs are required to place their graduates into paying jobs. By statute, a percentage of the total VocEd funding is set aside for tribal VocEd programs.

6.4.6. Department (DOL) JTPA Program. The DOL, under Title IV-A of the Job Training Partnership Act (JTPA), provides grants to **AI/AN** grantees to provide community-based employment and training services. JTPA programs provide a variety of services including on the job training (OJT), classroom training, and training assistance.

6.4.7. National Indian Gaming Commission. Beginning in 1983, following court decisions that tribes on reservations were not subject to certain state civil and regulatory laws, a number of tribes started to operate bingo and other forms of gaming. With the proliferation and expansion of gaming, Congress passed PL 100-497, the Indian Gaming Regulatory Act, in 1988. This act regulates gaming on Indian lands by creating the Commission to oversee class II and class III gaming procedures on tribal lands.

7.0. Environment

This section includes a broad spectrum of issues related to QOL for AI/AN youth from an environmental perspective. Many topics discussed in this section pertain to safety-safety associated with adequate shelter/housing, safety from environmental pollutants (involving removal of solid wastes and sewage treatment, clean air, water), safe transportation, etc.

7.1. Housing and Living Arrangements

Many **AI/AN** communities are in remote locations subject to harsh environmental conditions including extreme heat in the summer and extreme cold in the winter. Under such conditions, inadequate housing can be a matter of life or death. In fact, accidents are the greatest cause of death and disability of **AI/AN** youth. Most of these accidents are motor vehicle related; however, many accidents are related to fires. These fires which kill and injure **AI/AN** youth are often associated with inadequate housing-kerosine or electrical space heaters are used to supplement inadequate heating equipment.

The 1990 census revealed that there were 234,400 occupied housing units in Indian country, and that housing problems of **AI/ANs** are considerably more severe than those of other Americans. The percentage of **AI/AN** households that are overcrowded or lack plumbing or kitchen facilities (28%) is over 5 times greater than that for other Americans (5.4%). Deficiencies in structural condition and support systems (e.g., heating, electrical) are not measured; however, a study funded by the Department of Housing and Urban Development (HUD) revealed that when the condition of the housing was considered, the percentage of **AI/ANs** living in overcrowded or inadequate housing grew to 40 percent (Michelsons and Eschback 1995). This study also found significant variation

across tribes: Indian communities located relatively close to urban centers have fewer housing problems than communities located in remote areas. **Michelsons** and Eschback concluded:

- C1 Housing produced under HUD's Indian housing programs does have defects, but its availability has substantially improved living conditions for thousands of families. This housing stock accommodates about one fourth of all AI/AN households living in Tribal Areas.
- The most attractive direction for reforming Federal housing assistance in Tribal Areas over the long term should be to consolidate existing programs into more flexible mechanisms-grants that gives tribe and their **IHAs** broader latitude in planning, funds allocations, and implementation to address local housing needs as they see them, but hold them more clearly accountable for performance. However, tribal management problems must be addressed (through technical assistance and other means) before the tribes affected can gain the benefits that should arise from enhanced flexibility.
- Homeownership rates for **AI/AN** households at moderate- and higher-income levels are well below those for non-Indians at the same income levels. Private lenders and market intermediaries are beginning to recognize that expanded mortgage lending to AI/AN households and communities may be a promising market opportunity; however, policy support is needed to translate this opportunity into reality.

7.1.1 . Homelessness and Overcrowding. Household surveys show that homelessness is rare in Indian country. The lack of adequate housing is reflected in severe overcrowding because most **AI/ANs** who lack shelter are taken in by relatives or other tribal members.

Many **AI/AN** youth live in extended family situations which may include aunts, uncles, grandparents, cousins, or others. A study of AI/AN adolescent health reported the following results:

- 14 percent live with 5-6 other people in a dwelling with less than 4 rooms,
- 13 percent live with 7 or more people in a dwelling with less than 4 rooms,
- Average family size is nearly 6 people,
- 66 percent live in households of 4 - 8 persons.

As the size of the family increases, so does the concern for parental abuse, domestic violence, and poverty. In a household of 4 or less, 16 percent of adolescents expressed concern over physical abuse; 21.4 percent of adolescents living in a household of 7 or more expressed this concern. Similar concerns were expressed for violence between parents (17% vs 27%) and poverty (33% vs 41%). Adolescents are aware of the economic problems of their families. Over 36 percent indicated they worry very much about the economic survival of their families (University of Minnesota 1992).

7.1.2. DHUD Programs in Indian Country. A broad array of Federal housing assistance programs is available in Indian country. This assistance is dominated by two HUD programs which account for 88 percent of DHUD assistance: the Rental program—which operates like public housing—and the Mutual Help program—a homeownership (lease-purchase) program in which buyers make small monthly payments and, unlike the Rental program tenants, must cover their own operating and maintenance expenses. Both programs are dominated by the 187 Indian Housing Authorities (IHAs)—agencies whose boards are appointed or elected by the tribes they serve.

While small in comparison to Federal housing programs operating nationwide, these programs have had a significant impact in Indian country. There were 60,700 AI/AN occupied HUD assisted units in Tribal Areas in 1990. This number is the equivalent of 26 percent of all AI/AN households in those areas and 42 percent of those with low incomes.

7.1.3. Other Housing Programs. BIA's Housing Improvement Program (HIP) provides grants for housing improvements, targeted to very low-income households. The HIP is normally administered by the tribal governments. Most funds have been used for modest rehabilitation and repair of existing units rather than new construction, although the latter is allowable under the program. Although HIP has made valuable contributions, at current funding levels (\$20 million per year) it cannot be expected to make much of a dent in AI/AN housing problems.

Tenant-based assistance programs (Section 8 Certifications and Vouchers) help low-income households rent housing of their choice in the private market (HUD subsidies make up the difference between the market rent for the unit and what the tenant can afford to pay). This approach will not work in remote Tribal Areas where a large private housing stock does not exist.

Financing initiatives. The availability of private mortgage financing that most Americans take for granted has been largely withheld from Tribal Areas (mostly because lenders have perceived additional risks due to the inability to foreclose on trust land and other legal complexities). The FHA Section 248 mortgage insurance program was established in 1987 in the hope of offsetting these risks, but the program has rarely been used. A new (Section 184) loan guarantee program has been established as well, but it has only recently become operational.

Two HUD block grant programs have been used to support housing improvements in Federally recognized Tribal Areas: the Indian Community Development Block Grant (ICDBG) and the HOME Investment Partnership. Both are administered by tribal governments directly rather than their IHAs, and both permit substantially more local flexibility in spending decisions than occurs under categorical initiatives like the Rental and Mutual Help programs.

ICDBG is HUD's principal vehicle for supporting community and economic development activities in Indian communities. A total of over 1,300 project in 32 states were funded between 1980 and 1994. HOME is a block grant program, created in 1990 solely to support local housing initiatives. It can be used to support a variety of locally designed activities including tenant-based assistance, down-payments for home buyers, and housing production and rehabilitation programs.

7.1.4. Safe Drinking Water and Sanitation Facilities. Because of the remote location and lack of infrastructure, many AI/AN homes lack such services as running water and/or sanitation, telephone and electrical service, and public transportation. There is a direct relationship between waste water treatment and safe drinking water. Thus, as a matter of public health, the IHS has been actively involved in the provision of waste water treatment facilities in AI/AN communities and the installation of sanitation facilities in AI/AN homes. The major funding for this work has been provided by five sources: 1) IHS, 2) DHUD, 3) tribes, 4) local governments, and 5) housing authorities. Sanitation facilities are installed for existing homes as well as for new construction. Young children are especially vulnerable to unsafe drinking water, and the provision of safe drinking water in AI/AN communities has been an important factor in the significant decrease in infant mortality achieved over the last 40 years. While great progress has been made, large numbers of AI/AN youth still lack safe drinking water.

Each year, the MS is required by statute to estimate the funding that would be required to provide 1) first service, 2) to upgrade existing facilities, 3) to provide solid waste facilities, and 4) to provide assistance to operation and maintenance organizations. In 1996, the total amount needed was estimated to be \$630 million. The bulk of the needed funds (\$306 million) is needed for safe drinking water services with \$203 million needed for sewer facilities and services, and \$112 million needed for solid waste facilities.

7.2. Transportation Safety and Availability

The number one killer of AI/AN youth aged 1-24 years is accidents involving motor vehicles. Two factors contribute to these deaths: 1) use of alcohol and other drugs, and 2) failure to use seatbelts or car safety seats for preschool children. Clearly, efforts to reduce these deaths should target the use of alcohol and other drugs and the use of seat belts and child safety car seats,

7.2.1. Availability. Little information on the availability of transportation, public or private, was found in the study. One study of the availability of transportation on 7 reservations was conducted by the University of Minnesota (Anding and Fulton 1993). The reservations are located in 5 states: Utah, Colorado, Wyoming, Montana, North Dakota, South Dakota, and Minnesota. The study revealed that 80 percent of the reservation residents rely on a single vehicle, shared with other members of the household. Of these household vehicles, 25 percent are 5-10 years old, and another

25 percent are older than 10 years. Lack of transportation represented a significant threat to the respondents' QOL-the lack of transportation had forced:

- ❑ 36 percent to turned down desirable employment;
- ❑ 27 percent to forego additional education;
- ❑ 29 percent to experience a health crisis;

The majority of the respondents (52%) indicated that better transportation would improve their life a great deal. The average yearly household income for the 1,484 households in the study was less than \$15,000 for 75 percent of the households in the study indicating there are few resources available to purchase a reliable motor vehicle.

7.2.2. Risk Behaviors. In *State of Native American Youth Health*, a study conducted by the University of Minnesota, adolescents reported alarming trends related to transportation safety. These findings have been confirmed by a study conducted by the BIA in 1994 of a group of high school students at BIA schools. For example,

- ❑ 48 percent of males and 43 percent of females in grades 10-12 reported that they rarely or never wore seatbelts regularly in a car (compared to BIA results of 41%).
- ❑ 45 percent of the males in grades 10-12, and over 34 percent of the females in the same grades reported having driven while under the influence of alcohol during the past year.
- ❑ 21 percent reported that they had ridden in a vehicle operated by someone under the influence of alcohol during the past year.
- ❑ 44 percent of males and 58 percent of females in grades 10- 12 rarely or never wear helmets when on a motorcycle.
- ❑ 48 percent of males and 36 percent of females in grades 7-9 reported riding in the back of a pickup truck.

Of those who have seen parents drink 3 or more drinks before driving, 50 percent said they would have done the same thing.

Seven in 10 BIA students had ridden in a car driven by someone who had been drinking during the previous 30 days. One out of every four 12th grade BIA students drove while drinking alcohol during the previous 30 days. Seven in 10 students who rode motorcycles, never or rarely wore helmets. Nine in ten students who rode bicycles, never or rarely wore a helmet (BIA 1994).

7.2.3. Infrastructure and Equipment Safety. It is not uncommon for AI/AN communities to lack pedestrian facilities such as sidewalks and crosswalks. While reliable national data were not found, there are known problem areas. For example, US Highway 666, a two lane highway, runs from Gallup, NM to Window Rock and other sites in the Navajo nation. While the highway has no sidewalks, it is heavily used by AI/AN pedestrians traveling to and from Gallup. Each year there are

numerous collisions between pedestrians and motor vehicles on this road resulting in serious injuries and fatalities. In the 6 year period from 1982 to 1988 there were 22 fatalities resulting from collisions between pedestrians and cars on Highway 666 (Bill 1988).

Another transportation problem is lack of highway and bridge maintenance. Lack of funds often curtails removal of snow and ice from highways and for maintenance of bridges located on Indian reservations. These problems are exacerbated by the high percentage of older, unreliable motor vehicles on reservations (Anding and Fulton 1993).

7.3. Other Safety & Security Issues

7.3.1. Firearms and other Weapons. Illegal use of firearms and other weapons in **Indian** country constitutes a threat to the QOL of AI/AN youth and others. Nine out of 10 homicides in the United States involve firearms and homicide as the second leading cause of death of AI/AN youth aged 15-24. The immediate accessibility of a firearm or other lethal weapon often is the factor that turns an altercation into a lethal event (Sloan et al. 1988). Nonfatal violence such as fighting often precedes a homicide among young person (Luckenbill 1977). The **BIA** adolescent health risk study revealed that over 1 in 4 BIA students carried a weapon in the prior 30 days. The most common weapon carried was a **gun**—13 percent of BIA students reported carrying a gun in the previous 30 days (BIA 1994).

7.3.2. Safety at School. Over 10 percent of BIA students stated that they did not attend school at least 1 day in the previous 30 days because of feeling unsafe either at school or en route to school. These safety concerns may be reasonable since 1 in 10 **BIA** students reported being threatened with or actually injured with a weapon on school property in the prior 12 months. Of greatest concern, 1 in every 5 male students admitted to carrying a weapon on school property in the prior 30 days (BIA 1996).

8.0. Justice/Law Enforcement

Safety and security are important aspects of QOL and are discussed throughout this report. Nevertheless, there are direct relationships among safety, security, law enforcement and justice. Specifically, a reasonable QOL requires freedom from illegal assault (including homicide), loss of property (e.g., robbery, burglary), and discrimination (e.g., in employment, access to health care, etc.).

8.1. Threats to Safety and Security-Violence

The greatest threat to the safety and security of AI/AN youth is violence. The perpetrator of violent assaults is most likely to be a parent (i.e., family violence) or a peer, either in the form of an attack by an individual or by a group (gang violence). While violent crime has been falling in recent years in American cities, it has been increasing at an alarming rate on reservations.

8.1 .1. Homicide, Assaults, and Battery. The overall homicide rate for Federally recognized tribes has risen 87 percent since 1992. Homicide is the third leading cause of death for AI/ANs in the age groups 1-14 and 15-24 years. The homicide rate is 1.5 times higher for AI/AN youth than for the overall population, and 2.6. times higher than the rate for the white population. The increase in violent crime in Indian country has coincided with increasing gang activity, domestic violence, and child abuse.

Due to chronic under-reporting and in some cases no reporting at all, statistics understate the real extent of violent crime on Indian lands. While detailed data on homicides in Indian country is lacking, there are data for some reservations. For example, in 1995 the murder rate on the Gila River reservation in Arizona (103 per 100 thousand population) was over 10 times that of the United States (9 per 100 thousand) and almost twice that of the city of Detroit (53 per 100 thousand) (LeClare 1997).

Findings from the *State of American Indian Youth Health*, a study conducted by the University of Minnesota in 1992, indicate the following regarding violence among AI/AN youth:

- 40 percent reported hitting or beating someone up at least once in the past year.
- Half of the boys in grades 7-9, and over one-third of the girls (same grades) reported having been involved with interpersonal violence at least once in the past year.
- Approximately 25 percent of teens surveyed have been involved in a group fight at least once in the past year.
- 30 percent of the boys in grades 7-9 and 27 percent in grades 10-12 have participated in a group fight at least once over the past year; 23 percent of girls in grades 7-9 and 14 percent of girls in grades 10-12 have done the same.
- Younger boys are slightly more likely to have been involved in group fighting 3 or more times over the past year.
- Students who are regular users of marijuana or alcohol are more apt to engage in violence activities than others.
- Approximately 20 percent of students reported having been knocked out at least once or twice; boys experience such violence more than girls (**26% vs. 19%**).

Gangs and Violence. The BIA criminal investigations unit has identified more than 180 gangs in Indian country with a range of activities that include vandalism, theft, possession of firearms, sale of narcotics, and drive-by shootings. Findings from the Minnesota study on Indian youth included the following aspects of gang behavior:

- ❑ Over 15 percent of AI/AN youth report some level of personal affiliation with a gang. There is no difference in gang affiliation by gender.
- Cl 19 percent of students in grades 7-9 report some connection with gangs compared to 10 percent of those in grades 10- 12.
- ❑ 5 percent reported they spend a lot of time in gangs.
- ❑ Students in gangs are more likely to report being involved in multiple instances of violent behavior.

In 1996, at least 6 of the 46 homicides on the Navajo reservation were related to the 54 gangs on the reservation.

8.1.2. Sexual Assaults and Abuse. In 1993, BIA Social Services received 31,901 child abuse complaints over 10 percent (3,400) of which involved allegations of sexual abuse. BIA Law Enforcement reports that the rate for sexual offences, excluding rape and prostitution, in Indian country (228 per 100 thousand population), is over 5 times greater than that of rural counties (41 per 100 thousand). The rate for forcible rapes in Indian country (32.5 per 100 thousand) is 35 percent greater than that for rural counties (24 per 100 thousand). The rate for attempted rape in Indian country (15 per 100 thousand) is 5 times greater than that in rural counties (3 per 100 thousand).

It is clear that an initiative to improve the QOL of AI/AN youth must include efforts to decrease all forms of assault in Indian country.

8.2. Threats to Civil and Treaty Rights

Throughout the history of the United States, AI/ANs have experienced **discrimination** and violation of human and civil rights. For example, most AI/ANs did not become citizens of the United States until 1924 with the passage of the Indian Citizenship Act. Acknowledging unfair treatment by individuals, groups, states and others, the Federal government assumed trust responsibility for individual AI/ANs and for tribes. Nevertheless, many AI/ANs continue to report they experience discrimination and denial of their civil and treaty rights.

Because of the government-to government relationship between tribes and the Federal government, states, counties, and other political entities sometimes claim that AI/AN are ineligible for services. For example, AI/ANs otherwise eligible might be denied services of programs operated or funded by a state or county such as welfare or other social services. AI/ANs residing near an IHS-funded health care facility may be refused access to health care or otherwise discouraged from receiving

services at a state, county, or privately-operated facility and referred to the MS for care regardless of eligibility for MS services.

Tribal members with hunting, fishing, and other rights guaranteed by treaty with the United States are still harassed by individuals, groups, and governments. **AI/ANs** have reported discrimination and civil rights violations in many areas including 1) employment, 2) access to loans and capital, 3) access to public and private housing, 4) practice of religion, and 5) access to holy sites. Such discrimination is experienced directly by **AI/AN** youth and indirectly when their family members and other members of the tribe are discriminated against.

8.3. Other Justice-Related Problems

8.3.1. Lack of Detention and Correctional Facilities. *Detention facilities* are used to house the accused until time of adjudication and for short term stays generally associated with relatively minor crimes. *Correctional facilities* are generally used for longer stays and serve at least two functions: 1) protection of the community from dangerous offenders, and **2)** a place for the correction or rehabilitation of the offender to become a law-abiding citizen. Currently, tribal detention facilities for youthful offenders are in short supply-there are only 339 facilities nationwide. Even worse, there are virtually no tribal juvenile correctional facilities available that offer a full range of programs for education, rehabilitation, and drug treatment.

Because of the lack of facilities, youthful **AI/AN** offenders are often released into the community without formal arrest or incarceration and, thus, without rehabilitation. When juvenile offenders are especially violent, they are often incarcerated by the BIA in adult facilities. The existing detention facilities are generally overcrowded, 20-30 years old and are so dilapidated that they meet few building and safety codes. This situation is unlikely to improve because the BIA law enforcement budget has declined from \$78.5 million to 74.6 million from fiscal years 1992 to 1995 (**LeClare** 1997). The lack of detention and correction facilities can make a mockery of the efforts of police and the courts. For example, in 1996, the Navajo Nation police made 28 thousand arrests but only 121 beds were available in correctional facilities on the reservation.

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the Department of Justice, through research with the American Indian Law Center, has studied the needs of **AI/AN** juvenile justice systems, and has worked to meet the needs of juvenile offenders. One alternative under consideration is the traditional incarceration and for programs to help the offenders reenter their communities. Under **OJJDP's** Native American Alternative Community-Based Program, four grants were awarded to tribes-three in the southwest, and one in Minnesota. These grants allowed the tribes to develop alternative placement and reentry programs for **AI/AN** juvenile offenders.

Impact on BIA Boarding Schools. The BIA funds approximately 70 residential boarding schools. Because of the lack of juvenile correctional facilities and community-based treatment facilities, the boarding schools have become the ‘dumping ground’ for delinquent AI/AN youth.

AI/AN Youth in Federal Custody. There are relatively few juveniles in the Federal juvenile and criminal justice systems. In 1995, the Federal Bureau of Prisons reported having custody of 270 offenders who were 17 or younger at the time of their offense. Of these youth, over 50 percent were AI/ANs.

8.3.2. Lack of Law Enforcement Officers. Despite this increase in crime in Indian country, the number of Peace Officers in Indian country, per capita, is half that in the rest of the country. In 1996, the BIA budget (which includes law enforcement) was reduced by \$121 million resulting in a reduction of criminal investigators and tribal police. According to some tribal officials, this loss has adversely affected safety on reservations.

8.3.3. Alcohol/Substance Abuse. Alcohol and substance abuse are associated with most of AI/AN juvenile crime. Tribes report that more than 90 percent of juvenile and adult offenses occur when the perpetrator is under the influence of alcohol or other drugs. Most juvenile delinquents are intoxicated at the time of their arrest.

8.4. Federal Justice Responsibilities

Two Federal agencies have primary responsibilities for criminal investigation and justice on reservations-the BIA and the Department of Justice (DOJ), with the BIA having primary responsibility. The increasing crime rate in Indian country should be addressed through a partnership between the Federal and tribal governments. Although the DOJ enforces Federal law in much of Indian country, the solutions to the crime problem must come from within tribal communities.

The DOJ has two roles in responding to crime in Indian country:

- 1) Acting through the U.S. Attorneys’ **Offices**, it is responsible for the prosecution of major crimes and crimes between Indians and non-Indians in most of Indian country, and
- 2) a commitment to enhancing the capacity of tribes to confront the problems of crime and juvenile delinquency in their communities.

The Office of Justice Programs (OJP) within the Department of Justice is the primary resource for funding in Indian country. In the past, Indian communities have not received an adequate share of OJP funds and assistance. This has resulted from poor communication between OJP components and tribal governments, and from the funding mechanism in place - the pass through program.

The DOJ is working to improve and expand services in Indian country. For example, an American Indian and Alaskan Native Desk has been created within the OJP. This office was designed to coordinate programs and be responsive to the tribal concerns. Examples include:

- ❑ 66 grants to tribes for combating violence against women (domestic violence and sexual assault) totaling \$5.2 million.
- ❑ Victim's assistance programs (funding and provision of technical assistance) from the Office of Victims of Crime.
- ❑ Through the Children's Justice Act, \$1.5 million was provided to tribes to improve the investigation, prosecution, and handling of child abuse cases.
- ❑ Training of Federal, state, local, and tribal criminal justice professionals (from OVC). OJP's Bureau of Justice Assistance provides discretionary funding to Boys and Girls Clubs of America (BGCA) to aid in youth violence control and prevention. In 1996, BGCA provided \$1.3 million to 23 Indian tribes to establish 11 new clubs and continue to support 12 clubs on Indian reservations.
- ❑ OJP's Corrections Program Office awards formula grants to states to build correctional facilities and 2) administers a 0.3 percent set aside for tribal corrections facilities. Two grants were awarded to tribes— 1) Gila River Tribe of Arizona and 2) Yankton Sioux Tribe in South Dakota.
- ❑ OJP's Office of Juvenile Justice and Delinquency Prevention (OJJDP) focuses on providing national leadership, direction, coordination, and resources to prevent, treat, and control juvenile crime. Six states were selected to participate in SafeFutures, a comprehensive five-year discretionary program.
- ❑ Under the Community Oriented Policing Service (COPS) Office, tribal governments have been awarded \$44,148,645, for 250 grants in 33 states. This resulted in 595 funded police officer positions. Eleven tribes were among the 336 awards made under the Community Policing to Combat Domestic violence Program.

Tribes are taking advantage of these resources in addressing the range of juvenile crime: domestic violence and sexual assault, child abuse, correctional facilities, funding for additional police, and prevention programs.

9.0. Conclusions

Review of the materials collected in this study resulted in four conclusions:

1. Need for AI/AN youth initiative. The history of duplicity, maltreatment, and war against Indian tribes and Alaska Native villages still reverberates to this day. Amelioration of the QOL of AI/AN

youth and that of their communities will require coordinated systematic efforts by the Federal government in the context of Indian self-determination.

2. Spectacularly successful Federal programs can happen. Previous and on-going Federal initiatives have resulted in some spectacular successes (e.g., lowered maternal and infant mortality rates); these successes show what can be achieved. Many other Federal initiatives have produced little or no positive results. Likely reasons for failed initiatives include failure to secure tribal input and acceptance, inadequate resources, lack of coordination among stakeholders, and poor management.

3. Major changes in BIA and IHS. As the Indian self-determination process matures, tribes are increasingly assuming control and operation of programs previously operated by the lead Federal agencies dealing with tribes and Native villages-the BIA and MS. Consequently, the BIA and MS have sustained significant reductions in force and are in the process of restructuring. These changes must be factored into the proposed Federal initiative.

4. Better information systems needed. Comprehensive and detailed information about AI/ANs has always been difficult to collect. Even when data have been collected by one Federal agency, the data are often unknown to other programs both within the agency and to other agencies. Without baseline data and collection of appropriate indicators of progress, it will be impossible to evaluate the effects of the proposed AI/AN youth initiative. Assumption of control of programs by tribes can easily compound the problem of collecting and maintaining needed information systems.

10.0. Recommendations

In light of the study conclusions, the three recommendations are made.

1. Focus of the youth initiative. The Federal government, in consultation with the tribes and Alaska Native villages and their representatives, should develop a coordinated, systematic initiative to improve the QOL of AI/AN youth. This initiative should focus on the following interrelated areas:

- Alcohol and substance abuse prevention and treatment,
- CI Accident prevention
- CI Employment and economic development
- CI Education
- Crime and justice, and
- Housing.

2. Coordinated execution of the youth initiative. The planning and the execution of the initiative should actively involve and have the active support of the Federal agencies directly and indirectly involved as well as the tribes and Alaska Native villages.

3. Develop needed AI/AN information systems. The Federal government, in consultation with the tribes and Native villages, should develop and implement a plan to collect, maintain, and make accessible information on AI/ANs. Included in this information system should be baseline data and appropriate indices that can be used to assess the outcomes associated with the proposed initiative.

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Appendix 1. Matrix of Quality of Life Domains, Threats, and Key Federal Agencies

QOL Domain	QOL Threat	Youth Age Group	Description	Key Federal Agencies	Relevant Federal Programs
1.0 Health	1.1 Accidents	All	No. 1 cause of death for all age groups	IHS/DOT/HUD/BIA	
	1.2 Alcohol and other drug use	Adolescents	Threat emerges around age 12; includes FAS/FAE; impacts accidents	IHS/BIA/SAMSA	
	1.3 Obesity	Adolescents	Threat emerges around age 12	IHS/BIA/USDA	
	1.4 STDs	All		IHS/BIA	
	1.5. Asthma	All	Increasing prevalence	IHS/NIH	
	1.6. Diabetes	All	Increasing prevalence	IHS/NIH	
	1.7. Suicide	Adolescents	No. 2 cause of death of adolescents	BIA/IHS/NIH/SAMSA	
	1.6 Mental health/depression	All	Factor in suicide, A/SA, and school problems	IHS/BIA/NIH/SAMSA	
	1.9 Homicide/violence	All	Increasing prevalence in adolescence	IHS/NIH/DOJ/BIA/ED	
	1.10 Teen pregnancy	Adolescents		IHS/BIA/ED	
2.0 Education	2.1 School dropout	Children & Adolescents	Highest rates of any group	BIA/ED/Headstart	
	2.2 Low Achievement	Children & Adolescents	Lowest of any group	BIA/ED/Headstart	
	2.3 Alcohol and other drug use	Children & Adolescents	Key aspect of dropout and school problems	BIA/ED/IHS/SAMSA	
	12.4. Parental involvement	Children and Adolescents	Key component of education success	BIA/ED	
	2.5 Unemployment/Poverty	All	Component of hopelessness	BIA/ED/EDA/SBAM/BDA	
3.0 Employment/Economic Development	3.1 Unemployment	All	Multi-generational	BIA/EDA/SBAM/BDA/ANA	
	3.2 Poverty	All	Lowest income of any group	BIA/IHS/EDA/SBAM/BDA/ANA	
	3.3. Hopelessness	All	Key aspect of mental health, A/SA, school problems	BIA/IHS/EDA/SBAM/BDA/ANA	
	3.4. Welfare reform	All	Unique situation of AI/ANs not addressed	BIA/IHS/DOJ	
4.0 Environment	4.1 Inadequate housing	All	Overcrowded, substandard	BIA/IHS/DHUD	
	4.2 Transportation	All	Lack impacts employment and health	BIA/DOT	
	4.3. Unsafe water	All	Dwellings lack	BIA/EPA/HUD/IHS	
	4.4. Lack of waste water treatment	All	Health and environment threat	BIA/EPA/IHS/HUD	

QOL Domain	QOL Threat	Youth Age Group	Description	Key Federal Agencies	Relevant Federal Programs
5.0 Justice/Law Enforcement					
	5.1. Denial of treaty rights	All	Violations of sovereignty	DOJ/BIA	
	5.2. Denial of civil rights	All	Denial of access to services	All Departments	
	5.3. Gangs	Mostly adolescence	Juvenile delinquency	BIA/DOJ	
	5.4. Child abuse and neglect	All	High prevalence	BIA/IHS/DOJ	
	5.5. Family violence	All	High prevalence	BIA/IHS/DOJ	
	5.6. Assaults/homicide	All	No. 3 killer of adolescents	BIA/DOJ	
	5.7. Lack of correctional facilities and services	All	Crime and delinquency untreated; community security compromised	BIA/DOJ	

Appendix 2. List of Agencies Contacted for QOL Data

Agency	Points of Contact
Department of Health and Human Services	Clayton Old Elk, Georgia Buggs , Lucille Dawson
ACYF	Helen Scheirbeck, Ginny Gorman, Anita Grancipre, John Bushman, Roger iron Cloud
ANA	
Head Start	
HRSA	Judy Loretta Bragdon
IHS	Erik Broderick, Rick Smith, Vee Garcia, Darrell Pratt, Leo Nolan, Tom Crow, Phyllis Eddy
Department of Interior	Ed Simermeyer, Elizabeth Homer, Michael Anderson
BIA	Joanne Sebastian Morris, Bob Sterns, Lana Shaughnessy, Larry Blair, Sarah Hicks, Dalton Henry, Frank Carroll
Department of Justice	John Scalia, Tom LeClaire , Ann Mitchell, Soo Song, Michelle Betancourt, Judith Rubinwizh, Debra Purvis
Department of Commerce	Joe Hardy
Department of Education	Amos Goodfox
Department of Labor	Thomas Dowd, Veronica Dabney
Department of Transportation	
NHTSA	Ann E. Mitchell
Environmental Protection Agency	Kathy Gorospe, Maria Carroquino, Caren Rothstein, Theresa Fleming, Paula Goode, Meg Kelly
Housing and Urban Development	Francis Gras Louis
The White House	Miguel Bustos
UNITY	J.R. Cooke, Sunceri Dawson Rivers
National Indian Education Association	Lorraine Edmo

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