Understanding Urban Indians' Interactions with ACF Programs and Services

Literature Review

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LITERATURE REVIEW

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Introduction 1

This literature review supports *Understanding Urban Indians' Interactions with ACF Programs and Services*, a research study funded by the Office of Planning, Research and Evaluation (OPRE) in collaboration with the Administration for Native Americans (ANA) of the Administration for Children and Families (ACF), located within the U.S. Department of Health and Human Services (DHHS). The study addresses the following questions:

- What are the social service needs of low-income urban American Indian and Alaska Native individuals and families?
- What role do Urban Indian Organizations play in helping urban Native families meet their social service needs?
- Are urban American Indians and Alaska Natives aware of and accessing the services/programs offered by ACF? If not, what may be some of the barriers to access?
- What are some of the best state practices/policies for providing social services to urban Indian families?

This review summarizes what is known about the status of urban American Indian/Alaska Native (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 explores 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 is examined 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.

Brief History of Urban American Indians 2

The movement of AI/AN off the reservations and into America's cities is a little-examined chapter in American history. There is some uncertainty about the total population size of AI/AN prior to the arrival of European explorers, with figures ranging from slightly over 1 million individuals (a now-acknowledged low count) to more than 100 times that number (Mann, 2002, 2006; Grann, 2009: 270-277) There is little debate, however, about the impact of European settlers on the lives of Native Americans. Disease, slavery, and violence led to the demise of the indigenous populations such that by 1900, it is estimated there were only 250,000 AI remaining in the lower 48 United States (Thornton, 1984), which represents a population decline of 95 percent or greater. Thornton (ibid.) reports that north of the boundary of the coterminous United States, the population declined from over 2 million indigenous persons to no more than 150,000 by 1900.

From the late 18th into the middle of the 19th century, European westward expansion put increasing pressure on the surviving indigenous population. Between 1778 and 1871, the Federal government established nearly 400 treaties with the survivors of the different Indian nations, with numerous tribal leaders ceding their land in exchange for Federal protection. More than 56 million acres of those lands continue to be held in trust today and serve as the reservations for numerous tribes.[1] However, these legal contracts were not always honored and many tribes were forcibly removed from their homes to make way for European settlers. For instance, the Cherokees' 1791 treaty with the Federal government was challenged by the state of Georgia in 1830. Although the tribe took the case all the way to the U.S. Supreme Court where eventually Chief Justice Marshall ruled in their favor, President Andrew Jackson ordered the Cherokee off of their land. Those who did not leave voluntarily were "escorted" by Federal troops in the infamous "Trail of Tears" from Georgia to what is today eastern Oklahoma (Remini, 2001).

Historians generally agree that whether by treaty or gunpoint, American Indians were removed from land coveted by White settlers and onto reservations in some of the least desirable locations in the country. Sandefur (1989), for example, writes:

> The lands reserved for Indian use were generally regarded as the least desirable by whites and were almost always located far from major population centers, trails, and

[1] A summary of Federal Indian policy can be found on the Bureau of Indian Affairs (BIA) website at http://www.bia.gov/FAQs/

> transportation routes that later became part of the modern system of metropolitan areas, highways, and railroads. In sum, for most of the nineteenth century the policy of the U.S. government was to isolate and concentrate Indians in places with few natural resources, far from contact with the developing U.S. economy and society. (page 37)

As it did for many Americans, World War II ushered in a new era for American Indians and Alaska Natives (AI/AN). Those who enlisted or were drafted had the opportunity to leave the reservations and see other parts of the United States and the world. After completing their military service, many were reluctant to return to their rural lives and often took up residence in the port cities where the troop carriers dropped them off. The promise of steady work and a regular income reinforced the desire to remain in this new environment.[2] In many respects, this post-war shift from rural to urban life was the same for AI/AN as for other rural Americans, with immigrants to the cities hoping to obtain jobs and/or employment training, as well as better educational opportunities (Carpio, 2011; Fixico, 2000; Thornton, Sandefur, and Grasmick, 1982).

In 1956, however, the U.S. government turned this organic relocation of AI/AN into a Federal policy. The Indian Relocation Program aimed to engender self-sufficiency among AI/AN by moving them off of the reservations, where both employment and Federal assistance were limited, and into America's cities, which offered jobs and opportunities (e.g., vocational training). This program relocated over 100,000 American Indians from reservations to major cities throughout the country (Thornton, Sandefur, and Grasmick, 1982). Chicago, Los Angeles, St. Louis, and Denver were just a few of the original cities designated as relocation centers.

Many families did benefit from the Relocation policy in terms of economic status. Sorkin (1969), for example, found that 20 percent of urban AI/AN lived in poverty whereas 50 percent of AI/AN on reservations and tribal lands lived below the poverty line (as cited in Thornton, Sandefur, and Grasmick, 1982). More recent work (Harvard Project, 2004b) indicates that Indians living in cities increased their employment prospects and realized a standard of living that was better than on reservations (see Table 2-1). Among urban AI/AN, the standard of living has risen over the last 25 years.[3]

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[2] For a discussion of similar effects of World War II on another minority populations, see Berube (1991) and Kennedy and Davis (1994).

[3] Recent work indicates that AI/AN males who have more than 10 years of education, are highly skilled, and married are most likely to benefit economically in urban areas. However, this finding might not hold for urban AI/AN women. A small study of 20 urban AI/AN mothers conducted by Tsethlikai, Peyton, & O'Brien (2007) found that 90 percent of the participants had attained more than a high school education, yet the median income-to-needs ratio was 1.03; this means that half of the mothers were *below* a point just above the poverty threshold.

Table 2-1. Socioeconomic features of urban and other off-reservation Indians, 2000

	Population		College Attainment	Unemployment	Income per Capita	Age 20-64
	(000)	(%)	(%)	(%)	($1,999)	(%)
Indian *						
On Reservations	512	21	12	22	$7,959	49
In All Indian Areas	879	36	13	16	$9,435	51
Urbanized Areas	1,110	45	21	10	$15,312	62
Outside Indian Areas	1,568	64	20	10	$14,832	61
U.S.-Wide	2,448	100	18	12	$12,893	58
All Americans						
Urbanized Areas	195,815	70	34	6.0	$22,736	60
U.S.-Wide	281,422	100	31	5.7	$21,587	59

* Self-identified American Indian and Alaska Native alone (i.e., not in combination with any other racial category). Note that these geographic categories overlap; some reservations and Indian areas include urban areas.

Source: U.S. Census Bureau, Census 2000 Summary File 3.

Nevertheless, challenges were numerous and not all families found the economic prosperity that had hoped for. By the 1970s, many AI/AN families were faring poorly in these urban environments. Problems commonly noted by scholars and advocates included high rates of alcoholism, AI/AN youth dropping out of school at relatively high rates, and significant morbidity related to poverty (e.g., diabetes, chronic obstructive pulmonary disease – see Riste, Khan, and Cruikshank, 2001; Hsu, Lee, et al., 2012; Akinbami and Liu, 2011; inter alia), among other challenges. Ironically, while the Indian Health Service was established in 1955 and began to provide basic health care services to AI living on or near the reservations, many low-income urban Natives' health care needs remained unaddressed. Moreover, and to their detriment, many of these individuals who relocated to the cities lost their day-to-day connections with tribal and family members who could provide a safety net during difficult times.

The needs of these individuals did not go unnoticed. As early as 1958, AI/AN who were living in Seattle could receive assistance from the American Indian Women's Service League (AIWSL), which was founded explicitly to provide services and supports to the urban Native population.[4] Members of the AIWSL focused on "critical situations within the scope of women's activities—those affecting children, health, housing, etc.,"[5] and also created a voice for the Seattle AI/AN community. They also started two monthly newsletters (*Indian Center News* and *Northwest Indian News*) that carried

[4] http://depts.washington.edu/civilr/AIWSL.htm – accessed 6.18.14

[5] Ibid.

information about community events and services, as well as published articles written by AI/AN living in Seattle and other urban centers in the Pacific Northwest.

A second advocacy group, the United Indians of All Tribes Foundation (UIATF), also was formed in Seattle in 1970. Its mission was—and still is—to:

> …to foster and sustain a strong sense of identity, tradition, and well-being among the Indian people in the Puget Sound area by promoting their cultural, economic, and social welfare. This is accomplished through the development and operation of educational, social, economic, and cultural programs and activities benefiting local Native Americans, and by maintaining a strong link with Indian tribes and other urban Indian organizations and their allies throughout the State of Washington.[6]

Program areas addressed by UIATF include education and training, which covers both Head Start and Early Head Start; community development; arts and culture; healing and wellness, including programs focused on domestic violence and chemical dependency; and youth and family services, which includes both foster care and elder services.

Other advocacy organizations continued to emerge over time to address the social services needs of urban AI/AN. Among these were the National Council of Urban Indian Health, which was founded in 1998;[7] and the National Urban Indian Family Coalition.[8] The general American public may have been unaware of the challenges facing urban AI/AN, but within the AI/AN community the needs of urban members garnered significant attention.

In addition to the supports offered by these organizations, low-income urban AI/AN families also have had available to them self-sufficiency services and other programs offered by ACF. These programs include Head Start, Temporary Assistance for Needy Families (TANF), job training and development, the Low-Income Home Energy Assistance Program (LIHEAP), as well as foster care and adoption. In short, the ACF services target those areas specifically identified by AI/AN advocacy groups as being most critical to improving the welfare of urban AI/AN: children's education, financial and in-kind assistance for low-income families, as well as employment training and support.

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[6] http://unitedindians.org/about_mission.html – accessed 7.29.11

[7] http://www.ncuih.org/ – accessed 7.30.11

[8] http://nuifc.org/ – accessed 7.30.11

Despite this array of social services, data indicate that challenges continue for many urban AI/AN, including (as we discuss in subsequent chapters) higher rates of poverty, unemployment, and homelessness compared to the general population; lower levels of educational achievement; and higher rates of morbidity and mortality among urban AI/AN than among the non-AI/AN urban population. Little information is available to determine whether low-income urban AI/AN are utilizing services supported by ACF, and if they are not, why not? For instance, is the community simply unaware of these services? Or do they know of these Federal supports, but do not use them because of adverse historical experiences and/or cultural barriers? In either event, what can ACF do to improve the availability of services to urban AI/AN who might benefit from them? This study aims to find answers to these questions.

Complicated Concepts 3

At first glance, understanding the experiences of urban American Indians and Alaska Natives seems a straightforward task that involves focusing on tribal members in large cities. Upon further examination, however, one must define the context by clarifying the meaning of "urban areas" as distinct from "reservations," as well as take into account the inherent complexities of defining AI/AN identity. We explore these matters below.

3.1 What Does It Mean To Be an Urban Indian?

According to the United States Census Bureau (2010), urban areas represent densely populated and highly developed territories that encompass residential, commercial and other non-residential urban land uses.[9] Urban areas are comprised of densely settled core census tracts and census blocks that meet minimum population density requirements, and adjacent territory with low population density that links outlying densely settled territory to a densely settled core. Urbanized areas contain 50,000 or more people and urban clusters contain at least 2,500 but less than 50,000 people. Individuals living in such an area are generally referred to as "urbanized." Using this definition, some researchers have included as "urban" anyone of AI/AN descent who resides in large cities, suburban areas, and small cities, as well as AI/AN who live in towns and villages (Thornton, Sandefur, and Grasmick, 1982). Migration patterns also are used to define the urban population, with a number of books documenting the frequent movement of AI/AN from different tribes between cities and reservations due to seasonal economic opportunities (e.g., Blumenfeld, 1965; Hurt, 1961; Waddell, 1969).

But for sociologists and anthropologists, there are important nuances associated with the term "urban" (Thornton, Sandefur, and Grasmick, 1982). It is certainly a designation of place, but also relates to an enculturation process among AI/AN. Due to the internet and other forms of mass media, some American Indians living on a reservation could be viewed as having adopted urban cultural traditions (e.g., style of dress, language use, musical tastes) despite the fact that they never left the reservation. Conversely, an AI/AN living in a densely populated city due to economic necessity could be seen (and self-identify) as a traditional tribal member because s/he avoids aspects

[9] http://www.census.gov/geo/www/ua/2010urbanruralclass.html

of urban popular culture (Carpio, 2011). These traditional ways may affect the kinds of services individuals believe they need and the ways in which they access available services and supports.

3.2 What Does It Mean To Be an American Indian or Alaska Native?

According to Census 2010 data, 67 percent of individuals who self-identify as AI or AN alone, and 78 percent of those who self-identify as AI or AN alone or in combination with some other race, live outside of reservations or Alaska Native villages (United States Census Bureau 2012). These individuals self-identified as AI/AN, with some identifying themselves as members of the 566 federally recognized tribes, others indicating that they were members of the 109 tribes that were terminated by the federal government in the 1950s (ibid.) and still others identifying with no single tribe.

Although the United States Census Bureau allows for self-identification of AI/AN heritage and allows individuals to identify with more than one race, the question of what qualifies a person as an AI/AN has become a dominant issue for federally recognized, non-federally recognized, reservation, and non-reservation AI/AN. There are many different standards for qualification as an AI/AN, with tribes allowed to determine who qualifies as a member; some tribes require that a person have at least one-fourth or more Indian blood to be considered a tribal member and others require proof of Indian ancestry through identification of family bloodlines (Pevar, 1992). Another commonly used standard is that the person has some degree of Indian blood and maintains ties to a federally recognized Indian community (ibid.). Some AI Nations now require not only proof of blood quantum, but also proof of cultural identification (e.g., for Pueblo Indians, knowledge of one's clan) in order to obtain tribal membership or AI/AN status-based government employment. An individual also may not be eligible for enrollment in any tribe, even though he might be full-blooded American Indian; if his parents and/or grandparents have different tribal affiliations, he may not meet any of those tribes' blood quantum requirements.

The reliance on blood quantum as the defining factor of Indian identity for some tribes is frequently rejected by non-reservation AI/AN (Lobo, 2001). According to James L. Simmons (Thornton, Sandefur, and Grasmick, 1982:24), there are at least six ways of being identified as AI/AN in urban areas:

1. Legal definitions: the Bureau of Indian Affairs, Indian Health Services, and the Bureau of Indian Education all have standard definitions for what qualifies a person as an AI/AN and thereby entitles the individual to receive services;
2. Self-identification;
3. Recognition as AI/AN by the local community;
4. Perceptions by non-AI/AN;
5. Blood quantum, with the minimum amount of blood needed for tribal membership varying by tribe; and
6. Use of a cultural definition or requirement.

Aside from definitions of "degree of Indian identity," when it comes to examining what it actually *means* to be an urban AI/AN the issue of identity becomes even more complex. It would be overly simplistic to suggest that all AI/AN living on reservations are being raised with their cultural traditions whereas all AI/AN living in urban environments are being raised without their cultural heritage. On the other hand, some urban AI/AN have found cultural homes within the cities where they relocated or have lived throughout their lives (ibid.).

Regardless of whether AI/AN living in urban areas view themselves as having an AI/AN identity, being perceived as an AI/AN by non-AI/AN society can be associated with negative stereotypes and racism (Fixico, 2000). According to Fixico, Minneapolis, Sioux City, Rapid City, and smaller cities like Gallup, New Mexico are known for their antagonistic attitudes towards American Indians. Recently, Seattle has seen an increase in protests concerning racism and discrimination against AI/AN and First Nations people after the fatal shooting of John T. Williams, a 50-year-old totem carver (Mapes, 2010). The negative attitude of some members of mainstream society towards AI/AN has led to high rates of victimization, with AI/AN more likely to be victimized by members of another race than people of other races (U.S. Department of Justice, 2001). Approximately 60 percent of AI/AN victims of crime reported that the offender was white (U.S. Department of Justice, 2004). According to the U.S. Department of Justice (2001), the high level of victimization occurs across ages. A later report by the U.S. Department of Justice (2004) examining violent victimization across races reported AI/AN had high levels of violent victimization by geographic location (see Table 3-1).

Identity politics among tribal governments also can have profound implications for social service use. Urban Indian centers have different eligibility criteria for their services. For instance, some centers will provide services to anyone who self-identifies as American Indian, while others require proof of tribal enrollment.

Ultimately, we find that both "urban" and "American Indian/Alaska Native" cannot be regarded as simple, objective categories. The urban experience of every AI/AN is different and must be understood relative to community context and personal history. Given this, there is no consistent urban AI/AN experience to identify and link with service needs. Therefore, the aim of this study was to discover broad patterns of experience that can help ACF understand how to more effectively engage low-income urban AI/AN communities in the future.

Table 3-1. Victimization by type; race; and urban, suburban, and rural location

	Average annual victimization rates (per 1,000 persons age 12 or older)											
	Urban				Suburban				Rural			
Type of crime	White	Black	American Indian	Asian	White	Black	American Indian	Asian	White	Black	American Indian	Asian
Crimes of violence	59.1	68.0	147.4	27.1	43.8	48.5	136.1	24.4	34.0	31.1	93.0	20.5
Rape or sexual assault	2.4	2.7	12.1*	0.8*	1.6	1.4	6.5*	1.5	1.4	1.9	2.3*	0.0*
Robbery	7.5	14.5	26.3	8.2	3.7	7.6	7.9*	3.9	2.5	2.7	5.7*	1.4*
Aggravated assault	12.6	17.0	33.7	6.0	8.8	12.1	35.7	5.4	7.0	9.7	20.8	5.9*
Simple assault	36.5	33.8	75.3	12.1	29.6	27.3	86.0	13.6	23.0	16.7	64.2	13.2*
Serious violent crime	22.5	34.2	72.1	15.0	14.1	21.1	50.1	10.8	10.9	14.3	28.2	7.3*

Note: Serious violent crime includes rape and sexual assault, robbery, and aggravated assault.

* Based on 10 or fewer sample cases.

Current Demographics of Urban American Indians and Alaskan Natives

4

Understanding the assistance needs of the urban AI/AN population requires knowledge of the specific challenges facing this community and the scope of those issues. In this section, we briefly review several key demographic features of the urban community to establish the kinds of services and supports that are most needed.

4.1 Income

The 2013 federal poverty guidelines for a family of four in the lower 48 states and the District of Columbia is $23,550 a year; in Alaska, the level is $29,440.[10] However, some researchers suggest that for a family to meet its basic needs, it requires an income of at least twice the guideline amount.[11] The Census Bureau has produced statistics on the poverty level of AI/AN in the 30 cities or locations that have the highest populations of individuals who self-identify as AI/AN alone (i.e., not in combination with some other race) (see Table 4-1, next page). Because of the relatively small numbers, the margin of error is fairly broad; nevertheless, these statistics provide a good general indicator of the challenged economic status of many urban American Indians. One striking limitation is the lack of data on urban Alaska Natives who live in metropolitan areas of Alaska.

According to the Urban Indian Health Institute (UIHI) (2009), in UIHO areas, 30 percent of urban AI/AN children live in households with incomes below the poverty level, while the poverty rate for White families in the same areas is 7.3 percent. These percentages are similar to nationwide statistics which indicate that 31.6 percent of AI/AN children live in households with incomes below the poverty level while 9.4 percent of White children live in poverty (ibid.). Table 4-1 illustrates the percentages of AI/AN living in poverty in the 30 U.S. cities with the largest populations of individuals who self-identify as AI/AN alone (i.e., not in combination with some other race). They range from a low of 13 percent in Fort Worth, Texas to a high of more than 55 percent in Rosemont, AZ. Because of the small population numbers, however, these statistics have a large margin of error in either the

[10] http://aspe.hhs.gov/poverty/13poverty.cfm – accessed 12.18.13

[11] http://www.nccp.org/topics/childpoverty.html – accessed 12.18.13

positive or negative direction. For Tucson, for example, the true percentage of the population living below the poverty level is anywhere from 23.8 percent (31% - 7.2) to 38.2 percent (31% +7.2).

Table 4-1. Poverty rates for the AI/AN alone population in the 30 U.S. cities or places most populated by AI/AN alone: 2007-2011

Rank	City	Population	Number below poverty	Margin of Error	Percent below poverty	Margin of Error
1	New York City, NY	29,637	7,777	1,030	26.2	2.9
2	Phoenix, AZ	25,905	7,482	1,104	28.9	4.0
3	Albuquerque, NM	23,269	6,374	918	27.4	3.7
4	Los Angeles, CA	19,259	3,931	662	20.4	2.9
5	Oklahoma City, OK	18,255	4,381	677	24.0	3.2
6	Anchorage, AK	17,782	2,952	562	16.6	2.9
7	Verden Town, OK	16,124	3,716	624	23.0	3.3
8	Tucson, AZ	11,981	3,714	960	31.0	7.2
9	Zuni Pueblo CDP, NM	10,010	3,180	1,427	31.8	12.5
10	Mesa, AZ	9,966	2,276	701	22.8	6.4
11	Farmington, NM	9,441	2,792	845	29.6	7.5
12	San Antonio, TX	9,257	2,634	723	28.5	6.1
13	Tuba City, AZ	8,654	2,425	760	28.0	8.0
14	Gallup, NM	8,628	2,742	749	31.8	7.8
15	Shiprock CDP, NM	8,439	3,338	1,058	39.6	10.6
16	Houston, TX	8,219	2,090	668	25.4	7.3
17	Minneapolis, MN	6,956	3,359	573	48.3	7.4
18	Rapid City, SD	6,851	3,484	558	50.9	7.2
19	Denver, CO	6,841	1,988	518	29.1	6.3
20	Chicago, IL	6,743	1,692	376	25.1	5.2
21	Flagstaff, AZ	6,561	1,786	615	27.2	8.2
22	San Diego, CA	6,360	1,254	486	19.7	6.4
23	San Jose, CA	6,115	1,081	408	17.7	5.9
24	Portland, OR	5,819	2,208	618	37.9	8.4
25	Sacramento, CA	5,094	1,500	467	29.4	7.2
26	Ft Worth, TX	4,903	636	211	13.0	4.6
27	Oxnard, CA	4,807	811	426	16.9	8.6
28	Tempe, AZ	4,768	993	419	20.8	7.7
29	Rosemont, AZ	4,765	2,630	858	55.2	13.8
30	Seattle, WA	4,669	1,152	309	24.7	6.1

Source: US Census Bureau (http://www.census.gov/hhes/www/poverty/publications/Appendix_Tables1-24.pdf)

4.2 Housing

The lack of safe and affordable housing in urban areas is not a new phenomenon. Since the inception of the Industrial Revolution, individuals have migrated to cities in search of economic opportunity. Migrations increased the demand, gentrification reduced the supply, and it was not long before cities saw the development of "slums," such as the East End of London,[12] the Edinburgh Vaults,[13] and New York City's Five Points area.[14] The same dynamic extends into the present day, although policymakers have stepped in to try to reduce this "clustering" of poverty. The development of the Section 8 voucher program, for example, has provided low-income families, including urban AI/AN families, with subsidy vouchers that they can use for any rental housing for which the landlord is willing to accept the voucher payments.[15] A longstanding imbalance between housing supply and demand, however, has led to large numbers of families waiting years to receive vouchers. In New York City, for example, over 620,000 families benefit from the city's Public Housing and Section 8 programs; however, nearly 125,000 remain on the Section 8 waiting list, which closed to new applicants in 2007.[16] Urban AI/AN families are disproportionately affected by poverty and thus likely face significant challenges obtaining safe, decent, and affordable housing.

Importantly, HUD does have monies to improve housing access and availability for low-income American Indians and Alaska Natives: The Indian Housing Block Grant (IHBG) and the Federal Guarantees for Financing Tribal Housing Activities program (also known as the Title VI Loan Guarantee program). Because these monies are dedicated to meeting the housing needs of AI/AN living on tribal lands, most urban residents do not benefit from the programs. However, there are notable exceptions. For example, reservation land for the Pullyap tribe is located in what is now Tacoma, Washington. In 2012, the tribe received nearly $2.5 million in IHBG funds and an additional $3.8 million in Recovery Act monies to build numerous low-income rental units[17] for tribal members. The Reno-Sparks Indian Colony, located in Reno, Nevada, also received over $1.3 million in IHBG funds in 2012.[18] And in 2013, three tribally designated Housing Authorities in

[12] http://www.victorianweb.org/history/slums.html

[13] http://www.historic-uk.com/HistoryMagazine/DestinationsUK/Edinburgh-Vaults/

[14] http://www.urbanography.com/5_points/

[15] http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/rfp/s8bkinfo

[16] http://www.nyc.gov/html/nycha/html/about/factsheet.shtml

[17] Details obtained from HUD's 2014 Summary Statement on Native American Housing Block Grants appropriations, page L-13. Available at http://portal.hud.gov/hudportal/documents/huddoc?id=NAHSINGBLOCKGRANTS.pdf.

[18] http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2012/HUDNo.12-034 – both pages accessed 1.3.14.

Santa Fe (Nambe Pueblo, Northern Pueblos, and Pueblo of Pojoaque) received from $195,000 to nearly $700,000 in housing grant funds.[19]

In 2003, the U.S. Department of Housing and Urban Development (HUD) conducted an assessment of housing discrimination against Native Americans by focusing on markets in three states: Minnesota, Montana, and New Mexico. The HUD study found that very few AI/AN own their own homes: 58.8 percent in New Mexico, 33.9 percent in Montana and 41.5 percent in Minnesota. The study also used a paired testing methodology, whereby a White tester and a minority tester, who were assigned comparable demographic and financial characteristics, would inquire about the same available rental unit.[20] The only statistically significant finding was that in all three locations, Whites were favored over AI/AN in terms of agents informing the inquirer about the availability of units similar to the one advertised. In Montana Whites were favored over AI/AN in 18.2 percent of the paired tests; in Minnesota Whites were favored in 31.1 percent of the tests; and in New Mexico, Whites were favored over AI/AN 31.7 percent of the tests.

4.3 Mobility

American Indians are highly mobile (Urban Indian Policy Review Commission, 2007). For example, half of the urban AI/AN service recipients in Denver moved to a new home every 18 months (Urban Indian Health Commission, 2007). Similarly, a study by Duffy, Goldberg, and Buchwald (2006) examined the adequacy of postal mail as a method of contacting urban AI/AN clients at a UIHO. To test this method, 5,633 Native art calendars were sent via first class mail to clients, with 60 percent identified as AI/AN. A multi-step address verification process was conducted which included telephone contacts, web searches, and in-person visits. Only 61 percent of clients actually received the calendars, with the multi-step address verification process significantly less likely to locate a working address for AI/AN clients. The researchers were only able to locate accurate addresses for about 50 percent of the AI/AN clients. The more time that had passed since the last visit to the clinic, the less likely they were to find an accurate address for the AI/AN clients (ibid.). Some of the mobility of this population may be related to movement between urban areas and reservations, but, as suggested in the previous section, some may also be related to unstable living situations.

[19] PDF available at http://portal.hud.gov/hudportal/HUD?src=/press/press_releases_media_advisories/2013/HUDNo.13-092; click on hotlink for "local grants." Accessed 1.3.14.

[20] Home buying was tested only in New Mexico because of the low rates of AI/AN home ownership in the other two states. We report only the results of the rental tests here.

4.4 Urban American Indian and Alaska Native Children

The disproportionate rates of poverty among urban AI/AN families put their infants, children, and adolescents at a greater risk of adverse experiences and poor health outcomes. In this section, we describe just a few of the challenges to AI/AN child and youth well-being.

4.4.1 Infant Mortality

The post-neonatal death rates for urban AI/AN infants (5.4 per 1,000) are significantly higher than the rate for all (urban and rural) White infants (2.6 per 1,000), although slightly lower than the rate for all African American infants (5.8 per 1,000) (Baldwin, et al., 2002). Urban AI/AN and the general population differ significantly on a number of factors that contribute to poor birth outcomes. For example, Castor, et al. (2006) used Census data as well as birth and death certificate information available through the National Center for Health Statistics to compare AI/AN and Whites on factors associated with high infant death rates. The findings are listed in Table 4-2. A few notable examples are discussed here. Approximately 18.1 percent of rural AI/AN and 14.4 percent urban AI/AN have inadequate access to prenatal care; this is comparable to the percentage of all African Americans who have inadequate access to prenatal care (16.4%), but well below the rate for all Whites (6.8%). Similarly, and related, 5.2 percent of rural AI/AN births and 5.7 percent of urban AI/AN births suffer from low birth weight, lower than the rates of low birth weight babies born to African Americans (12.0%), but higher than the percentage of White births (4.7%) (Baldwin, op cit.). In addition, the Urban Indian Health Institute (2011) reported that the rate of births to mothers under the age of 20 was 12.9 percent for AI/AN in all UIHO service areas in comparison to 7.2 percent for all other races in the general UIHO service area population.

4.4.2 Unique status of AI/AN children due to the Indian Child Welfare Act

The issue of what determines AI/AN identity is particularly relevant to the enforcement of the Indian Child Welfare Act (ICWA). Going back over a century, it was common practice for courts to remove Indian children from their biological families and to place them with White families or in boarding schools. The explicit aim of this practice was to strip these children of their cultural identities (Earle, 2000). In 1978, ICWA was passed to bring an end to this practice in recognition

that "there is no resource that is more vital to the continued existence and integrity of Indian tribes than their children."[21] Today, under ICWA, tribes have jurisdiction over court proceedings involving any Indian child, regardless of where the child lives. It also requires all courts to notify tribes of Indian child placement (Earle, 2000). A number of states are currently lobbying Congress to issue standard criteria for what constitutes "Indian-ness," including a quantification of the level of cultural ties necessary to qualify (Rosales, 1998). On the other hand many American Indian and Alaska Native tribes and organizations have come together to demand that state courts enforce ICWA according to its terms.

Statistics on Children Placed in Care

In 2013, the Administration for Children, Youth, and Families, within ACF, used data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) to compare the number of children in foster care by race and ethnicity between 2002 and 2012 (Administration for Children, Youth, and Families, 2013). Findings indicate that over the course of that decade, the number of children in foster care declined across every ethnic group, with the largest decrease (47.1%) occurring among African American children. The number of AI/AN youth in foster care also declined markedly over this time period, from 9,735 in 2002 to 8,344 in 2012, which represents a 14.3 percent decrease (ibid., page 1). Nevertheless, AI/AN youth were disproportionately represented among the foster care population. In 2002, for every 1,000 AI/AN youth under age 18 in the general population, 14.1 were in foster care. This was second highest only to African American youth, who 17.4 per 1,000 rate in the same year. By 2012, with the significant decrease of African American youth in foster care, AI/AN youth had the highest representation rate in foster care, at 13.0 per 1,000 youth. The report notes that AI/AN youth have had the highest representation rate since 2009 (ibid., page 2).

[21] 25 U.S.C. 1901

Table 4-2. Poor birth outcomes/risk factors and factors associated with infant death among American Indians and Alaska Natives

	UIHO service area populations				Nationwide populations			
	AI/AN		General		AI/AN		General	
	%	95% CI	%	95% CI	%	95% CI	%	95% CI
Poor Birth Outcomes/Risk Factors (1991-2000)								
Low birth weight (<2,500 grams)	6.8	(6.6-7.0)	7.3	(7.2-7.3)	6.6	(6.5-6.7)	7.4	(7.4-7.4)
Premature birth	12.2*	(12.0-12.5)	10.8	(10.8-10.9)	12.1*	(12.0-12.3)	11.1	(11.0-11.1)
Mother's age <18	8.2*	(8.0-8.4)	4.6	(4.5-4.6)	8.2*	(8.2-8.3)	4.8	(4.8-4.9)
Mother unmarried	60.3*	(59.8-60.8)	34.8	(34.7-34.8)	57.4*	(57.2-57.7)	31.9	(31.9-31.9)
Received late or no prenatal care	7.4*	(7.2-7.6)	3.4	(3.4-3.5)	7.3*	(7.2-7.4)	3.0	(3.0-3.0)
Smoking during pregnancy	17.2*	(16.9-17.5)	10.7	(10.7-10.7)	21.1*	(21.0-21.3)	14.3	(14.3-14.3)
Alcohol use during pregnancy	0.3	(0.3-0.4)	0.3	(0.3-0.3)	0.3	(0.3-0.4)	0.3	(0.3-0.3)
Factors Associated with Infant Deaths (1995-2000)								
Mother unmarried	70.0	(61.4-79.5)	49.5	(48.5-50.2)	65.6	(62.1-69.1)	47.2	(46.9-47.5)
Low birth weight (<2,500 grams)	54.2	(46.6-62.6)	65.5	(64.7-66.3)	49.7	(46.7-52.8)	65.2	(64.8-65.6)
Premature birth	53.7	(45.5-62.8)	64.5	(63.7-65.4)	50.1	(46.9-53.6)	64.5	(64.1-64.9)
Smoking during pregnancy	25.2	(19.4-32.2)	15.5	(15.0-16.0)	29.8	(27.3-32.5)	19.5	(19.3-19.7)
Mother's age <18	11.2	(7.9-15.4)	7.0	(6.8-7.3)	10.2	(8.9-11.6)	7.6	(7.4-7.7)
Alcohol use during pregnancy	9.2	(5.8-13.9)	2.2	(2.0-2.4)	7.4	(6.2-8.9)	2.3	(2.2-2.4)
Received late or no prenatal care	7.4	(4.7-11.1)	3.0	(2.8-3.2)	7.1	(5.9-8.4)	2.7	(2.6-2.7)

AI/AN = American Indian/Alaska Native; UIHO = Urban Indian Health Organization; CI = confidence interval

* Statistically significantly higher for AIAN compared to the general population

Source: Castor et al., 2006

4.5 Urban AI/AN Youth

Researchers at the Urban Indian Health Institute produced a unique and important report on the status of urban AI/AN youth (UIHI, 2009) by exploring a variety of data sources, including U.S. birth certificate data between 2000 and 2002, data from the 2000 Census, mortality or U.S. death certificate data between 1999 and 2001, and data from the national Youth Risk Behavior Survey between 1997 and 2003. According to this report, in 2000 there were approximately 232,000 single-race American Indian and Alaska Native youth, ages 15 to 19, with 58 percent living in census-defined urban areas. In the following sections we describe findings from these and other researchers on the educational and health status of this population.

4.5.1 Education

The National Indian Education Association (NIEA) is an advocacy group dedicated to ensuring that all American Indian and Alaska Native youth have access to high-quality educational opportunities. NIEA has access to—and provides on its website—statistics from diverse sources (including Census, the Common Core of Data, data from the U.S. Bureau of Labor Statistics, among others) about educational achievement among this population.[22] For all AI/AN youth (both reservation and urban), the average Freshman graduation rate (defined as individuals who received a public school diploma in four years) for school year 2009-2010 as reported in the Common Core of Data (CCD) was 69 percent, which was notably lower than the rate for all students (78%) and that of White students specifically (83%).[23] Dropout rates in 2009 varied depending upon the data source. The Current Population Survey (CPS) (October 2009) defines a dropout as any youth between the ages of 16 and 24 who is not in high school and does not have a diploma or alternative credential. The CPS dropout rate for AI/AN students was 13 percent, which was much higher than the rate for White students (5%) and for all students combined (8%).[24] The American Community Survey (ACS) uses the same definition of "dropout," but reports a slightly higher dropout rate (15%) for the AI/AN population. This compares to a 6 percent rate for White students, and an 8 percent dropout rate overall.[25]

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[22] http://www.niea.org/Research/Databases-0024amp;-Reports.aspx

[23] Data summarized on the NIEA website at http://www.niea.org/Research/Statistics.aspx, but as reported by Stillwell and Sable (2013).

[24] Data summarized at http://www.niea.org/Research/Statistics.aspx; data are from the Current Population Survey and were reported by Chapman, Laird, Ifill, et al. (2012).

[25] Ibid.

When focused only on the urban AI/AN population, the dropout rate for AI/AN youth appears to be significantly higher. Based on data from the American Community Survey, for example, the Urban Indian Health Institute reported that in all UIHO service areas combined, 23.9 percent of all AI/AN age 25 and older have not completed high school or obtained a GED, which is statistically significantly higher than the 16.2 percent rate for the general population (UIHI 2011). It is not entirely clear why the dropout rate in urban areas should be so much higher than in non-urban settings, although this may be a statistical artifact based on how the target population was selected. That is, both the CPS and ACS numbers reported previously were for youth between the ages of 16 and 24. The UIHI calculations were based on the urban AI/AN population aged 25 and older, which includes individuals—many of whom may be in their 50s, 60s, or 70s—who may not have had the same access to educational opportunities as the youngest cohort.

Importantly, the NIEA also reports on what are often called "exceptional outliers," i.e., data points that stand out from the rest in a positive way rather than negative. On the basis of data obtained from the U.S. Department of Education in 2012, they note that the states with the highest AI/AN high school graduation rates include Tennessee (89%), New Jersey and Texas (both 87%), Arkansas (85%), Maine (82%), and Alabama (80%). In nine states, the AI/AN graduation rates were equal to or exceeded the rates for all students combined. And in Alabama, Arkansas, and Tennessee, the graduation rates for AI/AN youth exceed the rates for White students.[26] These rates are up to 40 percent higher than in some of the western states, suggesting potential value in exploring what is going "right" for AI/AN youth in these three outlier locations.

Very limited data related to educational achievement are available that are specific to urban AI/AN youth, although those that are available indicate significant disparities in between AI/AN youth and their non-AI/AN counterparts. For example, the National Center for Education Statistics (NCES) (2011) recently examined achievement in reading and mathematics in grades 4 and 8 in twenty-one urban districts. Data on urban AI/AN students were only reported for the city of Albuquerque, New Mexico and only for the 4th grade. In Albuquerque, fourth grade AI/AN students lagged behind their White peers in mathematics. Average 4th grade mathematics scores on tests for the National Association of Educational Progress (NAEP) were 254 for Whites, 229 for Hispanics, and 227 for AI/AN students. The NCES report found that reading achievement in Albuquerque schools followed a similar pattern. AI/AN students in the fourth grade had average reading scores of 195

[26] http://www.niea.org/Research/Statistics.aspx, data from the Four-Year Regulatory Adjusted Cohort Graduation Rates for the school year 2010-2011, as reported by the Department of Education (2012).

which placed them 36 points below the average reading scores of their White peers. Hispanic children had scores that were 30 points lower than White children's scores, on average (ibid.).

A report issued by The Center for Comprehensive School Reform and Improvement (2009) provided an overview of the status of AI/AN students and the need to engage these students with rigor and cultural relevance. Obtaining reliable education statistics on AI/AN youth is challenging due to the population's transiency and their low numbers in comparison to other ethnic groups. This report noted that the federal government currently administers several programs, such as Title VII, which require schools to address the cultural needs of AI/AN students. Federal data on the effectiveness of Title VII funds is not yet publically available; however, the National Indian Education Association obtained outcomes data from several states[27] that showed marked improvements in AI/AN student school attendance, academic achievement, and graduation rates in those districts receiving Title VII monies.

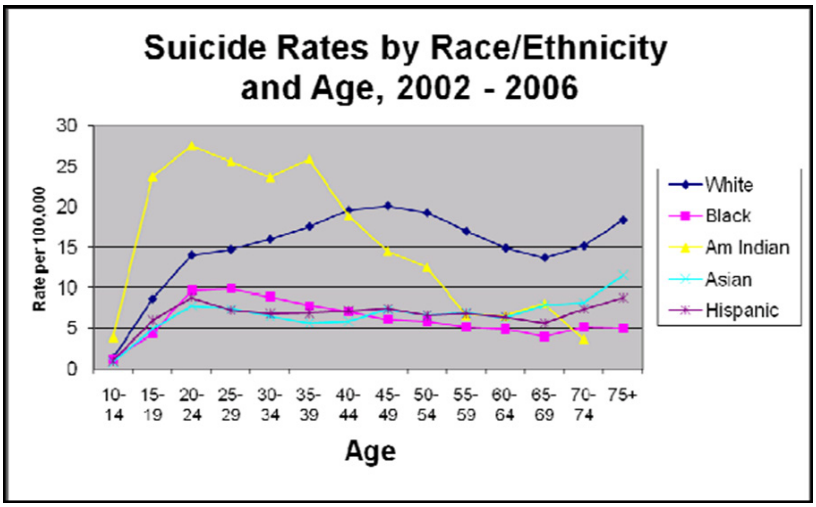
4.5.2 At-Risk Urban AI/AN Youth

For both AI/AN and White youth, unintentional injury was the leading cause of death with three-quarters of these deaths listed as motor-vehicle related. The second and third leading causes of death were homicide and suicide, with higher rates for AI/AN in comparison to all other ethnic groups (see Figure 4-1). Overall, in comparison to urban non-AI/AN youth, urban American Indian and Alaska Native youth are disproportionately represented on indicators of risk (Table 4-3, Urban Indian Health Commission, 2007). For example, 16.4 percent of urban AI/AN youth reported being forced to have unwanted sex compared to 6.6 percent of urban White youth. Psychiatric and substance use disorders are also significant issues affecting urban AI/AN youths. Bhatia and Bhatia (2007) emphasize these findings as significant because mental health problems experienced during childhood and adolescence may have considerable effect on growth and development, school performance, and peer and family relationships, as well as lead to increased suicide risk. Dickerson and Johnson (2010) also identify significant trends associated with alcohol and illicit drug use among urban AI/AN youths. In their study, Dickerson and Johnson analyze descriptive data among a clinical sample of AI/AN youths receiving mental health services in a large California metropolitan area. Their findings revealed high rates of mood and adjustment disorders, alcohol and marijuana use, and traumatic exposure. The urban AI/AN youth in the study also showed various mental health symptoms, such as feeling withdrawn, aggressive behaviors, attention problems, and internalizing/externalizing problems. Urban AI/AN youth in the sample also exhibited various risk factors that may explain the high rates of mental health and substance use

[27] Report accessed at: http://www.uteed.net/files/t7sh.pdf – 4.14.14.

problems. These risk factors included exposure to physical abuse and domestic violence and residing with individuals who have significant mental health and substance abuse problems.

Figure 4-1. Suicide rates by race/ethnicity and age, 2002-2006



Source: APA Fact Sheet: Mental Health Disparities: American Indians and Alaska Natives (2010). American Psychiatric Association, Office of Minority and National Affairs. Original data source: Centers for Disease Control and Prevention (WISQARS database, accessed in 2009). www.cdc.gov/injury/wisqars/index.html.

Table 4-3. Safety & Violence among AI/AN and White Youth in Urban Areas (1997-2003)

Behavior	AI/AN %	Whites %
In a physical fight	50	32.7
Medical treatment for injury from a physical fight **	10.8	3.1
Physically hurt by a boy/girlfriend**	17	8
Ever been pregnant or gotten someone pregnant	10.6	3.6
Had sexual intercourse for the first time before age 13	12.4	4.4
Ever used heroin	7.4	2.6
Ever used injected drugs	5.1	1.9
Tried marijuana for the first time before age 13	17.5	8.7
Used marijuana on school property ++	15.3	5.5
Used cocaine one or more times ++	8.7	3.6
Carried a weapon on school property ++	14.4	6
Threatened or injured with a weapon on school property **	17.5	7.4
Carried a gun ++	12.7	4.3
Attempted suicide	20.7	6.8
Did not go to school because of feeling unsafe ++	12.6	3.7
Medical treatment from a suicide attempt	10.5	1.9

** During the past 12 months

++ One or more of the past 30 days

Source: Youth Risk Behaviors Survey Data (1997-2003), reported in UIHI 2007.

4.5.3 Promoting Youth Resilience

The term resilience is used to refer to a set of qualities that foster a process of successful adaptation and transformation despite risk and adversity (Strand and Peacock, 2003). Resilience is one's capacity to endure, overcome or recover from hardships. Resilience is the ability to not give way to failure in school, substance abuse, mental health issues, or crime despite being subjected to harsh social and economic conditions (Strand and Peacock, 2003). According to the literature, enculturation and social connections are two protective factors that have played and continue to play important roles in fostering resilience among AI/AN children and families. If policy makers can understand what helps AI/AN to function well in the context of high adversity, they can incorporate this knowledge to new practice strategies. (Goodluck and Willeto, 2009)

Enculturation. Enculturation refers to the process by which an individual identifies with his or her own cultural roots and the degree to which an individual is embedded in traditional cultural practices, such as language and spiritual activities (Whitbeck, et al., 2004). Enculturation is critical in understanding the traditional cultural experiences of AI/AN people. It signifies a connection to tribal culture in terms of identity, involvement, and experience. The degree to which an AI/AN person adheres to tribal cultural values and manners can play an important role in his or her physical well-being and emotional state (Winderowd, et al., 2008).

Yet some of today's urban AI/AN *may* come from families whose cultural heritage was severely disrupted. Since the late 19th century, the Bureau of Indian Affairs' boarding school policy removed children from reservations and placed them in schools where the curriculum was purposely designed to enact cultural genocide by training the children to take on low skill and low status positions in White society (Slivka, 2011). The first federally funded boarding school opened in 1879. Many boarding school administrators kept track of the number of children who entered into employment in White society after graduation, with celebrations noted when rates exceeded 50 percent (American Indian Policy Review Commission, 1976).

Past research has shown that strong cultural ties, known as traditional ways, enhance one's resilience to severe life circumstances (Winderowd, et al., 2008). LaFromboise, Hoyt, Oliver, and Whitbeck (2006) found a positive relationship between higher levels of cultural involvement and higher levels of resiliency with pro-social behaviors among AI/AN adolescents. In another study, Belcourt-Dittloff (2006) found that cultural elements shield against harsh conditions and improve resilience in both AI/AN college students and AI/AN people living within urban communities. According to these studies, traditional cultural and spiritual practices, ethnic pride, and communal mastery lead to better life

satisfaction, more personal growth in the face of obstacles, and less mental distress. Native youth report that being well grounded and connected to their tribal culture is a major reason they stay and do well in school because it helps them gain a "good self-concept, a strong sense of direction, and tenacity" (Strand and Peacock, 2003). Involvement in cultural activities and education in Native history, language, and culture provide positive feelings about their culture and a sense of belonging among these youth, helping them to live comfortably in both their Native communities and urban areas.

Researchers have argued that knowing the cultural framework by which people understand their experiences can be helpful in establishing effective curative practices. Winderowd, et al. (2008), for example, assert that enculturation assessment of AI/AN children and families may help to improve counseling and treatment approaches with this particular population. Different methods of intervention may be suggested based on the degree to which an AI/AN individual identifies with traditional culture. Some individuals may be suspicious of or reluctant to visit health care providers, such as counselors and psychologists who are from the mainstream culture. Integrating culture and traditional ways into prevention and healing programs could be a strategy for better meeting the needs of AI/AN people (Whitbeck, 2006).

Social Connections. The importance of family and parenting are continually noted in the literature as being protective factors against adversity. For instance, the National Longitudinal Study of Adolescent Health (NLSAH) analyzed a nationally representative sample of more than 90,000 youth of all ethnicities to examine the social settings of adolescent lives, the ways in which adolescents connect with their social worlds, and the impact of the settings and connections on health and behavior (Strand and Peacock, 2003). The NLSAH reported that healthy youth who avoided risky behavior felt strongly connected with their families. They felt that they were understood, loved, wanted, and paid attention to by family members. They did not have access at home to guns, cigarettes, alcohol, or illegal drugs. None of their family members had attempted or committed suicide in the previous year. Their parents educated them on sexual intercourse and the use of contraception at an early age. Their parents also had high expectations for academics (Strand and Peacock, 2003). LaFromboise, et al. (2006) also came to similar conclusions on the role of family and parenting in potentially buffering American Indian youth against negative or harmful influences.

A study by Bergstrom, Cleary, and Peacock (2003) identified an additional protective factor for Native American youth, namely, feeling connected to one's tribal culture. Thus, strong school and community connections can promote resilience among AI/AN youth by making these students feel secure and comfortable. Promoting understanding of different cultures and life circumstances

among teachers, students, and school employees may also provide critical support for this vulnerable population.

Funding for Youth Risk Reduction. The high prevalence of risk factors for urban AI/AN youth points to the need to design activities to promote positive youth development and reduce risk. Attention is being paid to these issues nationally. For example, the U.S. Department of Justice just released a public service video to promote self-esteem in American Indian youth.[28] In addition, a number of recent federal funding opportunities support research on ways to improve outcomes for AI/ANs, including a call for research on Intervention for Health Promotion and Disease Prevention in Native American Populations released by the National Institute on Drug Abuse.[29]

The Administration for Children and Families has funding specifically targeting AI/AN populations,[30] such as the Social and Economic Development Strategies (SEDS) program. SEDS supports the principle that social and economic development are inter-related and essential for the development of healthy, self-sufficient Native American communities. This grant program through the Administration for Native Americans (ANA) emphasizes social and economic development projects that promote the establishment and maintenance of diversified local economies, the preservation of Native American cultures, and programs and services that safeguard the health and well-being of Native Americans. ANA's FY 2013 SEDS goals and program areas of interest are focused on strengthening children, families, and communities through community-based organizations, tribes, and village governments.

Targeted funding designed to improve educational outcomes for AI/AN youth is also available through initiatives such as the Title VII, Native Education, Elementary and Secondary Education Act, which provides support for culturally-based education approaches.[31]

[28] Available online at http://www.youtube.com/watch?v=uFjJT_0r9LE

[29] The full FOA can be found at http://grants.nih.gov/grants/guide/pa-files/PAR-11-346.html

[30] http://www.acf.hhs.gov/grants/open/foa/office/ana

[31] http://www2.ed.gov/about/offices/list/oese/oie/index.html

4.6 Urban American Indian/Alaska Native Adults

The data on urban American Indians/Alaska Natives of all ages is piecemeal, making it difficult to present a comprehensive picture of the status of adults. Below we present some basic information on adult employment and health challenges.

4.6.1 Employment Statistics

Recent research into the work status of American Indians indicate that the population continues to have much lower rates of employment than their non-AI/AN counterparts. Austin (2013) conducted an analysis of 2009-2011 American Community Survey (ACS) data and found that during that three-year time period, the employment rate for all American Indians was 64.7 percent, while the same rate for Whites was 78.1 percent. Statistics also indicated that Native people living outside of reservation lands were not faring much better than those who remained on the reservations. Austin (ibid.) examined the same ACS data for individuals 25-54 years of age, and found that between 2009 and 2011, the off-reservation employment rate was 65.9 percent compared to 63.4 percent for indivdiuals living on or near reservation lands (ibid.). Such statistics underscore the fact that the promise to American Indians of urban economic prosperity remains unfulfilled.

4.6.2 Health

There are numerous challenges to the health of urban AI/AN adults, including disproportionally high rates of morbidity and mortality from cardiovascular disease, diabetes, and behavioral health problems. Researchers at the Urban Indian Health Institute (UIHI) have reviewed numerous sources of data to assess the health status of those AI/AN living in Urban Indian Health Organization (UIHO) service areas (see page iii, UIHI 2011), including data from the decennial U.S. Census, the American Community Survey (ACS), and the Behavioral Risk Factors Surveillance System (BRFSS), among others. Much of the data presented below come from reports produced by UIHI; wherever possible, we have cited the UIHI report (full citations can be found in the "References" section of this report) along with the original data source reviewed by UIHI staff.

Cardiovascular Disease. The Centers for Disease Control and Prevention (CDC) report[32] that coronary artery disease is the leading cause of death among non-AI/AN individuals. It is also the leading cause of death among urban AI/AN (UIHI 2011). A review of BRFSS data between 2005 and 2010 indicated that in all UIHO service areas combined, 3.6 percent of AI/AN have ever been diagnosed with angina or coronary artery disease, compared to 3.5 percent of the general population (ibid., page 10). Contrary to trends among other racial and ethnic groups in the United States, however, cardiovascular disease rates among AI/ANs continue to rise (Howard, et al., 1999). Each year the American Heart Association, in collaboration with the National Institutes of Health, Centers for Disease Control and Prevention, and other government agencies reviews a variety of data sources[33] to report the latest trends in cardiovascular health and disease among the U.S. population. A statistical update released in 2013 (American Heart Association 2013) indicates that AI/AN disproportionately suffer from cardiovascular diseases, high blood pressure and stroke compared with the general population. Moreover, the report indicates that a high percentage of the AI/AN population has risk factors that are known to contribute to cardiovascular morbidity. For example, 26.7 percent of all AI/AN adults report smoking cigarettes, which is the highest rate among any racial or ethnic group (ibid., page e35). Living in an urban area does not appear to reduce this behavior; a report released by the Urban Indian Health Institute (UIHI, 2011), reviewing data from the Behavioral Risk Factor Surveillance System (BRFSS) found that between 2005-2010, in all UIHO service areas combined, 22.7 percent of AI/AN reported that they currently smoked. This was statistically significantly higher than the rate of 15.7 percent for all other races combined. The AHA Statistical Update also note that AI/AN adults have the highest obesity rate, at 40.8 percent (ibid., page e60). Urban AI/AN have a lower rate of obesity (31.7%) than the AI/AN population as a whole, but this is still higher than that of the general population (23.4%) (UIHI 2011).

Diabetes. Researchers also have noted that AI/AN have a high rate of diabetes, which significantly increases an AI/AN adult's risk of contracting heart and circulatory system diseases. The CDC examined data from the Indian Health Service collected between 1994 and 2004 and found that the prevalence of diabetes among AI/AN adults over 35 years of age increased from 8.5 percent to 17.1 percent over this time period (AHA 2013: e88). Data from the Behavioral Risk Factor Surveillance System (BRFSS) indicate the rate is lower among urban AI/AN, with 11.9 percent of AI/AN living in all UIHO service areas having diabetes compared with 7.8 percent of the general population, as shown in Figure 4-3 (UIHI, 2011). Finally, in comparison with the rest of the U.S. population,

[32] http://www.cdc.gov/heartdisease/facts.htm

[33] Sources include the National Health and Nutrition Examination Survey (NHANES), the National Center for Health Statistics (NCHS), data from the Veterans Healthcare Administration, national Medicare and Medicaid data, among others.

AI/AN face disproportionately higher mortality rates from diabetes. Finally, data from the National Center for Health Statistics indicated that the rate of death due to diabetes from 2005 to 2010 for AI/AN living in UIHO service areas was 28.3 per 100,000, which was significantly higher than the rate of 22.2 per 100,000 among the general urban population during this same period (UIHO, Seattle Indian Health Board, 2011).

Behavioral Health Disorders. According to the UIHC, the percentage of urban AI/AN adults who suffer from depression is likely higher than in rural areas because of isolation from tribal members or family, lack of access to adequate mental health care, and poverty. In addition, 15.1 percent of all AI/ANs living in UIHO service areas reported frequent mental distress compared with 9.9 percent in the general public (UIHO, Seattle Indian Health Board, 2011). In some cases, severe mental distress or mental illness can lead to self-harm or suicide. According to the UIHI report (2011), the rate of suicide among AI/ANs in all UIHO service areas is 7.6 per 100,000. Because of racial misclassification in death records, this rate could be even higher.

Additionally, statistics indicate a high rate of alcohol and drug use within the population. The National Survey on Drug Use and Health (NSDUH, 2007) reported that between 2002 and 2005, American Indians and Alaska Natives were more likely that members of other racial and ethnic groups to report an alcohol use disorder within the past year (10.7% versus 7.6%), and were nearly twice as likely to have a past year illegal drug use disorder (ibid.). Deaths from substance use and abuse are also high within the population. The UIHI report (2011) reveals that 12 percent of all AI/AN deaths in the United States are attributed to both acute and chronic health effects of alcohol misuse. Binge drinking, which is defined as five or more drinks on a single occasion for males and four or more drinks on a single occasion for females, presents both immediate and long-term health risks such as cirrhosis of the liver, high blood pressure and alcohol poisoning (UIHI, 2011). The incidence of binge drinking is significantly higher among urban AI/ANs compared with the general population. As Table 4-4 points out, the chronic liver disease and cirrhosis death rate in all UIHO service areas combined is 25.5 per 100,000 among AI/ANs, which is significantly higher than the rate of 10.4 per 100,000 among the general population. The alcohol-induced death rate among the urban AI/AN population is also considerably higher than that of the general population.

Two studies that examined trauma in urban AI/ANs found that incidents of trauma were frequently associated with drug and alcohol use. In King County, Washington, which has the seventh largest urban AI/AN community, admissions for stab wounds, bites and blunt force trauma were significantly higher for AI/ANs than for other groups (Sugarman and Grossman, 1996). In addition, 72.3 percent of all AI/AN admitted for trauma had blood-alcohol levels that exceeded 0.1 percent

(the blood alcohol content (BAC) limit for adult drivers in Washington State is .08%). In New York City, a survey of 112 urban AI/AN women revealed that 65 percent had experienced interpersonal violence, 28 percent reported childhood physical abuse, 48 percent reported rape, 40 percent reported domestic violence histories, and 40 percent reported multiple victimizations (Evan-Campbell, Lindhorst, Huang, and Walters, 2006). Indeed, the United States Department of Justice (2001) reported that AI/ANs experience the highest rates of overall crime and serious violent crimes regardless of where they lived, with a higher percentage of AI/AN victims stating that the offender was drinking or on drugs compared to victims of other races. Despite these statistics, very few UIHOs have funding available to provide mental health services.

Table 4-4. Mortality rates among American Indians and Alaska Natives, 1990-1999

	UIHO service area populations				Nationwide populations			
	AI/AN %		General %		AI/AN %		General %	
Overall and cause specific	Rate per 100,000	95% CI	Rate per 100,000	95% CI	Rate per 100,000	95% CI	Rate per 100,000	95% CI
Infant mortality	8.8^*	(7.9-9.8)	6.6^	(6.5-6.7)	8.9*	(8.5-9.3)	7.1	(7.0-7.1)
SIDS	1.8^*	(1.4-2 2)	0.7^	(0.7-0.7)	1.6*	(1.5-1.8)	0.8	(0.7 -0.8)
All Ages/All Causes	573.9	(564.4-583.7)	883.2	(882.4-884.0)	769	(763.7-774.4)	902.1	(901.7 -902.4)
Heart disease	145	(139.8-150.3}	290	(289.6-290.5)	206	(203.0-208.9)	289	(288.8-289.2)
Cancer	98	(94.0-102.2)	201.8	(201.5-202.2)	137.3	(135.0-139.6)	210	(209.9-210.2)
Accidents	42.7*	(40.7-44.9)	30.9	(30.8-31.1)	60.4*	(59.2-61.6)	35.5	(35.4-35.5)
Chronic liver disease and cirrhosis	27.5*	(25.9-29.3)	12.2	(12.1-12.3)	25.5*	(24.7-26.3)	10.4	(10.3-10.4)
Diabetes	32.0*	(29.7-34.4)	20.8	(20.7-20.9)	44.7*	(43.4-46.0)	22.9	(22.8-22.9)
Cerebrovascular diseases	34.5	(32.0-37.2)	61.2	(61.0-61.5)	48.8	(47.4-50.3)	65.4	(65.3-65.5)
Assault (homicide}	9	(8.3-9.9)	11.4	(11.3-11.5)	9.5*	(9.1-9.9)	8.2	(8.2-8.2)
Suicide	8.1	(7.3-8.9)	11.2	(11.1-11.3)	10.9	(10.5-11.4)	11.6	(11.6-11.7)
Chronic lower respiratory diseases	21.8	(19.9-24.0)	39.8	(39.7-40.0)	30	(28.9-31.1)	42.1	(42.0-42.2)
Influenza and pneumonia	20.6	(18.6-22 8)	26.5	(26.3-26.6)	25.1*	(24.0-26.2)	23.8	(23.7 -23.8)
Alcohol-related	28.1*	(26.5-29.9)	10.1	(10.0-10.2)	26.6*	(25.8-27.4)	7.3	(7.3-7.4)
Drug-related	9	(8.2-9.9)	9.4	(9.4-9.5)	10.5	(10.1-10.9)	12.9	(12.9-13.0)
Injury by firearms	8	(7.2-8.8)	14	(13.0-14.1)	6	(5.7-6.3)	6.2	(6.2-6.2)

Note. Cause-specific mortality rates for all ages are listed in rank order based on total numbers of deaths.

^ Rate calculated only for counties with populations greater than 250,000 based on 1990 census

* Statistically significantly higher for AI/AN compared to the general population

Source: Castor et al., 2006

4.7 Disabled Urban American Indians/Alaska Natives

Disability is defined as a long-lasting physical, mental, or emotional condition that makes it difficult to engage in daily activities (Castor, et al., 2006). Although AI/ANs have some of the highest rates of chronic disease and disability (Goins, Bogart, and Roubideaux, 2010), very little is known about disability rates and the service needs of urban AI/ANs. One study that analyzed U.S. Census data and vital statistics for the period of 1990 to 2000 reported that 25 percent of urban AI/ANs reported a disability (Castor, et al., 2006).

A survey by Marshall, Johnson, Martin, Saravanabhavan, and Bradford (1990) with a snowball sample of 100 urban American Indians with disabilities in Denver found that each participant reported 2.8 disabling conditions including arthritis (37%), diabetes (33%) substance abuse (24%), visual impairment (21%), heart problems (16%), orthopedic disorders (14%) and emotional disorders (12%). Sixty-four percent reported problems with walking and 50 percent reported functional limitations in obtaining a job. The average annual income reported was $10,319, with only 25 percent of the participants reporting employment. The majority of the participants reported that there was very little outreach to them from social service agencies. This finding is echoed by the results of a study conducted in 1987 by the American Indian Rehabilitation Research and Training Center, which stated that the State-Federal rehabilitation system provided relatively few services to American Indians in comparison to the general public (as cited in Marshall, et al., 1990). According to Marshall and colleagues, one of the primary problems in obtaining services was a lack of knowledge about the types of services that exist. Another critical issue was a lack of trust of non-AI/AN providers by AI/AN community members.

4.8 Veterans

As noted previously, American Indians and Alaska Natives have a long history of serving in the armed forces, with return from service associated with moving to urban areas in pursuit of employment and a better standard of living (Fixico, 2000). Yet Barse (1994) noted that AI/AN veterans do not utilize Veterans Affairs (VA) services as frequently as veterans from other races or ethnicities. Barse noted that some of the primary reasons for AI/AN not accessing VA services are: (1) lack of knowledge about the services the VA offers; (2) cultural insensitivity of VA staff members; (3) skepticism of government programs; (4) ignorance about AI/ANs among VA

provider staff and (5) negative stereotypes of AI/AN people. For rural AI/ANs, a lack of transportation to VA facilities was also noted as a barrier.

Given the increasing number of women and young adults who are veterans, it is important to understand how service in the military has impacted urban AI/AN families. As is the case for the urban AI/AN population in general, however, very little information exists. One study included data on urban AI/AN veterans. Westermeyer, et al. (2009) examined substance use disorder severity in AI/AN male and female veterans. The participants included 362 veterans drawn from communities in the north-central and southwestern areas in the U.S. and included roughly equal numbers of urban and rural residents, with females oversampled. The female veterans were 5.7 years younger on average than the men. The men and women did not differ statistically on employment, marital status, living situation, or urban versus rural residence. Men were more likely to be exposed to combat, but there was no gender difference in lifetime exposure to life-threatening and horrific experiences. There was no gender difference in lifetime alcohol use disorder, but men tended to be more likely to have a drug use diagnosis. There was no gender difference on co-morbidity with other lifetime behavioral disorders including antisocial personality disorder and pathological gambling. Men indicated that they had greater lifetime substance use disorder severity than woman and were less likely to seek care when they should have in the last year and since active military duty. Men were also more likely to seek care at VA centers than women. However, the data are unable to show patterns for urban AI/AN as a distinct subgroup.

These studies indicate that AI/AN returning from military service are a vulnerable population. In 2003, the VA and Indian Health Service (IHS) entered into a memorandum of understanding (MOU) to encourage resource sharing and to improve access and health outcomes for AI/AN veterans (Kramer, Finke, Saliba, Jouldjian, and Yano, 2010). Reports of the outcomes of this MOU have not been published as of this writing.

4.9 Gender Identity and Sexual Orientation Within the AI/AN Community

Over the last two decades, both gender identity and sexual orientation among Native Americans have received a fair amount of attention in the sociological and anthropological literature. These are complex concepts, made more so by the inherent challenges of identity politics and the competing hegemonies

of White European society and heterosexual norms. This section, therefore, offers the reader the broadest overview of the issues and challenges for American Indians around these two issues.

4.9.1 Two-Spirit People

There is general agreement that post-Columbian American Indian tribes recognized individuals who did not embrace rigid gender roles, who chose to dress as and adopt the ways of the other gender, and who might well marry someone of the same sex. A born-male, for example, might dress and take on the feminine role in a marriage to another man; a born-female might dress as a male, participate in hunting pursuits, and create a household with another woman. Such individuals have been referred to as "Two-Spirit people," although linguistic groups had their own terms, such as *winkte* (Lakota), *nadleehe* (Navaho), *hwame* (Mohawk).

There is not agreement, however, about the degree to which traditional cultures accepted Two-Spirit individuals. Many argue that gender role variance among pre-Columbian peoples was not merely accepted, but revered, with Two-Spirit persons taking on vaunted social positions. Any negative views of such persons, it has been said, resulted from the Puritanical views of early Europeans, who sought to replace traditional religions with Christianity (see, for example, Walters 1997:48-49). Indeed, Europeans referred to such individuals as *berdache*, a word of Arabic origin that translates roughly as "sodomite" and clearly conveyed the dominant society's opprobrium. Yet others have argued that the "acceptance" model is an overly romanticized view of pan-Indian culture, and that acceptance varied by tribe. Little Crow (1997), for example, asserts that the Dakota Santee expelled such persons from their villages because there was no clear place for them within the social order. This is contrast to the Lakota, he says, who viewed *winkte* as having special powers and as being able to be fully integrated into tribal life.

It is virtually impossible to validate any of these historical positions, as any written narrative of traditional views occurred post-contact, once the social order had already been severely disrupted. What we can validate, however, is that today, the notion of Two Spirit people is increasingly being embraced by American Indians as part of their traditional culture. What remains controversial is whether a Two Spirit person is a gender non-conformist (e.g., a heterosexual cross-dresser) or is someone whose sexual orientation is gay or lesbian. Many who endorse the gender variance-only model have argued that it is non-AI/AN society that has added the sexual dimension to the role, but there is not a consensus around this issue within the American Indian community. Brown (1997), in fact, has argued for six distinct roles within traditional American Indian culture: men and women,

not-men (born-women) and not-women (born-men), and gays and lesbians. This is a point of ongoing discussion.

4.9.2 Gay, Lesbian, Bisexual, and Transgender AI/AN

Regardless of the debates about the historical meaning of Two Spiritedness, for social service providers, it is important to recognize that contemporary urban LGBT American Indians must reconcile multiple marginal identities: as American Indians who face discrimination; as gay and lesbian people who face discrimination by both the larger and American Indian heterosexual societies; or as urban residents, who are not accepted by their reservation counterparts because they are viewed as "too acculturated" (see Walters, 1997; Rowell, 1997).

Designing culturally appropriate services for this population therefore means taking these multiple facets of identity and cultural encounters into account. Rowell (1997), for example, writes that early in the AIDS epidemic, HIV-positive American Indians were reluctant to seek services through the Indian Health Service because of the perceived lack of confidentiality near the reservation. In addition, because of the relatively small numbers of HIV/AIDS cases seen on the reservations at this time, IHS services were far less sophisticated than what was being offered in the urban centers. Yet those individuals who sought treatment through HIV/AIDS providers in the cities described feeling marginalized in these settings because of their Indian identity. Thus, the American Indian Community House, an Urban Indian Center in New York City, developed an AIDS treatment program as early as 1990 to ensure HIV-positive American Indians had a safe place to receive services.

A more recent article in the New York Times[34] describes the exodus of gay American Indians from anti-gay rural locations or reservations to the city, where they can create an accepting community of interest. In this particular instance, these urban immigrants have created an organization called the Northeast Two-Spirit Society.[35] Similar organizations, run by LGBT American Indians for LGBT American Indians, have sprung up in other urban locations across the country, such as The Bay Area American Indian Two Spirits in San Francisco,[36] the Two-Spirit Society of Denver,[37] and others.

[34] Dalton Walker (2007) Going Far from Home to Feel at Home. New York Times, July 17, 2007. (http://www.nytimes.com/2007/07/17/nyregion/17spirit.html - accessed April , 2013).

[35] http://www.ne2ss.org/

[36] https://www.facebook.com/baaitscommunity

[37] http://www.facebook.com/pages/Two-Spirit-Society-of-Denver/101905986514508

LGBT AI/AN may not feel comfortable within the larger LGBT community, but are creating spaces where they can celebrate their group identity as American Indians and their self-identity as gay and lesbian people.

Services for Urban American Indians and Alaska Natives 5

In Chapter 4, we examined the numerous challenges faced by urban AI/AN persons. In this chapter we first examine those services that are in place and that aim to promote physical and economic wellbeing among the urban AI/AN population. We explore the array of services offered by the Administration for Children and Families and also look at how urban Indian community centers and health organizations have attempted to meet the pressing needs of their communities. We then briefly describe the barriers to service use by AI/AN populations.

5.1 Efforts to Meet Urban AI/AN Service Needs

Both the Federal Government, states, and community-based service organizations offer programs that attempt to address the social service needs of vulnerable AI/AN populations. We first examine the services available through the Administration for Children and Families (ACF). We then examine those social services and supports being offered by Indian providers, including community centers as well as urban Indian health organizations (UIHOs). The reader will note that there is some overlap in service offerings because many Indian organizations serve as links for such ACF services as TANF.

5.1.1 ACF-Funded Services

The Administration for Children and Families (ACF) within the U.S. Department of Health and Human Services offers a wide array of programs and services to assist low-income families. Below are ACF programs either targeted to or serving a large proportion of AI/AN individuals. However, we do not know the extent to which these programs are accessed by urban versus non-urban American Indians.

ACF Services Available to the General Population and to American Indian and Alaska Natives

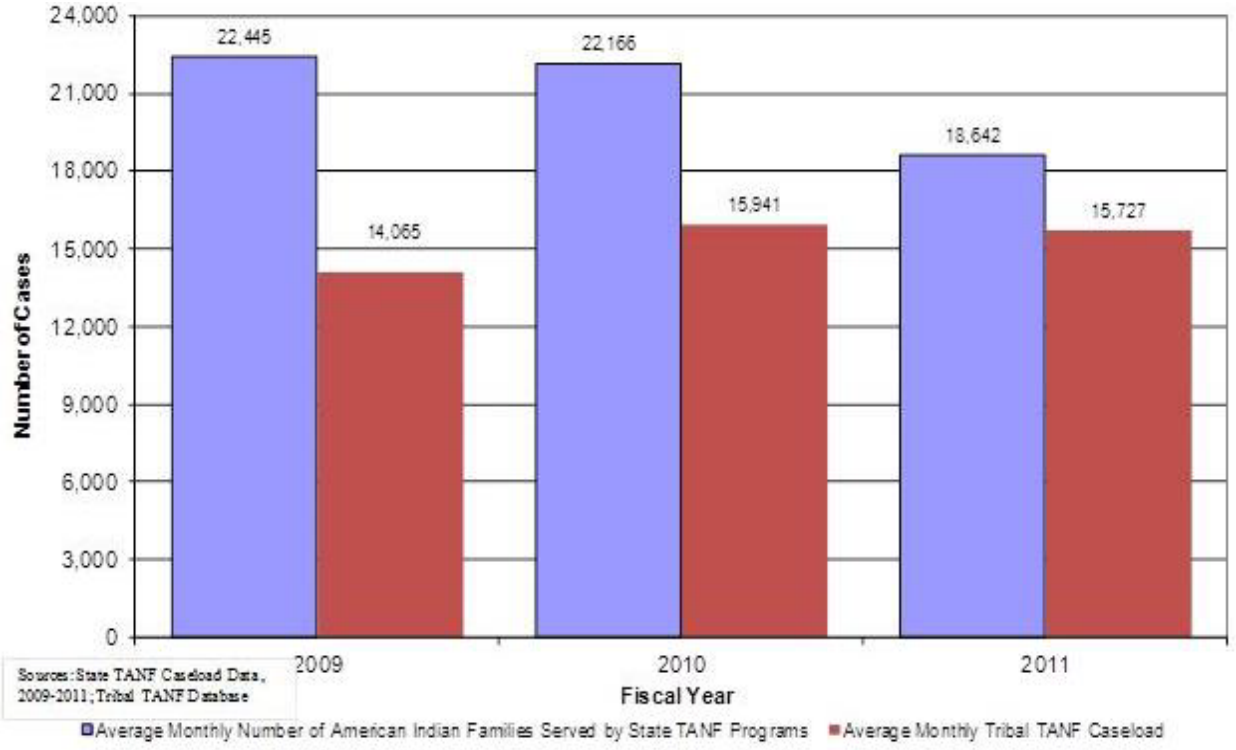
Temporary Assistance for Needy Families (TANF). The TANF program assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs. The Federal government provides grants to States to run the TANF program. These State TANF programs are designed to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; encourage economic self-sufficiency of parents by promoting job preparation and work; prevent and reduce the incidence of out-of-wedlock pregnancies; and encourage healthy relationships and two-parent families. States have broad flexibility to carry out their programs, and can determine the type and amount of assistance payments, the range of other services to be provided, and the rules for determining who is eligible for benefits. Frequently misunderstood, for example, is that AI/AN families residing in a state are eligible to receive TANF assistance from the state where they reside if they otherwise meet eligibility requirements.

There are also Tribal TANF programs that—for the most part—serve reservation-based Native people. However, there are a few examples of Tribal TANF programs that serve enrolled tribal members who may live in urban areas. For example, Torres Martinez Tribal TANF program serves tribal members throughout Los Angeles and Riverside Counties. Similarly, the Southern California Tribal Chairmen's Association (SCTCA), which serves a consortium of nearly 20 federally-recognized tribes, covers all enrolled tribal members throughout San Diego County.[38] AI/AN enjoy dual eligibility for TANF services in the states where they reside, but may not be dually enrolled.

Recent findings, however, suggest that AI/AN may not be accessing TANF supports for which they are eligible. The chart on the following page (Figure 5-1) illustrates a decline between 2010 and 2011 of approximately 4,000 AI/AN cases enrolled in state TANF programs, without a commensurate increase in cases in Tribal TANF programs (fewer than 2,000 cases between 2009 and 2011). This is despite an increase in the number of Tribal TANF programs being operated nationwide. Such data indicate the importance of understanding and mitigating AI/AN barriers to service use.

[38] (http://www.tanfonline.com/)

Figure 5-1. American Indian Families Served by State TANF Programs and Tribal TANF Caseloads, FY 2009 – FY 2011



Head Start. Head Start promotes the school readiness of low-income children ages birth to 5 by enhancing their cognitive, social, and emotional development.[39] In addition, the program provides comprehensive services to enrolled children and their families, including health, nutrition, social, and other services determined necessary through family needs assessments. Many Head Start programs also provide Early Head Start, which serves infants, toddlers, pregnant women and their families who have incomes below the federal poverty level. Head Start services are designed to be responsive to each child and family's ethnic, cultural, and linguistic heritage. Over a million children are served by these programs every year, including children in every U.S. state and territory and in American Indian and Alaska Native communities. Head Start programs serve approximately 36,000 children of AI/AN heritage. Approximately 23,000 of those children are served in the 152 AI/AN Head Start programs; the rest are served by non-tribal programs (U.S. Department of Health and Human Services, 2010a). Since 1965, nearly 30 million low-income children and their families have received these comprehensive services to increase the children's school readiness.

[39] (http://www.acf.hhs.gov/programs/ohs/)

Children from families with incomes below the poverty line are eligible for Head Start (pre-school, ages birth to 5) and Early Head Start services (birth to age 3 and pregnant women). Children from families receiving public assistance (TANF or SSI) or children in foster families are also eligible for Head Start and Early Head Start services, regardless of family income, as are children in homeless families.[40]

ACF has funded efforts to learn more about AI/AN children in Head Start. For instance, the ACF Office of Planning, Research and Evaluation (OPRE) awarded a cooperative agreement to the University of Colorado at Denver, to establish the American Indian Alaska Native Head Start Research Center (2005-2011) to ensure that research is responsive to the changing needs of AI/AN Head Start programs, children and families. The University of Colorado at Denver was also awarded a grant (2012-2016) (that built on the work of the American Indian Alaska Native Head Start Research Center) from OPRE to establish the Tribal Research Center on Early Childhood (TRC) to address gaps in research on child outcomes for young AI/AN children.

The Children's Bureau supports the health and welfare of America's children and families through a variety of means, including providing funds for essential services; offering guidance to state, local, and tribal authorities on federal law, policy, and regulations (such as ICWA); monitoring child welfare services to ensure positive outcomes for children and families; and providing training and technical assistance, as needed, to improve the delivery of services. Among the important programs funded by the Children's Bureau are Title IV-E programs, which provide states and tribes with monies for foster care, adoption, and guardianship programs; Title IV-B programs, which provides funds for family support and preservation, as well as monies to improve courts' handling of child abuse and neglect cases; and Child Abuse and Prevention Treatment Act (CAPTA) programs, which aim to improve state child protective services systems as well as provide funds to improve systems' investigation into reports of child abuse and neglect.

Office of Child Care (OCC). The Office of Child Care (OCC) is an office within ACF that helps low-income families access high-quality early and after-school child care services. OCC manages the Child Care and Development Fund (CCDF), which, among other things, provides subsidies to low-income families, resources to improve the quality of childcare nationwide, and supports research and evaluation of childcare practices and demonstration initiatives.

[40] http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/operations/mgmt-admin/eligibility-enroll/income/PovertyGuideline.htm

Office of Child Support Enforcement (OCSE). The Office of Child Support Enforcement (OCSE) is an office within ACF that partners with federal, state, tribal, and local governments to promote parental responsibility so that children receive support from both parents, even when they live in separate households. OCSE helps locate non-custodial parents, establishes paternity, and enforces court orders, among other duties. More than 50 Tribes operate their own child support agencies, ensuring that services are delivered in a culturally sensitive manner.[41]

Health Profession Opportunity Grants (HPOG) Program. The Health Profession Opportunity Grants (HPOG) program, funded by the Affordable Care Act (ACA) and administered by the ACF Office of Family Assistance, funded 32 five-year demonstration projects to design and implement innovative health workforce development training programs that target TANF recipients and other low-income individuals. Five of the demonstration projects were awarded to Tribal Organizations and Tribal Colleges that have established HPOG programs to educate and train participants recruited from Tribal communities. The programs are required to partner with key agencies –Tribal and state TANF offices, Tribal, local and state workforce investment boards, and state apprenticeship agencies – to facilitate a coordinated approach to workforce development and higher education. The programs also provide participants with an array of academic and social support services to enable participation in and completion of HPOG training. By supporting Tribal workforce development, the Tribal HPOG program has the potential to improve access to needed health services for Tribal people.[42]

Low-Income Home Energy Assistance Program (LIHEAP). The Low-Income Home Energy Assistance Program (LIHEAP) assists low-income households with their immediate home heating or cooling needs. Priority is given to those eligible households with the lowest incomes that pay a high proportion of their income for home energy; and eligible households having at least one member who is elderly, disabled, or a young child. The Federal government does not provide LIHEAP assistance directly to low income households. Instead, each direct-grantee, State, tribal or territory, designs and operates its own energy assistance program within broad Federal guidelines, using Federal LIHEAP funds. Eligibility requirements, types of assistance and program operating dates vary depending on the grantee.[43]

[41] http://www.acf.hhs.gov/programs/css/tribal-agencies

[42] https://www.acf.hhs.gov/programs/opre/resource/introduction-to-the-health-profession-opportunity-grants-hpog-program-and

[43] http://www.acf.hhs.gov/programs/ocs/programs/liheap

The Runaway and Homeless Youth Program. This program provides comprehensive services to ensure the safety of youth in at-risk situations. Services include[44]

- The **Basic Center Program** funds youth shelters that provide emergency shelter, food, clothing, outreach services, and crisis intervention for runaway and homeless youth. The shelters also offer services to help reunite youth with their families, whenever possible. Any State, unit of local government, public or private agency, Indian Tribe, organization, or institution is eligible to apply for these discretionary funds.
- The **Transitional Living Program for Homeless Youth (TLP)** addresses the longer term needs of older homeless youth and assists them in developing skills and resources to promote independence and prevent future dependency on social services. Housing and a range of services are provided for up to 18 months for youth ages 16-21 who are unable to return to their homes. Like the Basic Center program, any State, unit of local government, public or private agency, Indian Tribe, organization, or institution is eligible to apply for these discretionary funds.
- The **Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth Program** provides additional resources to organizations serving runaway, homeless, and street youth for street-based outreach and education to prevent the sexual abuse and exploitation of these young people. Any private, non-profit agency is eligible to apply for these funds.
- The **Youth Development State Collaboration Project Grants** provide demonstration grants to states for the purpose of developing or strengthening existing effective youth development strategies. These efforts focus on all youth, including youth in at-risk situations such as runaway and homeless youth; youth leaving the foster care system; abused and neglected children; and other youth served by the child welfare and juvenile justice systems. Any State or federally recognized Indian Tribe is eligible to apply for the grant.

ACF Services Available Only to the AI/AN Population

ACF supports a variety of programs and services targeted specifically to the AI/AN population. As noted previously, however, the degree to which these services are being accessed by the urban AI/AN population remains unknown.

The Native Employment Works (NEW) Program. The purpose of the NEW program is to enhance employment outcomes among members of federally-recognized Indian tribes and Alaska

[44] http://www.acf.hhs.gov/programs/fysb/programs/runaway-homeless-youth

Natives.[45] Organizations that operated a Tribal Job Opportunities and Basic Skills Training (JOBS) program in FY 1995 are eligible for NEW program funding. Allowable work activities under this program include:

- Educational activities, including support for GED, remedial, vocational, post-secondary, and alternative education;
- Training and job readiness activities, including job skills training, job readiness training, on-the-job training, entrepreneurial training, and management training; and
- Employment activities, including job search, job development and placement, community work experience, community service programs, traditional subsistence activities, and subsidized and unsubsidized public and private sector work experience and employment.

Program developers recognized that there are numerous barriers to employment beyond the skills of the individual, thus NEW offers services that support both job search and retention, including: transportation; child care; items such as uniforms, clothing, tools, and eyeglasses that are needed for employment or training; medical services; counseling; and other work and family sufficiency related services necessary to enable clients to participate in the program and to assist clients in preparing for, obtaining, and retaining employment.

Child Welfare Coordination Grants. These grants were made to 14 Tribes and tribal organizations to improve coordination between Tribal TANF and child welfare services for those families at risk of child abuse or neglect. Services to be offered through the grants include parenting groups, home visiting, and family resource centers. The three-year grant period began September 30, 2011 and runs until September 29, 2014.

Tribal IV-E Plan Development Grants. These 24-month grants were available to Tribes, Tribal organizations, or Tribal consortia that were seeking to develop a plan to implement a Title IV-E foster care, adoption assistance and, at Tribal option, guardianship assistance program. Awardees would have 24 months under the grants to develop the plan and submit it to the Department of Health and Human Services. In 2012, awards were made to five tribes, although none was located in an urban area.

Tribal Court Improvement Grants. Grants in this program can be used by Tribal courts to assess and improve the court's handling of child welfare cases. Grant monies, which may be in the amount

[45] http://www.acf.hhs.gov/programs/ofa/programs/tribal/new

of up to $150,000 for up to three years, can also be used to train judges, lawyers, and other legal personnel who may be involved in Tribal child welfare cases. In 2012, grants were made to seven tribes, one of which, The Pascua Yaqui Tribe, is located in an urban area (Tucson, Arizona).

Tribal Maternal , Infant, and Early Childhood Home Visiting Program (MIECHV). ACF administers the Tribal MIECHV program through a series of cooperative grants with Tribes and Urban Indian Organizations. Through this program, at-risk children and their families may receive home visits from nurses, social workers, or other providers who can provide any supports these families might need. Services can include parenting skills training to reduce the incidence of child abuse, referrals to specific service agencies, or assistance obtaining basic nutritional support for infants.

5.1.2 Administration for Native Americans (ANA)

ANA provides competitive financial assistance to eligible Tribes and Native American non-profit organizations in support of locally determined and designed projects that address community needs and goals. Among the many organizations eligible to apply for grants with ANA are Federally-recognized Indian Tribes, incorporated non-Federally recognized tribes, non-profit multi-purpose community-based Indian organizations, and Urban Indian centers.

Among the program areas supported by ANA are the following:

Social and Economic Development Strategies (SEDS) for Native Americans, which was noted previously in this report, is designed to assist Native communities in achieving the goal of economic and social self-sufficiency.[46] Project areas include:

- **Economic Development Projects.** Involves the promotion of the physical, commercial, technological, industrial, and/or agricultural components necessary for a sustainable local community. Applicants are encouraged to develop sustainable projects to support stable and diversified private sector local economies.
- **Social Development Projects.** Involves investment in human and social capital for advancing peoples' well-being. Applicants are encouraged to develop and implement culturally appropriate projects to enhance tribal, community, and village activities. Social

[46] https://www.acf.hhs.gov/programs/ana/programs/seds

development projects covered under this area support elders, positive youth development, and individuals with disabilities.

Native American Language Preservation and Maintenance. NLPM enables Native Communities to preserve and promote traditional language and culture. The language program provides funding for: conducting language assessments; development of language curriculum and materials; design and implementation of education projects.

Esther Martinez Immersion. The Esther Martinez Immersion program supports the revitalization of Native American languages to ensure the survival and continuing vitality of these languages and the culture of Native peoples for future generations. Grant awards made under this Funding Opportunity Announcement are for projects that contribute to the social development and self-sufficiency of Native communities through the preservation and maintenance of Native American languages. This initiative provides funding to support three-year projects being implemented by Native American Language Nests, Survival Schools, and Restoration Programs in accordance with P.L. 109-394.[47]

Environmental Regulatory Enhancement. These funds strengthen tribal governments by building capacity to identify, plan and develop environmental programs consistent with Native culture. Such projects help tribes and Alaska Native villages to formulate environmental ordinances, implement laws, and train resources in ways that are consistent with tribal culture and values.[48]

5.1.3 Services Provided to the AI/AN Community by the AI/AN Community

As briefly discussed in the historical section of this report (see Chapter 2, pp. 4-5), the American Indian community itself responded early on to the needs of tribal members who had relocated to the cities. 1953 saw the establishment of the American Indian Center of Chicago, followed by the Seattle Indian Center in 1958, and both the Tucson Indian Center and Friendship House Association of American Indians in San Francisco in 1963. Throughout the late 1960s and early 1970s, centers sprang up in cities as diverse as New York, Missoula, Kansas City, Los Angeles, and Detroit.[49] All shared the mission of ensuring that American Indians who found themselves living in cities, often

[47] http://www.acf.hhs.gov/grants/open/foa/view/HHS-2011-ACF-ANA-NL-0140

[48] https://www.acf.hhs.gov/programs/ana/programs/environmental-regulatory-enhancement

[49] The North American Indian Association of Detroit was formed in 1972, but was preceded by the North American Indian Club, a cultural resource for American Indians living in Detroit, which was founded in 1940.

far away from relatives and friends, had a gathering place where they could celebrate their culture and traditions and where they could receive any needed supports and services.

Today, there are over 60 centers around the country that are dedicated to serving the urban American Indian and Alaska Native population. Below is an illustrative list of the range of services and programs that some of these organizations administer.

Child Welfare Services

The Minneapolis American Indian Center (Minnesota) was established in 1975 and has an entire department devoted to the needs of Indian families who are experiencing difficulties with the child welfare system. The Center has two social workers who are trained in ICWA and who serve as liaisons for tribes throughout the state who have children in the court system. In addition, the Center has a court monitoring program to document which judges are failing to comply with ICWA laws and to ensure that remedial steps are promptly taken. Center data indicate that in 1993, court monitoring revealed that about one third of the cases heard in Hennepin County were not in compliance with the law.[50] The most recent data indicate in the intervening twenty years, through the efforts of the Center, fully 98 percent of the cases adjudicated in Hennepin County are now in compliance with the law (ICWA Court Monitor, January-March, 2013, page 3).

The National Indian Child Welfare Association (NICWA) works to address the issues of child abuse and neglect through training, public policy, research, and grassroots community development. In addition, NICWA works to support compliance with ICWA by helping tribes and other service providers to implement services that are culturally competent, community-based, and focused on the strengths and assets of families.

Employment and Training Programs

The American Indian Community House (New York City), which was established in 1969, has a "people oriented" program that encourages a goal of self-sufficiency through coordinated supportive services, training, and job placement assistance for AI/ANs. AICH also offers the

[50] http://www.maicnet.org/

Summer Youth Program, which is a 7- to 9-week, real world, work-based training program with incentives to encourage AI/AN youth and prepare them for entering the labor market.[51]

Education Programs

The United Indians of All Tribes Foundation (Seattle, Washington), which was created in 1970, offers both Head Start and Early Childhood Education and Assistance Program (ECEAP) services to children of low-income families. The ECEAP services are culturally adapted to AI/ANs, focus on the whole child, and encourage family participation. The Foundation also offers kindergarten programs that include Indian cultural activities, as well as a childhood development center for developmentally delayed or disabled AI/AN children.[52]

American Indian Health and Family Services of Southeastern Michigan (AIHFS), which was founded in 1978 in Detroit, administers a youth program, which includes tutoring services, after school activities, and a summer program. AIHFS also offers traditional teaching, which is culturally tailored to AI/AN children and includes traditional Native activities.[53]

The summaries above only provide a brief glimpse of the programs and services that are offered. Some of the larger centers have foster care recruitment and placement programs that seek to place AI/AN children in Native families in accordance with the Indian Child Welfare Act. Some of the centers have created museums, art galleries and theatres (Harvard Project, 2004; Harvard Project, 2007).

5.1.4 Other Federal Supports: Title VII Education Funding

The Title VII Indian Education Program is operated by the Department of Education and helps schools provide academic assistance, counseling, and cultural enrichment to AI/AN youth. Title VII programs provide behavioral, social, and academic supports for students within a cultural context. They also encourage family and community involvement and provide materials, training, and resources for teachers. Recent findings suggest that successful Title VII programs combine elements

[51] http://www.aich.org

[52] http://unitedindians.com

[53] http://www.aihfs.org

of Culturally Based Education, which "is the grounding of instruction and student learning in the values, norms, knowledge, beliefs, practices, experiences, and language that are the foundation of an indigenous culture," and high academic standards (National Indian Education Association, 2011).

The Department of Education also supports the National Indian Education Study (NIES), a two-part study that aims to describe the conditions under which AI/AN children are being educated. The first part of NIES assesses a nationally representative sample of 4th and 8th grade AI/AN students' performance in math and reading using the NAEP assessment tool. The second part focuses on the school-based cultural experiences of these same two cohorts of Indian youth. The study has been conducted biennially since 2005.

5.2 Barriers to Service Use

A key focus of this study by ACF is understanding the barriers to service use among the urban AI/AN population. In the following pages, we describe a few of the known challenges to AI/AN service receipt in general. Whether these are barriers to use of specifically ACF-funded services is unknown.

5.2.1 Fear

As described elsewhere in this report, the historical experience of racism and discrimination serves as a primary barrier to the use of mainstream services by American Indians and Alaska Natives. This is particularly true for families with children, who may be afraid to engage not only with the child welfare system, but with any non-Indian social service provider. Their concern may be that seeking critically needed services for which they are eligible and for which the local agency receives funds, such as nutritional support from a food pantry or financial assistance to pay a heating bill, could result in a call to child welfare services and the subsequent loss of their children to foster care. Ironically, the failure to ask for and obtain needed supports may well put the child in jeopardy, which in turn may lead to a call to child welfare services and judicial involvement.

5.2.2 Lack of Culturally Competent Services

An additional barrier to American Indians' willingness to seek assistance from non-Native service agencies is the lack of culturally competent or linguistically responsive service providers at those agencies. Social workers may be well-meaning, but not understand that urban American Indians residing in the same locality are eligible to access the same benefits and services as their non-Native fellow city dwellers, even if their reservation-based counterparts have access to benefits and services on the reservation. Substance abuse services may be available, but focus on the neurochemical aspects of addiction without taking into account the effects of historical trauma. A school tutor may concentrate on a middle-school student's difficulty with reading, but not realize that this student is bullied at school or isolated from his peers because of his American Indian heritage. Services that fail to incorporate broader aspects of the American Indian experience into their structure may be viewed by potential service recipients as inadequate and unhelpful. In the absence of a more holistic approach to service delivery, American Indians may choose not to access these services at all.

Conclusions and Recommendations 6

Our review of the recent literature regarding urban American Indians and Alaska Natives suggests the following conclusions:

- It is important to recognize the nuances associated with the term "urban" when studying AI/ANs who are living in America's large cities. It is certainly a designation of place, but also relates to an enculturation process among AI/ANs. Some AI/ANs living in cities may have resisted the cultural values associated with urban areas and retained more traditional beliefs and values. These traditional ways may affect the kinds of services individuals believe they need and the ways in which they access available services and supports;

- Both past and recent historical events continue to shape the lives and experiences of American Indians and Alaska Natives who are living in urban areas. The evidence suggests that many of these events, such as the Indian Relocation Act of 1956 and the assimilation objectives of the boarding school policy, have had adverse effects on some urban AI/ANs and thus must be recognized when attempting to address the needs of this population;

- There are numerous services available to low-income individuals living in urban areas, including many ACF services that aim to increase the self-sufficiency and well-being of financially distressed individuals and families. Urban Indian organizations complement federal services and programs by offering an array of culturally appropriate interventions for the urban AI/AN population; and

- The literature is lean with respect to helping the field understand which services urban AI/ANs use and, more importantly, any barriers to service use. As with any population living in poverty, financial limitations keep low-income urban AI/AN from accessing the services they need; but there are likely cultural barriers to service use that have yet to be addressed in the research literature.

Understanding Urban Indians' Interactions with ACF Programs and Services, the research study being funded by OPRE in collaboration with ANA that will follow this literature review, will endeavor to provide critical baseline information on the service needs and available supports for AI/ANs living in approximately three dozen different urban communities. Team members will conduct in-depth telephone interviews with directors of up to 35 urban Indian centers and their counterparts in local offices that provide ACF services. Through these interviews, the study team hopes to learn what services are being provided to the urban AI/AN population by the urban Indian centers, the extent

to which the AI/AN community is aware of and receiving ACF services, what the barriers to service use might be, and ways in which ACF might be able to better meet the needs of this population.

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