REPORT TO CONGRESS ON THE SOCIAL AND ECONOMIC CONDITIONS OF NATIVE AMERICANS

Fiscal Year 2014[1]

ADMINISTRATION FOR CHILDREN & FAMILIES

[1] The title typeface of this Report to Congress on the Social and Economic Conditions of Native Americans is in Plantagenet Cherokee font. The Cherokee language is written in a *syllabary*, a kind of alphabet in which each character represents a complete syllable. The syllabary was developed between 1809 and 1821 by a Cherokee named Sequoyah, (or ᎯᏪᏩ as his name is spelled in Cherokee) and it made reading and writing in Cherokee possible. After adoption of the syllabary in 1825, Cherokee literacy rates quickly surpassed that of surrounding European-American settlers. Sequoyah's extraordinary achievement is the only known instance of an individual creating a wholly new system of writing.

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2014 REPORT TO CONGRESS ON THE SOCIAL AND ECONOMIC CONDITIONS OF NATIVE AMERICANS

EXECUTIVE SUMMARY

INTRODUCTION

The U.S. Department of Health and Human Services (HHS) is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services through its administration of more than 100 programs across its operating divisions. On an annual basis HHS is responsible for almost a quarter of all federal outlays and administers more grant dollars than all other federal agencies combined. The Department manages programs that cover a vast spectrum of activities that impact health and human services outcomes throughout the life span.

The mission of HHS is to enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. HHS accomplishes its mission through its 11 operating divisions, including 8 agencies in the U.S. Public Health Service and 3 human services agencies. In addition, staff divisions provide leadership, direction, and policy management guidance to the Department.

Through its programming and other activities, HHS works closely with state, local, and U.S. territorial governments. In addition, the federal government has a unique legal and political government-to-government relationship with tribal governments and a special obligation to provide services to American Indians and Alaska Natives based on its relationship to tribal governments. HHS works with tribal governments, urban Indian organizations, and other tribal organizations to facilitate greater consultation and coordination among tribes, states, and HHS on health and human services issues.

Every four years, HHS updates its Strategic Plan, which describes its work to address complex, multi-faceted, and evolving health and human services issues. Each of the Department's operating and staff divisions contribute to the development of the HHS Strategic Plan, as reflected in the Plan's strategic goals, objectives, strategies, and performance goals. The HHS

Strategic Plan FY 2014-2018 describes the Department's efforts within the context of four broad strategic goals:

- Strategic Goal 1: Strengthen Health Care
- Strategic Goal 2: Advance Scientific Knowledge and Innovation
- Strategic Goal 3: Advance the Health, Safety, and Well-Being of the American People
- Strategic Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

NATIVE AMERICAN PROGRAMS ACT

The Native American Programs Act of 1974 (NAPA) created the Administration for Native Americans (ANA) for the purpose of promoting the economic and social self-sufficiency of all Native Americans, including federally recognized tribes, American Indian and Alaska Native organizations, Native Hawaiian organizations and Native populations throughout the Pacific Basin (including American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands). The Act, among other things, requires the Secretary to submit an annual Report to Congress on the Social and Economic Conditions of Native Americans. Specifically, Section 811A of NAPA (42 U.S.C. 2992-1) states:

> The Secretary shall . . . prepare and transmit to the President pro tempore of the Senate and the Speaker of the House of Representatives an annual report on the social and economic conditions of American Indians, Native Hawaiians, other Native American Pacific Islanders (including American Samoan Natives), and Alaska Natives, together with such recommendations to Congress as the Secretary considers to be appropriate.

This Report to Congress on the Social and Economic Conditions of Native Americans is issued in furtherance of this statutory requirement.

INTRA-DEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS

NAPA established the Intra-Departmental Council on Native American Affairs (ICNAA) to advise the Secretary on all matters affecting Native Americans that involve the Department. The membership of the Council is comprised of the heads of principal operating divisions within the Department and such additional members in the Office of the Secretary as the Secretary may designate.

Throughout fiscal year (FY) 2014, the ICNAA engaged in the following activities:

- Promotion of HHS policy to provide greater access and quality services for American Indians, Alaska Natives, and Native Americans (AI/AN/NAs) throughout the Department and, where possible, the Federal Government. For example, although, the Indian Health Service serves as the main conduit for the provision of federally supported health care for federally recognized tribal nations, this responsibility is shared with all HHS agencies because of the overarching government-to-government relationship between the federal government and the 566 tribal nations. ICNAA served to support this relationship across all of HHS, which fosters a more meaningful provision of health and human services for AI/AN/NA communities.
- Implementation of HHS policy and agency plans on consultation with AI/AN/NAs and Tribal Governments. Tribal consultation activities across HHS are an ICNAA priority, including, but not limited to, the annual two day HHS Tribal Budget Consultation sessions as well as the regional HHS tribal consultations that have proven to be very successful in ensuring that AI/AN communities have an opportunity to communicate their health and human services needs and priorities to senior HHS officials.

- Identification and development of comprehensive Departmental strategies to promote self-sufficiency and self-determination for all AI/AN/NA people including initiatives related to data, increased access to federal funding, and improved tribal-state relations.

NOTE ON CURRENT LIMITATIONS OF DATA ON NATIVE AMERICAN POPULATIONS

According to the most recent Department analysis of health and well-being data, there are a substantial number of policy areas for which data is not available to examine health and well-being for the separate American Indian, Alaska Native, Native Hawaiian, and Pacific Islander population groups.[2]

Part I of the FY 2014 Report on the Social and Economic Conditions of Native Americans includes Native American well-being indicators that primarily reflect disparities and negative outcomes. It does so because such indicators reflect contemporary social and economic conditions of Native American populations as compared with non-Native American populations. However, building on Part II's documentation of HHS' responses to Native Americans' social and economic conditions through grants, training and technical assistance, and outreach, Part III of the Report suggests areas for further study and development in addition to highlighting Native American models, strategies, and approaches holding promise for improving the well-being of Native American children, families, and communities. In future reports, HHS intends to continue this attention to Native American community assets, relational worldviews, protective beliefs and behaviors, and inherent Native American capacities to provide children, families, and communities the resources they need to grow and thrive across generations. In particular, while it remains critical to document disparities and to evaluate the effectiveness of interventions to "fix" existing problems, it is also essential to give attention to those "indigenous ways of knowing" that have the potential to inspire research, policies, and strategies that foster Native American resiliency and support Native American communities that are thriving.

METHODOLOGY FOR COMPILING SOCIAL AND ECONOMIC CONDITIONS DATA

The approach used to compile the data appearing in Part I of the FY 2014 Report to Congress on the Social and Economic Conditions of Native Americans consisted of two steps: identification of a range of publicly available governmental and non-governmental data sources and screening and review of such data sources to provide as comprehensive a picture of the social and economic conditions of Native Americans as possible.

ANA's Division of Policy identified potential data sources drawing from the following:

- Federal agencies with publicly available data sets
- National or regional Native American organizations
- Data repositories inclusive of Native Americans
- Publicly available data originating from studies of Native American communities

[2] Gaps and Strategies for Improving AI/AN/NA Data: Final Report, p. 2, (January 2007).

After data sources were identified, they were reviewed to determine their appropriateness in terms of currency and usefulness to Native Americans, Native American organizations, federal policy makers, state policy makers, researchers, and others interested in the health and well-being of American Indians, Alaska Natives, Native Hawaiians, and Native populations throughout the Pacific Basin (including American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands).

The data in this Report is meant to reflect the most current data from a variety of sources to describe the social and economic well-being of Native American populations. It is not meant to be an exhaustive listing of all data available on Native Americans.

KEY FINDINGS

This report contains summaries of Native American well-being indicators that describe the social and economic conditions of Native Americans as of FY 2014, documentation of HHS' responses to address such social and economic conditions, and strategies and approaches that point the way forward toward progress in Native American well-being. The report reflects the significant impact of HHS financial assistance, training, technical assistance, outreach, and other support to Indian tribes, Alaska Natives, Native Hawaiians, and Pacific Islanders located in Guam, American Samoa, and the Northern Mariana Islands. Some of the key highlights of this report include:

Demographics

- From the 2000 to the 2010 census, the American Indian and Alaska Native (AI/AN) population increased almost twice as fast as the total U.S. population, growing by 18 percent compared with 9.7 percent.
- Over half (52 percent) of Native Hawaiians and other Pacific Islanders (NHPIs) live in just two states: Hawaii (356,000) and California (286,000), with the states with the next largest NHPI populations being Washington (70,000), Texas (48,000), Florida (40,000), Utah (37,000), New York (36,000), Nevada (33,000), Oregon (26,000), and Arizona (25,000).
- Among NHPIs, the Polynesian group is the largest and includes Native Hawaiians, Samoans, Tongans, and Tahitians. The Micronesian group, the second largest, includes Chamoru from Guam but also includes other Chamoru and Carolinian from the Mariana Islands, Marshallese, Palauans, and various others.
- Approximately 42 percent of the AI/AN population is under 24 years old compared to 34 percent of the total population.
- According to the 2010 Census, 25 percent of AI/AN people lived on reservations or other U.S. Census defined tribal areas. However, while AI/AN people represent the United States' most rural population, a large and growing proportion of AI/AN people live and/or work in metropolitan areas with AI/AN people often moving back and forth between urban and rural areas, for short or long periods of time, for family, cultural, economic, educational, health, or other reasons.

Risk Factors

- Native Americans are disproportionately affected by trauma in childhood, including by adverse childhood experiences. Native American adolescents are more likely than other adolescents to witness violence or to have been physically abused, sexually abused, or neglected as a child, resulting in rates of PTSD that are three times the rates in the general U.S. population and equivalent to those of veterans returning from war zones.[3]
- It appears that certain risk factors are more common among AI/AN youth and they may contribute significantly to their higher suicide attempt and completion rates. These risk factors are not part of Native culture but are, instead, symptoms of other factors such as poverty, trauma, and depression that disproportionately affects AI/AN communities. For example, AI/AN youth ages 12 to 17 have the highest rate of alcohol use of all population groups. In 2006, more than 20 percent engaged in underage drinking. This rate is more than double that of any other group.

- The patterns of suicide among AI/AN youth and young adults suggest that such young people most frequently were responding to external stresses including significant family or interpersonal problems; had been using alcohol, drugs, or both; and generally had not previously seen any behavioral health professional.

Health

- Researchers find that the rates of obesity, diabetes and heart disease are consistently higher in AI/AN populations compared to other Americans. According to this research, many health disparities are related to social determinants of health, the conditions in which people are born, grow, live, work and age.
- The number of people without health insurance in the U.S. slightly improved in 2013 compared to 2012 but remained very high for AI/AN populations at 28.3 percent. [4]
- While declining, the early child bearing rate for Native American women is still disproportionally high and, due to lack of research, little is known of AI/AN women's experiences of motherhood at a young age or what factors influenced their becoming pregnant.
- Among persons aged 12 years or older, AI/ANs are more likely than persons from other groups to have needed treatment for alcohol use (14.4 vs. 7.6 percent). High substance use in American Indian communities appears to be linked to a range of social problems including violence, delinquency, and mortality from suicide or alcohol or other substance abuse.

Child welfare

- Across the U.S., AI/AN children are overrepresented in foster care at approximately a rate of 2.4 times their rate in the general population. Twenty-four percent of the states have a disproportionality index of more than 4.1.[5] Data reflects the positive impact of

[3] See Attorney General's Advisory Committee on American Indian and Alaska Native Children Exposed to Violence Report: Ending Violence So Children Can Thrive (November 2014), p.38.

[4] See 2014 statistics for AI/ANs published in CDC's "Health, United States" http://www.cdc.gov/nchs/data/hus/2015/105.pdf

[5] Disproportionality refers to the differences in the percentage of children of a certain racial or ethnic group in the country as compared to the percentage of the children of the same group in the child welfare system.

full compliance with the Indian Child Welfare Act (ICWA) on fostering essential connections of Indian children to family, community, and culture. Research with Native American populations reflects that a holistic sense of connectedness of individuals with their families and communities are important culturally-based protective factors against substance abuse and suicide.

Vulnerable populations

- When asked about their experiences of historical trauma, AI/AN lesbian, gay, and Two-Spirit[6] people report high rates of historical trauma including higher rates of intergenerational historical trauma than Native adults who do not identify as such.
- Based on available but incomplete data, homelessness appears to present disproportionately higher among American Indian, Alaska Natives, and Native Hawaiian and Pacific Islanders. While only approximately 1.7 percent of the national population self-identifies as AI/AN, 4.0 percent of all people experiencing sheltered homelessness, 4.0 percent of all sheltered individuals, and 4.8 percent of all sheltered families self-identify as AI/AN. Homelessness in Hawaii is a growing crisis, with 32 percent of all homeless in the state of Hawaii identified as Native Hawaiian.
- American Indians have higher per capita rates of violent victimizations than any other group in the United States. Their rate for sexual assault in 2000 was 7.7 per 1,000 women, compared to 1.1 for white women and 1.5 for African American women. Previous sexual assault is often a factor for women that later go on to be prostituted or trafficked making Native American women are extremely vulnerable to human trafficking.

Native language and education

- In 1990, the year Congress passed the Native American Languages Act, there were 281,990 who replied 'yes' they spoke a Native American Language in the United States Census, in 2000 there were 353,340 and in 2010, there were 372,095. A growing amount of research has found that despite challenges, Native youth are looking to language, prayer, crafts, dancing, singing, death/mourning traditions, and sharing of history through stories as sources of strength and helpful to build resilience.
- Research demonstrates that by age 2, AI/AN children begin to fall behind on measures of specific cognitive skills in vocabulary, listening comprehension, matching and counting. By age 4, smaller percentages of AI/AN children demonstrate age-appropriate language, literacy, mathematics and color-identification skills, compared to the total population of children.
- The vast majority of AI/AN students—92 percent—attend local public schools operated by state and local educational authorities and the other 8 percent of AI/AN students attend one of 183 Bureau of Indian Education (BIE) schools located on 63 reservations in

[6] 'Two Spirit' refers to a male-bodied or female-bodied person with a masculine or feminine essence. Two Spirits can cross social gender roles, gender expression, and sexual orientation. The roles of Two Spirit people can vary from tribe to tribe. They could be name givers, match makers, medicine people, holy people, peace-makers, mediators, warriors, adoptive parents, and much more.

23 states.[7]

- While Native American students are more likely than their peers to attend rural schools, approximately one-third of students attend urban or suburban schools.
- AI/AN youth are the least likely of all student populations to attend a high school that offers Advanced Placement courses. Only one in four AI/AN high school students who take the American College Test (ACT) score at the college-ready level in math, and only about one-third score at the college-ready level in reading.
- Today, there are 32 accredited Tribal Colleges and Universities (TCUs) operating in more than 15 states and one TCU in Canada. In the fall of 2010, TCUs were serving 19,070 students from more than 250 federally recognized tribes and 47,000 local community members through community-based education programs. TCUs offer valuable services to tribal community members, host cultural activities, support tribal governments and social services, and administer health programs, and job programs. In addition, TCUs frequently provide the only library services in their communities. For example, the library at Ilisagvik College serves individuals across 89,000 square miles of the North Slope connecting remote Alaska villages. According to fall 2010 enrollment data, 8.7 percent of AI/AN college students were attending one of the 32 accredited TCUs and, according to the National Center for Education Statistics, the number of AI/AN students enrolled in TCUs increased by 23 percent between 2001 and 2006.

Income and Employment

- In 2013 the median household income of those who identified as AI/AN was $36,252 compared with $52,176 for the nation as a whole.[8]
- In 2013, the National Center for Children in Poverty reported that 69 percent of AI/AN children under the age of six live in low-income families, 62 percent of AI/AN children between the ages 6 and 11 live in low-income families, and 58 percent of AI/AN children between the ages of 12 and 17 live in low-income families.[9]
- In 2013, roughly 50 percent of all AI/AN children had no parent with full-time, year-round employment compared with 24 percent of non-Hispanic white children. This is important because without at least one parent employed full-time, children are more likely to fall into poverty themselves.[10]
- AI/AN children were 30 percent more likely to live in high-poverty areas than non-AI/AN children.
- As of 2000, AI/AN's median wealth was equal to only 8.7 percent of the median wealth among all Americans and, while, for most Americans a home is a key source of wealth, Native Americans have a significantly lower homeownership rate than do non-AI/AN. The homes AI/ANs do own tend are worth less than those of non-AI/AN individuals.

[7] The body of the report from which these bullets are derived includes the source citation: U.S. Department of Interior, Bureau of Indian Education. Webpage at http://bie.edu/HowAreWeDoing/index.htm
[8] See footnote 162.
[9] See footnote 164
[10] Id.

- Over the course of 2009-2011, data from the American Community Survey (ACS) demonstrated the AI/AN employment rate among 25-54 year olds was 64.7 percent, 13.4 percentage points lower than white Americans.
- To reduce the AI/AN unemployment rate among the 25- to 54-year-old population to the white American rate would require approximately 91,000 jobs. In contrast, to increase the AI/AN employment rate to the white American rate would require more than twice as many jobs—approximately 234,000.
- Even when AI/ANs are similar to white Americans in terms of factors such as age, sex, education level, marital status, and states of residence, AI/AN rates of employment are 31 percent lower than those of white Americans.

PART I. SOCIAL AND ECONOMIC CONDITIONS DATA

WHO ARE NATIVE AMERICANS?

For purposes of the annual HHS Reports to Congress on the Social and Economic Conditions of Native Americans, 'Native Americans' refers to American Indians, Alaska Natives, Native Hawaiians, and other Native Pacific Islanders including Natives of American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands. American Indian and Alaska Native peoples belong to the indigenous tribes of the continental United States (American Indians) and the Indigenous tribes and villages of Alaska (Alaska Natives). Native Hawaiians are descendants of the aboriginal people who occupied and exercised sovereignty in the area that now comprises the state of Hawaii. The term 'other Pacific Islanders' includes Indigenous Chamorro, Guamanian, and Samoan peoples living in American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands. Tens of millions of indigenous peoples lived in North and South America long before European explorers seized lands and natural resources from the continent's Native inhabitants.[11] Such inhabitants made up sovereign tribal Nations with their own established systems of self-government.

AMERICAN INDIANS/ALASKA NATIVES (AI/AN)

According to the decennial 2010 Census,[12] 5.2 million people in the United States identified as American Indian and Alaska Native (AI/AN), either alone or in combination with one or more other groups. Of this number, approximately 3 million people identified as AI/AN alone.[13] In 2010, the total U.S. population grew by 9.7 percent, from 281.4 million in 2000 to 308.7 million. In comparison, during that time period, the American Indian and Alaska Native-alone population increased almost twice as fast as the total U.S. population, growing by 18 percent.[14] As of 2013, there were an estimated 1.7 million AI/AN family households (households with a householder who was AI/AN alone or in combination with another group). Of these, approximately 38.5 percent were married couple families.[15]

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[11] For example, the Iroquois League of Five Nations was established in the 1100's by the Mohawk, Oneida, Onondaga, Cayuga, and Seneca.

[12] It should be noted there is clear evidence the U.S. census consistently undercounts Native Americans. This disparity is compounded by political complexities of who can claim Native American heritage. Native Americans are the only group in the United States that must prove who they are based on tools of measurement invented by the federal government.

[13] All data originating from the 2010 Census counts as 'American Indian or Alaska Native' all those who marked the "American Indian or Alaska Native " checkbox or reported entries such as Navajo, Blackfeet, Inupiat, or Yup'ik.

[14] U.S. Census Bureau: The American Indian and Alaska Native Population: 2010, 2010 Census Briefs, p. 3 (January 2012). Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf

[15] U.S. Census Bureau: 2011-2013 American Community Survey. Retrieved from https://www.census.gov/newsroom/facts-for-features/2014/cb14-ff26.html

The AI/AN population is not evenly spread across the United States. The majority of AI/AN peoples (45 percent) live in the Western regions of the United States. The remainder lives in the South (31 percent); the Midwest (17 percent); and the Northeast (9 percent).[16] While the proportions of the AI/AN alone or in combination population for the Northeast and Midwest remained stable, the proportions for the South and West changed slightly from 2000 to 2010. Compared with 2000, the proportion of the AI/AN alone or in combination population in the South increased by 2 percent and decreased by about 2 percent in the West. In 2010, the ten states with the largest AI/AN alone or in-combination populations were California, Oklahoma, Arizona, Texas, New York, New Mexico, Washington, North Carolina, Florida, and Michigan. Among these states, three experienced substantial rates of growth in their AI/AN alone or in combination populations from 2000 to 2010: Texas (48 percent increase), North Carolina (40 percent increase), and Florida (38 percent increase).[17]

The 2010 Census shows that New York City had the largest AI/AN alone or in combination population followed by Los Angeles. Four of the ten places with the largest AI/AN alone or in combination populations were in the West: Los Angeles, California; Phoenix, Arizona; Anchorage, Alaska; and Albuquerque, New Mexico. Another four were in the South with two in Texas (Houston and San Antonio) and two in Oklahoma (Oklahoma City and Tulsa).[18] The place with the greatest proportion of AI/AN alone or in combination was Anchorage, Alaska with over 12 percent of the total population identifying as AI/AN alone or in combination. Other places with large proportions of AI/ANs alone or in combination were Tulsa, Oklahoma (9.2 percent of the total state population), Norman, Oklahoma (8.1 percent of the total state population), Oklahoma City, Oklahoma (6.3 percent of the total state population), Billings, Montana (6 percent of the total state population), Albuquerque, New Mexico (6 percent of the total state population), Green Bay, Wisconsin (5.4 percent of the total state population), Tacoma, Washington (4 percent of the total state population), Tempe, Arizona (4 percent of the total state population), Tucson, Arizona (3.8 percent of the total state population), and Sioux Falls, South Dakota (3.6 percent of the total state population).[19]

Currently, with the recent addition of the Pamunkey Tribe of Virginia,[20] there are 567 federally recognized sovereign tribal nations referred to variously as tribes, bands, pueblos, nations, and Native Villages. These nations are located across 35 states and share formal, legal government-to-government relationships with the United States. In addition, there are 334 state recognized

[16] See U.S. Census Bureau, supra, note 15
[17] Id. at 6.

[18] Id. at 11.

[19] Id.

[20] The Pamunkey Indian Tribe was acknowledged as a federally recognized Indian Tribe by the Bureau of Indian Affairs on July 2, 2015 having satisfied each of seven mandatory criteria for acknowledgement set forth in 25 C.F.R. 83.7. This determination is final and effective September 29, 2015. See http://www.bia.gov/cs/groups/public/documents/text/idc1-030831.pdf. The Pamunkey Tribe is the first federally recognized tribe in Virginia.

Indian tribes in the United States recognized as Indian tribes by the states within whose borders they are located.[21]

According to the 2010 Census, the AI/AN alone or in-any-combination tribal groupings with 100,000 or more responses were the Cherokee, the Navajo, the Choctaw, the Chippewa, the Lakota, the Apache, and the Blackfeet.[22] In Alaska, the Yup'ik tribal grouping contained the greatest number of people (29,000) who identified with one tribal grouping and did not identify with another group. The two largest Alaska Native alone or in-any-combination tribal groupings were Yup'ik and Inupiat. The third largest tribal grouping was Tlingit Haida followed by the Alaska Athabascan tribal grouping and the Aleut tribal grouping.[23]

NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS (NHPI)

In 1997, the Office of Management and Budget revised Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting and separated the 1976 category "Asian and Pacific Islander" into two groups: "Asian" and "Native Hawaiian or other Pacific Islander."[24] In May 2010, the Native Hawaiian and Pacific Islander Alliance and the Asian and Pacific Islander American Health Forum issued joint guidance advocating that the preferred and appropriate reference to the latter communities should be 'Native Hawaiian and Pacific Islander (NHPI).[25]

According to the 2010 Census, 1.2 million people in the United States identified as NHPI, either alone or in combination with one or more other groups.[26] In 2010, nearly three-fourths of those who identified as NHPI, alone or in combination, lived in the West (71 percent). The remainder lived in the South (16 percent), in the Northeast (7 percent), and in the Midwest (6 percent). Over half (52 percent) lived in just two states: Hawaii (356,000) and California (286,000). In addition to Hawaii and California, the states with the next largest NHPI populations in 2010 were

[21] See http://www.ncsl.org/research/state-tribal-institute/list-of-federal-and-state-recognized-tribes.aspx for list of state recognized Indian tribes compiled by the National Conference of State Legislatures (February 2015)

[22] See U.S. Census Bureau, supra note 15 at 18.

[23] Id. at 19.

[24] Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity."(Oct. 30, 1997) Retrieved from https://www.whitehouse.gov/omb/fedreg_1997standards.

[25] See https://www2.ed.gov/about/inits/list/asian-americans-initiative/what-you-should-know.pdf. White House Initiative on Asian Americans and Pacific Islanders (WHAAPI) Fact Sheet: What You Should Know About Native Hawaiians and Pacific Islanders (NHPIs).

[26] According to OMB, 'Native Hawaiian or Other Pacific Islander' refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. The Native Hawaiian and Other Pacific Islander Population: 2010, p.2. (May 2012) Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf

Washington (70,000), Texas (48,000), Florida (40,000), Utah (37,000), New York (36,000), Nevada (33,000), Oregon (26,000), and Arizona (25,000).[27]

Native Hawaiians, Samoans, and Chamoru are indigenous peoples to Hawaii, American Samoa, and the U.S. Territory of Guam. Pacific Islanders include diverse populations who differ in language and culture and they include Polynesian, Micronesian, and Melanesian backgrounds. The Polynesian group is the largest and includes Native Hawaiians, Samoans, Tongans, and Tahitians. The Micronesian group, the second largest, includes Chamoru from Guam but also includes other Chamoru and Carolinian from the Mariana Islands, Marshallese, Palauans, and various others.

With colonization, Native Hawaiians lost land and language and key elements of the NHPI collectivist lifestyle were devalued, including Indigenous approaches to health and self-sufficiency.[28] The resulting marginalization of Native Hawaiians is demonstrated by the high rate of poverty related to low educational attainment, low-wage jobs, and the high prevalence of chronic disease related to food insecurity and limited access to health care.[29]

CONTEXT AND PRINCIPLES UNDERLYING THE FEDERAL-TRIBAL GOVERNMENT-TO-GOVERNMENT RELATIONSHIP

In 1970, President Nixon declared that termination, the federal policy to terminate Indian tribal governments, sell tribal land, and move AI/AN peoples to assimilate them into 'American' society, was wrong and should be replaced by Indian *self-determination* which recognized the importance of Indian Nations running the programs that affect them. For 45 years, federal law and policy has been aimed at promoting self-determination through self-governance by federally recognized Indian tribes. Self-determination has enabled tribes to make significant progress in addressing social, economic, and cultural conditions in AI/AN communities and reflects a political equilibrium which has held for nearly half a century.

In September 2004 President George W. Bush issued a Memorandum on Government-to-Government Relationship with Tribal Governments stating:

> The United States has a unique legal and political relationship with Indian tribes and a special relationship with Alaska Native entities as provided in the Constitution of the United States, treaties, and Federal statutes. Presidents for decades have recognized this relationship.

[27] The Native Hawaiian and Other Pacific Islander Population: 2010, p.7. (May 2012) Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-12.pdf

[28] J. Boyd and K. Braun, *Supports for and Barriers to Healthy Living for Native Hawaiian Young Adults Enrolled in Community Colleges*. Preventing Chronic Disease (2007). Retrieved from http://www.cdc.gov/pcd/issues/2007/oct/07_0012.htm

[29] Id.

> ***
> My Administration is committed to continuing to work with federally recognized tribal governments on a government-to-government basis and strongly supports and respects tribal sovereignty and self-determination for tribal governments in the United States.[30]

In 2013, President Barack Obama reaffirmed longstanding federal policy in establishing the White House Council on Native American Affairs stating:

> The United States recognizes a government-to-government relationship, as well as a unique legal and political relationship, with federally recognized tribes. This relationship is set forth in the Constitution of the United States, treaties, statutes, Executive Orders, administrative rules and regulations, and judicial decisions. Honoring these relationships and respecting the sovereignty of tribal nations is critical to advancing tribal self-determination and prosperity.
> ***
> To honor treaties and recognize tribes' inherent sovereignty and right to self-government under U.S. law, it is the policy of the United States to promote the development of prosperous and resilient tribal communities[.][31]

The above principles form the context of the annual HHS report on the social and economic conditions of Native Americans and inform the research and practice implications reflected in Part III.

TRIBAL LANDS

Place—land, water, and air—is fundamental to Native American cultures and respect for the environment and sustainable practices are embedded in day-to-day living. In addition, place is critical to tribes' exercise of self-governance and self-determination. The total land mass under American Indian or Alaska Native legal control is approximately 100 million acres, the equivalent of what would be the fourth largest of the U.S. states. American Indian reservation and trust lands make up approximately 56 million acres, with Alaska Villages controlling approximately 44 million acres under the Alaska Native Claims Settlement Act. In addition, tribally controlled land shares over 250 miles of international borders.

Indian reservations are geographic areas with defined legal boundaries. Such reservations may be made up solely of trust lands, or trust lands combined with fee land owned by tribes, individual tribal members, and non-Indians. Through the General Allotment Act of 1887, (also referred to as the Dawes Act), the federal government converted community held tribal land into small parcels for individual ownership. Further, as a result of the Dawes Act, approximately 2/3 of Indian reservation land passed out of Indian hands.[32]

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30 Presidential Memorandum on the Government-to-Government Relationship with Tribal Governments (September 2004)
31 Executive Order 13647, section 1-*Policy.*
32 Felix Cohen, Handbook of Federal Indian Law § 1.04 (2015)

According to the 2010 Census, 25 percent of AI/AN people lived on reservations or other U.S. Census defined tribal areas.[33] However, while AI/AN people represent the United States' most rural population, a large and growing proportion of AI/AN people live and/or work in metropolitan areas. This has tremendous implications for the provision of federally supported services, such as child care services, where funding to tribes or tribal organizations is allocated based solely on Indian populations living on or near reservation land. It is not clear whether or to what extent such AI/AN populations have meaningful access to federally funded services and supports provided by states in urban metropolitan areas. Since, in 2010, the majority of AI/AN people lived outside of American Indian and Alaska Native areas, Native researchers have concluded that "urban" is not a kind of Indian, but is an experience, and one that most Indian people have had.[34] These proportions of reservation-based compared with urban Indians in 2010 were similar to 2000 Census numbers. It is clear, therefore, that AI/AN people often move back and forth between urban and rural areas, for short or long periods of time, whether for family, cultural, economic, educational, health, or other reasons.

HAWAIIAN HOME LANDS

Hawaiian Homelands are managed in trust by the Department of Hawaiian Home Lands, established in 1920 by the Hawaiian Homes Commission Act. The Act, made in response to a dwindling Native Hawaiian population, set aside approximately 200,000 acres of land as a permanent homeland for Native Hawaiians.[35] After demonstrating ancestry, Native Hawaiians may apply for homestead leases (residential, agricultural, or pastoral), and pay an annual lease rate of $1.00/year for each year of a 99-year lease.[36]

Hawaiian 'home lands' are public lands held in trust by the state of Hawaii for the benefit of Native Hawaiians. A Hawaiian home land is not a governmental unit, but is a specific tract of land, with defined boundaries, that is owned by the state of Hawaii. To be eligible to apply for a Hawaiian home land homestead lease, individuals must meet two requirements: (1) they must be at least 18 years old, and (2) they must be a Native Hawaiian defined as "any descendant of not less than one-half part of the blood of the races inhabiting the Hawaiian Islands prior to 1778."[37]

[33] See U.S. Census supra note 15 at 11-12.

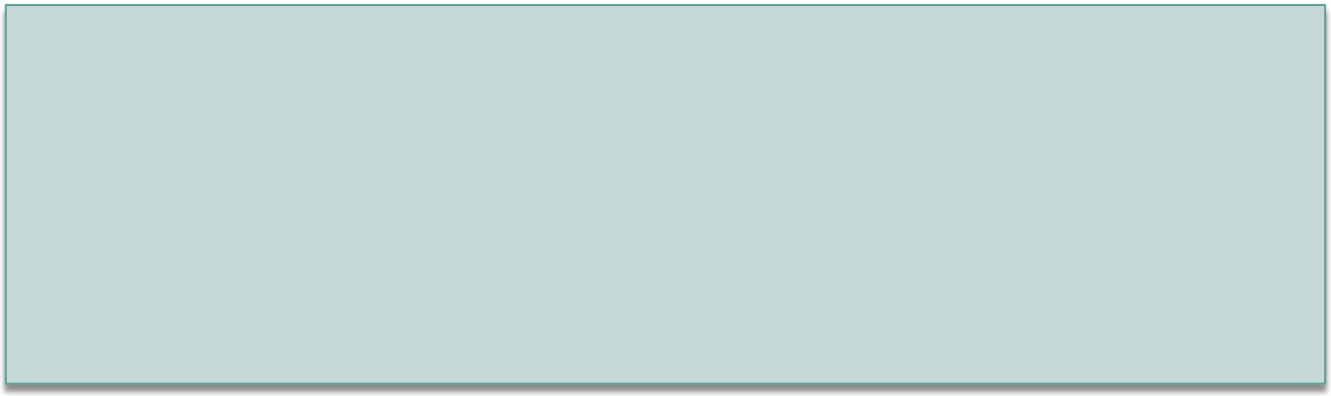
[34] Angela Gonzales, "*Urban (Trans)Formations: Changes in the Meaning and Use of American Indian Identity*," in Susan Lobo and Kurt Peters (eds), American Indian and the Urban Experience, Altamira Press, pp. 178-80.

[35] See Section 3 of the Hawaiian Homes Commission Act.

[36] See Department of Hawaiian Homelands website. http://dhhl.hawaii.gov/hhc/laws-and-rules/

[37] Department of Hawaiian Home Lands. Retrieved from http://dhhl.hawaii.gov/applications/applying-for-hawaiian-home-lands/

FY 2014 FOCUS: NATIVE AMERICAN YOUTH



Approximately 42 percent of the AI/AN population is under 24 years old compared to 34 percent of the total population.[38] With respect to Native Hawaiians and Native Pacific Island populations, there is no current data available. According to the U.S. Census Bureau, "[t]hroughout the decade, the Census Bureau will release additional information on the Native Hawaiian and Other Pacific Islander population, including characteristics such as age, sex, and family type, which will provide greater insights to the demographic characteristics of this population at various geographic levels."[39] However, until such time as such data is available, the most current age data reflected that, in 2008, almost 34 percent of Native Hawaiians and Pacific Island Natives were under the age of 18.[40]

Native American youth are the special focus of this FY 2014 Report on the Social and Economic Conditions of Native Americans in response to the President's call to action with respect to Native youth and because of the special role that Native youth have as citizens of tribal nations and Native Hawaiian and other Pacific Island communities in leading their communities into the 21st century. As this Report reflects, persistent poverty and other systemic challenges have combined to result in low academic and educational outcomes, poor health, and limited opportunities for self-sufficiency. Because they contribute to a sense of hopelessness among youth, such conditions have dire consequences for individual youth, their families, and Native American communities and tribal nations. However, this Report brings a focus to Native American children and youth because they are the living spirit of their respective peoples, their unique cultures, and our Nation's history and it is within these youth that hope, not hopelessness, persists.

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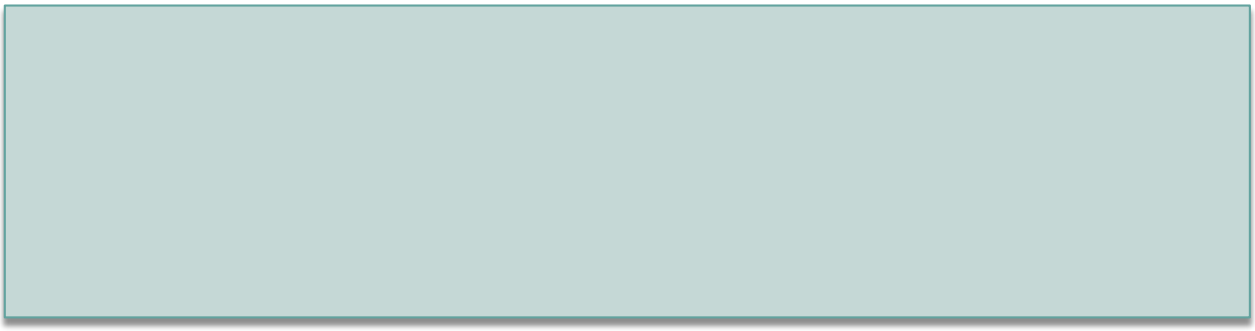
[38] National Congress of American Indians (NCAI). Retrieved from http://www.ncai.org/about-tribes/demographics

[39] See U.S. Census supra at note 16 at 20.

[40] White House Initiative on Asian Americans and Pacific Islanders. Fact Sheet: What You Should Know About Native Hawaiians and Pacific Islanders. Retrieved at https://www2.ed.gov/about/inits/list/asian-americans-initiative/what-you-should-know.pdf

A. SOCIAL CONDITIONS OF NATIVE AMERICANS
1. ADVERSE CHILDHOOD EXPERIENCES (ACES) AND TRAUMA



Adverse Childhood Experiences (ACEs) like abuse and neglect, parental loss, or living in a household with an alcoholic family member, can create dangerous levels of stress and derail healthy brain development, resulting in long-term impacts on learning, behavior and health.[41] The good news is that a growing number of policy makers and researchers are exploring strategies for mitigating the impact of ACEs through strategies to build resilience.[42]

ACEs were first assessed through the ACEs Study, a longitudinal study of adults conducted by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente. The Study revealed a strong dose–response relationship between adversity in childhood and increased morbidity and mortality in adulthood including alcoholism and alcohol abuse, depression, illicit drug use, risk for intimate partner violence (IPV) and suicide attempts.[43] Of the 10 types of childhood trauma measured in the ACE Study, five are personal (physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect) and five are related to other family members (a parent who's an alcoholic, a mother who's a victim of domestic violence, a family member in jail, a family member diagnosed with a mental illness, and the loss of a parent). Each

[41] See e.g., J. Shonkoff, A. Garner; Section on Developmental and Behavioral Pediatrics. *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, Retrieved from http://pediatrics.aappublications.org/content/129/1/e232.full; the Center for Disease Control. *Adverse Childhood Experiences Study (ACE Study)* at http://www.cdc.gov/violenceprevention/acestudy/; and T. Brockie, M. Heinzelmann, and J. Gill. *A Framework to Examine the Role of Epigenetics in Health Disparities among Native Americans*. Nursing Research and Practice. (2013). Retrieved from http://www.hindawi.com/journals/nrp/2013/410395/

[42] See e.g. K. Ginsburg, Building Resilience in Children and Teens: Giving Kids Roots and Wings. American Academy of Pediatrics. 3d edition (2014), K. Ginsburg, Raising Kids to Thrive: Balancing Love with Expectations and Protection with Trust. American Academy of Pediatrics. 1st edition (2015), and C. Goodluck and A. Willetto. *Seeing the Protective Rainbow: How Families Survive and Thrive in the American Indian and Alaska Native Community.*(2009) Retrieved from http://www.aecf.org/m/resourcedoc/aecf-howfamiliessurviveindianandalaskan-2009.pdf

[43] V J Felitti, R F Anda, D Nordenberg, D Williamson, A Spitz, V Edwards, J Marks. *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults*. The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258 (1998)

adverse experience counts as one. Therefore, a person who's been physically abused, with one alcoholic parent, and a mother who was victimized by domestic violence has an ACE score of three.

ACEs link to differences in the function of the stress-response system including the neuro-endocrine system, the parasympathetic nervous system, and the immune system. These changes have substantial long and short-term impacts on health and well-being[44] and appear to be shaped by epigenetic modifications which alter the function but not the structure of genes. Epigenetic modifications are an individual's molecular response to the environment and occur in an effort to preserve that individual's health by increasing the accessibility of genes that relate to immediate survival. These genes code for proteins that prepare the individual to be able to respond to the stressor faced through a fight or flight response.[45] However, in Native Americans communities, the stressors most encountered are chronic, not acute. Therefore, these adaptive responses likely result in over activation of this stress-response system causing substantial negative consequences on the health and well-being of Native Americans, individually and across generations.[46] Native Americans are disproportionately affected by trauma in childhood, including by ACEs.[47] Native American adolescents are more likely than other adolescents to witness violence or to have been physically abused, sexually abused,[48] or neglected as a child, resulting in rates of PTSD that are three times the rates in the general U.S. population and equivalent to those of veterans returning from war zones.[49] Among the AI/AN population, assaultive trauma in childhood is linked to the highest risk for PTSD, suggesting that this ACE is specifically linked to this high risk for psychiatric disorders among AI/AN adolescents.[50]

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[44] C Hostinar, R Sullivan, M Gunnar, *Psychobiological mechanisms underlying the social buffering of the hypothalamic-pituitary adrenocortical axis: a review of animal models and human studies across development*, the Psychological Bulletin, 2013.

[45] C. Kurasawa and E Street, *Epigenetics and the embodiment of race: development origins of U.S. racial disparities in cardiovascular health*, American Journal of Human Biology, vol. 21, no. 1, pp. 2-15 (2009)

[46] Id.

[47] S.M. Manson, J. Beals, S. A. Klein, and C.D. Croy, *Social epidemiology of trauma among two American Indian reservation populations,* American Journal of Public Health, vol. 95, no. 5, pp.851-859 (2005); R.W. Robin, B. Chester, J.K. Rasmussen, *Intimate Violence in a Southwestern American Indian tribal Community*, Cultural Diversity and Mental Health, vol.4, no. 4, pp.335-344 (1998)

[48] "Every woman you've met today has been raped. All of us . . . we all know each other. Please tell Congress and President Obama before it is too late." Statement of Alaska Native Tribal leader to Indian Law and Order Commission. See slide 21at https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0CDQQFjADahUKEwiH8d3CjsDHAhVFcj4KHd30Dh4&url=http%3A%2F%2Fwww.americanbar.org%2Fcontent%2Fdam%2Faba%2Fevents%2Fcriminal_justice%2Fannual2015_Making_Native_America_Safer.ppt&ei=YjbaVYe4GsXk-QHd6bvwAQ&usg=AFQjCNGDpIMByyJJ7X-AZjEKLVapeaDGvA&sig2=vQH58hb2kfgjV0v8mVDe_Q

[49] Id. at slide 38.

[50] P.B. Peters, D.K. Novins, A. Fickenscher, and J. Beals, *Trauma and Post Traumatic Stress Disorder symptomatology: Patterns among American Indian Adolescents in Substance Abuse Treatment*, American Journal of Orthopsychiatry, vol. 76, no. 3, pp. 335-345 (2006)

Unique to Native Americans is the identity-based stress associated with historical trauma as well as discrimination. Historical trauma has been defined as both the "collective experience of violence perpetrated against indigenous Peoples in the process of colonizing the Americas"[51] and, by Maria Yellow Horse Braveheart, as "a constellation of characteristics associated with massive accumulative group trauma across generations."[52] Recognition of inter-generational transmission of trauma goes back to the mid-1960s. For example, clinicians observed and were concerned about the high numbers of children of survivors of the Nazi Holocaust seeking treatment[53] and research has shown that children of Holocaust survivors experience a stress vulnerability that is greater than their peers.[54] Research is needed to evaluate the extent to which Native American youth experience heightened vulnerability.

For the AI/AN populations, the effects of historical trauma are transmitted across generations with symptoms of complicated bereavement and complex PTSD.[55] Over 50 percent of Native Americans indicate that they think about loss related to historical trauma, such as loss of language, loss of culture, and loss of land, at least occasionally which caused them psychological distress.[56] In addition to historical trauma, discrimination has been associated with early substance use among Native American children, and suicidal behavior, anger, and aggression among adolescents.[57] Historical trauma and discrimination combined with other ACEs appears to be a significant contributor to health disparities. This reflects a reality in which Native American children too often live their lives in fight, flight, or freeze mode.[58] Unable to

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[51] T.N. Brockie, M. Heinzelmann, J. Gill, *A framework to examine the role of epigenetics in health disparities among Native Americans*. Nursing Research and Practice, (2013)

[52] *Gender Differences in the Historical Trauma Response Among the Lakota* in Journal of Health and Social Policy (Haworth Press, Inc., 10(4), 1021 (1999)

[53] Y. Danieli, *Families of Survivors of the Nazi Holocaust: Some Long- and Short-term* Effects in Milgrim, N. (ed). Psychological Stress and Adjustment in Time of War and Peace. Hemisphere Publishing Corp: Washington DC (1980)

[54] Z. Soloman, M. Kotler, M. Mikulincer, *Combat-related Post Traumatic Stress Disorder Among Second Generation Holocaust Survivors: Preliminary Findings*, American Journal of Psychiatry 145(7), pp, 865-868 (1988) and H. Barocas and C. Barocas; *Wounds of the Fathers: The Next Generation of Holocaust Victims*, International Review of Psychoanalysis, 5, pp. 331-341 (1979)

[55] J. P. Gone, *A Community-based Treatment for Native American Historical Trauma: Prospects for Evidence-based Practice*, Journal of Consulting and Clinical Psychology, vol. 77, no. 4, pp. 751–762 (2009)

[56] L. B. Whitbeck, X. Chen, D. R. Hoyt, and G. W. Adams," *Discrimination, Historical Loss and Enculturation: Culturally Specific Risk and Resiliency Factors for Alcohol Abuse Among American Indians*, Journal of Studies on Alcohol, vol. 65, no. 4, pp. 409–418 (2004) and C. L. Ehlers, I. R. Gizer, D. A. Gilder, and R. Yehuda, *Lifetime History of Traumatic Events in an American Indian Community Sample: Heritability and Relation to Substance Dependence, Affective Disorder, Conduct Disorder and PTSD*, Journal of Psychiatric Research, vol. 47, no. 2, pp. 155–161 (2013)

[57] K. J. Sittner, L. Hartshorn, L. B. Whitbeck, and D. R. Hoyt, *Exploring the Relationships of Perceived Discrimination, Anger, and Aggression Among North American Indigenous Adolescents*, Society and Mental Health, vol. 2, no. 1, pp. 53–67 (2012) and see L. B. Whitbeck, X. Chen, D. R. Hoyt, and G. W. Adams, supra note 43.

[58] See A. Dapice, C. Inkanish, B. Martin, P. Brauchi; *Killing Us Slowly: When We Can't Fight and We Can't Run* published in Native American Times, September 2002. Retrieved from http://www.tkwolf.org/research/78-killing-us-slowly.html?start=3 and Dolores Subia BigFoot, *Trauma Informed Care in Indian Country*. Retrieved from

concentrate, their brains are incapable of learning and they fall behind in school. Such children respond to the world as a place of constant danger, not trusting adults, and unable to develop healthy relationships with peers. Despair, shame, and frustration follow. As AI/AN children transition to adulthood, they may find comfort in abusing alcohol, tobacco, or drugs, or in taking risks and anything that allows them to escape, even briefly, painful memories and despair.

For members of traumatized groups such as AI/AN people, individual trauma and the emotional, psychological, and biological responses occur in a specific context. For example, an organization partially funded by an ANA Social and Economic Development Strategies (SEDS) grant organized gatherings in a number of Native communities to discuss Native youth resilience and intergenerational communication. In one community, adults were saying, "The kids aren't interested in culture – they're only interested in their technology." However, youth expressed that they were very interested in language and culture but felt that the adults did not care about them. The grantee dug deeper and learned that the adults were concerned that their trauma would negatively impact their children, and so they kept their distance. And the youth expressed that they didn't communicate their stressors to their parents and grandparents because, compared to their parents' and grandparents' trauma, their stress didn't seem as bad. Youth also felt that they needed to protect their parents and elders so did not want to share their own trauma and stressors with them. It became apparent it was not true that the generations did not care. It was that they cared so much that their mutual focus was, above all else, protecting one another.[59]

To date, few studies have examined ACEs among Native American children or adolescents and no large scale studies have focused specifically on the unique experiences of reservation-based children, adolescents, and young adults. The CDC/Kaiser ACEs Study initially assessed a predominantly white and educated sample of adults and the population-based Longitudinal Studies of Child Abuse and Neglect (LONGSCAN) assessed 933 primarily white and African-American adolescents. The lack of large-scale research on Native American populations is problematic because it means that we lack a body of research that explains the persistently high rates of suicide, depression, substance abuse, and Post-Traumatic Stress Disorder (PTSD) prevalent in many Native communities or that evaluates culturally specific variables and their relationship to health outcomes.

In a promising development, a study was recently published based on research conducted in 2011 that analyzed the relationship between six ACEs and risk behaviors and mental health outcomes for reservation-based tribal members.[60] This study (the Brockie study) collected data from 293 reservation-based Native American tribal members between the ages of 18 and 24 using a web-based questionnaire. The study found, for the population studied, that the most

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http://www.nationaldec.org/goopages/pages_downloadgallery/downloadget.php?filename=30199.pdf&orig_name=trauma__care_in_ic_2_-_db_02182015.pdf

[59] Recounted by Project Officer of ANA Social and Economic Development Strategies (SEDS) grant number 90NA8206.

[60] T. Brockie, G. Dana-Sacco, G. Wallen, H. Wilcox, J. Campbell. *The Relationship of Adverse Childhood Experiences to PTSD, Depression, Poly-Drug Use, and Suicide Attempt in Reservation-Based Native American Adolescents and Young Adults.* American Journal of Community Psychology. (2015) 55: 411-421.

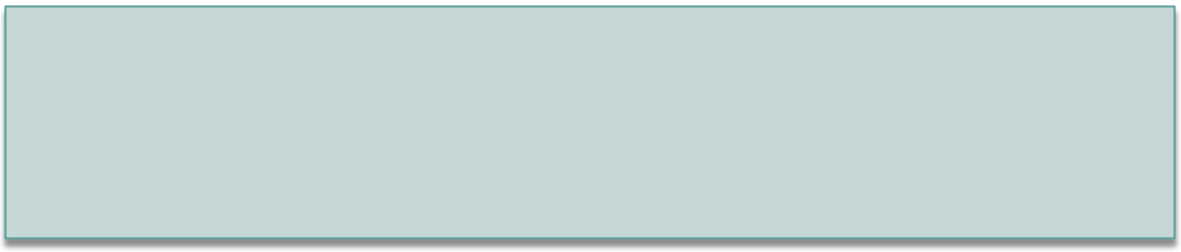
prevalent ACE was emotional abuse (48 percent) and the least prevalent was sexual abuse (20 percent). Across the study population at least 30 percent reported emotional neglect, physical neglect, or witnessed of violence against their mother, while 40 percent reported emotional abuse. Females were more likely than males to report emotional abuse and sexual abuse, while males were more likely to report physical neglect. Those not attending school were more likely than those attending school to report physical abuse, emotional neglect, and witnessing intimate partner violence. The majority (80 percent) of those who witnessed violence against their mother indicated the perpetrator was a partner or ex-partner. Significant differences in adverse experiences were found for age group and school attendance. Older study participants (20 to 24 years) had higher ACE scores than younger participants and those not attending school had higher ACE scores than those attending school. Overall, 37 percent reported high ACE scores (3 to 6) while 58 percent reported an ACE score of at least 2.

After controlling for age, gender, tribal affiliation, and school attendance, the Brockie study found that each additional ACE increased the odds of depression symptoms (57 percent), poly-drug use (51 percent), PTSD symptoms (55 percent), and lifetime suicide attempts (37 percent). Another key finding of the Brockie study was that discrimination and historical loss exacerbated the impact of ACE factors. This indicates the need to evaluate Native American health status as a function, in part, of collective trauma. Study findings indicated that abuse and neglect, witnessing violence against one's mother, historical loss associated symptoms and discrimination were common and strongly linked to depression symptoms, poly-drug use, PTSD symptoms, and suicidal ideation.

AI/ANs have demonstrated elevated rates of poverty, violence, substance abuse, depression, and other psychological problems when compared to non-AI/AN white individuals.[61] It is essential to understand these factors as co-occurring, meaning that a Native American person is simultaneously at risk for all of these factors, creating a potentially severe web of social and psychological risks that impact health and well-being.

[61] See California Tribal Epidemiology Center (CTEC), *California American Indian Community Health Profile*, California Rural Indian Health Board (2009), Retrieved from http://www.crihb.org

2. SUICIDE



Suicide is a difficult and complex subject with no apparent single reason, cause, or emotional state that can be said to directly lead to suicidal ideation. Research shows that mental and behavioral health problems, stressful life events, and substance abuse, disruptions within the family, traumatic experiences, access to firearms or other lethal means, impulsivity and lack of support are strongly associated with heightened suicide risk. However, while substantial research has been conducted on suicidal behavior, risk factors, and trigger events in the general population, federally funded research within AI/AN communities has been very limited in comparison. What is known is that:

- Suicide is the second leading cause of death for Indian youth ages 15 to 24 residing in IHS service areas and is 6.6 times higher than the national average.
- Suicide is the 6th leading cause of death overall for males residing in IHS service areas and ranks ahead of homicide.
- AI/AN young people ages 15 to 34 make up 64 percent of all suicides in Indian country.[62]
- For AI/ANs between the ages of 15 and34, the suicide rate is approximately 250 percent higher than for the general population.[63]

It appears that certain risk factors are more common among AI/AN youth and they may contribute significantly to higher suicide attempt and completion rates. These risk factors are not part of Native culture but are, instead, symptoms of other factors such as poverty, trauma, and depression that disproportionately affects AI/AN communities. For example, AI/AN youth aged 12 to 17 have the highest rate of alcohol use of all population groups. In 2006, more than 20 percent, or one out of every five AI/AN youth, engaged in underage drinking.[64] This rate is more than double that of any other group. AI/AN youth were also more likely than other groups

[62] *Trends in Indian Health: 2014 Edition* compiled and published by the HHS Indian Health Service, Office of Public Health Support, Division of Program Statistics Retrieved from https://www.ihs.gov/dps/includes/themes/newihstheme/display_objects/documents/Trends2014Book508.pdf

[63] Centers for Disease Control and Prevention (2013) and American Psychology Association (2014)

[64] Substance Abuse and Mental Health Services Administration (SAMHSA). (2006). National Survey on Drug Use and Health, 2006. Rockville, MD

to perceive minimal risk of harm from substance use and research indicates that the lower the perceived risk, the less likely a person is to seek help for substance abuse.[65]

Factors apparently contributing to high rates of AI/AN suicide are acculturation and lack of belief that the future will be better. Acculturation has been connected to increased rates of alcoholism, family conflict, and adolescent suicide. The extent and expression of acculturation can take several different forms and one of the shortcomings in current research is a failure to distinguish between different types of acculturation. Acculturation explains the process of cultural and psychological change. Acculturation is often understood as the equivalent of assimilation, or the loss of tribal identity resulting from the spread of the dominant culture and it is traumatic. It is important to note there are multiple aspects of acculturation important to consider. For example, acculturation can include integration, identifying with both a cultural and a dominant identity. It can include separation, rejecting the dominant culture, marginalization, or a failure to identify with any culture. Several studies have suggested a link between acculturation and suicide. In one such study spanning 22 years, researchers found a correlation among the New Mexico Apache, Navajo, and Pueblo communities between acculturation level and suicide rates with the Pueblo experiencing both the highest level of acculturation and the highest suicide rates while the Navajo experienced the lowest level of acculturation and the lowest suicide rates.[66]

The lack of belief that the future will get better results from environmental factors that flow from historical and present day disparities in housing, educational opportunities, food quality and availability, employment opportunities and wages, geographic isolation, forced relocation, and poverty. Such disparities contribute to and feed into the loss of purpose and suicidal ideation. Until recently, few people attempted to find an answer to the difficult question of why suicide rates are disproportionately high among AI/AN youth compared to the general population. According to available data, approximately 30 percent of American Indian youth living on or near reservations had considered or attempted suicide, a rate about 2.5 times higher than that of the general population for the same age group.[67] Furthermore, suicide, at a rate of 37.1 deaths/100,000, is the second leading cause of death among AI/AN youth age 15 to 24.[68] Suicide rates are highest for AI/AN males: more than 2.5 times higher than the average rate for 15 to 19 year olds; nearly 1.5 times higher than the average rate for 20 to 24 year olds; and more than 1.5 times higher than the average rate for 24 to 34 year olds.[69]

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[65] S. Freedenthal, and A. Stiffman, *Suicidal Behavior in Urban American Indian Adolescents: A Comparison with Reservation Youth in a Southwestern State*. Suicide and Life-Threatening Behavior, 34(2), 160–171.

[66] M. Leach, Cultural Diversity and Suicide: Ethnic, Religious, Gender, and Sexual Orientation Perspectives. The Haworth Press (2006).

[67] M. Tirado, *The Darkest Hour: Native American Youth and Suicide,* American Indian Report, 12(1), pp.10-13 (2006).

[68] L. Wissow, Suicide Attempts among American Indian and Alaska Natives in E. Rhoades (ed), American Indian Health, The Johns Hopkins University (2000).

[69] Centers for Disease Control and Prevention. Deaths: Leading causes for 2004, National Vital Statistics Reports, 56(5), (2007), Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_05.pdf

The patterns of suicide among AI/AN youth and young adults suggest that such young people most frequently were responding to external stresses including significant family or interpersonal problems; had been using alcohol, drugs, or both; and generally had not previously seen any behavioral health professional.[70] The lack of available, high quality, culturally responsive behavioral health care continues to have a profound effect on suicide completions with evidence demonstrating that more than 90 percent of all youth who die by suicide had unaddressed mental health needs prior to their deaths.[71]

As referenced earlier in this Report, violence and trauma—both historical and contemporary—have significant and long-term effects on the mental health and well-being of AI/ANs across generations. AI/AN youth and young adults experience violence as witnesses and as victims at rates higher than those for the general population. For example, according to the National Violence Against Women survey, at least one out of every three AI/AN women has been subject to intimate partner violence. Intimate partner violence includes rape, physical assault, or stalking and AI/AN women have the highest rates of intimate partner violence compared to all other groups.[72]

An on-going sense of loss and community disconnection are factors that are believed to be significant predictors of AI/AN suicide.[73] 'Culture' has been defined as what a group of people have developed "to assure its survival in a particular physical and human environment."[74] Such an understanding raises questions about the way in which historical trauma may contribute to the suicide rates of AI/AN youth. What happens to a group of people when they are torn away from their culture? What happens to their ability to survive? How do they adapt to trauma and what

[70] R. Carmona, U.S. Surgeon General's testimony on suicide prevention among Native American youth, before the Indian Affairs Committee, U.S. Senate, June 15, 2005. Retrieved from http://www.surgeongeneral.gov/news/testimony/t06152005.html

[71] National Indian Child Welfare Association, Testimony on suicide prevention among Native American youth, before the Indian Affairs Committee, U.S. Senate, June 22, 2005. Retrieved from http://www.nicwa.org/legislation/S556_HR2440/T24000-0.pdf

[72] National Women's Health Information Center, U.S. Department of Health and Human Services. Minority Women's Health: Violence. Retrieved from http://www.4woman.gov/minority/americanindian/violence.cfm

[73] See Wissow supra at note 52.

[74] D. Hoopes and M. Pusch (eds) Multicultural Education: A Cross Cultural Training Approach Intercultural Press (1979)

effect does this adaptation have on them personally and as part of a community? Because "culture, and the people who are part of it, interact," these reactions to trauma become part *of* the culture. Understanding and unpacking the many risk factors for suicidal behavior requires additional data on the influence of culture and community because AI/AN risk factors present the core questions that challenge all youth and young adults: "Who am I?," "What is the meaning of my life?," and "Where am I going in life?" The broader question faced by Native American youth includes: "Who are we as a people?"

Its own unique history, current and former location, culture, economy, government, and resources shape each tribe or village. The lack of AI/AN community-level data remains a persistent problem for policy and decision-makers. With regard to suicide as well as other indicators of health and social well-being, the collection and analysis of local data, from individual AI/AN communities, is critical and key to counteract the erroneous perception that all tribes and villages can be viewed as one Indian culture or monolithic community.

3. HEALTH DISPARITIES

Health disparities (or health inequalities) are gaps in health outcomes or determinants between segments of the population. Existing data suggest that Native Americans suffer disproportionately from a variety of mental and physical health problems, which may largely stem from the social marginalization and high poverty rates they experience. For example, researchers found that the rates of obesity, diabetes and heart disease were consistently higher in AI/AN populations compared to other Americans.[75] According to this research, many health disparities are related to social determinants of health, the conditions in which people are born, grow, live, work and age. Specifically, clear disparities have emerged for AI/AN substance abuse, posttraumatic stress, violence, and suicide. Obesity, poor nutrition and related health problems also have their own unique, complex history and explanations on tribal lands. Among the findings of the CDC's latest published Health Disparities and Inequalities Report are data relating to the social determinants of health.[76] Such data demonstrated that AI/ANs are at increased risk for food insecurity and diet-related chronic disease,[77] limited access in AI/AN communities to healthy food retailers or supermarkets, over 20 percent of AI/AN wage and

[75] R. Hutchinson and S. Shin, *Systematic Review of Health Disparities for Cardiovascular Diseases and Associated Factors among American Indian and Alaska Native Populations*, PLoS ONE 9(1) (January 15, 2014), Retreived from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0080973

[76] Health Disparities and Inequalities Report: United States 2013, Centers for Disease Control, Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

[77] See also A. Gordon and V. Oddo, *Addressing Child Hunger and Obesity in Indian Country: Report to Congress*, Mathematica Policy Research (2012).

salary workers are employed in high risk occupations, and between 2008 and 2010 the rate of AI/AN adults age 18 to 64 without health insurance held at approximately 34 percent.[78]

The two leading causes of death of AI/AN children between the ages of 1and 4 between 2007 and 2009 were unintentional injuries and homicide.[79] Unintentional injury deaths were 3.9 times higher for AI/AN than for all other populations, with the majority of those involving motor vehicles. In the same time period, the two leading causes of death of AI/AN children ages 5 to 14 and AI/AN children ages 15 to 24 were unintentional injury and suicide.[80]

The AI/AN age-adjusted death rates are 1.2 times higher than that for all other U.S. populations. The rate of death due to tuberculosis is 5.5 times higher, the rate of death due to chronic liver disease is 4.7 times higher, the rate of death due to diabetes is 3.1 times higher, and the rate of death due to homicide 1.9 times higher.[81] AI/AN death rates were below those of all other U.S. populations for Alzheimer's disease (0.5 times lower), HIV infection (0.9 times lower), and major cardiovascular disease (0.9 times lower).[82] Life expectancy at birth for AI/AN populations between 2007 and 2009 was 73.7 years compared with the life expectancy at birth for white populations of 78.5 years.[83] The table below indicates the morbidity disparity rates between Native Americans and all other U.S. races.

American Indians and Alaska Natives (AI/AN) in the IHS Service Area

2007-2009 and U.S. All Races 2008

Age-adjusted mortality rates per 100,000 population	**AI/AN Rate 2007-2009**	**U.S. All Races Rate 2008**	**Ratio: AI/AN to All U.S.**
ALL CAUSES*	943.0	774.9	1.2
Diseases of the heart	182.4	192.1	0.9
Malignant neoplasm	170.8	176.4	1.0
Unintentional injuries	94.5	39.2	2.4
Chronic lower respiratory diseases	43.2	44.7	1.0

[78] 2014 statistics for AI/ANs published in CDC's "Health, United States" http://www.cdc.gov/nchs/data/hus/2015/105.pdf

[79] See *Trends in Indian Health: 2014 Edition* supra at note 53, p. 50.

[80] Id. at 51-52.

[81] Id at 60.

[82] Id.

[83] Id at 143.

Age-adjusted mortality rates per 100,000 population	**AI/AN Rate 2007-2009**	**U.S. All Races Rate 2008**	**Ratio: AI/AN to All U.S.**
Diabetes mellitus	61.0	22.0	2.8
Chronic liver disease and cirrhosis	43.1	9.2	4.7
Cerebrovascular diseases	39.1	42.1	0.9
Influenza and pneumonia	24.1	17.8	1.4
Nephritis, nephrotic syndrome	22.1	15.1	1.5
Intentional self-harm (suicide)	18.5	11.6	1.6
Septicemia	16.5	11.3	1.5
Alzheimer's disease	14.6	24.4	0.6
Assault (homicide)	11.0	5.9	1.9
Hypertensive heart and/or kidney disease	12.8	13.9	0.9
Parkinson's disease	5.1	6.6	0.8

In terms of patient care, 83 percent of Indian Health Service hospitals had fewer than 50 beds compared with 33 percent of other U.S. short stay hospitals.[84] The leading cause of ambulatory medical clinical impressions visits in Indian Health Service and tribal direct and contract facilities for AI/AN youth ages 15 to 24 were supplementary classification conditions (physical exam, surgical follow-up, medical follow-up, lab screening, x-ray, preventive health care) followed by mental disorders.[85] The leading cause of ambulatory medical clinical impressions visits in Indian Health Service and tribal direct and contract facilities for ages 45 to 54 was supplementary classification conditions followed by endocrine, nutritional, and metabolic disorders.[86]

[84] Id at 170.

[85] Id at 176.

[86] Id. at 178.

Data from 2010 indicates that the top ten leading causes of death among Native Hawaiians and Pacific Islanders are:[87]

1. Cancer
2. Heart Disease
3. Stroke
4. Unintentional injury
5. Diabetes
6. Influenza and Pneumonia
7. Chronic lower respiratory disease
8. Kidney disease
9. Alzheimer's disease
10. Suicide

In addition, 2011 data demonstrates Native Hawaiians and Pacific Islanders' rates of HIV per 100,000 population for both males and females exceed their white counterparts.[88] While health researchers have paid less attention to Native Hawaiians, this population also experienced similar patterns of elevated morbidity. For example, a 2009 study by University of Hawaii researchers found that Native Hawaiians and other Pacific Islanders are among the highest risk demographic groups for heart disease in the United States.[89]

4. HEALTH INSURANCE

A major goal of the Affordable Care Act (ACA) was to put American consumers back in charge of their own health care. The ACA also includes the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA), which extended current law and authorized new programs and services within the Indian Health Service (IHS).

The ACA ensures new rights and benefits to all American Indians and Alaska Natives. More than 2 million Native Americans and their families receive health care from IHS funded facilities. Under the ACA, members of federally recognized tribes, including Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders have access to new health care coverage benefits and protections.[90] Other benefits are available to individuals who are otherwise eligible for services from the IHS, a tribal program, or an urban Indian health program. If an individual or family does not have insurance coverage through a job, for coverage through

[87] Center for Disease Control and Prevention, Mortality Data, Deaths, Final Data for 2010.

[88] Centers for Disease Control and Prevention, Health Disparities in HIV/AIDS. Retrieved from http://www.cdc.gov/nchhstp/healthdisparities/Hawaiians.html

[89] See http://epirev.oxfordjournals.org/content/31/1/113.full#sec-16

[90] ANCSA shareholders are "eligible" because they are considered members of Indian tribes under the statutory definitions used of Indian tribe used for these benefits.

Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace is available to help AI/ANs find and enroll in an insurance plan that fits the individual's circumstances and meets their needs. Special provisions of the ACA authorize tribal members to enroll in Marketplace coverage once per month at any time of the year and there is no limited enrollment period for such individuals. The special benefits under the ACA for tribal members who choose to enroll in health insurance coverage allow, for example, a family of four with an income up to approximately $70,650 or $88,320 in Alaska, to enroll in and access health care without deductibles, co-payments, and co-insurance. In addition, no matter how much income is earned, if an individual or family enrolls in an insurance plan, these costs are not imposed when the individual or family is seen in an IHS, tribal or urban Indian health facility, or through referral from a Purchased/Referred Care (PRC) program. For many reasons, enrollment in a health insurance plan through the Marketplace is important. Alaska Native and American Indian people can use this and all other types of health care coverage—Medicaid, Veteran's Benefits, Alaska's Children's Health Insurance Program (CHIP), Medicare or insurance provided by employers—at tribal health facilities. This results in the ability of local tribal health facilities ability to bill insurance to help build an even stronger tribal health system for generations to come.

If tribal members enroll in a private health insurance plan through the Health Insurance Marketplace they can receive or keep receiving health services from the IHS, tribal health programs, or urban Indian health programs[91] as well as receive health care services covered under their insurance plan through on the Health Insurance Marketplace. By enrolling in health coverage through the Marketplace, Medicaid, or CHIP, AI/ANs have better access to services that the IHS, tribal programs, or urban Indian programs (known as I/T/Us) may not provide.

While the Marketplace application requires reporting of income to determine eligibility for financial assistance for Marketplace insurance plans, Medicaid, and the Children's Health Insurance Program (CHIP), the required income information is the same as that reportable on federal income tax returns including the same IRS income exemptions for, for example, income from treaty fishing rights. Most AI/AN trust income and resources aren't counted when determining eligibility for these programs.

Medicaid and the CHIP are available to provide expanded access to health care services; services that a local Indian health clinic might not be able to provide. If an individual is eligible for services from I/T/Us, including PRC they do not have to pay Medicaid premiums or enrollment fees. And Indians who are currently receiving or have ever received such services through I/T/Us or PRC do not have to pay out-of-pocket costs such as copayments, coinsurance, or

[91] The Indian Health Service contracts with urban Indian organizations to provide services to urban populations for which special statutory eligibility criteria apply. To be eligible for the exemption as an urban Indian, an individual must reside in an urban center where an IHS funded urban Indian health program is located and meet one or more of the following four criteria: (1) Be a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member, (2) Be an Eskimo or Aleut or other Alaska Native, (3) Be considered by the Secretary of the Interior to be an Indian for any purpose, of (4) Be determined to be an Indian under regulations promulgated by the Secretary.

deductibles for Medicaid services, and do not have to pay any out-of-pocket costs for CHIP. Finally, individuals can continue to get services through an I/T/U even if the I/T/U is not a provider in the program's managed care network.

The ACA requires most to have minimum essential coverage or to pay a fee. AI/ANs and others eligible for health care services through I/T/Us do not have to pay any fee for not having health insurance coverage. This is the Indian health coverage exemption. Members of federally recognized tribes, ANCSA Corporation shareholders, and people who are otherwise eligible for services through an IHS care provider can apply for the Indian exemption two ways:

- By filling out an exemption application and mailing it to the Marketplace
- By claiming it when filing a federal income tax return

Even with the increased availability of health care coverage and special exemptions and flexibilities under the ACA, the percentage of single-race American Indians and Alaska Natives who lacked health insurance coverage in 2013 was 26.9 percent compared with 14.5 percent for the nation as a whole.[92]

Despite the availability to IHS-funded health care, substantial numbers of AI/ANs do not have access to facilities that offer a full array of health care services. According to a report by the Center on Budget and Policy Priorities, AI/AN patients who need major surgery or cancer treatments, for example, are routinely referred to specialists outside of Indian lands and at least two-thirds of those referral claims were rejected. This places vulnerable AI/ANs at risk of either paying major medical bills themselves or doing without needed treatments.[93] In summary, the number of people without health insurance in the U.S. slightly improved in 2013 compared to 2012 but remained very high for AI/AN populations.

Health Insurance by population group

Population Group	Number Uninsured 2012	Percent Uninsured 2012	Number Uninsured 2013	Percent Uninsured 2013	Number Uninsured Difference	Percent Uninsured Difference
All races	45,615	14.8	45,181	14.5	*-434	*-0.2
White	29,991	13.1	29,638	12.9	*-353	*-0.2
White, not Hispa	20,156	10.4	19,815	10.2	*-341	*-0.2
Black	6,629	17.3	6,604	17.1	-25	*-0.2
American Indian	**686**	**27.4**	**662**	**26.9**	***-24**	**-0.5**

[92] See Note 86.

[93] Center on Budget and Policy Priorities, *Medicaid Expansion Could Cut Native Americans' Uninsurance Rate by Half*, (November 19, 2012)

Alaska Native						
Asian	2,321	15.0	2,329	14.6	8	*-0.4
Native Hawaiian and Other Pacific Islander	95	18.0	92	17.9	-4	-0.1
Hispanic (any race)	15,164	29.0	15,107	28.4	-57	*-0.7

Source: U.S. Census Bureau, 2013 American Community Survey. (Numbers in thousands.)

5. TEEN PREGNANCY

Among non-Hispanic white teens, the birth rate in 2013 was 19 births per 1,000, while among black teens, it was 39 births per 1,000. Latina teens have the highest birth rate, at 42 births per 1,000 teens. The birth rate for Native American teens was 31 births per 1,000, while among Asian/Pacific Islander teens, the birth rate was 9 births per 1,000.

Researchers have stressed the importance of understanding women's family history when studying early childbearing (ECB). Factors associated with a young woman's risk for ECB and repeat pregnancy include ethnic minority status,[94] being a daughter of an ECB mother,[95] socioeconomic status,[96] diminished parental involvement,[97] living with a single parent,[98] and lower educational levels.[99]

While declining, the ECB rate for Native American women is still disproportionally high and, due to lack of research, little is known of AI/AN women's experiences of motherhood at a young age or what factors influenced their becoming pregnant. This lack of data may reflect difficulties of recruiting young AI/AN women into research studies or the challenges of sampling from a diverse population with over 560 tribes speaking at least 200 languages. One community-based participatory study, conducted in 2010, revealed a number of findings that suggest areas of further research. This study involved 30 AI/AN women, living on Indian reservations, who had

[94] C. Crittenden, N. Boris, J. Rice, C. Taylor, D. Olds, *The Role of Mental Health Factors, Behavioral Factors, and Past Experiences in the Prediction of Rapid Repeat Pregnancy in Adolescence*, Journal of Adolescent Health, 44(1): 25-32 (2009).

[95] J. Manlove, E. Ikramullah, L. Minceili, E. Holcombe, S. Danish, *Trends in Sexual Experience, Contraceptive Use, and Teenage Childbearing: 1992-2002, Journal of Adolescent Health, 44(5): 413-23 (2009).*

[96] L. Raneri, C. Wiemann, *Social Ecological Predictors of Repeat Adolescent Pregnancy*, Perspectives in Sexual Reproductive Health, 39(1): 39-47 (2007).

[97] Id.

[98] C. Bonell, E. Allen, V. Strange, A. Oakley, A. Copas, A. Johnson, J. Stephenson, *Influence of Family Type and Parenting Behaviors on Teenage Sexual Behavior and Conceptions*, Journal of Epidemiological Community Health, 60 (6): 502-06, (2006).

[99] See L. Raneri supra note 75.

given birth as teenagers.[100] The study indicated that the women's chaotic childhoods prompted an accelerated maturity. This theme was characterized by stories of growing up fast and engaging the world as quickly maturing youth. The women's stories demonstrated how they matured developmentally, socially, psychologically, and emotionally beyond their chronological ages. They cared for and parented younger siblings, managed households, worked out of the home to help provide for their families, socialized with older adolescents and younger adults, balanced education demands with familial obligations, and gained a worldly wisdom that they used to their advantage.

The theme of diminished childhoods evokes a sense of a lost childhood. At one end of their experience they were children, physically inhabiting a young body and treated by the world as a child. On the other end of their accumulated experience, they existed as mature beings, guided by concerns and their embodied knowledge of their situations. Through their early lives, these women walked not just one path, but multiple paths going back and forth between childhood, adolescence, and adulthood.

6. SUBSTANCE USE DISORDERS

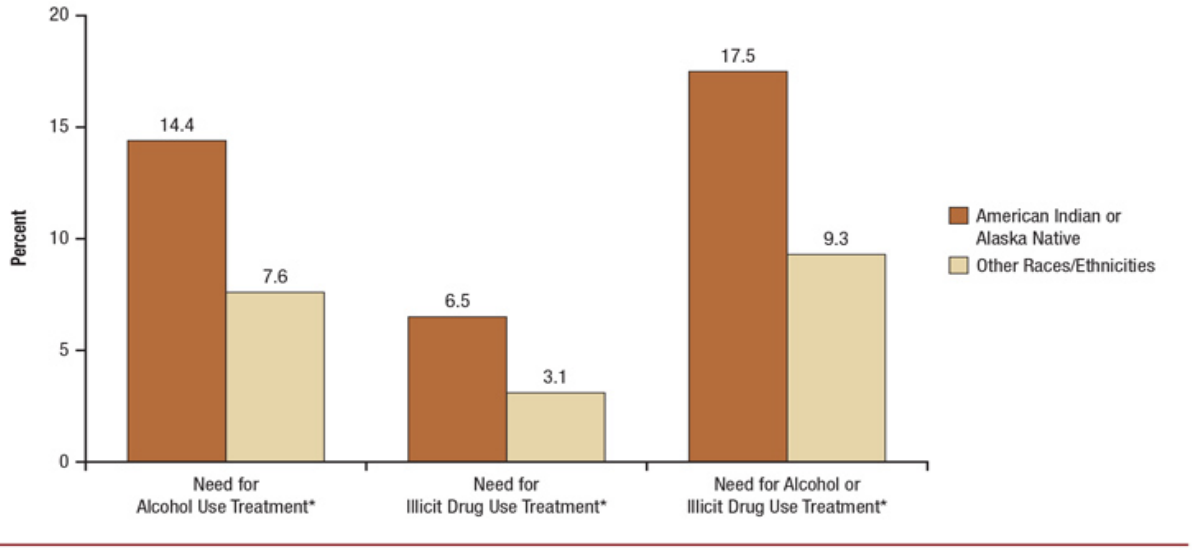
AI/ANs have disproportionately high rates of substance use disorders.[101] According to the Treatment Episode Data Set 42,074, or 2.5 percent, of the 1.7 million substance abuse treatment admissions in the United States were AI/AN adults aged 18 or older in 2010, although only 0.9 percent of the U.S. population was AI/AN.[102] In 2010, the National Survey on Drug Use and Health (NSDUH) estimated that the percentage of AI/AN adults in need of substance abuse treatment in the past year was higher than the national average.[103] Combined 2003 to 2011 data indicate that AI/ANs were more likely than persons from other groups to have needed treatment for substance use in the past year. In other words, 17.5 percent of AI/ANs and 9.3 percent of persons from other groups (22.8 million persons) age 18 and older needed treatment for illicit drug or alcohol use.

[100] J. Palacios, H. Kennedy, *Reflections of Native American Teenage Mothers*, Journal of Obstetric, Gynecologic, and Neonatal Nursing, 39 (4): 425-434 (2010). The design of this study is community-based participatory research involving 30 AI/AN adult women, living on a reservation, who had given birth to children as teenagers.

[101] Greenfield, B. L., & Venner, K. L. *Review of substance use disorder treatment research in Indian country: Future directions to strive toward health equity*. American Journal of Drug and Alcohol Abuse, 38(5), 483-492 (2012)

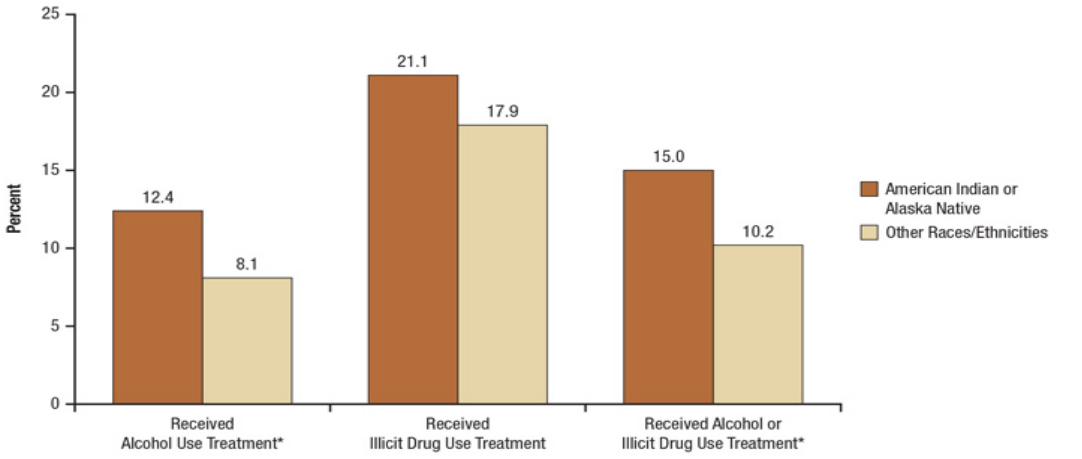
[102] Humes, K. R., Jones, N. A., & Ramirez, R. R. (2011). Overview of race and Hispanic origin: 2010 (Census Brief; C2010BR-02). Retrieved from http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf

[103] Office of Applied Studies.The NSDUH Report: Substance use among American Indian or Alaska Native adults. Rockville, MD: Substance Abuse and Mental Health Services Administration (June 2010)



* Difference between American Indians or Alaska Natives and persons of other races/ethnicities is significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2003 to 2005, 2006 to 2010 (revised March 2012), and 2011.



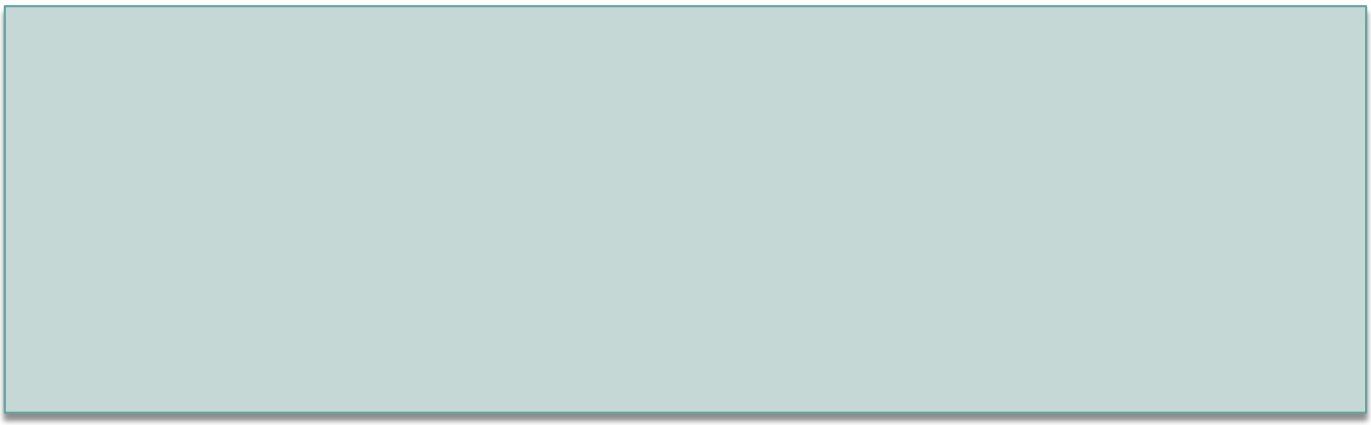
* Difference between American Indians or Alaska Natives and persons of other races/ethnicities is significant at the .05 level.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2003 to 2005, 2006 to 2010 (revised March 2012), and 2011.

It has long been known that American Indian communities are particularly vulnerable to problems with substance use, which are tied in part to limited socioeconomic opportunity. However, because national surveys do not fully capture drug use patterns on or near reservations, the true scope of the problem has been elusive. A new study, specifically focusing on American Indian youth, reveals alarming substance use patterns, including patterns of drug use beginning much earlier than is typical for other Americans.[104] In this study, a team of National Institute on

[104] L. R. Stanley, S. Harness, R. Swaim, F. Beauvais, *Rates of Substance Use of American Indian Students in 8th, 10th, and 12th grades living on or near Reservations: Update 2009-2012*. Public Health Report, 129 (2): 156-63 (March-April 2014).

Drug Abuse (NIDA)-funded prevention researchers at Colorado State University analyzed data from the American Drug and Alcohol Survey given to American Indian students at 33 schools on or near reservations in 11 U.S. states between 2009 and 2012. A comparison with nationwide data from the Monitoring the Future (MTF) survey is striking, particularly in the much higher prevalence of drug and alcohol use in 8th and 10th graders compared to national averages. Since



1975, the MTF survey has measured drug, alcohol, and cigarette use and related attitudes among adolescent students nationwide. In 2014 a total of 44,892 students from 382 public and private schools participated in the survey. Between 2009 and 2012, 56.2 percent of American Indian 8th graders and 61.4 percent of those in 10th grade had used marijuana, compared to 16.4 percent of 8th graders and 33.4 percent of 10th graders in the MTF survey. American Indian students' annual heroin and Oxycontin use was about two to three times higher than the national averages in those years.

Also noteworthy was the finding that American Indian youth are initiating alcohol and drug use earlier than are their non-native counterparts. Past-month (current) use of marijuana and alcohol (including binge drinking) were at the same level from 8th through 12th grade for the American Indian students, which sharply contrasts with the steep increases from 8th to 12th grade seen through the MTF survey. Although current alcohol use by American Indian 12th graders was lower than the MTF survey average, current marijuana use stood at 35 percent for American Indian seniors—much higher than the 21.5 percent in the MTF survey.

7. CHILD WELFARE

From the time the first European settlers interacted with indigenous peoples in North America and elsewhere, Indian tribes have struggled against assimilationist policies established by the federal government which sought to destroy tribal cultures by removing Native American children from their tribes and families. One description of such a policy is reflected in the

charter of the first boarding school on the Navajo reservation in the 1890s stating as its purpose, "to remove the Navajo child from the influence of his savage parents."[105]

Later, child welfare practices by state child welfare and human service agencies resulted in the unwarranted removal of Indian children from their tribes and families. Throughout the 1950s and 1960s, the federal government worked with the Child Welfare League of America to remove Indian children from their families and tribes and place them in non-Indian homes. In the 1960s and 1970s, the federal government began implementing a new policy of self-determination. Out of this, tribal sovereignty and self-governance was fostered, allowing tribes to operate programs once solely administered by the federal government. It also increased federal support and benefits available to tribes to strengthen capacity and self-sufficiency. Against this backdrop, the Indian Child Welfare Act (ICWA) was enacted in 1978 to address the problems facing families and tribes as a result of the loss of their children.

ICWA has been characterized as embodying the gold standard for child welfare policy and practice in the United States[106] and its purpose is to "protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by the establishment of minimum federal standards for the removal of Indian children and the placement of such children in homes which will reflect the unique values of Indian culture.[107] Data reflects the positive impact of full compliance with ICWA on fostering essential connections of Indian children to family, community, and culture. Research with Native American populations reflects that a holistic sense of connectedness of individuals with their families and communities are important culturally based protective factors against substance abuse and suicide.[108]

In 2011, the lead Judges of the National Council of Juvenile and Family Court Judges' (NCJFCJ) Dependency Model Courts convened to hear testimony from Native adoptees and Native birth mothers who described their permanent loss of connection and culture as a result of their experiences with state child welfare systems.[109] These judicial officials heard testimony on the history of ICWA and of systematic state and federal practices to intentionally break up Indian families.[110] They also heard how essential Indian children are in maintaining connections to

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[105] P. Boss, W. Doherty, R. aRossa, W. Schumm, S. Steinmetz (eds), Sourcebook of Family Theories and Methods: A Contextual Approach, Springer Science+Business Media (2004)

[106] Casey Family Programs, Child Welfare League of America, Children's Defense Fund, Donaldson Adoption Institute, North American Council on Adoptable Children, Voice for Adoption, Annie E. Casey Foundation, Black Administrators in Child Welfare, Inc., the Children and Family Justice Center, the Family Defense Center, the First Focus Campaign for Children, the Foster Care Alumni of America, FosterClub, the National Alliance of Children's Trust and Prevention Funds, the National Association of Public Child Welfare Administrators, the National Association of Social Workers, the National Court Appointed Special Advocate Association, and the National Crittenton Foundation *amicus curiae* Brief in Adoptive Couple v. Baby Girl, No. 12-399 at p.4. (2013)

[107] See 25 USC 1902

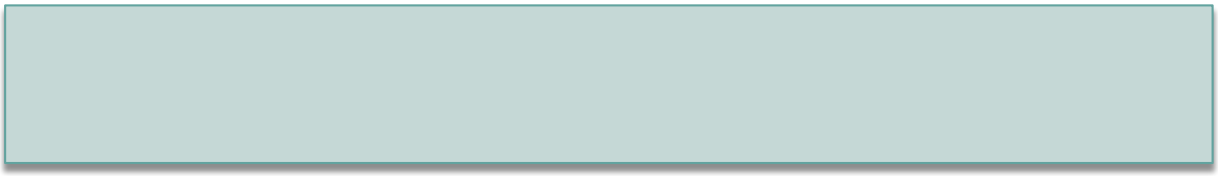
[108] See J. Allen, G.Mohatt, C. Fok, D. Henry, *Suicide Prevention as a Community Development Process: Understanding Circumpolar Youth Suicide Prevention Through Community Level Outcomes*, International Journal of Circumpolar Health 68(3): pp.274-91 (2009), G. Mohatt, S. Rasmus, L. Thomas, J. Allen, K. Hazel, C. Hensel, *Tied Together Like a Woven Hat: Protective Pathways to Alaska Native Sobriety*, Harm Reduction Journal, 1(1) (2004)

[109] Video and other sources from this meeting can be found at http://ncjfcj.org/our-work/tribal-work

[110] Id. Also, it is important to note that many tribal leaders and child welfare advocates argue that 'trafficking' can describe the organized system in which Indian children are taken across state lines for quick private adoptions to wealthy couples seeking

family, community, and culture and of the centrality of ICWA in fostering such connections. In ICWA statute, Congress recognized the significance of such connections:

> …there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children and that the United States has a direct interest, as trustee, in protecting Indian children who are members of or are eligible for membership in an Indian tribe; that an alarmingly high percentage of Indian families are broken up by the removal, often unwarranted, of their children from them by nontribal public and private agencies and that an alarmingly high percentage of such children are placed in non-Indian foster and adoptive homes and institutions; and that the States, exercising their recognized jurisdiction over Indian child custody proceedings through administrative and judicial bodies, have often failed to recognize the essential tribal relations of Indian



> people and the cultural and social standards prevailing in Indian communities and families. The Congress hereby declares that it is the policy of this Nation to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families…[111]

As described earlier in this report, one of the Adverse Childhood Experiences, or ACEs, is the loss of a parent. That trauma, combined with an Indian child's removal from her or his family or tribe, is re-traumatizing with impacts that are not fully understood. Today, AI/ANs report on the ongoing impact of past government policies on Native American children, their families, and their tribes as well as on ICWA's unrealized vision of keeping Indian children connected with their tribes and tribal heritage. Such reports speak to the need for high standards for services to Indian families and high standards for removal of Indian children from their families and tribes. Although ICWA was passed more than 30 years ago, it is not clear how well state agencies and courts have implemented ICWA's requirements into practice. In part, this may be due to misunderstandings of the law, including when and how to apply it. State courts may not act on the belief their state has Indian children (particularly if they have no federally recognized tribes within state boundaries), so do not make appropriate ICWA inquiries, which makes it impossible to apply the law as intended. ICWA is important even in states without federally-recognized tribes within their boundaries and in states with relatively low numbers of Native people. This is because census data shows that 75 percent of Nati ve people live at least part-time in urban

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domestic babies in the U.S. These children generate huge legal fees in the processing of these adoptions including fee splitting arrangements among attorney and adoption practitioners.

[111] 25 U.S.C. 1901, et seq.

settings, not on tribal land, and that the population of tribal people living off tribal lands is growing. Regardless of the make-up of its population, it remains state agencies' and courts' responsibility to fully comply with ICWA. Even in states with large Native populations, there may be confusion regarding how and when to apply the law, including providing notice to tribes and making active efforts to prevent removal and reunite children with their Indian families as required under ICWA. This is further complicated by the fact that there is not national comprehensive data on the status of AI/AN children at any stage in the adoption or foster care system and states rarely have mechanisms in place to assess their on-going compliance with ICWA.

Tribes have asked for assistance to better understand how states are performing related to ICWA and whether this may have some impact on the Native American high disproportionality rates and poor outcomes for Native American children and families involved in the foster care system. In December 2015, the Administration for Children, Youth, and Families (ACYF), Childrens' Bureau, issued a report, *States' Consultation and Collaboration with Tribes and Reported Compliance with the Indian Child Welfare Act: Information From States' and Tribes' 2015-2019 Child and Family Services Plans*.[112] This report is a summary of the information states provided in their 2015–2019 Child and Family Services Plans (CFSPs) in accordance with the statutory requirements under title IV-B of the Social Security Act, regarding their compliance with the Indian Child Welfare Act (ICWA) and their consultation and collaboration with tribes.[113,114] This report also includes information reported in a sample of tribes' CFSPs pertaining to ways in which states consulted and collaborated with tribes. In addition, the report identified examples of: (1) How states consult with tribes, (2) How states assess compliance with ICWA, including data sources used to assess compliance, (3) Potential inconsistencies between how states report consulting and collaborating with tribes and how tribes report states' efforts in these areas, and (4) Promising approaches and practices for complying with ICWA or consulting and collaborating with tribes.

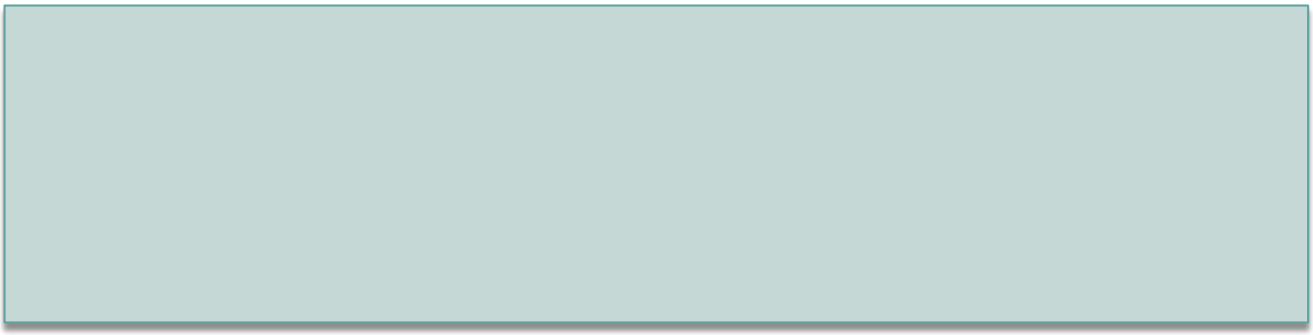
Disproportionality is defined as "the level at which groups of children are present in the child welfare system at higher or lower rates than they appear in the general population."[115] Across the U.S., AI/AN children are overrepresented in foster care at a rate of 2.4 times their rate in the general population. Twenty-four percent of the states have a disproportionality index of more than 4.1 and, in Minnesota, the disproportionality index is 13.9.[116] Furthermore, in contrast to the African-American population of children, disproportionality has increased for AI/AN children since 2000.[117] A full understanding of the scope of disproportionality requires one go

[112] See http://www.acf.hhs.gov/sites/default/files/cb/state_tribal_cfsp_2015_2019.pdf
[113] See 42 USC 622 (b).
[114] The requirements for the CFSPs are laid out at 42 U.S.C. 622. Section 622(b)(9) requires that the CFSPs "contain a description, developed after consultation with tribal organizations…of the specific measures taken by the State to comply with the Indian Child Welfare Act.
[115] See National Council of Juvenile and Family Court Judges, *Disproportionality Rates for Children of Color in Foster Care (Fiscal Year 2012)*, Technical Assistance Bulletin (May 2014)
[116] Id.

[117] Id.

beyond one point in the child welfare process (presence in state child welfare system) and assess how AI/AN children are treated at multiple decision points in the child welfare process, such as in intake reports, investigations, substantiation, and placements.

8. LESBIAN/GAY/TWO-SPIRIT



'Two-spirit' is a term that was created by Native American gay, lesbian, bisexual and transgender people in approximately 1990 as an umbrella term to include the tribally specific terms used to refer to those who are "not male and not female" or who "take on" the other gender, as well as an umbrella term for those Native Americans who define themselves as lesbian, gay, bisexual, and transgender (LGBT). Two-spirit individuals, generally, denote people who feel their bodies simultaneously manifest both a masculine and a feminine spirit, or a different balance of masculine and feminine characteristics than usually seen in masculine men and feminine women. The term originates from the Ojibwe word 'niizh manitoag' or 'two spirits' and was created to substitute for earlier and biased terms used by anthropologists and colonists.[118] Individual tribes often have particular terms for two-spirt people in their communities. Examples include:

- Nadleeh (Navajo)
- Kwido (Tewa)
- Winkte (Lakota)
- Dubuds (Pauite)
- Aayahkwew (Cree)

It is estimated that 168 of the remaining North American Native languages have terms for people who do not exclusively live their lives in the role of 'male' or 'female.'[119] Separate from terms, many Native American cultures have distinct spiritual or social roles for two-spirits, including medicine people, treaty negotiators, foretellers of the future, marriage brokers, and those who take in orphans.[120]

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[118] Anguksuar, *A Post Colonial Perspective on Western (Mis)Conceptions of the Cosmos and the Restoration of Indigenous Taxonomies* in Two Spirit People: Native American Gender Identity, Sexuality, and Spirituality, S. Jacobs, W. Thomas, S. Lang (eds), University of Illinois Press (1997), pp. 217-222.

[119] M. Garrett, *Counseling Native American Gay, Lesbian, and Bisexual People*, American Counseling Society (2003)

[120] S. Lang, Men as Women, Women as Men: Changing Gender in Native American Cultures, University of Texas Press (1998)

Colonization has had a significant impact on two-spirit existence. For example, when colonists arrived on North America, many missionaries and colonists targeted two-spirit people for death because they were seen as offensive to the colonists' churches. As a result, many Native communities hid their two-spirit people resulting in two-spirit individuals and communities going underground or being exterminated. The existence and identification of two-spirit people varied then and still varies today. Conformity to religious norms around gender and sexual identity were enforced in reservations and boarding schools. Many contemporary Native American communities are disconnected from their two-spirit traditions or have adopted a colonial or missionary perspective shared by the dominant society that saw two-spirit people as shameful. This has contributed to a sense of loss and trauma for individual two-spirit peoples and two-spirit individuals, when asked about their experiences of historical trauma, report high rates and report higher rates of intergenerational historical trauma than Native adults who are not two-spirit.[121]

9. HOMELESSNESS AND RUNAWAY NATIVE YOUTH

Homelessness is often described as an extreme manifestation of poverty and as this Report demonstrates, historically, Native Americans represent one of the most impoverished groups in the country. Persistent poverty and inadequate housing continue to be key issues that impact members of tribal communities.[122]

Using data from HUD, about 62 percent of the sheltered homeless population identified as members of a minority group.[123] 'Shelter nights' are a count of the number of people who arrive at the shelter and are provided a bed multiplied by the number of nights. The number of unmet requests for shelter is a count of the number of unmet requests for shelter due to programs being at capacity. In 2014, the average shelter stay was nearly 3 weeks and there were 3,408 unmet requests. African Americans comprised 41.8 percent of the population using shelter programs, representing the largest single racial group in shelter programs. Other minority groups include: White Hispanic (10.1 percent), multiple races (6.5 percent), American Indian or Alaska Native (2.4 percent), Asian (0.8 percent), and Native Hawaiian or other Pacific Islander (0.9

[121] K. Balsam, B. Huang, K. Fieland, J. Simoni, K.Walters, *Culture, Trauma, and Wellness: A Comparison of Heterosexual, Lesbian, Gay, Bisexual, and Two-spirit Native Americans*, Cultural Diversity and Ethnic Minority Psychology, 10(3): pp. 287-30; K. Walters, T. Evans-Campbell, J. Simoni, T. Ronquillo, R. Bhuyan, *"My Spirit in my Heart": Identity Experiences and Challenges Among American Indian Two-Spirit Women*, Journal of Lesbian Studies, 10(1-2), (2006), pp. 125-149.

[122] *Conducting Homeless Counts on Native American Lands: A Toolkit*, Corporation for Supportive Housing (CSH) and The Housing Assistance Council (HAC), (2013). Retrieved from http://www.ruralhome.org/storage/documents/rpts_pubs/na_homeless_count_toolkit.pdf

[123] HUD defines 'sheltered homeless persons' as all persons residing in emergency shelter or transitional housing and 'sheltered homeless individuals' as a subset of 'sheltered homeless persons' including homeless persons who are homeless as individuals rather than as members of a family household.

percent).[124] This represents 2013 HUD data as 2014 data will not be available until later in 2016.

The HUD data on Native Americans experiencing homelessness represents primarily urban, non-reservation populations because, with few exceptions, HUD Point-in-Time data collection on homeless populations does not include reservation areas.[125] Based on available data, homelessness appears to present disproportionately higher among American Indian, Alaska Natives, and Native Hawaiian and Pacific Islanders. As indicated in HUD's Annual Homeless Assessment Report (AHAR), while only 1.2 percent of the national population self-identifies as AI/AN, 4.0 percent of all people experiencing sheltered homelessness, 4.0 percent of all sheltered individuals, and 4.8 percent of all sheltered families self-identify as AI/AN (HUD, 2012).[126] Native Hawaiians do not fare better. Statewide, 12,000-15,000 people are homeless at some point during the year and 32 percent of Hawaii's homeless are of Native Hawaiian ethnicity.

A review of the literature indicates that American Indian, Alaska Native, and Native Hawaiian (AI/AN/NH) people are at a higher risk for factors that lead to or prolong the experience of homelessness, including: disproportionately higher rates of poverty; high rates of domestic violence; and high prevalence of mental health and substance use disorders. Native populations also face challenges associated with acculturation,[127] racism and stereotyping, and unresolved grief from historical trauma.[128] All of these factors contribute to the disproportionate representation of Native Americans among people experiencing homelessness.

While comprehensive data is not widely available, both research and consultation with subject matter experts indicate that homelessness and housing instability are significant problems on tribal lands and can take several forms, but is most often evidenced by severe overcrowding (multiple families residing in confined living quarters) and substandard housing.

Available data indicates that up to 8.8 percent of households in Native American communities are overcrowded compared with 3.0 percent nationwide.[129] Unsheltered homelessness is not as common in tribal communities as it is in many urban areas. Thus the majority of tribes do not operate shelters to serve community members who do experience unsheltered or "street"

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[124] See https://www.hudexchange.info/resource/4404/2013-ahar-part-2-estimates-of-homelessness-in-the-us/

[125] Disaggregated data for unsheltered homeless AI/AN populations are not available from HUD Point-in-Time counts.

[126] U.S. Department of Housing and Urban Development, Office of Community Planning and Development (2012). *The 2011 Annual Homeless Assessment Report to Congress*.

[127] See M. Leach supra at note 55.

[128] *Expert Panel on Homelessness among American Indians, Alaska Natives, and Native Hawaiians*. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. (2012)

[129] *Housing on Native American Lands*: *Rural Research Report*, Housing Assistance Council. (2013).

homelessness. Such circumstances create additional challenges for identifying homeless AI/AN individuals and families as well as implementing effective crisis response strategies.

Reports have indicated that as many as one in five (19 percent) people living on tribal lands are living in overcrowded housing situations.[130] Quantification regarding homelessness and housing instability is complicated by the fact that many members of tribal communities do not consider doubled-up or overcrowded living situations as representing 'homeless,' but rather as a culturally appropriate response to ensuring the well-being of family and community members. However, it is still important to address the housing needs faced by AI/AN households. Overcrowding, substandard housing, and homelessness are common in AI/AN communities and such precarious housing conditions are sometimes referred to as "near-homeless." The most recent data, a 2010 GAO report, notes that during the 10-year period between 1999 and 2009, the number of AI/AN households living in units that lacked kitchen facilities jumped by nearly 10 percent, while the number of AI/AN households struggling with housing expenses greater than 50 percent of their income jumped by 43 percent.[131] Overcrowding may lead many people to leave tribal lands to seek housing opportunities elsewhere–some of which may account for the disproportionate rates of homelessness identified in urban areas among AI/AN populations.

While there is no single definition of the terms "runaway youth" or "homeless youth," both groups of youth can be characterized as sharing the risk of not having adequate shelter, lacking stability in their lives, disruptions in education, as well as increased risk for engaging in harmful behaviors while away from a permanent home. Each year, thousands of U.S. youth run away from home or are asked to leave their homes and become homeless. According to research conducted by the Congressional Research Service in 2013, American Indian, Alaska Native, Native Hawaiians and Pacific Islanders are overrepresented in national statistics on number of runaway and homeless youth accessing services.[132]

To address homeless youth, the McKinney-Vento Homeless Assistance Act of 1987 (P.L 100-77, 42 U.S.C. § 11301 et seq.) was one of the first major federal legislative responses to homelessness. Title VII of the Act includes provisions to ensure the enrollment, attendance, and success of homeless children and youth in school. Under the Act, schools must work to eliminate any barriers, such as transportation, that may prohibit students from attending school, and are required to appoint a liaison to work with homeless students and their families.

The Office of Head Start tracks data on the number of children service in Head Start programs that are defined as homeless under the McKinney-Vento Act. Through the Program Information

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[130] See U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, supra at note 89.

[131] *Report to Congressional Committees: Native American Housing*, U.S. Government Accountability Office (2010). Retrieved from http://www.gao.gov/assets/310/301157.pdf

[132] See *Runaway and Homeless Youth: Demographics and Programs (January 15, 2013)*Congressional Research Service at http://www.nchcw.org/uploads/7/5/3/3/7533556/crs_2013_rhya_history_and_lit_review.pdf

Report, which collects data annually from each Head Start and Early Head Start program, there is some national level data on the number of children identified as homeless at some point during the program year. For the 2013 and 2014 program year, this number was 48,853 children, or 4.6 percent nationally. Looking at those children who are identified as homeless in programs served by American Indian and Alaska Native Head Start (Region XI programs), the total number is 1,848 or 7.7 percent of the 23, 969 total children served in Region XI. However, this is an incomplete data set due to the fact that nearly 50 percent of all AI/AN children enrolled in Head Start or Early Head Start programs are served outside of Region XI. In addition, we do not have information on the number of Native Hawaiian and Pacific Islander homeless children served, nor do we know the exact percent of American Indian and Alaska Native homeless children served in Region XI or nationally, because the category of homeless children is not broken down by race.[133]

10. HUMAN TRAFFICKING

Human trafficking is the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.[134] Often linked with runaway and homeless youth, human trafficking, also known as modern day slavery, is a growing concern despite having existed in Native communities for centuries since the earliest European contact.[135] While Native communities have a long historical experience of trafficking, the United States has recently begun to systematically address this issue domestically, primarily with regard to sexual exploitation.

Runaway and homeless youth[136] are at much greater risk of violence and sexual exploitation and many have reported traumatic events before leaving home which exposes them to re-traumatization while trying to survive on the streets. That makes these youth particularly vulnerable to trafficking and the sex trade. In addition, AI/AN youth are also over-represented in the juvenile justice system for status offenses, including truancy, curfew and running away. [137] Combined, this increased vulnerability and risk makes having a safe sanctuary so critical for Native youth. In fact, most Native youth describe access to safe shelter as one of their most critical needs.

[133] Data from the Office of Head Start Program Information Report 2014

[134] U.N. Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Article 3, paragraph (a).

[135] E.g., according to his journal accounts, Christopher Columbus engaged in the exploitation of Indigenous peoples he encountered, including providing Native women and girls for his crew.

[136] See Part I. at section 7. Homelessness and Runaway Native Youth.

[137] Puzzanchera, Charles & Hockenberry, Sarah. (July 2014). Juvenile Court Statistics 2011. National Center for Juvenile Justice. Available at: http://www.ncjj.org./Publication/Juvenile-Court-Statistics-2011aspx.

Since the passage of the Trafficking Victims Protection Act (TVPA) in 2000, law enforcement investigators, social service providers, and the general public have reported cases of forced labor, debt bondage, involuntary servitude, and sex trafficking, impacting a diverse range of populations including men, women, and children, who are U.S. citizens, lawful permanent residents, or foreign nationals.[138] The TVPA defines "severe forms of trafficking in persons" as:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. [139]

A victim need not be physically transported from one location to another in order for the crime to fall within these definitions. Human trafficking cases occur across the country, in tribal, rural, urban, and suburban settings and in a wide range of industries. Specifically, the 2014 Trafficking in Persons Report stated that "trafficking can occur in many licit and illicit industries or markets, including in brothels, massage parlors, street prostitution, hotel services, hospitality, agriculture, manufacturing, janitorial services, construction, health and elder care, and domestic service." [140]

Native American communities and Native American women have fallen victim to trafficking and sexual assault at alarming rates. When compared to other population groups within the United States, Native women remain the most frequent victims of physical and sexual violence.[141] According to one of the most comprehensive studies done on the trafficking of Native women, a unique mixture of poverty, homelessness, and generational trauma in Native communities make the women and children extremely vulnerable to trafficking.[142] Native American women operate in a unique sphere in America's past and present, and their role within society helps to explain why they continue to experience high rates of human trafficking, domestic violence, and sexual assault.

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[138] ACF's guidance to State and Services on Addressing Human Trafficking and of Children and Youth in the United States. https://www.acf.hhs.gov/sites/default/files/cb/acyf_human_trafficking_guidance.pdf

[139] Section 103 of TVPA; 22 U.S.C. § 7102(a).

[140] United States Department of State (June 2014). Trafficking in Persons Report. Retrieved from: http://www.state.gov/j/tip/rls/tiprpt/2014/?utm_source=NEW+RESOURCE:+Trafficking+in+Persons+R

[141] Pierce, Alexandra & Koepplinger, Szanne. National Online Resource Center on Violence Against Women. New language, old problem: Sex trafficking of American Indian women and children (October 2011). Retrieved from: http://www2.ncfy.com/literature/docs/21464-New_Language_Old_Problem.pdf

[142] Farley, M., Matthews, N., Deer, S., Lopez, G., Stark, C., & Hudson, E. Garden of Truth: *The Prostitution and Trafficking of Native Women in Minnesota*. (October 2011). Retrieved from: http://www.prostitutionresearch.com/pdfs/Garden_of_Truth_Final_Project_WEB.pdf

American Indians have higher per capita rates of violent victimizations than any other group in the United States.[143] Their rate for sexual assault in 2000 was 7.7 per 1,000 women, compared to 1.1 for white women and 1.5 for African American women.[144] This clearly indicates that sexual assault is a crisis for Native American women, and previous sexual assault is often a factor in women that later go on to be prostituted or trafficked. Traffickers often target the homeless or the economically disadvantaged, and given the prevalence of these factors, it should come as no surprise that Native American women are extremely vulnerable to trafficking. In fact, research suggests that traffickers deliberately target homeless or impoverished Native women and children who are desperate to meet their survival needs.[145]

Trafficking of Native Americans in Rural Communities

Although trafficking is more typically rooted in urban areas, some factors can make rural areas uniquely susceptible to human trafficking. One such example particularly affecting AI/AN women in North Dakota, South Dakota, and Montana is illustrative. This is an area called the Bakken shale formation, where fracking operations are drawing thousands of mostly male workers.[146] Although data is limited, statistics show a growing trend of human trafficking in North Dakota. Victims' advocates and experts say that the region's oil boom has highlighted the issue of prostitution. This has been especially important to the state's tribal communities, which have populations of young people who are most at-risk of falling prey to traffickers. The regional oil boom, encompassing North Dakota, Montana, and South Dakota are subjected to a whole new set of problems in addition to persistent poverty, and lack of economic opportunity because these states are located atop the Bakken shale formation.

South Dakota's U.S. Attorney Brendan V. Johnson's 2012 annual report stated, "We have seen a 30 percent increase in human trafficking cases filed over the past three years…South Dakota has not been immune from this epidemic…We have seen young girls recruited from our communities and then 'groomed' by pimps to perform commercial sex acts. The girls quickly find themselves locked into a world of violence and degradation, but threats, fraud and coercion from the pimps make it extremely difficult for them to leave."[147]

In August 2014, Montana Sen. Jon Tester held a listening session at Fort Peck Community College in Poplar, Montana, to respond to the escalating crime figures in the areas around the Bakken oil project. "Tribal police departments lack the resources to investigate and detain human trafficking offenders. By no fault of their own, these departments are often ill-equipped to

[143] Id.

[144] Id.

[145] Id.

[146] See http://www.nativetimes.com/news/crime/7499-prosecutors-in-nd-sd-warn-about-human-trafficking and http://www.huffingtonpost.com/2012/04/23/bakken-oil-crime_n_1445410.html

[147] See http://www.justice.gov/usao-sd/pr/united-states-attorney-brendan-johnson-issues-2012-annual-report

root out the players in trafficking rings that can span reservation, state, and national boundaries," Tester said. "Because of the patchwork of tribal, state, and federal jurisdiction, tribes also often lack the ability to prosecute and appropriately punish offenders in tribal courts."[148] Trafficking and associated problems are exacerbated by lack of laws that could adequately prosecute trafficking, law enforcement officials that are swamped and unable to cope with the huge increases in population, and tribal officials lacking adequate authority to properly deal with the influx of non AI/AN settlers.[149] Anecdotally, Native American advocates report that perpetrators may actually target Native women because federal law gives tribal law enforcement little authority over nontribal perpetrators. This creates a complex and confusing system where it is often unclear whether cases will fall under state or federal jurisdiction. As a result, perpetrators can virtually assault women without fear of retribution. This obviously creates a very difficult and complex situation for law enforcement that often leads to failures to prosecute.

At the August listening session in Fort Peck, Sen. Tester also noted that limited treatment options available to victims also represent a major challenge. He stated that "The survivors are often children or young adults from impoverished homes with broken family ties. Help for them is rarely available in the Native community—or even within a manageable drive."

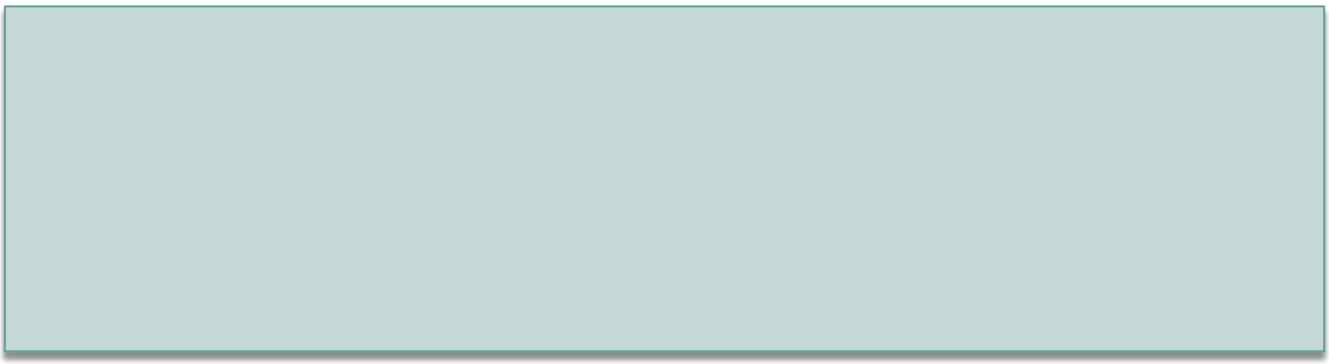
Victims in the Fort Berthold Reservation must drive several hours to either Minot or Bismarck to have a rape kit performed—and advocates say this is only the first step in a long process of healing. Janet Routzen, Executive Director of the White Buffalo Calf Woman Society, an advocacy group serving women in south central South Dakota's Rosebud Sioux community since 1977, states that steps toward healing require securing housing and support services for victims for at least a year, in addition to any treatment they may need for drug or alcohol dependency or mental illness. Victims can't move forward until they feel stable, she said. "It's the old story of prostitution." "We tend to think it's their choice. A lot has to do with getting trapped in situations. I got calls from a young girl. In this conversation, the mother is addicted to meth and was placing her child up for sale. When it is such a situation day to day and a child doesn't have shoes or food, a parent may head for the street and become additionally traumatized."[150]

[148] See http://www.indian.senate.gov/news/press-release/testers-listening-session-shines-light-growing-human-trafficking-problem

[149] http://www.theatlantic.com/national/archive/2013/02/on-indian-land-criminals-can-get-away-with-almost-anything/273391/

[150] Id.

11. NATIVE LANGUAGES AND CULTURES



Native American language and culture have important roles to play in American Indian, Alaska Native, Native Hawaiian, and Pacific Islander communities. Native languages, in particular, are essential means of transmitting cultural identity and advancing, for future generations, indigenous knowledge and traditions. The importance of Native language as an expression of culture cannot be underestimated and, particularly for youth, knowledge of cultural, linguistic, and spiritual traditions can serve as protective factors for at-risk Native communities.[151] In addition, there is evidence that Native language revitalization efforts promote resilience in Native individuals and communities.[152] A growing amount of research has found that despite challenges, Native youth are looking to language, prayer, crafts, dancing, singing, death/mourning traditions, and sharing of history through stories as sources of strength and helpful to build resilience.[153] Such youth report that protecting these traditional ways is important to understand their historical connection to their ancestors and something to refer back to in difficult times. Bringing culture back to the community and having knowledge of the words used by their ancestors may restore a sense of belonging and create expectations related to responsibility and ownership for youth.

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[151] See e.g., O. McIvor, A. Napoleon, K. Dickie, *Language and Culture as Protective Factors for At-Risk Communities*, Journal de la Santé Autochtone (November 2009) and R. Sanchez-Way and S. Johnson, *Cultural Practices in American Indian Prevention Programs*, in Juvenile Justice: Challenges Facing American Indian Youth (December 2000) retrieved at https://www.ncjrs.gov/html/ojjdp/jjnl_2000_12/cult.html and C. DeCou, M. Skewes, and E. Lopez, *Traditional Living and Cultural Ways as Protective Factors Against Suicide: Perceptions of Alaska Native University Students*, in International Journal of Circumpolar Health (2013) retrieved at http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/20968

[152] See e.g., O. McIvor, A. Napoleon, K. Dickie, *Language and Culture as Protective Factors for At-Risk Communities*, Journal de la Santé Autochtone (November 2009) and R. Sanchez-Way and S. Johnson, *Cultural Practices in American Indian Prevention Programs*, in Juvenile Justice: Challenges Facing American Indian Youth (December 2000) retrieved at https://www.ncjrs.gov/html/ojjdp/jjnl_2000_12/cult.html and C. DeCou, M. Skewes, and E. Lopez, *Traditional Living and Cultural Ways as Protective Factors Against Suicide: Perceptions of Alaska Native University Students*, in International Journal of Circumpolar Health (2013) retrieved at http://www.circumpolarhealthjournal.net/index.php/ijch/article/view/20968

[153] See e.g., C. Goodluck and A. Willeto, *Seeing the Protective Rainbow: How Families Survive and Thrive in the American Indian and Alaska Native Communities*, Annie E. Casey Foundation, p. 1 (2009)

After decades of forced assimilation, and sometimes punishment, for speaking Native American languages, Native American youth report high levels of interest in learning more of their languages and cultural lifeways, for the knowledge and wisdom of their ancestors. At the same time, elders and language speakers report enthusiasm for sharing their lifetime knowledge before they pass on.

In 1990, the year Congress passed the Native American Languages Act, 281,990 individuals ages 5 and over reported in the United States Census that they spoke a Native American Language, in the 2000 Census there were 353,340 and in 2010 Census, there were 372,095. It is encouraging that, overall, Native American languages are gaining speakers, but such gains are not universal for all languages and Native communities, as shown in the table below. Still, the fact that the estimated number of individuals ages five and over listed as speaking American Indian and Alaska Native languages has increased over the last ten years, by nearly 20,000, is a foundation upon which to build. We can see from the table below that some languages have been maintaining, some gaining, and others (in red below) have seen language loss in terms of speaker decline. In spite of such losses, efforts at language preservation and revitalization continue to be made and it is clear that each person that speaks and passes on their Native language, especially to children, is a reason for hope.

American Indian and Alaska Native Languages Spoken at Home by American Indians and Alaska Natives age 5 and over in 2000 and 2010, populations with 2,000 or more speakers. (Source U.S. Census Bureau 2000 and 2010)

	2000 Number of Individuals, age 5 and over	**2010 Number of Individuals, age 5 and over**
All American Indian and Alaska Native languages	353,340	372,095
Navajo	173,800	169,471
Yupik	15,997	18,950
Dakota	17,466	18,616
Apache	12,502	13,063
Keres	10,522	12,945
Cherokee	12,009	11,610
Choctaw	9,272	10,343
Zuni	6,903	9,686
Ojibwa	6,919	8,371
Pima	9,220	7,270
Inupik	5,995	7,203
Hopi	6,769	6,634
Tewa	3,736	5,176
Muskogee	5,009	5,064
Crow	4,149	3,705
Shoshoni	2,724	2,211

	2000 Number of Individuals, age 5 and over	2010 Number of Individuals, age 5 and over
Cheyenne	2,075	2,156
Eskimo	2,206	2,076
Tiwa	1,995	2,009

12. EDUCATIONAL OPPORTUNITY AND ATTAINMENT

Studies of early childhood development measures demonstrate that, at nine months, AI/AN infants show no measurable developmental differences from the general population. However, by age two, AI/AN children begin to fall behind on measures of specific cognitive skills in vocabulary, listening comprehension, matching and counting. By age four, smaller percentages of AI/AN children demonstrate age-appropriate language, literacy, mathematics, and color-identification skills, compared to the total population of children.[154] Executive Order 13592, signed in 2011, recognized the need to take action to address the early childhood achievement gap and established an Initiative on American Indian and Alaska Native Education (Initiative). The Executive Order noted the following:

> It is the policy of my Administration to support activities that will strengthen the Nation by expanding educational opportunities and improving educational outcomes for all AI/AN students in order to fulfill our commitment to furthering tribal self-determination and to help ensure that AI/AN students have an opportunity to learn their Native languages and histories and receive complete and competitive educations that prepare them for college, careers, and productive and satisfying lives.

The Executive Order further outlined that the Initiative shall help expand educational opportunities and improve educational outcomes for all AI/AN students, including opportunities to learn their Native languages, cultures, and histories and receive complete and competitive educations that prepare them for college, careers, and productive and satisfying lives, by, among other things, strengthening the relationship between the Department of Education, which has substantial expertise and resources to help improve Indian education, and the Department of the Interior and its BIE, which directly operates or provides grants to tribes to operate an extensive primary, secondary, and college level school system for AI/AN children and young adults[155]

More than 140,000 kindergarten students nationwide were held back in the 2011 to2012 school year. This represents approximately four percent of all kindergarten students in public schools. Native Hawaiian, other Pacific Islander, American Indian, and Native Alaskan students are held

[154] U.S. Department of Education, *Tribal Leaders Speak: The State of Indian Education 2010 Report of Consultations with Tribal Leaders in Indian Country*, (November 2011).

[155] Executive Order 13592 (December 2, 2011), Retrieved from https://www.whitehouse.gov/the-press-office/2011/12/02/executive-order-13592-improving-american-indian-and-alaska-native-educat

back a year at nearly twice the rate of white children with seven percent of AI/AN children held back and nearly eight percent of Native Hawaiian and other Pacific Islander children.[156]

The vast majority of AI/AN students—92 percent—attend local public schools operated by state and local educational authorities. States have a responsibility to educate all students who live within the state's borders, including students who are members of Indian tribes.[157] The other eight percent of AI/AN students attend one of the183 Bureau of Indian Education (BIE) schools located on 63 reservations in 23 states.[158] Of the 183 BIE schools, 34 percent (63 schools) are in poor physical condition and 27 percent are more than 40 years old.[159] The estimated cost of repairs across all BIE schools is $967 million.[160] While Native American students are more likely than their peers to attend rural schools, approximately one-third of students attend urban or suburban schools.[161]

Sixty percent of BIE-funded schools do not have adequate digital bandwidth or computers to meet the requirements of new assessments aligned to college and career ready standards.[162] AI/AN youth experience major disparities in many other aspects of their education. Overall, AI/AN students score far lower than other students on national tests; the gap in reading and math test scores between AI/AN and non-AI/AN students is more than half of a standard deviation throughout their educational careers. Only 22 percent of AI/AN fourth graders and 17 percent of AI/AN eighth graders scored at the "proficient" or "advanced" levels in math in 2011.[163] The American Indian/Alaskan Native high school graduation rate is 67 percent, the lowest of any demographic group across all schools.[164] The most recent Department of Education data indicate

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[156] U.S. Department of Education, Office for Civil Rights, *Civil Rights Data Collection: Data Snapshot – Early Childhood Education*, Issue Brief No. 2 (March 2014). Retrieved from https://www2.ed.gov/about/offices/list/ocr/docs/crdc-early-learning-snapshot.pdf

[157] The federal trust responsibility or other obligations "do not undermine the independent responsibilities of states and local governments." Felix Cohen Handbook of Federal Indian Law §§ 22.01[3], 22.03[1][b] (Neil Jessup Newton ed. 2012). Quoted in 2014 Native Youth Report, Executive Office of the President (December 2014). Retrieved from https://www.whitehouse.gov/sites/default/files/docs/20141129nativeyouthreport_final.pdf

[158] U.S. Department of Interior, Bureau of Indian Education. Webpage at http://bie.edu/HowAreWeDoing/index.htm

[159] Poor condition is determined by the BIE by formula. If the Cost of Deficiencies/Current Replacement Value is greater than .10 the school is determined to be in poor condition. One way to think about this is that the cost of repairs are greater than 10 percent of the value of the school itself.

[160] Bureau of Indian Education Study Group, Findings and Recommendations, p. 20. Submitted to the Secretaries of the Departments of the Interior and Education (June 27, 2014) [the BIE Blueprint]. Retrieved from http://www.doi.gov/news/loader.cfm?csModule=security/getfile&pageid=537280

[161] *The State of Education for Native Students*. The Education Trust, p.4 (August 2013)

[162] J. DeVoe and K. Darling-Churchill, *Status and Trends in the Education of American Indians and Alaska Natives*: U.S. Department of Education, National Center for Education Statistics, p. 126

[163] National Center for Educational Statistics, U.S. Department of Education, National Indian Education Study 2011: *The Educational Experiences of American Indian and Alaska Native Students at Grades Four and Eight* (2011), Retrieved from http://nces.ed.gov/nationsreportcard/pdf/studies/2012466.pdf

[164] *Indian Students in Public Schools- Cultivating the Next Generation: Hearing on Indian Education* before the S.

that the Bureau of Indian Education (BIE) schools fare even worse, with a graduation rate of 53 percent, compared to a national average of 80 percent.[165]

AI/AN students who do manage to graduate from high school and go on to college are often ill equipped to succeed once enrolled. Many AI/AN students attend high schools that simply do not have the right courses or opportunities that are a prerequisite for a successful college experience. For example, few AI/AN youth have opportunities to enroll in high-level math courses in high school, such as calculus, or in other rigorous high school classes, which are a gateway to higher education. AI/AN youth are the least likely of all student populations to attend a high school that offers Advanced Placement courses.[166] Only one in four AI/AN high school students who take the American College Test (ACT) score at the college-ready level in math, and only about one-third score at the college-ready level in reading.[167] Only 52 percent of Native American students who graduated high school in 2004 enrolled in college immediately after high school, compared with 74 percent of the general population.[168] Of all Native American students who enrolled in college in the fall of 2008, only 41.0 percent completed a bachelor's degree by 2014 compared with 63.2 percent of white students who enrolled in the fall of 2004.

The statistics described above describe a devastating reality: AI/AN youth and AI/AN education are in a state of crisis. Low rates of educational attainment perpetuate cycles of limited opportunity for higher education or economic success for AI/AN peoples. This crisis, in turn, has grave consequences for tribal nations, who need educated youth and adults to lead tribal governments, develop AI/AN economies, contribute to the social and economic well-being of Native communities, and sustain AI/AN languages and cultures.

Comm. on Indian Affairs, 113th Cong. (2014) (testimony of William Mendoza, Exec. Dir., White House Initiative on Am. Indian and Alaska Native Educ.).

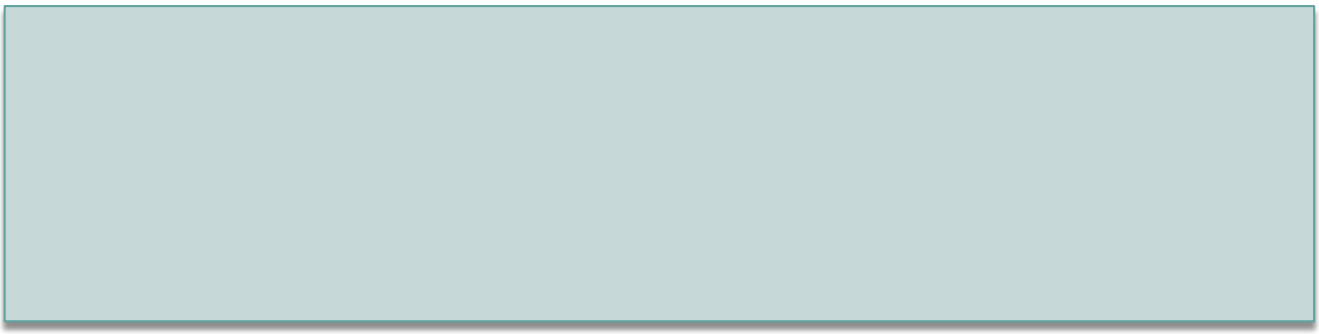
[165] See M. Stetser and R. Stillwell, U.S. Department of Education, National Center for Education Statistics, *Public High School Four-Year On-Time Graduation Rates and Event Drop-out Rates: School Years 2010-11 and 2011-12* 10 (2014). Retrieved from http://nces.ed.gov/pubs2014/2014391.pdf

[166] C. Theokas and R. Saaris, *Finding America's Missing AP and IB Students*. The Education Trust. (June 2013), Retrieved from http://www.edtrust.org/sites/edtrust.org/files/Missing_Students.pdf

[167] American College Testing, *The Condition of College and Career Readiness*, (2012). Retrieved from http://www.act.org/research-policy/college-career-*read iness*-report-2012

[168] See *The State of Education for Native Students* supra at note 122, page. 10.

13. TRIBAL COLLEGE AND UNIVERSITIES (TCUS)



In 1968, the Navajo Nation opened the first TCU in Tsaile, Arizona, the Navajo Community College. The college, now Diné College, recognized that a post-secondary education centered on Navajo culture addressed a significant community need. Soon after the college opened, TCUs opened in California, North Dakota, and South Dakota. Today, there are 32 accredited TCUs operating in more than 15 states and one TCU in Canada. In the fall of 2010, TCUs were serving 19,070 students from more than 250 federally recognized tribes and 47,000 local community members through community-based education programs.[169] Despite the diversity among TCUs, tribal identity is at the core of each and all share larger missions to strengthen and preserve tribal sovereignty, culture, and language and to serve their communities.

All TCUs offer associate degree programs; 13 offer baccalaureate programs, and 2 offer master's degree programs. Sixty-three percent of TCU students are 16-24 years old, 33 percent are 25-49, and 4 percent are over 50 years old.[170]

TCUs play key roles in preserving tribal traditions, culture, and languages. For example, the Oglala Lakota College, which operates the Porcupine Head Start/Early Head Start program, established a Lakota immersion program for enrolled children which also offers a 12-hour immersion course for parents, family members, and others who want to learn Lakota. In another example, using an ANA language grant, Stone Child College created a Cree language curriculum and implemented a Cree language immersion classroom for newborns up to age three with plans to establish a Cree language nest. Young children will be immersed in Cree language for eight hours a day and become the next generation of fluent Cree speakers and represent the Tribe's best opportunity to preserve and maintain Cree Nation.

TCUs offer valuable services to tribal community members, host cultural activities, support tribal governments and social services, and administer health programs, and job programs. In addition,

[169] American Indian Higher Education Consortium American Indian Measures for Success (AIMS) 2009-2010 Fact Book: Tribal Colleges and Universities Report, p.3 (May 2012)

[170] Id. at 4.

TCUs frequently provide the only library services in their communities. For example, the library at Ilisagvik College serves individuals across 89,000 square miles of the North Slope connecting remote Alaska villages. TCU libraries often serve as tribal archives through the collection of documents and records, recording oral histories from Elders, and preserving art and other cultural treasures.

According to the most current (Fall 2010) enrollment data, 8.7 percent of AI/AN college students were attending one of the 32 accredited TCUs. AI/AN students composed 78 percent of the combined total enrollment of these institutions. The percentages of AI/AN students attending TCUs are increasing yearly. According to a study by the National Center for Education Statistics, the number of AI/AN students enrolled in TCUs increased by 23 percent between 2001 and 2006.[171]

B. ECONOMIC CONDITIONS OF NATIVE AMERICANS

1. POVERTY

AI/AN youth often live in communities that have long suffered from high rates of poverty and unemployment, health disparities, substance abuse, domestic violence and child abuse, and increased youth gang activity. In 2013, the median household income of those who identified solely as AI/AN was $36,252 compared with $52,176 for the nation as a whole.[172]

Growing up in poverty has significant effects on children's cognitive development and ability to learn, and the risks posed by economic deprivation are greatest among children who experience persistent poverty. In 2013, the National Center for Children in Poverty reported that 69 percent of AI/AN children under the age of six live in low-income families,[173] 62 percent of AI/AN children between the ages 6 and 11 live in low-income families, and 58 percent of AI/AN children between the ages of 12 and 17 live in low-income families.[174] Two of the five poorest counties in the United States —those with the lowest per capital income—are located on Indian reservations. These are Oglala Lakota County in South Dakota (known as Shannon County until May 2015), located entirely on the Pine Ridge Indian Reservation and home of the Oglala Sioux Tribe, and Ziebach County in South Dakota, located almost entirely within the Cheyenne River Indian Reservation and home of the Cheyenne River Sioux Tribe.[175]

[171] White House Initiative on American Indian and Alaska Native Education, U.S. Department of Education. Retrieved from http://www.ed.gov/edblogs/whiaiane/tribes-tcus/tribal-colleges-and-universities/

[172] U.S. Census Bureau: 2011-2013 American Community Survey. Retrieved from https://www.census.gov/newsroom/facts-for-features/2014/cb14-ff26.html. See also Table S0201 at http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t for most current data.

[173] 'Low-income' is defined as at or above 200 percent of the federal poverty level.

[174] National Center for Children in Poverty. Retrieved from http://www.nccp.org/publications/fact_sheets.html

[175] 2008-2012 American Community Survey. U.S. Census Bureau, U.S. Department of Commerce.

This data takes on greater significance given that the federal poverty level is considered by some researchers to be an inadequate measure of a minimally basic standard of living. For 2014, the HHS poverty guideline was $23,850 for a family of four.[176] When some researchers have quantified actual basic living expenses across the country, they find that, at a minimum, families need an income of *twice* the federal poverty level to cover the actual costs of food, housing, health care, transportation, and child care.[177] In 2013, roughly 50 percent of all AI/AN children had no parent with full-time, year-round employment, compared with 24 percent of non-Hispanic white children. This is important because without at least one parent employed full-time, children are more likely to fall into poverty.[178] AI/AN children were 30 percent more likely to live in high-poverty areas than non-AI/AN children.[179]

In 2013, the median family income of households headed by NHPI populations was $50,591, while the poverty rate of those identifying solely as Native Hawaiians and other Pacific Islander was 20.1 percent.[180]

2. WEALTH AND EMPLOYMENT

AI/ANs are a relatively low wealth population. In 2000, AI/AN's median wealth was equal to only 8.7 percent of the median wealth among all Americans.[181] While, for most Americans, a home is a key source of wealth, Native Americans have a significantly lower homeownership rate than do white Americans, and the homes they do own tend to be worth less than those of white Americans.[182] As data demonstrates, many AI/AN communities are economically depressed with jobless rates that are high. One major factor behind the high poverty rates and low wealth of AI/AN population is their low rate of employment. Without steady and stable work, it is difficult for any individual to rise out of poverty. Without a well-paying job, it is difficult to save, purchase a home, and build wealth. Therefore, increasing AI/AN employment appears key to addressing Native American poverty and to build Native American wealth. While the *unemployment* rate is the most commonly used measure of joblessness, it is not the best measure for populations suffering from chronically high unemployment, such as AI/AN

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[176] Retrieved from https://www.federalregister.gov/articles/2014/01/22/2014-01303/annual-update-of-the-hhs-poverty-guidelines

[177] Economic Policy Institute. Family Budget Calculator. Retrieved from http://www.epi.org/%20resources/budget/

[178] Kids Count 2015 Data Book, p.20.

[179] Id at p. 33.

[180] U.S. Census Bureau: 2011-2013 American Community Survey. Retrieved from https://www.census.gov/content/dam/Census/newsroom/facts-for-features/2015/cb15-ff07_asian_american-pacific_islanders.pdf

[181] M. Chang, *Lifting as We Climb: Women of Color, Wealth, and America's Future*, 2010, p. 14. Retrieved from http://www.insightcced.org/uploads/CRWG/LiftingAsWeClimb-WomenWealth-Report-InsightCenter-Spring2010.pdf

[182] Insight Center for Community Economic Development, *The Racial Gap in Homeownership and Home Lending* (2009). Retrieved from http://www.insightcced.org/uploads/CRWG/Racial%20Gap%20in%20Homeownership%20Spring%202009.pdf

populations. In these communities a significant segment of the population stops looking for work because their odds of finding work are historically and persistently very low. Once someone stops looking for work, they are no longer counted as unemployed because they are not defined as in the labor force. To be "unemployed," one has to be actively looking for work. For these reasons, the *employment* rate, or the employment-to-population ratio, is a better measure for populations suffering from chronically high unemployment. Here, the measure of AI/AN employment reflects the share of the AI/AN population that is working. Whether or not individuals are actively looking for work does not affect this measure.

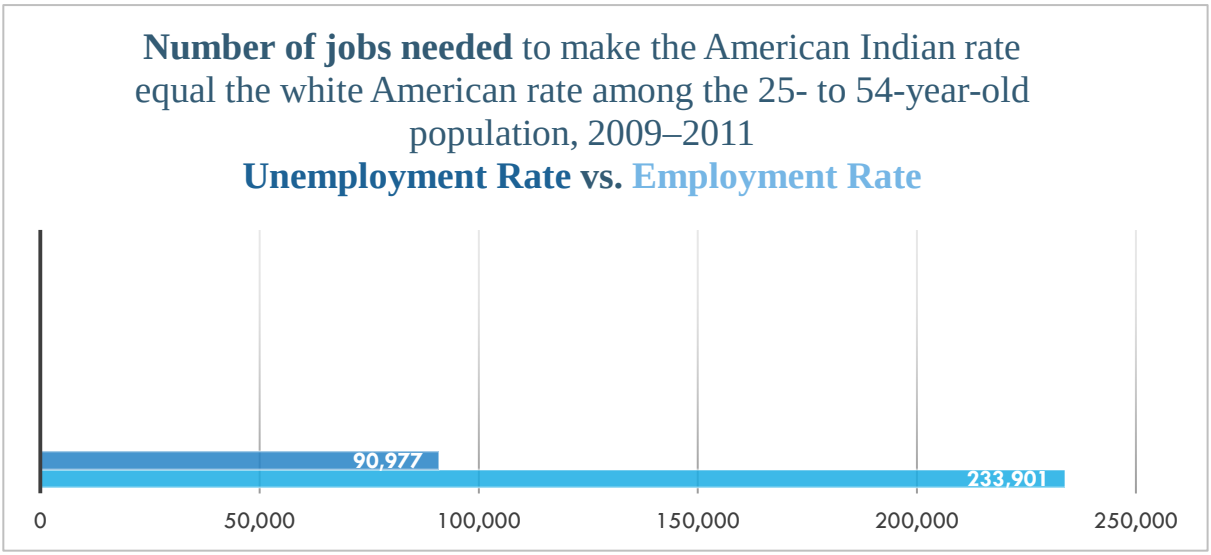
Over the course of 2009-2011, data from the American Community Survey (ACS) demonstrated the AI/AN employment rate among 25-54 year olds was 64.7 percent, 13.4 percentage points lower than white Americans. This is a very large disparity. While the ACS has a relatively large sample of American Indians, there is reason to believe that the survey still underrepresents the most disadvantaged Native Americans.[183] This is so because the more disadvantaged a population is, the harder it is to ensure representative coverage in surveys.[184]

For all 25- to 54-year-olds, the Great Recession resulted in a 3.1 percentage-point decline in the employment rate from 2007 to 2010.[185] Relative to white Americans, AI/ANs typically live under economic conditions comparable to a recession with impacts four times as harmful as the Great Recession's overall effects. The figure below illustrates the value of focusing on the *employment* rate over the *unemployment* rate by showing that to reduce the AI/AN *un*employment rate among the 25- to 54-year-old population to the white American rate would require approximately 91,000 jobs. In contrast, to *increase* the AI/AN *employment* rate to the white American rate would require more than twice as many jobs—about 234,000. This is a significant difference.

[183] N. DeWeaver, *The American Community Survey: Serious Implications for Indian Country* (unpublished white paper). (2010)

[184] J. Schmitt and D. Baker, *Missing Inaction: Evidence of Undercounting of Non-Workers in the Current Population Survey*. Center for Economic and Policy Research (2006)

[185] S. Ruggles, T. Alexander, K. Genadek, R. Goeken, M. Schroeder, M. Sobek, *Integrated Public Use Microdata Series: Version 5.0 (machine readable database)* University of Minnesota (2013) reported in *Native Americans and Jobs*, Economic Policy Institute (2013).



The data demonstrates that, while the employment rate of American Indians on reservations (63.4 percent) is lower than that of those off reservations (65.9 percent), both rates are low and only 2.5 percentage points apart.[186] Therefore, it is reasonable to conclude that the low AI/AN employment is not limited to the on-reservation population.

The factor that appears to most increase AI/AN's odds of employment is educational attainment. Data shows that AI/ANs with advanced degrees have seven times the odds of AI/ANs s with less than a high school education. The odds decline for each step down in educational attainment, but even AI/AN GED holders have about 50 percent greater odds of being employed than otherwise similar AI/ANs with less education.[187] Finally, even when AI/ANs are similar to white Americans in terms of factors such as age, sex, education level, marital status, and states of residence, their odds of being employed are 31 percent lower than those of white Americans.[188] According to Algernon Austin, author of a 2013 Economic Policy Institute (EPI) report on Native American unemployment, "American Indians suffer from a variety of problems somewhat similar to African Americans. You have lower levels of education [and] continued discrimination in the labor market… improving education attainment of American Indians would likely produce a significant increase in their employment rates."[189]

[186] Id.

[187] Id.

[188] Administration for Native Americans, Division of Policy, Analysis of American Community Survey data 2009-2011.

[189] A. Austin, *Native Americans and Jobs: The Challenge and The Promise*, Economic Policy Institute, Briefing Paper #370, (December 2013) Retrieved from http://s3.epi.org/files/2013/NATIVE-AMERICANS-AND-JOBS-The-Challenge-and-the-Promise.pdf

When jobs are not available in AI/AN home communities, job seekers must leave such communities to access job opportunities. In addition, when jobs (and the resources they bring) are not available on reservations or tribal communities, it forces people to spend money elsewhere. For example, a dollar that someone in the local AI/AN community could earn for providing services like repairing a car, selling groceries, or offering professional services, are simply not present when goods and services are not available in AI/AN communities due to lack of capital, lack of skills, lack of education or vocational training, or other reasons. This, in turn, contributes to Native American communities being less self-sufficient because they are unable to create jobs within the community. Finally, since there are approximately 1.2 million AI/AN youth between under the age of 24, there is a large bubble in the 15-24 age group that require training and education in order to participate in the increasing advanced and technical U.S. economy.

PART II. HHS RESPONSES TO THE SOCIAL AND ECONOMIC CONDITIONS OF NATIVE AMERICANS

Part II of this Report contains summaries of available data from the Staff Divisions and Operating Divisions in the Department reflecting responses to the social and economic conditions of Native Americans through grant awards, contracts, training, technical assistance, and other supports in 2014. The data is this Part demonstrates the extent to which HHS programs and services support a wide spectrum of health and human services activities aimed at removing barriers that stand between Native Americans and their opportunities to succeed.

A. FINANCIAL ASSISTANCE – RESPONSE TO CONDITIONS

OFFICE OF THE SECRETARY – OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

The Office of the Assistant Secretary for Health (OASH) oversees 12 core public health offices — including the Office of the Surgeon General and the U.S. Public Health Service Commissioned Corps — as well as 10 regional health offices across the nation and 10 Presidential and Secretarial advisory committees. OASH promotes the development and utilization of best practices, program and policy development, and capacity-building for direct care services for American Indians, Alaska Natives, Native Hawaiians, and Pacific Islanders. In FY 2014, OASH public health offices awarded $7,575,145 to address health disparities, improve data collection and research ethics, set and measure national health improvement goals, develop HIV/AIDS research and programming, address the unique health promotion and disease prevention needs of women and adolescents, improve pregnancy outcomes through awareness programming, and ensure the emergency preparedness of the nation’s first responders.

OFFICE OF MINORITY HEALTH

In FY 2014, the Office of Minority Health (OMH) provided 13 continuation awards, in the amount of $2,865,298, to 11 Native American organizations and to those providing services to Native American populations that specifically address disease prevention and health promotion. The Office of Minority Health (OMH) did not have any new competitive funding opportunities specific to or awarded to American Indian/Alaska Native (AI/AN) organizations in FY 2014.

OFFICE OF MINORITY HEALTH RESOURCE CENTER

The Office of Minority Health Resource Center (OMHRC) was established in 1987 as one of its initial efforts to respond to recommendations of the 1985 Report of the Secretary's Task Force on Black and Minority Health. First authorized by statute in 1990, it was reauthorized along with OMH by the Patient Protection and Affordable Care Act of 2010 (42 USC 300u-6). OMHRC serves as OMH's connection to the public for health disparities and minority health information, resources, and capacity building services. OMHRC houses vital information, virtually accessible, regarding health and health disparities and provides capacity building training for minority-serving nonprofits, as well as training to local and state health departments seeking to work more effectively with communities of color. Requests for OMHRC training on effective grant writing for community constituent groups is a service frequently provided to AI/AN tribes and organizations. OMHRC houses the nation's largest repository of information on health issues specific to African Americans, American Indians/Alaska Natives, Asian Americans, Hispanics, Native Hawaiians, and Pacific Islanders. To date, the Knowledge Center collection includes over 50,000 documents, journal articles and organizational profiles about or related to minority health issues. There are five main functional areas: Library/Knowledge Center Services, Information Services, Information Technology, Communications, and Capacity Building.

In FY 2014, OMHRC awarded a total of 5 grants totaling $395,590 to support the Guam Office of Minority Health to address the non-communicable disease burden in areas such as substance abuse, nutrition, alcohol abuse, and obesity; to support the design and implementation of an on-line assessment of core competencies for public health professionals and organizational infrastructure; to fund Health Information Campaign contracts in Guam and Hawaii; host the Micronesian Youth Services Network regional conference; and support to the non-profit Congress in Guam to explore and exchange ideas, programs and strategies to implement best practices in Guam, the CNMI, Hawaii, and the Republic of the Marshall Islands.

OFFICES OF REGIONAL HEALTH ADMINISTRATOR – REGION V

The Minority Health Interstate and Tribal Data Quality Workgroup, housed in Region V, met monthly from January 2014 through November 2014 to: (1) identify data gaps and challenges to collecting, analyzing, and reporting accurate and reliable health status data on all racial and ethnic minority populations including AIs; and (2) work collaboratively to improve the availability and quality of indigenous, racial, and ethnic minority health data. Throughout 2014,

the Workgroup met to develop a framework that will result in the Region V Minority Health Profile Report. In addition, the Regional Minority Health Consultant (RMHC) attended the U.S. Department of Health and Human Services, Region V, and the Midwest Alliance of Sovereign Tribes Tribal Consultation Meeting. Finally, the Health Resources and Services Administration (HRSA) and RMHC began planning for a grant writing workshop for tribes scheduled for summer 2015 in the IHS Bemidji Area. The training will be coordinated by the OMHRC.

OFFICE OF POPULATION AFFAIRS

The Office of Population Affairs (OPA) serves as the focal point to advise the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including adolescent pregnancy, family planning, and sterilization, as well as other population issues. In 2014, the OPA Region IX office provided support through discretionary Title X grants to address Native American, Native Hawaiian and Pacific Islander communities experiencing high teen pregnancy and STD rates. These communities frequently have higher rates of maternal and infant morbidity and mortality related to multiple causes including a lack of prenatal care, high rates of diabetes, and substance abuse. They frequently experience difficulty accessing medical services due to geographical and transportation challenges, financial obstacles to paying for care, and concerns related to receiving confidential care in small communities. In addition to direct funding to multiple grantee organizations for clinical and community education services, there were several sub-recipient agencies of the statewide grantee in Hawaii, which focus on the Native Hawaiian population. The Title X program also offers training and technical support to all funded agencies through the Family Planning National Training Centers. In 2014, they provided information on a wide range of topics from administrative issues to the Affordable Care Act outreach and enrollment support and up-to-date information on the latest in evidence-based clinical care. In FY 2014, OPA funded six awards for a total of $3,600,100 to Native American, Native Hawaiian, and Pacific Islander applicants. In FY 2014, the funded agencies increased the number of unique clients to whom they provided services and support.

ADMINISTRATION FOR CHILDREN AND FAMILIES

The Administration for Children and Families (ACF) is comprised of numerous grant making or contracting offices, including Regional offices around the country. Each office is specialized in its mission, supporting a variety of initiatives that empower Native American families and individuals and improve access to services in order to create strong, healthy Native American communities. The grant-making offices included in the 2014 Report are:

- The Administration for Native Americans
- The Administration on Children, Youth, and Families,
    - The Children's Bureau
    - The Family and Youth Services Bureau
- The Office of Child Care
- The Office of Child Support Enforcement
- The Office of Community Services

- The Office of Family Assistance
- The Office of Head Start

ACF's programs fund a variety of programs and projects, the breadth of which allows it to positively affect the lives of Native American individuals and families.

ADMINISTRATION FOR NATIVE AMERICANS (ANA)

Established in 1974 through the Native American Programs Act (NAPA), the Administration for Native Americans (ANA) serves all Native Americans, including federally recognized tribes, American Indian and Alaska Native organizations, Native Hawaiian organizations and Native populations throughout the Pacific Basin (including American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands). ANA promotes self-sufficiency for Native Americans in two ways. First, ANA provides discretionary grant funding, training, and technical assistance in support of community-based projects that address the current social and economic conditions in Native American communities. The second way in which ANA promotes Native American social and economic self-sufficiency is through advocacy and policy development on behalf of Native Americans.

ANA's support of Native American self-sufficiency is based on the following core principles:

- Native communities are self-sufficient when they generate and control the resources necessary to meet their social and economic goals and the needs of community members.
- The responsibility for achieving self-sufficiency resides with Native governing bodies and local leadership.
- Progress toward self-sufficiency requires planning and resources consistent with long-range community goals.

ANA's project grants are awarded under three main program areas: (1) Social and Economic Development Strategies (SEDS); (2) Native Language Preservation, Maintenance and Immersion; and (3) Environmental Regulatory Enhancement (ERE).

SOCIAL AND ECONOMIC DEVELOPMENT STRATEGIES (SEDS)

ANA promotes social and economic self-sufficiency in communities through the award of SEDS grants. These competitive financial assistance grants support locally determined projects designed to reduce or eliminate community problems and achieve community goals. Native American communities are encouraged to plan and implement projects that increase community and individual productivity through community development that is sustainable. SEDS grants fund social and economic development projects in on- and off-reservation Native communities and provide federal support for self-determination and self-governance among Native American people. Special initiatives under the SEDS program in 2014 include Sustainable Employment and Economic Development Strategies (SEEDS) and the Native Asset Building Initiative (NABI). In 2014, ANA funded 63 new or continuation SEDS grants, totaling approximately$13.8 million.

In 2013, ANA launched a special SEDS funding initiative: Sustainable Employment and Economic Development (SEEDS). The four priorities that ANA promoted through the SEEDS initiative were: the creation of sustainable employment opportunities; the provision of professional training and skill development to increase participants' employability and earning potential; the creation and development of small businesses and entrepreneurial activities in Native American communities and; a demonstrated strategy for and commitment to keeping jobs and revenue generated by project activities within the Native communities being served. In 2014, ANA awarded 29 new and continuation SEDS- SEEDS grants, totaling approximately$10.2 million.

In 2012, ANA launched a special SEDS funding initiative: Native Assets Building Initiative (NABI). NABI is a partnership between ANA and Office of Community Services (OCS). The partnership focuses on building the capacity of tribes and Native organizations to effectively plan projects and develop competitive applications for funding under the OCS' Assets for Independence (AFI) program. The AFI focus of each project requires that eligible participants are given access to matched savings accounts, called Individual Development Accounts (IDAs), in which participants save earned income for the purchase of a home, for business capitalization, or to attend higher education or training. Participants are also given access to other supportive services that enable them to become more financially secure. The IDA portion of the project is funded by OCS.

ANA funds may be used to pay for costs associated with the administration of the AFI-funded IDA project and the provision of other asset building activities, such as financial literacy education and coaching on money management and consumer issues. Applicants submit one application identifying a single work plan with two budgets, reflecting OCS-AFI funding and ANA-SEDS funding separately. Each successful application receives two awards; one from OCS, and one from ANA. In 2014, ANA awarded the following 11 new and continuation SEDS- NABI grants, totaling approximately $2.7 million.

NATIVE LANGUAGES (NL)

ANA awards Native Language Preservation and Maintenance and Esther Martinez Native Language Immersion grants to support Native Americans efforts to preserve and strengthen Native community's cultures. Such grants address both social and economic conditions of Native Americans because the use of Native language builds identity and encourages community progress toward social unity and self-sufficiency. Recognizing that the history of federal policies toward Indian and other Native American people has resulted in a dramatic decrease in the number of Native American languages that have survived over the past 500 years, Congress enacted the Native American Languages Act (Public Laws 101-477 and 102-524). The intent of the Act is to assist native communities to reverse this decline. In addition, in 2006, Congress passed the Esther Martinez Native American Languages Preservation Act (Public Law 109-394). The law amends the Native American Programs Act of 1974 to provide for the revitalization of Native American languages specifically through Native language immersion and restoration programs. ANA funding provides opportunities to assess, plan, develop and implement projects to ensure the survival and continuing vitality of native languages. Applicants for funding are encouraged to involve elders and other community members in determining proposed language

project goals and implementing project activities. In 2014, ANA made 42 new and continuation Native language Preservation and Maintenance (P&M) grant awards, totaling approximately $8.1 million, and 21 new and continuation Esther Martinez Native American Language Immersion (EMI) grant awards, totaling approximately $4.3 million.

ENVIRONMENTAL REGULATORY ENHANCEMENT

Growing awareness of environmental issues on Indian lands has resulted in increased attention to address these issues. ANA's Environmental Regulatory Enhancement (ERE) grants provide tribes with resources to develop legal, technical and organizational capacities for protecting their natural environments. ERE projects focus on environmental programs in a manner consistent with tribal culture for Native American communities. They build tribal capacity, allowing involvement in all aspects of each project, including environmental issue identification, planning, development, and implementation.

The links between tribal sovereignty, organizational capacity and protection of the environment are central components of the ERE program. Applicants are required to describe a land base or other resources (a river or body of water, for example) over which they exercise jurisdiction as part of their application. In 2014, ANA made 12 new or continuation ERE grant awards, totaling approximately $1.7 million.

ADMINISTRATION ON CHILDREN, YOUTH, AND FAMILIES

The Administration on Children, Youth and Families (ACYF) oversees programs that support:

- Social services that promote the positive growth and development of children, youth and their families
- Protective services and shelter for children and youth in at-risk situations
- Adoption for children with special needs

These programs provide financial assistance to states, community-based organizations, and academic institutions to provide services, carry out research and demonstration activities, and manage training, technical assistance and information dissemination. A Commissioner appointed by the President leads the ACYF which is comprised of two bureaus—the Children's Bureau and the Family and Youth Services Bureau—each responsible for different issues involving children, youth and families. Each Bureau has an Associate Commissioner. The Children's Bureau (CB) focuses on improving the lives of children and families through programs that reduce child abuse and neglect, increase the number of adoptions that support and nurture children, and strengthen foster care. The Family and Youth Services Bureau (FYSB) supports the organizations and communities that work to put an end to youth homelessness, adolescent pregnancy, and domestic violence.

CHILDREN'S BUREAU

The Children's Bureau (CB) collaborates with federal, state, tribal and local agencies to improve the overall health and well-being of our nation's children and families. With an annual budget of almost $8 billion, CB provides support and guidance to programs that focus on:

- Strengthening families and preventing child abuse and neglect,
- Protecting children when abuse or neglect has occurred; and
- Ensuring that every child and youth has a permanent family or family connection.

Federally-recognized Tribes, tribal organizations and tribal consortia are eligible to apply to receive direct funding for formula grant programs authorized under titles IV-B and IV-E of the Social Security Act.

The Stephanie Tubbs Jones Child Welfare Services Program assists states and Tribes to improve their child welfare services with the goal of keeping families together. States and Tribes provide services in support of the following purposes: (1) protecting and promoting the welfare of all children; (2) preventing the neglect, abuse, or exploitation of children; (3) supporting at-risk families through services which allow children, where appropriate, to remain safely with their families or return to their families in a timely manner; (4) promoting the safety, permanence, and well-being of children in foster care and adoptive families; and (5) providing training, professional development and support to ensure a well-qualified child welfare workforce. Services are available to children and their families without regard to income. In FY 2014, CB made 189 awards under the Stephanie Tubbs Jones Program totaling $6,329,344.

The Promoting Safe and Stable Families (PSSF) Program provides grants to state and eligible Tribes to support operation of a coordinated program of family preservation services, community-based family support services, time-limited reunification services, and adoption promotion and support services. In FY 2014, CB made 135 awards totaling $10,284,150. Eight tribes that applied were not awarded funding as a special provision in the Social Security Act at section 432(b)(2)(B) prohibits making grant awards to Tribes whose allotment under the statutory formula would be less than $10,000.

Two programs—the Chafee Foster Care Independence Program (CFCIP) and Education Training Vouchers (ETV)—provide funds to states and eligible Tribes to help youth in foster care and former foster youth ages 18-21 make a successful transition from foster care to self-sufficiency by providing educational, vocational and other services and supports. The ETV program provides funds for vouchers for postsecondary education and training. Tribes with an approved title IV-E directly operate a title IV-E program or Tribes that have a title IV-E Tribal/State cooperative agreement or contract have the option to apply to receive a grant directly from ACF. In FY 2014, CB made four awards totaling $84,808 under the CFCIP and three awards totaling $24,436 under the ETV program.

Since FY 2009, CB has published an annual Funding Opportunity Announcement (FOA) for title IV-E Plan Development Grants. The purpose of the FOA is to make one-time grants to tribes, tribal organizations, or tribal consortia that are seeking to develop, and within 24-months of grant receipt, submit to CB a plan to implement a title IV-E foster care, adoption assistance and, at

tribal option, guardianship assistance program. Tribes may use grant funds for purposes such as developing code and policies to meet IV-E requirements; developing a cost allocation methodology; developing capacity to collect and report data; developing or strengthening case planning and case review systems; and training agency staff and stakeholders. Grantees may apply for up to $300,000. In 2014, ten tribes applied for title IV-E plan development grants and five tribes were awarded funding effective September 30, 2014.

In addition to the above, Indian tribes are eligible, under 42 USC 679c, for formula funds to support tribal foster care, kinship guardianship, and adoption assistance payments and programs.

FAMILY AND YOUTH SERVICES BUREAU

The Family and Youth Services Bureau (FYSB) is comprised of two divisions: the Division of Adolescent Development and Support (DADS) and the Division of Family Violence Prevention and Services (FVPSA). In addition, FYSB supports nationwide crisis hotlines for runaway youth and victims of domestic violence. The FYSB funds an array of programs at the state, tribal and community levels.

Division of Adolescent Development and Support

The Division of Adolescent Development and Support is responsible for two major grant programs: the Adolescent Pregnancy Prevention (APP) Program and the Runaway and Homeless Youth (RHY) Program.

Through its APP Program, to prevent pregnancy and the spread of sexually transmitted infections among adolescents, FYSB supports state, tribal and community efforts to promote comprehensive sex education, adulthood preparation programs and abstinence education. The Tribal Personal Responsibility Education Program (Tribal PREP) promotes proven and culturally appropriate methods for reducing adolescent pregnancy, delaying sexual activity among youths and increasing condom use and other contraceptives among sexually active youth in native communities. Programs follow design guidelines intended to honor tribal needs, traditions and cultures. Discretionary grants are available to tribes to combat the disproportionately high rates of teen pregnancy and birth. Tribal PREP programs are authorized for funding through the end of FY 2014 and included a planning year as well as three implementation years. Programs were encouraged, to the extent possible, to use models (or elements of models) of existing adolescent pregnancy prevention programs that have been proven by scientific research to be effective in changing behavior. If existing models could not be adapted for a particular Tribe or Native community, programs must show how new strategies were likely to be effective based on the unique cultural needs of their youth and relevant theories of behavior change. This practice-based evidence may be drawn from prior experiences, practices, or customs from an array of promising youth-serving programs.

Tribal PREP programs targeted youth, ages 10-19, at the highest risk or vulnerable for pregnancies. This group included, but was not limited to, youth in or aging out of foster care, homeless youth, youth with HIV/AIDS, pregnant and/or parenting youth who were under 21 years of age, and youth who lived in areas with high adolescent birth rates. In addition to

educating youth about abstinence and contraceptive use, Tribal PREP projects also prepared young people for adulthood by addressing three or more of the subjects below:

- Healthy relationships, including development of positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage and family interactions;
- Positive adolescent development, including promotion of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects;
- Financial literacy, to support the development of self-sufficiency and independent living skills;
- Parent-child communication skills;
- Education and employment preparation skills; and
- Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

In FY 2014, 16 tribes and tribal organizations received a total of $3.6 million in Tribal PREP funds. Additionally, three Pacific Island grantees received $1.03 million in PREP funding. Each of the Tribal PREP grantees incorporated strategies into their programs that helped address the challenges and barriers existing around teen pregnancy prevention – many of which relate to those issues ancillary to the essence of adolescent sexual health. Isolation, chemical dependency, family dysfunction, poverty, and other factors were addressed to effectively reduce teen pregnancy rates in the community. A number of grantees took a multi-faceted, culturally-grounded approach to the sexual health of their youth. For example, Tewa Woman United (TWU) in New Mexico, implemented a project, the first of its kind in Tewa speaking Pueblo communities, that served a diversity of Native youth (each of the six Tewa speaking pueblos is unique) and acknowledged the burden of unresolved grief from historical and intergenerational trauma that makes Native American youth vulnerable to risks and causes barriers to healthy behaviors. In another example, the Turtle Mountain Band of Chippewa developed an approach that ensures wherever possible, adherence to the values and norms of the Chippewa culture will be adapted into determined evidence-based program models. Tribal PREP projects and the FYSB staff worked to address local conditions and the challenges of Native American youth in a wide array of settings. PREP Tribal organizations such as the California Rural Indian Health Board, Inc. (CRIHB) and the Inter Tribal Council of Arizona, Inc. frequently engaged in coalition-based efforts addressing multiple locations. In this way, they overcame distance and the constraints of small staffs by coordinating across regions and settings.

Widespread concern emerged in the early 1970s about youth who were away from home and in at-risk situations, often through no fault of their own. At that time, efforts to help these young people were primarily local with few federal resources available to help shelter runaway and homeless youth or reunite them with their families. The 1974 Juvenile Justice and Delinquency Prevention Act (Public Law 93-415) changed this. Through Title III, now named the Runaway and Homeless Youth Act, Congress provided for the creation of community shelters called basic centers that would provide emergency care to runaway young people who weren't already receiving services from the child welfare or juvenile justice systems. In 1975, FYSB funded the

first 66 basic centers with $5 million. In FY 2014, 299 grantees received a total of $53.35 million, including 2 AI/AN grantees. Data on runaway and homeless youth served by FYSB-funded grantees is maintained in the National Extranet Optimized Runaway and Homeless Youth Management Information System (NEO-RHYMIS). The NEO-RHYMIS collects information twice during the fiscal year from grantees on the basic demographics of the youth, the services they received, and the status of the youth (i.e., expected living situation, physical and mental health, and family dynamics) upon exiting the programs.

According to the FY2012 NEO-RHYMIS report of all grantees, while AI/AN youth make up 1 percent of the service population, they make up 2.4 percent of the youth aged 10-19 served by grantees. NHPI youth make up approximately 0.2 percent of the service population, they make up 0.6 percent of the youth aged 10-19 served by grantees.

FYSB's Basic Center Program (BCP) is intended to establish or strengthen community-based programs that meet the immediate needs of runaway and homeless youth and their families. The programs provide youth up to age 18 with emergency shelter, food, clothing, counseling and referrals for health care. Most basic centers can provide 21 days of shelter for up to 20 youth at a given time. There are exceptions for jurisdictions that have different standards for licensing. Basic centers seek to reunite young people with their families, whenever possible, or to locate appropriate alternative placements. In 2014, Basic Centers provided emergency shelter for more than 30,000 youth on the streets. In FY 2014, two AI/AN grantees received BCP funding.

In addition to BCP grants, FYSB awards grants under the Transitional Living Program (TLP) that support projects that provide long-term residential services to homeless youth to help them make a successful transition to self-sufficient living. Young people must be between the ages of 16 and 22 to enter the program. The services offered are designed to help young people who are homeless, have left the homes of parents due to family conflict, or have left and are not expected to return home. Pregnant and/or parenting youth are eligible for TLP services. Transitional living programs are required to provide youth with stable, safe living accommodations, and services that help them develop the skills necessary to become independent. Living accommodations may include host-family homes, group homes, maternity group homes, or supervised apartments owned by the program or rented in the community. In 2014, transitional living programs helped nearly 3,000 homeless youth transition to life on their own. In FY 2014, 200 grantees received $43.65 million in TLP funding, including one AI/AN grantee.

Division of Family Violence Prevention and Services

The Family Violence Prevention and Services Act (FVPSA) provides the primary federal funding stream dedicated to providing immediate shelter and supportive services for victims of family violence, domestic violence or dating violence and their dependents. Of the $135 million available to FYSB for FVPSA activities in 2014, approximately $13.3million in FVPSA formula grants were distributed based on population to 238 Tribes in 27 states. Local tribal domestic violence programs served 30,860 victims of domestic violence and their children in 2014. This is 2.3 percent of clients served by FVPSA-funded programs. Thirty-six percent of those served by

tribal programs were under the age of 18 and 15 percent were between 18-24. Eighty-eight percent of adults served were female, 12 percent were male and 10,646 were children. In 2014, tribal grantees provided an average of 18 shelter nights for each individual served, but had 1,101 unmet shelter requests (a count of the number of unmet requests for shelter due to programs being at capacity).[190]

FYSB-funded tribal programs, paid staff and over 3,800 volunteers in tribal domestic violence programs provided supportive services for individuals and in groups. Supportive services included crisis intervention, safety planning, support groups, individual counseling, educational services, legal advocacy, personal advocacy, housing advocacy, medical advocacy, information/referral, transportation and home visits. Over 86,200 crisis calls were made to local tribal domestic violence programs for crisis counseling, shelter services or other services. Almost 90,000adults and youth received education and prevention presentations.[191]

Local domestic violence programs provided immediate shelter to victims of domestic violence and their dependents. Tribal programs may operate their own shelter facilities, contract with hotels, or access volunteer safe homes to meet the needs of victims.

C. OFFICE OF CHILD CARE

The Office of Child Care (OCC) supports low-income working families by providing access to affordable, high-quality early care and afterschool programs. The Child Care and Development Fund (CCDF), authorized by the Child Care and Development Block Grant Act (CCDBG) and Section 418 of the Social Security Act, makes block grants available to States, Territories, and tribes to assist low-income families, families receiving temporary public assistance, and those transitioning from public assistance in obtaining child care so they can work or attend training or receive education. CCDF promotes quality child care to support children's healthy development and learning by supporting child care licensing, quality improvement systems to help programs meet higher standards and support for child care workers to attain more training and education. To support CCDF services, OCC establishes and oversees the implementation of child care policies and provides guidance and technical assistance to States, Tribes and territories as they administer CCDF programs. In 2014, OCC provided a total of $105.5 million in CCDF funds to AI/AN and Native Hawaiian grantees and an additional $9.5 million to grantees in America Samoa, Guam, and the Confederated Northern Mariana.

D. OFFICE OF CHILD SUPPORT ENFORCEMENT

Federal funding for tribal child support enforcement programs is based on a tribal Child Support Enforcement (CSE) application, which includes the proposed budget and a description of the nature and scope of the tribal CSE program and gives assurance that the program will be administered in conformity with applicable requirements of the CSE program (Title IV-D of the Social Security Act), federal regulations, and other official issuances of HHS that specifically apply to tribes and tribal organizations. A tribe or tribal organization may apply for federal

[190] See Tribal Domestic Violence Services Data Sheet at http://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_tribal_20150731.pdf
[191] Id.

funding in one of two ways. First, a tribe or tribal organization may apply to operate a CSE program that meets all of the 14 mandated requirements (as specified in federal regulations) for a tribal CSE program. If the tribe or tribal organization can apply on this basis, it is considered a comprehensive tribal CSE program if approved by the HHS Secretary. If a tribe or tribal organization does not currently meet the regulatory requirements, it may apply for start-up funding. A tribe or tribal organization that applies on this basis (and has such a plan approved) is considered to be operating a tribal CSE start-up program. Unlike state CSE programs that are funded by both state and matching federal dollars, tribal CSE programs that are designated as start-up programs can be funded solely by federal dollars. Tribal CSE programs that are considered fully operational (i.e., comprehensive programs) are funded at 90 percent of total program expenditures for the first 3 years of the program, and at 80 percent subsequently. The non-federal share of CSE program expenditures may be in cash and/or in-kind, fairly valued, by the tribe or tribal organization and/or by a third party. Both state and comprehensive tribal CSE programs are entitlement programs and they both receive mandatory funding on an open-ended basis (meaning that they receive federal matching funding for all reasonable, necessary, and allocable expenditures on the CSE program). As of April 2014, 54 federally recognized Indian tribes received Title IV-D funding to operate comprehensive tribal child support programs with an additional 7 continuing to receive start-up planning funds to put a program in place. In 2014, four tribes transitioned from the start-up phase to full comprehensive program status and one new start-up application was approved. The start-up phase allows the time for tribes to develop a culturally appropriate child support program that meets the federal requirements. In FY 2014, OCSE provided a total $45,848,333 to Indian tribes and tribal organizations.

E. OFFICE OF COMMUNITY SERVICES

The Office of Community Services (OCS) partners with states, communities and agencies to eliminate causes of poverty, increase self-sufficiency of individuals and families and revitalize communities. Our social service and community development programs work in a variety of ways to improve the lives of many. OCS's main goals are to:

- Serve the economic and social needs of low-income individuals and families
- Provide employment and entrepreneurial opportunities
- Promote individual self-sufficiency through the creation of full-time, permanent jobs
- Assist community development corporations in utilizing existing funding for neighborhood revitalization projects
- Provide financial and technical resources to state, local, public and private agencies for economic development and related social service support activities
- Provide energy assistance to low-income households

The Office of Community Services (OCS) administers 5 social service and community development initiatives. These are:

1. Assets for Independence (AFI), including the Native Asset Building Initiative (NABI)
2. Community Economic Development (CED)
3. Community Services Block Grant (CSBG)

4. Low Income Home Energy Assistance Program (LIHEAP), including the Leveraging Incentive Program and the Residential Assistance Challenge Program (REACH)
5. Rural Community Facilities Program

Assets for Independence

OCS administers the Assets for Independence (AFI) program, a competitive, discretionary grant program with authority to make awards to non-profit entities that demonstrate a collaborative relationship with a local community-based organization whose activities are designed to address poverty in the community and the needs of community members for economic independence and stability.

AFI grants support local demonstration projects that provide special-purpose, matched savings accounts called Individual Development Accounts (IDAs) to eligible individuals. Every dollar of earned income that an AFI project participant deposits into their IDA is matched (from $1 to $8 in combined federal and non-federal funds) by the AFI project. AFI participants use their IDAs and project matching funds for one of three allowable assets: purchase a first home; capitalize or expand a business; or fund post-secondary education or training. AFI grantees also assist participants in obtaining the skills and information necessary to achieve economic self-sufficiency. Grantees are encouraged to tailor the strategies and services they offer to the needs of their project participants and the opportunities in their community. Examples of activities in this area include financial education, asset-specific training, financial coaching, credit-building services, credit/debt counseling, and assistance with tax credits and tax preparation. AFI projects may also provide other supportive services for participants. Grantees often work with a variety of partners (e.g., financial institutions, community-based organizations, etc.) in order to implement their project successfully.

AFI currently has grantees that are serving the Native American, Native Hawaiian and Alaskan Native communities. As referenced above in the Administration for Native Americans (ANA) subsection, OCS and ANA have collaborated since 2012 to focus on building the capacity of tribes and Native organizations to effectively plan projects and develop competitive applications for funding under the AFI program.

ANA funds may be used to pay for costs associated with the administration of the AFI-funded IDA project and the provision of other asset building activities, such as financial literacy education and coaching on money management and consumer issues. AI/AN applicants submit one application identifying a single work plan with two budgets, reflecting OCS-AFI funding and ANA-SEDS funding separately with each successful application receiving two awards; one from OCS, and one from ANA. The IDAs and related services offered by AFI projects provide an opportunity for Native communities to cultivate their existing assets and expand asset building services within their communities.

In FY 2014, OCS reviewed 5 applications from tribes/tribal and Native applicants, and made 2 awards totaling $272,463.

Community Economic Development

Under Community Economic Development (CED), OCS awards funds to community development corporations (CDCs) that address the economic needs of low-income individuals and families through the creation of sustainable business development and employment opportunities. Eligible organizations are required to be private, non-profit organizations that are community development corporations (CDC) including Tribal and Alaskan Native organizations. CDCs must be governed by a tripartite board of directors that consists of residents of the community served, and local business and civic leaders. CDCs must have as their principle purpose planning, developing or managing low-income housing or community development projects. In addition to the traditional CED projects, starting in FY 2013, grant awards were made for the CED- Healthy Food Financing Initiative (HFFI). The HFFI promotes a range of interventions that expand access to nutritious foods, including developing and equipping grocery stores and other small businesses and retailers to sell healthy food in communities that currently lack these options. Residents of these communities are often found in economically-distressed areas, which are sometimes called "food deserts," and typically served by fast food restaurants and convenience stores that offer little or no fresh produce.

The CED program provides discretionary grant funds to tribes, tribal organizations, Native Hawaiians and/or Pacific Islander-serving organizations that are CDCs. In FY 2014, OCS received 6 applications from Native American applicants and awarded 3 CED and 1 HFFI grant totaling $2,418,522.

Community Services Block Grant

The Community Services Block Grant (CSBG) provides assistance to States, tribes, Territories and local communities working through a network of Community Action Agencies and other neighborhood-based organizations for the reduction of poverty, revitalization of low-income communities, and the empowerment of low-income families and individuals in rural and urban areas to become fully self-sufficient. The CSBG Act contains the following special provisions pertaining to payments to Indian tribes and tribal organizations:

- Indian tribes and tribal organizations may receive CSBG funds directly from HHS, if it is determined that the members would be better served through direct Federal funding rather than through state CSBG funding.
- All tribes and tribal organizations must be recognized as a state or Federally-recognized tribe in order to receive CSBG funding.
  The governing body of a tribe or tribal organization applies for direct funding under the CSBG Act by submitting a request to OCS and completing a CSBG application and related submissions that meet statutory requirements.

  State CSBG allocations are based, in part, on the eligible population. Tribal grants are calculated based on eligible population size relative to the eligible population within the state, and the state CSBG allocation is reduced by the share awarded directly to tribes. The allocation for each tribe and tribal organization is based on the population figures

from 33-year old census data dating to 1981 Census, unless there is an agreement between the state and tribe about current population figures. Because of the outdated Census information, the OCS, in its CSBG program, encourages the state and newly funded state or federally-recognized tribes to negotiate and agree on current population figures. Negotiated agreements between states and tribes are submitted in writing to OCS as part of the application process. Indian tribes and tribal organizations receiving direct CSBG funds provide services and activities addressing employment, education, better use of available income, housing, nutrition, emergency services and health care services to low-income Native American elders, adults, families, adolescents and young children.

In FY 2014, Tribal CSBG grantees used Emergency Assistance funds to prioritize meeting the basic self-sufficiency needs of low-income tribal members. Emergency Services include temporary housing, rent or mortgage assistance; cash assistance/short-term loans; energy or utility assistance; as well as emergency food, clothing and medical services. In 2014, 57 tribes and tribal organizations across 21 states received direct CSBG grant funding in the amount of $5.2 million.

Low Income Home Energy Assistance Program

The mission of the Low Income Home Energy Assistance Program (LIHEAP) is to assist low-income households, particularly those with the lowest incomes that pay a high proportion of household income for home energy, primarily in meeting their immediate home energy needs. A portion of the funding can be used for low cost residential weatherization assistance to improve a home's energy efficiency, such as through caulking, insulation, system repairs and replacements. Directly-funded LIHEAP grantees may also apply for two optional programs funded by LIHEAP, if funding is available. The Leveraging Incentive Program provides an additional grant based on how much additional, non-federal resources the grantee received and coordinated with its federal LIHEAP funding. Such resources can be cash, such as tribal funds, utility discounts or in-kind donations such as free or discounted air conditioning units. The Residential Energy Assistance Challenge Program (REACH) provides a supplemental grant based on a grantee's proposal to run a pilot or innovative project relating to home energy assistance and the health and safety of the household. Both types of grants must be implemented by the end of the federal fiscal year following the year of the grant.

Tribal grantees have a great deal of flexibility and discretion in the policies and procedures they set in administering their LIHEAP block grant funds in order to meet the unique needs of the Native Americans in their service territory. For example, grantees can provide certain assistance with LIHEAP funding to assist households affected by natural disasters, such as temporary housing if they are without home heating or cooling. The federal LIHEAP statute expects that grantees will target LIHEAP assistance to the most vulnerable members, such as low income households that pay the highest proportion of their income towards their home heating or cooling bills and have a senior, a person with a disability, and/or a young child. The federal statute also sets a range for grantees to establish their income eligibility threshold (the greater of 150 percent of federal poverty guidelines, FPG, or 60 percent of state median income, but no lower than 110 percent of FPG). LIHEAP grantees may add other eligibility criteria beyond the income

threshold if they wish. LIHEAP grantees also have discretion in how they set their LIHEAP benefit levels, provided they vary the benefit levels by at least three factors including household income, the number of eligible household members, and one or more factors about the household home energy need (such as the dwelling type, primary fuel source, or other similar factor). All LIHEAP grantees must provide some type of crisis assistance through at least March 15th each year, and such assistance must be provided within 48 hours for a regular crisis or 18 hours if it is a life-threatening crisis.

In FY 2014, OCS had $3.42 billion in funding available for LIHEAP with no contingency or emergency funds. Of the total amount available, 155 tribal grantees received funding totaling $38.7 million in direct LIHEAP funding, consisting entirely of regular LIHEAP block grants.

Rural Community Development

The Rural Community Development (RCD) is an OCS grant program that provides training and technical assistance for small water and wastewater systems in low-income rural communities to ensure that residents have access to safe water systems. In FY 2014, OCS awarded a total of $664,570 to two tribal organizations for use during a 12-month budget period. These funds assisted the tribes in achieving and maintaining compliance with the Safe Drinking Water Act, Clean Water Act, and other applicable state and tribal regulations. At this time OCS does not collect or maintain data on the specific needs of Native American Communities for which RCD grant funds may be accessed.

F. OFFICE OF HEAD START

Established in 1965, Head Start promotes school readiness for children in low-income families by offering educational, nutritional, health, social, and other services. Since 1965, Head Start has served more than 32 million children, birth to age 5, and their families. In 2014, Head Start was appropriated approximately $8.6 billion, including $7.8 billion awarded directly to public agencies, private nonprofit and for-profit organizations, tribal governments and school systems to operate Head Start programs in local communities. Of this amount, approximately $222.7 million (or slightly less than 3 percent) was awarded to Indian tribes and tribal organizations for AI/AN Head Start and Early Head Start programs to serve slightly more than 4 percent of Head Start/Early Head Start funded enrollment. In addition to the amount appropriated for the administration of local Head Start and Early Head Start programs, an additional $500 million was newly appropriated for Early Head Start-Child Care Partnerships and Early Head Start Expansion and training and technical assistance received $203.3 million to improve the quality of services provided by grantees.

The Office of Head Start (OHS) funds ten public and private non-profit entities to provide comprehensive early childhood development services in the territories of American Samoa, CNMI and Guam and in the state of Hawaii. Services in Hawaii are provided on the islands of Oahu, Maui, Molokai, Lanai, Kauai, and Hawaii. Although services are not specifically provided through Native Hawaiian organizations, 6,981 children and families who were identified as Native Hawaiian and/or are Pacific Islanders received Head Start and Early Head

Start services, according to the 2014 OHS Program Information Report (PIR). In 2014 the OHS awarded a total of $222,722,353 to tribal Head Start and Early Head Start grantees to provide services to 21,988 children.

G. OFFICE OF FAMILY ASSISTANCE

The Office of Family Assistance (OFA) is responsible for providing program guidance and technical assistance to:

- Federally recognized American Indian tribes and certain identified Alaska Native entities in development, implementation, and administration of tribal Temporary Assistance for Needy Families (TANF) programs;
- Federally recognized tribes and tribal organizations in implementation and administration of Native Employment Works (NEW) programs;
- Tribes and tribal organizations administering TANF programs in implementation and administration of Tribal TANF – Child Welfare Coordination projects; and
- Tribal entities in implementation and administration of Health Profession Opportunity Grants.

Where appropriate, OFA provides general and specific information, guidance, and technical assistance to tribes, tribal organizations, and state and federal agencies on issues relating to these programs, related legislation, and other initiatives affecting these programs.

Federally recognized Indian tribes can apply for funding to administer and operate their own TANF programs. This option is described under section 412 of the Social Security Act, as amended by Pub.L.104-193. As of January 1, 2015, there are 70 approved Tribal TANF programs. These programs serve 284 federally recognized Tribes and Alaska Native Villages. TANF gives federally recognized Indian tribes flexibility in the design of welfare programs that promote work and responsibility and strengthen families. Similar to states, they receive block grants to design and operate programs that accomplish one of the four purposes of the TANF program.

Indian tribes are required to submit a three-year Tribal TANF plan to the Secretary of the Department of Health and Human Services (HHS) through the Administration for Children and Families (ACF) for review and approval. The approved Tribal TANF programs then receive a portion of the state TANF block grant from the state where the tribe is located.

In FY 2014, OFA awarded $187,198,146 in annual Tribal Family Assistance Grant (TFAG) allocations to 65 tribes or tribal organizations.

The NEW program began July 1, 1997 and replaced the former Tribal JOBS program. In FY 2014, there were 78 NEW grantees including all of the entities eligible by law for NEW program funding. By law, only federally recognized Indian tribes and Alaska Native organizations that operated a Tribal JOBS program in FY 1995 are eligible for NEW program funding. NEW grant awards are set at FY 1994 Tribal JOBS funding levels. The purpose of the NEW program is to make work activities available to grantees' designated service populations and service areas.

Allowable work activities include job creation, educational activities, training and job readiness activities, and employment activities. NEW funds may be used for supportive and job retention services that enable participants to prepare for, obtain, and retain employment. In FY 2014, OFA awarded $7,558,020 in NEW grants to tribal organizations. In addition to administering Tribal TANF programs, fourteen Tribal TANF grantees administered discretionary grants in 2014 totalling $1,875,000 for the coordination of Tribal TANF and Child Welfare services to tribal families at risk of child abuse or neglect. These grant awards were intended to develop models of effective coordination of Tribal TANF and child welfare services provided to tribal families at risk of child abuse or neglect. These projects were tailored to meet the needs of each tribe and featured activities such as home visiting, multi-departmental teams, family resource centers, and moms' and dads' groups. The project period for these grants was three years beginning September 30, 2011 and ending September 29, 2014.

In 2014, five tribal grantees administered discretionary Health Profession Opportunity Grants (HPOG) that provided education and training to TANF recipients and other low-income individuals for occupations in the health care field that pay well and are expected to experience labor shortages or be in high demand. Total annual funding for these tribal HPOG cooperative agreements in FY 2014 was $9,086,887. The project period for these grants is 5 years, from September 30, 2010, to September 29, 2015.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

The mission of the Agency for Healthcare Research and Quality (AHRQ) is to produce evidence to make healthcare safer, higher quality, more accessible, equitable and affordable, and to work within HHS and with other partners to make sure that the evidence is understood and used. In FY 2014, AHRQ continued support for numerous efforts that focus on AI/AN populations. Among those were three that focused on improving health care data for AI/AN.

One grant was awarded for a project titled: *Biobanking in Native Communities: Culturally-driven Deliberations and Consensus*. This project addressed the data demonstrating that AI/ANs have striking cancer-related health disparities. Although AI/ANs might benefit from bio- specimen studies, their experience with unethical and unregulated research has led them to distrust scientists, especially genetic researchers. Sensitive issues include the ownership and appropriate use of bio-specimens and the relation between individual rights and tribal regulations. The project aims to: (1) Develop or adapt culturally appropriate educational materials; (2) Use these materials to conduct an educational session for a group of 30 AI/AN community members at each of our 7 sites; (3) Randomize participants at each site into a deliberative (DI) and a non-deliberative (NDC) group; (4) Use the TurningPoint audience response system to administer a survey to all participants 3 times: before and after the educational session, and again after the DI or NDC session; and (5) Evaluate and analyze survey and deliberative data for use by tribal entities and the National Congress of American Indians.

In addition, AHRQ entered into to two interagency agreements to support the Tribal Health Research Advisory Council and the Intradepartmental Council for Native American Affairs.

CENTERS FOR DISEASE CONTROL

The Centers for Disease Control and Prevention (CDC) works around the clock to protect America from health, safety, and security threats, both foreign and in the United States. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, result from human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same. CDC increases the health security of our nation. As the nation's health protection agency, CDC saves lives and protects people from health threats. To accomplish its mission, CDC conducts critical science and provides health information that protects our nation against expensive and dangerous health threats, and responds when these threats arise.

In FY 2014, CDC awarded more than $34.6 million through grants and cooperative agreements to Native American communities, including AI/AN tribes and Native American-, Native Hawaiian-, and Pacific Islander-serving organizations. In addition, more than $12.6 million in total funds were awarded through contracts to Native American communities, including AI/AN tribes, and Native American, Native Hawaiian, and Pacific Islander corporations or firms. The areas of funding and allocations are as follows:

Tribal Infectious Disease Control Laws - The Office for State, Tribal, Local, and Territorial Support (OSTLTS) awarded a total of $9,532,206 to seven tribal governments or organizations funded through the National Public Health Improvement Initiative (NPHII) that supported approximately 250 federally recognized tribes.

Infectious Diseases - CDC's National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) funded ongoing epidemiologic/analytical projects involving IHS, Alaska Native Tribal Health Consortium, CDC Arctic Investigations Program (AIP), and other agencies and CDC divisions. They are designed to detect and describe disease burden and health disparities for overall and specific infectious diseases among the AI/AN population. Analyses provide information for developing prevention strategies and vaccination policies, and reducing health disparities related to infectious diseases. Findings increase awareness of specific infectious diseases and highlight disease, population, and geographic target areas for further investigating health disparities. Studies that were completed in FY 2014 or are currently ongoing include (1) analyses on VTE (thrombosis), RSV, pneumonia, LRTI, HCV, HIV, vitamin D deficiency, all hospitalizations, HPV warts incidence & vaccination, and chlamydia surveillance using IHS data;(2) an analysis of infant infectious disease in Alaska using IHS data; (3) analyses of infectious disease in all ages and preventable hospitalizations in Alaska using IHS data and the Alaska State Inpatient Database; and (4) analyses of traumatic brain injuries, Huntington's Disease, amyotrophic lateral sclerosis, and Parkinson's Disease in the Navajo.

Surveillance, Epidemiology, and Laboratory Support - The Epidemic Intelligence Service (EIS) matched an EIS officer to a newly-created EIS assignment at the Northwest Tribal Epidemiology Center (NWTEC) of the Northwest Portland Area Indian Health Board (NWPAIHB) in Portland, Oregon. The NWTEC is one of 12 tribal epidemiology centers across the country and receives funding from multiple sources, including CDC's Center for Surveillance, Epidemiology and Laboratory Services (CSELS) and the Indian Health Service. NWPAIHB is a nonprofit tribal

organization and represents 43 tribes in Idaho, Oregon, and Washington. The EIS officer will work with the tribes to develop and conduct projects that serve the interests of the tribes while meeting the EIS program Core Activities for Learning. To date, the EIS officer has worked on activities including, but not limited to, the Native American Research Centers Summer Institute, the Indian Health Service's National Data Warehouse repository, emergency preparedness and outbreak response among Portland area tribes, and the NWPAIHB Tribal Health Profiles Project.

FOOD AND DRUG ADMINISTRATION (FDA)

FDA is responsible for protecting the public health by assuring the safety, efficacy and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. FDA is also responsible for advancing the public health by helping to speed innovations that make medicines more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medicines and foods to maintain and improve their health. FDA also has responsibility for regulating the manufacturing, marketing and distribution of tobacco products to protect the public health and to reduce tobacco use by minors. Finally, FDA plays a significant role in the Nation's counterterrorism capability. FDA fulfills this responsibility by ensuring the security of the food supply and by fostering development of medical products to respond to deliberate and naturally emerging public health threats.

As a regulatory Agency, the FDA does not award as many grants as most HHS operating divisions. However, in FY 2014, FDA awarded one grant of $2,000 to the Coeur d'Alene Tribe of Idaho from the FDA Office of Regulatory Affairs to pay for tribal inspectors to attend training in support of the Retail Program Standards. The FDA's Center for Tobacco Products also awarded contracts to two tribes for tobacco retail compliance check inspections. These two contract awards were the first CTP has made to tribal governments to conduct retail inspections.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The mission of the Health Resources and Services Administration (HRSA) is to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. Comprising five bureaus and ten offices, HRSA provides leadership and financial support to health care providers in every state and U.S. territory. HRSA grantees provide health care to medically vulnerable individuals living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), pregnant women, mothers, and children. HRSA supports the training of health professionals and the improvement of systems of care in rural communities. HRSA oversees organ, bone marrow, and cord blood donation; supports programs that compensate individuals harmed by vaccines; and maintains databases that protect against health care malpractice and health care waste, fraud, and abuse.

HRSA shares many priorities with the AI/AN and Native Hawaiian and Pacific Islander (NH/PI) communities, including but not limited to: reducing the burden of disease, increasing health professional workforce development, increasing health information technology investments in health care facilities that serve AI/ANs and NH/PIs, and improving access to funding and grant

opportunities. Tribes, tribal organizations, and the U.S. Pacific territories and freely associated states are encouraged to apply for HRSA funding opportunities for which they are eligible.

Bureau of Health Workforce

The Bureau of Health Workforce (BHW) provides grants to health professions schools and training programs, including tribal grantees and entities serving tribal populations, to support the education and training of culturally competent primary care providers, and to increase access to quality health services, especially for rural and underserved populations. In FY 2014, HRSA's BHW funded 24 grants to tribal, Native Hawaiian, or Pacific Islander entities totaling $13.3 million. In Academic Year 2013-2014, BHW-sponsored programs supported training for 15,621 AI/AN/NA/PI health professional students. The Bureau of Health Workforce (BHW) improves the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. This is accomplished through three priorities:

- Preparing a workforce that increases the number of diverse, culturally competent primary care providers representing various disciplines;
- Improving workforce distribution throughout the nation, particularly in underserved, rural, and tribal areas; and
- Transforming health care delivery by supporting innovate models of care that integrate health care services and disciplines.

National Health Service Corps

The National Health Service Corps (NHSC) offers financial support to primary care providers who practice in areas of the country that have too few health care providers and are medically underserved. As of September 30, 2014, 643 tribal clinical sites were able to offer loan repayment to eligible clinicians practicing at these sites. That compares to 60 such sites at the end of 2010 before the automatic approval of tribal sites issued in May 2011. The Affordable Care Act permits tribal, IHS, and Urban Indian health facilities that exclusively serve tribal members to qualify as NHSC sites, extending their ability to recruit and retain primary care providers by utilizing NHSC scholarship and loan repayment incentives.

As of September 30, 2014, NHSC supported 391 clinicians serving at tribal, IHS, and Urban Indian health sites across the country; and 51 NHSC clinicians identified themselves as AI/AN. Of those 391 clinicians, 90 were physicians, 64 were nurse practitioners, 13 were certified nurse midwives, 51 were physician assistants, 82 were dentists, and 12 were dental hygienists. The total also included 79 clinicians who provided mental and behavioral health services in tribal sites as licensed professional counselors, health service psychologists, marriage and family therapists, licensed clinical social workers, or psychiatric nurse specialists. These clinicians are part of the more than 9,200 primary care clinicians currently providing care in the NHSC.

IHS and HRSA continue to work together to increase utilization and availability of the NHSC Program as a recruitment tool to fill health professional vacancies at tribal sites. Hundreds of providers have learned about open job opportunities at tribal sites through the NHSC's Virtual Job Fairs. In FY 2014, BHW hosted three Virtual Job Fairs to recruit for 400 job vacancies,

which included presentations from more than 90 NHSC sites (representing 570 facilities) from 43 states and Washington, D.C. Over 445 providers participated.

Native Hawaiian Scholarship Program

The purpose of the Native Hawaiian Scholarship Program (NHHSP) is to provide funds to Papa Ola Lokahi to provide administrative support for Native Hawaiians who are awarded HRSA funds as students of health professions schools, in return for a commitment to provide primary health services to the Native Hawaiian population in the State of Hawaii. Three main components comprise the NHHSP:

- Scholarships to Native Hawaiians pursuing careers in designated health care professions,
- Training of NHHSP scholars in ways to provide culturally appropriate health care services in Hawaiian communities, and
- Placement of NHHSP scholars in priority Native Hawaiian communities following the completion of their training.

Bureau of Primary Health Care

The Bureau of Primary Health Care administers the Health Center Program which funds health centers in underserved communities that provide access to high quality, family-oriented, comprehensive primary and preventive health care for people who are economically, geographically, or medically vulnerable, or face other obstacles to obtaining health care. More than 550 health center sites have opened in the last 3 years as a result of the Affordable Care Act. Today, nearly 1,300 health centers operate approximately 9,000 service delivery sites that provide care to nearly 23 million patients in every state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin. Based on Uniform Data System (UDS) information from FY 2013, Health Center Program grantees served over 259,000 AI/ANs and more than 235,000 NH/PIs. HRSA supports health centers in all six USAPI jurisdictions, with two sites in the Federated States of Micronesia.

In FY 2014, HRSA awarded more than $38 million in on-going funding to Native American grantees plus supplemental support totaling more than $15.8 million provided by the Affordable Care Act. The following are examples of this funding activity:

- In October and November 2013, HRSA awarded more than $6 million in two rounds of Health Center Program New Access Point funding to eight Tribal Health Centers to establish new health center sites. Five of the awards went to new Tribal Health Center grantees and three went to existing grantees. These awards bring the total number of dually funded Tribal/Urban Indian health centers to 32.
- In July 2014, HRSA awarded $54.6 million in Affordable Care Act funding to support 221 health centers in 47 states and Puerto Rico to establish or expand behavioral health services for over 450,000 people nationwide. Health centers will use these new funds for efforts such as hiring new mental health professionals, adding mental health and substance use disorder services, and employing integrated models of primary care. One Tribal Health Center (The Aleutian Pribilof Islands Association in Anchorage, Alaska) and three Urban Indian Health Centers (Native American Rehabilitation Association Inc.

in Portland, Oregon, Seattle Indian Health Board in Seattle, Washington, and First Nations Community Health Center in Albuquerque, New Mexico) received $999,966 in funding.

- On September 12, 2014, HRSA awarded $295 million in Affordable Care Act funding to 1,195 health centers in every U.S. state, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific Basin to expand primary care services. These awards will allow for increased access to comprehensive primary health care services by hiring an estimated 4,750 additional staff (including health care providers); staying open for longer hours; and expanding the care they provide to include new services, such as oral and behavioral health, pharmacy, and vision services. These investments will help health centers reach an estimated 1.5 million new patients nationwide, including over 137,000 oral health patients and more than 38,000 mental and substance abuse patients. Twenty-four Tribal Health Centers and seven Urban Indian Health Centers received a total of $6,383,208 in Affordable Care Act expanded services funding.
- In July 2014, HRSA announced the availability of $100 million in Affordable Care Act funding to expand access to primary care through new health center sites across the country in 2015. This opportunity not only increased access to health care services but it also continues to broaden the outreach and enrollment efforts already being utilized by health centers to link individuals to affordable coverage options. Approximately 150 new health center sites are anticipated to be established as a result of this funding. This funding opportunity closed on October 10, 2014, and over 500 applications were received. At the time of this report, HRSA anticipated announcing awards in May 2015. Tribal organizations were eligible to apply.

HRSA's support to Native Hawaiians//Pacific Islanders includes the Native Hawaiian Health Care Systems (NHHCS) Program. The NHHCS Program is authorized under the Native Hawaiian Health Care Improvement Act of 1988, which was reauthorized under the Affordable Care Act. Under NHHCS, grantees are charged with improving the quality of health among Native Hawaiian people through health education; disease prevention; case management; enabling services (non-clinical services that support the delivery of health care); and primary health care services. In FY 2014, NHHCS grantees received a total of $12,339,016 under the NHHCS program. Focusing on disease prevention and health promotion, since 1992, these systems have developed programmatic initiatives reflective of their respective island Native Hawaiian population's health needs and concerns. All of the NHHCSs on all the Hawaiian Islands provide health screenings, educational services, primary care, as well as transportation and other enabling services directly to Native Hawaiians. HRSA provided the following technical assistance to the NHHCS program in FY 2014:

- Targeted technical assistance including strategic planning for key management staff and the Board of Directors; reviewing current priorities; determining a formula for allocation of funding; identifying appropriate data elements for program management and performance improvement as well as to HRSA for program monitoring, technical assistance, and documenting the value and impact of the program.
- The Hawaii Primary Care Association (HPCA) is funded by HRSA to provide technical assistance to grantees. HPCA works with all six of the grantees in the NHHCS Program:

Ho`ola Lahui Hawaii, Hui Malama Ola Na Oiwi, Hui No Ke Ola Pono, Inc., Ke Ola Mamo, Inc., Na Pu'uwai, Inc., and Papa Ola Lokahi. The HPCA provides training and technical assistance related to patient-centered medical home and Electronic Health Record implementation. They also conducted Centers for Medicare & Medicaid Services (CMS), Advanced Primary Care Practice Demonstration to consolidated health centers on a statewide and regional basis.

- HRSA funds a national cooperative agreement with the Association of Asian Pacific Community Health Organizations (AAPCHO). The AAPCHO provides training through webinars and dissemination of materials to health centers that serve Asian American and NH/PI. The AAPCHO also encourages health centers to participate in a Health Information Exchange, which measures improvements in key clinical quality and performance measures related to hepatitis B, diabetes, childhood immunizations, emergency room utilization, and early notification of pregnancy to health care plans.

HIV/AIDS Bureau

The HIV/AIDS Bureau's (HAB) mission is to provide leadership and resources to assure access to and retention in high quality, integrated care and treatment services for vulnerable people living with HIV/AIDS and their families. The Ryan White HIV/AIDS Treatment Extension Act of 2009 is federal legislation that addresses the unmet health needs of persons living with HIV (PLWH) disease by funding core medical and support services that enhance access to, and retention in care. First enacted by Congress in 1990, the legislation was amended and reauthorized in 1996, 2000, 2006, and again in 2009. The Ryan White HIV/AIDS Program (RWHAP) reaches over 530,000 individuals each year, making it the federal government's largest program specifically for care and treatment services for PLWH.

In January and May 2014, HRSA announced its continuing support of the RWHAP Part C Early Intervention Service Program to the Alaska Native Tribal Health Consortium with a grant of $463,124 and to the Anchorage Neighborhood Health Center in the amount of $329,788. Both grantees serve the Native American communities in Anchorage, Alaska, and in the various rural communities throughout Alaska. For both grantees, the 2014 budget period was the final year of a 3-year project period that started in 2012 to provide comprehensive HIV primary medical care and support services to persons living with HIV disease. Moreover, the Alaska Native Tribal Health Consortium received a Part C supplemental award for $38,000 for the Increasing Access to HIV Care and Treatment Initiative from FY 2012 to 2014. Both organizations are long-standing grantees that have provided excellent care and have created a comprehensive health care system for persons living with HIV in Alaska. The Anchorage Neighborhood Health Center has provided HIV services under the RWHAP Part C program since 2000, and the Alaska Native Tribal Health Consortium has provided HIV services as a RWHAP Part C grantee since 2001.

Through its AIDS Education and Training Center (AETC) Program, the RWHAP is working to improve access to healthcare services for individuals, including Native Americans living with HIV/AIDS. Further, RWHAP AETCs work to improve HIV education and training among health care providers who care for Native American populations living with, or at risk for,

HIV. AETCs have received funding to work with individual Tribes to assess training needs and to plan, design, and implement needs-based, culturally responsive, training programs related to HIV prevention, diagnosis, and treatment. The cornerstone of this project is the pre-training work that the AETCs conduct with individual communities to build trust, gain access to healthcare providers, and receive permission to offer training. Furthermore, AETCs work to reduce stigma, design HIV testing programs, and assist community leaders to understand the risk posed by HIV within their communities, including Tribes. The AETC experience ensures that relationships and trust are established for the most successful intensive longitudinal training and capacity-building services with Tribes, communities, and organizations. AETCs report that they are seeing the results of the work from prior years of pre-training and are poised to reach more Tribal communities to assist Tribal leadership and health care providers to reduce stigma and increase access to HIV care and testing services in multiple regions throughout the United States.

Maternal and Child Health Bureau

The purpose of the Maternal and Child Health Bureau (MCHB) is to provide leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the maternal and child health population that includes all of the nation's women, infants, children, adolescents, and their families, including fathers and children with special health care needs. In 2014, HRSA's MCHB awarded $2.6 million to tribal grantees, with the majority of these funds supporting tribal grantees as part of the Healthy Start Program.

The Healthy Start Program goals include reducing the rate of infant mortality and improving perinatal outcomes, through grants, to project areas with high annual rates of infant mortality in one or more subpopulations. The purpose of this program is to address significant disparities in perinatal health including disparities experienced by Hispanics, AI/AN, African-Americans, Asian American/Pacific Islanders, and immigrant populations; and disparities in prenatal health occurring by virtue of education, income, disability, or living in rural/isolated areas. Other MCHB grant programs include:

Home Visiting Program

In March 2014, through the Protecting Access to Medicare Act, Congress provided $400 million to continue the Home Visiting Program in FY 2015. This funding is in addition to the $1.5 billion provided for the Home Visiting Program in FYs 2010 through 2014. The $1.5 billion funding includes a three percent set-aside for grants to tribal entities. In addition, through the statewide needs assessments and the identified priority populations, many State Home Visiting Programs have included tribal populations residing in at-risk communities. There are currently 25 tribal grantees in 14 states.

The Tribal Home Visiting Program, administered by ACF, provides grants to Indian tribes, consortia of tribes, tribal organizations, and Urban Indian organizations. The Tribal Program mirrors the state program, with the goal of supporting the development of healthy and successful AI/AN children and families through a coordinated home visiting system. As of the end of FY 2014, ACF had awarded approximately $44.6 million to Tribal Home Visiting Program grantees,

including $10.5 million in FY 2012, $11.5 million in FY 2013, and $12 million in FY 2014. To date, the Tribal Home Visiting Program has awarded 25 grants (cooperative agreements) totaling $21 million to three "cohorts" of grantees in 14 states. Grants for all three cohorts were awarded competitively for five years, contingent on the availability of funds. In 2014, 2,383 AI/AN participants were served through state Home Visiting Programs. AI/AN participants made up more than 45 percent of total participants in three of the states funded: North Dakota (76 percent), New Mexico (53 percent), and South Dakota (46 percent). Tribal grantees have provided nearly 18,000 home visits since the start of the Program.

Five state Home Visiting Programs are effectively engaging tribal communities in culturally appropriate and participatory ways, maintaining contracts with Local Implementing Agencies (LIA) associated with tribal populations in Arizona, Maine, Mississippi, Washington, and Wisconsin.

Federal Office of Rural Health Policy

The Federal Office of Rural Health Policy (FORHP) coordinates activities related to rural health care within HHS. FORHP engaged in a wide spectrum of activities, from research and policy development to the management of grants that create access to health care in rural areas. Through some of its research activities, FORHP supported various research projects that studied areas of known health disparities among racial and ethnic minority populations.
HRSA and FORHP shares many priorities with Native American populations, including but not limited to: reducing the burden of disease; increasing health professional workforce development; increasing health information technology investments in Tribal and Urban Indian facilities; and improving access to funding and grant opportunities. In FY 2014, FORHP funded 22 awards to Tribal entities and those impacting Native Hawaiian and Pacific Islander communities totaling $12,450,971.

INDIAN HEALTH SERVICE

The mission of the Indian Health Service (IHS) is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS provides comprehensive primary health care and disease prevention services to approximately 2.2 million American Indians and Alaska Natives. The IHS combines preventive measures involving environmental, educational, and outreach activities with therapeutic measures to form a single national health system. Members of federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by IHS. Most appropriated IHS funds are for AI/ANs who live on or near reservations or Alaska Villages. Congress also has authorized funding to support programs that provide some access to health care for AI/ANs who live in urban areas.

IHS health services are provided directly, through tribally contracted and operated health programs, and through services purchased from private providers. The federal system consists of 27 hospitals, 59 health centers, and 32 health stations. American Indian Tribes, tribal organizations, and Alaska Native corporations administer 18 hospitals, 284 health centers, 79 health stations, and 163 Alaska village clinics under the authority of the Indian Self-Determination and Education Assistance Act (ISDEAA). In addition, 33 urban Indian health projects provide a variety of health and referral services.

The Indian health model and the participation of Indian people in decisions affecting their health has produced significant health improvements for American Indians and Alaska Natives over time. Indian life expectancy has increased by about 10 years since 1973 and mortality rates have decreased for maternal deaths, tuberculosis, gastrointestinal disease, infant deaths, unintentional injuries and accidents, pneumonia and influenza, homicide, alcoholism, and suicide.

In 2014, the IHS provided the majority of its services through direct provision of health services, tribally operated health programs under the authority of the ISDEAA, services purchased from private providers, and urban Indian health programs. Specifically, In FY 2014 IHS received a total of $5.6 billion, +$342 million above FY 2013. While the IHS provides significant support to promote the health and well-being of AI/AN populations that goes beyond grant funding, the entirety of this support is not reflected in this Report. IHS grant programs focused on specific health issues include:

- American Indians into Nursing Program (NU) – The purpose of this grant program is to recruit and train AI/AN individuals to be nurses. The grant program is awarded to schools of nursing to increase the number of nurses who deliver care to the AI/AN population. In FY 2014, IHS awarded one NU grant totaling $414,924.

- Healthy Lifestyles in Youth Project (HLY) – This cooperative agreement provides funding for Tribes or Tribal organizations to promote healthy lifestyles among AI/AN youth. In FY 2014, IHS awarded one HLY grant totaling $1 million.

- Injury Prevention Program (IPP) – The purpose of this grant program is to promote the capacity of tribes and tribal/urban/non-profit Indian organizations to build sustainable, evidence-based injury prevention programs. In FY 2014, IHS awarded 23 IPP cooperative agreements totaling $1,020,000.

- Methamphetamine and Suicide Prevention Initiative (MSPI) – Provides targeted resources for methamphetamine and suicide prevention and intervention services to tribal communities in Indian Country with the greatest need for these projects. In FY 2014, IHS awarded 129 MSPI grants totaling approximately $14.2 million.

- National Medical Professional Recruitment and Continuing Education Program (HRP) – This program funds a cooperative agreement to enhance medical professional recruitment and continuing education programs, services, and activities for AI/AN people. In FY 2014, IHS awarded one HRP grant totaling $25,000.

- Office of Urban Indian Health Programs, Urban Indian Education and Research Organization Cooperative Agreement Program (UIHP3) – Funds a national urban Indian organization to act as an education and research partner for IHS Office of Urban Indian Health Programs and urban Indian organizations funded under the Indian Health Care Improvement Act. In FY 2014, IHS awarded one UIHP3 grant totaling $1.15 million.

- Special Diabetes Program for Indians (SDPI) – Beginning in 1998, the SDPI grant program provided annual funding to 333 non-competitive grant programs to begin or enhance diabetes prevention programs in Indian communities, as well as to address diabetes treatment. The result has been the creation of innovative, culturally appropriate strategies that address diabetes care and education in AI/AN communities. In FY 2014, IHS awarded 301 SPDI grants across 36 states totaling approximately $136 million.

- Tribal Management Grants (TMD) – The IHS Tribal Management Grant Program is intended to build the management capacity of Tribes and Tribal organizations. The goal is to improve their management systems and capacity to assume IHS programs, services, functions, and activities of under the ISDEAA. In FY 2014, IHS awarded 16 TMD grants totaling $1,412,000.

NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH) is the steward of medical and behavioral research for the Nation. The mission of the NIH is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and to reduce illness and disability. The NIH provides leadership and direction to programs designed to improve the health of the Nation by conducting and supporting research:

- In the causes, diagnosis, prevention, and cure of human diseases;
- In the processes of human growth and development;
- In the biological effects of environmental contaminants;

- In the understanding of mental, addictive, and physical disorders; and
- In directing programs for the collection, dissemination, and exchange of information in medicine and health, including the development and support of medical libraries and the training of medical librarians and other health information specialists.

The NIH mission is carried out through 27 Institutes and Centers (IC) and Offices of the Director. Central to the NIH process is the conduct and support of medical and behavioral research according to a research priority structure. The NIH accomplishes its research goals with a competitive grant-award process to universities, medical schools, local or state governments, and other research institutions that will foster fundamental creative discoveries, innovative research strategies, and their applications. In FY 2014, the NIH funded over 500 grants that were relevant to Native Americans, including 131 grants to AI/AN or NH/PI researchers for a total of $46,680,165. In addition, the NIH funded $644,651,822 to Tribal Colleges and Universities (TCU) and American Indian and Alaska Native-Serving Institutions (AIANSI) for research and development and training.

In addition, the NIH awarded nearly $31 million in FY 2014 to invest in innovative approaches to training and mentoring researchers, including those from backgrounds underrepresented in biomedical sciences. These awards were part of a projected five-year program to support more than 50 awardees and partnering institutions in establishing a national consortium to develop, implement, and evaluate approaches to encourage individuals to pursue and persist in biomedical research careers. Each of these initiatives has components addressing AI/AN populations and collectively, these awards aim to enhance representation of diverse groups, including AI/AN, in the NIH-funded workforce. This consortium is comprised of three integrated initiatives:

Building Infrastructure Leading to Diversity

Building Infrastructure Leading to Diversity (BUILD) is a set of 10 experimental training awards designed to implement and study innovative and effective approaches to engaging students from diverse backgrounds in biomedical research and to prepare students to become future contributors to the NIH-funded research enterprise. The BUILD awardees will work with multiple partnering institutions to provide robust research training and mentorship experiences for students and faculty. Two BUILD awardee institutions and their partners aim to serve significant numbers of AI/AN students: University of Alaska, Fairbanks and Portland State University, and their partners which include University of Alaska-Southeast, Ilisagvik College, and University of Alaska-Anchorage.

The National Research Mentoring Network

The National Research Mentoring Network (NRMN) will develop a nationwide network of mentors and mentees spanning all biomedical disciplines and will develop best practices for mentoring, mentor training, and professional development opportunities for mentees and mentors. The NRMN grantees' leadership team included investigators with demonstrated commitment to serving AI/AN populations and partnerships with organizations, including: the Society for the Advancement of Chicanos and Native Americans in Science (SACNAS), American Indian Science and Engineering Society, Association of American Indian Physicians,

Northern Arizona University Center for American Indian Resiliency, Washington State University Behavioral Health Collaborative in Rural American Indian Communities, and the University of Washington Regional Native American Community Networks Program. For more information about awardees and their partners, visit http://commonfund.nih.gov/diversity/fundedresearch.

The Coordination and Evaluation Center

The Coordination and Evaluation Center (CEC) will coordinate consortium-wide activities and assess the efficacy of the training and mentoring approaches developed by the BUILD and NRMN awardees. Given the wide range of geographical, racial, ethnic, linguistic, and cultural diversity represented by the BUILD and NRMN awardees and their partners, the CEC will allow for the rigorous analysis of which interventions are most effective within which context and for which populations. These findings will have implications for recruiting, training, and mentoring of diverse groups nationwide, including AI/AN.

In FY 2014, NIH also provided funding to 3 Tribal Colleges, Universities, and 18 American Indian and Alaska Native-Serving Institutions for research and development, totaling nearly $608 million.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within HHS that leads public health efforts to advance the behavioral health of the nation. Its mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA has significantly increased the number of grant awards and funding to tribes and tribal organizations and to expand the Partnerships for Success Initiative to include tribes, increased technical assistance by the SAMHSA Tribal Training and Technical Assistance Center, and other actions. In November 2013, SAMHSA supported 100 grants to 76 tribes and tribal organizations at a one-year funding level of $68,892,420. By September 2014, support to tribes and tribal organizations had grown to 146 grants to 96 tribes and tribal organizations at a one-year funding level of $96,088,832.

Approximately two-thirds of SAMHSA's funding goes to states through block grants, the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG) to serve all state citizens. By law, the Red Lake Band of Chippewa Indians is the only tribe to receive SABG funds.
Eligible applicants in SAMHSA's requests for applications include state and local governments, federally recognized tribes, tribal organizations, urban Indian organizations, public or private universities and colleges – including tribal colleges, and community and faith-based organizations. Consortia of tribes or tribal organizations are eligible to apply, with each participating entity indicating its approval.

B. TECHNICAL ASSISTANCE, TRAINING, AND OUTREACH

OFFICE OF THE SECRETARY – OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

OFFICE OF MINORITY HEALTH RESOURCE CENTER

The Office of Minority Health Resource Center (OMHRC) Capacity Building Division conducted a total of nine capacity building trainings throughout the Pacific region in 2014. Trainings were conducted in five out of the six USAPIs including American Samoa, the CNMI, the Federated States of Micronesia, Guam and Palau. Training topics included Financial Management, Program Evaluation, Grant Writing, Strategic Planning, and HIV Counseling Testing Referral training. A total of 209 individuals participated in the capacity building trainings, representing a total of 101 health departments and divisions, local government agencies, community-based organizations, and faith-based organizations. All of the trainings received high ratings on evaluations.

OFFICES OF REGIONAL HEALTH ADMINISTRATOR

Region IX/Offices of Pacific Health (San Francisco and Honolulu)

In 2014, Region IX's Office of Pacific Health provided a variety of types of technical assistance and consultation supports. The Regional Office provided TA and consultation services to USAPI health departments on fiscal capacity building; compiled and distributed an expanded annual report (*Grants to the Outer Pacific FY 2014*) that provided detailed information on federal grant programs, eligibility, and funding amounts for the Pacific jurisdictions; participated in annual Pacific Island Health Officer Association meetings providing TA on available federal resources and assistance programs; updated an HHS/Pacific communications procedure to enhance coordination with the Pacific health departments on health issues in the Pacific; participated in the WHIAAPI meeting to develop strategies for enhancing AAPI communities' access to federal resources; collaborated with the HHS Supply Service Center in Perry Point, MD, on development and implementation of a regional formulary and strategies to enhance pharmaceutical procurement for the Pacific; provided TA to the Pacific Island collegiate nursing program directors to facilitate completion of activities under a Robert Wood Johnson Foundation and awarded a HRSA grant to strengthen nursing education in the USAPI. The Regional Office participated in the Interagency Hawaii Federal workgroup to address Asian Americans, Native Hawaiians and Pacific Islanders (AANHPI) health concerns, networked with other federal agencies to build capacity in these communities; participated on the Hawaii Healthcare Transformation workforce taskforce to ensure a focus on rural needs and recruitment of the AANHPI individuals into health professions careers. Region IX OMH and Office on Women's Health (OWH) collaborated with the Regional Office to produce a document titled *Catalogue of Promising Practices which Address Non-Communicable Diseases in the USAPI*.

C. THE PRESIDENT'S COUNCIL ON FITNESS, SPORTS, AND NUTRITION

The objectives of the President's Council on Fitness, Sports, and Nutrition (PCFSN) are to expand interest in and awareness of the importance of regular physical activity, fitness, sports participation and good nutrition for Americans of all ages by encouraging the development, improvement, or enhanced coordination of programs that promote healthy lifestyles. The PCFSN does not have grant-making authority. Objectives are accomplished by providing consultation and TA; creating partnerships with public, private, and non-profit organizations; releasing publications and maintaining a web presence (via web site and social media); and by accessing or capitalizing on a variety of outreach opportunities.

PCFSN joined the First Lady to launch *Let's Move!* Active Schools in February 2013 and serves as the federal lead on this initiative, which empowers school champions to create early, positive physical activity experiences for all students. The initiative promotes a physical activity and physical education solution that aims to create opportunities for students to be active before, during, and after school. In addition to serving all schools nationwide, *Let's Move!* Active Schools has targeted outreach to the Native American population through the Bureau of Indian Education and the *Let's Move! In Indian Country* initiative of the First Lady's campaign. Program partners of *Let's Move!* Active Schools also provide priority to schools based on need (Title 1 status).

During FY 2014, PCFSN provided the following in-kind support and TA to Native American communities:

- Began development of the "*Rosebud Reservation's Kids Move in School*," which launched in November 2014 to celebrate Native American Heritage Month. As of January 2015, the video received more than 1,400 views.
- Collaborated with partner organizations (i.e., NIKE and Fuel-Up-To-Play-60) to prepare content for delivery during a targeted panel session entitled *Let's Move!* Moving a Nation towards a Healthier Future at the NIKE N7 Summit held on October 3, 2014.
- Coordinated with the Office of the First Lady, The White House; National Institutes of Health - Division of Nutrition Research Coordination; Centers for Disease Control and Prevention - National Center for Chronic Disease Prevention and Health Promotion; Administration for Children and Families, Office of Child Care; and, the IHS to prepare content for delivery during a *Let's Move! In Indian Country* webinar entitled *Federal Resources and Activities for Preventing Childhood Obesity in American Indian and Alaska Native Youth* held on November 19, 2014, in celebration of Native American Heritage Month.

ADMINISTRATION FOR CHILDREN AND FAMILIES (ACF)

Administration for Native Americans

As part of the ongoing efforts to improve health outcomes for Native community, HHS awarded a contract to Native American Management Services (NAMS), an independent private service organization to help increase the health insurance enrollment of the Native population. The grant award is the result of collaboration between the Administration for Native Americans (ANA) and the Centers & Medicare and Medicaid Services (CMS) to promote enrollment by AI/ANs in Medicaid, the Children's Health Insurance Program (CHIP), and insurance policies available

through the Health Insurance Marketplace (HIM). The contract seeks to encourage awareness of all the benefits and rights that accrue to AI/AN persons through healthcare reform and earlier laws and regulations.

Section 804 of NAPA requires ANA to provide training and technical assistance to build the capacity of eligible Native American tribes and organizations to apply for and administer ANA grants. In FY 2014 ANA organized its training and technical assistance efforts in four regional Training and Technical Assistance Centers under contracts as follows:

- Native American Management Services – Eastern Region (Eastern portion of the United States from North Dakota to Texas and all states on the East Coast)
- Kauffmann and Associates – Western Region (Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming)
- Three Star Enterprises LLC – Alaska Region (Alaska)
- Ka'ananiau LLC – Pacific Region (Hawaii, American Samoa, Guam, and Commonwealth of the Northern Mariana Islands)

In fiscal year 2014, a total of $2,739,584 was available for training and technical assistance. Training and technical assistance activities are split into two types: pre-award assistance focusing on capacity building and creating successful funding proposal and post award assistance focusing on administrative and project operations including project implementation and closeout.

ANA, in collaboration with regional training and technical assistance providers, provides three types of free training and technical assistance to prospective applicants across the U.S and the Pacific territories:

- Project planning and development training;
- Pre-application training; and
- Pre-application electronic technical assistance.

Project planning and development trainings provide prospective ANA applicants with skills to plan successful community development projects. Participants learn how to:

- Work with community and key partners to identify and document specific problems that stand in the way of meeting community goals
- Create a project work plan to address those problems and attain community goals;
- Develop measurable outcomes and impacts to the community; and
- Determine the level of resources and funding needed to implement the project.

Training sessions are offered free of charge to tribes and Native American, Native Alaskan, Native Hawaiian and Pacific Islander non-profit organizations. However, participants must pay their own travel costs to attend. Previously unfunded ANA applicants are strongly encouraged to attend project planning and development training.

Pre-application trainings provide prospective ANA applicants with "nuts and bolts" information on the federal application process and ANA Funding Opportunity Announcements for Social and

Economic Development Strategies (SEDS), Native Language Preservation and Maintenance, and Environmental Regulatory Enhancement. Participants learn how to:

- Register and apply on grants.gov;
- Understand the ANA Funding Opportunity Announcement Evaluation Criteria; and
- Format, package, structure and submit an application for ANA funding consideration.

The training sessions are offered free of charge to tribes and Native American, Native Alaskan, Native Hawaiian and Pacific Islander non-profit organizations. Each participant must pay their own travel costs to attend. Pre-application training participants are asked to bring a defined project idea. At registration, participants are asked to submit a summary of the proposed project, including goals and objectives. Pre application training is provided as individualized assistance to prospective ANA applicants through the phone or email. This is Pre Application ETA (Electronic Technical Assistance). For this type of training, potential applicants are asked to complete as much of the ANA application as possible so that the assistance provided is individualized and efficient.

Post-award technical assistance provides support for project implementation and is provided through regional post-award training for all ANA grantees. Post-award trainings are designed to provide awarded ANA grantees with information on how to effectively administer, manage, track and report their ANA projects. Participants learn:

- The roles and responsibilities of ANA, the Office of Grants Management (OGM), and the Division of Payment Management (DPM);
- How to read their Notice of Grant Award (NGA);
- How to complete and submit the required quarterly reports (Objective Progress Report andSF425);
- How to submit a timely non-competing grant continuation application;
- How to submit requests for non-routine grant amendments;
- Techniques to enhance participation of youth and elders in project activities; and
- How to build and document community support.

Post award training sessions are offered free of charge to new ANA grantees and the travel costs are included in the financial award.

ADMINISTRATION ON CHILDREN, YOUTH, AND FAMILIES

CHILDREN'S BUREAU

The Children's Bureau (CB) has provided technical assistance to tribes through Regional Office staff and, beginning, in October 2014, through the new Child Welfare Capacity Building Collaborative, a partnership of three Centers – the Center for Tribes, the Center for States, and the Center for Courts. This new structure consolidated and integrated services that had previously been organized by topical area and geographic region in an attempt to increase coordination, leverage resources and provide more strategic service provision.

The Capacity Building Center for Tribes serves as the principle vehicle for delivering effective, high-quality technical assistance (universal, constituency-focused, and tailored) to tribal child welfare agencies to successfully meet current and future standards and requirements described in statute and federal regulations (including those specified under titles IV-B and IV-E of the Social Security Act), to improve organizational and system performance, and to improve outcomes for tribal children, youth and families. In addition, the Center for Tribes was responsible for increasing the knowledge, skills and resources of tribal child welfare professionals and their partners.

Throughout much of 2014, however, and within the former Children's Bureau Training and Technical Assistance Network, the National Resource Center for Tribes (NRC4Tribes) served as the focal point for coordinated and culturally competent child welfare T/TA for tribes for five years, until September 30, 2014. Until the end of its five-year cooperative agreement, the NRC4Tribes worked collaboratively with tribes and the T/TA Network to assist tribes in the enhancement of child welfare services and the promotion of safety, permanency and well-being for American Indian/Alaska Native children and families. After five years of providing outreach, general training events, technical assistance, regional tribal gatherings and national webinars, the NRC4Tribes reached more than 150 tribes in 28 states. Besides providing training and technical assistance, the NRC4Tribes regularly sponsored webinars and provided many resources on a range of child welfare topics through its website. While the NRC4Tribes is no longer operating, the website and its resources remain online and available to the public for access of child welfare information.

Additional training and technical assistance provided to the Native American community by the NRC4Tribes included implementation of Tribal Child Welfare Assessments. Assessments of a tribal child welfare program offered tribal child welfare staff, management and tribal leaders an opportunity to evaluate current practices and procedures and identify improvements. Tribes also used assessments to determine if they were ready to begin developing a Tribal-State title IV-E agreement or apply for direct title IV-E funding to support operation of foster care, adoption assistance and guardianship assistance programs. An assessment helped identify the necessary activities and supported development of a plan to assist tribes to begin a Tribal-State title IV-E agreement or a federal title IV-E application process.

The NRC4Tribes also provided support to Tribal Title IV-E Plan Development Grant Projects. Since 2009, 27 tribes have received grants to assist them in developing title IV-E plans, to

prepare to operate their own title IV-E foster care, adoption assistance and guardianship assistance programs. During FY 2014, the NRC4Tribes continued to provide assistance to current grantees and past development grantees in the following activities:

- Hosted peer-to-peer calls with the grantee group to identify technical assistance needs; provide a forum for discussion and question/answers about the IV-E program development;
- Collaborated with National Resource Center for Child Welfare Data and Technology to provide on and off-site technical assistance related to management information systems development;
- Collaborated with the National Resource Center for Diligent Recruitment in assisting title IV-E program development on foster care program improvement; and
- Partnered with the National Resource Center for Organizational Improvement in conducting organizational assessments that provide tribal leaders an opportunity to consider their current practices and procedures and how they would like their program to function in the future.
- Coordinated extensively with the Training and Technical Assistance Coordination Center (TTACC) to plan, implement, and track all tribal technical assistance – from initial intake through the completion of project work plan.

FAMILY AND YOUTH SERVICES BUREAU

The Family and Youth Services Bureau (FYSB)'s Adolescent Pregnancy Prevention program funded T/TA contracts in support of all grantees, including Tribal PREP. RTI provides T/TA support to Tribal PREP grantees primarily through its sub-grantee, Native American Management Services (NAMS). Training and technical assistance funding directed specifically to Tribal projects was estimated at $218,800.

C. OFFICE OF CHILD CARE

The Office of Child Care (OCC) provides a variety of support including technical assistance and professional development services targeted to support Child Care and Development Fund (CCDF) administrators and their staff in identifying and implementing effective policies and practices that build integrated child care systems to help parents work and to promote the healthy development of young children.

Through the OCC's Child Care Technical Assistance Network (CCTAN), the OCC provides training and technical assistance to states, territories, tribes and local communities. This involves assessing CCDF grantees' needs, identifying innovations in child care administration, and promoting the dissemination and replication of solutions to the challenges that grantees and local child care programs face.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Centers for Disease Control and Prevention (CDC) provides extensive technical assistance to the public, including Native Americans, to fulfill its mission. In many cases, due to the nature of cooperative agreements, such support and technical assistance are intertwined.

FOOD AND DRUG ADMINISTRATION

According to the Centers for Disease Control (CDC), American Indian and Alaska Nativeshave the highest prevalence of cigarette smoking (about 22%) compared to any other population group in the United States. The Food and Drug Administration works with and provides technical assistance to Tribal governments in two distinct areas through its Center for Tobacco Products (CTP): inspections on tribal lands and retailer training. The CTP maintains contact with Tribal stakeholders, including Tribal government leaders, Tribal health leaders, public health professionals, and other relevant federal agencies to ensure ongoing engagement:

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration's (HRSA) Office of Federal Assistance Management (OFAM) provides national leadership in the administration and assurance of the financial integrity of HRSA's programs, and provides technical assistance and oversight for all HRSA activities to ensure that resources are utilized and protected. HRSA's OFAM provided on-going technical assistance and outreach to Native American communities through grant writing trainings, in partnership with the HRSA Office of Regional Operations (ORO) and the Office of Minority Health (OMH); webinars and webcasts on the application process; outreach and technical assistance at the regional level, in partnership with ORO; as well as efforts to increase the number of Native American grant reviewers. In FY 2014, the HRSA Reviewer Recruitment Module (RRM) database (which is utilized to track grant reviewer information), contained 195 reviewers that indicated they were affiliated with a Native American Tribe or Urban Indian organization and 147 reviewers who identified as Native American.

Office of Regional Operations

The Office of Regional Operations (ORO) works through HRSA's ten regional offices to improve health care systems and America's health care safety net; increase access to quality care; reduce disparities; and advance public health. As the agency liaison and regional leader, ORO maintains strategic partnerships with tribal stakeholders nationwide. The agency's regional office staff provides ongoing technical assistance utilizing a variety of mechanisms to address the needs of tribal communities.

During FY 2014, ORO staff participated in seven regional Tribal Consultations. Consultation sessions covered current health issues facing tribes and their requests for assistance for top priorities including:

- challenges with Affordable Care Act implementation (Navigators and call center staff lacking information on the Affordable Care Act specific to AI/AN populations);
- lack of funding opportunities reserved for Tribes or Tribal organizations (funding opportunities for health center and other grants on or near Tribal lands);
- challenges faced when applying for HRSA grants; 340B Drug Pricing Program reimbursement;
- recruitment and retention of health care professionals (in particular behavioral health providers due to increase of behavioral health conditions including prescription and non-prescription drug use, and suicide);
- the need for resources for Diabetes Self-Management Training (DSMT) and Intensive Behavioral Therapy for Obesity;
- reauthorization of the Special Diabetes Program for Indians; Healthcare facility construction; and
- the need to establish agreements with states to coordinate the sharing of data.

INDIAN HEALTH SERVICE

In FY 2014, the Indian Health Service's (IHS) Division of Grants Management (DGM), provided over 41 training sessions to over 139 IHS project officers, tribes, and non-tribal grantees. Training topics included: Grants.gov systems user training, the funding opportunity announcement process, the objective review process, HHS/IHS financial management requirements, pre- and post-award requirements, carryover requirements, Grantsolutions training for project officers and grantees, the discretionary grants process, project officer training, and various other policy and agency/HHS grant related topics.

The DGM also assisted the AI/AN community in locating potential future funding resources by posting nine new IHS funding opportunities to the HHS Grants Forecast Website at https://extranet.acf.hhs.gov/hhsgrantsforecast and eight to the IHS Grants Policy Website at http://www.ihs.gov/NonMedicalPrograms/gogp/index.cfm?module=gogp_funding. The DGM posted 100 percent of all IHS funding opportunities synopses and links to the full announcements on Grants.gov (www.grants.gov) to provide information on available guidelines for application submission, eligibility, and program/grants management requirements for new and continuing applicants. These postings resulted in DGM issuing $4,644,438 in FY 2014 grant funds, including awards to both tribes/tribal organizations and non-tribal entities.

NATIONAL INSTITUTES OF HEALTH

In 2014, the National Institutes of Health (NIH) supported Native Americans and Native communities through the following technical assistance activities:

Worker Training Program

The Worker Training Program (WTP) funds a national network of over 100 non-profit safety and health training organizations to provide training to workers who handle hazardous materials,

hazardous waste, or are involved in emergency response to hazardous materials incidents. Through its awardees, the WTP has trained over 1,200 AI/AN individuals, including tribal employees of natural resource, law enforcement, emergency medical, fire service, and public works agencies. The Alabama Fire College (AFC) trained nearly 700 American Indians from 14 tribes to protect themselves and their communities from hazardous materials encountered in workplaces and during emergency response operations through their partnership with the Native American Fish and Wildlife Society (NAFWS). Key training occurred at Confederated Tribes of the Umatilla Indian Reservation (Cayuse, Walla Walla, and Umatilla) and at three tribes in Albuquerque, NM (the Jicarilla Apache tribe, Eight Northern Indian Pueblo Council, and the Pueblo of Sandia Tribe). At the NAFWS National Conference and Pacific Northwest Regional Conference in Pendleton, Oregon, the AFC offered two eight-hour, hazardous awareness trainings for the Confederated Tribes of the Umatilla Indian Reservation and one class at the National Conference to the Yakima Tribe of Washington State.

Worker Training Program Conducts Training to Reach Underserved Workers in Remote Locations

The Worker Training Program (WTP) conducts training to reach underserved workers in remote locations who are engaged in activities related to hazardous materials and waste generation, removal, containment, transportation, and emergency response. Between August 1, 2013 and June 30, 2014, the Western Region Universities Consortium (WRUC) trained 2,329 workers in 150 courses for a total of 25,868 contact hours. Course offerings included hazardous waste site, emergency response, hazmat transportation, and hazard communication classes, as well as occupation-specific courses. During this time, courses were provided in the Pacific Islands and on American Indian reservations. Sixteen percent of the participants were AI/AN and 8 percent were Asian/Pacific Islander.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a variety of technical assistance opportunities and web and written materials to help communities, and especially tribes, apply for funds to prevent and address mental and substance use disorders and promote emotional health among youth. Once funded, SAMHSA provides technical assistance workshops for grantee program directors, coordinators, principal investigators, and evaluators, including community-based organization representatives. Grantees receive information on grant monitoring to ensure compliance with the terms and conditions of their awards, including reporting, data submissions, and programmatic technical assistance on how to assess their community needs, identify their capacity, develop and implement their plans and evaluate their success. Government project officers also conduct site visits to grantees and provide technical assistance to address outstanding concerns that grantees may experience.

There are two SAMHSA technical assistance centers specifically devoted to tribal issues:

- ***SAMHSA Tribal Training and Technical Assistance Center (Tribal TTA Center).*** The Tribal TTA Center provides tribes and tribal organizations access to culturally relevant and evidence-based support to address mental and substance use disorders, suicide prevention, and promotion of mental health.
- ***National American Indian and Alaska Native Addiction Technology Transfer Center (AI/AN ATTC)***. The AI/AN ATTC provides workforce development resources, manuals, webinars, and curricula to increase the skills of the substance use disorder workforce in providing culturally and linguistically sensitive services; and, increase the number of AI/ANs in the substance use disorders workforce. Trainings include:
    - Clinical Supervision: Clinical Supervision is training developed by the ATTC network and is currently being adapted for work with AI/AN behavioral health/substance abuse treatment workforce members.
    - Workforce Development: The AI/AN ATTC is working to culturally adapt the National Workforce Development Survey and utilize it with AI/AN providers. This project will enable SAMHSA to better understand issues of recruitment and retention among providers in Indian Country and how they differ from the rest of the country.

Among SAMHSA's presentations, workshops, and other outreach to Native Americans were:

- ***Tribal Policy Academy (TPA) on Early Diversion for Justice-Involved AI/AN Youth.*** SAMHSA and the MacArthur Foundation collaborated to host a TPA event on June 3-5, 2014, in Albuquerque, New Mexico. The TPA assisted four tribes, who sent delegations of up to eight tribal members each, to develop diversion plans and policies for justice-involved youth with behavioral health needs. Federal partners included the Bureau of Indian Affairs, Bureau of Justice Assistance, IHS and the Centers for Medicare &Medicaid Services. Each of the participating tribes received intensive technical assistance in preparation for and following the TPA.
- ***National Network to Eliminate Disparities in Behavioral Health (NNED)***. The Office of Behavioral Health Equity (OBHE) hosted its fourth annual training event, *NNEDLearn*, on April 6-9, 2014 at the Santa Ana Pueblo's Tamaya Resort near Albuquerque, New Mexico. The event included five training tracks to build skills in evidence supported and culturally appropriate clinical and consumer practices.
- ***Health Reform Outreach and Enrollment Strategies for Urban Indians***. OBHE supported the National Council of Urban Indian Health to identify effective Affordable Care Act outreach and enrollment strategies for urban Indians and to provide training and technical assistance to Urban Indian Health Programs to implement these strategies, and develop a strategy brief.

PART III. PRACTICE AND RESEARCH IMPLICATIONS

The 2014 Report to Congress on the Social and Economic Conditions of Native Americans reflects HHS' understanding that Native Americans are a diverse and resilient population for whom an array of HHS services and supports, tailored to the needs of local communities, makes a positive difference. In addition, the Report has practice and research implications for the future. In particular, this Report suggests that coordinated, integrated evidence-based approaches

to health and human services can measurably improve outcomes and meaningfully support thriving Native American children, families, and communities. In addition, bringing together stakeholders from all parts of the federal-to-local system, including through tribal consultation, can effectively build a strong continuum of support and care—prevention, early intervention, short-term and long-term services, and responsive care—for Native Americans, particularly Native youth. HHS grants, technical assistance, training, and consultations play a vital role in the harnessing and nurturing of Native resilience or innate capacity for well-being. In resilience literature, this is referred to as "ordinary magic"[192] and forms the basis for a comprehensive action plan supporting Native Americans with the essential building blocks to live healthy and successful lives.

It is intended that this Report will help to increase understanding of what works in public health and human service practice. To that end, as provided in the HHS 2010-2015 Strategic Plan, HHS is committed to improving the quality of public health and human service practice by conducting applied, translational, and operations research and evaluations. HHS also uses evidence from research and evaluation to inform policy and program implementation by identifying approaches that help people make healthy choices and assist communities as they work to improve the health and well-being of their populations, support safety and stability of individuals and families, and help children reach their full potential.

As part of the HHS mission to provide health and human services to the nation, including Native Americans, the Department is committed to continuously improving the delivery of those services. The Department accomplishes this goal, in part, through the evaluation of HHS-funded programs to assess the performance and progress of these programs in achieving their intended objectives. For example, in January 2014, the ACF Office of Planning, Research, and Evaluation (OPRE) published *Coordination of Tribal TANF and Child Welfare Services: Early Implementation*. This study described the first year of activities of the 14 tribes and tribal organizations who in 2011 received demonstration grants from the Office of Family Assistance (OFA) for Coordination of Tribal TANF and Child Welfare Services to Tribal Families at Risk of Child Abuse or Neglect. The overarching goal of this study was to document the way in which tribal grantees are creating and adapting culturally relevant and appropriate approaches, systems, and programs to increase coordination and enhance service delivery to address child abuse and neglect.[193] In March 2014, OPRE published *Tribal Health Profession Opportunity Grants (HPOG) Program Evaluation*, an interim report providing an overview of the tribal Health Profession Opportunity Grants (HPOG) grantees' progress over the first two years of the program. Initial evaluation findings were organized around program structure, program processes, and education and employment outcomes as was prepared by the Tribal HPOG evaluation team, comprised of NORC at the University of Chicago, Red Star Innovations and the National Indian Health Board.[194] In July 2014, OPRE published *Understanding Urban Indians'*

[192] A. Masten, *Ordinary Magic: Resilience Processes in Development* in American Psychologist (March 2001). Retrieved at http://mina.education.ucsb.edu/janeconoley/ed197/documents/mastenordinarymagic.pdf

[193] See http://www.acf.hhs.gov/programs/opre/resource/coordination-of-tribal-tanf-and-child-welfare-services-early

[194] See http://www.acf.hhs.gov/sites/default/files/opre/tribal_hpog_interim_report_clean_version_formatted_full_reportv2.pdf

Interactions with ACF Programs and Services: Literature Review summarizing what is known about the status of urban AI/AN children and families including their history of engagement with government services and the potential impact historical policies have had on current government service use. It also explored urban AI/AN families' cultural engagement and ways in which cultural identification might pose barriers or facilitate access to services provided by ACF. In addition, existing literature was reviewed for information about how the context in which these families live might facilitate or impede access to services. Finally, the review incorporates what is known about the current level of urban AI/AN need for and utilization of ACF-funded services.[195]

As the HHS Secretary stated in 2010 in introducing the HHS 2010-2015 Strategic Plan:

> We must also frequently look closer at old programs and existing services and ask: What needs to be changed? How can we serve Americans better? What can be done less expensively, faster, and with greater transparency?

The following addresses evidence-based practices, relationships between awareness of connectedness and protective factors, and trauma-informed services, policies, and care.

A. SELECT PRACTICE IMPLICATIONS

Building a Relevant Evidence Base

Native American programs and projects funded by HHS in FY 2014 demonstrate the promise of local, community-identified tools that address Native American health and well-being disparities. Such programs and projects substantially contribute to a developing evidence base of locally designed strategies that promote the social and economic well-being of Native American peoples and communities. National, regional, and program-level tribal consultations have consistently raised concern with the lack of Native Amercian-specific evidence based prevention and intervention practices informed by the unique needs of AI/AN children, families, and communities. In particular, there is often tension between evidence-based models that are not culturally grounded nor sufficiently tested with the AI/AN population, and culturally grounded AI/AN models whose efficacy is questioned.[196] There are a number of evidence-based practices assumed effective for AI/AN people because they were utilized with diverse ethnic groups. These practices are then proposed to be applied to AI/AN populations with minimal, superficial and often stereotypical cultural adaptations including such things as substituting Native names or themes in early childhood curriculum content or serving fry bread at a meal. The result in this first scenario is that the practice remains inherently based upon the culture of the non-Native developers with AI/AN 'window-dressing' so that the model appears AI/AN on the outside but is

[195] See http://www.acf.hhs.gov/sites/default/files/opre/urban_ai_an_literature_review.pdf

[196] See S. Yellow Horse and M. Yellow Horse Brave Heart, *Healing the Wakanheja: Evidence-based, Promising, and Culturally Appropriate Practices for American Indian/Alaska Native Children with Mental Health Needs,* in Native American Children, The Takini Network, University of Denver.

internally flawed and culturally irrelevant on a deeper more meaningful and more profoundly specific level.

The opposite scenario is the culturally based, culturally congruent, and culturally grounded practice that emerges from traditional AI/AN worldviews and lifeways. In these cases, AI/AN culture, behavioral norms, relationships and attributes are included and reflected in service to particular AI/AN populations. Such practices often have never been formally evaluated or replicated. Claims of success are based upon local observations and anecdotal information. While these observations may be promising and apparently effective, such models have not advanced to the level of being universally regarded as 'evidence based.'

There are at least three approaches to reconcile these tensions. First, culturally relevant research and evaluation of Native-driven practices incorporated into formal evaluations, particularly participatory evaluation approaches; promote Native American engagement and ownership of culturally rigorous practices. Second, adequately supported Native American-developed and designed models, strategies, and approaches, rather than the application of practices developed with other populations in Native communities, holds significant promise for the development of culturally responsive and effective place-based solutions to persistent social and economic challenges. Finally, a culturally relevant evidence-base forms the basis for formal federal as well as community-level participatory evaluations to test and verify such effectiveness leading to potentially replicable models. Evaluation methods that incorporate culturally appropriate study instruments and methods and utilize Native American community members directly as key informants, consultants, and experts appear to be most promising. The ACEs data described in this Report suggest that building an evidence base for Native youth programming that provides opportunities to disrupt negative, unhelpful, and harmful narratives about Native youth, may contribute to youth agency, leadership, and creativity that casts aside competing narratives of Native youth as victims of poverty and neglect who are irretrievably damaged.

Protective Factors

Attention to risk and protective factors are crucial to understanding and addressing the needs of Native American peoples, matching such needs to culturally appropriate interventions, and evaluating progress over time. With respect to protective factors, research with Native American populations has identified a holistic sense of connectedness of the individual with their family, community, and natural environment as an important culturally based protective factor against substance abuse and suicide.[197] For example, while some AI/AN communities have experienced suicide rates as much as ten times the national rate, others have rates that are much lower than the national rate. This may be due to variations in the extent of cultural continuity within individual communities or the extent to which protective factors are fostered at the local level.

A 1999 study of risk and strengthening protective factors among AI/AN youth showed that "adding protective factors was equally or more effective than decreasing risk factors in terms of

[197] See note 95.

reducing suicidal risk."[198] Based on emerging research, strengthening protective factors appears to be an effective community-level strategy. Protective factors, similar to risk factors, are cumulative and interrelated. Approaches that enhance the way in which young people feel connected to community and family combined with strategies that strengthen their ability to cope with life's challenges (resilience), may help youth to achieve their full potential as individuals as well as decrease suicidal ideation.

Protection of children against harm is embedded in centuries-old Native American spiritual beliefs, child-rearing methods, extended family roles, and systems of clans, bands, and societies. Although this cultural aspect has been threatened and undermined over time because of historical trauma, traditional cultural values have nonetheless survived. Adherence to Native spiritual practices of AI/AN ancestors correlates with decreased suicide attempts and such practices may usefully inform the delivery of human services in Native American communities.[199] For example, among individuals from a Northern Plains tribe living on or near a reservation, high levels of cultural spiritual orientations (based on an index compiled by tribe members and tested for relevance), even when adjusted for age, gender, education level, alcohol and substance abuse and mental distress, were correlated with reduced risk of suicide attempts. Researchers have suggested that cultural spirituality may offer a way to bring meaning and order to an understanding of the world and thereby increase resiliency.[200] In addition to spirituality, strong family connections, communication with family regarding problems, social support, positive perceptions of education, a nurse or clinic at schools and positive relationships with tribal leaders have all emerged as protective factors. Consistent attention on concepts of connectedness among Native Americans and the relationships between awareness of connectedness and protective factors, risk factors, recovery, and resiliency holds promise for improved and effective health and human service delivery. Focusing on protective factors with respect to Native youth has considerable advantage because a focus on their strengths in overcoming difficulties can mitigate negative outcomes. Improvements in risk and protective factors can be pathways to better outcomes for youth, including permanent connections and well-being. Achieving sustainable gains can help put youth on a path toward a healthy adolescence and positive transition to adulthood.

Trauma-Informed Services, Policies, and Care

[198] Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). *Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors.* Archives of Pediatric Adolescent Medicine, 153, 573-580.

[199] C. Alcantara and J. Gone, *Suicide in Native American Communities: Transactional-Ecological Formulation of the Problem,* in Suicide Among Racial and Ethnic Groups: Theory, Research, and Practice, F. Leong and M. Leach (eds) pp. 173-199 (2007).

[200] Id.

The elevated rates of substance abuse, health disparities, and exposure to trauma experienced by Native Americans and described in this Report, suggest more specific, intensive, and culturally responsive interventions and supports are needed, particularly to help Native youth reach developmental milestones associated with health and well-being.

AI/AN children and youth experience complex trauma, including cultural trauma, historical trauma, inter-generational trauma, and present trauma. Cultural trauma refers to attacks on the fabric or connections of Native society affecting the essence of Native communities and their members. Historical trauma describes the cumulative exposure of traumatic events that effect individuals but continue to affect subsequent generations. Inter-generational trauma occurs when trauma is not resolved, is internalized, and passed from one generation to the next. Present trauma describes the vulnerability and harm that Native youth experience on a daily basis today. For example, AI/AN LGBT-Two Spirit youth have significant experience with trauma such as abuse and exposure to violence, often resulting in homelessness. It is essential that health and human services are trauma-informed in how they approach and support Native youth to facilitate their healing, growth, and well-being.

Increased collaboration among agencies at all levels (local, state, and federal) and across human and health services, including child welfare, health systems, and economic development will be necessary in order to increase the number of Native American children who are appropriately assessed for trauma using validated assessment tools. Such assessments necessitate appropriate evidence-based interventions to meet Native American children's needs. The Center for Medicaid and CHIP Services (CMCS) is addressing childhood trauma by improving access to care, treatment, and services for children, youth, and families exposed to traumatic events. In addition, CMCS is working closely with the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify characteristics of complex trauma that would qualify as chronic under the Health Homes state plan benefit.

The science of epigenetics (literally, 'above the gene') indicates genes can carry the effects of trauma experienced by ancestors and can influence how Native Americans react to trauma and stress. The Academy of Pediatrics reports the way genes work in our human bodies determines neuroendocrine structure and is strongly influenced by experience. Neuroendocrine cells help the nervous and endocrine (hormonal) system work together to produce substances such as adrenaline (the hormone associated with the fight or flight response). Trauma experienced by earlier generations of Native Americans can influence the structure of the genes of later generations, making them more likely to "switch on" negative responses to stress and trauma. While a significant amount of research on epigenetics is emerging, Native American healers, medicine people, and elders have known that inter-generational trauma is real and is a contributing cause of depression and diabetes.

B. SELECT RESEARCH IMPLICATIONS

IMPROVING SOCIAL AND ECONOMIC OUTCOMES

BUILDING WEALTH

As described earlier in this Report, AI/ANs are a relatively low wealth population with its median wealth equal to only 8.7 percent of the median wealth among all other Americans. As the Department closes its commemoration of 50 years engaging in the 'War on Poverty,' such facts suggest areas for further research and analysis.

Researchers Stephen Cornell and Joseph P. Kalt found that strong and culturally appropriate tribal leadership is associated with higher employment rates.[201] In their analysis, tribes governed by a chief executive or a legislature, typically a parliamentary tribal council, had better employment outcomes than tribes governed by a general council. The researchers also found that for the tribal government to be effective, it needed to be grounded in the cultural traditions of the tribe and not simply on forms that were at one time imposed by the federal government. In addition, many tribes lack access to capital, credit, and financial services. This stifles entrepreneurship and other economic development activities that lead to job creation. Native American community development financial institutions (CDFI) may be an important solution to this problem. The Four Bands Community Fund, a Native American CDFI in Eagle Butte, S.D., illustrates some of the potential of these institutions. Four Bands has served nearly 4,000 clients and disbursed approximately 580 microloans, small business loans, and credit-builder loans totaling $4.1 million.[202] It has also contributed to the establishment or expansion of more than 100 Native-owned businesses and the creation or retention of more than 400 jobs on the Cheyenne River Indian Reservation. More and stronger Native American CDFIs would facilitate Native American economic self-determination through wealth-building and entrepreneurship.

Finally, of all the variables in the analysis of AI/AN employment opportunities, educational attainment produce the largest positive effect on individuals' opportunities of employment. Therefore, the development of policies that can increase Native American educational attainment appear to have the strongest potential for improving the employment rates of American Indians and there are many policies that may be effective at accomplishing this. Educational attainment is a product of not just a child and the child's school, but also the family and community resources and supports available to the child. Children from disadvantaged socioeconomic backgrounds tend to do worse in school than other children precisely because they come from such disadvantaged socioeconomic backgrounds.[203] Research in the areas of improved maternal and child health; early childhood education where 'quality' is measured by culturally and linguistically relevance and responsiveness; strategies to address low high school graduation rates; and, as referenced above, improvements in the quantity and quality of data about Native Americans all may contribute to improved economic outcomes for Native Americans.

IMPROVED MATERNAL AND CHILD HEALTH

[201] S. Cornell and J. Kalt, *Where's the Glue: Institutional and Cultural Foundations of American Indian Economic Development,* Journal of Socio-Economics, 29: pp. 443-70. (2000).

[202] See http://www.fourbands.org/about.htm

[203] D. Burkam and V. Lee, *Inequality at the Starting Gate: Social Background Differences in Achievement as Children Begin School*, Economic Policy Institute (September 2002).

In consideration of future research on improving Native American maternal and child health, it may be instructive to look to the research on African Americans. While African American students perform worse than white students on standardized tests, African American test scores have improved over time, and the African American–white test score gap narrowed considerably over the 1980s. Recent research suggests that this narrowing was due to improved neonatal health outcomes for African American children following the desegregation of hospitals in the 1960s. Researchers have concluded that "investments in health through increased access at very early ages have large, long-term effects on [educational] achievement."[204] As demonstrated earlier in this Report, a larger proportion of Native Americans than whites are uninsured, and they fare poorly on health access measures. The post-neonatal mortality rate of Native Americans is about twice that of whites. Therefore any improvement of Native American maternal and child health, such as through ACF's Tribal Maternal, Infant, and Early Childhood Home Visiting program, appears likely to improve the educational performance of Native American children.

EARLY CHILDHOOD EDUCATION

Research has shown that high-quality early childhood education can have long-term positive impacts on educational attainment. The best programs increase the likelihood of high school and college completion.[205] AI/AN three- and four-year-olds have one of the lowest rates of preschool enrollment. From 2009 through 2011, 58 percent of AI/AN children were not enrolled in preschool, compared with 50 percent of non-Hispanic white children.[206] For the AI/AN children who are enrolled in preschool, the data suggest that whites have access to better quality early childhood education than nonwhites.[207] To improve AI/AN children's educational outcomes, they require, not simply higher preschool enrollment, but enrollment in high-quality early education programs that meaningfully incorporate such children's Native culture and language and measure quality by the extent to which such is accomplished. More research is needed to understand the extent to which such a focus affects educational and social outcomes.

INCREASE HIGH SCHOOL GRADUATION RATES

One-fifth of Native Americans do not have a regular high school diploma, compared with about one-tenth (11.3 percent) of whites. Native Americans who obtain regular high school diplomas have higher odds of finding employment than those who drop out of high school and those who obtain GEDs. The following strategies suggest policies that may be adopted to increase high school graduation rates among Native American youth.

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[204] K. Chay, J. Guryan, B. Mazumder; *Birth Cohort and the Black-White Achievement Gap: The Roles of Access and Health Soon After Birth*, Working Paper 15078, National Bureau of Economic Research (June 2009).

[205] S. Barnett and C. Belfield, *Early Childhood Development and Social Mobility*, Future Child, 16(2), pp. 73-98 (2006).

[206] Kids Count 2012 Data Book

[207] See Burkham and Lee supra at note 186.

- Academic Support: Identify early AI/AN students at risk for dropping out that include indicators such as low class attendance, suspensions, course failures, and low scores on assessments.
- Behavioral Intervention: Establish planned, individualized programs of interventions that are culturally appropriate and are designed to relieve or minimize mental, emotional, physical, or other symptoms associated with mental or emotional disturbance, alcohol, or drug issues.
- Family Engagement: Engage and inform parents and families of children's school performance and behavior in school. Assist parents in gaining knowledge and skills to engage with other parents, faculty, staff, and community partners.
- Health and Wellness: Recognize the importance of student health and wellness with school-based activities that promote physical and emotional wellness as well as spiritual connectedness.
- Mentoring: Effectively engage student peers as mentors to build academic and social-emotional, as well as traditional, knowledge and skills.
- Work-Based Learning: Support work-based learning programs to expand and enhance student's learning with job site experiences and facilitate successful transitions from school to work.

DATA

Understanding and improving the economic conditions of Native Americans requires reliable data. Unfortunately, as described throughout this Report, there are questions about the accuracy and quality of national data about Native Americans. This necessitates additional research to assess the accuracy of national data sets for studying Native Americans and for understanding their true economic and social conditions. Critical to this, are surveys designed specifically to collect tribal-level data. The limited amount of reliable empirical research on Native Americans and Native youth leaves many gaps and questions for further research. Such research fall into three main categories: (1) the causes, scope, and characteristics of Native Americans; (2) the efficacy of interventions, approaches, and strategies at individual and community level; and (3) service planning and infrastructure.

The ability to accurately describe the causes, scope, and characteristics of Native American peoples and communities is important for the planning and funding of interventions and strategies that can address the diversity of Native American populations.

Data is the foundation for good decision making. However, historically, quantitative and qualitative data on the Native American population has been incomplete and often unreliable, resulting in AI/ANs and NHPIs being one of the most undercounted groups of any population in the U.S.

It has been often stated that the U.S. Census is planned at the national level but carried out at the local level, community by community, across the country. This is especially true than in AI/AN communities. As the social and economic indicators in this Report demonstrate, many Indian tribes must rely on Federal assistance programs to help improve economic opportunities and living conditions among AI/AN peoples. A significant portion of federal aid intended to benefit

such populations is based on the information collected in the Census and relied on by federal funding agencies.

With regard to the on-reservation AI/AN population, which only partially reflects the total AI/AN population given that approximately 75 percent may be considered 'urban' at any given time, the U.S. Census Bureau officially acknowledged in a recent report that the data from its American Community Survey (ACS) on the characteristics of the on-reservation Indian population is often of questionable reliability. The report confirms what independent analysts have known for years.[208] The little publicized report, released in April 2015, is entitled "The Reliability of ACS 5-Year Estimates of Race Groups and American Indian and Alaska Native Populations" and was developed by a group of researchers in the Bureau's Decennial Statistical Studies Division.

The ACS is the Bureau's replacement for what was formerly a "long form" questionnaire distributed as part of the decennial census. Like the decennial "long form," the ACS is intended to gather information on the socio-economic characteristics of the U.S. population -- like employment and income -- down to small local areas -- like reservations.

Data is collected in the ACS on a continuous basis. Questionnaires are mailed to a sample of households every month of every year. This enables the Bureau to publish ACS data every year, not just every ten years as was the case with the former "long form" data. The percentage of population sampled by the ACS is much smaller than that sampled with the old long form. The smaller sample size has a major impact on the reliability of the results. This problem was raised even before the ACS became implemented as a national effort.

As a result of the smaller sample size, the Census Bureau has to aggregate the responses it receives from the ACS for smaller communities over five consecutive years in order to have enough data to publish what the agency considers to be reliable estimates. The resulting data sets are labeled "5-year estimates." The recent Bureau report focused on the ACS 5-year estimates for the 2006 to 2010 time period in analyzing the characteristics of the AI/AN population. The AI/AN population is further divided into two components, an "alone" component and an "in combination" component. The "alone" component consists of persons identifying themselves on the race question on the ACS questionnaire by checking only the box for AI/AN. Those checking the AI/AN box, and simultaneously the box for another major racial group, are considered as AI/AN "in combination" with another race. The "alone or in combination" figure adds these two components together.

As its test of reliability, the report used a common statistical measure called a "coefficient of variation." Coefficients of variation (CVs) are a measure of the relative amount of sampling error in an estimate based on a sample of a total population. CVs are expressed in percentage terms. The higher the CV, the less reliable the results from a sampling error perspective.

[208] The analysis of U.S. Census Bureau ACS data is substantially based on ANA Policy Division discussion with Norm DeWeaver and his paper, *Can You Count on the ACS Numbers for the On-Reservation Indian Population?* (June 2015)

There is no universally accepted level at which a CV is believed to indicate that a sample estimate is reliable or unreliable. The way the estimate is used is important in judging reliability. For example, will the estimate be used to determine the amount of grant money going to each individual tribe in an Indian program that allocates its money by formula? Or will the estimate be used as just an estimate of the characteristics of a reservation's Indian population? In analyzing ACS data over the years, one standard of reliability suggested by a Census Bureau researcher on ACS issues, Ms. Deborah Griffin, stated:

> Estimates with CVs that are less than 15 percent are generally considered reliable, while estimates with CVs that are greater than 30 percent are generally considered unreliable.

This suggests that CVs in the 15 to 30 percent range are of questionable reliability. The following are the findings of *The Reliability of ACS 5-Year Estimates of Race Groups and American Indian and Alaska Native Populations*:

- The median CV for the number of AI alone unemployed in the 196 AI/AN areas was 33 percent. (The median is the level at which half of the values fall below and half above that figure.)

- The median CV for the for the percentage of AI alone persons in poverty was 23.6 percent.

- The median CV for the percentage of AI alone persons under 18 years of age living in poverty was 29.7 percent.

- The median CV for households receiving food stamp/SNAP benefits in the previous 12 months was 28.0 percent.

In the case of the number of unemployed, the median falls in the unreliable range, using the standard suggested by the Census Bureau researcher. In the other three cases, it is close to that range, although slightly below it. The report expressed no concern about the possibility that ACS data found to be outside reasonably acceptable limits of reliability might be used for purposes where the results affect the allocation of funds or other consequential decisions, such as the design o f programs for low income individuals and families.

The Summary section of the report noted: "The main observation is that the level of reliability and size of the CVs were largely dependent on the size of the population on which the estimates were based." The statement simply reflects the basic principle of survey research -- the size of the sample relative to the total size of the population surveyed is the principal determinant of the reliability of the results. The Census Bureau's recent report had the effect of confirming what many have been pointing out for years about ACS data. Namely, the ACS 5-year estimates for several key characteristics of the AI/AN alone population at the individual reservation level frequently fall outside the limits of reliability as measured by the coefficients of variation of those estimates. Finally, the section of the recent Bureau report that looked at the reliability of the population characteristics for the on-reservation Indian population computed CVs for 297

key characteristics of persons counted as AI alone living in 196 American Indian and Alaska Native areas. The following are some key findings:

- 49 of the 86 largest reservations, 57.0 percent, had a CV in the reliable range (0 to 15.0 percent)
- 36 of the 86, 41.9 percent, had a CV in the questionable range (15.1 to 30.0 percent)
  The remaining 1 reservation, or 1.2 percent, had a CV in the unreliable range (over 30.0 percent)

With respect to AI/AN population characteristics, variables that are key to federal decision-making and funding allocations, it may be useful to encourage tribes to undertake their own data collection efforts as well as provide technical assistance and financial resources to facilitate this to ensure reliability.

In the area of health care, section 4302 of the Affordable Care Act (ACA) includes provisions to strengthen Federal data collection efforts by requiring that all national Federal data collection efforts collect information on race, ethnicity, sex, primary language and disability status. The law also provides HHS with the opportunity to collect additional demographic data to aid in the understanding of health and health care disparities. The ACA requires that data collection standards for health and health care measures be used, to the extent that it is practical, in all national population health surveys collecting self-reported data. Improved health data collection can be expected to result in improved opportunities to evaluate not only the health status of Native Americans, but also to improve the ability of HHS to evaluate the impact the Department's ongoing efforts to address the social and economic conditions of Native American peoples.