



**Strategies for Justice:
Advanced Investigation and
Prosecution of
Child Abuse and Exploitation**
October 6-10, 2014, Phoenix, AZ

Strategies for Justice is an advanced multidisciplinary national training conference for prosecutors, law enforcement, medical and mental health professionals, forensic interviewers, child advocates and allied professionals. Multi-disciplinary teams are encouraged to register as a team. NDAA will welcome the National Link Coalition to the conference where the group will host their bi-annual Link Summit and offer several workshops to attendees. Visit www.ndaa.org to view the agenda and course registration information.

Unsafe Havens I

November 17-21, 2014, AOL Headquarters,
22000 AOL Way, Dulles, VA 20166.

Unsafe Havens I offers training for prosecutors handling technology-facilitated crimes against children. Utilizing a mixture of lectures, case studies and small group discussions, prosecutors will gain in-depth understanding of the technology and best practices for building strong cases. This training is designed to follow the trajectory of a typical case from initiation of investigation, pretrial considerations, case presentation, to appellate considerations. In addition, experts will present on: medically proving age of children in exploitation cases, psychological issues regarding offender behavior, computer forensics, emerging technologies, human trafficking, cognitive development of children, and compliant teenage victims. Attendees will be responsible for paying all travel costs, but there is no registration fee. Space is limited to 60 prosecutors. Applications must be in by September 30, 2014. Acceptance letters will go out on October 3, 2014. Any questions should be directed to Jason Allen (jallen@ndaa.org or 703-549-9222).

This project was supported by Grant No. 2012-CI-FX-K007 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Update

Children's Advocacy Centers and Indian Country

By Randall Cooper¹

In this article, the author explores the extent to which child abuse professionals in Indian Country have adopted multi-disciplinary frameworks and the Children's Advocacy Center model.

Child abuse professionals in Indian Country are developing multidisciplinary frameworks and collaborating with the Children's Advocacy Center networks in the United States to improve criminal justice and medical/public health responses to child victims of violence. Local professionals are navigating available regional and national resources to implement evidence-based practices.

Rates of Child Maltreatment and Sexual Abuse in Indian Country

The rate of sexual violence and child maltreatment in Indian Country far exceeds rates of sexual and familial violence in other communities in the United States. According to a 2012 publication by the United States Department of Health and Human Services (HHS), state agencies in 2011 reported nearly 680,000 of substantiated cases of child maltreatment in the United States.² A previous HHS report found that Native American and Alaska Native children were 50% more likely to become the victim of sexual abuse than Caucasian children.³ Native American adults are twice as likely to experience a rape or sexual assault compared to all other races.⁴ Department of Justice statistics indicate that American Indian and Alaska Native women suffer a higher rate of rape and sexual assault than any other group of people in the United States,⁵ and Native American youth have a four-fold increase for multiple victimizations.⁶

Contributing factors such as poverty, unemployment, familial stresses, and violence occur at a higher rate on Indian reservations.⁷ Family alcohol problems elevate the risk of child sexual or physical abuse.⁸ Geographically or socially isolated families are at higher risk for sexual abuse.⁹ Younger children are at an increased risk of being victims of physical and sexual abuse.¹⁰ For American Indian and Alaskan Native communities, almost one third of the population is younger than fifteen years old.¹¹

Survivors of sexual abuse face a lifetime of emotional, physical and sexual difficulties directly caused by the abuse including a three times greater likelihood of developing psychiatric disorders or abusing drugs and alcohol.¹² The difficulty of improving institutional responses to child sexual abuse, physical abuse and neglect is particularly pronounced in small, rural communities where resources are limited, and where both prosecutors and investigators must have a working knowledge of all crimes and cannot specialize in one area such as sexual assault.¹³

While rates of sexual victimization of children vary from tribe to tribe, the single most important mechanism for any native community to effectively investigate and prosecute child abuse is a multidisciplinary framework tied to the support of Children's Advocacy and Family Justice Centers.¹⁴ Multidisciplinary teams represent the guiding principle of the Children's Advocacy Center framework based on the principle of collaboration "during child abuse investigations, thereby preventing duplication and fostering a sense of teamwork that benefits both the investigation and the child."¹⁵ While many reservations are located in the poorest and most geographically isolated regions in the country, Native American commu-

nities do possess the personnel necessary to serve as the foundation of an effective multidisciplinary team.¹⁶ A diverse set of communities in Indian Country already have well-established multidisciplinary teams or Children's Advocacy Centers, which should serve as working models for the future.

A Coordinated Approach to Child Abuse

A Multidisciplinary Team (MDT) is defined as a team with members from a range of disciplines, which regularly meet to review cases of child abuse and neglect.¹⁷ In Indian Country, one of the greatest challenges regarding cases of child sexual abuse involves the lack of criminal prosecution of these cases.¹⁸ In one analysis of child abuse prosecutions in Indian Country, only 2% of the serious child abuse cases were prosecuted federally and only 3% of child abuse offenders risk conviction.¹⁹

For this reason, multidisciplinary teams include prosecutors, law enforcement, child protective services and medical/mental health professionals.²⁰ The primary goal of law enforcement is to investigate the circumstances of injury/abuse and support prosecution if indicted. Child Protective Services assess family dynamics/safety and the needs of both family and child. Medical and mental health professionals provide necessary medical and psychological care for the child, and expertise when medical evidence is available.²¹

Children's Advocacy Centers (CACs) are programs established to coordinate the activities of the multidisciplinary team in a child friendly environment. An important component of the Child Advocacy Center is for the child to come to the facility to be interviewed once, by a single interviewer, to prevent the child from being re-traumatized in multiple interviews by different disciplines involved in the investigation. The physical facility varies greatly in terms of size and sophistication, but every Child Advocacy Center focuses on providing a comfortable, child-friendly and homelike environment. According to the Native American Children's Alliance, "a Child Advocacy Center can be located anywhere in a community: in residential neighborhoods, as part of a large facility, or even in a strip mall. Some Children's Advocacy Centers are part of a larger agency that may provide a variety of services to children."²² However, Children's Advocacy Centers play an equally important role in ensuring that children who have been victims of abuse receive forensic medical evaluations, ongoing victim advocacy, and trauma-focused evidence-supported mental health treatment. Child victims who receive services at Children's Advocacy Centers are twice as likely to receive specialized medical exams and also far more likely to receive referrals for specialized mental health treatment than those whose investigations occur outside the CAC setting.²³

Disparity of Child Advocacy Services in Indian Country

The National Children's Alliance (NCA) is the national association and accrediting body for Children's Advocacy Centers and multidisciplinary teams in the US and abroad. Through grants to local communities to start and improve Children's Advocacy Centers, quality assurance activities, and technical assistance and training, the National Children's Alliance helps communities offer necessary medical, emotional, legal, investigative, and victim advocacy services in a child friendly location—ensuring that children are not further victimized by the systems intended to protect them. The National Children's Alliance, in collaboration with the National Child Protection Training Center and the National Children's Advocacy Centers, works side-by-side with programs and professionals throughout the country to minimize trauma for abused children, and break the cycle of abuse,

leading to increased prosecution rates for perpetrators. The National Children's Alliance evaluates advocacy centers and multidisciplinary teams for membership based on ratings for an extensive set of national standards including; cultural competency, forensic interviews, victim advocacy, medical evaluation, mental health services, case review, case tracking, organizational capacity, and child-focused setting.

Based on the extent and quality of services in these fields, a Children's Advocacy Center may achieve one of four levels of NCA membership; Affiliate membership, Satellite membership, Associate/Developing membership, and Accredited membership. NCA currently has 765 member advocacy centers and multidisciplinary teams in the United States. Very few accredited Children's Advocacy Centers are located on Indian Reservations and operated by the tribe.

While Children's Advocacy Centers now provide services to two-thirds of all U.S. counties, one-third of counties remain underserved; those underserved areas are typically rural, geographically isolated, and/or resource-poor.²⁴ Unfortunately, many tribes are located in geographically isolated areas of the country without a nearby Children's Advocacy Center. An analysis of Indian Reservations and NCA Children's Advocacy Centers confirms that, on average, reservations are a 62 mile drive to the nearest accredited center. The survey included only communities in the continental U.S., and average driving distance is only one measure among a wide range of conditions. Not all tribes are geographically isolated; many reservations are located close to or within metropolitan areas with a Children's Advocacy Center. However, one in five reservations is between 100 and 300 driving miles from an advocacy center. A variety of complex factors exist; one example is weather conditions on remote rural roads—on large reservations, bad weather can make travel to the multidisciplinary team meeting place impossible for its members.²⁵ Driving distance is a less meaningful factor if the tribe and closest Children's Advocacy Center do not maintain a working relationship. In most cases, the nearest Children's Advocacy Center is not operated by or affiliated with a tribal community. However, Children's Advocacy Centers report that roughly 2% of all child victims served within their centers are Native American or Alaska Native children.²⁶ In a recently completed survey conducted by National Children's Alliance, 134 Accredited and 33 Associate/Developing Children's Advocacy Centers indicate that they have a signed a memorandum of understanding with tribal law enforcement or federal agencies with investigative responsibilities on tribal land or regularly serve children from reservations operated by the tribe.²⁷

An important aspect of any multidisciplinary team within the context of Indian Country is effective delivery of culturally appropriate practices and treatment for the child. "Children who have been marginalized because of discrimination related to race, ethnicity, and poverty, may feel too disempowered to tell about abuse."²⁸ Talking about sensitive, and potentially traumatic events like sexual acts, may be particularly difficult for Native children with less exposure to western "definitions of truth, time, and abstraction."²⁹

"It is important to have professionals available who are not only bilingual but also knowledgeable about the tribe's traditions, culture and social structure. Such knowledge can avoid misinterpretation of non-verbal communication. Most professionals interviewing children in Indian Country are not necessarily familiar with the child's native language; but, there are a number of ways to conduct the interview while maintaining a culturally responsible approach."³⁰

National research statistics, geographic, cultural and economic conditions demonstrate the significant disparity of services for child victims of violence / sexual abuse in Indian Country. Many of the country's largest Indian communities lack access to culturally appropriate services for their child victims. For example, North Dakota, a state with the seventh highest proportion of Native Americans (2000 Census) does not have any Indian-operated Children's Advocacy Centers. Child victims on the Rosebud Reservation in South Dakota must travel two and a half hours or more across the state (in ideal road conditions) to receive the treatment they need. The Wind River Reservation Child Advocacy Center in Wyoming reported the highest volume of cases (15-20 per month), and lacks the funding to support permanent staff or programs for victims. Like many Indian communities, the Wind River Child Advocacy Center does not have a consistent working relationship with tribal police.

Successful Programs Serving Indian Country

Despite the troubling statistics, many innovative working models for Children's Advocacy Centers exist in Indian Country. No two models are the same, since each tribe experiences its own set of circumstances, strengths, and challenges. Some programs are administered by the tribe or an independent group in the tribal community. Other models are based on a strong working relationship between tribal authorities and a nearby Children's Advocacy Center that serves both native and non-native communities.

The first Child Advocacy Center founded specifically to serve Indian Country is administered by the Eastern Band of Cherokee in Cherokee, North Carolina. Heart-to-Heart Child Advocacy Center is the location for tribal and federal law enforcement, tribal child protective services, prosecution, mental health, and medical and educational agencies to come together under one roof as a multidisciplinary team. The center also provides counseling for non-offending family members, community education and training, and crisis intervention. Heart-to-Heart has been recognized by the Office of Justice Programs as a "Promising Practice in Indian Country" and is a fully accredited member of the National Children's Alliance. The founder of the center, Regina Rosario, was a detective with her tribe's law enforcement agency. "As a detective, I found that a lot of our cases were falling by the wayside. I went to a training session in Huntsville. We toured their first CAC. I realized that this was something that my community needed to protect our kids."³¹

Another successful program, the Crow Nation Tribal Child and Adolescent Referral Evaluation Center (Children's Advocacy Center)—or CARE Center—operates out of the Behavioral Health Department of the Crow / Northern Cheyenne Hospital in Crow Agency, Montana. The multidisciplinary team meets monthly to review cases, while the center operates one afternoon a week with an average of two cases per week. The multidisciplinary team consists of members from the Bureau of Indian Affairs (BIA), tribal law enforcement, an Indian Health Service pediatrician and child clinical psychologist, state social service workers, tribal attorneys (Indian Child Welfare Act specialist and criminal prosecutor), and an assistant United States attorney. The success of the CARE center prompted the team to open a second facility, in January 2010, in Lame Deer on the adjacent Northern Cheyenne Reservation. The FBI recently awarded one of the center's founders with the FBI Director's Community Leadership Award.

In New Mexico, the VOICES (Valuing Our Integrity with Courage, Empowerment, and Support) program of Tewa Women United is an example of a private, Indian-operated organization that

provides multidisciplinary team coordination and other support services for nearby Native communities. Based in Santa Cruz, the center receives referrals from state and local police, the FBI, Santa Clara Tribal Police, San Juan Tribal Police, and the BIA. Eighty percent of forensic interviews conducted at the center assisted child victims of sexual assault, with the remaining cases split between child victims of physical abuse and child witnesses. The center also offers further access to counseling and therapy.

A similar innovative and privately operated tribal Children's Advocacy Center—Wiconi Wawokiya—serves the Crow Creek, Lower Brule, and Rosebud reservations in central/southern South Dakota. Located on the Crow Creek Reservation in Fort Thompson and one of the first of its kind, the fully operational center provides culturally appropriate services to child victims. Wiconi Wawokiya conducts forensic interviews and medical exams, provides emergency legal advocacy, court advocacy, medical advocacy, mental health therapy, and follow-up services. The Office of Justice Programs recognizes Wiconi Wawokiya as a "promising practice in Indian Country." Wiconi Wawokiya is a fully accredited member of the National Children's Alliance.

In Tucson, Arizona, the Southern Arizona Children's Advocacy Center is an example of a non-Indian operated Children's Advocacy Center that serves the general population of its surrounding region. It does, however, work collaboratively with two Indian communities in the region—the Pascua Yaqui and Tohono O'odham. Tribal law enforcement from both communities brings child victims to the center for necessary forensic services. In 2011, the center saw six Pascua Yaqui children and 28 Tohono O'odham children as part of its criminal investigations of child abuse.

In the upper Midwest, the Family Advocacy Network of Northern Minnesota recently opened in Bemidji. This is another example of a non-Native Children's Advocacy Center that serves nearby reservations and operates cooperatively with tribal law enforcement and child protection agencies. The center serves the general surrounding population in the region, but has received support from nearby tribal communities—over half of the center's clients come from the Red Lake, White Earth and Leech Lake reservations.

Conclusion

Looking toward the future, the reality is that many tribes are at an economic disadvantage and unable to fund new facilities. In many communities the construction or purchase of physical space for an advocacy center is not a practical expectation; this is a significant barrier, but Children's advocacy center proponents have been innovative. The practical first-step for any community is to build a multidisciplinary team as the foundation for future efforts. "Although most tribes do not have access to an entire building or house to donate for use as a CAC, the tribal communities are adept at using available resources. A community may decide to develop their multidisciplinary team and brainstorm about how to obtain a facility to house a CAC"; when new building projects are announced by the tribe, the multidisciplinary team should advocate for access to one or two rooms to provide interviews and mental health services.³²

Professionals in the children's advocacy movement agree that a multidisciplinary team approach is foundational in protecting the legal rights of children and getting the victims the services they need to heal. Successful Children's Advocacy Centers and multidisciplinary team models already exist in and serve Indian Country. Tribal leaders, community leaders and professionals will need to continue to build

collaborative relationships and develop the skills, knowledge and tools necessary to create and sustain the multidisciplinary team model for investigating and prosecuting child abuse in Indian Country.

Endnotes

- 1 Randall Cooper is a Tribal Liaison/Research Analyst with the National District Attorneys Association's National Center for Prosecution of Child Abuse.
- 2 Children's Bureau, U.S. Dep't of Health and Human Serv., *Child Maltreatment 2011* xi (2012).
- 3 Children's Bureau, U.S. Dep't of Health and Human Serv., *Child Maltreatment 2011* 28 (2012).
- 4 Nicole P. Yuan, et al., *Risk Factors for Physical Assault and Rape Among Six Native American Tribes*, 21 J. of Interpersonal Violence 1566, 1567 (2006) available at <http://www.sagepub.com/gabbidonstudy/articles/Yuan.pdf>.
- 5 See Lawrence A. Greenfeld & Steven K. Smith, *American Indians and Crime* (U.S. Dept' of Justice 1999) available at <http://bjs.ojp.usdoj.gov/content/pub/pdf/aic.pdf>; Patricia Tjaden & Nancy Thoennes, *Full Report of the Prevalence, Incidence and Consequence of Violence Against Women: Findings From the National Violence Against Women Survey* (U.S. Dept' of Justice 2000), available at <http://www.ncjrs.org/pdffiles1/nij/183781.pdf>; Ronet Bachman, *The Epidemiology of Rape and Sexual Assaults Against American Indian Women: An Analysis of NCVS Data, Address to the Federal Response to Sexual Assault on Indian Women Federal and Tribal Working Group* (Sept. 29, 2003); Patricia Tjaden and Nancy Thoennes, *Extent, Nature, and Consequences of Rape Victimization: Findings from the National Violence Against Women Survey*, 14 (U.S. Dept' of Justice 2006).
- 6 Tomika N. Stevens et al., *Variable Differentiating Singly and Multiply Victimized Youth: Results From the National Survey of Adolescents and Implications for Secondary Prevention*, 10(3) Child Maltreatment 211, 219.
- 7 Victor I. Veith, *In My Neighbor's House: A Proposal to Address Child Abuse in Rural America*, 22 Hamline L. Rev. 143, 143 (1998) (discussing the prevalence of prevalence of child abuse in rural communities due to factors of drugs, alcohol, poverty, mental illness and a lack of necessary services); See Bobby Wright & William G. Tierney, *American Indians in Higher Education: A History of Cultural Conflict, in Structured Inequality in the United States: Critical Discussion on the Continuing Significance of Race, Ethnicity and Gender* 92, 97 (Adalberto Aguirre, Jr. & David V. Baker eds., 2000) (stating that unemployment rate for American Indians living on reservations is 8%; percentage of American Indians living in poverty is three times national average); see also Indian Health Service, *Trends in Indian Health 2002-2003*, chart 2.6, at http://www.ihs.gov/nonmedicalprograms/ihs_stats/files/Trends%20Part%202-Population%20Stat.pdf (displaying the unemployment rate for American Indian males at 13.1% compared to 5.7% of males in all races; unemployment rate for American Indian females is 11.7% compared to 5.8% of females in all races).
- 8 Tomika N. Stevens et al., *Variable Differentiating Singly and Multiply Victimized Youth: Results From the National Survey of Adolescents and Implications for Secondary Prevention*, 10(3) Child Maltreatment 211, 219 (Aug. 2005).
- 9 See Irl Carter & Lawrence J. Parker, *Intrafamilial Sexual Abuse in American Indian Families*, in *Family Sexual Abuse: Frontline Research and Evaluation* 106, 110 (Michael Quinn Patton ed., 1991).
- 10 Tomika N. Stevens et al., *Variable Differentiating Singly and Multiply Victimized Youth: Results From the National Survey of Adolescents and Implications for Secondary Prevention*, 10(3) Child Maltreatment 211, 219; See also Children's Bureau, U.S. Dep't of Health and Human Serv., *Child Maltreatment 2006*, 26 (2008).
- 11 Indian Health Service, *Trends in Indian Health 2002-2003*, chart 2.4, available at http://www.ihs.gov/nonmedicalprograms/ihs_stats/files/Trends%20Part%202-Population%20Stat.pdf. (Thirty one percent of the Native American/Alaska Native population is younger than 15 years old. For all other races only 21 percent of the population is younger than 15 years old.)
- 12 Kenneth S. Kendler, M.D., et al., *Childhood Sexual Abuse and Adult Psychiatric and Substance Abuse Disorders in Women: An Epidemiological and Co-twin Control Analysis*, 57 Archives of General Psychiatry 953-959 (2000).
- 13 See generally, Victor I. Veith, *In My Neighbor's House: A Proposal to Address Child Abuse in Rural America*, 22 Hamline Law Review 143 (1998).
- 14 Paul D. Steele, *Child Sexual Abuse among Socially Marginalized Groups: Cultural and Governmental Influences Perpetuating Maltreatment in American Indian Country*, 4 Forum on Public Policy (Spring 2009), available at <http://forumonpublicpolicy.com/spring09papers/nextgenspr09.html>.
- 15 Robert H. Giles, *Difficult Economic Times Prove Value of Multidisciplinary Approaches to Resolve Child Abuse*, Update (Nat'l Cent. For Prosecution of Child Abuse, Alexandria, Va) Vol. 22, No. 1 2009, at 1.
- 16 Gary D. Sandefur, *American Indian reservations: The first underclass areas?* 12(1), Focus, 37-41, (1989) available at <http://irp.wisc.edu/publications/focus/pdfs/foc121f.pdf>.
- 17 Eidell B. Wasserman, *Multidisciplinary Teams and Child Protection Teams*, (Univ. of Oklahoma College of Medicine 2000), available at <http://www.oumedicine.com/docs/ad-pediatrics-workfiles/mdtcpt.pdf?sfvrsn=2>.
- 18 Wasserman, supra note 17, at 4.
- 19 Steele, supra note 14, at 13. (Of 100 serious cases of child abuse occurring in Indian Country, only two cases were prosecuted in federal court. Of 6,000 cases of child abuse occur in Indian Country each year, with offenders standing only a three percent chance of eventual conviction).
- 20 Wasserman, supra note 17, at 4.
- 21 Wasserman, supra note 17, at 5.
- 22 Native Am. Children's Alliance, *Revised Guidelines for Child Advocacy Centers in Indian Country* (2009) available at <http://ebookbrowse.com/guidelines-for-child-advocacy-centers-in-indian-country-pdf-d233564351>.
- 23 Wendy A. Walsh et al., *Which Sexual Abuse Victims Receive a Forensic Medical examination? The impact of Children's Advocacy Centers*, 31 Child Abuse and Neglect 1053-1068 (2007); Daniel W. Smith et al., *Service outcomes in physical and sexual abuse cases: A comparison of child advocacy center-based and standard services*, 11 Child Maltreatment 354-360 (2006); Lauren Edinburgh et al., *Caring for Young Adolescent Sexual Abuse Victims in a Hospital-Based Children's Advocacy Center*, 32 Child Abuse & Neglect 1119-1112 (2008).
- 24 Nat'l Children's Alliance, *Annual Report* (2011); available at <http://www.nationalchildrensalliance.org/file.php/4498/2011NCAAnnualReport.pdf>
- 25 Wasserman, supra note 17, at 11.
- 26 Nat'l Children's Alliance, *Annual Report* (2011); available at <http://www.nationalchildrensalliance.org/file.php/4498/2011NCAAnnualReport.pdf>
- 27 Interview with Theresa Huizar, Executive Director, National Children's Alliance, via email, (May 20-24, 2013).
- 28 Steele, supra note 14, at 19.
- 29 Steele, supra note 14, at 12.
- 30 *Native Am. Children's Alliance*, supra note 22, at 7.
- 31 Online Video: *Strategies for Justice: Advanced Investigation and Pro ecutio* of Child Abuse and Exploitation (National District Attorneys Association 2010) available at <http://vimeo.com/16247621>
- 32 *Native Am. Children's Alliance*, supra note 22, at 10.