Developed Through the Support of the Annie E. Casey Foundation

KIDS COUNT:

American Indian and Alaska Native Children and Families Data Resource Inventory

Prepared by
The National Center for American Indian and Alaska Native Mental Health Research

JANUARY 1, 1998

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Acknowledgments

This Data Resource Inventory is the result of the labor of a number of individuals: Spero M. Manson, Ph.D, who directed the effort, Denise Middlebrook, Ph.D., Catherine Dempsey, M.P.H. and Paula Scott. Special thanks are in order to the latter three who spent an incalculable number of hours phoning and faxing requests of potential contributors. They came to appreciate why KIDS COUNT grantees, who, for the most part, are much less familiar with the governmental and nongovernmental sources of such information, expressed great frustration at the difficulty encountered in their search for data relevant to the health and welfare of American Indian and Alaska Native children and families. The fugitive nature of the data is nearly equaled by the confusing, rabbit warren-like array of programs and agencies that gather it. A note of appreciation also is extended to the agency or program representatives who took time from busy schedules to provide this information. Unanticipated government furloughs and disruptive weather already had burdened otherwise full workloads that cried out for their attention.

Introduction

One of the many programs developed by the Annie E. Casey Foundation is the KIDS COUNT program, an effort to identify, examine, and support both national and state-by-state projects on indicators of child well-being. In 1990, the Foundation published the first national KIDS COUNT Data Book, followed by state-level KIDS COUNT data books in 1991, 1992, and 1994. While these publications represent an unparalleled effort to report on the condition of U.S. children at the subnational level, they often fall short of adequately reviewing or representing indicators of child and family well-being in Indian/Native populations. Indeed, several local KIDS COUNT programs recognized in advance that this might be the case, and attempted to identify appropriate sources of data specific to this special population for inclusion in their indexing activities. They met with varying degrees of success. Staff voiced considerable frustration at their inability to ferret out these data sources, much less to understand the limits thereof. Hoping to remedy this problem, The Annie E. Casey Foundation contracted with the National Center for American Indian and Alaska Native Mental Health Research to gather information to facilitate access to sources of data relevant to the health and well-being of Indian/Native children and families, thereby increasing the likelihood that such information will be included in future reports.

Numerous government agencies maintain data relevant to the health and well-being of Indian/Native children and families. Examples include the Indian Health Service (IHS), Bureau of Indian Affairs (BIA), Administration for Children, Youth, and Families (ACYF), Department of Housing and Urban Development (HUD), Department of Education (DOE), and tribes, themselves. Each, in turn, especially the IHS, BIA, and tribes, administer a wide array of programs concerned with various aspects of child and family functioning. Within the IHS, there is the Mental Health and Social Services Programs Branch (MHSSPB), Alcohol and Substance Abuse Programs Branch (ASAPB), the primary care system, and contracted services. Likewise, the BIA provides services and maintains data relevant to criminal justice encounters, education, social services, child protection, and housing. Tribes may and often do cover the same areas through their own, independently managed means.

Government agencies are not the only source of such information about Indian/Native children and families. Community-based organizations such as urban Indian health programs, urban Indian centers, national advocacy groups (e.g., American Indian Health Care Association, National Indian Health Board and its area members), and more local, specialized programs (e.g., Indian-specific family shelters, Indian-operated public school districts) also represent repositories of data relevant to the KIDS COUNT project mission. These data sources, however, governmental and nongovernmental, are fragmented, not well known to those unfamiliar with Native populations, and frequently difficult to access.

This document is intended to ease the search for such data sources. Yet, it is only a step in the desired direction. These data do not exist in a vacuum, but rather take on meaning within important programmatic, historical, and cultural contexts. It is not sufficient to inquire about their statistical limitations, of which there will be many, as inevitably is the case. One needs to appreciate the basic assumptions that underpin them: assumptions that vary in terms as basic as "Who is an Indian?" Then, too, past experiences in regard to collaboration with other, non-Indian agencies will affect the responsiveness to inquiries. Nor should one underestimate the powerful stigma of long-held stereotypes that convey messages of deficiency, cultural disintegration, and social pathology. The kinds of data housed in these governmental and

nongovernmental repositories often are presented in ways that perpetuate such stereotypes. No wonder, then, Indian and Native communities resist, sometimes quietly, other times not. The promise represented in this document will be realized to the extent that true partnerships emerge among the stakeholders, Native and non-Native alike.

Federal Human Services Programs

Agency: Office of Special Education and Rehabilitative Services, Office of Special Programs, U.S. Department of Education

Type of Agency: Federal Human Services Program

Purpose of Agency:

Charged with implementing provisions for children with disabilities as part of the Individuals with Disabilities Act (IDEA). This is the major federal program in special education where all students served have an Individualized Education Program (IEP) at their schools.

Programs Sponsored:

- Formula Grant Program: awards to states based on the number of students between the ages of 3-21 served under Part B of IDEA (Part B awards are allocated based on the number of children served). Awards are also made for the estimated number of infants and toddlers aged 0-2 years residing in each site under Part H of the IDEA (Part H awards are allocated based on the U.S. Census data estimates for all kids).

- Discretionary Grant Program divided in following way: Research, Parent Training, Personal Preparation. These awards are given to entities to fund a variety of projects related to special education. Awards under Personnel Preparation are given to train special education personnel and to establish training centers for parents of children with disabilities. Other parts of the act fund discretionary programs in research and demonstrate projects for service delivery.

Office of Special Education (OSEP) also provides direct assistance to states to implement IDEA through its monitoring process. OSEP collects data from the states on children served under IDEA.

Kinds of Data Collected:

Native American-specific data are collected by the BIA for the OSEP Disability Project. The target population consists of all kids (ages 6-21) served by BIA, enrolled in schools with IEP programs (a total of 6,731 kids from schools with IEP programs).

Contents of Data:

Data are available on age by disability, age by disability by placement or school setting, single year of age by disability by exiting status (graduation or dropout), and personnel data. The disabilities categories assessed include: specific learning disabilities, speech or language impairment, mental retardation, serious emotional disturbance, multiple disabilities, hearing impairments, orthopedic impairments, visual impairments, other health autism, deaf/blindness and traumatic/injury .

Strengths and Weaknesses:

This data set represents a fairly expanded count of several disability categories. Long-term time series analyses can be conducted (the data has been collected on an annual basis since 1976), and the stability of the data set is noteworthy.

The data do not represent true prevalence rates of disabilities, rather the only an estimate for services. The data is not accessible on the individual level. Therefore, race indicators cannot be identified, except for the data collected by the BIA. In addition, only cross-tabs are available, and no sub-state data is collected.

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Agency: Administration for Native Americans (ANA), Administration for Children and Families,
U.S. Department of Health and Human Services

Type of Agency: Federal Human Services Program

Purpose of Agency:

Administration for Native Americans (ANA) promotes the goal of social and economic self-sufficiency of American Indians, Alaska Natives, Native Hawaiians and other Native American Pacific Islanders, including Native Samoans. The ANA is the only federal agency serving all Native Americans, and provides grants, training and technical assistance to eligible Tribes and Native American organizations representing 2.2 million individuals. The major goals of the ANA are to: 1) assist Tribal and village governments, Native American institutions, and local leadership to exercise control and decision-making over their resources; 2) foster the development of stable, diversified local economies and economic activities which will provide jobs, promote economic well-being, and reduce dependency on public funds and social services; and 3) support local access to, control of, and coordination of services and programs.

Programs Sponsored:

The range of projects which help to promote the economic and social development of Native Americans include: 1) Social and Economic Development Strategies; 2) Native American Languages Program; and 3) Inter-departmental Council on Native American Affairs. Specific examples of these projects include: creation of new jobs and development or expansion of business enterprises and social services initiatives, establishment of Tribal employment offices, formulation of new codes and management improvement to strengthen the governmental functions of tribes and Native American Organizations, and establishment of local court systems.

Kinds of Data Collected:

Two major reports are legislatively mandated: 1) a periodic report to Congress on streamlining, consolidating, and coordinating Native American programs, and 2) the Annual Report which outlines social and economic conditions among Native Americans. The latest version of the annual report The Social and Economic Conditions of Native American Populations will be available in August 1996. Information obtained for this report is collected from a variety of sources: ANA grantees, government, private, university, and program specific data.

Contents of Data:

The Social and Economic Conditions of Native American Populations Report (August, 1996) consists of six chapters: an overview of the report, tribal sovereignty, children and families' living conditions, education and social services, and special populations. The report reviews the following categories of health indicators among Native American children and families:

- Tribal sovereignty: Indian tribal governments, federal trust responsibility, history of federal Indian policy and law, and current Indian policy;

- Children and families' living conditions: size and composition of household, economic status and labor force participation, living conditions, housing on reservation and trust lands, employment: income/employment on reservations, trust land and tribal jurisdiction statistical areas in the states of Oklahoma and Alaska, and income-generating resources in Indian country;

- Health: IHS service and user populations, health problems, improvements in Native American status and utilization of IHS health care;

- Education: early childhood, elementary, secondary and post secondary education;

- Social services: mental health services, individual issues expressed by service providers, programs and services for families and children, barriers to service delivery, budget and BIA services, and

- Special populations: veterans and the disabled.

Strengths and Weaknesses:

The data used for the reports are from several sources: grantees, government, private sector, IHS, and the 1990 U.S. Census. For the most part (with the exception of the IHS trends report) the data are not well-defined, nor are they collected systematically.

Contact Information:

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Agency: Indian Health Service (IHS),
Public Health Service (PHS),
Department of Health and Human Services (DHHS)

Type of Agency: Federal Human Services Program

Purpose of Agency:

The mission of the Indian Health Service (IHS) is to provide a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs.

Programs Sponsored:

The Department of Health and Human Services (DHHS), through the Indian Health Service (IHS) and Public Health Service (PHS), is responsible for providing federal health services to American Indians and Alaska Natives. The goals of the IHS are to raise the health status of the American Indians and Alaska Natives to the highest possible level. IHS has developed an information system called the Resource and Patient Management System (RPMS) in which data are entered on computers located at 200 IHS and tribal health facilities throughout the continental United States and Alaska. Statistical reports are generated at the IHS Data Center located in Albuquerque, New Mexico. A key element of the RPMS is the Patient-Care Component (PCC), which provides for the confidential collection, storage and output of a broad range of health data resulting from inpatient, outpatient and field services.

Kinds of Data Collected:

Two statistical reports are produced by IHS on an annual basis: The IHS Trends in Health Report (1995), and Regional Differences Report in Indian Health (1995). The IHS Trends in Indian Health report contains basic statistical information regarding IHS programs and the health status of Native Americans. Information pertaining to IHS structure, demography, patient care and community health are included. Historical trends are depicted and comparisons to other population groups are made when appropriate. The IHS companion report, Regional Differences Report in Indian Health, contains current regional differences.

Data are collected from the intake forms authorized for use at IHS facilities. The forms assess the following main content areas: patient registration and administration, pharmacy, immunization tracking, dental services, clinic scheduling, contract health services, and quality assurance. The IHS clinic is a major input point for data to support health care delivery, planning, management and research.

Contents of Data:

In the reports data are summarized in tables and charts grouped into six main categories, with some examples provided below:

- IHS structure: information on the number and type of facilities, region, units, operated by tribes, hospitals, health centers, health stations;

- Population statistics: race, age, income of all served by IHS facilities;

- Patient care statistics: number of discharges from IHS facilities, days by type of service, patient demographics, ambulatory visits, obstetric deliveries, types of services rendered;

- Natality and infant/maternal mortality statistics: infant mortality, life expectancy, live births, infant birth weight, maternal death, neonatality mortality rate, post-neonatality rate;

- General mortality statistics: leading cause of death, alcoholism, tuberculosis, accidents, diabetes mellitus, pneumonia and influenza, suicide, homicide;

- Community health statistics: alcoholism and substance abuse data, public health nursing visits, community health representatives activities, sanitation facilities, community name, type, number of homes provided with sanitation facilities, sewage, water facilities, funds allocated to provide sanitation facilities and funds expended;

Strengths and Weaknesses:

The population is defined as the IHS service populations which consists of Native Americans eligible for IHS services. The IHS reports are the most extensive and comprehensive of any reporting on Native Americans. The IHS reports covers a user population of 1,150,000 extending to reservation and some urban areas.

IHS service population estimates are based on official U.S. Census Bureau (1990) county data. The census category (American Indian, Eskimo, and Aleuts), however, creates some ambiguity in terms of appropriate denominator. Furthermore, this category only comprises .8% of the entire population so in many cases the sample size will not meet statistical thresholds need to extrapolate outward to the rest of the population. The IHS population estimates should be contrasted with the IHS user population estimates that are shown in the Regional Differences Report. These estimates are based on the IHS patient registration system. Patients who receive direct or contract health services from IHS or tribally operated programs are registered. In addition, the IHS service populations between Census years (1980 and 1990) are estimated by a smoothing technique in order to show a gradual transition between Census years, resulting in upward revisions to service populations prior to a Census, e.g., the Native American population enumerated was 8% higher than that estimated by IHS in 1989. IHS service populations beyond the last Census (1990) are projected through linear regression techniques, using the most current ten years of Indian birth and death data provided by the National Center for Health Statistics. The social and economic data are also from the 1990 Census. Data was not available on the county level. The state level estimates w ere used to develop estimates for an IHS service area.

Contact Information:

Additional Indian health status information can be obtained from the IHS Division of Statistics. Specific responsibilities are as follow:

General Information:

Dr. Anthony D'Angelo, Director Program Statistics,
Indian Health Service, Department Health and Human Service
Parklawn Building, 5600 Fishers Lane
Rockville, MD 20857
PH: (301)- 443-1087

Demographic Statistics:

- Aaron O. Handler, Chief, Demographic Statistics Branch
- Linda J. Querec, Statistician
- JoAnn N. Pappalardo, Computer Systems Analyst
- Barbara A. Moore, Statistical Assistant

Patient Care Statistics:

- Stephen F. Kaufman, Chief, Patient Care Statistics Branch
- Bonnie M. Matheson, Computer Assistant

Copies of this and other Division publications may be obtained from

Priscilla Sandoval or Monique E. Alston, Division Secretaries
The Division address and phone number are as follows:

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These, other IHS publications, and additional information about the IHS is available on the IHS Home Page on the Internet.

The address is:
http://www/ihs.gov/

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FAX: (605) 226-7670

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Albuquerque Area Indian Health Service
505 Marquette, N.W. Suite 1502
Albuquerque, NM 87102-2163
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Bemidji Area Indian Health Service
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Billings Area Indian Health Service
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711 Central Avenue
Billings, MT 59103
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FAX: (406) 657-6333

California Area Indian Health Service
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Sacramento, CA 95825-1097
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Voice Mail: (916) 978-4191 Ext.101
FAX: (916) 978-4216

Nashville Area Indian Health Service
711 Stewarts Ferry Pike
Nashville, TN 37214-2634
Telephone: (615) 736-2400
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Navajo Area Indian Health Service
P.O. Box 9020
Window Rock, AZ 86515-9020
Federal Express Address:
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Window Rock, AZ 86515
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FAX: (602) 871-5896

Oklahoma City Area Indian Health Service
Five Corporate Plaza
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Oklahoma City, OK 73112
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FAX: (405) 945-6870

Phoenix Area Indian Health Service
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Phoenix, AZ 85016-5981
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Portland Area Indian Health Service
1220 S.W. Third Avenue
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Portland, OR 97204-2892
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Tucson Office of Health Program Research & Development
Indian Health Service
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Tucson, AZ 85746-9352
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Agency: Alcoholism / Substance Abuse Program Branch (ASAPB),
Office of Health Programs (OHP)
Indian Health Service (IHS)
Department of Health and Human Services (DHHS)

Type of Agency: Federal Health and Human Services Program

Purpose of Agency:

VISION: So that the unique balance, resiliency and strength of our American Indian and Alaska Native cultures are supported and enriched, we at the IHS ASAPB strive to eliminate the disease of alcoholism and other drug dependencies and the associated pain it brings to individuals of all ages, families, villages, communities, and tribes.

MISSION: To improve the overall health care of American Indian and Alaska Native individuals, families, villages, communities, and tribes; to reduce the prevalence and incidence of alcoholism and other drug dependencies; to support the efforts of American Indian and Alaska Native communities toward achieving excellence in holistic alcoholism and other drug dependency treatment, rehabilitation, and prevention services for individuals and their families; to advocate for and support tribal alcoholism and other drug dependency treatment and prevention efforts; to promote the capacity for self-determination, self governance, and; to advocate for American Indians and Alaska Natives and service providers by actively participating in professional, regulatory, educational and community organization at the national, state, and tribal levels.

Kinds of Data Collected:

The Chemical Dependency Management Information System (CDMIS) contains basic information regarding IHS funded Alcoholism and Substance Abuse (ASA) program(s) activities such as client assessment and treatment. Chemical Dependency programs are located at IHS operated facilities, Urban facilities and tribally run facilities. Information collected ranges from basic demographics, patient and/or client utilization's, staff activity and qualifications, community prevention activities, program disposition, and program funding sources.

Data is collected by directly entering data into a personal computer, or by completing paper forms specifically designed for use by ASA and having data entered later. The original software package, from which CDMIS developed, the Resource Patient Management System, RPMS, was designed to be paperless.

The main content areas (Core Data Set) are patient registration, client primary and other problems, type of drug(s) being used (including alcohol), arrest rates, hospitalization rates, a staged assessment instrument which evaluates severity of alcohol/drug use in the following domains: Alcohol/drug use history, physical, emotional, social, cultural/spiritual and behavioral conditions at Intake, Discharge, and FollowUp. Direct client treatment activity is also tracked and evaluated. Clients are tracked via FollowUp(s) for intervals of up to two years after discharge. Readmits are also tracked within this two year time period. Community prevention activity data and ASA staff information are also collected.

Contents of Data:

Reports generated from CDMIS fall into eight report groups. Each report group is related to the "type of contact" chosen at the time of data entry. Contact types are: Initial Intake, Client Services, Transfer/Discharge/Close, Information/Referral, Crisis Intervention/Brief Intervention, Reopens, Prevention activities and general staff activity and other types of information such as credentials.

There are approximately eighty generic pre-formatted reports containing from (5) to (18) variables related to a particular type of contact. Examples of reports are as follows:

- Client statistics: tribe, age, gender, insurance, income, and community. Note: CDMIS utilizes and is linked to the IHS Patient Registration module for all its population and demographic information.

- Client treatment information such as status at intake, discharge, and FollowUp; as well as services provided during a particular treatment episode.

- Activities which do not require a client be identified, such as information/referral, crisis brief/intervention, and prevention activities.

- Program information related to funding sources, component characteristics such as programs funded to provide both inpatient and outpatient services and general staff information.

Strengths and Weaknesses:

The population defined in this data set consists of those American Indian and Alaska Native ASA programs utilizing the RPMS CDMIS software and/or importing CDMIS core data from other software packages into the national database located in Albuquerque, NM. Information is limited at the national level to aggregate data consisting of 33 core items for primarily trend analysis, planning and research. More detailed information can be compiled and collected but only at the local community program level.

The Chemical Dependency Management Information System (CDMIS) uses the RPMS Patient Registration software package, as does all other RPMS packages for its demographic information on all patients. This configuration allows for better management of basic patient information and consistency among all RPMS packages. All RPMS packages can be cross-linked to share information related to patients with necessary crosswalks programmed to pass only information previously defined by package developers and managers. For example, CDMIS, beginning with Version 4.1 generates a service Bill which can be printed on site and submitted for billing to third party organizations or the program can send its information to the IHS RPMS Billing Package for billing purposes. Each program has the option to choose which method to utilize, but neither method is required.

Inconsistencies in reporting, connectivity, data entry, training, and staff turnover make this database difficult to keep current. Versions 3 and 4 contained primarily "canned" reports which were useful at the Area and National levels. With the anticipated release of Version 4.1 in 1997, users will be given the option of creating an ASCII flat file which can be imported into any statistical software package where data can be manipulated with greater ease and flexibility.

Child and Adolescent Data:

Under the Indicators section CDMIS can capture by Program, Area, State, and National:

a. Number of births to unmarried teens ages 15-19.
b. Arrest rates ages 10-17.
c. Percent teens who are high school drop out ages 16-19.
d. Percent of teens attending school and not working ages 16-19.
e. Percent of families with children headed by a single parent.

Under Social Characteristics:

a. Percent of children without health insurance (Note: CDMIS does not specifically ask this question, rather CDMIS uses its link to IHS RPMS Patient Registration software package to obtain this information).

In the near future CDMIS will link and share information with the IHS RPMS Mental Health and Social Services software package which will allow for the development of a more comprehensive Behavioral Health Software Package.

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Agency: Mental Health and Social Services Program Branch (MH/SSPB)

Type of Agency: Office of Health Programs (OHP)
Indian Health Services (IHS)
Department of Health and Human Services

Purpose of Agency:

Indian Health Service mental health and social service programs are community oriented clinical and preventive programs responding primarily to reservation populations. The programs have the following objectives:

To assure that the highest quality of care possible is available to American Indian and Alaskan Native populations through access to a full range of mental health and social services.

To assist tribes and Alaskan Native corporations to develop, staff, and manage their own mental health and social services program efforts by providing training, consultation, and technical assistance in identifying and fashioning methods of dealing appropriately with dysfunctional behaviors in their communities.

To articulate Indian Health Service clinical and preventive efforts appropriately with these locally based programs as well as other health and human service delivery systems available to the community.

Advocate the resource needs for services to address mental illness and other forms of emotional distress, e.g., suicide, family violence, child abuse, in American and Alaskan Native communities.

Kinds of Data Collected: Indian Health Service Information Systems

The Indian Health Service Resource Patient Management System (RPMS) is a decentralized automated information system that is made up of several integrated software applications. These applications operate with a single data base structure so that information need only be entered once to be available to all users.

The intent of the RPMS is to provide information processing capability directly to the end users to support meaningful and immediate access to information to their clinical and resource management requirements and to collect core information for a national data base.

A major strength of the RPMS system is the articulation and integration of data from a number of discipline specific data files, each designed to address particular discipline or administrative concerns. While each of these files contains information germane primarily to that discipline or office, the Patient Care Component (PCC) contains an electronic abstract of pertinent patient information from each of these systems, in the patient's file.

The Mental Health/Social Service reporting system is one of the several discipline specific components of the Resource and Patient Management System (RPMS). The MH/SS reporting system contains the IHS reporting requirements from both the Generic Activities Reporting System (GARS) and the Patient Care Component (PCC) of the RPMS. These IHS Service-wide reporting requirements are specified in the IHS Core Data Set Requirements (CDSR) included in FR V.59, No. 13, pg 3252-80, Jan. 20, 1994.

The module is designed for use at a specific site and articulates with the registration module for patient information, the PCC for medical information, and the pharmacy module for medications issued by IHS pharmacies. While the module is not dependent on PCC and will run whether or not PCC is implemented, as long as the registration module is operational, we recommend that it be activated as an adjunct to the PCC.

The system can be thought of as an activities reporting system in which clinical activities record more in depth information about the patient, and the provider's interaction with the patient. These data are stored in a MH/SS data file and include: clinical and non-clinical activities of providers (See attached Activity Codes), behavioral aspects of clinical problems, using a greatly expanded version of the DSM-IV V-Codes, couched in descriptive terms, and clinical information about specific patients (See attached Purpose of Visit Codes), which is stored in the patient's MH/SS file using MH/SS Problem Codes or DSM-IV diagnostic terms. When appropriate, the PCC data files are automatically updated from the MH/SS data file, eliminating the need for reporting on more than one system. All diagnostic information is converted to ICD-9-CM codes to comply with IHS standards during this process.

Confidentiality of information has always been of concern to Mental Health and Social Service providers. Several aspects of this module attempt to address these concerns. Information in the MH/SS data file is accessible only by program staff so programs have to take the responsibility for their own data entry. To facilitate the data entry process users code their own data, and an option allows providers to enter their own data. Programs can tailor the module for local use, during the Set-Up, by selecting from a range of options which control the specificity of the information passed to the PCC. Sensitive issues can be "glossed", to preclude inadvertent disclosure, without significant loss of data for clinic, management, and billing purposes.

Users can record their data on the standard MH/SS encounter form (IHS-524), a group(ed) services form and an activities log and rely on support staff for data entry or they may enter data directly. Where required a "hard-copy" of the record can be generated for inclusion in a patient's chart. To address concerns about confidential information in the patient's chart providers who enter their own data can print a "hard copy" of the record with the information in Presenting Problem, the Subjective/Objective, the POV Label, and the Comments fields suppressed, with a note to see the provider for the details of this encounter.

Locally, a MH/SS health summary for an identified patient which incorporates data from the MH/SS data file, the PCC data file, the Pharmacy data file, and the Registration file can be generated by MH/SS program staff.

An option for recording extensive Treatment Plan information is also available. Treatment Plan data are stored in the MH/SS patient file and a "hard-copy" of the plan, which includes a routine review component, can be generated to meet clinical and quality assurance requirements. A report which will list Treatment Plans needing review is included.

A very powerful set of report writers which use the MH/SS data file, data elements from the PCC and the Registration file are available locally to generate a wide range of ad-hoc reports (See Attached Reports Menu Options).

While most of these reports are available only in hard copy, one of the more powerful report generators allows for the user to generate an electronic file (following the extract format described below) for use in a local data base.

Standard clinical and management reports for MH and SS reporters can be generated using PCC, and specialized reports from the PCC data base can be customized by using Q-man as well.

On a regularly schedule basis, statistical extracts of site specific data will be forwarded to Area. At Area these data extracts are merged into an Area MH/SS data file, in a flat ASCII files using a standard format (See attached Extract Field Definitions). This allows Areas to use the Data Base Management Systems (DBMS) of their choice locally. Copies of the consolidated Area data files will be forwarded to Headquarters and merged into a service-wide data file which will serve as the Headquarters aggregate data base for Mental Health and Social Service programs. Both Area and Local programs will have access to a menu driven set of reports from these files using the standard IHS protocols.

In addition to providing much more precise information to the local clinical staff involved in managing these conditions, and linking these program services to the billing modules driven by PCC, the system captures the kinds of management level data which have become particularly important for local and service-wide accountability. The year 2000 Objectives identified for use with the Indian Health Care Improvement Act (HCIA) are one set of example some of these data are designed to address. Mental Health and Social Service Programs are particularly concerned with the issues of suicide, child abuse, and domestic violence. The possibility of using a single system, even a single reporting form, to address all these reporting concerns is, of course, of considerable interest to the potential user. In addition, the specific attention to data issues concerned with third party billing, e.g., case definition, CPT procedure codes, and treatment plan components, strengthen the module.

ACTIVITY CODES
BY
ACTIVITY CATEGORIES

GENERAL

The Activity Codes are organized by Category to assist the provider in filling out the form. The Categorical labels are for organizational purposes and cannot be used alone to report activities. Aggregate reports can be organized by activity category.

All the Activity Codes shown with a three letter acronym are assumed to involve services to a specific patient so you will be prompted for the patient's identity during data entry in order that these data can be added to a particular patient's visit file.

Patient Services (Patient Always Present)

11 - SCN Screening
12 - EVL Assessment/Evaluation
13 - IND Individual Treatment/Counseling/Education
14 - FAM Family/Group Treatment
15 - REF Information and/or Referral
16 - MED Medication/Medication Monitoring
17 - TST Psychological Testing
18 - FOR Forensic Activities
19 - DSG Discharge Planning
20 - FAC Family Facilitation
21 - FOL Follow-through/FollowUp
22 - CAS Case Management
23 - OTH Other PT Services not identified here
48 - CIP Crisis Intervention

Support Services (Patient Not Present)

24 - SUP Material/Basic Support
25 - INF Information and/or Referral
26 - MEA Medication/Medication Monitoring
27 - FOA Forensic Activities
28 - DSA Discharge Planning
29 - FAA Family Facilitation
30 - FUA FollowUp/Follow-through
31 - CAA Case Management
32 - Clinical Supervision
33 - Technical Assistance
34 - Other Support Services
49 - CIA Crisis Intervention

Community Services

35 - Collaboration
36 - Community Development
37 - Preventive Services
38 - Patient Transport
39 - Other Community Services

Education/Training

41 - Education/Training Provided
42 - Education/Training Received
43 - Other Education/Training

Crisis Intervention

48 - CIP Crisis Intervention (Patient Present)
49 - CIA Crisis Intervention (Patient Not Present)

Administration

51 - Committee Work
52 - Surveys/Research
53 - Program Management
54 - Quality Improvement
55 - Supervision
56 - Records/Documentation
57 - Child Protective Team Activities
59 - Other Administrative

Consultation

61 - PRO Provider Consultation
62 - CHT Patient Consultation (Chart Review Only)
63 - Program Consultation
64 - Staff Consultation
65 - Community Consultation

Travel

71 - Travel related to patient care
72 - Travel not related to patient care

Placements

75 - OHP Placement (PT Present)
76 - OHA Placement (PT Not Present)

Cultural Issues

81 - TRD Traditional Specialist Consult (PT Present)
82 - TRA Traditional Specialist Consult (PT Not Present)
83 - Tribal Functions
84 - Cultural Education to Non Tribal Agency/Personnel

PURPOSE OF VISIT CODES

GENERAL

The purpose of the Visit Codes are organized by category for conceptual clarity only. The categorical labels are for organizational purposes only and cannot be used to report activities. These categories can be used to block information for reports.

The following tables show which ICD Code (shown in the parenthesis) is passed to the PCC when that MH/SS Problem Code is used as a POV. Where a code is marked with the asterisk * the phrase "See (PROVIDER) for details of this Problem" will be appended to the narrative that is passed to the PCC. Those marked with a bullet • will have the phrase "Diagnostic Impression" prefaced to the information passed to the PCC. See Set-Up for other options which may be used in this process.

In the Definitions Section of the POV Codes note that the Psychosocial Problems Category includes the full range of DSM-IV diagnostic codes. The V-CODES shown are ICD V-Codes. Do Not use the DSM-IV or ICD V-Codes for POV's.

Medical/Social Problems Category

1 - HEALTH/HOMEMAKER NEEDS	(V60.4)
2 - CROSS CULTURAL ISSUE	*(V62.9)
3 - UNSPECIFIED MENTAL DISORDER	*(V40.9)
4 - PHYSICAL DISABILITY/REHABILITATION	(V57.9)
5 - PHYSICAL ILLNESS, ACUTE	(V15.89)
6 - PHYSICAL ILLNESS, CHRONIC/TERMINAL	(V15.89)
7 - NON-COMPLIANCE W/ TREATMENT REGIMEN	(V15.81)
8 - FAILED APPOINTMENTS, NO SHOW	(V15.81)

PSYCHOSOCIAL PROBLEMS CATEGORY

NOTE: In addition to the Full range of DSM-IV Diagnostic codes, the following Problem Codes may be used as problem descriptors. When these problem codes are the ICD-9 code shown in the parenthesis will be passed to the PCC (using the IHS Standard Crosswalk in Option 3) prefaced by the phrase "Diagnostic Impression."

Organic Mental Disorders

9 - SENILE AND PRE-SENILE CONDITION	•(290.0)
10 - ALCOHOL WITHDRAWAL DELIRIUM	•(291.0)
11 - DRUG WITHDRAWAL SYNDROME	•(292.0)
12 - OTHER ORGANIC MENTAL DISORDER/NOS	•(294.8)

Other Psychoses

13 - SCHIZOPHRENIC DISORDER	•(295.90)
14 - MAJOR DEPRESSIVE DISORDER	•(311)
15 - BIPOLAR DISORDER	•(296.7)
16 - DELUSIONAL DISORDER	•(297.1)
17 - PSYCHOTIC DISORDER NEC	•(298.9)

Neurotic, Personality and Other Nonpsychotic Disorders

18 - ANXIETY DISORDER	•(300.00)
19 - PERSONALITY DISORDER	•(301.9)
20 - PSYCHOSEXUAL DISORDER	•(302.9)
21 - SPECIAL SYMPTOM NEC	•(307.9)
21.1 - MEDICATION-INDUCED DISORDER	•(995.2)
22 - SLEEP DISORDER	•(307.47)
23 - EATING DISORDER	•(307.50)
24 - ADJUSTMENT DISORDER	•(309.9)
25 - DISRUPTIVE BEHAVIOR DISORDER	•(312.9)
26 - IMPULSE CONTROL DISORDER	•(312.30)

Alcohol and Drug Abuse

27 -	ALCOHOL DEPENDENCE	•(303.90)
28 -	DRUG DEPENDENCE	•(304.90)
29 -	ALCOHOL ABUSE	•(305.00)
30 -	DRUG ABUSE	•(305.90)

Disorders First Evident in Infancy, Childhood, or Adolescence

31 -	DISORDER OF INFANCY, CHILDHOOD/ADOL.	•(313.9)
32 -	PERVASIVE DEVELOPMENTAL DISORDER	•(299.81)
33 -	MILD MENTAL RETARDATION	•(317)
34 -	MODERATE TO PROFOUND MENTAL RETARDATION	•(318.0)
35 -	UNSPECIFIED MENTAL RETARDATION	•(319)

Other

36 -	PSYCHIC FACTORS ASSOCIATED WITH DISEASE	•(316)
37 -	FACTITIOUS DISORDER	•(300.19)
38 -	OTHER SUSPECTED MENTAL CONDITION	(V71.09)
38.1 -	DIAGNOSIS DEFERRED, AXIS I OR AXIS II	(799.9)

Suicide

39 -	SUICIDE (IDEATION)	(300.9)
40 -	SUICIDE (ATTEMPT/GESTURE)	(300.9)
41 -	SUICIDE (COMPLETED)	*(798.1)

ABUSE CATEGORY

Child Abuse (Victim)

995.5-	". . . PROVIDER NARRATIVE . . ."	(995.5)
42 -	CHILD ABUSE (SUSPECTED), UNSPECIFIED	(995.5)
42.1 -	CHILD ABUSE (SUSPECTED), PHYSICAL	*(V15.4)
42.2 -	CHILD ABUSE (SUSPECTED), EMOTIONAL	*(V15.4)
42.3 -	CHILD ABUSE (SUSPECTED), SEXUAL	*(V15.4)

Partner Abuse (Victim)

43 -	PARTNER ABUSE (SUSPECTED), UNSPECIFIED	(995.81)
43.1 -	PARTNER ABUSE (SUSPECTED), PHYSICAL	*(V15.4)
43.2 -	PARTNER ABUSE (SUSPECTED), EMOTIONAL	*(V15.4)
43.3 -	PARTNER ABUSE (SUSPECTED), SEXUAL	*(V15.4)

Adult Abuse (Victim)

995.81 -	". . . PROVIDER NARRATIVE . . "	(995.81)
44 -	ADULT ABUSE (SUSPECTED), UNSPECIFIED	(995.81)
44.1 -	ADULT ABUSE (SUSPECTED), PHYSICAL	*(V15.4)
44.2 -	ADULT ABUSE (SUSPECTED), EMOTIONAL	*(V15.4)
44.3 -	ADULT ABUSE (SUSPECTED), SEXUAL	*(V15.4)

Child/Partner/Adult Abuse (Perpetrator)

45 -	ABUSIVE BEHAVIOR (ALLEGED), UNSPECIFIED	*(V15.4)
45.1 -	ABUSIVE BEHAVIOR (ALLEGED), PHYSICAL	*(V15.4)
45.2 -	ABUSIVE BEHAVIOR (ALLEGED), EMOTIONAL	*(V15.4)
45.3 -	ABUSIVE BEHAVIOR (ALLEGED), SEXUAL	*(V15.4)

Rape

46 -	RAPE (ALLEGED/SUSPECTED)	(V71.5)
46.1 -	RAPE (ALLEGED/PERPETRATOR)	(V71.5)
46.2 -	INCEST SURVIVOR (ALLEGED)	*(V15.4)

NEGLECT CATEGORY

47 -	CHILD NEGLECT (SUSPECTED)	(V61.29)
48 -	ADULT NEGLECT (SUSPECTED)	(995.81)
49 -	PARTNER NEGLECT (SUSPECTED)	(995.81)

FAMILY LIFE PROBLEMS CATEGORY

51 -	ALCOHOL RELATED BIRTH DEFECT ARBD	*(V13.7)
51.1 -	FETAL ALCOHOL SYNDROME FAS	(760.71)
52 -	CHILD OR ADOLESCENT ANTISOCIAL BEHAVIOR	(V71.02)
53 -	ADULT/CHILD RELATIONSHIP	(V61.20)
54 -	UNCOMPLICATED GRIEF REACTION	(V62.82)
55 -	ILLNESS IN FAMILY	(V61.49)
56 -	MARITAL PROBLEM	(V61.1)
57 -	SIBLING CONFLICT	(V61.8)
58 -	SEPARATION/DIVORCE	(V61.0)

FAMILY LIFE PROBLEMS CATEGORY (CONT.)

59 -	FAMILY CONFLICT	(V61.8)
60 -	INTERPERSONAL RELATIONSHIP	(V62.81)
61 -	ADULT ANTISOCIAL BEHAVIOR	(V71.01)
62 -	OTHER FAMILY LIFE PROBLEM	(V62.89)

PREGNANCY/CHILDBIRTH PROBLEMS CATEGORY

63 -	PREGNANCY CONFLICT	*(V61.8)
64 -	ADOPTION	*(V68.89)
65 -	FAMILY PLANNING	(V26.4)
66 -	PREGNANCY CONCERNS	*(V61.8)
67 -	TEENAGE PREGNANCY	*(V61.8)
68 -	HIGH RISK PREGNANCY	(V23.9)
69 -	OTHER CHILDBEARING PROBLEMS	*(V61.8)

SOCIOECONOMIC PROBLEMS CATEGORY

78 -	ALTERNATE HEALTH RESOURCES	(V68.89)
79 -	FINANCIAL NEEDS/ASSISTANCE	(V60.2)
80 -	HOUSING	(V60.1)
81 -	NUTRITION	(V65.3)
82 -	EMPLOYMENT	(V62.0)
83 -	TRANSPORTATION	(V60.8)
84 -	CO-WORKER DIFFICULTIES	(V62.2)
85 -	OTHER SOCIOECONOMIC PROBLEMS	(V60.8)

SOCIOLEGAL PROBLEMS CATEGORY

86 -	FORENSIC: CRIMINAL	(V62.5)
87 -	FORENSIC: CIVIL	(V62.5)
88 -	OTHER SOCIOLEGAL PROBLEMS	(V62.5)

EDUCATIONAL/LIFE PROBLEMS CATEGORY

89 -	ACADEMIC PROBLEM	(V62.3)
90 -	SCHOOL BEHAVIOR PROBLEM	(V40.3)
91 -	SCHOOL DROPOUT	(V62.3)
92 -	VOCATIONAL REHABILITATION	(V57.2)
93 -	PEER CONFLICT	(V62.81)
94 -	PHASE OF LIFE PROBLEM	(V62.89)

ADMINISTRATIVE PROBLEMS CATEGORY

95 -	CONTINUING EDUCATION	(V65.40)
96 -	TRAINING NEEDS	(V65.49)
97 -	ADMINISTRATION	(V68.9)
98 -	EMPLOYEE ASSISTANCE PROGRAM	(V65.49)
99 -	OTHER ADMINISTRATIVE PROBLEMS	(V68.9)

MENTAL HEALTH AND SOCIAL SERVICES EXTRACT RECORD DEFINITION

CHAR POS	LENGTH	ITEM NAME	DESCRIPTION/EDITS
1	1	Record Type	Type of record. A = Add
2-8	7	Date of Service	Internal FM Format. CYYMMDD Example: 2940312
9-14	6	Loc. of Data	Location of computer where data transaction was generated. ASUFAC. Example: 202022
15	1	Program Type	M = Mental Health S = Social Services O = Other
16-21	6	Loc. of Encounter	Location where the encounter took place. ASUFAC. Example: 202022
22-28	7	Comm. of Service	Community of Service, STCTYCOM code.
29-35	7	Comm. of Service	Community of Service, ASUCOMM code.
36-37	2	Activity Code	2 digit Activity Code. See standard activity code table.
38	1	Type of Contact	1 digit Type of Contact code. 1=ADMINISTRATIVE OFFICE 2=OUTPATIENT 3=INPATIENT 4= FIELD 5=HOME 6=SCHOOL 7=CHART REVIEW 8=TELEPHONE 9=EMERGENCY ROOM 0=CONSULTATION
39-41	3	# served	Number served. Numeric, left zero filled. Example: 001, 323, 020
42-46	5	Activity time	Activity time in minutes. Left zero filled. Example: 00060, 00003, 00600

CHAR POS	LENGTH	ITEM NAME	DESCRIPTION/EDITS
47	1	Inpatient disposition	Inpatient Disposition. 1=INPATIENT PSYCH 2=IHS HOSPITAL 3=RESIDENT 4=SHELTER 5=PARTIAL CARE 6=INPATIENT MEDICAL 7=ALCOHOL/DRUG REHAB 8=LONG TERM CARE Blank is valid and acceptable
48	1	APPT/WALK-IN	Appoint/Walk-In A=APPOINTMENT W=WALK-IN U=UNSPECIFIED Blank is valid and acceptable
49	1	Interpreter Util.	Interpreter Utilized. Y=YES N=NO Blank is valid and acceptable
50-55	6	Primary Provider	Primary Provider. Affiliation
50	1	Affiliation	Discipline Code and Initials.
51-52	2	Discipline Code	Initials are left blank filled.
53-55	3	Initials	Example: 114BD, 180LAB
56-61	6	Secondary Provider#1	Secondary Provider. Affiliation
56	1	Affiliation	Discipline Code and Initials.
57-58	2	Discipline code	Initials are left blank filled.
59-61	3	Initials	Example: 114BD, 180LAB
62-67	6	Secondary Provider #2	Next Secondary Provider Affiliation, Discipline Code and Initials. (As Above)
68-73	6	Secondary Provider #3	Next Secondary Provider Affiliation, Discipline Code and Initials. (As Above)
74-79	6	Purpose of Visit 1	Problem Code or DSMIV Diagnosis. Examples: 30, 311., 300.30, 18 Left blank filled.

CHAR POS	LENGTH	ITEM NAME	DESCRIPTION/EDITS
80-85	6	Purpose of Visit 2	Problem Code or DSMIV Diagnosis. Examples: 20, 311., 300.30, 18 Left blank filled.
86-91	6	Purpose of Visit 3	Problem Code or DSMIV Diagnosis. Examples: 20, 311., 300.30, 18 Left blank filled.
92-97	6	Purpose of Visit 4	Problem Code or DSMIV Diagnosis. Examples: 20, 311., 300.30, 18 Left blank filled.
98-109	12	Patient Identifier	Artificially derived site specific Identifier for unduplicated counts.
110	1	Sex of Patient	F=Female M=Male
111-117	7	DOB of Patient	Internal FM Format. CYYMMDD Example: 2940312
118-124	7	Comm. of Residence	STCTYCOM code of patient's community of residence.
125-131	7	Comm. of Residence	ASUCOM code of patient's community of residence.
132-134	3	Tribe Code	Code of patient's tribe of membership. Example: 096
135	1	Medicare Eligible	If patient was eligible for Medicare on the date of encounter, this field will contain a Y, otherwise, it will contain a N.
136	1	Medicaid Eligible	If patient was eligible for Medicaid on the date of encounter, this field will contain a Y, otherwise, it will contain a N.
137	1	Private Ins. Eligible	If patient is eligible for Private insurance on the date of encounter, this field will contain a Y, otherwise, it will contain a N.

THE HH / SS PCC REPORTING SYSTEM (HH / SS PCC)

SECTION 1 PATIENT LISTINGS

ACTIVE CLIENT LIST
PATIENT GENERAL RETRIEVAL
DESIGNATED PROVIDER LIST
PATIENTS SEEN AT LEAST N NUMBER OF TIMES
ACTIVE CLIENT LIST USING CASE OPEN FILE
PATIENTS SEEN BY AGE & SEX
PATIENT LIST FOR PERSONAL HX ITEMS

SECTION 2 MH/SS RECORD/ENCOUNTER REPORTS

LIST MH/SS RECORDS STANDARD OUTPUT
LIST MH/SS RECORDS GENERAL RETRIEVAL OUTPUT
POTENTIALLY BILLABLE MH/SS VISITS

SECTION 3 WORKLOAD ACTIVITY REPORTS

ACTIVITY REPORT (GARS #1)
ACTIVITY REPORT BY PRIMARY PROBLEM (GARS #2)
ACTIVITY RECORD COUNTS
PROGRAM ACTIVITY TIME REPORTS
FREQUENCY OF ACTIVITIES
FREQUENCY OF ACTIVITIES BY CATEGORY

SECTION 4 PROBLEM SPECIFIC REPORTS

SUICIDE REPORT (AGE & SEX)
ABUSE REPORT (AGE & SEX)
FREQUENCY OF PROBLEMS (DSM)
FREQUENCY OF PROBLEMS (MH/SS)
FREQUENCY OF PROBLEMS BY PROBLEM CATEGORY

Strengths and Weaknesses:

This system's major strengths follow from its primary design as a clinical support system which facilitates decision making and treatment planning in patient care at a specific site. The wide range of optional uses, constructed around a core of standard information fields allow programs to tailor the use to meet local needs. We consider the capacity for direct data entry by providers a strength along with the powerful ad-hoc report writing capabilities. Articulation with PCC takes advantage of the full range of IHS software that relies on that system as a primary data base, including the billing modules. The ASCII flat file extract facilitates both merging of multiple sites and compatibility with a wide range of Data Base Management Software systems.

The system's integrative strength may be it's major weakness however, since it works best as a part of a larger system. It can be run as a stand-alone but for a variety of reasons we do not recommend its implementation in this mode. The other shortcoming of this system is that it is an optional system for Tribal programs and not all IHS program sites have been able to implement it.

Children and Adolescent Data

Indicator data from clinical systems can be compiled by site, State and IHS wide, but only from participating locations. Both the later complications may be uneven for this reason.

Social Characteristics are available through the system's link with the Patient Registration package, but may be limited by both item inclusion and system implementation.

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203 Federal Building
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Nashville, TN 37214-2634
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NAVAJO AREA IHS
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Michael Flood, MSW (Acting)
Social Services Program
SAN XAVIER IHS INDIAN HEALTH
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Tucson, AZ 85746-9352
(520) 295-2425
FAX: (call for fax #)

Agency: Office of Rural Health Policy (ORHP), U.S. Department of Health and Human Services

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Office of Rural Health Policy (ORHP) promotes better health care service in rural America. ORHP is responsible for policy advocacy and information development. The office works both with government at federal, state, and local levels and with the private associations, foundations, providers, and community leaders to seek solutions to rural health care problems. In particular, the ORPH promotes rural health research within the U.S. Department of Health and Human Services and supports such research in six national rural health research centers across the country. In addition, the ORPH sponsors a National Clearinghouse for the collection and dissemination of rural health information.

Programs Sponsored:

The ORHP sponsors rural health research at six centers: the State University of New York at Buffalo, the University of Minnesota, the University of North Carolina at Chapel Hill, the University of North Dakota, the University of Southern Maine, and the University of Washington.

Native American-specific studies are currently underway at The Center for Rural Health, University of North Dakota School of Medicine, and in The HIV/Education Coalition Programs in Alaska and New Mexico.

The Center for Rural Health houses several programs, both federally and state-funded. They include: the North Dakota State Office of Rural Health, The North Dakota Primary Care Office, the State Physician Loan Repayment program, the UND Rural Health Research Center, and the research arm of the National Resource Center on Native American Aging.

The HIV/AIDS Education Prevention Program is based on the hypothesis that a community coalition approach to risk reduction can be effective in reaching isolated and/or at risk communities. The program goals are to improve the HIV information dissemination system and support a network for rural health care providers. Target populations include the Jicarilla, Apache Nation in New Mexico and Alaska Natives in Southeast Alaska.

Kinds of Data Collected:

Currently, rural health research centers study the critical issues facing rural communities in their quests to secure adequate, affordable high-quality health services. Often, they provide important insights into the solutions of these problems. The Center for Rural Health is a research and service unit of the UND School of Medicine. As such, it works with rural communities and state agencies to promote the viability of rural health delivery systems, and to collect and analyze data relevant to that goal.

The Center collects very little data itself, but rather utilizes secondary data in its research activities. Relevant primary data derives from the Turtle Mountain Chippewa Reservation (North Dakota) and among Native Hawaiians, examining the elder caregiving patterns of Native American Families. In addition, it currently is collecting data examining the oral and dental health status of Native Hawaiians. Secondary data utilized includes the 1987 Survey of American Indians and Alaska Natives (SAIAN) collected by the Agency for Health Care Policy and Research.

The HIV/Education project collects mainly qualitative data, including needs assessments and evaluations to monitor program impact .

Contents of Data:

The SAIAN data contains survey data from approximately 2000 Native American families, representing 6,500 respondents. This is a very large data set focusing on utilization of health care services, insurance coverage, and health status. The dental study contains data from approximately 200 elder native Hawaiians on their health beliefs, dietary habits; utilization of dental services, and clinic oral health status. The caregiver data contains information on the use of formal and informal services to assist native elders in every day activities.

Strengths and Weaknesses:

Rural health research centers are exploring many important issues: how state health care and market-driven reform affect rural areas; the National Health Service Corps' success in increasing retention of physicians it places in rural areas; how to better define the limitations of "primary care hospitals" that different states are trying to design in order to retain services in areas that no longer can support full service hospitals; and how to provide rural people with access to mental health services. In addition, the ORPH publications program provides information on rural health for policy makers, program administrators, researchers, and advocates.

The HIV/Education Coalition Program emphasizes a culturally sensitive intervention credible to the target group; the project addresses health problems within the context of related socio-economic issues and the effort contributes to community empowerment by strengthening indigenous leadership and organizations. The ORPH continues to support the development and implementation of health promotion as well as disease and risk reduction interventions that utilize a community coalition approach.

Contact Information:

For more information on the Office of Rural Health Policy please contact:

Cathy Waseman
Director of Information Services
Office of Rural Health Policy
U.S. Department of Health and Human Services
5600 Fishers Lane Road
Rockville, MD 20857
PH: (301) 443-0835
FAX: (301) 443- 2803

For more information on The Center for Rural Health, University of North Dakota, School of Medicine please contact:

Jack Geller, Ph.D.,Director
The Center for Rural Health
University of North Dakota, School of Medicine
P.O. Box 9037
Grand Forks, ND 58202-9037

Agency: Office of Native American Programs (ONAP), Office of Indian and Public Housing, U.S. Department of Housing and Urban Development (HUD)

Type of Agency: Federal Human Services Program

Purpose of Agency:

The main objective of the Office of Native American Programs (ONAP) is to maximize the effectiveness of federal grants by developing cooperative and successful partnerships with Tribal governments and Indian Housing Authorities.

Programs Sponsored:

The following programs are sponsored:

- The Indian Housing Programs: (Rental, Mutual Help, Section 8 Vouchers) provide assistance to eligible low-income Native Americans through local Indian Housing Authorities; IHA Development programs provide funding to build new units or substantially rehabilitate existing units; IHA Management Operations operate and manage housing for lower income Native American families on the reservation; Indian Housing Operating Subsidies; and Indian Housing Modernization.

- Public and Indian Housing Drug Elimination Program provides grants to combat drug-related crime in Indian housing developments; Drug-Elimination Technical assistance grants program provides funds to assess needs, train staff, and eliminate drugs and drug-related crime.

- The Youth Sports Program provides funds for sports, cultural, recreational and other activities designed to appeal to youth as alternatives to the drug environment in Indian housing developments.

- Family Investment Centers provide families living in public and Indian housing access to education and employment opportunities to achieve self-sufficiency and independence.

- Early Childhood Development in Indian Housing is a cooperative effort to expand Head Start programs and child care to provide full day services for children residing in Public and Indian Housing developments: the program facilitates employment opportunities for low-income parents and guardians while providing education, health screening and nutrition for their children.

- The Resident Opportunity Program provides grants to resident management organizations to develop human service programs; HOPE grant program provides homeownership programs for eligible families; Indian Home Investment Programs fund housing for low-income people; Indian Community Development Grants ICDBG) provides community development funding to Indian tribes and Alaska Native villages; and emergency Shelter Grants to determine housing needs and estimate family help improve the quality of existing emergency size.

Kinds of Data Collected:

An Annual Report, entitled The Assessment of American Indian Housing Report (1995), provides statistics and data for the preceding fiscal year. It is developed using Internal U.S. Department of Housing and Urban Development (HUD) information systems. Data collected are primarily fiscal (i.e., Native Americans who live on trust or restricted housing funding programs), where necessary the U.S. Census data is used to provide demographic information.

Contents of Data:

The Annual Report provides a detailed overview of all HUD initiatives, such as a program outline, a review of program administration and accomplishments, and a fiscal report. The fiscal report includes the following types of data:

- Regional: percent of funds allocated for Administration, Finance, Maintenance Occupancy, Modernization, & Development.

- Construction starts and completion: percent of total units, $ amounts awarded, applications received, projects received, funds requested, projects approved, occupancy rates, percent in rates of collection, tenant account receivables (TARs) by program, TARs by unit, and operating subsidy.

- Drug Elimination Grants: drug elimination technical assistance grants, youth sports program funding, tenant opportunity program funding totals and by-office break-down (applications received/awarded).

- HOPE/HOME Program: program applications received/funds requested, grants/units awarded, funds granted, percent funded.

- Indian Community Development Block Grant Program: program applications/projects received, funds requested, projects/funds approved, type-received/approved/percent; emergency shelter grant funds awarded.

Strengths and Weaknesses:

The report represents the only overview of all initiatives sponsored by HUD. In addition, the report is updated annually.

The report is not widely distributed (no mailing lists); assessments of housing needs only; and it is unclear how data is collected; demographic data is not reported.

Contact Information:
Dominic Nessi
Office of Native American Programs
Office of Indian and Public Housing
U.S. Department of Housing and Urban Development
451 7th Street, SW, Room B133
Washington, DC 20410
PH: (202) 755-0032

Agency: Division of Law Enforcement (DLES),
Bureau of Indian Affairs,
U.S. Department of Interior

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Division of Law Enforcement (DLES) is responsible for several programs that provide direct support to Bureau of Indian Affairs (BIA) and tribal law enforcement and detention programs.

Programs Sponsored:

Several programs are sponsored:

- National Child Abuse Reporting Hotline: The BIA has a toll free telephone number for reporting incidents of child abuse in Indian Country (800) 633-5155.

- FBI Criminal History Checks: The BIA processes fingerprinting criminal history checks for the tribal employees whose responsibilities include contact or control over children.

- Internal Affairs: This branch is responsible for conducting investigations on any allegations of misconduct, excessive force or criminal activity by BIA and tribal law enforcement and detention personnel.

- Special Investigations: Five criminal investigators specializing in the investigation of child abuse are assigned to area offices. There is one investigator specializing in archaeological resource protection.

- Information Management: The Indian Child Protection and Family Violence Prevention Act mandates conformity with the FBI's National Incident Based Reporting System (NIBRS)

- Police and Detention: This unit inspects and evaluates field BIA and tribal law enforcement and detention programs. Comprehensive reports are provided outlining recommendations for improvements. A detention specialist assists with planning for new/ renovated detention facilities.

- Drug Enforcement: This unit is responsible for eradicating marijuana plants and assisting BIA and tribal police with the investigation of other illegal drugs. DEB conducts undercover drug buys for local police and also participates with regional drug enforcement task forces composed of federal, state, and local agencies. This highly trained, tactical-ready unit also serves as the BIA's emergency response team, available to assist any tribe in dealing with unusual law enforcement situations or extreme emergencies.

Kinds of Data Collected:

Two data collection forms are used: The Child Abuse Hotline Incident Report Form and The Detention Facility Intake Form. The Child Abuse Hotline Incident Report Form collects information on the child abuse cases, including, a detailed description of the incident and the names and addresses of the victim, the suspect and the complainant. Police officers are supposed to complete an Intake Form on all kids coming through the detention facility. In addition, court records maintain information on each juvenile: police contact, description of the incident; action taken; alcohol involved; and the name of the police officer.

Contents of Data:

The Child Abuse Hotline Incident Report Form assesses information from the child and guardian, such as complaint; victim data-of-birth, gender; suspect description, suspect date-of-birth, location and description of incident. The Detention Facility Intake Forms are not collected uniformly across the detention facilities. A model Intake form provided by the Walter Minor Detention Facility in Eagle Butte is a model of the most comprehensive form to date. The Intake Form includes four main topic areas:

- Admission reporting: a description of the all charges;

- Health screening: the police officer is asked to assess whether the child is suicidal, under the influence of alcohol or drugs, mentally ill, carrying any weapons, and taking any medication;

- Suicide Screening: the officer is asked to report any signs/symptoms of suicidal behavior, history of mental health problems, alcohol/drug abuse, attempted suicide, type of supervisor (routine, active, constant), and referral information for mental health care and emergency mental health care. A new nationwide information management system is being implemented to conform with the FBI's national incident-based reporting system. These programs will be distributed to all tribal and law enforcement programs.

Strengths and Weaknesses:

New intake forms developed for the Walter Minor Detention Facility Model will be implemented in October 1996 in all detention facilities. In addition, once the monitoring system is in place potentially several sources of data may be collected and maintained.

Currently, only a few of the detention facilities have intake forms. The intake forms are not completed systematically. The name and charge is always filled out on the forms, but the rest of the information is rarely completed. Consequently, only partial reporting of the information collected in juvenile detention facilities is the current norm.

Contact Information:

Warren Le Beau
Bureau of Indian Affairs
Division of Law Enforcement, Detention Program
124 Fourth St. SW, Room 201
Albuquerque, NM 87102
PH: (505) 248-7937

For further information regarding the intake forms please contact:

Walter Minor Detention Facility
D Street,
Eagle Butte, SD 57625
Rolletta Pretty Weasel
Juvenile Administrator
PH: (605) 964-4578

For more information specific to a given area, contact the appropriate agency listed by the Regional BIA Area Offices provided below.

Nebraska, North Dakota, and South Dakota

115 4th Avenue, S.E.
Aberdeen, South Dakota 57401
PH: (605) 225-0250 Ext. 343

Minnesota, Iowa, Michigan, Wisconsin

Chamber of Commerce Building
15 South Fifth Street - 6th Floor
Minneapolis, Minnesota 55402
PH: (612) 349-3383

Colorado and New Mexico

165 First Street N.W.
Albuquerque, New Mexico 87125
PH: (505) 766-3170

East Oklahoma

Old Federal Building
5th & Okmulgee Street
Muskogee, Oklahoma 74401
PH: (918) 687-2295

Kansas and West Oklahoma

WCD-Office Complex
P.O. Box 368
Anadarko, Oklahoma 73005
(405) 657-6315

Navajo Res., only, Arizona, Utah, and New Mexico

P.O. Box M. Box 1
Window Rock, Arizona 86515
PH: (602) 871-5151

Montana and Wyoming

316 North 26th Street
Billings, Montana 59101
PH: (406) 657-6315

Arizona, Nevada, Utah, and Idaho

#1 North First Street
Phoenix, Arizona 85004
PH: (602) 241-2305

N.Y., Maine, Louisiana, Florida, North Carolina, Mississippi, Conn., and Rhode Island
1951 Constitution Avenue, N.W.
Washington, D.C. 20245
PH: (703) 235-2571

Oregon, Washington and Idaho

1425 Irving Street, N.E.
P.O. Box 3785
Portland, Oregon 97208
PH: (503) 231-6702

Alaska

709 West 9th Street
Federal Building
P.O. Box 3-8000
Juneau, Alaska 99802
PH: (907) 586-7177

California

Federal Office Building
2800 Cottage Way
Sacramento, California 95825
PH: (916) 484-4682

Agency: Division of Social Services,
Bureau of Indian Affairs,
U.S. Department of Interior

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Department of the Interior is responsible for most nationally owned public lands and resources, and American Indian reservation communities. This division consists of three main components: social services, general assistance, and child welfare assistance.

Programs Sponsored:

The BIA Division of Social Services administers social services on nearly every reservation and BIA administrative jurisdictions in Oklahoma and Alaska. General assistance programs provide assistance for needy families and the Child Welfare Assistance program places Indian children in foster homes for the protection and care of needy Indian children.

Kinds of Data Collected:

The individual programs collect child abuse and neglect data with The BIA Central Office - Division of Social Services Intake Form. The regional offices are responsible for reporting data collected to the U.S. Department of Interior, BIA, Division of Social Services Headquarters to be reviewed, summarized, and published in a monthly Newsletter. The data collected are summarized below.

Contents of Data:

Child abuse and neglect indicators are summarized and reported in the monthly Newsletter which is distributed to the tribes and the regional offices. The data elements collected and summarized by the BIA Social Services Division include:

- agency office
- evidence of substance abuse
- type of referral made (either child abuse or child neglect)
- evidence of sexual abuse
- results of the investigation are described and coded as substantiated or unsubstantiated
- referral to court, social services, no action (yes/or no)

Strengths and Weaknesses:

The mains strengths are access to child abuse and neglect data summarized on a monthly basis. Due to budget limitations, the data is only distributed to the tribes. The data collection form is limited to a yes or no summary indicator, resulting in under-reporting. In addition, no demographic or background information on the victim is available.

Contact Information:

Betty Tippeconnic, Child Welfare Specialist
Division of Social Services
Bureau of Indian Affairs, U.S. Department of Interior
1951 Constitution Ave., NW Mailstop 310-SIB
Washington, DC 20245
PH: (202) 208-2721

For information specific to a given area, see the complete directory of Regional Bureau of Indian Affairs Area Offices listed under The Division of Law Enforcement, Bureau of Indian Affairs, U.S. Department of Interior.

Agency: Economic Development Division,
Bureau of Indian Affairs,
U.S. Department of Interior

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Economic Development Division is the focal point of the Bureau of Indian Affairs Indian economic development activities. The division is responsible for publication and reports of all labor force statistics and coordinates the disbursements of federal funding to Indian tribes in the areas of job-training, social assistance and labor.

Programs Sponsored:

Several programs are sponsored by the Economic Development Division: the loan guarantee program, management and technical assistance, community and reservation economic development, adult vocational-training programs, and the direct employment-assistance program. Special programs include: the Lakota tribe development program, the unified tribal college and the national iron workers training program, and preparation of reports on demographic indicators of employment.

Kinds of Data Collected:

A special report was developed in 1993, The Indian Service Population and Labor Force Estimate Report, from information generated each month by the reservation agencies. Local BIA agencies collected data from tribes, household surveys, school records, employment records, tribal election statistics, tribal membership rolls and BIA program service records. The report provides estimates of the service population of the BIA and the population's labor force status (consists of persons employed or persons seeking work) for 1993. The report supplies estimated information related to the labor force itself. The following labor force statistics are reviewed: those who are unable to work either because they are student status or other; those who are employed, not employed, percent not employed (the potential labor force); the actual labor force (total employed), total seeking work, percent unemployed, and total population earning $7,000 or more.

Contents of Data:

The data includes the labor force status of the 1,183,967 Indians residing on or adjacent to reservation lands. The population is defined as the total Indian population of the U.S., as reported in the 1990 U.S. Census. The data is confined to those members of an Indian tribe who are one-fourth degree or more blood quantum descendants of a member of any tribe, band, nation, colony, pueblo, or community including Alaska Native villages or regional village cooperation defined in or established pursuant to the Alaska Native Claims Settlement Act.

The following population and labor force estimates are presented:

- population and labor force by states
- population and labor force data by BIA area office and state; and
- population and labor force by tribe, states and servicing BIA organizational elements

In addition, the data are organized by state and three age groups: under 16, 16-64, and over 65. The data is categorized by the 32 states with the highest Indian populations and by BIA area regions.

Strengths and Weaknesses:

The report is considered the official base line data for all Bureau data and reports, providing a more specific profile of the reservation than the U.S. Census. This is the best record available which serves as a demographic indicator of employment. However, there still is considerable debate about the accuracy of the data obtained at the Tribal level.

Accuracy of information varies due to size of geographic areas covered, isolation of many communities, and differing levels of cooperation. In the majority of cases, data are estimated and not representative of an actual count. In the areas where data were not obtained, 1991 or 1989 data were used. The population estimate is based on the 1990 U.S. Census which is self-reported and includes American Indians, Eskimos and Aleuts who reside on or adjacent to the reservation or off reservation in urban areas. The data do not provide labor force statistics for Indians who reside in urban or rural areas not adjacent to the reservations or who are not members of an Indian tribe at least one-fourth blood quantum.

Contact Information:

Charles Van Pelt, Acting Director
Economic Development Division
Bureau of Indian Affairs,
U.S. Department of Interior
1849 'C' Street, NW -- Mail Stop 2528
Washington, DC 20240
PH: (202) 208-5116

For more contact information see the complete directory of Regional BIA Area Offices listed under The Division of Law Enforcement, Bureau of Indian Affairs, U.S. Department of Interior.

Agency: Office of Indian Education Programs (OIEP),
Bureau of Indian Affairs,
U.S. Department of Interior

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Office of Indian Education Programs (OIEP) is located within the Bureau of Indian Affairs, in the U.S. Department of Interior, and is responsible for line-direction and management of all Bureau of Indian Affairs education functions, such as the formation of policies and procedures, supervision of all program activities undertaken within the office's jurisdiction, and the approval of the expenditure of funds appropriated for the Bureau of Indian Affairs Indian education functions.

Programs Sponsored:

In spring of 1994, a Bureau wide effort was undertaken to survey all ninth through twelfth grade students enrolled in Bureau-funded schools. The survey instrument selected was the Youth Risk Behavior Survey (YRBS). The YRBS is administered nationally every two years in over 100 selected high schools across the country. However, this was the first time the YRBS was given uniformly in Bureau-funded high schools.

Kinds of Data Collected:

The YRBS survey assessed the risk behaviors of young Native Americans to inform future prevention initiatives to address these identified behaviors. All stakeholders were informed of the YRBS survey (Tribal leaders, schools, parents and students). All respondents understood that participation, although encouraged, was completely voluntary. One hour of one day was selected in the month of March at each of the participating schools to implement the survey. There were no make-ups for absences.

Contents of Data:

The survey examined the following health risk behaviors:

- seat belt use, motorcycle and bicycle safety
- carrying a weapon
- attempted suicide
- violence on school property
- tobacco use, alcohol use, other drug use, drug use on school property
- sexual behaviors
- HIV awareness (or lack of)
- dietary behaviors
- physical activity
- and age of initiation of selected risk behaviors.

Results from the 1994 BIA/Youth Risk Behavior Survey indicated that BIA students engaged in behaviors that put them at risk for significant mortality, morbidity, disability, and social problems which extend from youth into adulthood.

Strengths and Weaknesses:

The report summarized the results of the 1994 Bureau of Indian Affairs/Youth Risk Behavior Survey (BIA/YRBS). The survey consisted of a large sample, 5,217 BIA high-school students interviewed during the spring of 1994, resulting in a 75% student response rate. Forty-five of the 52 BIA funded high schools participated (87% response rate). Survey results are statistically representative of all BIA students in grades nine through twelve. The overall participation rate was 65%. A weighting factor was applied to each student record to adjust for non-response.

The national YRBS yields information on a limited subgroup of Indian students, namely those attending BIA-funded high schools. Additional analyses are needed in order to adequately assess its statistical reliability and validity. Moreover, the multi-state geography that serves as the catchment area for these schools makes it difficult to relate the status of students residing at a given facility to the state of origin or school location.

Contact Information:

Lana Shaughnessy, Education Specialist
Office of Indian Education Programs
Bureau of Indian Affairs
U.S. Department of Interior
18th & C Streets, NW
Washington, D.C. 20240
PH: (202)219 -1127
FAX : (202) 219-9583

For more information specific to a given area, see the complete directory of Regional BIA Area Offices listed under The Division of Law Enforcement, Bureau of Indian Affairs, U.S. Department of Interior.

Agency: Office of Juvenile Justice Delinquency Prevention (OJJDP), Office of Justice Programs, U.S. Department of Justice

Type of Agency: Federal Human Services Program

Purpose of Agency:

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) falls under the Office of Justice Programs (OJP) and comprises the Research and Program Development Division, the Training and Technical Assistance Division, the States Relations and Assistance Division, the Concentration of Federal Effort Program, the Missing Children's Program, and the Information Dissemination and Planning Unit. Within the OJJDP, the National Institute of Juvenile Justice and Delinquency Prevention (NIJJDP) houses the Research and Program Development Division and the Training, Dissemination, and Technical Assistance Division.

Programs Sponsored:

The OJJDP sponsors seven divisions and programs: information and planning unit, research and program development division, special emphasis division, state relations and assistance division, training, dissemination, and technical assistance division, concentration of federal efforts program, and the missing children's programs. The Special Emphasis Division, provides funding for projects in special populations. The Native American Alternative Community-based Program specifically addresses Native American youth. This program provides training and technical assistance to Native American tribes to develop community-based intervention programs for youths reentering the community after incarceration. This project is currently funded at five sites: National Indian Justice Center, Petaluma, CA; Red Lake Band of Chippewa Indians, Red Lake, MN; Pueblo of Jemez, Jemez Pueblo, NM; Gila River Indian Community, Sacaton, AZ; and The Navajo Nation, Window Rock, AZ. Each of the sites receives funding for their programs as well as training and technical assistance.

Kinds of Data Collected:

Building on past OJJDP initiatives in intensive supervision and community-based aftercare, this effort has developed alternative programs for adjudicated delinquents and re-entry programs for those returning from institutional placement. The program incorporates cultural elements from traditional programs used for Native American youth offenders.

Contents of Data:

The assessment process occurs after the child is arrested and before the initial court hearing. The assessment includes the completion of the Program Intake Form and the qualitative assessment of the child's family and school environment. The assessments are entered into the child's case file and are reviewed by the judge at the child's court hearing. Information is collected from several sources to accurately present the child's case to the judge. The

following information is collected on the child, parents and family: name of the child, mother and father, clan, address, and action taken (to be completed by supervisor). In addition, home visits are conducted to assess the family environment, setting, and household composition, and school records are obtained. Other information is noted: history of previous offenses, history of child abuse and child neglect are also recorded. A report is prepared and action recommended, e.g., court order, probation, or treatment plan in conjunction with the family.

Strengths and Weaknesses:

The program reinforces the family support structure and develops treatment designed to integrate the family. The program has successfully helped incarcerated youth reenter the community.

The assessments are subjective based on the evaluator's perception of the child's environment. The data are not collected systematically, and forms are not always completed, resulting in partial reporting.

Contact Information:

The grantees for the Native American Alternative Community-based Programs are:

National Indian Justice Center, INC.
7 Fourth Street, Suite 46,
Petaluma, CA 94952
Joseph Meyers, Project Director
PH: (707) 762-8113

Red Lake of Chippewa Indians
PO Box 550
Red Lake, MN 56671
Judy Roy, Project Director
PH: (218) 679-8113

Pueblo of Jemez,
PO BOX 100
Jemez Pueblo, NM 87204
Roger Fagua, Project Director,
PH: (505) 834-7359

Gila River Indian Community
PO Box 97,
Sacaton, AZ 85247/
Laura Yergan, Project Director
PH: (602) 899-1012

The Navajo Nation,
PO Drawer E,
Window Rock, AZ 86515
Edward B. Martin, Project Director,
PH: (602) 871-7669

Special Emphasis Division, OJJDP,
Eugene Rhoden, Program Manager
PH: (202) 307-5914

If interested in the National Training and Assistance Center contact:

National Training and Assistance Center
11990 Grant Street, Suite 318
Northglenn, CO 80223
PH: (303) 457-9947
FAX: (303)451-1049

National Advocacy Organizations

Agency: American Humane Association

Type of Agency: National Advocacy Organization

Purpose of Agency:

To prevent cruelty, abuse, neglect, and exploitation of children and animals and to assure that their interests and well-being are fully, effectively and humanely guaranteed by an aware and caring society.

Programs Sponsored:

The data collection and analytic component of the National Child Abuse and Neglect (NCANND) systematically collects and tracks information on child abuse nationwide. The AHA provides technical team participation in the National Child Abuse and Neglect Data System of HHS (NCAND) and produces Detailed Case-Data Reports (DCDR).

Kinds of Data Collected:

The Detailed Case Data Component (DCDC) is based on state child protection data sources. Currently, eleven states participate: Florida, Illinois, Louisiana, Massachusetts, New Jersey, North Carolina, South Carolina, Pennsylvania, Texas, Vermont, and Washington. American Indian data can be accessed via a "Race" field with a "Native American" value. The sample is defined as all known in the state who have reported child abuse (e.g., through State automated child abuse registries or State automated child welfare information systems).

Contents of Data:

Several variables are collected in all states in the following categories:

- trends in child abuse (physical, and sexual abuse, educational and medical neglect) sources of all reports; children by disposition (type of abuse)
- rate of maltreatment (a generic term for both abuse and neglect) by states
- rate of disposition by state
- victim by type of maltreatment
- victim rates by type of maltreatment
- age, sex and race of victims

In addition, the NCANDS collects several detailed data case fields. The main categories include:

- Report data refers to the child's description of the abuse (e.g. , disposition)
- Child data describes the demographics of the child (e.g., age at report, date of birth, sex, race, living arrangement, prior victim status).
- Child victim data reviews the emotional and physical health of the child as well as the services available and used by the child (e.g. emotionally disturbed, physically disabled, family support services, independent and transitional living services, case management, counseling and foster care services).
- Perpetrator data reviews the demographics of the perpetrator, relationship to the child, and prior abuse history of the perpetrator.

Strengths and Weaknesses:

The case level data which address reports, children, perpetrators, and the associated maltreatment allows for powerful and flexible aggregation of data. All data are collected under strict protocols and quality-control procedures, such as three levels of editing and internal review, multiple coding levels.

The data represent the cases of child maltreatment that are known to child protective services agencies through their reporting and investigating mechanisms. Consequently the data under-represent all child abuse cases. Furthermore, not all states participate due to budget constraints and inability to provide the internal data collection system necessary to collect all NCANDS data. In addition, there is variability among states on how the data is collected. For example, some states use "indicated" to mean strong indicator or unsure, rather than to indicate definitely whether the abuse occurred or not.

Parallels to Child Trends:

These data reflect the case level detail of reported instances of child maltreatment.

Contact Information:

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John Fluke, Ph.D., Director of Program Analysis
American Humane Association
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PH: (303) 792-9900
FAX: (303) 792-5333

Additional copies of the annual report and updated tables for earlier years of the SDC (1990-1992) may be obtained from:

National Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182 Washington, D.C. 20013-1182
1-800-FYI-3366

Agency: American Indian Health Care Association (AIHCA)

Type of Agency: National Advocacy Organization

Purpose of Agency:

The American Indian Health Care Association (AIHCA) is a national minority non-profit organization whose mission is to develop, promote, and support culturally sensitive health services to achieve optimal health, social and economic well-being for all American Indians and Alaska Natives.

Programs Sponsored:

Current projects include: Native American Women's Health Tracking System (NAWHTS), breast and cervical cancer screening with computerized follow-up; Uniform Clinical Reporting (UCR), statistical analysis of urban health survey; National Cancer Institute (NCI) follow-up of Native American Women and Wellness (NAWW) study; IHS Computer System Evaluation Project; and IHS Project to Redesign and Install Model Systems. AIHCA has a membership of 35 urban Indian health programs nationwide. Examples of the affiliated urban health programs and clinics are as follows: Alaska - none; Arizona - Traditional Indian Alliance, Native Americans for Community Action, Inc.; and Montana - North American Indian Alliance, Missoula Indian Center, Native American Center, and Indian Health Board of Billings. For a complete listing see contact information.

Kinds of Data Collected:

- Standardized intake form (the Uniform Clinical Reporting Form) is used for all patients served by member clinics. A battery of questions assesses dental, medical, and mental health status of all patients.

Contents of Data:

The following data elements are collected:

- Dental: diagnostic/preventive; periodontics; removable prosthetics; oral surgery; restorative; cast restorations; endontic

- Primary Care: new patient; established patient; maternity care; immunizations; injections; laboratory (in-house); contract lab; diagnosis; patient/household composite/demographics; spousal information

- Medical History: symptoms; illnesses; injuries; surgeries; habits (alcohol, smoking); current status; alcohol/substance abuse treatment; pregnancy history, contraceptive information, weight-gain, shortness of breath, and cancer rates

- Patient Demographic information of the child (if applicable), self or responsible party and spouse of patient: tribe, years living on the reservation, marital status, address, employment status, marital status, and education

Strengths and Weaknesses:

The use of the Uniform Clinical Reporting Form may serve as a potential repository of data for other agencies.

The clinics do not complete the intake forms systematically - only 50% report information. The data collections forms only allow for a yes or no response in the medical history section, limiting the accuracy of the data collected.

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American Indian Health Care Association
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For more information refer to the complete listing of the American Indian Health Care Affiliated Clinics provided below.

ABERDEEN AREA:

Nebraska Urban Indian Health Coalition, Inc.
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Donna Polk

South Dakota Urban Indian Health, Inc.
122 East Dakota
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Charles Walker

ALBUQUERQUE AREA:

First Nations Community Health Source
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Trula Breuninger

Denver Indian Health & Family Services
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Stephen Byers

BEMIDJI AREA:

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American Indian Health & Family Services
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Norine Smith

BILLINGS AREA:

American Health Board of Billings, Inc.
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Marjorie Bear Dont Walk

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Bill Walls

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Susette Schwartz

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Elva Siler

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Joanne Stucius

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Rosemary Richmond

Agency: National Congress of American Indians (NCAI)

Type of Agency: National Advocacy Organization

Purpose of Agency:

The National Congress of American Indians (NCAI) is the oldest and largest representative national Indian organization. It is organized as a representative congress of consensus on national priority issues. The NCAI is based on the following founding principles: protect Indian and Native traditional, cultural rights; seek services for Native government and people; secure and preserve native rights, enhance the quality of life of Native people, and promote a better understanding among the general public of Native issues.

Programs Sponsored:

- Current programs and issues include the protection of programs and services to benefit Indian families, specifically targeting Indian youth and elders. Indian education: including Head Start, elementary and post-secondary adult education, enhancement of Indian health care including prevention of juvenile substance abuse, and HIV-AIDS prevention.

- Protection of Indian culture and rights: environmental protection and natural resources management; promotion of the right of Indian economic opportunity both on and off reservation, including securing programs to provide incentives for economic development, and protection of the right of all Indian people to have decent, and safe and affordable housing.

- Specific Projects: NCAI, in partnership with the National Indian Policy Center, conducted a two-year evaluation and assessment of the Dept. of Health and Human Services Community-Based Family Resources Program administered through the Administration for Children, Youth and Families (1995). This program provides funding to states willing to take a holistic approach to family support services and the prevention of child abuse and neglect, and to assist tribes in designing and implementing family resources and support programs.

- The evaluation and assessment included site visits to tribal family service programs, and a survey of tribal family programs throughout the lower 48 states and Alaska. A guide was prepared: The Strengthening of the American Indian Family: A Family Resource and Support Model (1995). The guide includes five components: an overview of the Community-based Family Resource Program, suggested steps to follow in your own community, description of the program, an overview of existing holistic tribal family-service programs, a directory of government and private funding resources that will support the tribe's efforts in Community-Based Family Resource Programs, and copies of all data collection forms used.

Kinds of Data Collected:

Data is collected through process and outcome evaluations. The programs were monitored through the analysis of data gathered from agency forms and site visits. Tribal programs collected data from fact sheets, staff activity reports, client tracking, surveys and evaluation reports.

NCAI reviewed tribal programs that are currently adopted holistic, comprehensive, and culturally based efforts to serve American Indian families. Some examples include: the Cherokee Challenge, the Seneca Positive Parenting, the Ute Mountain Project Homebase, and the Michigan Inter-tribal Families First programs.

Contents of Data:

The Community-based Family Resource Program used the following intake/uptake forms for data collection purposes:

- Family Support Center Intake/Uptake Form
- Family Resource Scale
- Support Functions Scale
- The Family Needs Scale

The Family Support Center Intake Form covers demographics, household composition, description of housing (including shelters), parenting status and family planning (birth control method used), SES, all sources of income, education, employment, sources of health care treatment facilities, plans for attaining the services and barriers to care.

The Family Resource Scale assesses the extent to which the family has adequate resources (time, money) to meet the needs of the family as a whole, as well as the needs of the individual family members.

The Support Functions Scale asks the respondent to describe how much help he/she needs from a list of twenty different types of assistance.

The Family Needs Scale reviews forty-one different types of help or assistance offered and asks the respondent to what extent they need the help. The evaluations assessed the process used in establishing services or the outcome those services had on the population.

Process evaluation questions identified the following: the process used to set-up the program, how clients were recruited, the services the program provided, estimated the cost of the services and how many clients served monthly and annually. The outcome evaluations ascertained whether the program met its stated goals, the number of parents employer through program efforts, trends in child abuse and neglect referrals among program clients and the changes that occurred in the process of providing family services to the community.

Strengths and Weaknesses:

The guide provides an overview of the Community-Based Family Program, a how-to-guide to start initiatives in one's own community, and a profile of tribal service programs that meet the criteria for this program (holistic, preventative and child-based care). In addition, the guide

provides a directory of government and private funding resources to support the tribe's effort to establish a Community-Based family Resource Program, a list of agencies and organizations supporting families, federal regional contacts, and a listing of American Indian Human Services Programs. However, the guide does not review any of the health indicators from the Scales and Intake Forms used to collect data.

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Agency: National Indian Child Welfare Association (NICWA)

Type of Agency: National Advocacy Organization

Purpose of Agency:

Established in 1983 as a regional child welfare resource center known as the Northwest Indian Child Welfare Institute, the National Indian Child Welfare Association (NICWA) took on a national focus in 1994. Under the direction of an all-Indian board of directors, the mission of NICWA is "to work to insure that every Indian child has access to community-based, culturally-appropriate services which help them grow up safe, healthy, and spiritually strong--free from abuse, neglect, sexual exploitation and the damaging effects of substance abuse."

To achieve this goal, NICWA programs focus on the following three important areas:

Community Development

- Providing consultation and technical assistance to tribes on developing Indian child welfare services
- Developing child abuse awareness campaigns
- Organizing local tribal community members as advocates for children
- Assisting tribal Head Start and childcare programs to prevent child sexual abuse
- Promoting substance abuse prevention

Public Policy Development

- Facilitating policy discussions between tribes and state and Federal government
- Enhancing tribal access to funding sources
- Advocating for compliance with the Indian Child Welfare Act
- Monitoring federal legislation and the budget process as they impact Indian families
- Training in cross-cultural services

Information Exchange

- Training over 500 Indian child welfare workers annually
- Conducting annual National American Indian Conference on Child Abuse and Neglect
- Providing information to every Indian child welfare program in nation
- Maintaining Indian child welfare resource library
- Publishing and distributing training curriculum

Programs Sponsored:

Some of the specific projects which support NICWA's activities include:

- Family Preservation and Substance Abuse Training project: providing training and technical assistance for the staff of tribal family preservation programs

- Native American Mental Health Access project: designed to increase tribal access to federal, state, and private mental health resources for Indian children

- Community Development Initiative: designed to increase tribal access to public and private child welfare funding sources

- Indian Child Welfare Organizational Improvement: provides on-site technical assistance for tribal Indian child welfare program administrators on topics related to program management

Kinds of Data Collected:

Data collected through these projects includes information on the various state, federal, and private funding resources available to tribal social service programs; barriers to tribal access of these funding sources.

Other data collected by NICWA includes U.S. Census statistics and various reports through the Bureau of Indian Affairs, Indian Health Services, and other organizations which document Indian child welfare data. The information collected by NICWA is catalogued and stored in a Resource Library.

Contents of Data:

The NICWA projects described earlier are generally not designed for the purpose of collecting data on the indicators of health and well-being of Indian children. Most focus on the delivery of training, technical assistance, and resource materials. Other projects explore methods to give tribes greater access to stable social service funding sources. Some NICWA projects are exploratory studies investigating service delivery problems and successes, such as:

- Gathering and Sharing: An Exploratory Study of Service Delivery to Emotionally Handicapped Indian Children. The purpose of this study was to increase the level of understanding of issues involved in providing services to emotionally handicapped Indian children, including estimating the number of emotionally handicapped Indian children in the Northwest, current services to these children, service delivery barriers, identifying exemplary programs addressing these problems.

- Native American Children's Mental Health Access Project: An Exploratory Assessment of Tribal Access to Children's Mental Health Funding. This study provides an overview of Indian children's mental health issues and the process of increasing access to services for Indian children who are emotionally disturbed.

- Developing Effective Tribal Child Welfare Services in the Context of the Washington Tribal State Agreement and the Centennial Accord: A Tribal Child Welfare Administrative/ Services Capacity Review. This project is designed to gather, compile, and analyze data on the current child welfare service delivery capacity and service utilization of all tribes and urban Indian organizations in the State of Washington and to provide DCFS a report profiling each tribe's capacity building needs and estimated costs of meeting those needs.

NICWA has also developed a brief report, The Status of the American Indian Child: Challenges to Providing Healthier Environments, which focuses on the health and physical and mental well-being of Indian children. This report is a culmination of data extracted and organized from other sources, including the 1990 U.S. Census, Office of Technology Assessment, Bureau of Indian Affairs, and Indian Health Service.

NICWA maintains a resource library which consists of over 2,300 books, articles, and working papers on Indian child welfare and related issues. It is catalogued on a computer database and stores more information on child abuse and neglect in Indian communities than any other library in the nation.

Strengths and Weaknesses:

The strength of NICWA's data related to tribal funding and service access is that it is unique and not readily available from any other source. A weakness of NICWA data is that most projects conducted by NICWA do not specifically document health and well-being indicators and the data collected through the special reports is exploratory in nature.

The resource library contains a substantial amount of Indian child welfare information. However, only limited data are available on certain topics such as current foster care and adoption placement rates for Indian children on a state-by-state basis.

Parallels to Child Trends Report:

NICWA studies review policies and services systems as opposed to individual child issues. The ability of tribes to access particular services or funding streams have a direct impact on the well-being of children in these communities and, thus, may have parallels to the Child Trends Report.

Contact Information:

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National Indian Child Welfare Association
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Portland, OR 97201
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FAX: (503) 222-4007

Agency: National Indian Health Board (NIHB)

Type of Agency: National Advocacy Organization

Purpose of Agency:

The National Indian Health Board (NIHB) serves to advocate and represent the views of Tribal governments to ensure the health status of Indian people will be elevated to the highest levels possible. This organization is committed to advise government and private agencies, as to priorities, policies, and guidelines for the delivery of health services to needy American Indians and Alaska Natives.

Programs Sponsored:

The NIHB encourages Tribal government officials, health care providers and consumers throughout Indian country to study, share and seek solutions to challenges affecting health care delivery in Indian communities. For example, one of NIHB's initiatives for 1995 was "Reduction, reorganization and resiliency: Fostering Native solutions for healthy children, healthy families and healthy communities." In addition, in conjunction with IHS, NIHB established work groups, such as the Indian Health Design Team to change the existing health care delivery system.

Kinds of Data Collected:

Profiles of all participating NIHB tribes were collected and used to inform policy and facilitate the role of NIHB as advocates of the tribal and Urban Indian programs.

Contents of Data:

Data was collected from over 265 tribes. The information collected is on the program level to inform policy and promote healthy families and communities. The following factors were assessed to produce tribal profiles: 1) estimates mileage round-trip commuting distance for clients; 2) funding sources for health services; 3) total expenditures for health services and how much was provided by IHS; 4) list of all services provided; 5) list of the top 5 unmet health related needs of their tribe or urban program; 6) the major issues their organization has with the federal government [under/inadequate funding]; 7) whether the organization participates in a State-Tribal task force or other forum for health care planning and reform; 8) whether their state reimburses tribes and urban Indian programs for health care provided to Medicaid recipients; 9) whether their organization has a coordinated Tribal-State-Federal Data System; 10) whether their state provides block grants; 11) identifies ways their organization is impacted by state health care reform; 12) determines how states resolve issues of sovereignty with the tribes; 14) defines the most important issues the organization has with the state government; and 15) defines the role of the Federal government should have to help the Tribe, Indian organizations and States governments to work together.

Strengths and Weaknesses:

The data collected are health services oriented with implications for changing policy on the local, state and national levels. Initiatives were defined from the tribal with implications for data collection and monitoring in Indian communities. For example, the number of tribes without a coordinated Tribal-State-Federal Data System; and whether their organization has funding to support such a system. If the data are summarized or synthesized it is reviewed in the NIHB Health Reporter which circulates biannually. The Health Reporter provides an overview of trends from NIHB-sponsored projects and does not go into great detail. However, project specific contact information is specified and further information can be obtained.

Contact Information:

Yvette Joseph-Fox, Executive Director
National Indian Health Board
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Denver, CO 80222
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More information at the local level may be obtained through the offices of the National Indian Health Board of Directors provided below.

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ALASKA AREA:

Lincoln Bean
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FEDERAL EXPRESS
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ALBUQUERQUE AREA:

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Representative-Member at Large
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Regional / State Organizations

Area Health Boards

Although the National Indian Health Board serves as a national advocate on behalf of Indian and Native communities, and works closely with, as well as represents common interests among various regional entities, it is not isomorphic with the Area Health Boards initially supported by the Indian Health Service as a primary mechanism for community input at the latter's administrative area level. Consequently, Area Health Boards have developed into a formidable set of organizations that, in addition to their historic consultative role, now engage in a wide spectrum of health care activities that generate data relevant to the KIDS COUNT agenda. This section describes one of these boards in detail, offering some insight into their potential contribution to the development of indicators.

Agency: Aberdeen Area Tribal Chairmen Health Board

Type of Agency: Regional / State Organization

Purpose of Agency:

The Aberdeen Area Tribal Chairman Health Board (AATCHB) represents seventeen tribal governments in the States of North Dakota, South Dakota, Nebraska, and Iowa. The purpose of the AATCHB is to provide the Indian people of the Aberdeen Area with a formal Representative Board as a means of communicating and participating with the Aberdeen Indian Health Service, and other health agencies and organizations on health matters.

In addition, the Aberdeen Area Tribal Chairmen Health Board level sponsor and direct projects that produce indicators of health and well-being of Native children and families, such as The Alcohol Developmental Disabilities Project (Aberdeen, SD).

Programs Sponsored:

The Aberdeen Area Alcohol Related Developmental Disabilities Project (ARDD) is designed to aggressively deal with Alcohol Related developmental disabilities by using prevention strategies, training, follow-up and tracking, and careful monitoring. The prevention and training efforts are centered on the populations that have the highest risk for ARDD, American Indians living on reservations, and the individuals with limited income who have limited access prenatal care. However, the resulting program has applications to other populations.

The ARDD Project has five goals/ components:

- Goal 1: Training: Nineteen tribal communities in the Aberdeen Area will increase utilization of prenatal services and decrease the incidence of alcohol, tobacco, and other drug used by pregnant women.

- Goal 2: Surveillance: The interdisciplinary Consortium for the Prevention of ARDDs will develop an interdisciplinary system of surveillance. The system will include the CRTs in screening and referring children suspected of having ARDD.

- Goal 3: Intervention: The ARDD Project and staff contribute to the development of proven and effective intervention strategies for children with ARDD. These strategies include development of a screening instrument for identifying maternal substance abuse; compilation of resources; and collaboration with ongoing research where appropriate.

- Goal 4: Treatment: Women identified within the Aberdeen Area as abusing substances during pregnancy will receive counseling and/or treatment by certified counselors.

- Goal 5: Follow-up and Tracking: The ARDD Project staff will collaborate with AAIHS and Tribal health program systems for follow-up and tracking children with ARDD.

Kinds of Data Collected:

The project completed the training component of the study in September, 1995. The target population consisted of IHS Aberdeen Service Areas and the states of South Dakota, North Dakota, Iowa, and Nebraska. Currently, they are working on sustaining the project moving toward surveillance, intervention and service delivery. A screening instrument is being developed. The screening instrument will assess maternal substance use and risk factors for ARDD.

Contents of Data:

Specifically, the data set includes: levels of alcohol consumption, frequency of alcohol consumption, adverse effects of alcohol use (physical, social, economic), demographics (age, education, occupation tribal affiliation) and whether any one has complained of the respondent alcohol use- if yes, a probe is used to determine the nature of the problem/complaint.

Most of the data collected is qualitative, includes outcome evaluations and community impact evaluations.

Strengths and Weaknesses:

The information developed and implemented in this study is replicable for all tribal communities.

The project has only completed the training phase of the study. The interdisciplinary system of surveillance sounds promising, however it has not been established yet. In addition, the timeline for summarizing the data is not mentioned. There was no formal mechanism for collecting data. The project relied mostly on volunteers.

Contact Information:

Ed Parsells, Project Director
The Alcohol Related Developmental Disabilities Project
Aberdeen Area Tribal Chairman Health Board
Aberdeen, South Dakota
PH: (605) 229-3846

For further information please refer to the list of Area Health Boards provided below.

Aberdeen

Aberdeen Area Tribal Chairmen's Health Board
Berkshire Plaza
408 8th Avenue NW, Suite 205
Aberdeen, SD 57401
Telephone: (605) 229-3846
FAX: (605) 229-5864

Albuquerque

Albuquerque Area Indian Health Board, Inc.
301 Gold Avenue SW, Suite 105
Albuquerque, NM 87102
Telephone: (505) 764-0036
FAX: (505) 764-0446

Alaska

Alaska Native Health Board
(CRIHB)
1345 Rudakof Circle, Suite 206
Anchorage, AK 99508
Telephone: (907) 337-0028
FAX: (907) 333-2001

California

California Rural Indian Health Board

650 Howe Avenue, Suite 200
Sacramento, CA 95825
Telephone: (916) 929-9761
FAX: (916) 929-7246

Nashville

United Southern and Eastern Tribes (USET)
711 Stewarts Ferry Pike
Nashville, TN 36214
Telephone: (615) 872-7900
FAX: (615) 872-7417

Phoenix

Inter-Tribal Council of Arizona, Inc.
4205 North 7th Avenue, Suite 200
Phoenix, AZ 85013
Telephone: (602) 248-0071
FAX: (602) 248-0080

Portland

Northwest Portland Area Indian Health
Board (NPAIHB)
520 SW Harrison Street, Suite 400
Portland, OR 97201
Telephone: (503) 228-4185
FAX: (503) 228-8182

Commissions on Indian Affairs

A majority of states, recognizing the unique legal, social, and economic relationship between themselves and American Indian/Alaska Native communities within their boundaries, have chartered an office or commission that is responsible for liaison with this special population. Mission, scope of work, areas of interest, staff size, and level of activity vary significantly from one commission or office to another. However, most are deeply concerned about the health and well-being of Indian/Native children and families.

This section provides an overview of one of these state commissions as an example. This example is followed by contact information for similar commissions or offices in other states.

Agency: Colorado Commission of Indian Affairs (CCIA)

Type of Agency: Regional / State Organization

Purpose of Agency:

The Colorado Commission of Indian Affairs (CCIA) was established in 1973 by the Colorado general assembly in recognition of the special status of the two Ute tribes within its state boundaries (Ute Mountain Ute and Southern Ute). The purpose of the CCIA is to enhance the relationship between the tribes and state government. This relationship was extended to include all Indian people residing within the state, most of whom are enrolled members of other Indian tribes. The CCIA was established and is administered within the office of the Lieutenant Governor, who is automatically designated as chairperson of the Commission.

Programs Sponsored by the Agency:

The CCIA is charged with the responsibility of coordinating intergovernmental dealings between tribal governments and the state; investigating the needs of Indians of this state and to provide technical assistance in the preparation of plans for the alleviation of such needs.

The CCIA membership is made up of two tribal members, one from each tribe, two Indian members-at-large and representatives from major departments of state government, and the Lieutenant Governor as chairperson.

Kinds of Data Collected by Agency:

The CCIA collects information pertaining to the needs and issues of Indian people of the two Ute tribes and other Indians living within the state. This information relates directly to the goals established annually to guide the work of the commission. This data covers needs and issues pertaining to human services and health, educational and training issues and services, economic development (especially natural resources, water and land), legal issues, corrections, veterans' affairs, and special needs that may arise as one-time issues. Most of the needs and issues affect both Indians and non-Indian populations of the state, including governmental jurisdiction issues regarding taxation, tribal and state laws, economic development, natural resources, and gambling.

Content of Data:

The data collected pertains to the needs and issues identified above. As indicated, some needs and issues are of continuing concern, such as health, education, economic needs, and jurisdictional issues. Other concerns may be taken care of by the attention and action given to it during a given year.

The data may be anecdotal, such as information provided by testimony of the Commissioners and by Indian and non-Indian people. Other data may come from reports generated by other entities, government and nongovernmental, through formal studies.

Much of the content of the data focuses on the needs of Indian children and families relating to economic, health, and education matters.

Strengths and Weaknesses of the Data:

As indicated above, information provided to the CCIA ranges from informal complaints involving personal views and perceptions of an issues to formal studies and reports with varying degrees of research sophistication.

Parallels to Child Trends Reports:

Information provided to or gathered by the CCIA concerning children may show such things as trends in the education achievements or lack thereof of school-aged children and in relation to health matters such as rates of disease, and immunization.

Contact Information:

Lieutenant Governor Gail Schoettler
or
Executive Secretary
Colorado Commission Indian Affairs
Office of the Lieutenant Governor
130 State Capitol
Denver, CO 80203
PH: (303) 866-3027
FAX: (303) 866-5469

For more information please refer to the directory of Commissions on Indian Affairs provided below.

Alabama

Alabama Indian Affairs Commission
339 Dexter Ave., Suite 113
Montgomery, AL 36130

Alaska

Assistant for Alaska Native Affairs
Office of the Govenor
Pouch A
Juneau, AK 99811

Arizona

Arizona Commission on Indian Affairs
1645 W. Jefferson, Suite 433
Phoenix, AZ 85007
Clinton, M. Pattea, Chair

California

California Native American Heritage Commission
915 Capitol Mall
Sacramento, CA 95814
Loretta Allen, Chair

Colorado

Colorado Commission on Indian Affairs
130 State Capital
Denver, CO 80203
PH: (303) 866-2087

Connecticut

Connecticut Indian Affairs Council
Department of Environmental Protection
165 Capitol Ave., Room 240
Hartford, CT 0106

Florida

Florida Governor's Council on Indian Affairs
512 E. College Ave.
Tallahassee, Fl 32301
Joe A. Quetone, Executive Director
PH: (904)-488-0730

Georgia

Office of Indian Heritage
330 Capitol Ave., S.E.
Atlanta, GA 30334

Hawaii

Hawaii Council of Indian Affairs
P.O. Box 17627
910 N. Vineyard Blvd.
Honolulu, HI 96817
Jole Ide, Director

Idaho

American Indian Coordinator
State House
Boise, ID 83720

Iowa

Office of the Governor
State Capitol
Des Moines, IA 50319

Louisiana

Governor's Commission on Indian Affairs
P.O. Box 44455, Capitol Station
Baton Rouge, LA 70804

Maine

Maine Indian Affairs Commission
State Health Station No. 38
Augusta, ME 04333

Maryland

Maryland Commission on Indian Affairs
45 Calvert St.
Annapolis, MD 21401
Patricia L. King, Director
PH: (301) - 974- 2531

Massachusetts

Massachusetts Commission on Indian Affairs
One Ashburton Place, Room 104
Boston, MA 02108
John A. Peters, Executive Director
PH: (617) 727- 6394

Michigan

Michigan Commission on Indian Affairs
Department of Management and Budget
P.O. Box 30026
611 W. Ottawa St.
Lansing, MI 48909
PH: (517) - 373- 0654

Minnesota

Assistant to the Governor for Indian Affairs
State Capitol No. 122
St. Paul, MN 55155

Montana

Governor's Office of Indian Affairs
1218 E. 6th Ave.
Helena, MT 59620
Don Wetzel, Coordinator of Indian Affairs
PH: (406) 444-3702

Nebraska

Nebraska Indian Commission
P.O. Box 94914
State Capitol
Lincoln, NE 68509

Nevada

Nevada Indian Commission
3100 Mill St., Suite 206
Reno, NV 89502
Leslie L. Blossom, Director
PH: (702) 789- 0347

New Jersey

New Jersey Indian Office
300 Main St., Suite 3F
Orange, NJ 07050
James Lone Bear Revey, Chairman
PH: (207) 675-0694

New Mexico

Indian Advisory Commission
P.O. Box 1667
Albuquerque, NM 87107

New York

New York State Dept. of Indian Services
General Donovan State Office Building
125 Main St., Room 471
Buffalo, NY 14203

North Carolina

North Carolina Commission on Indian Affairs
P.O. Box 27228
227 E. Edenton St., Room 229
Raleigh, NC 27611

North Dakota

North Dakota Indian Affairs Commission
State Capitol Building., 1st Floor
Bismarck, ND 58505
Juanita J. Helphrey, Executive Director
PH: (701) 224-2428

Oklahoma

Oklahoma Indian Affairs Commission
4010 N. Lincoln Blvd.
Oklahoma, City OK 73105

Oregon

Commission on Indian Services
454 State Capitol
Salem, OR 97310
Kathy Gorospe, Director
PH: (503) 378-5481

South Carolina

Assistant to the Governor
P.O. Box 11450
Columbia, SC 29211

South Dakota

South Dakota Office on Indian Affairs
Kneip Bldg., 2nd floor
Pierre, SD 57501

Texas

Texas Indian Commission
P.O. Box 2960
Austin, TX 78768-2960
Raymond D. Apodaca, Executive Director
PH: (512) - 458- 1203

Utah

Utah Navajo Development Council
27 South 100 East
Blanding, UT 84511
Herbert Clah, Executive Director
PH: (801) - 678- 2285

Virginia

Indian Affairs Coordinator
Section of Human Resources
9th Street Office Building, Room 622
Richmond, VA 23219

Washington

Washington Commission for Indian Affairs
1057 Capitol Way
Olympia, WA 98504

Governor's Office on Indian Affairs
605 11th Ave. S., Suite 112
Olympia, WA 98504
Miche's Aguilar, Director

Wisconsin

Wisconsin Governor's Indian Desk
P.O. Box 7863
Madison, WI 53701

Wyoming

Wyoming State Indian Commission
2660 Peck Ave.
Rivertone, WY 82501

State Departments of Health

State departments of health actively participate in KIDS COUNT indexing and monitoring activities. However, discussion with several program grantees indicate that they may not be aware of, and thus fail to inquire about, special initiatives that, though not Indian- or Native-specific, nonetheless capture data relevant to their efforts. The example provided below illustrates a program within a given state department of health that includes a American Indian/ Alaska Native race/ethnicity descriptor in its client information system, whereas other programs in the same department do not. Consequently, it may be important to review carefully program, branch, and division variations in client/patient tracking procedures.

Agency: Colorado Department of Public Health & Environment

Type of Agency: Regional / State Organization

Purpose of Agency:

The mission of the Health Statistics Section of the Health Department is to improve the reproductive health status of Coloradans by enabling families to achieve their desired fertility. Goals are to promote lifestyles and behaviors that improve health status; emphasize the value of family planning as a public health priority; assure access to early and appropriate prenatal services; and to assure access to comprehensive women's health services.

Programs Sponsored:

The two statewide public health programs within Women's health are the prenatal and family planning programs.

Kinds of Data Collected:

The family planning program collects data on every client served in 70 clinic sites.

The prenatal program collects data on every client served in 26 contracting agencies. This data set is outcome based; data is collected only once after a client delivers her baby, or terminates with the program either because she terminated the pregnancy, or moved.

Contents of Data:

The data set includes an unduplicated count of clients served in a 12 month period; and a demographic profile of clients with the following components:

- Gender by age and race: (Asian/Pacific Islander, Black, Native American/Alaskan, and White) gender by age and ethnicity (Hispanic/Latino).

- Income as a percent of poverty level: (100% of poverty and below; 101% - 150%, 151% - 200%, 200%+).

- Contraceptive methods/female users: - selected services delivered during family planning visits (Pap Smear, breast exam, HIV tests, and screening for sexually transmitted infections).

- Characteristics of the mother: age of mother (11-14, 15, 16, 17, 18, 19, 20-24, 25-29, 30-34, 35-39, 40+); risk of poor pregnancy outcome by age of mother; by education of mother, risk of preterm labor by age of mother; by education of mother, annual income and education level of mother, infant birth weight by education level of mother, number of previous births to mother (para).

- Complications of pregnancy: infant birth weight by para / infant birth weight by number of visits, risk of poor pregnancy outcome, and preterm labor by gestation age, Percent of low birthweight births by age of mother (Low birthweight is defined as infant birth weight of 5 lb. 8 oz or less).

- Treatment provided: number of home visits, number of prenatal visits; number of women receiving nutrition services, and prior family planning services.

Strengths and Weaknesses:

As with any data set, we rely on the accuracy of the raw data submitted to us by providers in the contract agency sites. Limitations also include the inability of a site to collect their own data and be able to see in a faster way how they're performing. Data is submitted to us monthly, either electronically or mostly by disk from a PC-based system, then loaded into the mainframe. Turnaround time to get accurate reports back from our data services section can be up to 8 weeks. The data from the Women's Health Section reflect clients served in the prenatal program; they are not necessarily reflective of women, or birth in general in Colorado.

Parallels to Child Trends:

The Health Statistics Section of the Department can provide data from birth certificates. This parallels the Kids Count data; in fact, Kids Count data on low birthweight, infant mortality, births to unmarried teens, and age data came from Health Statistics. These data reflect births for the entire state, not just data from the 5,000 women served in the prenatal program.

Contact Information:

Joan Henneberry, Director, Women's Health
Colorado Department of Public Health & Environment
4300 Cherry Creek Drive, South
Denver, CO 80222
PH: (303) 692-2483
FAX: (303) 782-5576

Tribal Health Programs

Tribal Health Programs

The Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) offered Indian tribes the opportunity to assume management of programs operated for their benefit by the Bureau of Indian Affairs (BIA) and by the Indian Health Service (IHS). In IHS, the self-determination provision has been implemented primarily as a contract program, with decentralized administration through IHS area offices. Recently, a new, more far-reaching approach to fulfilling the spirit of self-determination has been introduced, and is commonly referred to as "compacting". "Compacting" represents the direct, large scale, unmediated transfer of authority and financial resources from federal to tribal government to reorganize, implement, and operate programs once, in this case, the responsibility of the IHS. Each tribe has, a consequence of this history of increased local autonomy, developed, to varying degrees, their own internal health management and delivery capacities. Though most employ the IHS Resource and Patient Management System (RPMS) (see Federal Human Services Programs, Indian Health Service), tribal health programs or departments also frequently maintain separate data bases, typically of narrower focus, that may directly relevant to local KIDS COUNT efforts. This section presents, as an example, one tribal health program, followed by contact information for its counterpart in twelve select states.

Agency: Puyallup Tribal Health Authority

Type of Agency: Tribal Health Program

Purpose of Agency:

To continuously improve and promote wellness for and in partnership with the Puyallup Tribal Community in a culturally sensitive and appropriate manner.

Programs Sponsored:

Medical Clinic, Dental Clinic, Mental Health, Puyallup Tribal Treatment Center, Drug and Alcohol Treatment Center (both inpatient and outpatient), and Community Health and Case Management.

Kinds of Data Collected:

Two forms are used to collect data: the Individual Application for Health Care Services and the IHS Patient Care Component (PCC). The former is used to register new patients and verify tribal enrollment status. The patient completes the PCC form after each visit. All data collected are entered into the IHS Resource and Patient Management System (RPMS).

The Individual Application for Health Care Services collects the following information:

- Demographics: name, address, birthplace, age, sex, number in household, blood quantum, tribe enrolled, social-security number
- Employment: employment status, and name of employer
- Insurance: and type of insurance or other coverage (Medicaid, Medicare, Veterans Administration).

The PCC assesses these indicators:

- diagnostic information (psychiatric, medical)
- drug/alcohol use
- medical history
- immunization information,
- last visit treatment

Contents of Data:

Utilizes IHS RPMS computer system that registers patients based on tribal enrollment (all patients must be enrolled in federally recognized tribes). The information contains patients' personal history and medical history including all costs associated with contract health services.

Strengths and Weaknesses:

Specific information can be accessed in the RPMS. This IHS system can sort by age range, diagnosis, names, etc. It would be useful to obtain children's health status information.

Internally - the system works well for what it is designed to do, but does not interface with other computer systems outside of IHS. It was outdated by the time IHS installed the system in their IHS and Tribal clinics.

Contact Information:

Rex Harrison, Health Planner
Puyallup Tribal Health Authority
2209 E. 32nd St.
Tacoma, WA 98404
PH: (206) 593-0232 ext. 519
FAX: (206) 272-6138

For more information refer to the listing of the Tribal Health Planners in the select twelve KIDS COUNT grantee states provided below.

Arizona

Martin J. Antone
Ak Chin Indian Council
42507 West Peters & Nall Road
Maricopa, AZ 85239
PH: (602) 568-2227

Delia Carlyle
Title VI Director
Rt. 2, Box 27
Maricopa, AZ 85239

Virgil Lewis
CHR Director
48203 W. Farrell
Maricopa, AZ 85239

Rita Pancott
Title VI Director
PO Box 7
Sacaton, AZ 85247

Mary V. Thomas
Gila River Indian Council
PO Box 97
Sacaton, AZ 85247

Mimi Buchanan
Seed Farm Career Center
Seed Farm Career Center
Sacaton, AZ 85247

Lewis Lane
Social Services Director
PO Box 97
Sacaton, AZ 85247
PH: (602) 562-3311

Theresa Wall
Tribal Health Director
PO Box 97
Sacaton, AZ 85247
PH: (602) 562-3311

Vi Johnson
CHR Director
PO Box 97
Sacaton, AZ 85247
PH: (602) 562-3311

Robert Lewis
CHR Director
Route 1, Box 216
Scottsdale, AZ 85256
PH: (602) 941-7277

Larry Polingyumptema
Tribal Health Director
Route 1, Box 216
Scottsdale, AZ 85256
PH: (602) 941-7277

Evelyn Burns
Title VI Director
Route 1, Box 216
Scottsdale, AZ 85256
PH: (602) 941-7277

Clinton Pattea
Mohave-Apache Council
(Fort McDowell) PO Box 17779
Fountain Hills, AZ 85269
PH: (602) 837-5121

Dolley Bzubevold
Social Services Director
PO Box 17779
Fountain Hills, AZ 85269

Daniel Eddy
Colorado River Tribal Council
Route 1, Box 23-B
Parker, AZ 85344
PH: (602) 669-9211

Clifford Turnbowl
Social Services Director
Route 1, Box 23-B
Parker, AZ 85344
PH: (602) 669-9211

Fritz Brown
Quechan Tribal Council
PO Box 11352
Yuma, AZ 85364
PH: (619) 572-0213

John Duncan
Tribal Health Director
PO Box 0
San Carlos, AZ 85550
PH: (602) 475-2361

Steve Achin
Social Services Director
Route 1, Box 216
Scottsdale, AZ 85256
PH: (602) 941-7277

Ivan Makil
Salt River Pima-Maricopa
Indian Community Council
Route 1, Box 216
Scottsdale, AZ 85256
PH: (602) 941-7277

Bennidick Smith
Health Director
Yazapi Road
PO Box 17779
Fountain Hills AZ 85269

Aaron Swick
CHR Director
Route 1, Box 23-B
Parker, AZ 85344
PH: (602) 669-9211

David Ingram
Tribal Health Director
Route 1, Box 23-B
Parker, AZ 85344
PH: (602) 669-9211

Marily Swafford
Social Services Director
PO Box 11352
Yuma, AZ 85364
PH: (619) 572-0213

Priscilla Webb
CHR Director
PO Box 11352
Yuma, AZ 85364
PH: (619) 572-0213

Harrison Talgo
San Carlos Tribal Council
PO Box 0
San Carlos, AZ 85550
PH: (602) 475-2361

Iris Peterson
Social Services Director, BIA
PO Box 209
San Carlos, AZ 85550
PH: (62) 941-7277

Sylvester Listo
Tohono O'odham Council
PO Box 837
Sells, AZ 85634
PH: (602) 383-2221

Matilda Juan
Title VI Director
PO 837
Sells, AZ 85634
PH: (602) 383-2221

Tony Sanchez
Title VI Director
7474 S. Camino de Oeste
Tucson, AZ 85746
PH: (602) 883-2838

Maria Cruz
Tribal Health Director
7474 S. Camino De Oeste
Tucson, AZ 85746
PH: (602) 883-2838

Virgil Kessay
CHR Director
PO Box 1210
Whiteriver, AZ 85941
PH: (602) 383-2221

Vonda Clarkson
Title VI Director
PO Box 700
Whiteriver, AZ 85941
PH: (602) 383-2221

Heddy Kalewood
Tribal Health Director
PO Box 1210
Whiteriver, AZ 85941
PH: (602) 383-2221

Ethel Bullis
Title VI Director
1244 San Carlos Avenue
San Carlos, AZ 85550
PH: (62) 941-7277

Eddie Brown
Health Director
PO Box 837
Sells, AZ 85634
PH: (602) 383-2221

Martin Pancho
CHR Director
PO Box 837
Sells, AZ 85634
PH: (602) 383-2221

Lydia Goudeau
CHR Director
7474 S. Camino de Oeste
Tucson, AZ 85746
PH: (602) 883-2838

Dr. Octaviana Trujillo
Pascua Yaqui Tribal Council
7474 S. Camino De Oeste
Tucson, AZ 85746
PH: (602) 883-2838

Ronnie Lupe
White Mt. Apache Tr. Council
PO Box 700
Whiteriver, AZ 85941
PH: (602) 338-4346

Suzy Tenlgibith
Social Services Director
PO Box 1870
Whiteriver, AZ 85941
PH: (602) 383-2221

Leon Nuvayestewa
Tribal Health Director
PO Box 123
Kykotsmovi, AZ 86039
PH: (602) 734-2441

Myrna Pavatea
Department of Human Services
Hopi Tribe
PO Box 123
Kykotsmovi, AZ 86039
PH: (602) 734-2441

Berdiva Cespuch
Social Services Director
PO Box 68
Kykotsmovi, AZ 86039
PH: (602) 734-2441

Richard Diwald
Department of Health
960 Rodeo Way
Peach Springs, AZ 86434
PH: (602) 769-2216

Tim Knowland
Tribal Health Director
PO Box 197
Peach Springs AZ 86434
PH: (602) 769-2216

Rudy Clark
CHR Director
PO Box 179
Peach Springs, AZ 86434
PH: (602) 769-2216

Janet Hillis
Navajo AAA
PO Box 1390
Window Rock, AZ 86515

Leila Hett-Tully
Div. Social Welfare
PO Box 4590
Window Rock AZ 86515

Albert Hale
Navajo Nation
PO Box 9000
Window Rock, AZ 86515

Ferrell Secakuka
Hopi Tribal Council
PO Box 123
Kykotsmovi, AZ 86039
PH: (602) 734-2441

Beatrice Norton
CHR Director
PO Box 123
Kykotsmovi, AZ 86039
PH: (602) 734-2441

Delbert Havatone
Hualapai Tribal Council
PO Box 179
Peach Springs, AZ 86434
PH: (602) 769-2216

Leota Suminimo
Title VI Director
PO Box 179
Peach Springs, AZ 86434
PH: (602) 769-2216

Cora Phillips
CHR Director
PO Box 1390
Window Rock, AZ 86515

Leila Hett-Tully
Div. Social Welfare
PO Box 4590
Window Rock AZ 86515

Ledia Helptulley
Social Services Director
PO Box 4590
Window Rock, AZ 86515

Alaska

Andrea Laiti
Social Services Director
320 W. Willoughby Ave., Suite 300
Juneau, AK 99801
PH: (907) 586-1432

Richard McKinley
Sr. Program Coordinator
320 W. Willoughby Ave., Suite 300
Juneau, AK 99801
PH: (907) 586-1432

Edward K. Thomas, President
Central Council Tlingit & Haida
Indian Tribes of Alaska
320 W. Willoughby Ave., Suite 300
Juneau, AK 99801
PH: (907) 586-1432

Idaho

Keith Tinno
Fort Hall Business Council
PO Box 306
Fort Hall, ID 83203
PH: (208) 238-3700

Social Services Director
PO Box 306
Fort Hall, ID 83203
PH: (208) 238-3700

Viola Rodriques
Elderly Nutrition Dir.
PO Box 306
Fort Hall, ID 83203
PH: (208) 238-3700

Mellisa Grant
Tribal Health Director
PO Box 306
Fort Hall, ID 83203
PH: (208) 238-3700

Loretta Halfmoon
Sr. Citizens Program
PO Box 305
Lapwai, ID 83540
PH: (208) 843-2253

Sam Penney
Nez Perce Tribal Exec. Comm.
PO Box 305
Lapwai, ID 83540
PH: (208) 843-2253

Vonda Osburn
CHR Director
PO Box 305
Lapwai, ID 83540
PH: (208) 843-2253

Tome Al Roubideaux
BeneWah Medical Center
1115 B Street
PO Box 388
Plummer, ID 83851
PH: (208) 686-1800

Clifford St. John
Tribal Health Director
Coeur D'Alene Tribe
Plummer, ID 83851
PH: (208) 686-1800

Ernest Stensgar
Coeur D'Alene Tribal Council
Plummer, ID 83851
PH: (208) 686-1800

Paula Hathaway
BeneWah Medical Center
1115 B Street
PO Box 388
Plummer, ID 83851
PH: (208) 686-1800

Marlene Justus
Title VI Director
Rt. 1, Box 11FA
Plummer, ID 83851
PH: (208) 686-1800

Minnesota

Terri Buck
Health Director
1158 Island Blvd.
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Urban Indian Health Programs

Urban Indian Health Programs

In the early 1970s, the federal government became increasingly interested in programs to assist urban Indians. As early as 1972, the Indian Health Service began to fund urban health programs through its community development branch under the general authority of the Snyder Act. Since then, up to 42 such projects have received financial support from the IHS. The Indian Health Care Improvement Act of 1976 explicitly authorized urban Indian organizations to contract with the IHS to operate health centers and to increase Indian access to public assistance programs. Urban Indian health programs are distinct from reservation-based health programs by their emphasis on increasing access to existing services funded by other public and private sources rather than directly providing or paying for services. However, a number of these efforts do emphasize direct care in addition to referral and linkage functions. Urban Indian health programs vary widely in terms of services provided, sophistication of patient information management systems, and coverage of the local population. Nonetheless, their experiences and data offer important insights into the health and well-being of urban Indian/Native children and families. This section presents an overview of one of the country's largest and most successful urban Indian health programs as an example. Contact information for it follows immediately thereafter.

Agency: Indian Health Board of Minneapolis (IHB)

Type of Agency: Urban Indian Health Program

Purpose of Agency:

The mission of the Indian Health Board of Minneapolis (IHBM) is to administer a health and charitable organization providing opportunities through the Medicine Wheel Approach to promote the physical, mental, spiritual, and environmental well-being of people by offering traditional Native American, Western, and North American healing practices. The Indian Health Board of Minneapolis (IHB) accomplishes these objectives through the operation of its comprehensive primary care clinic which offers medical, dental, WIC/nutrition, and counseling & support services to American Indian and Phillips's Neighborhood residents of south Minneapolis. IHB has served this community for the past twenty-five years.

Programs Sponsored:

IHB's patient population 18 years of age and under comprised more than 45% of all patients seen in 1995. These figures are consistent with the past several years as noted in the IHB Annual Report. Services aimed at infants, children, and families are:

- Medical: WIC, Lead Poisoning, Family Planning, Health Education, Prenatal Program, FAS/FAE Program, Immunization Outreach, Health Screenings, AIDS Prevention Education and the Teen clinics which address Adolescent Sexuality.

- Dental: The dental clinic no longer makes school visits to targeted elementary schools, but continues to work with Medical and WIC programs to perform appropriate screenings and provide necessary dental care.

- Counseling & Support: individual therapy for children, teens, adults, and families, family and group therapy, crisis intervention, walk-in counseling, outreach and referrals for chemical dependency treatment, support groups for children, teens, and young mothers, psychiatric assessments for children and teens, consultation with schools, community agencies, and professionals, and social work support.

- Transportation: Children over 10 years of age are provided free transportation services to and from the clinic when they participate in C&S groups, as well as families, especially single mothers with small children. They are also provided these services and all patients with any transportation needs.

- Traditional Health: This program provides monthly consultation with a traditional Lakota interpreter (medicine man) who meets with individuals and families to address issues of concern. An Inipi or Sweat Lodge and Lowampi ceremonies are held and many Indian families attend these ceremonies for the purpose of healing and well-being. A youth group targeting the introduction and support of Indian youth to learn traditional cultural/spiritual practices will begin in Spring of 1996.

Kinds of Data Collected:

The clinic collects data which is driven by the broad range of federal, state, local and private agencies that support the above services. Across all programs, encounter data by age, race, gender and insurance status are collected. In the development of proposals, IHBM does refer to "State of the City" (Minneapolis) and the "State of the State" (Minnesota) to collect the types of data provided in the KIDS COUNT Child Trends Report.

Contents of Data: See above description.

Strengths and Weaknesses:

The limitations of the data collected by IHBM is that it is often driven by multiple funding sources. In a recent update of the Annual Needs Assessment, IHBM had to extrapolate the actual number of patients that earned below the poverty level. IHBM has developed an RFA which will be sent to Management Information System Vendors which will address the clinic's needs to identify discrete patient users of each clinic as well as those patients using multiple services.

Contact Information:

Carol Marquez-Baines, M.P.H., Planner
Indian Health Board of Minneapolis
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Minneapolis, MN 55404
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FAX: (612) 721-7870

Agency: Seattle Indian Health Board

Type of Agency: A Multi-Service Community Health Center for Medical, Dental, Mental Health, Substance Abuse, and Community Education Services.

Purpose of Agency:

The Seattle Indian Health Board (SIHB) is a non-profit, multi-service, community health center for medical, dental, mental health, chemical dependency, and community education services. Our mission is to assist American Indian and Alaska Natives improve and maintain their physical, mental, emotional, social, and spiritual well-being with respect for cultural traditions, and to advocate for the needs of all Indian people, especially the most vulnerable members of our community.

Services Provided:

Medical Clinic:

- Physical Exams and Checkups
- Prenatal and Delivery
- Family planning
- Women/Infants/Children (WIC)
- Immunizations/Well Child Care
- Nutrition
- Specialty Care
- Sexually Transmitted Diseases
- HIV Testing/Counseling
- Homeless Services
- Pharmacy & Lab

Dental Clinic:

- Restorations (fillings)
- Oral Surgery & Extraction's
- Crowns, Bridges, & Dentures
- Cleaning & Sealing
- Endodontic (root canals)
- Periodontics (gums)
- Oral Hygiene
- Pharmacy

Substance Abuse Treatment:

- Adolescent & Adult Inpatient
  24 Hour Treatment Program:
  28 Day Intensive
  60 Day Recovery

- Outpatient (Adult):
  Group Therapy
  Family Counseling
  Case Management
  12 - Step Support Group (AA)
  Substance Abuse Education

Mental Health

- Native American Counseling Center:
  Individual
  Family
  Group

- Crisis Intervention
- Case Management
- Cultural Enrichment Activities
- Domestic Violence Advocates
- Parenting Support Group
- Assessments

Prevention & Community Education:

- AIDS Outreach/Prevention Classes
- Children of the Circle (substance abuse prevention support group)
- Parenting Classes
- Indian Heritage School Program
- Health Promotion/Special Events
- Speakers Bureau

Kinds of Data Collected:

The Seattle Indian Health Board maintains a client tracking system using information collected on the Intake Forms. Types of data collected and reported in compliance with various grant guidelines are:

- Active clients by age and gender
- Clients by race/ethnicity - including tribal affiliation
- Household income status
- Encounters by department, medical, dental , WIC, outpatient, substance abuse, Native American Counseling Center, Community Health Case Management Outreach and Education/Prevention
- Immunizations
- Personnel and encounters by cost center and type of provider for reporting period
- Costs before and after distribution by functional cost center for reporting period
- Accounts receivable, charges and collections by source of funds for reporting period
- Summary for receipts and expenditures for reporting period

Contents of Data: (see above description)

Strengths and Weaknesses:

- Walk-in access
- Service to all of King County
- Home visits
- Telephone access to provider
- Payment options
- Information referral
- Assessments/examinations
- Case management
- Same day appointments
- Outreach
- Average years of services/staff professional
- Native American staff/provider
- Traditional health liaison available
- Periodic independent review
- Redundancy (multiple/backup staffing)
- Customer complaint resolution
- Full licenser
- Regular business hours
- 24 hour availability
- Multiple service locations
- Degreed staff
- Waiting list

Contact Information:

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For more information specific to Urban Indian Health Programs in given geographic areas, see the complete listing provided below.

IHS, URBAN INDIAN HEALTH PROGRAM BRANCH
DIVISION OF ACQUISITIONS AND GRANTS OPERATIONS,
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Fresno, CA 93727

PHONE(209) 255-0261
FAX(209) 255-2149

IHS, NASHVILLE AREA UIHPB COORDINATOR

Mr. William H. Dew
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Internet: wdew@ihs.ssw.dhhs.gov
PHONE(615) 736-2478
FAX(615) 736-2391

AMERICAN INDIAN COMMUNITY HOUSE

Ms. Rosemary Richmond, Exec. Dir.
404 Lafayette, 2nd Floor
New York, NY 10003

PHONE(212) 598-0100 x232
FAX(212) 598-4909

Clinic Director: Anthony Hunter
A/SAP Director: Verlain White

PHONE(212) 598-0100 x236
PHONE(212) 598-0100

NORTH AMERICAN INDIAN CENTER OF BOSTON, Inc

(Vacant)
105 South Huntington Avenue
Jamaica Plains, MA 02130

PHONE(617) 232-0343
FAX(617) 232-3863

Clinic Director: Barbara Namias

PHONE & FAX (see above)

A/SAP Director: Ann Souza
Tecumseh House, 107 Fisher Avenue
Roxbury, MA 02120

PHONE(617) 731-3366
FAX(617) 738-6717

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Ms. Jenny Notah
P.O. Box 9020
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PHONE(602) 871-5821
FAX(602) 871-5896

NATIVE AMERICANS FOR COMMUNITY ACTION

Mr. Dana Russell, Executive Director
2717 North Steves Blvd., Suite 11
Flagstaff, AZ 86004

PHONE(520) 526-2968
FAX(520) 526-0708

Clinical Director: Ms. Patty Holst
1355 North Beaver, Suite 160
Flagstaff, AZ 86004

PHONE(520) 773-1245
FAX(520) 773-9429

IHS, OKLAHOMA CITY AREA UIHPB COORDINATOR

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Five Corporate Plaza @ 3625 NW 56th Street
Oklahoma City, OK 73112

Internet: mpatters@ihs.ssw.dhhs.gov
PHONE(405) 945-6825
FAX(405) 945-6870

DALLAS INTER TRIBAL CENTER

Ms. Mary Biermann, Executive Director
209 East Jefferson
Dallas, TX 75203

Emma Olea, Admin. Assistant
PHONE(214) 941-1050
FAX(214) 941-6537

OKLAHOMA CITY INDIAN CLINIC

Mr. Terry Hunter, Executive Director
4913 West Reno
Oklahoma City, OK 73127

PHONE(405) 948-4900
FAX(405) 948-4933; 4932

Clinic Director: Dr. Saeed

Extension 238

INDIAN HEALTH CARE RESOURCE CENTER

Ms. Carmelita Skeeter, Executive Director
915 South Cincinnati
Tulsa, OK 74119

PHONE(918) 582-7225
FAX(918) 582-6405

Clinic Director: Robert Lawson, D.O.

HUNTER HEALTH CLINIC

Ms. Susette Schwartz, CEO
2318 East Central
Wichita, KS 67214

PHONE(316) 262-3611
FAX(316) 262-0741

Clinic Director: J. R. Jones, P.A.

IHS, PHOENIX AREA UIHPB COORDINATOR

Mr. Richard Heller
3738 North 16th Street, Suite A
Phoenix, AZ 85016-5981

Internet: rheller@ihs.ssw.dhhs.gov
PHONE(602) 640-2106
FAX(602) 640-2557

NEVADA URBAN INDIANS, Inc.

Ms. Janet W. Reeves, Executive Director
2100 Capurros Lane, Suite A
Sparks, NV 89431

PHONE(702) 356-8111
FAX(702) 356-8080

NATIVE AMERICAN COMMUNITY HEALTH CENTER

Ms. Erma Mundy, Executive Director
3008 North Third Street, Suite 100
Phoenix, AZ 85012

Ms. Marlene Gentry, Assist. Exec. Dir.
PHONE(602) 266-9166
FAX(602) 263-7870

Clinic Director (Vacant)

PHONE(602) 495-9925

INDIAN HEALTH CARE CLINIC

(Vacant), Administrative Director
350 South 700 East
Salt Lake City, UT 84102

PHONE(801) 359-6906
FAX(801) 533-2650

Clinic Director: Peter Hasby, M.D.
Indian Alcohol Recovery Center
375 South 300 West
Salt Lake City, UT 84101

(same address & phone number above).
PHONE(801) 328-8515
FAX(801) 328-9040

IHS, PORTLAND AREA UIHPB COORDINATOR

Mr. Frank Grayshield
1220 S.W. Third Avenue, Room 476
Portland, OR 97204-2892

Internet: fgrayshi@ihs.ssw.dhhs.gov
PHONE(503) 326-2017
FAX(503) 326-7280

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PHONE(206) 324-9360
FAX(206) 324-8910
Exec. Dir(206) 324-9360 [x 1102]

Clinic Director: Peter Talbott, M.D.

(same address & phone number above)

NARA of the NW, Inc.

Mr. Gary Braden, Acting Executive Dir.
17645 NW St. Helens Hwy
Portland, OR 97231

Kim Rogers, Admin. Assistant
PHONE(503) 621-1069
FAX(503) 621-0200

Health Clinic Admin: Jackie Mercer
2901 East Burnside, Portland OR 97214
A/SAP Outpt Treatment Center
1438 SE Division, Portland, OR 97202

PHONE(503) 230-9875
FAX(503) 230-9877
PHONE(503) 231-2641
FAX(503) 231-1588

IHS, TUCSON AREA UIHPB COORDINATOR

Mr. James Powers
Office of Health Program Research & Devlpm't
7900 South J Stock Road
Tucson, AZ 85746

PHONE(520) 295-2508
FAX(520) 295-2602

INTER-TRIBAL HEALTH CARE CENTER

Ms. Corrine Jymm, Executive Director
2925 South 12th Avenue
Tucson, AZ 85713

PHONE(520) 882-0555
FAX(520) 623-6529

Clinic Director (Vacant)

Urban Indian Centers and/or Special Urban Programs

Urban Indian Centers

A significant portion of the American Indian and Alaska Native population resides off reservation, either in rural, non-reservations areas or cities. Indeed, over the last four decades, the U.S. Census has documented a steady increase in the number of Native people who dwell in urban or suburban America. As one might expect, numerous issues have arisen in regard to the welfare of this segment of the American Indian and Alaska Native population. These concerns often revolve around displacement from a familiar cultural environment, reduced contact with other Native people who are important to sustaining a sense of collective identity, inadequate skills to cope effectively with the demands of urban living, and social, economic, as well as health conditions that place them at added risk. Beginning, then, in the 1960s, community-based organizations emerged in an attempt to address such concerns. Referred to generally as "urban Indian centers", these efforts grew to encompass, in many instances, multi-plex service agencies that offer a range of programs intended to facilitate survival in a fast-paced, typically impersonal environment quite different than the communities of origin.

There are many different models of urban Indian centers, ranging from small drop-in programs through information and referral efforts and specialized services, to large scale service agencies. There seldom is a single fiscal sponsor common to all of them. Nevertheless, these centers represent a potentially important source of data as to the welfare of urban Indian/Native children and families. One example is provided below to illustrate the kind of information that may be available. This example is followed by a list of similar centers in other cities.

Agency: Denver Indian Center

Type of Agency: Urban Indian Center and / or Special Urban Program

Purpose of Agency:

The Denver Indian Center serves a diverse group of tribes, the majority of which represent the Southwest, Northern and Southern Plains. The Denver Indian Center provides services and activities promoting self-sufficiency in a culturally sensitive atmosphere. The Denver Indian Center serves as a major source for American Indian families who are in need of direct services through its wide range of programs. It also serves as a gathering place for social, cultural and recreational activities, providing a full-circle of support for American Indians and their families.

Programs Sponsored:

The Denver Indian Center sponsors six programs:

- Adult education: provides services designed to assist the adult student to successfully meet his/her educational objectives

- Circle of Learning: is an educational services program which focuses on nurturing the American Indian child, parents, and the family. It offers daily pre-school education at two locations, home-based instruction and parent education. The services combine basic skills instruction with social interaction and life experiences. The program developed the Circle Never Ends curriculum.

- Employment and training: the job training and partnership act seeks to enhance the employability and employment prospects for American Indians. The program provides vocational and skills training, and short-term work experience and advocates the needs of unemployed American Indians.

- Seniors program: provides American Indian elders with social and supportive services. The program offers arts and crafts activities, emergency food and clothing, counseling and referral services.

- Youth program: the youth project is a year round center for American Indian youth, 6-18 years old. The programs provide daily opportunities for youth to build strong social relationships in a safe, nurturing environment, explore personal value and practice goal setting accomplishments. The activities include youth lacrosse teams, mentorships, field trips and youth video programs, basketball, and volleyball.

- Community and family resources: the community and family resources program encompasses the following services: outreach, counseling, emergency food, clothing and shelter referral, information on available resources, crisis intervention, and emergency shelter.

Kinds of Data Collected:

Each program collects data using an Intake Form. The forms are completed on all applicants for services. Data collected include:

- Ethnic status: tribal affiliation, tribal agency and proof of tribal affiliation is required

- Education status: student, school drop-out (8th grade or less), school drop-out (greater than 9th grade), high-school graduate or equivalent, post high-school attend, name, location of high-school, college or trade school, additional skills (typing, carpentry, word processing, electronics, welding)

- Veteran status: whether they served on active duty, recently separated veteran, disabled veteran or Vietnam-era veteran

- Family members' income: listing all family members, age, relationship, source of income, both within 6 months and on an annual basis, and whether the respondent or family receives food stamps, other social services, cash welfare payments

- Employment status: list all previous jobs, employer, address, length of employment, job tittle, duties, wage and reason for leaving, and information about current employment status

Contents of Data: See above description

Strengths and Weaknesses:

The Denver Indian Center maintains a client tracking system using the information collected on the Intake forms. The Center is required by its fiscal sponsors to complete the Intake Forms, resulting in a high completion rate. The form enables the Center to track the progress and activity of a client for at least 45 days and up to two years. The information assessed on the forms provides useful documentation of all activity with clients. The forms are not always completed by the same person, except in the Job-Training program where intake clerks are responsible for interviewing the client, leading to potential biases of data collected.

Contact Information:

Linda Harry, Executive Director
Denver Indian Center
4407 Morrison Road
Denver, Colorado
PH: (303) 936-2688
FAX: (303) 936-2699

For more information please refer to the listing of Special Urban Centers and Programs provided on the next three pages.

Arizona

Phoenix Indian Center
333 W. Indian School Rd.
Phyllis J. Bigpond, Executive Director

California

American Indian Center
of Central California
P.O. Box 607
32980- Auberry Rd.
Auberry, CA 93602-0607
Cari Lewis, Administrative Assistant
PH: (209) 855-2695

Southern California Indian Center
P.O. Box 2550 (92642)
12755 Brookhurst St.
Garden Grove, CA 92640
Alma E. Rail, Board President
John Castillo, Director
Walter Feather, Operations manager
PH: (714) - 530-0221

Intertribal Friendship House
523 E. 14th St.
Oakland, CA 94606
Sharon Bennet, Executive Director
Caroline Chicago, Secretary
Charlene Flood, Social Worker/Outreach
Telesfor Lujan, Senior Center Coordinator

Kansas

The Indian Center of Lawrence
P.O. Box 1016, 1920 Moodie Rd.
Lawrence, KS 66044
Bertha K. Lieb, Executive Director

Maryland

Baltimore American Indian Center
113 South Broadway
Baltimore, MD 21231
Barry Richardson, Executive Director
PH: (301) 675-3535

Urban Indian Child Resource Center
390 Euclid Ave.
Oakland, CA 94601
Carol Marquez-Baines, M.P.H. , Director
PH: (415) 832-2386

Hawaii

American Indian Center of Honolulu
810 North Vineyard Blvd.
Honolulu, HI 96817
John H. Ide, Contact
PH: (808) 847-3544

Illinois

American Indian Center
1630 West Wilson
Chicago, IL 60640
Hank Bonga, Director
PH: (312) 275-5871/561-8183

Iowa

Sioux City American Indian Center
619 6th St.
Sioux City, IA 51102
Williams Lowry, Contact
PH: (712) 255- 8957

Massachusetts

Boston Indian Council, INC.
105 South Huntington
Jamaica Plain, MA 02130
Jimmy L. Sam, Executive Director
PH: (617) 232-0343

Minnesota

Minneapolis American Indian Center
1530 East Franklin Ave.
Minneapolis, MN 55404
Francis Fairbanks, Executive Director
PH: (612) 871-4555

Michigan

North American Indian Association of Detroit, Inc.
22720 Plymouth Rd.
Detroit, MI 48239
Irene Lowry, Director
PH: (313) 535- 2966

Genessee Indian Center
124 West First St.,
Flint, MI 48502-1311
Jennifer A. Smith, Executive Director
PH: (313) 239- 6621

Saginaw Inter-tribal Association, Inc.
3239 Christy Way
Saginaw, MI 48603
Victoria G. Miller, Executive Director
PH: (517) 792-4610

Missouri

American Indian Center
4115 Connecticut
St. Louis, MO 63116

Southwest Missouri Indian Center
322-D East Pershing
Springfield, MO 65806
Maxine Leather, Executive Director
Robert Enna, Prevention Specialist
PH: (417) 869-9550

Montana

Billings American Indian Council
P.O. Box 853
Billings, MT 59103
PH: (406) 248-1648

Nebraska

Lincoln Indian Center, Inc.,
1100 Military Rd. Lincoln, NE 68505
Sidney Beane, Executive Director
PH: (402) 474- 5231

Nevada

Nevada Urban Indians
917 East Sixth St.
Reno, NV 89502
Susan Numan, Executive Director
Janice Frehse, Health Director
Jean Eben, Fiscal Officer
Cheryl Forebam, Admin. Assistant
PH: (702) 329-2573

New Jersey

New Jersey American Indian Center
503 Wellington Place
Aberdeen, NJ 07747

New York

American Indian Community House
404 Lafayette St. 2nd Floor
New York, NY 10008
Rosemary Richmond, Executive Dir.
PH: (212) 598-0100

North Dakota

Fargo-Moorhead Indian Center
P.O. Box 1814
Fargo, ND 58107
Sheron Brown Konecki, Executive Dir.
PH: (701) 593-6863

Oklahoma

American Indian Center
Valley
1698 N.W. 35th
Oklahoma City, OK 73117

Oregon

Urban Indian Program
1634 S.W. Alder
Portland, OR 97205

Ohio

Cleveland American Indian Center
5500-02 Loraine Ave.,
Cleveland, OH 44102
PH: (216) 961-3490

Native American Indian Center
1535 South High St.
Columbus, OH 43207

Texas

American Indian Center of Dallas, Inc.
1314 Munger Blvd.
Dallas, TX 75206
Larry Grospe, Executive Director
PH: (214) 826-8856

Dallas Inter-Tribal Center, Inc.
209E Jefferson
Dallas, TX 75203
Richard Lucero, Executive Director
PH: (214) 941-1050 (Community/Health)
PH: (214) 941-6535 (Employment/Training)

Pennsylvania

United American Indians of the Delaware

225 Chestnut St.,
Philadelphia, PA 19106
Angelique Seay, Executive Director
PH: (215) 574- 9020/ 2/3/4

Council of the Three Rivers American Indian
Centers, Inc.,
200 Charles St.
Pittsburgh, PA 15238
Russell Sims, Executive Director
PH: (412) 782- 4457

Vermont

Abenaki Self-Help Association
P.O. Box 276
Swanton, VT 05488

Washington

American Indian Community Center
East 801 Second Ave.
Spokane, WA 99202
Leonard Hendricks, Executive Director
PH: (509) 489-2370

Urban Indian Educational Programs

Again, due to the increasing presence of Indian and Native people in urban settings, and concern in regard to the effects of inner-city public schools on academic achievement, absenteeism, and dropout among this population of youths, a variety of special educational programs have developed to improve the fit between the classroom environment and Indian/Native students. Though some of these efforts may be federally sponsored (see Department of Education under Federal Human Services Programs), others are not. Consequently, inquiry at the level of individual school districts may reveal important sources of data that can speak to indicators in the KIDS COUNT initiative and that may lend themselves to aggregation. One such example is reviewed below.

Agency: Denver Public Schools Indian Program

Type of Agency: Urban Indian Center and / or Special Urban Program

Purpose of Agency:

The Project for Indian Education, the Denver Public Schools (DPS), American Indian Education Committee (AIEC) and the American Indian Education Advisory Council (AIEAC) work as a partnership cooperatively to identify and assess the needs of the Indian community for the purpose of setting priorities for the project components. The goals of the project are to reduce absenteeism, the number of dropouts, improve academic performance, and to reinforce pride in the Native culture.

Programs Sponsored:

Indian education/DPS provides several program activities, such as tutoring for homework, study skills sessions, resource library checkouts (books, videos, cassettes), art/culture classes. Musical instrument checkout, Indian clubs, Parent committee activities (AIEC), sports programs, and tribal enrollment research. In addition, several of the DPS schools are Focus School Sites. The Focus Schools provide Native American parents the opportunity to send their children to a school with more Native American students.

Kinds of Data Collected:

The AIEC program conducts needs assessments to assess project effectiveness and monitor project operations. To be eligible for the DPS or Focus School program all children must complete The Indian Student Eligibility Form, and The Native American Focus School Program Application. In addition, a needs assessment was conducted for The Project For Indian Education.

Contents of Data:

The Native American Focus School Program Application assesses the following information: name, tribal affiliation, sex, date of birth, parent's or guardian's name, address, phone, schools serving the child's area of residence, school the child currently attends, grade level, and whether the child is enrolled in Special Education. In addition, The Native American Focus School Program Transfer Form is completed by the school principal. This form certifies the child's ethnicity status to transfer into the Focus School Program. All students must complete the Student Eligibility Certification Form. This is the standard from the Department of Education, Office of Indian Education.

Parents complete the following information: name of child, school name, name of tribe, band or group, whether the tribe band or group is federally recognized (including Alaska Native states recognized, terminated, or an organized Indian group that received a grant under

the Indian Education Act of 1988), name of child with tribal membership, proof of member ship (membership or enrollment number), name and address of organization maintaining membership data for the tribe, band or group, and the parent's signature and mailing address.
The needs assessment consisted of evaluating the Project for Indian Education in terms of quality of the instruction and services offered, such as rank order the five most important areas of need in your school, describe the cultural activities that the evaluator would like to see implemented and rate the quality (very good, okay, poor) and importance (very important, somewhat important, not important) of the programs offered (tutoring, talented children, Native American appreciation, Native Cultural arts skills, career planning, academic development, parent/school relations and knowledge of tribal history).

Strengths and Weaknesses:

All forms are maintained in the Denver Public Schools Central Administration database for tracking and monitoring purposes. All information collected on the forms is accessible through this system. The limitations of the forms stem form the oversimplification of many of the questions. For example, the ethnicity question only allows for one ethnic group, therefor all multiracial people are not reflected on these forms. In addition, respondents have complained the Needs Assessment Form is too wordy and find terms like quality and important vague and confusing.

Contact Information:

Darius Smith
Director Denver Public School Indian Program
Project for Indian Education
Contemporary Learning Academy
150 South Pearl Street
Denver, CO 80209
PH: (303) 764-3497
FAX: (303) 764-3499

Urban Indian Alcohol and Substance Abuse Programs

For the very same reasons that other urban Indian programs have emerged in cities across America, so too has a diverse array of agencies that provide alcohol and substance abuse services. These particular agencies often began as relatively small efforts: an all-Indian Alcoholics Anonymous support group, an outpatient counselor attached to a health program, or a half-way house. Eventually, a number of them grew to encompass sophisticated in- and out-patient programs that emphasize not only culturally sensitive, but culturally derived forms of care. Whereas many initially focused on the needs of chronic alcoholic males, they have expanded dramatically to include women, youth, and families. Sources of fiscal support vary considerably, and may include IHS contract funding, state alcohol and drug monies, church donations, private giving, and federal grants, to name a few. Increasingly strict accountability required by such sponsors has led to improved client information management systems. The resulting data is likely to be relevant to local KIDS COUNT indexing, monitoring, and advocacy activities. This section presents an overview of a large, multi-faceted urban Indian alcohol and substance program that illustrates the kind of services and ensuing information that may be available from such agencies. Contact information for similar programs in other cities follows immediately thereafter.

Agency: Eagle Lodge, Inc.

Type of Agency: Urban Indian Center and / or Special Urban Program

Purpose of Agency:

Established in 1972, Eagle Lodge has provided 24 years of culturally sensitive substance abuse treatment to Native Americans who suffer from chemical dependencies. Licensed by the Colorado Department of Health, Alcohol and Drug Abuse Division (ADAD), Eagle Lodge considers addiction to be a treatable illness within an environment that promotes spiritual, cultural, and personal awareness. Knowing that the Native American's place in society is an integral part of his identity, the outcome goal for each client is the attainment of a high level of wellness.

Programs Sponsored:

Program services are delivered through three components: a 90 day Primary Residential Facility and a two-phase intensive Outpatient Program. Eagle Lodge also has in place a formalized Case Management Program that addresses all patients from the point of intake through post treatment planning and assists in areas of housing, employment, vocational training and in obtaining social services if needed. In 1994 Eagle Lodge expanded its treatment scope to include patients with co-morbid mental illness and substance abuse issues. The treatment of these "dual" or "multiple" diagnostic patients includes twelve step AA, NA, among other methods, with emphasis on American Indian Culture and Spirituality. Patients receive cognitive therapy, psychotropic medications and other current mental health treatments. In addition to certified alcohol and drug treatment counselors certified through the State Alcohol and Drug Abuse Division (ADAD), staff include two psychiatrists and nurse interns from a local university. Other treatment components include a prevention program that involves not only youth but parents as well, and has incorporated the theme "Living Within The Circle, a Focus on the Family". Activities within the component include teaching youth about native plants and their use in traditional ceremonies as well as their role from an ecological perspective. Another component is the Pearl Project which provides substance abuse treatment to incarcerated youth at the Lookout Detention Facility in Golden,CO and assists with re-integration into the community after release.

Kinds of Data Collected:

Client familial and psychosocial history, client personal history and current situation, client medical history, current diagnosis, prognosis and treatment.

Contents of Data:

Locale, date of birth, gender, tribe, birthplace, parental history, (i.e., age, present health status, cause of death, marital status, description of relationship), family size, place in birth order, adoption information, familial history (i.e., family member with drinking/drug abuse problem, family health history, family childhood activities, description of personal relationships within family setting, description of parents relationship, religion, family financial status, community type),personal history: substance abuse legal information, judicial system history, medical/mental history to include agency, admission, and discharge, social services/education/military history, type of discharge, employment history, marital history, current admission assessment (i.e., mood, conversation rate, and quality).

Strengths and Weaknesses:

Eagle Lodge maintains communication with all referring agencies. Patient information (e.g., bio-psychosocial, substance abuse, mental health histories, etc.) sent from referral agencies facilities patient treatment.

The referral information sent by referring agencies is not always timely nor is it always complete. The patient's "self report" is subjective and in some instances the information given is slanted, especially for patients who are referred by the courts, and want to portray themselves in a favorable light. In addition, the client population is transient and frustrates effective follow-up post-discharge.

Contact Information:

Mr. Pat Chaney, Executive Director
Eagle Lodge, Inc. - Residential
1264 Race St.
Denver, CO 80206-2811
PH: (303) 393-7773

Eagle Lodge, Inc. - Outpatient
2801 E. Colfax Avenue, Suite 306
Denver, CO 80206
PH: (303) 329-6789

For more information please refer to the listing of Alcohol and Substance Abuse Programs provided below.

California

Native American Alcoholism and Drug Abuse Program

1815 39th Ave. No. A
Oakland , CA

Four Winds Lodge
1565 East Santa Clara St.
San Jose, CA 95116

Iowa

Native American Alcoholism Treatment Program
P.O. Box 790-A
2720 Larpenteau Ave., Bldg. 544
Sargeant Bluff, IA 51504

Nebraska

Four Winds Alcohol Program
613 S. 16th St.
Omaha, NE 68102

New Jersey

New Jersey American Indian Center
503 Wellington Place
Aberdeen, NJ 07747

SIPI Alcoholism Program
P.O. Box 10146, 9169 Coors Rd., NW
Albuquerque, NM 87114

Utah

Indian Alcoholism Counseling and Recovery House Program
P.O. Box 1500
538 South West
Salt Lake City, UT 84102

Wisconsin

American Indian Council on Alcoholism
2240 West National Ave.
Milwaukee, WI 53208
PH: (414) 931- 8111

Wyoming

Thunderchild
VA Hospital, Bldg. 24
Sheridan, WY 82801

Specialized Centers / Institutions

Specialized Centers / Institutions

A number of centers and institutions have appeared over the last two decades that place special emphasis on the investigation of the health and well-being of American Indian/Alaska Native people. Examples include the National Center for American Indian and Alaska Native Mental Health Research at the University of Colorado Health Sciences Center, The University of New Mexico's Center on Alcoholism, Substance Abuse, and Addictions, Colorado State University's Tri-Ethnic Drug Prevention Center, American Indian Research at the University of Washington, and the University of Arizona's Native American Research and Training Center. These and other programs are systematically compiling a wealth of evidence relevant to many KIDS COUNT indices, although the available data tend to be limited by geography and time. Nevertheless, each may shed important light on local program efforts to develop appropriate comparisons. Several examples follow.

Agency: EMK, INC.

Type of Agency: Specialized Center / Institution

Purpose of Agency:

EMK Inc. is a planning firm specializing in a variety of specialized facility types, primarily adult and juvenile detention, police, courts, and residential, and institutional placements for adults and youth. EMK has provided services to eleven tribes in sixteen locations, as well as services to the Bureau of Indian Affair's Division of Law Enforcement, Division of Social Services and the Facilities Management and Construction Center. EKM staff serve as technical assistants and training consultants to the National Institute of Corrections, providing service to government agencies. EMK provides services at all phases of the facility planning project. Most data is collected as part of the needs assessment phase of the project.

Programs Sponsored: N/A

Kinds of Data Collected:

Juvenile Indian detention/planning of new facilities for tribes. Needs assessment information for Indian kids in justice system in two groups (tribes). Collect similar data for 19-20 tribes to use in their criminal justice planning efforts. Data also available for "casino" tribes who have high rates of at-risk kids. Have a nationwide data base on Navajo juvenile justice. Conduct population forecasting using IHS, Tribal, and Census data. Have Lakota-specific data on recidivism, substance abuse, mental health, and behavior of kids in custody.

Contents of Data:

EMK collects shelter-care and juvenile detention rates. Specifically, reports include the number of juveniles arrested, police contacts, a description of why they were arrested, release information, and where the juveniles live.

Strengths and Weaknesses:

The information is only helpful about certain tribes. Data are not collected systematically at the tribal level, resulting in a low 25% response rate, and information that has to be "generalized". Most agencies and tribes do not know how to use the data they collect. Information does not seem to be valued by the tribes. The Choctaw data are best since it is consistently collected by demographer who is rigorous and systematic.

Contact Information:

Ms. Gail Elias, Principal
EMK, INC.
201 East Simpson
Lafayette, CO 80026
PH: (303) 665-8056
FAX: (303) 665-8059

Insert graphics here

Agency: National Center for American Indian and Alaska Native Mental Health Research,
University of Colorado Health Sciences Center (UCHSC)

Type of Agency: Specialized Center / Institution

Purpose of Agency:

The National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR), a program within the UCHSC Department of Psychiatry, is one of five minority group mental health research centers sponsored by the National Institute of Mental Health, and is the only program of this type in the country focusing specifically on American Indian and Alaska Native populations. Its mission to significantly advance the knowledge base in regard to the assessment, epidemiology, care, and prevention of alcohol, drug, and mental disorders in these communities and to increase the representation of Indian and Native scientists in this endeavor.

Programs Sponsored:

The NCAIANMHR has four major program functions: (1) research; (2) research training; (3) information dissemination, and (4) technical assistance.

The research component formulates, designs, conducts, and reports studies within four areas of inquiry. These areas of inquiry cut across the developmental life span and include: (a) determining and improving the performance characteristics of self-report measures of serious psychological dysfunction and structured diagnostic interviews for assessing alcohol, drug, and mental (ADM) disorders; (b) establishing the prevalence and incidence of ADM disorders, as well as related risk factors, through descriptive and experimental epidemiological investigations; (c) developing and evaluating methods for detecting and managing ADM disorders presented in a spectrum of human service settings (e.g., primary care clinics, schools, detention facilities, social service programs), and (d) examining the effectiveness of interventions for preventing ADM disorders and promoting well-being. The resulting program of research currently involves 32 different Indian and Native communities and entails a funding portfolio in excess of $18 million, which derives from tribal, private, state, and federal (NIMH, NIAAA, NIDA, IHS, DVA) sources (see attachments for descriptions of ongoing studies). The NCAIANMHR's central office in Denver has a large, interdisciplinary faculty that includes psychiatry (child/adolescent; adult), psychology (clinical, social, community, and counseling), anthropology (medical), sociology, social work, psychiatric epidemiology, biostatistics, and public health. Six field offices, located in Indian communities and staffed by local tribal members, support the field-based research and provide immediate, ongoing linkage to participating tribes. Lastly, the NCAIANMHR maintains an extensive collaborative network of 30 Research Associates, whose involvement is established through formal institutional agreements with 17 universities and agencies. Half of the NCAIANMHR's faculty and staff are themselves American Indian: the largest single, programmatic concentration of such professionals in the nation.

The research training component offers unique educational opportunities for undergraduates, predoctoral and medical students, residents, post-doctoral trainees, and senior scholars. The NCAIANMHR co-sponsors, with the UCHSC's NIAAA-funded Alcohol Research Center, a Summer Alcohol Research Institute that provides a 10 week program of research training designed for 6-8 American Indian and Alaska Native junior and senior undergraduates. Each trainee is assigned to a senior faculty member who serves as the primary mentor, and supervises a structured research experience that introduces the student to the fundamentals of scientific inquiry in basic as well as clinical fields. The NCAIANMHR regularly accepts two medical students each summer (between the first and second years) for placement in one of its active studies, thus expanding their exposure to health-related concerns in culturally different populations. The NCAIANMHR also sponsors an American Indian Clinical Psychology Internship Program, which provides full support to two trainees each year to participate in a specialized clinical training experience that capitalizes on field placements in urban and rural/reservation programs serving Indian people. At least two residents in psychiatry typically seek placement at the NCAIANMHR for 6-12 month electives during their senior year. These placements emphasize the interaction between clinical and research endeavors, and prepare residents to bring the latter more fully to bear on the former, with special emphasis on cross-cultural issues. The NCAIANMHR's approach to training postdoctoral and senior scholars is less formalized, in a programmatic sense, reflecting the diversity of experience and needs that these individuals bring to this level of education. Supported by individual fellowships (i.e., NRSA awards, APA postdoctoral fellowship, and career development grants), junior faculty often require basic training in research skills (i.e., design, instrumentation, survey or interview methods, and analytic methods) and immersion in ongoing studies that operationalize these competencies, as acquired. The NCAIANMHR regularly supervises several trainees at this level. Specific research placements are tailored to their particular substantive interests. Lastly, senior scholars, usually, 10 or more years postdoctorate, participate in the NCAIANMHR's Scholar-in-Residence Program. This program offers up to six months of housing, secretarial support, computer resources, and access to specialized bibliographic materials to senior scholars committed to collaborating on projects (i.e., research studies, journal articles, books, curriculum development) of mutual interest to the National Center and the individual in question.

The information dissemination component is comprised of two activities: the maintenance of an extensive computerized bibliography on Indian and Native mental health and publication of a professionally refereed journal, American Indian and Alaska Native Mental Health Research. Established in 1986, the NCAIANMHR's computerized bibliography systematically identifies, abstracts, and indexes journal articles, government documents, program reports, and books directly relevant to the mental health of American Indians and Alaska Natives. The bibliography now contains over 3,500 items, which are available for use by NCAIANMHR students, staff, faculty, and Research Associates. American Indian and Alaska Native Mental Health Research, published four times annually by the University Press of Colorado, offers a forum for empirical work on the cause, assessment, epidemiology, treatment, and prevention of ADM disorders and related phenomena among American Indians and Alaska Natives. The journal has a large audience that includes health planners, policy-makers, service providers, and scientists.

The technical assistance component involves the maintenance of a Resource Directory that systematically inventories individuals, programs, and agencies that represent sources of expertise with respect to mental health research, service, and education specific to Indian and Native communities. This aspect of the NCAIANMHR has been enhanced significantly by a recent award from the Robert Wood Johnson Foundation, which established us as the National Program Office for the Healthy Nations Initiative. The Healthy Nations Program is designed to encourage and facilitate comprehensive, culturally syntonic approaches to substance abuse prevention among Indian and Native youth. This $15 million two-phase, six year program includes a series of technical assistance activities that promises a large scale transfer of important knowledge and intervention experiences to this special population. February 1, 1994, further technical assistance, training, and educational resources became available upon award of $1.2 million from the Administration on Aging which established the Native Elder Health Care Resource Center (NEHCRC) -- one of two new National Resource Centers for Older American Indians, Alaska Native Natives, and Native Hawaiians -- as a sister program of the NCAIANMHR within the Department of Psychiatry. The NEHCRC's primary mission is to promote the delivery of culturally competent health care to this special population.

Kinds of Data Collected:

The NCAIANMHR has a number of recently completed and ongoing studies in the areas of research noted above. Examples follow.

American Indian Vietnam Veterans Project.. In 1983, Public Law 98-160 directed the Veterans Administration to conduct a nationwide study of PTSD and other psychological problems in readjusting to civilian life among Vietnam war veterans. This study is commonly referred to as the National Vietnam Veterans Readjustment Survey (NVVRS). The results revealed that 15.2 percent of all male Vietnam theater veterans are current cases of PTSD, with a lifetime prevalence equal to nearly one-third of these veterans, or almost a million men. Major racial differences in these rates, notably increased risk among African American and Hispanic veterans, were observed, but could not be explained. Additional findings underscored the paucity, inadequacy, and underutilization of needed services. Congress subsequently mandated that the NVVRS be replicated among American Indian, Alaska Native, Native Hawaiian, and Japanese American Vietnam veterans, ethnic minority groups that had been significantly underrepresented in the original study.

The American Indian Vietnam Veterans Project (AIVVP) is part of a large, multi-site study being conducted to fulfill this mandate. The AIVVP is comprised of four distinct, but related stages of research taking place in two reservation communities situated in the northern plains and southwest. The first stage entailed an item-by-item review of the NVVRS instrumentation, employing focus groups of Vietnam veterans, their family members, service providers, and elders, to identify means of improving comprehension. This effort was augmented by longer term ethnographic inquiry (life histories, key informant interviews, and participant observation) to illuminate the cultural construction of PTSD and local responses to it. The second stage involved the development of a sound, ecologically relevant sampling frame. Eligible participants have been restricted to Vietnam veterans of the two tribes who are enrolled members and currently live on or near their reservations. Three hundred veterans from each community were randomly selected for interview. The third stage was a 5-hour lay-administered interview that covers childhood, family and marital history, parenting, education, occupation, military service, physical health status, post-service experiences (M-PTSD), self-perceptions, attitudes, and non-

specific distress, stressful and traumatic events, social support, health services utilization, experience in Vietnam, and psychiatric status (CIDI). The fourth stage was a clinical reinterview of all participants deemed probable cases of PTSD based on their Mississippi-PTSD scores reported in the prior stage and a small control group screening below that threshold. Originally 30% of the 300 veterans at each site were presumed likely to screen positive on the M-PTSD; however, actual rates currently approximate almost 70%. Experienced psychiatrists and clinical psychologists conducted the follow-up Structured Clinical Interviews for Diagnosis (SCID), supplemented by measures of functioning and trauma (IES). At the present time, only preliminary data from the lay-administered interview conducted at the northern plains sites is available for discussion. These data clearly indicate that the Vietnam veterans from said sites exhibit significantly higher rates of PTSD, Major Depressive Disorder, and Alcohol Abuse/Dependence than their counterparts in the NVVRS.

Flower of Two Soils Reinterview. Indian adolescents have been found to be at nearly five times greater risk of emotional disorder than their non-Indian counterparts. Moreover, the academic performance of Indian students deteriorates significantly over time, which is consistent with their markedly high rates of school dropout. The Flower of Two Soils study was designed to investigate the potential relationship between these two phenomena among youth in four culturally distinct reservation communities in the United States and Canada. Beginning in 1984, cohorts of children in grades two and four from each community were assessed once annually for three years with a battery of measures of their intellectual abilities, academic achievement, and mental health status. The latter was examined from three perspectives: that of the teacher, the parent/guardian, and the child him- or herself. The participating communities were chosen in order to represent quite different cultural areas, namely the northern plains, southwest, eastern woodlands, and northwest coast.

In 1991, the NCAIANMHR sought to reinterview the 251 northern plains children who took part in the prior phase of the study. At the time of the initial interviews, the children were between 8 and 10 years old; during the reinterview, they ranged from 13 to 18 years of age, a period when Indian youth seem to experience particularly high risk for developing emotional disorders. One hundred and nine teenagers (54 females, 55 males; grades 8 to 11) were successfully followed up. The earlier instrumentation included the Diagnostic Interview Schedule for Children (DISC) (Costello, Edelbrock, Dulcan, Kalas, & Klaric, 1984), which, for purposes of the reinterview, was replaced by the much revised DISC-2.1C (Shaffer, Schwab-Stone, Fisher, Davies, Piacentinie, & Gioia, 1988). The latter version included the previously mentioned PTSD module. Parent and teacher reports were again gathered, in addition to youth self-report. This particular reinterview included a concurrent assessment by an experienced clinician.

Forty-three percent (43.1%; n=47) of the 109 respondents received a diagnosis of at least one major disorder: Anxiety Disorders 17.4%, Affective Disorders 9.3% (Major Depression, 6.5%), Disruptive Behavior Disorders 22% (Conduct Disorder, 9.5%), Substance Use Disorders 18.4% (Alcohol Dependence, 9.2%), Anorexia and Bulimia 1%, and Post-Traumatic Stress Disorders 5%. Of these individuals, 20.2% qualified for a single diagnosis; the remainder were assigned multiple diagnoses. Almost half of the respondents with a Disruptive Behavior Disorder or an Affective Disorder also qualified for a Substance Abuse Disorder.

Health Survey of Indian Boarding School Students. Most studies of psychopathology among Indian youth are cross-sectional, offering little insight into the periods of risk, onset, course, and abatement of the various mental health problems that may beset them. This has been true especially with respect to an environment thought to be one of the greatest hazards to their well-

being: boarding schools. Consequently, the Health Survey of Indian Boarding School Students was launched in 1988 to establish the prevalence and incidence of symptoms of depression, anxiety, suicidal behavior, and substance abuse in such settings, as well as to clarify the relative contribution of stressful life events, coping strategies, social support, mastery, and self-esteem to these outcomes. The setting is a fully accredited, tribally controlled secondary school located in the southeastern United States. Of the approximately 200 students, grades 9-12, in attendance, 96% live there in dormitories throughout the school year. The vast majority (92%) are from the region and belong to five local, culturally similar tribes. A self-report questionnaire is administered to the students twice each academic year, typically in October and April.

During the 1989-90 school year, 85 students were selected from the 163 participants in the fall survey for clinical interview based on Suicidal Ideation Questionnaire scores. These individuals represented the first (n=42) and third quartiles (n=43) of SIQ scores; 61 of them were successfully questioned about their mental health status, employing the DISC-2.1C and its PTSD module. Due to the 3 month delay between the time at which the students completed the survey and when the DISC interviews were completed, not all of the 85 students were available for interview. In addition, during the week of the interviews, a number of additional students were absent for a variety of reasons and, thus, unavailable for interview. Consequently, a total of 61 DISC interviews were obtained. Of these, all 43 individuals (21 female; 22 male) scoring in the third quartile of the SIQ received the DISC interview. Only 18 (11 female; 7 male) of those belonging to the first quartile completed the interview. This was not surprising given the greater stress and symptomatology reported by the latter group, which predicts more frequent absence, indeed school dropout. The students interviewed ranged from 14 to 20 years of age; all four grades (9-12) are represented.

Diagnostic status was established according to DSM III-R criteria by way of the DISC 2.1C interview. All DISC 2.1C modules were administered so that each student was assessed with regard to the presence of a variety of anxiety disorders, eating disorders, elimination disorders, tic disorders, academic skills disorders, affective disorders, psychotic disorders, disruptive behavior disorders, substance abuse disorders, and for miscellaneous disorders such as elective mutism, pica and trichotillomania. The assessment battery included the PTSD module which was being field-tested by Columbia University at the time.

The three most common diagnoses assigned across both groups were Conduct Disorder (18%), Major Depression (15%), and Alcohol Dependence (13%). Of additional clinical interest is that across both samples, 25% of the students indicated that they had made a previous suicide attempt, 40% within the past 6 months. In comparing the two groups by specific diagnoses, individuals from the first SIQ quartile were significantly more likely to be diagnosed with any psychiatric diagnosis, any anxiety disorder, any mood disorder, and any behavior disorder.

Foundations of Indian Teens. Despite general recognition of the influence of cultural factors on assessment methods, only limited progress has been accomplished in regard to American Indians Hence, in 1992-93, the Foundations of Indian Teens project was initiated to develop more reliable and valid measures of psychopathology among Indian adolescents, with special emphasis on trauma. The study proceeded in three phases. Focus groups were convened to discuss the nature of trauma in general, to elicit examples of particularly traumatic events, and to review a portion of a screening survey specific to the PTSD diagnostic criteria. A self-report survey, which included screeners for PTSD, depression, problem-drinking, anxiety, conduct disorder, subsequently was administered to 297 Indian adolescents, grades 9-12, attending a high school in a large southwestern Indian community. Sixty-five students reporting a traumatic event plus eight or more concomitant symptoms underwent a second stage clinical interview,

which employed a current version of the DISC (Version 2.3). At present, only data from the school-based self-report survey are available for reporting.
The PTSD screener included in the survey was a modified version of the PTSD Interview (PTSD-I), DSM-III-R version. Having reviewed the relevant assessment literature, it became clear that most measures specific to PTSD are designed for administration by interview rather than self-report. Moreover, few are relevant to children and adolescents. Those which are focus primarily on trauma related to sexual abuse. The majority of adult measures continue to emphasize combat-related trauma. Hence, the PTSD-I was chosen and adapted for self-report, largely because of its close correspondence with diagnostic criteria. The original seven-point Likert scale was modified to a dichotomous (yes/no) format, for two reasons. The NCAIANMHR's extensive prior experience with Indian youth indicates that such simplification is desirable when possible. For screening purposes, it was assumed that a yes/no format would provide adequate information to distinguish adolescents at high risk of PTSD.

Because of these adaptations, considerable attention was devoted to describing the DSM-III-R criterion A. Drawing from the DIS, the DISC 2.3, and the PTSD-I, the following stimulus was developed for eliciting the traumatic event description:

> "Have you ever experienced something that is so horrible that it would be very upsetting to almost anyone? Some examples might be: Situations in which you thought you were going to die, or where your life was seriously threatened. Other examples might be: You saw somebody killed, or get hurt very badly; or, someone you felt close to was killed or got hurt very badly. Has anything like that ever happened to you? How many things like that have happened to you? What was the worst thing like that you have experienced?"

In response, nearly 51% (n=151) of the students reported that they had experienced a traumatic event. Thirty-seven percent described experiencing more than one such event, with 16% numbering four or more. Approximately half of those experiencing a traumatic event endorsed 8 or more PTSD symptoms (of 17 possible) on this self-report measure.

Voices of Indian Teens Project. The Voices of Indian Teens project is a five-year research project funded by the National Institute for Alcohol Abuse and Alcoholism, involving semi-annual school-based data collection, with community follow-up of youth not in school. The Voices project is currently located in 10 high schools in five western sites: South Central (1 school), Northern Plains (2 schools), Northwest (1 multi-tribal school), Southwest/non-Pueblo (1 school), and Southwest/Pueblo (5 schools). Participation rates for the first wave of data collection ranged from 52% to 87%, with an average of 74%. The final sample of Wave 1 Indian youth includes 2056 Indian youth, made up of 49% males and 51% females.

During the first year of the Voices project, a pilot study was designed to shorten longer, widely utilized measures to a smaller subset of items that would operate similarly to the longer measures. For Wave 1 data, the internal consistency coefficients of these shortened scales ranged from .54 to .93, with an average of .80. At the same time, focus group work explored whether the measures were comprehensible to Indian youth--whether the youth would be able and willing to answer these questions in a meaningful manner, and whether the questions were not culturally inappropriate for Indian youth. These pilot efforts permitted the inclusion of 26 culturally appropriate and psychometrically sound constructs (for example, substance use/abuse/dependence, depression, anxiety, academic achievement, delinquent behavior, social support, peer values and pressure, ethnic identity, stressful life events, drinking patterns and contexts, community values and attitudes toward alcohol, etc.) within a survey which still can be completed within a 45- to 50-minute class period.

One of the most important set of constructs of the Voices project focus on a number of aspects of alcohol use. As noted earlier, studies relying on surveys typically lack context and phenomenological depth. For example, little quantitative work to date has focused on aspects of the context within which teens drink. The Voices survey includes a number of close-ended questions about a teenager's patterns and contexts of alcohol use--e.g., when you drink, with whom do you drink? when you drink, where do you drink? Although analyses are currently underway, we expect that we will be able to explore important ecological aspects of alcohol use which might mediate or moderate alcohol use among Indian adolescents.

Moreover, much of the research literature concerning the measurement of alcohol use has utilized rather simplistic approaches to the operationalization of the variable of adolescent alcohol consumption. In general, quantity or frequency measures act as a proxy not only for use, but also for abuse and drinking-related problems. Using a double-cross-validation design, an underlying three-factor structure emerged: alcohol use, negative consequences of drinking, and problem drinking. This more complex conceptualization of adolescent alcohol consumption has opened new avenues for inquiry.

As noted above, the Voices study continues, having just completed Wave 7, in Fall, 1995 with similar sample sizes and distributions as prior waves. A recent award from the National Institute of Child Health and Human Development permits us to follow large cohorts from two of the sites over the next five years. This follow-up study, entitled Pathways to Choice (Choices), seeks to understand the different developmental pathways open to young Indian people, and the role that various factors may play in their transition to marriage, parenting, college education, work, and other culturally valued statuses.

Contents of Data: (see descriptions provided above)

Strengths and Weaknesses:

These and other NCAIANMHR studies share a similar commitment to employing state-of-the-art measurement strategies that are theoretically informed and culturally sensitive. Careful attention is given to the performance characteristics of the different instruments used to gather this information. Qualitative and quantitative research techniques are blended in order to complement the weaknesses of either and to place survey-based and clinical findings within the local sociocultural contexts necessary to their interpretation. Much of the NCAIANMHR's research is comparative. Only the most current studies are of sufficiently large scale to permit limited generalizability to significant portions of the Native population. Several of these efforts are longitudinal. Relatively little data exist with respect to Alaska Native communities; virtually none in regard to urban areas.

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Agency: National Center for Children and Poverty

Type of Agency: Specialized Center / Institution

Purpose of Agency:

The National Center for Poverty (NCCP) mission is to identify and promote strategies that reduce the number of young children living in poverty in the United States, and improve the health and well-being of the millions of children under six who are growing up poor. NCCP is broad based and interdisciplinary. Activities include interagency collaboration on issues concerning child poverty, state-by-state policy analysis; analyses of community-based programs; field-based studies; policy-oriented and demographic evaluation research; publications and information dissemination; conferences presentations; and sponsored meetings.

Programs Sponsored:

Projects fall within several categories: early childhood care and education; child and family health; family and community support; cross-cutting; multistate policy analyses; demographic and evaluation research; and communications. The goal is to inform policymakers and program directors about ways to meet the health needs of infants, toddlers, and preschoolers, by drawing lessons from Head Start and other comprehensive program models. "Strategies For Promoting Health and Assuring Access to Health Care in Child Care Settings" involves three pilot projects in Connecticut, Texas, and New Mexico that tested the feasibility of working through ecumenical groups to mobilize congregations to improve access to primary health care services for poor young children. A 1995 resource brief, "The Role of Local Churches in Promoting Child Health: Lessons from Research and Practice". NCCP's demographic research and analysis group recently began work on a project that examines racial and ethnic differences in low birthweight, infant mortality, and child cognitive development. The Center is engaged in background work for a successor volume to the 1990 volume, Five Million Children: A Statistical Profile of Our Poorest Young Citizens. As with the original publication, a national portrait of young children in poverty will be the main topic, but the new volume will also provide comprehensive state-by-state analyses.

Kinds of Data Collected:

The data set is derived from the Current Population Survey data. The Racial Statistics Branch of the Current Populations Survey provides micro-data samples for possible use. To access data relevant to Native Americans one must manipulate the Current Population Survey data set. The ethnic group break down is as follows: White, African American, Hispanic, other (American Indian, Pacific Islander, and Alaskan Native, and Asian) and unknown.

Contents of Data:

The Current Population Survey data set examined indicators of poverty for youth in the U.S. Several of the KIDS COUNT indicators were used in this data set:

- risk factors: poverty (defined by the government poverty rate); parent level of education, maternal and paternal employment, full-time, part-time employment status, male unemployment, number of men in the workforce, overcrowded housing, Medicaid eligibility

- state level: state expenditures of at risk-child care (Title 4A), early care and education spending, health insurance and Medicaid funding, funding for Pre-K, and a review of comprehensive programs of child health

Strengths and Weaknesses:

The NCCP's publications program develops, publishes, and disseminates information on young children in poverty for policymakers, program administrators, researchers, and advocates. Thirty titles are currently in print for nominal charges, including monographs, reports, resource briefs, issue briefs, speech reprints, working papers, and a slides set. The Center disseminates a newsletter three times a year at no charge to subscribers. The Center maintains a comprehensive multi-disciplinary library of published and unpublished materials pertaining to child poverty and to child and family health, early childhood care and education, family and community support, and service integration. Data relevant to Native American populations can be extracted in the states with the highest Native American populations. In addition, the data set can be analyzed on the case and the state level.

The data is only analyzed by three race indicators: Black, White and Hispanic, and other. Native-American indicators can be accessed by ordering the Current Population Report Series (updated annually) on CD-ROM. This database contains all of the survey data and includes the following race indicators: White, Black, Hispanic, Asian-Pacific Islander, Puerto-Rican, Mexican, White of Non-Hispanic Origin, and Other.

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For more information see the list provided on the next page of Native American publications available from the National Center for Children and Poverty.

Native American Publications Available from the
National Center for Children and Poverty.

1. Rec# 7976. McCarthy, R. J. The Indian Child Welfare Act: in the best interests of the child and tribe. Clearinghouse Review. 1993 Dec; 27(8): 864-873Serials. CHILD CUSTODY / EVALUATION / FEDERAL REGULATIONS / JOURNAL ARTICLE / LEGAL ASPECTS / NATIVE AMERICANS / RACISM / STATES / SUBSTITUTE CARE.

2. Rec# 7975. Moore, S. C.; Wilson, C. E. "Like pinning fog to a wall"--emerging issues in Indian health care: how ongoing Indian health care reform will mesh with the Clinton administration's national health care reform agenda. Clearinghouse Review. 1993 Dec; 27(8); 854-863 Serials. FEDERAL GOVERNMENT / HEALTH CARE / JOURNAL ARTICLE / LEGAL ASPECTS / NATIVE AMERICANS / REFORM

3. Rec# 7938. McAdoo, H. P., ed. Family ethnicity; strength in diversity. Thousand Oaks, CA: Sage Publications; 1993 E 185.5 M111f ASIAN AMERICANS / BLACK AMERICANS / COLLECTIONS / HISPANIC AMERICANS / MINORITY GROUPS / NATIVE AMERICANS.

4. Rec# 7210. Lefkowitz, D.: Underwood, C. Personal health practices: findings from the survey of American Indians and Alaska natives. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Center for General Health Services Intramural Research; 1991. Note: National Medical Expenditure Survey Research Findings no. 10. GOVERNMENT REPORT.

5. Rec# 7209. Johnson, A.: Taylor, A. Prevalence of chronic diseases: a summary of data from the survey of American Indians and Alaska natives. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Center for General Health Services Intramural Research; 1991 Jul. Note: National Medical Expenditure Survey Research Findings no. 3. GOVERNMENT REPORT.

6. Rec# 7208. Cunningham, P.; Schur, C. Health care coverage; findings from the survey of American Indians and Alaska natives. Washington, DC: U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research, Center for General Health Services Intramural Research; 1991 Jul. Note: National Medical Expenditure Survey Research Findings no. 8. GOVERNMENT REPORT.

7. Rec# 7194. University of Minnesota Hospital and Clinic, Division of General Pediatrics and Adolescent health. Native American teen suicide rate high / health status ranked low in national survey. Minneapolis, MN: March 24, 1992. Note: See full report The State of Native American Youth Health Vertical Files--NATIVE AMERICANS. ADOLESCENT / NATIVE AMERICANS / NGO REPORT / SUICIDE

8. Rec# 7181. Edwards, W. S.; Berlin M. Questionnaires and data collection methods for the Household survey and the survey of American Indians and Alaska natives. Washington, DC: U.S. Department of Health and Human Services: 1989 Sep. Note: National Medical Expenditure Survey Methods 2.

9. Rec# 6696. Select Committee on Children, Youth and Families, U.S. House of Representatives. Confronting the impact of alcohol labeling and marketing on Native American health and culture. Washington, DC: U.S. government Printing Office: 1992. RG 580.D76 S464c. ALCOHOL ABUSE / GOVERNMENT REPORT / MCH / NATIVE AMERICANS.

10. Rec# 5786. Fallis, A. F. Technology expands the reach of family services in rural South Dakota. Family Resource Coalition Report. 1992; 11(1):20. Serials. COMPUTERS / INFORMATION AND REFERRAL SERVICES / JOURNAL ARTICLE / NATIVE AMERICANS / POVERTY / RURAL AREAS / SD.

11. Rec# 4914. University of Minnesota. The State of Native American Youth Health. Minneapolis, MN: university of Minnesota; 1992 Feb. Note: 2 Copies RA 563 U58s. HEALTH STATUS / NATIVE AMERICANS / NGO REPORT / OUTCOMES / YOUTHS.

12. Rec# 4322. Pence, A. R. The first nations: the MLTC/SCYC project, Networking bulletin: Empowerment and Family Support. 1991 Mar; 2(1): 24-25 CHILD CARE PROGRAMS / CANADA / EMPOWERMENT / JOURNAL ARTICLE / NATIVE AMERICANS.

13. Rec# 3999. Hodgkinson, H. L. (and others). The demographics of American Indians: one percent of the people: fifty percent of the diversity. Washington, DC: Center for Demographic Policy and Institute for Educational Leadership: 1990. E 77 H689d.
NATIVE AMERICANS / NGO REPORT

14. Rec# 3948. Dorris, M. The broken cord. New York: Harper Collins: 1989. RG 629.F45 D716b. BOOK / FETAL ALCOHOL SYNDROME / NATIVE AMERICANS.

15. Rec# 2824. Sandefur, G. D. American Indian reservations: the first underclass areas:

16. Focus. 1989 Mar; 12(1): 37-41

17. ARTICLE / HISTORY / NATIVE AMERICANS.

18. Rec# 1161. Honigfeld, L. S.; Kaplan, D. W. Native American postneonatal mortality.

19. Pediatrics. 1987; 80(4): 575-578. Note: This is in Vertical Files under MCH--MORTALITY--INFANTS/.INFANTS / JOURNAL ARTICLE / MORTALITY / NATIVE AMERICANS.

20. Rec# 680. Vanlandingham, M. J. (and others). Birthweight-specific infant mortality for Native Americans compared with whites, six states. American Journal of Public Health. 1988; 78(5): 499-503. INFANTS / JOURNAL ARTICLE / LOW BIRTH WEIGHT / MORTALITY / NATIVE AMERICANS / RACIAL DIFFERENCES / WHITE AMERICANS.

21. Rec# 349. Smith, E. M. Health care for Native Americans: who will pay. In: Inglehart, J. K., ed. Health and poverty. Milwood, VA: Project HOPE; 1987: 123-129. Note: This is Volume 6, Number 1, Spring 1987 of Health Affairs. RA 427 124h. FINANCING / HEALTH CARE / JOURNAL ARTICLE / NATIVE AMERICANS.

22. Rec# 296. National Child Welfare Leadership Center, Families and children of color: a fact book 1985. Chapel Hill, NC: National Child Welfare Leadership Center; 1985. HV 699 N277f. ASIAN AMERICANS / BLACK AMERICANS / HISPANIC AMERICANS / MINORITY GROUPS / NATIVE AMERICANS / NGO REPORT / STATISTICS

Agency: Native American Educational Services, Center for Advanced Study and Research

Type of Agency: Specialized Center / Institution

Purpose of Agency:

The Center for Advanced Study is a branch of the Native American Educational Services College, representing the advanced study branch of the institute. NAES is the only private American Indian controlled Bachelor of Arts College in the United States. The NAES has four locations: Chicago, IL; Minneapolis, MN; Menominee Reservation in Wisconsin; and Fort Peck Reservation in Montana. The Center for Advanced Study supports the curriculum development of NAES and initiated a graduated program in tribal affairs and community development. The Center for Advanced study conducts research on issues relevant top the four communities served by the NAES.

Programs Sponsored:

The Center for Advanced Study and Research is engaged in a series of initiatives designed to identify strategies to ensure permanence for Native children removed from or at high risk of removal from their birth families. In addition to seminars and training provided by NAES, intensive research produced a report on the status of Native American children: A Condition of Crisis Children in Native America (1995).

Kinds of Data Collected:

The report consists of seven chapters discussing the following issues pertinent to Native youth and families: a discussion of the current condition of Native American youth; U.S. Census statistics on Indian children and families; poverty and welfare statistics; health statistics; summary of welfare legislation for Native Americans; and child rights and family issues. In addition, it includes an addendum that examines the statistics for the KIDS COUNT categories used by the Casey Foundation, with special emphasis on Native Americans.

Contents of Data:

Reviews the data from the existing reports on Native American youth, such as the Indian Child Welfare Report (1988), Opportunities to Improve Child Welfare Services and Protection for Native American Children (1994), The State of Native American Youth Health (1992), Trends in Indian Health and Regional Differences in Indian Health (1992). Several indicators of health and well-being are discussed: demographics, household and poverty statistics, conditions of poverty, social pathologies, poverty and welfare statistics, health statistics, and social policy initiatives.

Strengths and Weaknesses:

First attempt to provide an overview of all existing literature on Native American youth and families across several dimensions, such as demographics, poverty status, welfare status, social history, and social policy. The report critiqued the existing literature on Native youth and families and identified several initiatives. In addition, an extensive Native American child and family bibliography is provided (recently updated, October 1995).

Limitations stem from the difficulty in locating data sources specific to Native American youth and families. The report is organized by content area and by category of statistics provided, such as U.S. Census Statistics on Indian Children and Families, and Poverty and Welfare Statistic, Health Statistics. Several data sources are combined to summarize each category and the sources listed are not necessarily the latest version. It may be useful to cross-reference the reports reviewed within each category, in the index.

Parallels to Child Trends:

The report reviewed several indicators parallel to the Child Trends Report: demographic change (national population under 18, percent of national population under 18); social characteristics (percent of women giving birth, children without health insurance); income and poverty (median income for families with children, per capita income, percent of children in extreme poverty); and fathers and families (percent of children living in households, percent of children living in neighborhoods where the majority of males worked six months of the year).

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Agency: The Navajo Child Sexual Abuse Project (NCSAP)

Type of Agency: Specialized Centers / Institutions

Purpose of Agency:

The Navajo Child Sexual Abuse Project (NCSAP) was established to treat children who have been sexually abused. This kind of abuse has become more prevalent in Navajo communities.

Programs Sponsored:

NCSAP provides Western therapy and traditional intervention to the victims, their siblings and the non-offending parent(s). The Western Therapy includes one-to-one sessions and group therapy, such as play, clay, sand tray and expressive arts. The traditional services are provided for families preferring traditional intervention on behalf of the family. Traditional intervention will include but is not limited to: Crystal Gazing, Hand Trembler services, and Medicine Men with specific recommended ceremonies. In addition, non-offending parent groups learn to parent themselves and their children, learn the cycle of violence, learn about addictions, and the traditional aspects of child learning. Services for siblings include group and individual sessions on positive self-esteem, sexual abuse and protection, and expressive arts therapy.

Kinds of Data Collected:

The Navajo project collects information on the children referred into the program. All referrals are funneled through the Navajo Nation Government or through the Agency Division of Social Services. The Navajo Child Sexual Abuse Project Referral and Intake Form is the standard form used to enter the program. In addition, The Navajo Traditional Survey Form - Saad-Baa-ee'deetiin: is used for families who seek traditional healing.

Contents of Data:

The following information is ascertained from The Navajo Child Sexual Abuse Project Referral and Intake Form :

- Victim information: sex, census number, social security number, date of birth, religion, clan, school name, teacher's name, name of school, and victim's mailing address

- Parents' information: mother and father's name , address, clan, chapter affiliation, employment, employer, address of employer, religion, social security, the parents' awareness of the molestation, attitude of mother and/or father toward victim, attitude toward perpetrator, and marital status of parents

- Household information: information about other family members (date of birth, age sex, in/out of home, relationship) and other caregivers if applicable (see above for parental information collected); who reported the abuse, name of victim, and the victim's relationship to child

- Description of the type of molestation: total number of incidents, duration (week, month, years), medical exam (yes/no), location, type of molestation (the lists of items distinguish between types of sexual acts, propositioning, voyeurism, pornographic materials, fondling, types of intercourse, rape, and other)

- Information on the perpetrator: name, sex, age, date of birth, relationship to victim, whereabouts of perpetrator, perpetrator's attitude toward victim and family, and perpetrator's use of alcohol

The Navajo Traditionally Survey Form - Saad-Baa-ee'deetiin assesses the following information:

- Identification with clan members: knowledge of his/her clan, father's mother's clan, maternal grandfather clan, paternal grandfather clan, pride of being in the clan, and whether the respondent was married thorough the Navajo traditional system using the ceremony basket

- Language: whether they speak Navajo, can count in Navajo (100 or more), adequate vocabulary, make a formal speech, can interpret English into Navajo, and read with expression in Navajo

- General well-being: appears to be happy, willing to help and shares, understanding Navajo life, speaks reads and writes Navajo, and understands bi-cultural society

- Social skills: respect self and right or others, shows positive attitudes, listens and follows instruction, accepts responsibility, and works well with hands

- History: under worlds: dark blue-yellow-white w/glitter, first man/first woman, changing woman, twin purpose and adventure, and Spanish and Whiteman civil war,

Strengths and Weaknesses:

The Navajo Child Abuse Project has a comprehensive and detailed Intake form for child sexual abuse. The forms are a model for future sexual abuse programs. In addition, the program emphasizes traditional healing and incorporates a combination of traditional and western therapy into case management. There is a tremendous need to computerize all of the information collected. Currently all data entry is manual. A new Child Central Registry System (CCRS) is proposed to facilitate retrieval of demographics, statistics and enhance case management. In addition, The Navajo Sexual Abuse Project has limited manpower, and a large volume of clients served, making it difficult to review cases and determine eligibility in a timely manner. A computer system would facilitate the tracking and monitoring of clients and provide the efficient retrieval of information.

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Agency: Graduate School of Social Work, University of Denver

Type of Agency: Specialized Center / Institution

Purpose of Agency:

Dr. Moran is an Associate Professor in the School of Social Work, University of Denver and Principal Investigator for The Seventh Generation Project, funded by NIAAA. For purpose of the project see below.

Programs Sponsored:

The Seventh Generation project is a community-based alcohol prevention program targeting urban Native American fourth and fifth graders who live in four counties (Denver, Jeffco, Adams, and Arapahoe) in the Denver area. The seventh generation project is an alcohol prevention project that uses American Indian culture as the organizing principle to address the more standard methods of prevention, such as establishing conservative norms around drinking, presenting a decision-making model and teaching refusal skills.

Kinds of Data Collected:

The project began July 1, 1993 with a proposed completion date of June 30, 1988. Data collection methods include: conducting a survey and pilot testing an alcohol prevention intervention curriculum with Native American youth. The curriculum is a four-month program which meets once a week with kids for two hours at six sites: five elementary and one middle schools in Denver area. The target population is defined as 200 Native American fourth and fifth graders in the Denver area.

Contents of Data:

The survey examines the following constructs: ethnic identity, perceived social support, alcohol beliefs, self-esteem, alcohol expectancies, children's depression, decision-making, self-concept and information about substance use.

Strengths and Weaknesses:

This study is the first of its kind to examine the three norms of alcohol prevention with a cultural context in urban Native American youth. The study design includes a pre- post test of impact of intervention, pilot-testing of survey, and a target of 200 kids to complete the survey.

The weaknesses stem from the difficulties of conducting research with youth: the researcher does not have direct access to the child for recruitment and consent purposes. Consequently, the researcher has to rely on mailings and the school system to contact children to participate

in the study. The projects response rates have been low (30%) due to difficulties in recruitment. In addition, pilot-testing the survey has indicated locus of control scales have low reliability (.51)

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Agency: The Center on Alcoholism, Substance Abuse, and Addictions (CASAA) of the University of New Mexico

Type of Agency: Specialized Center / multiple university based programs

Purpose of Agency:

The Center on Alcoholism, Substance Abuse, and Addictions was created in 1989 by combining a number of diverse programs that pre-existed at the University. The purpose was to establish an interdisciplinary center which could address the full range of substance abuse and addiction problems which face New Mexico and other western states. The Center strives for excellence in three areas: Education/Prevention, Research, and Treatment. CASAA aims to improve and enhance the health of New Mexicans and others in the West through comprehensive programs that integrate education, prevention, treatment, and research in the context of multi cultural settings. The problems of alcohol, substance abuse, and addictions are pervasive and require a unified approach that empowers public and local constituencies and promotes collective action. The major goals are as follows:

- To function as a unique resource on substance abuse and addictions;
- To provide citizens with the opportunity to pursue health service careers in substance abuse;
- To deliver high quality health services to various ethnic and socioeconomic groups in the western United States;
- To serve as a recognized source of unique and highly specialized knowledge and services;
- To contribute new knowledge by supporting high quality collaborative research;
- To provide analysis and recommendations about public policies;
- To develop demonstration projects;
- To work in partnership with communities to identify and address local problems;
- To ensure that new federal and other grant funding is available to address issues related to substance abuse and addictions.

Programs Sponsored:

The Center on Alcoholism, Substance Abuse, and Addictions applies for grants and contracts to sponsor a variety of programs in education, prevention, research, and treatment. Many of these programs serve American Indians of all ages. Currently, we have collaborative arrangements with a number of tribes and non-Indian communities to provide services and technical assistance for treatment programs, research and demonstration projects, long term evaluation of needs and programs, and education programs which lead to advanced degrees.

Kinds of Data Collected:

A variety of data are collected through CASAA's many research, evaluation, and treatment programs. Data on treatment outcome exist from a number of special studies, but also for routine services delivered by the Center. Special survey data on a number of areas related to substance abuse and gambling are available within the Center. School-based population data are available from some locales within New Mexico.

Contents of the Data:

CASAA's data span a variety of disciplines and a variety of topics. Epidemiologic data exist on a number of problems including American Indian suicide, Fetal Alcohol Syndrome, motor vehicle crashes, and knowledge and opinions about gambling, drinking and drug use, college drinking and drug use, and related areas.

Management Information System Data exist for treatment services provided, in some cases for American Indian populations in a unique cultural context.

Prevention evaluations for a variety of age groups have been performed by the Center for local communities and some of these data sets are of interest to American Indians.

Other special data sets exist regarding selected substance abuse areas such as the prevention of Fetal Alcohol Syndrome, the effectiveness of prevention of drunk driving, and the efficacy of certain substance abuse policies.

Strengths and Weaknesses:

CASAA does not maintain long-term ongoing data sets in most of its areas. Since most of its funding is from special contracts and grants from agencies such as the National Institutes of Health, Centers for Disease Control, and other short-term sources, we have many cross sectional data sets on specific topics. Therefore, the soft money funding influences the continuity of the topic, focus, and scope of the data. Our strength is in performing highly technical scientific studies on selected topics in the areas of substance use and abuse and related behavioral health topics.

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Agency: Tri-Ethnic Center for Prevention Research

Type of Agency: Specialized Center / Institution

Purpose of Agency:

The Tri-Ethnic Center for Prevention Research is a research laboratory within the Psychology Department at Colorado State University that has been designated a Center of Excellence by the University and the Colorado Commission on Higher Education. It is designed and organized to be a national and international resource for the study of drug abuse prevention. The Center has a 25 year history of broad-based, multidisciplinary and multifaceted research efforts aimed at understanding community dynamics and the social, psychological, and cultural factors that contribute to adolescent drug use and to related problems such as school dropout, delinquency, violence, deviance, and victimization. Through a variety of activities, the Center explores prevention methods aimed at reducing drug use and the harm it causes, and supports and coordinates cross-cultural research studies that explore and test prevention theories and methods.

Programs Sponsored:

Research efforts of the Tri-Ethnic Center include a variety of studies funded through the Center grant from the National Institute of Drug Abuse, R01 projects, and other faculty and student research projects. The Center's activities have a strong focus on culture and cultural identification, with some studies comparing findings across ethnic minority groups. Results are translated into culturally congruent prevention theory and research plans.

Kinds of Data Collected:

The Tri-Ethnic Center is currently conducting two research projects with Native children and adolescents, one that examines the epidemiology and correlates of Indian drug abuse, and another that focuses on patterns of substance abuse among school dropouts. Similar projects exist which focus on Mexican American youth. Another Center activity, which spans all minority populations, is the development of a scale that measures the preparedness of communities to engage in prevention activities.

Contents of Data:

The Epidemiology and Correlates of Indian Drug Abuse. Initiated in 1974, this ongoing project examines drug and alcohol abuse, violence, victimization, gang involvement, and school dropout and adjustment among American Indians in grades 4-12.

The Patterns of Drug and Alcohol Abuse among Indian School Dropouts. This project compares American Indian dropouts with those who have remained in school, exploring reasons for and patterns of dropout.

Strengths and Weaknesses:

The Epidemiology and Correlates of Indian Drug Abuse study includes Indian youth across the Nation, although it focuses primarily on those who live on reservations. The Patterns of Drug and Alcohol Abuse among Indian School Dropouts project is the first comprehensive study of American Indian dropouts, and includes both urban and reservation-based populations.

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Agency: Center for American Indian and Alaskan Native Health, Johns Hopkins University School of Public Health

Type of Agency: Specialized Center / Institution

Purpose of Agency:

The Johns Hopkins Center for American Indian and Alaskan Native Health is a result of more than two decades of collaboration between the Johns Hopkins University and American Indian tribes. The objective of the Center is to work in partnership with tribes to provide strategies backed by sound research to improve the health and well-being of American Indians and Alaskan Natives. The Center operates nine satellite health stations of the Navajo, White Mountain Apache, and Gila River Indian reservations and is engaged in projects with American Indian communities in South Dakota, North Carolina, Oklahoma, California, New Mexico, and Alaska.

Programs Sponsored:

The Center is currently involved in three research efforts involving American Indian children and adolescents: Vaccine efficacy trials, a breast-feeding and well baby promotion program for pregnant teens, and the newly launched "Native Vision" program.

Kinds of Data Collected:

Vaccine Trials. One of the Center's most recent biomedical achievements involved proving the efficacy of a new vaccine that virtually eliminated pervasive death and disability from Haemophilus influenzea type b, the bacterial disease that was causing extremely high rates of life-threatening meningitis (10 to 50 times the national average) among American Indians. A more robust vaccine that would confer immunity in early infancy was evaluated and its use was widely implemented by the Center. This successful vaccine campaign has wiped out a leading killer of American Indian children. Other biomedical research efforts include an investigation of RSV (Respiratory Syncytial Virus), one of the leading causes of lower respiratory illness among Indian children. The Center has also conducted efficacy trials of oral rehydration therapy, and of vaccines for hepatitis A, rotavirus, and pneumococcal disease.

Changing Our Lives Through Sharing Our Strength. The Center received a seed grant in 1995 to launch a multi-year initiative to promote nutrition and health lifestyles for pregnant adolescents on the Navajo, White Mountain Apache, and Gila River reservations. The goal is to improve the future and well-being of Indian teen mothers, their offspring, and families. Native field workers are linked to expectant teen mothers at their first prenatal visit, and are followed until their baby's six-month birthday. Field workers stress the importance of good nutrition and abstinence from alcohol during pregnancy and postnatal breast feeding. Counseling and referrals are provided regarding gestational diabetes, traditional parenting, and diabetes, obesity, and pregnancy prevention.

Native Vision. The Center, in partnership with the National Football League Players Association and the Nick Lowery Charitable Foundation, is initiating a health, fitness, and achievement program for American Indian children. The goal is to combat the high rates of school drop out, alcohol and drug abuse, depression, suicide, lack of opportunity, and low self-esteem that now plague Indian teens. Native Vision will promote life skills and cultivate individual and community enrichment through a team sports model that involves NFL players and other professional athletes as role models and mentors. The program will include one-on-one mentoring relationships between youths and adults, safe places for developing marketable skills during nonschool hours, a healthy start for children age 3 and under, a healthy lifestyles curriculum implemented in high schools, and an opportunity to give back through community service. By the year 2000, it is hoped that up to 10 reservation communities will be involved in the program.

Contents of Data:

Epidemiological data, including rates of various diseases and of breastfeeding. Data on educational attainment, career aspirations, alcohol use, and mental health among attendees of the Native Vision camp.

Strengths and Weaknesses:

Much of the Center's data belongs to Indian communities, whose permission is needed to access it. Although the Center works with a variety of tribes, much of the research concerns Southwestern tribes and reservation populations.

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