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Epidemiology of Child Maltreatment Determinants in Alaska Native and American Indian Populations in Alaska

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The Indigenous population of Alaska or "Alaska Native people" can be further classified based on cultural, geographic, and other characteristics as Aleuts, Inupiat, Yupik, Athabascans, Tlingit, and Haida. Although these crude subclassifications may reflect some cultural or geographic similarities, they may not be consistent with traditional Indigenous distinctions representing an array of unique cultural, ancestral, and genetic differences.

By the mid-eighteenth century, there were an estimated 80,000 Alaska Native people, but contact with the Russian and European peoples brought various social ills and epidemics that had drastic impacts. While actual population losses are unknown, estimates range between 50% and 80% (Bjerregaard, Young, Dewailly, & Ebbesson, 2004; Fleming, 1992; Sandberg, Hunsinger, & Whitney, 2013).

The Indigenous populations of Alaska have experienced much historical trauma, including mass illness, forceful removal of children from family settings to attend boarding schools, loss of traditions, marginalization, substance abuse, and violence. Collectively, these traumatic experiences have likely contributed to the current health status of the Alaska Native population (La Belle, Smith, Easley, & Charles, 2005).

One social ill that continues to impact the Alaska Native population disproportionally (relative to the Alaska non-Native population) is child maltreatment (Parrish, Young, Perham-Hester, & Gessner, 2011). Child maltreatment is often defined similarly across agencies but differs with respect to jurisdictional responsibility and operationalization. For the purposes of this article, child maltreatment is defined using the public health definitions as described by the CDC; thus, maltreatment consists of both acts of commission (physical, sexual, and psychological abuse) and acts of omission (physical, emotional, medical, education neglect, and failure to supervise adequately) (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). It should be noted that the application of these definitions may not be consistent across all groups due to population practices and traditional values (i.e., educational neglect could be represented by the education system in one community and by hunting, fishing, or a trade in another).

The causes of child maltreatment are multifaceted with likely no single causal mechanism; however, specified patterns and behaviors do exist, which may increase one's risk of maltreatment (Thompson et al., 2012; Turner et al., 2012). The most likely root causes of maltreatment can be best understood under a socio-ecological framework that incorporates the influences at the macro and micro levels (Evans-Campbell, 2008). Such influences of historical trauma, loss of community and culture, substance abuse, mental health, economic status, and disease are all likely part of a diverse, dynamic, and complex causal chain leading to each single incident of maltreatment (Evans-Campbell, 2008).

This article will not address causality but will rather provide an overview and description of child maltreatment and factors among the Alaska Native population from a variety of publicly available data sources in an attempt to elucidate some of the simplistic yet striking social determinants potentially contributing to childhood neglect and violence. This description can provide a context for which maltreatment prevention efforts can be realized.

Finally, it should be remembered that the crude grouping of all Alaska Indigenous people into one classification of "Alaska Native people" represents a large diversity of people each with distinct cultural practices, history, and traditions. These unique cultural and community experiences should be incorporated when implementing population-based public health interventions as well as providing direct clinical services.

Data Sources

Utilizing five primary publicly available data sources, this article provides a descriptive assessment of Alaska Native children's experiences with known risk factors and reported maltreatment. Except for the child protective services (which use self-reported and/or observed race), all other sources defined race as maternal race indicated on the child's birth certificate. The five data sources are briefly described as follows:

Child Protective Services (CPS)
The Office of Children's Services (OCS) is the State of Alaska's CPS agency. By state law, all reported cases of child maltreatment that come to its attention are documented. Further statutory regulations govern the operational definitions of what reports are screened in and investigated. OCS is primarily responsible for responding to and investigating all reports of maltreatment for children <18 years of age occurring in the home under a designated caregiver's supervision.

Child Death Review
Since 1989, the Maternal Infant Mortality Review (MIMR) committee has reviewed all deaths of infants and mothers that the Alaska Bureau of Vital Statistics reports to them. The MIMR committee is made up of various professionals (including physicians, content experts, nurses, epidemiologists, social services, and others). The MIMR committee reviews information regarding the death from a variety of sources (including vital records, medical records, first responder reports, autopsy, police, court, child protection, and social media) and comes to a consensus on the causes, contributors, and key circumstances of each death. This committee has increased sensitivity in detecting maltreatment-related mortality that may not meet the level required by judiciary definitions for prosecution. This is accomplished by applying a public health approach and utilizing medical and psychological definitions to identify cases where maltreatment probably or possibly contributed to the death rather than requiring a specific legal determination.

Pregnancy Risk Assessment Monitoring System (PRAMS)
The PRAMS questionnaire collects self-reported information on maternal attitudes, experiences, and behaviors before, during, and after delivery of a live newborn infant. PRAMS was initiated in 1987 by the CDC by funding five states and the District of Columbia, and it has been ongoing in Alaska since 1990. Currently 40 states and New York City are participating in PRAMS, representing nearly 78% of all annual live births in the United States. Using a mixed model design (mail and phone questionnaires), mothers are complex sampled and surveyed, and responses are weighted to represent the population (Gilbert, Shulman, Fischer, & Rogers, 1999; Shulman, Gilbert, & Lansky, 2006).

Alaska PRAMS samples approximately one in every six live births, with stratified sampling of the births occurring by maternal race (Alaska Native and non-Native) and birth weight (<2500g and ≥2500g). Response rates have maintained (for the most part) above 70%.

Childhood Understanding Behaviors Survey (CUBS)
The CUBS survey in Alaska is a 3-year follow-up to PRAMS respondents. The CUBS questionnaire asks about maternal, family, and child experiences and behaviors. Among eligible respondents from 2006–2009 births, the average response rate for CUBS was 51.3%. Like PRAMS, CUBS attempts to preserve population representation by applying complex weighting and nonresponse adjustments.

All PRAMS and CUBS data presented (unless otherwise noted) come from the *Alaska Maternal and Child Health Data Book 2011: Alaska Native Edition* (Young, Perham-Hester, & Kemberling, 2011).

The Alaska Surveillance of Child Abuse and Neglect (SCAN)
Established in 2008 by the MCH-Epidemiology Unit of the Alaska Division of Public Health, the Alaska SCAN program provides a public health approach to describing maltreatment at the population level. The SCAN program links multiple data sources in an attempt to provide a more comprehensive assessment of the incidence and factors contributing to maltreatment. While the general definition of maltreatment is similar to other agencies (acts of commission and omission by a designated caregiver), the operationalization of this definition crosses jurisdictional boundaries and applies tiered public health focused definitions of maltreatment with varying degrees of sensitivity and specificity (not limited to any agency determination or legal definition).

Population Description
The 2012 population of Alaska was estimated at 732,298 persons, among which 16.8% identified as American Indian and/or Alaska Native and 70.1%, as Caucasian. The largest city, Anchorage, had an estimated 40.1% (n=298,842) of Alaska's population. Among the Alaska Native population, 76.5% lived outside Anchorage (59.3% among the Caucasian population). Of the estimated 122,944 Alaska Native people, 50.2% were male and 49.9% were female (Robinson, Hunsinger, Howell, & Sandberg, 2013).

The estimated 2012 child population (ages 0–14 years) was 158,865 (21.7% of the total population), among which 22.5% were Alaska Native and 62.7% were Caucasian. Approximately 78.0% of Alaska Native children lived outside of Anchorage (Robinson et al., 2013).

Alaska is geographically expansive with 570,641 square miles of land with a small population density per land mass (1.2 persons per square mile, compared with 87.4 for the total U.S.), which makes providing services a unique challenge. Texas, the next largest geographic state, has 261,232 square miles of land mass and a population density of 96.3 persons per square mile (Figure 1). Wyoming has the lowest population density in the contiguous U.S. at 5.8 per square mile, which is still nearly 5 times that of Alaska (U.S. Census Bureau, 2014). Much of Alaska is inaccessible by road, requiring the use of a plane, boat, snow machine, or dogsled to reach many Alaskan communities (Figure 1).

Figure 1. State of Alaska Superimposed on the Contiguous United States

Source: Alaska Division of Public Health photo stock; approximate scaling.

General Population Characteristics

The average life expectancy at birth in 2010 for all Alaskans was 76.1 years for males and 80.5 for females. Among the Alaska Native population, it was 68.6 years for males, and 73.3 for females. The median age in 2010 was 26.7 and 35.4 years among the Alaska Native and non-Native populations, respectively (Hunsinger, Howell, & Whitney, 2012).

The overall Alaska teen birth rate is similar to the national average (41.9 vs 41.5 per 1,000 females ages 15–19 years). The teen birth rate among Alaska Native women, however, was 2.7 times that of non-Native Alaskan women (82.3 vs 30.1 per 1,000 females ages 15–19 years). Unintended pregnancy among Alaska Native women has declined from 54.3% in 2000 to 50.5% in 2008, but the prevalence is still 39% greater than non-Native women (50.5% vs 36.3%). Not surprising, women less than 18 years of age had the highest prevalence of unintended pregnancies resulting in a live birth among both Alaska Native and non-Native women (77% and 84%, respectively) (Young, Perham-Hester, & Kemberling, 2011).

Childhood Stressful Life Events

Violence in the Home

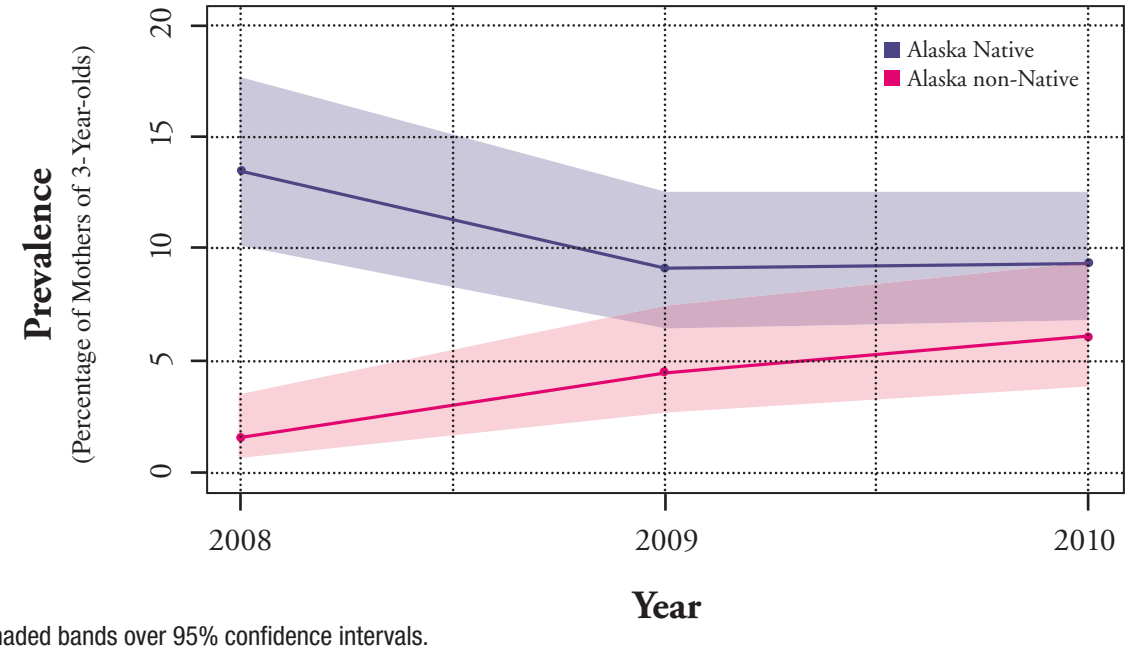
Children who are raised in homes with violence can be adversely impacted, leading to many lifelong negative social and health effects (Anda et al., 2006). Respondents of the CUBS questionnaire were asked about various events that their 3-year-old child may have ever experienced prior to completion of the survey. Within Alaska in 2010, 6.9% (95%CI 5.1%, 9.3%) of mothers reported that their child had seen violence or physical abuse in person; stratified by Alaska Native and non-Native race groupings, the prevalence was 9.4% (95%CI 6.9%, 12.6%) and 6.1% (95%CI 3.9%, 9.4%), respectfully (unpublished CUBS data, 2013). From 2008 through 2010, the trend has decreased among Alaska Native mothers and slightly increased among non-Native mothers (Figure 2). Although the disparity between mothers reporting the child has witnessed violence has attenuated, the Alaska Native population remains significantly elevated ($p<0.05$; unpublished CUBS data, 2013).

According to PRAMS, from 2000 to 2008 the percentage of Alaska Native women reporting physical abuse during the 12 months before they became pregnant has declined 61% (16.2% to 6.4%) but is still higher than that for non-Native women (3.9% in 2008). The percentage of Alaska Native women reporting a controlling partner 12 months before, during, or after pregnancy was consistently higher compared with non-Native women (11.2% vs 7.4% in 2008).

Parenting Practices

Knowledge, and likely more important, attitudes and use of appropriate and effective discipline practices for a misbehaving child, can be difficult to assess. Discipline practices specified in the CUBS survey were designed for the general population and

Figure 2. Three-Year-Old Children Seeing Violence or Physical Abuse, CUBS Data, Alaska 2008–2010



Shaded bands over 95% confidence intervals.

may not reflect traditional methods used. Furthermore, age-appropriate discipline, correction, and expectations can be difficult for many parents. While many experts oppose any form of physical punishment, the impact of "nonabusive" spanking is mixed and currently no law prohibits corporal discipline by Alaska parents (bruises or other marks could be reported if detected) (Larzelere, 2000; Slade & Wissow, 2004).

Among the forms of general discipline practices measured on CUBS, talking to the child was the most common and similar in prevalence for both Alaska Native and non-Native mothers (80% and 86%, respectively). Dissimilar parenting actions between Alaska Native and non-Native mothers include using a "time out" distraction or redirection, removing privileges, and spanking with an object (Figure 3).

Family Instability

Indications of family instability are diverse and may include factors such as paternal involvement, homelessness, and job loss by a parent or caregiver. While these indicators are dynamic over time and require longitudinal assessment with relation to the actual influence on completed maltreatment, the contrasting differences between Alaska Native and non-Native populations are compelling (Sarkadi, Kristiansson, Oberklaid, & Bremberg, 2008). Among births occurring in Alaska for the years 2008 through 2011, 6.0% of births had no father's name listed on the birth certificate. Alaska Native mothers (12.6%) were significantly more likely ($p < 0.05$) to be missing a father's name on the birth certificate compared with non-Native mothers (3.6%).

In 2010, the proportion of Alaska Native (73.0%) and non-Native (76.4%) mothers of 3-year-olds reporting that their child spent every day with the father in the past week was similar, but it was significantly different among those reporting no paternal contact days in the past week (9.7% vs 4.9%, respectively; $p<0.05$) (unpublished CUBS data, 2013).

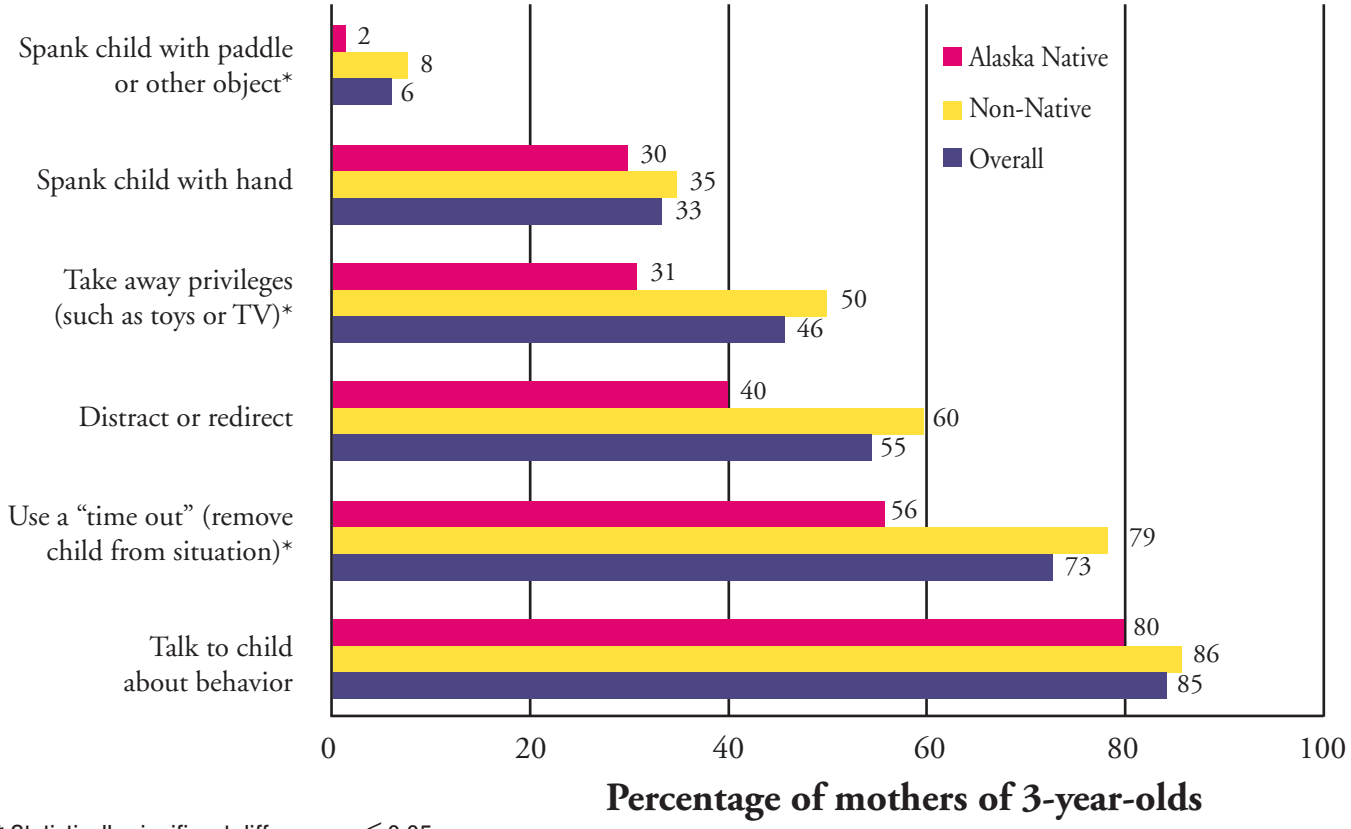
From the PRAMS survey during 2007–2008, compared with non-Native women, Alaska Native women were more likely ($p<0.05$) to report loss of a job (10% vs 6%), homelessness (5% vs 3%), a death of someone close to them (28% vs 15%), separation or divorce (11% vs 7%), respondent or her husband or partner went to jail (11% vs 4%), someone close had a problem with drinking or drugs (27% vs 15%), or arguing with their husband or partner more than usual (28% vs 24%).

Child Maltreatment Statistics

Child Protection

From 2009 through 2012, nearly 42,251 unique children ages 0–18 years had at least one alleged allegation of maltreatment reported and recorded by Alaska child protective services (total alleged allegations against these alleged victims = 144,056). The number of allegations per child ranged from 1 to 52, with 57% having 2 or less and 95% having 10 or less total allegations. Each

Figure 3. Discipline Actions Taken by Parents When Child Was Misbehaving, by Action, CUBS Data, Alaska, 2008



* Statistically significant difference, p ≤ 0,05

alleged incident of maltreatment can have multiple allegations (e.g., 1 maternal allegation and 1 paternal allegation).

From 2008 through 2012, the total annual number of allegations received by OCS consistently increased. Neglect allegations experienced the sharpest increase, followed by mental injury, abuse, and (last) sexual abuse (Vadapalli & Hanna, 2013). Race was known for nearly 75% of the children reported to child protection (36% Alaska Native, 38% non-Native, and 26% unknown).

Abusive Head Trauma (AHT)

A recent study published by the SCAN program for the years 2005–2010 reported an incidence of 34.4 (95%CI 25.1, 46.1) per 100,000 children < 2 years of age in Alaska (56.0; 95%CI 39.4, 77.1, among infants <1 year old) (Parrish, Baldwin-Johnson, Volz, & Goldsmith, 2013). This study utilized the CDC pediatric AHT definitions and applied the coding algorithm to a multisource database that included records from vital statistics, the Violent Death Reporting System, MIMR-CDR, Alaska Trauma Registry, hospital discharges, and Medicaid claims to increase the case capture rate (multisource linkage captured 49% more AHT cases than any source alone).

Among Alaska Native children, the incidence of AHT per 100,000 children < 2 years was 33.1 (95%CI 16.5, 59.2). Relative to Caucasian children, the incident rate ratio (IRR) was 1.3 (95%CI 0.6, 2.8) with no significant difference detected. While no statistically significant disparity between Alaska Native and Caucasian races was present, both races still exhibit an elevated AHT incidence indicating a need for statewide AHT primary prevention efforts (Parrish et al., 2013).

Longitudinal Maltreatment

The SCAN program has followed all 2008 Alaska births (n=11,330) through 2012 to assess the hazard of maltreatment by age 4 years. The birth cohort was linked with death records, annual residence applications for the Permanent Fund Dividend (PFD), and child protection records to define the cohort. The PFD database contains all Alaska resident applications for a resource dividend of the State oil return investments (nearly all eligible residents register). Cohort members were censored for

Table 1. Basic Birth Characteristics Among the 2008 Birth Cohort by Alaska Native and non-Native Race Classifications*

	Alaska Native	non-Native	p-value†
Allegation of Maltreatment			
Yes	1034 (35.9)	1111 (13.3)	<0.001
No	1844 (64.1)	7224 (86.7)	
Missing	0 (0.0)	0 (0.0)	
Marital Status			
Unmarried	1963 (68.2)	2263 (27.2)	<0.001
Married	912 (31.7)	6066 (72.8)	
Missing	3 (0.1)	6 (0.0)	
Maternal Age			
<19 years	301 (10.5)	329 (4.0)	<0.001
19+ years	2577 (89.5)	8000 (96.0)	
Missing	0 (0.0)	6 (0.1)	
Maternal Education			
<12 years	791 (27.5)	800 (9.6)	<0.001
12 years	1523 (52.9)	3679 (44.1)	
12+ years	491 (17.1)	3691 (44.3)	
Missing	73 (2.5)	165 (2.0)	
Paternal Name§			
Not Present	338 (11.7)	273 (3.3)	<0.001
Present	2540 (88.3)	8062 (96.7)	
Missing	0 (0.0)	0 (0.0)	

*117 missing a race classification and excluded from analysis
†calculated using a chi-square test
§paternal name present on the birth certificate

leaving the cohort at time (t) for deaths (n=76), and they were interval censored for an annual nonlinkage with the PFD database (proxy for leaving the state).

Basic demographic birth factors stratified by Alaska Native and non-Native classification are presented in Table 1. In addition to having a greater crude proportion of maltreatment allegations, all factors known to be associated with an increased risk of maltreatment are elevated among the Alaska Native population compared with the non-Native population.

During the study period, Alaska Native children born in 2008 had an incidence of experiencing at least one valid allegation of maltreatment by age four of 8.2 per 1,000 person-months (95%CI 7.2, 8.7). The crude hazard ratio comparing Alaska Native children to non-Native children was 2.6 (95%CI 2.3, 2.8). Upon adjustment for limited confounders (marital status, maternal age, maternal education, and paternal name on birth certificate) the adjusted hazard ratio (albeit still significant) decreased to 1.4 (95%CI 1.3, 1.6). Likely with more complete adjustment for other known confounders, the association found here could be mitigated even further or removed and should be interpreted cautiously (unpublished SCAN data, 2013).

Cycle of Violence

Another recent study from SCAN linked the Alaska PRAMS data to CPS reports to assess the etiologic association between a maternal self-reported history of intimate partner violence (IPV) 12 months prior to pregnancy and subsequent allegations of maltreatment of the birth child by age 2 years. Adjusting for multiple identified confounders (marital status, poverty, maternal age, maternal smoking, maternal race, maternal education, and maternal race/IPV interaction) the stratum-specific odds ratios (OR) for Alaska Native children (2.6; 95%CI 1.2, 4.5) and non-Native children (2.6; 95%CI 1.2, 5.6) were approximately equivalent. This indicates that a history of maternal exposure to IPV even prior to the birth of a child is a substantial indicator of potential maltreatment regardless of Alaska Native or non-Native race classifications (unpublished SCAN data, 2013).

Infant Maltreatment-Related Mortality

Among the 366 infant fatalities that occurred in Alaska during 2005–2010 and that have been reported to MIMR, 69 (19%) were maltreatment related. Based on a public health model, the MIMR Committee determines that fatalities were maltreatment related if abuse or neglect contributed or probably contributed to the death, or if negligence contributed. The percentage of maltreatment-related infant fatalities during this time period could be as high as 25% if deaths with possible abuse or neglect or probable negligence are included, and as low as 16% if only those deaths with definite abuse, neglect, or negligence are included.

Where race was known, 24% of all Alaska Native infant (n=153) fatalities were maltreatment related, compared with 14% among non-Native infants (n=192, 5.7% missing; p<0.047). From 2005 to 2010, the incidence of maltreatment-related infant mortality among Alaska Native infants was 2.1 (95%CI 1.5, 2.9) per 1,000 live births, which is 3.7 (95%CI 2.3, 6.1) times that of non-Native infants. While the overall infant mortality trend has significantly decreased from 2005 through 2010 (p=0.013), the maltreatment-related infant mortality incidence trend remained flat (p=0.952). Although the Alaska Native maltreatment-related mortality has been on a slight downward trend since 2008, a large degree of year-to-year variability is present and additional years of

data are needed to see if this continues. The Alaska Native and non-Native maltreatment-related infant mortality incidence trends from 2005 through 2010 have both remained flat (p=0.693 and p=0.542, respectively).

Conclusion

Alaska Native children currently disproportionally experience more contributing factors and episodes of maltreatment than do their non-Native counterparts. One study indicated that the odds of experiencing a report of maltreatment among Alaska Native children could be up to 4 times that of non-Native children (Parrish et al., 2011). Further studies also suggest that Alaska Native children are at an increased risk of maltreatment-related mortality relative to non-Native children (Parrish & Gessner, 2010).

While racial disparities persist and variations in causal pathways may differ, the influence of race itself can largely be mitigated with appropriate confounder control at all levels of the socio-ecological framework. Maltreatment and other violence is often a symptom of the underlying multifaceted etiology contributing to instability in family and community. Due to the geographical size of Alaska and limited mental health and substance abuse services in rural Alaska, innovative prevention efforts (e.g., telemedicine programs) are needed. A focus should be on integrating cultural practices and increasing protective factors rather than limited short-term interventions aimed at preventing maltreatment only. Efforts to strengthen the individual, family, and community will have a greater impact on the long-term health and safety of families (DeBruyn, Chino, Serna, & Fullerton-Gleason, 2001; Scribano, 2010).

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About the Author

Jared W. Parrish, MS, is an epidemiology doctoral student at the University of North Carolina at Chapel Hill. His dissertation work is building a longitudinal birth cohort through data linkages and multiple imputations to elucidate and construct weighted cumulative maltreatment risk profiles throughout the life course. Mr. Parrish has served as a senior epidemiologist with the MCH-Epidemiology Unit of the Alaska Division of Public Health and as manager and developer of the Alaska Surveillance of Child Abuse and Neglect program. He has primarily focused his efforts on applying epidemiologic approaches to more completely quantify the incidence of child maltreatment.

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A Consideration of U.S. Educational Systems in the Experience of Historical Trauma for American Indians and Their Descendants

Kathryn England-Aytes, MS, EdD

> *The war for Indian children will be won in the classroom. Whoever controls our education controls our future.*
>
> **— Wilma Mankiller (1945–2010)**
>
> *Principal Chief, Cherokee Nation, Oklahoma (1985–1995), as cited in N.S. Hill, Oneida, 2010*

Nearly three centuries after the arrival of the European colonists, the devastating impact of educational policies directed at Native American children can still be felt within Native communities. Current mainstream educational policies may still directly challenge tribal identification and traditional values for Native students, thus remaining a source of cultural conflict and negation of the individual and cultural identity (Marr, 2012; Jacobs, Cajete, & Jongmin, 2010; Grande, 2004; Deloria & Wildcat, 2001). It is important for educators to understand the unique roles that historical trauma and unresolved grief play in the lives of Native students, their families, and their communities. Cultivating awareness and empathetic concern in the educational process may help reduce the legacy of historical trauma for future generations.

Historical Trauma: A Disease of Time

Historical trauma has been called a "disease of time," with the accumulation of disease and social distress reaching into succeeding generations (Aboriginal Healing Foundation, 2004, p. 6). One of the challenges in understanding this concept is that it entails the ability to conceptualize how events that took place in the distant past affect the present. A substantial body of research has emerged on historical trauma among American Indian and Alaskan Native populations in the past two decades. Dr. Maria Yellow Horse Brave Heart's landmark work defined historical trauma as cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences (Brave Heart-Jordan & DeBruyn, 1995; Yellow Horse Brave Heart & DeBruyn, 1998; Brave Heart, 2003).

In their work with Native child populations, Dolores Subia-Bigfoot and Burris described three primary types of trauma in Indian Country: *cultural trauma*, which is caused by an attack that affects the essence of a community and its members; *historical trauma*, which is caused by cumulative exposure to traumatic events that affect an individual and continue to affect subsequent generations; and *intergenerational trauma*, which refers to trauma that is not resolved but internalized and passed from one generation to the next (Subia-Bigfoot & Burris, personal communication, 2007).

Addressing the cumulative impact of historically traumatic events on Native peoples in educational settings requires an understanding of colonization, cultural identity, tribal citizenship, sovereignty, and federal policies directed at Native people.

Early Educational Policies: Missionaries, Treaties, and Becoming Wards of the State

Eurocentric education for Native Americans began as missionary efforts by European colonizers as early as the 1630s. Jesuit missionaries attempted to convert Native Americans to Christianity, which proved difficult, as revealed by the following Huron comment to Jesuit missionary Jean de Brébeuf in 1635:

> You tell us fine stories, and there is nothing in what you say that may not be true; but that is good for you who come across the seas. Do you not see that, as we inhabit a world so different from yours, there must be another heaven for us, and another road to reach it? (*A Huron Indian …*, 1635/2007, p. 6)

Colonizers regarded education as a necessary bridge to Christianize and "civilize" Native Americans. Curricula and teaching were implemented without consideration for the values

of Native peoples themselves, setting the stage for generations of mis-education (Boyer, 1997) and cumulative trauma. Ultimately, American Indian educational policy became inextricably intertwined with federal policies directed toward the elimination or assimilation of Native populations.

Throughout the nineteenth century, the U.S. federal government initiated hundreds of treaties with sovereign Native American nations who exchanged lands for the provision of education, healthcare, and protection from continued expansion. In spite of government promises to leave Indian Territory unmolested, westward expansion continued, fueled by the fur trade, an ever-growing push for land for white settlement, gold discoveries, and the higher calling of Manifest Destiny.

In 1862, Secretary of the Interior Caleb B. Smith discussed federal policy focused on acquiring possession of Indian land in a description of land grants for higher education in agricultural and mechanical arts:

> The rapid progress of civilization upon this continent will not permit the lands which are required for cultivation to be surrendered to savage tribes for hunting … although the consent of the Indians has been obtained in the form of treaties, it is well known that they have yielded to a necessity to which they could not resist…. Instead of being treated as independent nations [as in the past] they should be regarded as wards of the Government. (as cited in Phillips, 2003, p. 23)

Such policies were implemented with federal and state mandates to remove all American Indians to tribal reserves, disrupting sacred relationships to the land and forcing assimilation through education and religious indoctrination. Finally, although the tragic effects of differential immunity to diseases between populations are well documented as an unintended consequence of peoples coming into contact with one another for the first time, Europeans interacting with Native Americans also deliberately used diseases and their transmission as a biological weapon of choice with which to decimate the Indigenous peoples of the North American continent, resulting in countless deaths (Brave Heart-Jordan & DeBruyn, 1995; Deboe, 1940; Deboe, 1983; Duran & Duran, 1995; Jacobs et al., 2010; Ross, 1998; Zinn, 2003).

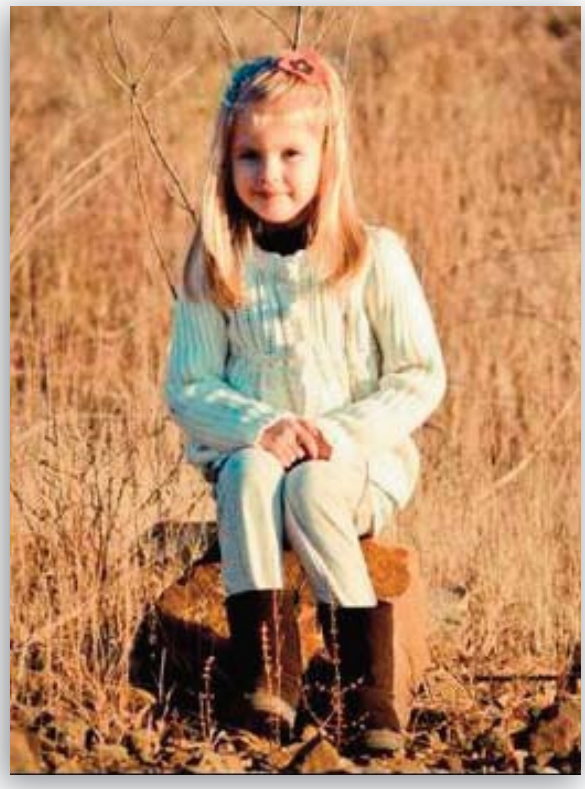
Even those charged with enforcing federal policy struggled with the morality of it. In his observations of conditions in the Indian Territory in the early 1840s, a frustrated Major Ethan Allen Hitchcock described his views of conflict between the U.S. government and the Cherokee, Choctaw, Muskogee Creek, Chickasaw, and Seminole Nations—or the Five Civilized Tribes as they were known at that time:

> The government is in the wrong, and this is the chief cause of the persevering opposition of the Indians, who have nobly defended their country against our attempt to enforce a fraudulent treaty. The natives used every means to avoid a war, but were forced into it by the tyranny of our government. (Hitchcock, E. A. 1840s/1909, p. 120)

Removal and Resistance: Walking to Indian Country

Indian territories in Oklahoma and South Dakota were initially established to accommodate westward expansion. In 1830, Congress passed the Indian Removal Act, which appropriated funds for relocation—by force if necessary—of all Native Americans to Indian Territory. Federal officials were sent to negotiate removal treaties with southern tribes, many of whom reluctantly signed, exchanging one form of genocide for another (University of Nebraska, 2010).

Arguably, although all tribes removed to the Indian Territory shared similar experiences of hardship and suffering, the Cherokee removal, known as the Trail of Tears, continues to be one of the most recognized accounts of Indian removal in American history. The Cherokee had sought to retain rights to their remaining lands in Georgia by bringing a lawsuit against the state, eventually prevailing in a companion suit decided in favor of Cherokee boundaries by the U.S. Supreme Court (Worcester v. Georgia, 1832).



Ignoring the Supreme Court's ruling, President Andrew Jackson initiated policies to terminate title to Indian land in a number of states (including Georgia shortly after gold was discovered on Cherokee land) and to relocate all Indian populations to the Indian Territory, which eventually became the state of Oklahoma (Cherokee Nation History Course, 2000). In the winter of 1838–39, the U. S. Army rounded up an estimated 16,000 Cherokee men, women, and children and interned them in forts built in North Carolina, Georgia, Alabama, and Tennessee, where hundreds died from illness and harsh conditions before they could be removed to Indian Territory. There is no official government record of the number of Cherokee who died as a result of the removal, but it is estimated that some 4,000 died en route or shortly after arrival (Foreman, 1934).

Following the Civil War, all tribally controlled educational systems were abolished. The federal education philosophy for American Indians became an effort to

> educate the Indian in the ways of civilized life in order to preserve him from extinction, not as an Indian, but as a human being…[H]e cannot exist encysted, as it were, in the body of this great nation…. To educate the Indian is to prepare him for the abolishment of tribal relations to take his land in severalty, and in the sweat of his brow and the toil of his hands to carry out, as his white brother has done, a home for himself and family. (U.S. federal agencies, n.d., as cited in Clarke, 1993, p. 15)

Throughout the rest of the nineteenth and early twentieth centuries, as settlers regarded Indians' control of land and natural resources as serious threats toward expansion and economic goals, a number of acts were passed by the U.S. Congress. The language of the 1871 Indian Appropriations Act effectively destroyed sovereignty for Native people living in the United States:

> PROVIDED, That hereafter no Indian nation or tribe within the territory of the United States shall be acknowledged or recognized as an independent nation, tribe, or power with whom the United States may contract by treaty…. (p. 544)

Allotment and Assimilation: Losing Ground in Indian Country

By the late nineteenth century, the treaty system was replaced with laws "giving" American Indians ownership of what was left of their original lands. The General Allotment Act was passed in 1887 by the United States federal government to regulate Indian land. It enabled the government to land that had been collectively owned for centuries and the power to divide it into separately owned lots, while distributing any unoccupied or excess land to white settlers.

U.S. Congressman Henry Dawes, the author of the General Allotment Act, or the "Dawes Act" as it became known, had great faith in private property as a means to "civilize" recalcitrant natives. To be civilized, he reportedly said, was to "wear civilized clothes...cultivate the ground, live in houses, ride in Studebaker wagons, send children to school, drink whiskey [and] own property" (quoted by Nebraska Studies, n.d., p. 1).

Communal tribal land was cut into allotments of 160-acre parcels and "given" to individual tribal members. The U.S. Government intended to hold allotted land "in trust" for 25 years, so Indians would not sell the land or return it to tribal reserves. The Act went on to offer Indians the benefits of U.S. citizenship—if they took the allotments, lived separately from their tribes, and became "civilized." The relationship between educational policy and land transfers of this period is illuminated by a Lakota Sioux elder: "They made us many promises, more than I can remember, but they never kept but one; they promised to take our land and they took it" (attributed to Lakota elder in Clarke, 1993, chap 2, p. 6). In the half century following the Dawes Act, additional federal statutes resulted in the transfer of approximately 90 million acres of land from American Indian to white owners.

While the process of decimation of ancestral lands, forced relocation to reduced land holdings, and the ultimate dismantling of those holdings had an enormous impact on Native peoples, it was the abolition of tribal education and the imposition of federally mandated residential schools that extended the cultural decimation of Native communities into subsequent generations.

Boarding Schools: Killing the Savage—Saving the Man

Historians have compared the residential school system to a penal system. Indian children as young as age 5 were taken from their families and housed in overcrowded, inadequate facilities; forbidden to use their Native language; and punished for noncompliance with ankle chains and solitary confinement. Refusing to send one's children to boarding school could result in parents' arrest and a reduction or elimination of food rations (Clarke, 1993). Capt. Richard Henry Pratt, a decorated officer in the Civil War who had supervised prisoner of war camps for the Union, was the architect of residential school policies, which he justified (as the Carlisle School founder in 1892) with this argument:

> It is a great mistake to think that the Indian is born an inevitable savage. He is born a blank, like all the rest of us. Left in the surroundings of savagery, he grows to possess a savage language, superstition, and life. Transfer the savage-born infant to the surroundings of civilization, and he will grow to possess a civilized language and habit. (reprinted in Pratt, 1973, p. 266)

The Bureau of Indian Affairs (BIA) established 25 residential boarding schools to which hundreds of thousands of children were sent or forcibly removed between 1880 and 1970. Established as quasi-military institutions with harsh indoctrination and systematic suppression of Native culture, children learned English, Christianity, and agricultural and domestic skills. They were away from their families for months or years at a time, and conditions at many schools included long-term physical and sexual abuse of students, malnutrition, and medical neglect (Adams, 1995; Andrews, 2002; American Indian Heritage Support Center, 2012; Grande, 2004; American Indian Institute, 2012).

The legacy of residential schools has been experienced in subsequent generations as unresolved historical trauma and grief (Richie, 2008; Duran, 2006).

Federal Termination: A Solution to the 'Indian Problem'

In 1944, a U.S. Senate Select Committee on Indian Affairs offered recommendations on achieving "the final solution of the Indian problem" (U.S. Senate, 1969, p. 14). Federal officials announced that Indian assimilation must be the goal of Indian policy, recommending a termination of the trust status of Indian lands and a return to individual self-reliance.

Following WWII, U.S. officials once again suggested a solution to the "Indian problem" with termination and urbanization policies. The Hoover Commission, appointed by President Truman, recommended assimilation policies aimed at integrating Indians into mainstream U.S. society as one way to relieve the federal government of the financial responsibilities entailed by its trust relationship with the tribes. A 1948 Committee on Indian Affairs (reporting to the Commission on Organization of the Executive Branch) claimed that "assimilation must be the dominant goal of public policy" and that

> the basis for historic Indian culture has been swept away…. Traditional tribal organization was smashed a generation ago…. Assimilation cannot be prevented. The only questions are: What kind of assimilation and how fast? (pp. 44-45, as cited in Prucha, 1986, p. 1039)

Throughout the 1950s, Congress pursued this misguided effort to end all federal aid and, in many cases, federal protection for Native Americans. One such policy, the American Indian Urban Relocation Program**,** was designed to induce rural Natives to relocate to seven major urban areas where jobs were reportedly more plentiful. Relocation offices were set up in Chicago, Denver, Los Angeles, San Francisco, San Jose, St. Louis, Cincinnati, Cleveland, and Dallas with promises of a better life for Native people willing to relocate far from their original homes (Clarke, 1993).

An estimated 750,000 Native Americans migrated to the cities between 1950 and 1980, many through the Relocation Program. BIA employees were supposed to orient new arrivals and manage financial and job-training programs for them; however, as was the case with so many earlier agreements, often those promises were not kept. Frequently, the children of these relocated families struggled to adapt to unfamiliar surroundings, and their experiences in public education only served to heighten the loss and grief of relocation (Clarke, 1993).

Civil Rights and Activism

The Civil Rights movement of the 1960s produced a generation of Indian activists who sought significant and permanent change in federal policies for Native Americans, not only with respect to education but also with regard to other disastrous policies.

In 1969, Senate Report 91-501, commonly known as the Kennedy Report, was published by the Special Subcommittee on Indian Education, Senate Committee on Labor and Public Welfare.

Senator Edward Kennedy observed the following:

> The coercive assimilation policy has had disastrous effects on the education of Indian children…schools which fail to recognize the importance and validity of the Indian community…a dismal record of absenteeism, dropouts, negative self-image, low achievement, and ultimately,

> academic failure for many Indian children; a perpetuation of the cycle of poverty which undermines the success of all other Federal programs. (p. 21)

Self-determination, a term from the Indian Education Act of 1972, suggested that American Indians should control their own tribal destinies (Lankford & Riley, 1986). The Act funded programs to address low-achievement and high-dropout rates among Native American students as well as bringing some dramatic changes in the way Indian education was funded and administered. The hope was that if Native Americans regained control over the education of their own children, those children would begin to make measurable gains in all levels of education, including higher education.

The Self-Determination Act of 1975 funded technical training and BIA staff support, and required federal programs to work with tribes so they might assume greater control of their members' education; however, most educational programs remained Eurocentric in their curriculum and teaching. Native teachings that emphasized indigenous wisdom were deemed inferior to mainstream, Western-style teaching (Jacobs et al., 2010).

Lessons of Remembering: Responding to Historical Trauma

Culturally responsive teaching is defined as using "cultural knowledge, prior experiences, and performance styles of diverse students to make learning more appropriate and effective for them" (Gay, 2000, p. 29). This pedagogy embraces the effectiveness of teaching to and through the strengths of Native students. Culturally responsive pedagogy benefits all students, but it requires a degree of cultural literacy often absent in mainstream classrooms. Regrettably, the vast majority of American Indian students are taught by non-Native teachers, and no attempt to assist Native students can occur apart from an acknowledgment that mainstream educational policy has failed Native students and damaged tribal efforts to preserve cultural identity. There has been little effort to acknowledge the legitimacy of the cultures of Native students and to connect academic abstractions with their socio-cultural realities.

In *Critical Neurophilosophy and Indigenous Wisdom*, Jacobs and colleagues (2010) suggest that awareness of one's own place in the world is critical to meaningful relationships with others. Indigenous wisdom "holds that technology, including that which supports the neurosciences, is an important aspect of humanity, but that without a deeper understanding of the sacred, natural world, its consequences will continue to disrupt the balance of life on Earth" (p. 11). This view honors the Native understanding that education is a comprehensive process of life and learning, undertaken within a cultural experience, and that wisdom is never "mastered" or fully known.

Native education explores an awareness of one as an integral part of a larger Creation that is physical and spiritual, animate and inanimate, real and mystical. The importance of a person's character and how to make use of what one learns is of great significance. This is first measured within the context of family and community and determines whether one's life is in balance—what Cherokees would describe as "having a good mind" (Cross, 1998; Jacobs et. al., 2010; Mankiller, personal communication, 2009). The awareness of this fundamentally ingrained worldview, which roots the individual in generations of one's people, provides the basis for presenting educational materials that engage the world of the Native student.

Effective education provides tools for living, not rules for living. Such tools rules need to be grounded in the traditions of the people being educated. To the extent to which educators demand that a student's roots be forfeited, any curriculum becomes a weapon of destruction.

According to Ringell and Brandell (2010), Native Americans experience contemporary events on an ongoing basis that have the potential to be traumatic at individual and cultural levels at much higher rates than for other racial groups. Research on the interaction between the response of Native Americans to historical trauma and their contemporary experiences of trauma, mistreatment, injustice, and discrimination has suggested that the interplay between direct trauma experiences and transgenerational trauma is best understood against the backdrop of distal patterns of collective

harm (Whitbeck, Adams, Hoyt, & Chen, 2004). First-hand experiences of discrimination, injustice, poverty, and social inequality may reinforce ancestral knowledge of historical trauma (Brave Heart, 2003; Williams, Neighbors, & Jackson, 2003).

Although there is no single *correct* way for educators to address the complexities of historical trauma and unresolved grief among Native students and their communities, in *Teaching Truly: A Curriculum to Indigenize Mainstream Education* (England-Aytes, 2013), Native educators discuss the history of Native educational policies and contemporary teaching practices with generalizable suggestions for educators. The contributors suggest that educators consider the following:

1. *Acquire a basic understanding of the experience of Indigenous people in the United States.* With over 560 federally recognized tribes in the United States, there is no generic Native American. Native identity exists on a continuum ranging from traditional to highly assimilated. Educators interacting with specific tribes should become familiar with specific tribal history and contemporary experiences.

2. *Go beyond simply acquiring knowledge*. Culture is a complex concept with characteristics that can be difficult to define. Explore the internal representations of Indigenous culture—such as values, beliefs, and attitudes—with tribal members, particularly elders, and learn how those internal experiences are expressed and shared externally.

3. *Introduce community-level connections and collaborations with Native institutions*. Educators know that students learn best when they are actively engaged in the material. Ongoing relationships and collaborations with Native institutions provide opportunities to engage in hands-on learning about Native culture and traditional communities.

4. *Do not limit student learning about Native Americans to a historical context*. There are currently more than four million people in the United States who identify as American Indian or Alaska Native (National Urban Indian Family Coalition, 2008). Regularly engage students with contemporary Native experiences; use local Indigenous experts and sites. Native history should not be taught as a separate category of U.S. history: American history ***is*** American Indian history.

5. *Pay attention to behaviors that could indicate experience of traumatic events, including psychological stress*. Knowing the historical, social, economic, and cultural contexts in which students live can help educators respond appropriately to behaviors indicating primary or secondary trauma. Make the connection between current behaviors and historical distress.

6. *Recognize and acknowledge current experiences of discrimination and social injustice of Native people and the failure of most institutions to acknowledge responsibility in past wrongs*. In May of 2010, during an event at the Congressional Cemetery in Washington, D.C., Senator Sam Brownback read a joint resolution of the 111th U.S. Congress, formally apologizing to American Indian tribes for federal policies and historical acts of "violence, maltreatment and neglect." (U.S. Senate, 2009–2010). Some in Indian Country felt the apology should have been offered publicly by the President and that it was specifically worded *not* to suggest any compensation due to Native people as a result of such acts; however, it marked an important acknowledgement of historical wrongs (Pember, 2011).

Becoming aware of how Eurocentric education has affected Native students is an important step in acknowledging and responding to historical trauma and unresolved grief, as well as honoring Indigenous wisdom in contemporary educational settings. As Native educators, we must continue to share in a personal and public discourse that encourages preservation of Indigenous knowledge, embraces diversity of thought, and restores balance for Native people.

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Cultural Enhancement of Mental Health Services for American Indian Children

Dolores Subia BigFoot, PhD, and Lana O. Beasley, PhD

Within the field of children's mental health, there has been a distinct move to create transportability of evidence-based treatments (Hoagwood, Burns, Kiser, Ringeisen, & Scheonwald, 2001; Stirman, Crits-Christoph, & DeRubeis, 2004). This has led to a myriad of "cultural adaptations" for a variety of populations to increase engagement and cultural congruency. One specific area of interest is increased adaptation of services provided for American Indian/Alaska Native populations, specifically American Indian/Alaska Native children.

The adaptation of evidence-based treatments within an American Indian/Alaska Native well-being framework presents an opportunity to enhance healing through the blending of science and Indigenous culture. Undertaking an adaptation such as this is complicated. What makes an adapted model successful is not just the translation of language but also the translation of core principles or concepts of the model so that they become meaningful to the culturally targeted group while maintaining fidelity to the original model. There are many considerations that were made at the onset of model enhancement for Indian Country, including the services for both child and family-extended family, understanding trauma exposure from historical to current, and being sensitive to cultural differences among tribal groups.

Specific Enhanced Models

In 2003, as part of the National Child Traumatic Stress Initiative (NCTSI), the University of Oklahoma Health Sciences Center (OHASC), Center on Child Abuse and Neglect established the Indian Country Child Trauma Center (ICCTC) to develop trauma-focused treatments and outreach materials specifically designed for American Indian/Alaska Native children and their families. ICCTC identifies existing evidence-based treatments that share common elements with American Indian/Alaska Native cultural beliefs and practices. Our goal was to design culturally relevant approaches that respect shared and tribal-specific teachings, practices, and understandings while recognizing the substantial individual variability in cultural affiliation among American Indian/Alaska Native people. The interventions, the Honoring Children Series, were developed with consultation and input from a variety of cultural consultants. ICCTC continues training and weekly phone consultation for urban, reservation, rural, and/or isolated tribal communities by being available for case consultation to assist in better implementation.

Parent Child Interaction Therapy (PCIT)

Honoring Children, Making Relatives (HC-MR) is the cultural enhancement of PCIT that focuses on the incorporation of American Indian/Native Alaska's teachings, practices, rituals, traditions, and cultural orientation. HC-MR represents the fundamentals of PCIT set within a context of American Indian/Alaska Native philosophies by applying Circle Theory and Old Wisdom. The *Parent Training Manual for American Indian Families* (BigFoot, 1989) served as the basis for the cultural enhancement, outlining the underlying parenting and cultural concepts that were elaborated by the ICCTC and their cultural consultants and were complementary to PCIT.

As can be seen in the original work of the first author, traditional American Indian/Alaska Native beliefs hold that children need and desire the warmth, concern, and encouragement they gain from parents, grandparents, aunts, uncles, brothers, and sisters (BigFoot, 1989). Traditional cultural beliefs assumed that each child possessed the qualities to develop into a worthwhile human being. Tribal community expectations for good behavior were ingrained and likely served as an impetus for children to flourish within the boundaries of their surroundings (Atkinson, Morten, & Sue, 1998).

Critical is the understanding that a child was received by all relatives and that the child was affected by all interactions, just as attachment theory and family systems theory would suggest.

As described by BigFoot (1989), caregivers' responsibility was to cultivate the positive nature of the child and to touch the child with honor and respect. Because a child was considered a gift from the Creator, caretakers had the responsibility to return to the Creator a person who respected him- or herself and others. Tribal teachings held that one could positively reinforce American Native/Alaska Native children by honoring them through ceremonies, name giving, or recognition events (e.g., honorary dinners, dances, giveaways). Indigenous parents and relatives encouraged correct behavior by acknowledging traits that would be helpful as the child grew into adulthood.

A child's efforts and accomplishments may indirectly be acknowledged by a giveaway, dinner, or renaming. In a giveaway to honor a child, family members might assemble highly valued items to be given to nonrelated individuals who exemplified the good traits developing in the child. For example, a grandfather might stand before the gathering and announce the reason for the giveaway and how it was to honor his grandchild. Sometimes a giveaway was spontaneous, with the caregiver removing personal items of clothing, jewelry, or other possessions to acknowledge the occasion. Many times small items would be given inconspicuously to a child by an adult with a comment such as, "I am giving this to you because you always listen to your parents, you always seem happy to obey them." So although many doubt that praise as required in PCIT will be accepted by parents, the use of praise to encourage positive actions is an old American Indian/Alaska Native method of rearing children.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Honoring Children, Mending the Circle (HC-MC) is the cultural enhancement of TF-CBT that focuses on the clinical application of the healing process of trauma within a traditional framework. This framework supports the beliefs of the American Indian/Alaska Native culture of spiritual renewal leading to healing and recovery.

The framework for HC-MC is the circle. For many Indigenous people, the circle is a sacred symbol that has long been used to understand the world. The symbolism of the circle is old wisdom transmitted in oral stories, carved into rock formations, sculpted in wood or clay, woven into reed baskets, or painted in colored sand. The most widely recognized American Indian/Alaska Native symbolic circle is the Medicine Wheel. The constructions of the Medicine Wheel and its teachings have been documented since 7,000 BC (Stanford Solar Center, 2008). The concept of the circle is incorporated into American Indian/Alaska Native lifestyles through practices, teachings, and ceremonies such as at the beginning of the grand entry for pow wows, the physical placement of participants during sweat lodge, shape of the drum, ceremonial structures such as medicine lodges and many kivas, and dwellings such as grass or reed shelters and wattle or daubs.

The HC-MC circle is conceptualized as a model of well-being. The HC-MC circle is based on tribal teachings but remains flex-

ible to accommodate individuals of diverse cultures and spiritual and religious beliefs. It is an elaboration on the CBT core construct of the cognitive triangle that our thoughts, feelings and behaviors are interconnected. Core HC-MC constructs are based on American Indian/Alaska Native worldviews: (1) all things are interconnected, (2) all things have a spiritual nature, and (3) existence is dynamic. HC-MC defines well-being as balance and harmony both within and between one's spiritual, relational, emotional, mental, and physical dimensions.

Spirituality serves as the core of the HC-MC circle. Central to wellness and healing is the American Indian/Alaska Native belief that all things, human and earth, have a spiritual nature. Spirituality has played and continues to play an important role in the individual and collective well-being of American Indians. The spiritual dimension is interwoven and intertwined with the physical, mental, emotional, and relational well-being dimensions.

HC-MC defines personal imbalance as disharmony in one or more of these dimensions. Imbalance may manifest through trauma exposure as spiritual disconnection, unhealthy behaviors, emotional instability, distorted beliefs, or poor relationships. As a result, the goal of the healing process is to restore one's personal balance within the five dimensions, thus re-establishing personal well-being and diminishing trauma responses.

Treatment for Children With Problematic Sexual Behaviors (PSB)

PSB is a promising practice that incorporates treatment for both children and caretakers. The program focuses on psychoeducation and enhancing safety skills for both children and caretakers through teaching children rules that help keep themselves and other children safe.

Honoring Children, Respectful Ways (HC-RW) is the cultural adaptation of Treatment for Children With Problematic Sexual Behaviors for American Indian/Alaska Native children demonstrating inappropriate sexual behaviors. The adaptation was designed to honor children and promote their self-respect as well as respect for others, their elders, tradition ways, well-being, animals, and all living things. The HC-MR adaptation seeks to honor what makes American Indians and Alaska Natives culturally unique through recognizing and respecting the beliefs, practices, and traditions within their families, communities, and Tribes that are inherently healing and therapeutic. The Honoring Children, Respectful Ways model teaches about rules, privacy, feelings, sexual development, boundaries and personal space, supervision and attentiveness, self-control and self-discipline, intimacy and social relationship, and being a good relative toward self and others.

Summary

The Honoring Children Series of interventions has at its core to promote better understanding of an individual's responses to the environment; to identify feelings, thoughts, and actions; and to build on a cultural framework toward healing and better ways of interaction with self and others.

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Suicide Prevention: A Culture-Based Approach in Indian Country

Clayton Small, PhD

"Why are you still holding on to the past? It's been long time ago!" Most American Indian–Alaska Native (AI/AN) people have heard this comment from a non-Indian at some time in their lives. Upon hearing this comment, they shake their heads and say to themselves, "Where do I begin, and how do I help you understand?!" This cultural divide is very real and is caused by misunderstanding, lack of knowledge, denial, and unwillingness to hear the truth.

Humans are for the most part capable of forgetting and forgiving after a traumatic experience when and if that experience stops, but unfortunately, many AI/AN people continue to experience colonization (although colonization takes different forms today), racism, and stereotyping. Despite the efforts of some healing movements in Indian country, the devastation of losing their land, the imposed laws that violated their culture, and the broken promises by the government continue to affect the daily lives of Native people and persist in creating a feeling of mistrust, betrayal, and doubt.

Most Americans are oblivious to the truthful history of what the AI/AN people experienced. What happened to Native people was inevitable in terms of the federal government wanting the land and gold in the homelands of AI/AN people. How they took these resources is unconscionable when viewed in the light of truth. These acts include the Indian problem being given to the Department of War, after which entire tribes were killed, forced from reservations, and forbidden to practice their spirituality-religion; buffalo and horses were killed and diseases introduced; children were sent to federal government or parochial boarding schools; and families were relocated to cities. The policy at the boarding schools was "Kill the Indian and save the person." So again, "Get over it and move on!"

AI/AN people struggle with healing challenges that run deep and result in unhealthy behaviors that are passed on to the next generation. Ongoing traumatic incidents for AI/AN people result in unhealthy ways of coping that lead to tremendous health disparities for many Natives compared with other races in the United States. It is common knowledge that the causes of these disparities for AI/AN men, for example, are rooted in historical trauma, racism, impact of colonization, loss of traditional roles, loss of connections to cultural ceremonies and spirituality, poverty, and unemployment.

Increased Risk for Suicide

AI/AN death rates are nearly 50% greater than those of non-Hispanic whites (Centers for Disease Control [CDC], 2014). For AI/AN youth, suicide fatalities and related risk factors—including substance abuse, violence and bullying, coping with trauma, and depression—have reached a crisis point. According to CDC, suicide rates were nearly 50% higher for AI/AN people compared with non-Hispanic whites, and they were more frequent among AI/AN males and persons younger than age 25. CDC concluded that patterns of mortality are strongly influenced by the high incidence of diabetes, smoking prevalence, problem drinking, and health-harming social determinants.

In May 2013, the Men's Health Network in cooperation with the Office of Minority Health and Indian Health Services developed a report to raise awareness of the growing health disparities among AI/AN males in the United States, entitled "A Vision for Wellness and Health Equity for American Indian and Alaska Native Boys and Men" (Men's Health Network, 2013). The report suggests that health disparities among AI/AN men compared with women and all other U.S. racial and ethnic groups are extreme and the situation is worsening.

For example, the CDC reports that more than half of American men's premature deaths are preventable and, even excluding pregnancy-related office visits, American women make twice as many preventive care visits as men. AI/AN males experience death rates 2 to 5 times greater than AI/AN females for suicide, HIV/AIDS, homicide, unintentional injuries, diabetes, firearm injury, and alcohol-related deaths. For cancer, heart disease, and liver disease, AI/AN males experience death rates 10%–50% higher than AI/AN females (CDC, 2014).

Barnes, Adams, and Powell-Griner (2010) documented that, overall, AI/AN males experience greater disparities in health status and general well-being than *any* other group defined by the combination of race and gender. In their survey, AI/AN males indicated often feeling "hopeless" and "worthless," thus highlighting the tragic and disturbing state of all disparities, including

the extremely high rates of suicide among AI/AN males for the age groups ranging from adolescents to mid-life.

These contributing social factors in Indian Country are a call to action by tribal leaders and federal agencies to take a more assertive approach in public health prevention, intervention, and treatment of these escalating health disparities among Native populations in the United States. Unfortunately, very little research to date has been funded to Native organizations to study the root causes and develop AI/AN men's prevention and intervention culture- and strengths-based curricula.

Finding common ground between AI/AN and non-Indians (including federal, state, and city agencies) requires, first, an awareness of the concept of colonization (Blauner, 1972) and realizing the devastating effect that it creates, especially if the colonists continue to practice its power over the colonized**.** Second, the truthful description in history books as to what really happened historically to AI/AN people needs to be told. In addition, it is important for AI/AN people to understand the impact of colonization, to acknowledge it, and to overcome the challenges for the self, family, and community. This healing process for AI/AN people requires partnerships with federal and state agencies that have a common understanding of the historical context and a consensus among stakeholders about how to proceed.

More research and approaches are needed for AI/AN men that will validate the causes of the health disparities and lead to appropriate interventions. President Obama's White House initiative, "My Brother's Keeper" (**http://www.whitehouse.gov/my-brothers-keeper**), has potential to meet these needs for AI/AN men. A beginning would be the funding of a National AI/AN men's Resource and Training Center that could provide awareness, technical assistance, and training for AI/AN males throughout Indian Country, as well as assist in the development and implementation of programs for AI/AN men at the reservation and urban community level.

In an effort to address some of the problems facing AI/AN people, Native PRIDE, a national AI/AN nonprofit organization based in New Mexico (**www.nativeprideus.org**), has developed two curricula: Native HOPE (Helping Our People Endure) and the "Good Road of Life: Responsible Fatherhood" programs.

Native HOPE

Native HOPE is a suicide prevention, peer-counseling curriculum (youth helping youth). This program addresses suicide prevention, violence prevention, stress and trauma, and depression. Clayton Small, PhD (Northern Cheyenne), created this curriculum in 2004 because he realized that most suicide prevention programs simply provided education and awareness and did not incorporate culture- and strength-based approaches or integrate healing into the process. Because of the historical context already examined, Native PRIDE recognized that these enhancements were critical to the Native HOPE curriculum. In addition, the interactive, Native HOPE curriculum allows AI/AN people to address serious health and wellness challenges while having fun learning.

The curriculum is delivered to approximately 2,000 youth per year in school and community settings throughout Indian Country. It consists of a 1-day training of trainers of local teachers, counselors, mental health professionals, substance abuse counselors, social workers, spiritual and traditional healers, and so on. They practice being a clan leader and assist Dr. Small in conducting a 3-day training with youth. This team walks through the program, practices skills in group process and facilitation, and is present during the 3 days. This builds capacity of this team to replicate the training in the future with other youth from their school and community. The process moves fluidly from the large group to small clan groups. The adult-youth ratio is one adult to from six to eight youth in the clan groups. The youth know immediately that this is a cultural gathering because of the use of prayer, humor, songs, dances, artwork, and medicines such as cedar, sage, and sweet grass. The youth and adults are challenged to share their tribal-specific culture during the 3-day retreat, and evening activi-

ties are encouraged, such as talking circles (support groups), sweat lodge, and social dances. A Spirit Room is created where youth can have one-to-one conversations with counselors anytime during the 3 days. The adult team conducts a debriefing session at the end of each day to review progress and identify at-risk behavior that needs immediate follow-up, for example, suicide, violence, or abuse and neglect. Great care is taken to create a safe environment for the youth, and they quickly feel comfortable in an atmosphere where a sense of belonging is maintained.

During the program, youth share openly and honestly about their life, family, and community in the clan groups and large group activities. Tears of healing are often demonstrated by youth, as well as fun and humor in the team trust-building activities. The youth often share, "This program saved my life" or "I know how to help my peers" and "It's okay to ask for help." The 3rd day includes the youth developing a strategic action plan for follow-up activities. This includes organizing a youth council that conducts ongoing prevention and leadership activities; conducting fundraising and sponsoring talking circles (support groups); conducting presentations to the school board, tribal council, and parent groups; and conducting peer-to-peer messages (role playing). This process is effective and validates that working with AI/AN youth requires a comprehensive cultural approach that incorporates wellness and healing.

The Native HOPE curriculum is endorsed by the Indian Health Services and SAMHSA as an effective culture-based prevention program. We are thankful that the federal agencies are embracing culture-based programs, even though they have not all completed the vigorous, time-consuming, and costly evidence-based protocol for effectiveness. We know this process works because we hear it directly from the AI/AN youth, and the evaluation data show evidence that culture-based programs make a positive impact on the well-being of AI/AN youth.

Good Road of Life: Responsible Fatherhood

The "Good Road of Life: Responsible Fatherhood" is a culture-based curriculum that uses sources of strength such as spirituality, humor, and healing to assist Native men and their family members to address the impact of colonization, trauma, racism, and other challenges that threaten the well-being of children and families. The program was funded by the Administration for Native Americans (ANA) to develop, field-test, and make available their culture- and strengths-based curriculum to AI/AN men, women, and families for 4 years (2008–2012).

The "Good Road of Life: Responsible Fatherhood" program is based upon the doctoral dissertation study of Clayton Small (Northern Cheyenne) and was completed in 1996 at Gonzaga University (Spokane, Washington). It addresses challenges in wellness and recovery for AI/AN men. This ANA project was implemented by Native PRIDE, who delivered 10 trainings in five tribal communities, reaching 895 Native men, women, and family members. Pre- and posttests of AI/AN male participants indicated enlightened self-awareness of the relationships with their own fathers and families and learning "letting go" (healing), communication skills, and forgiveness. The Administration for Native Americans (ANA) currently funds "Responsible Fatherhood" programs to AI/AN tribes and organizations, yet it is not enough to meet the tremendous need to intervene with AI/AN men to help address their personal wellness challenges that, if addressed, will lead to the elimination of domestic violence and incarceration of AI/AN males and promote increased quality family time and family preservation.

Men with depression and suicide issues, substance abuse, or domestic violence issues were referred for support and counseling. Participants made commitments to complete follow-up homework, such as joining talking circles (support groups), exploring spirituality and sources of strength, researching family history (behaviors), forgiving parents, and increasing quality family time. The participants worked in a peer-counseling (adults helping adults) approach with at least one other adult from their community. Several tribal colleges, substance abuse programs, social services programs, and mental health programs are integrating the GRL into their work with clients. As a result of this project, Native families have more involved spouses, fathers, sons, and brothers who can draw upon sources of cultural strength, as well as benefit from other men who are a positive role model for their communities.

Next Steps

The Native HOPE and the Good Road of Life are two examples of culture- and strengths-based approaches that are effective prevention and intervention programs for Native men, women, youth, and families. What makes these curriculums unique is their focus on strengths, culture, humor, spirituality, and participation. We create a safe environment (belonging) for participants and utilize Native stories, art, and songs to introduce themes (risk factors) that need to be addressed by participants. Humor and fun are an important element for Native people. It is essential for prevention trainings to incorporate interactive humor as a means to create a safe place for learning, address serious risk factors, and promote healing in the context of utilizing culture and spirituality. Federal agencies are beginning to acknowledge this learning process for Native populations and endorse culture-based approaches more so than in the past.

More funding is needed for Native communities to utilize these culture-based approaches as most do not have the resources to pay for the services on a fee-for-service basis. Reducing the health disparities among Native populations is not a quick fix due to the historical trauma, racism, poverty, and other ongoing daily challenges of survival for Native people. Healing can help move individuals from surviving to living a full and joyous life. This renaissance movement is catching fire in Indian Country, and it is exciting and impossible to resist. It is a demonstration of the resiliency of Native people of North America who overcame a federal policy of colonization that had a theme of "Kill the Indian, save the person." The healing movement continues as AI/AN people are thriving and moving beyond surviving. In the words that I use to inspire others, "Cry, heal, forgive, and let your tears be the food that waters your future happiness…."

Some countries in the world have made formal apologies to their Indigenous peoples as a result of colonization, and this has made it easier for the indigenous population to move on. As stated in the Australian Parliament: "For the pain, suffering and hurt of these Stolen Generations, their descendents and for their families left behind, we say sorry. To the mothers and fathers, the brothers and sisters, for the breaking up of families and communities, we say sorry. And for the indignity and degradation thus inflicted on a proud people and a proud culture, we say sorry. We the Parliament of Australia respectfully request that this apology be received in the spirit in which it is offered as part of the healing of the nation" (Parliament of Australia, 2008).

Yes, a formal, sincere apology would be helpful. We are not saying that an apology is the answer to all the devastations that have occurred, but it's a beginning for awareness, understanding, and maybe trust. To the question: "Why don't they get over it and move on?" I would reply, "Come live in our world for a while…. Come join our trainings, and I guarantee that your question will be answered."

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Clayton Small, PhD, has been an elementary, middle, and high school principal on reservations and in urban communities. He has been a faculty member at the University of New Mexico, University of Montana, and Gonzaga University and has served as a CEO for Indian Health Services and directed several nonprofit organizations. His organization, Native PRIDE, provides prevention, wellness, healing, and leadership training throughout Indian Country. He has developed prevention programs for the Bureau of Indian Affairs, Indian Health Services, SAMHSA, and the Department of Justice. He has comprehensive knowledge and experience in community mobilization, strategic visioning, Indian education, organizational development, youth leadership, prevention, wellness/healing, team trust building, cultural competency, and creating positive change. Dr. Small conducts training and facilitation nationally and internationally. His programs offer leadership and hope for American Indian, Alaska Native, and First Nations people. Contact: **claytonsmall@aol.com**

Washington Update

John Sciamanna

The spring of 2014 brought the President's proposed budget, new vacancies to fill at HHS, and the start-up of the Commission on Child Fatalities. Despite a number of varying and important discussions taking place, little progress had been made by late spring, which likely means a more contentious summer and a fall tied to the mid-term elections in November.

Commission on Child Abuse and Neglect Fatalities

On February 24, 2014, the presidential Commission on Child Fatalities Due to Child Abuse and Neglect held its initial meeting of full membership. The agenda was taken up by comments of the commission members as well as some reflective comments of the architects of the legislation. Staff from the House Ways and Means and Senate Finance Committees addressed members on the intent the legislation. They encouraged members to draft recommendations with an eye toward areas of law and policy at the federal level that may be obstructing greater efforts to prevent child deaths.

Congressman Lloyd Doggett (D-TX), an early sponsor of the legislation, also addressed members. He urged them to be creative, not limited by the enabling legislation, and willing to look across systems. He highlighted related programs, such as the home visiting program (MIECHV, Title V), and the need to reauthorize the law. Doggett urged the commission to be pragmatic and recognize the political realities of the budget situation, but he also strongly urged members not to allow politics to limit their recommendations. Other topics raised by the Congressman included the issues of toxic stress, the need to examine caseloads and caseworker challenges, and lack of services to a significant percentage of children who are substantiated for child abuse and neglect. He assured the commission that when the report is issued, it will get attention.

The hearing included a presentation by the Children's Bureau on current data available through the National Child Abuse and Neglect Data Systems (NCANDS). Some commission members were surprised by the fact that all fifty states do not necessarily report data in every field. They were also surprised to learn that the data system of reporting is voluntary. Data from the last report indicate that an estimated 1,640 children died due to maltreatment, the highest total since 2009, when 1,740 children died due to maltreatment. The last reported rate of child deaths was 2.20 per 100,000 children, also the highest since 2009. Consistent with previous years, 70% of child deaths were children under 3 years of age. The rate of child deaths is most severe for children under 1 year; in 2012, the rate was 18.8 per 100,000 children under age 1.

Commissioner Michael Petit argued that actual child deaths are much higher due to the varying ways a state may collect data. As a result, an extensive discussion took place on how states compile data. For example, if a child died but there are no siblings or other children in the family and there was no earlier involvement by CPS, that child death may not be included in child death numbers. Critics suggest that the number is closer to 3,000 child deaths per year. A wide-ranging discussion also occurred on how states screen cases of child abuse and why some children may be screened out. The Commission is asked to consider critical issues such as the following: How child protective services should interact with other systems; what the risk factors are and how to identify and protect children at risk; which communities have effective strategies to prevent child deaths; current strategies that use technology and mapping; what we know about the tribal communities (very little from national data); and how to address our lack of information in that regard. Commissioner Zimmerman raised several issues regarding the tribal community and the need for the commission to place some focus on this area as well as rural areas.

The issue of how and when to craft recommendations was discussed with some congressional staff, urging caution in recognizing limited resources. There were suggestions not just from Congressman Doggett but also by commission members such as Commissioner Wade Horn that suggested they ought not be limited by budget neutrality.

A list with an expanded biography and a link to the legislation are available on the National Child Abuse Coalition Web site.

Appropriations

In March, the President released his FY 2015 budget. The budget agreement (PL 113-67) that replaced the sequestration for 2 years has established budget ceilings for FY 2015. As a result, the Senate did not pass a budget resolution and instead started the appropriations process directly. The President proposed requests

that were similar to last year's budget. One proposal is a continuation of a proposed expansion of a universal prekindergarten program. Within child welfare, the most significant change is a new proposal to create a joint effort by the Administration for Children and Families (ACF) and the Centers for Medicare and Medicaid Services (CMS) to improve treatment for children in foster care, particularly in regard to the overuse of psychotropic medication. The remaining child welfare services are at levels last established in the January agreement in the FY 2014 appropriation (PL 113-46). Total ACF funding for 2014 is $51 billion, a slight increase of $157 million.

Beyond the new funding for the joint ACF-CMS proposal, most other child welfare services programs remain at 2014 levels. Title IV-E foster care, adoption assistance, and kinship care are awarded funding based on the number of children eligible. Funding for Child Welfare Services (CWS) and Promoting Safe and Stable Families (PSSF) remains at 2014 levels, which ended up being somewhere between the cuts imposed by the sequestration cuts and what the programs were awarded in presequestration 2011. Several of these child welfare programs continue to lose funding. In addition to the funding for these programs, child protection and prevention programs also were requested at 2014 levels. The CAPTA state grants and the Community-Based Child Abuse Prevention (CB-CAP) funds are all at the 2014 levels and slightly lower than in 2011.

Other significant child welfare-related proposals include the Administration's request to restore the Social Security Block Grant (SSBG) to its presequestration level of $1.7 billion. The Administration is also seeking to increase to $10 million funds to address domestic sex trafficking through the Office of Refugee Assistance. In January, an initial $1.7 million was provided for competitive grants to address domestic commercial sexual exploitation. How this initial funding would be awarded is still being developed.

The Administration proposal for a joint project by ACF and CMS to address the overuse of psychotropic medications is an attempt to promote evidenced-based interventions targeting children in the foster care system. For each of the next 5 years, $50 million would be available through ACF along with an additional $100 million a year through Medicaid. Many of the specifics are still to be worked out, but the funding awarded through ACF would help build capacity by enhancing the child welfare workforce; providing reliable screening and assessment tools; coordinating between child welfare and Medicaid, especially for early and periodic screening, diagnosis, and treatment (EPSDT); training for foster parents, adoptive parents, guardians, and judges; implementing evaluation tools; and providing data. At the same time, CMS would provide incentive grants to state Medicaid agencies if they could achieve certain targets and goals regarding services to children in foster care and similar children. The goal is to enhance services that would not just reduce the overuse of psychotropic medications for children in foster care but also enhance the therapies and services to children and families in this population. The outcome has the potential to improve services for a population of children and families beyond foster care placements.

The President resubmitted his vision for expanded prekindergarten (pre-K) and early childhood education. The 2014 appropriations deal provided initial seed funding of $250 million. There would be $1.3 billion in matching federal funds for states that already have programs with funds to be used to expand the quality and availability of current services. Generally, early target populations are families at 200% of poverty and below, although a larger population would be served. States would have to meet rigorous standards beyond what they have been required to provide under the current child care system of block grants. The pre-K portion would be funded by increasing the current tobacco tax—the same as last year.

An important component is the expansion of Early Head Start, which would receive $650 million in FY 2015, an increase of $150 million within the Head Start program. As proposed last year, this expansion would link Early Head Start to center and family-based care seeking to significantly improve the quality of services provided. The Administration would add $120 million to the Head Start program to continue current initiatives to improve the quality of current Head Start programs. Total funding for Head Start (both Early Head Start and Head Start) would increase from $8,598 in FY 2014 to $8,868 billion in FY 2015.

Child Care Reauthorization

On March 13, the Senate passed a child care reauthorization by a vote of 96 to 2. The legislation (S 1086) would reauthorize the Child Care and Development Block Grant (CCDBG) for the first time since 1996, when it was extended as part of the creation of TANF. HELP Committee Chair and bill-sponsor Senator Tom Harkin said, "We know that learning begins at birth, and the preparation for learning begins before birth. That's why access to high-quality child care and early education programs are so critically important." He went on to say,

> The updates to this bill will ensure that the CCDBG program is both a support for working families as well as rich early-learning opportunity for children, including infants and toddlers and children with disabilities. This bill is a testament to how Congress can enact meaningful change by working together across party lines. I am

> encouraged by the HELP Committee's growing record of bipartisan accomplishments.

As an authorization, it does not offer actual funding but provides the framework for the annual appropriations and child care allocation process. Child care funding includes not only $2.3 billion in annual appropriations but also a mandatory fund written into the TANF law that is currently set at $2.9 billion. Senator Barbara Mikulski (D-MD), Senator Richard Burr (R-NC), HELP Committee Chair Tom Harkin (D-IA), and Senator Lamar Alexander (R-TN) have sponsored the legislation. Alexander issued the following statement:

> Washington ideas are often big and burdensome with lots of rules, but this child care program has survived for more than two decades with a simple idea: Give states grants so they can help low-income parents pay for the child care that best suits their families. This year it helped the parents of about 1.5 million children receive child care so they could go to work or get an education and move up the economic ladder and reach the American dream. I am pleased the Senate passed it today after a good debate, during which senators had the opportunity to offer amendments and get votes on those amendments, and I hope we can achieve more good results like this. (**http://www.chattanoogan.com/2014/3/12/271651/Senate-Begins-Debate-On-Child-Care-Bill.aspx**)

The lone votes in opposition were cast by Senator Mike Lee (R-UT) and Senator Tom Colburn (R-OK), who both wanted to offer amendments: one requiring Social Security numbers for children receiving child care and another limiting funding for overlapping government programs on early childhood education.

Hearings on Pre-K

While the Senate acted on a reauthorization and the President unveiled his pre-K proposal, Congress was beginning a hearing on its own ideas. The House hearing opened with remarks by Committee Chairman Congressman John Kline (R-MN), who spent much of his statement focused on what he sees as the number of overlapping government child care programs. For his part, ranking Congressman George Miller (D-CA) refuted some of the claims about the number of programs that exist and talked about the importance of expanding early childhood education. He also dissected the testimony of the Government Accountability Office (GAO). For example, the GAO research and testimony indicated that it found 45 different programs that deal with early childhood education and child care, suggesting an overlap. During the question and answer period, Congressman Miller highlighted the GAO information that indicated 75% of the programs identified as overlapping actually had different missions aside from providing child care, such as the Child and Adult Feeding Care Program, which focuses on nutrition services and does not provide child care.

Home Visiting Extended

On March 27, the House gave approval to a bill that will likely extend the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program—the Home Visiting program—into 2015. This came about when the House of Representatives passed another "patch" to the Medicare law to modify the current formula under Medicare that determines how doctors are reimbursed. The "doc-fix," as it is called, has become an annual congressional ritual since it was included in a 1997 budget act. The coalition of home visiting programs and supporters had been working aggressively over the past several weeks to get any kind of Home Visiting program extension attached to the Medicare bill under the belief it might be one of the only or the only vehicle bill that would be passed this year. The MIECHV program first included as part of the ACA was authorized for 5 years with current funding set at $400 million a year in mandatory funds. The program sets new standards for the allocation of human service funding in that it requires states to spend 75% of their funding on evidenced-based and research-based models. The remaining 25% can be used for more experimental models, but this amount too must undergo serious evaluation.

Although Congress has taken to passing the Medicare doc-fix (SRG) bills annually, this year's effort took a few different turns and time was running out on how long Congress had to amend the formula. While Finance Committee Chair Senator Ron Wyden (D-OR) was crafting a permanent fix that would stretch out beyond 10 years, Senate Majority Leader Harry Reid (D-NV) and Speaker John Boehner (R-OH) were planning a deal that would extend the patch through this year. That House–Senate deal included funding for the Home Visiting program. The deal had been reached on the eve before the vote, but overnight the doctor groups started to sound the alarm about the shortness of the arrangement. When it looked like the House leadership might lose the vote (they needed two-thirds approval because it had been taken up bypassing the Rules Committee), behind-the-scenes discussions occurred by which it was agreed there would be a voice vote with neither side asking for a roll call. Because disagreements prevailed within both House caucuses, the maneuver allowed members not to be on the formal voting record. Once the House moved the bill, the Senate was scheduled to act. That was delayed, however, until today. It is likely that Wyden will have his vote, which is likely to fail because Republicans do not like using as savings the end of the war costs. When the vote fails, the Senate is expected to move the House bill. The deal allows the Home

Visiting program to continue for one more year, but the coalition will now have to refocus on the next round.

HHS Vacancies

Secretary of Health and Human Services Kathleen Sebelius is staying in her position while the Senate works the confirmation process for Sylvia Mathews Burwell. President Obama announced the appointment of Burwell on April 11 at the same time that Secretary Sebelius announced her departure. It is hoped that Burwell, the current Director of the Office of Management and Budget (OMB), will not require extensive Senate evaluation because she received 96 votes when that Senate approved her OMB role in late April 2013. She also served at the White House during the Clinton presidency. In addition, she has worked in the private sector for the Walmart and Melinda Gates Foundations in-between the two Democratic presidencies. The concern is that some Senators may attempt to make a statement on the Affordable Care Act by delaying her nomination. She has to testify before two Senate committees, the Finance Committee and the HELP Committee, but only the Finance Committee will actually vote on her nomination.

Currently, HHS has a pending nomination for the Secretary, a pending nomination for Assistant Secretary for the Administration for Children and Families (ACF), and a vacancy for the Administration on Children Youth and Families (ACYF), a position left vacant when Bryan Samuels stepped down last year. The Senate Finance Committee must approve the ACF position. President Obama nominated Maria Cancian on February 12 for that office. The Administration for Children and Families has jurisdiction over 18 offices that cover most of the services outside of health care and research, such as child welfare, welfare, child care, Head Start, refugee assistance programs, Native American Services, and community services. The position requires Senate confirmation. The last time the position was filled by a confirmed Assistant Secretary was September 2009, when President Obama appointed Carmen Nazario. Assistant Secretary Nazario served until the next summer, when she left due to family matters.

Adoption Incentives Program Funding Reauthorization

In December, the Senate Finance Committee passed the Supporting At-Risk Children Act of 2013. The legislation bundled together a reauthorization of the adoption incentives fund, new legislative language to address domestic sex trafficking through child welfare, and provisions that deal with child support collection, including provisions to address international treaties.

The Adoption Incentives program requirements differ from a House bipartisan bill (HR 3205) in how it allocates funds for the placement of children from foster care into adoptive families. Both bills now provide an award for kinship care placements, although the Senate provides a higher award than the House bill. In addition, the Senate creates a broader definition of kinship care placements. Both bills require a greater accountability of state savings that is being realized by states as federal adoption assistance is expanded each year due to the 2008 Fostering Connections to Success Act (PL 110-351). Both bills extend the

Family Connections Grants, which currently fund kinship navigator programs, residential drug treatment, family finding services, and family group decision-making services.

In regard to the issue of sex trafficking of children from the child welfare system, the bill creates a number of new requirements on state screening, data reporting, and services to youth, although the new requirements are not accompanied by any additional funding. Policies and procedures would have to be in place to screen, identify, and determine services for victims of trafficking for youth up to age 21 (or at a state's option to age 26). It defines sex trafficking consistently with the federal law that deals with international victims.

The bill also deals with those young people in foster care who end up in what is generally viewed as long-term foster care. They are young people who may be classified as under "another planned permanent living arrangement" or APPLA for short. Youth age 16 or older could be considered "APPLA" would be covered by additional court hearings and documentation. It would create a definition in law for a "prudent parent" standard. Each child would have to have someone in a foster home or residential facility who could meet these standards. The bill would also require that a child age 14 or older be directly involved in his or her own case planning (currently required of youth 16 and older). In addition, the legislation would require a bill of rights provided to youth age 14 or older who are in foster care, kinship care, or adopted and specify in law that anyone 14 or older who exits foster care have a birth certificate, Social Security card, driver's license, and a bank account (unless the child decides not to have a bank account). Failure to do this will require a reduction in a state's reimbursement under Title IV-E.

Once the Senate decided to bundle new Adoption Incentive funding with trafficking issues, action on all the legislation was delayed, in part due to the change in leadership within the Senate Finance Committee. More significant, the Senate delay beyond last December cost the $15 million a year in offset (savings) that was going to be used for Family Connections Grants. Now the legislation is stalled as members look for a new way to pay those.

CFSRs to Continue

The Children's Bureau (CB) has announced the third round of the Child and Family Services Reviews (CFSR). The reviews are a detailed assessment of each state's child welfare system. The first round was conducted in 2001, and this third round is beginning in FY 2015. The CFSRs are a result of a 1994 congressional mandate that was included as amendments to the Social Security Act (PL 103-432). The law required HHS to review state child welfare programs to ensure "substantial conformity" with state plan requirements in Titles IV-B and IV-E of the Social Security Act. State child welfare programs are to be measured or judged by certain areas or standards. Over the next several years, HHS and the states will work to develop this review process according the dictates of the law.

States are assessed on 14 outcomes, with each state measured by seven child and family outcomes and seven systemic outcomes. If a state does not "substantially achieve" an outcome, penalties can be imposed, but, regardless of a penalty, states have to implement Program Improvement Plans (PIPs). As was the case in the first two rounds, the reviews will be staggered with all states covered over a 4-year period (FY 2015–2018).

In the first round of reviews, no state "passed" (achieved substantial conformity) in its CFSR. Because of this, all states were required to complete a Performance Improvement Plan (PIP). This plan gave states the opportunity to work to improve specific outcome and systemic factors. The PIP is a 2-year process with an extra year allowed for states to realize negotiated improvements in their outcome data.

In this round, the Children's Bureau is making some revisions in how data from states are collected and reviewed in an attempt to provide a more accurate assessment. Changes are being made in how on-site interviews with stakeholders and case-level data are assessed, and how statewide data are used to make the determination of whether or not a state is in conformity on safety and permanency outcomes. The statewide data indicators are based on data available in states' Adoption and Foster Care Analysis and Reporting System (AFCARS) and National Child Abuse and Neglect Data System (NCANDS).

About the Author
John Sciamanna is Executive Director of the National Children's Coalition and was Director of Policy and Government Affairs for the American Humane Association (AHA), overseeing AHA's legislative agenda in Washington, D.C., and working specifically with the Administration, Congress, and other national groups. For close to two decades, he has been working on children's issues, and in the last decade, he has more specifically focused on child welfare issues. Before joining AHA, he worked in the U.S. Senate as a legislative assistant, with the American Public Human Services Association (APHSA) as Senior Policy Associate, and most recently as Codirector of Government Affairs for the Child Welfare League of America.
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APSAC News

Whitaker Named *Child Maltreatment* Editor

Dr. Daniel Whitaker, a professor at the Georgia State University School of Public Health and director of the National SafeCare™ Training and Research Center in its Center for Healthy Development, will become editor in chief of APSAC's quarterly journal, C*hild Maltreatment,* beginning fall of 2014.

"Dr. Whitaker is a distinguished scholar with a long record of service to the field," said Candice Feiring, the current editor of *Child Maltreatment*, in a letter announcing the appointment. "He brings to the task before him an incisive scientific mind; deep understanding of research, practice, and dissemination of interventions for child maltreatment; a commitment to APSAC's interdisciplinary mission; and a clear plan for the journal in the years ahead."

Viola Vaughan-Eden, president of APSAC, said, "Dr. Whitaker is a well-known researcher and scholar who has immense expertise in the field of child maltreatment. APSAC is thrilled that he is on board to maintain the high publishing standards we have come to expect from *Child Maltreatment*."

Still Time to Attend APSAC's Colloquium This June in New Orleans

APSAC will host its 22nd Annual Colloquium, June 11–14, at the Sheraton in New Orleans, Louisiana.

The Colloquium will feature more than 90 institutes and workshops that address all aspects of child maltreatment, including prevention, assessment, intervention, and treatment with victims, perpetrators, and families affected by physical, sexual, and psychological abuse and neglect. Cultural considerations will also be addressed.

Seminars have been designed primarily for professionals in mental health, medicine and nursing, law, law enforcement, education, prevention, research, advocacy, child protection services, and allied fields. To help attendees select their seminars, the Colloquium is divided into convenient tracks: Cultural Diversity, Child Protection/Law Enforcement, Interdisciplinary, Forensic Interviewing, Law, Mental Health, Medicine and Nursing, and Prevention. In addition, the Colloquium offers several special events and ample networking opportunities, poster presentations, exhibits, and an awards ceremony.

The educational goal of APSAC's Colloquium is to foster professional excellence in the field of child maltreatment by providing interdisciplinary professional education. Upon completion of this activity, participants should be able to:

Identify physical abuse, sexual abuse, and neglect in children

Treat abused and neglected children

Apply model examination techniques for assessment of abused and neglected children

Describe and utilize the most up-to-date information concerning working with abused and neglected children to improve patient care

Prepare and report quality testimony in court cases, both as experts and as witnesses

The 22nd Annual Colloquium is co-sponsored by APSAC with support from the Institute for Continuing Education. Continuing education credit is offered for a variety of disciplines and is awarded on a session-by-session basis with full attendance required at the sessions attended. Representatives from the Institute will be on site to accept applications for continuing education credit and to assist conference attendees. A separate processing fee is required.

Complete details and registration are available on the Web at **www.apsac.org** The site also features a downloadable, printable PDF version of the conference brochure.

2014 Child Forensic Interview Clinic Takes Place in Seattle July 14 –18

APSAC's Child Forensic interview Clinic offers 40 hours of intensive training on investigating interviewing of children. Attendees will receive a balanced review of several protocols and will develop their own customized narrative interview approach based on the principles taught during the clinics.

APSAC pioneered the Forensic Interview Clinic model to focus on the needs of professionals responsible for conducting forensic-investigative interviews with children in suspected abuse cases. Interviews with children face intense scrutiny and increasingly require specialized training and expertise. These comprehensive clinics provide a unique training experience that offers personal interaction with leading experts in the field of child forensic interviewing. Developed by top experts, APSAC's curriculum teaches a structured narrative interview approach that emphasizes best practices based on research and is guided by best interests of the child.

The clinic is being offered July 14-–8, 2014, in Seattle, Washington. Details and registration are available on the APSAC Web site, **www.apsac.org.**

Conference Calendar

June 11–14, 2014
22nd APSAC Annual Colloquium
American Professional Society
on the Abuse of Children
New Orleans, LA
877.402.7722
apsac@apsac.org
http://www.apsac.org

July 13–15, 2014
International Family Violence and Child Victimization Research Conference
Family Research Laboratory and Crimes Against Children Research Center at the University of New Hampshire
Portsmouth, NH
603.862.1888
frl.conference@unh.edu
http://cola.unh.edu/frl/conference

July 14–18, 2014
APSAC Child Forensic Interview Clinic
American Professional Society
on the Abuse of Children
Seattle, WA
877.402.7722
apsac@apsac.org
http://www.apsac.org

July 23–26, 2014
2014 NASW National Conference
National Association of
Social Workers (NASW)
Washington, DC
http://www.naswconference.org

August 11–14, 2014
26th Annual Crimes Against Children Conference
Dallas Children's Advocacy Center
Dallas, TX
conference@dcac.org
http://cacconference.org/dcac/default.aspx

September 7–10, 2014
19th International Conference on Violence, Abuse, and Trauma
"Linking Research, Practice, Advocacy, and Policy"
Institute on Violence, Abuse,
and Trauma (IVAT)
San Diego, CA
858.527.1860
ivatconf@alliant.edu
http://www.ivatcenters.org

September 15–18, 2014
XXth ISPCAN Conference on Child Abuse and Neglect
International Society for Prevention
of Child Abuse and Neglect
Nagoya, Japan
303.864.5220
ispcan@ispcan.org
http://www.ispcan.org/event/Japan2014

September 9–11, 2014
Extended Forensic Interviewing Training
National Children's Advocacy Center
Salt Lake City, UT
256.533.5437
http://www.nationalcac.org/ncac-training/efi-training.html

October 2, 2014
ISS-USA Annual Conference
"Cooperation, Communication, and Compassion: Developing Child-Centered Practice in Law, Social Work, and Policy for Cross-Border Families"
International Social Service—USA
Branch, Inc. (ISS-USA)
Baltimore, MD
443.451.1200
jringel@iss-usa.org
http://www.iss-usa.org/news-press/2014-annual-conference

October 11–14, 2014
9th Annual Conference on Differential Response in Child Welfare
The Kempe Center for the Prevention
and Treatment of Child Abuse and
Neglect at the University of
Colorado Denver
Seattle, WA
303.630.9429
amy.hahn@childrenscolorado.org
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/pediatrics/subs/can/DR/Pages/DiffResp.aspx

APSAC ADVISOR

Opinions expressed in the *APSAC Advisor* do not reflect APSAC's official position unless otherwise stated. Membership in APSAC in no way constitutes an endorsement by APSAC of any member's level of expertise or scope of professional competence.

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