

A Collaborative and Trauma-Informed Practice Model for Urban Indian Child Welfare

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Preventing the breakup of the American Indian family is the fundamental goal of the Indian Child Welfare Act (ICWA). However, few models exist to provide CPS workers and other practitioners with effective and practical strategies to help achieve this goal. This article presents a collaborative and trauma-informed family preservation practice model for Indian Child Welfare services with urban-based American Indian families. The model encompasses both systemic and direct practice efforts that assist families facing multiple challenges in creating a nurturing and more stable family life. System-level interventions improve the cultural responsiveness of providers, encourage partnerships between CPS and community-based providers, and support ICWA compliance. Direct practice interventions, in the form of intensive case management and treatment services, help parents/caregivers become more capable of meeting their own and their children's needs by addressing challenges such as substance abuse, trauma and other mental health challenges, domestic violence, and housing instability. Evaluation of the practice model suggests that it shows promise in preventing out-of-home placement of Native children, while at the same time improving parental capacity, family safety, child well-being, and family environment.

Working with urban American Indian (also referred to herein as “Native”) families with child welfare issues requires that Child Protective Services (CPS) workers possess a commitment to family engagement and preservation, while utilizing case management skills, knowledge of Native history, and a trauma-informed approach. This article presents a child welfare intervention model for urban Native families based on a decade of service provision (comprising family preservation, reunification, and ICWA advocacy services) to more than 1,000 Native families by the community-based Denver Indian Family Resource Center (DIFRC), which works collaboratively with public child welfare agencies in the Denver metropolitan area. Evaluation of the model and its discussion in this article focuses on its use with families receiving family preservation services in two targeted programs (a total of 72 families).

The vast majority of American Indians now reside in urban areas (U.S. Census Bureau, 2004); thus, an urban Indian is an individual who lives in either a large U.S. metropolitan area or a smaller city or town rather than on a reservation or in a tribal community. The challenges faced by American Indian families living in cities may include environmental problems such as housing insecurity, unemployment, and criminal justice system involvement, in addition to clinical issues such as untreated mental illness, substance use, and severe trauma histories. This combination, coupled with cultural and worldview differences, may make it difficult for workers to know where to begin in an Indian Child Welfare case (Lucero, 2007). However, DIFRC’s model has demonstrated that certain practice interventions can help multi-problem families develop skills, create a nurturing family life, and regain hope.

Historical Context

The troubled history of American Indian families in the child welfare system is intimately linked to the painful history of Federal Indian Policy and accompanying actions that destroyed community and family ties. By the end of the nineteenth century, Indian tribes had been decimated and displaced by war, disease, and federal

policies, and thousands of children had been removed to distant boarding schools whose goals were to sever family and tribal ties and educate Native children in the ways of the dominant white culture (Adams, 1995; Hoxie, 1989).

During the twentieth century, policies and practices continued to break up families and erode the well-being of American Indians. Despite the protests of Native parents, family members, and tribes, by mid-century the Indian Adoption Project—a joint effort of the Child Welfare League of America and the Bureau of Indian Affairs—had resulted in a widespread adoption of Native infants to white families (Cross, Earle, & Simmons, 2000; George, 1997). Older Native children continued to be sent to boarding schools, where they often experienced physical and/or sexual abuse, and where the environment typically deprived them of normal attachment and a nurturing family life (Goodluck, 1980). It is important that CPS workers have an understanding of the continuing impact of this history on contemporary Native families, and of the historical trauma that has ensued from it, as a first step in working in a culturally responsive way (Braveheart & DeBruyn, 1998; Lucero, 2007; Weaver, 1998).

In addition to historical trauma, American Indian families also experience high levels of lifetime trauma, including violence (Greenfield & Smith, 1999; Evans-Campbell, Lindhorst, Huang, & Walters, 2006), premature death (Manson, Beals, Klein, Croy, & AI-SUPERPPF Team, 2005), and racism (Duran, 2006). Agencies serving American Indian families may need to provide either trauma-specific or trauma-informed services, or both. Trauma-specific services include direct mental health interventions to reduce symptoms of PTSD or other mental health consequences of trauma (Herman, 1997; Bussey & Wise, 2007). Trauma-informed services, offered by agencies that are not primary providers of therapy, are based on an understanding of client trauma and a commitment to avoiding methods and policies that re-traumatize individuals (Harris & Falot, 2001; SAMHSA, n.d.).

An understanding of history and historical trauma is also crucial to understanding the need for the Indian Child Welfare Act of 1978 (Public Law 95-608, 1978). ICWA was passed at the request of tribes

who called for efforts to stem the loss of their member children. The Act's intention was to prevent Indian children who became involved in the child welfare system from losing connections to their tribal cultures and families. However, removal of Indian children and placement with non-Indian families has continued at disproportionately high rates (Mannes, 1993; Plantz, Hubbel, Barrett, & Dobrec, 1989). For example, in Colorado, American Indian children 18 and under are only 0.45% of the total population; however, they make up 2.2% of the state's child welfare caseload and 2.5% of the foster care population (Colorado Department of Human Services, 2005). Disproportionately high rates of placement for American Indian children have also been documented in California (Magruder & Shaw, 2008), Minnesota (Johnson, Clark, Donald, Pedersen, & Pichotta, 2007), and Iowa (Richardson, 2008).

There have been several studies focused on the child welfare needs and experiences of urban American Indians, who now comprise more than 64% of the total Native population of the U.S. (U.S. Census Bureau, 2004). Mindell, Vidal de Haymes and Francisco (2003) described the systems interventions, such as enhanced training for CPS workers, ICWA advocacy, and capacity-building, that resulted from a collaboration between university, state and community partners in Illinois. Richardson (2008) provided the results of a demonstration program implemented in Iowa to reduce placement disparities for American Indian children. This program, which utilized an American Indian liaison to the Department of Human Services and the introduction of collaborative and empowering work with American Indian families, resulted in fewer out-of-home placements and increased satisfaction both in families and among CPS workers. Both articles point to the importance of systems interventions in order to increase ICWA compliance and to improve families' experiences. The current article adds to the literature on working with American Indians by presenting a practice model that incorporates both direct services for child welfare-involved Native families and systemic interventions at the CPS and community levels.

A Practice Model for Urban Indian Child Welfare: The DIFRC Family Preservation Model

The Denver Indian Family Resource Center (DIFRC) was established in 2000 as a resource for American Indian families involved with child welfare systems in the seven-county metropolitan Denver area. The agency works collaboratively with public child welfare systems to provide intensive case management and culturally responsive services in family reunification and preservation cases, ICWA advocacy on behalf of families and tribes, and access to an extensive referral network of service providers skilled at working with American Indians. Since its inception, DIFRC has actively developed collaborative partnerships and formal working agreements with county child welfare departments in the Denver area. This collaboration has enhanced services to American Indian families through systemic changes in child welfare departments, such as the development of protocols for early identification of American Indian children and training in culturally responsive services to improve practice skills for caseworkers and supervisors. Direct practice services offered by DIFRC to American Indian families have included case management, advocacy, referrals for substance abuse *and* mental health evaluation and treatment, parenting and other psychoeducational groups, and activities for youth and parents that strengthen cultural involvement and cultural identity. Together, these collaborative and systemic efforts and direct services comprise the agency's intensive family preservation practice model for urban Indian child welfare.

The DIFRC Family Preservation Model (DIFRC FPM) supports the call of the Indian Child Welfare Act to provide remedial services and rehabilitative programs intended to prevent the breakup of the Indian family. As such, the model's direct practice interventions are intended to strengthen Native families to ensure that children are in homes that are safe and nurturing, and that parents/caregivers are healthy, balanced, and capable of meeting their own and their children's needs. The model's systemic interventions outline CPS and community practices that strengthen collaboration, improve the cultural responsiveness of providers, and support ICWA compliance.

The direct practice and systemic interventions of the DIFRC FPM are summarized in Table 1.

The direct practice interventions in the model are delivered through concentrated and family focused case management services that help build family capacity and self-sufficiency, and recognize the importance to children of maintaining connections to their tribal cultures and extended family networks (both in the city and on the reservation/tribal community). To date, the DIFRC FPM has been implemented only with urban American Indians, and its interventions have not been tested in tribal child welfare settings. However, the trauma-informed approach of the model, as well as many of its direct practice interventions, would be appropriate for use with American Indian families regardless of urban or tribal setting. In addition, in a recent large-scale national needs assessment, tribal child welfare programs indicated a need for child welfare practice models that can enhance family engagement and increase collaboration with state and county CPS departments (Leake, Lucero, Walker, & McCrae, 2011).

Services to each family begin with an early intervention meeting, such as a Team Decision-making Meeting (TDM) convened by a CPS department or a similar family decision-making meeting set up by DIFRC. This meeting follows quickly after a family contacts DIFRC or is referred by CPS or another community agency. Meeting attendees can include family members and their support persons, service providers, CPS representatives, the DIFRC family preservation worker, and other appropriate parties; the goal of the meeting is to identify family strengths and challenges and develop an initial safety plan for the child(ren). Following this meeting, the direct practice interventions of the model call for a series of strengths-based, culturally appropriate, and trauma-informed assessments; concentrated and family-focused case management services individualized for each family; referrals for material resources; and evaluations for medical, substance abuse, and mental health issues (including PTSD). And, when indicated, appropriate treatment for those areas that have been identified as impacting individual and family well-being is arranged. Families with substance abuse issues (noted by CPS or disclosed by

the family) receive a formal substance abuse evaluation, and, if needed, are referred for inpatient or outpatient services. Families are also invited to participate in groups available at DIFRC, such as the Nurturing Parenting Program, the Fatherhood and Motherhood is Sacred program, and other activities that strengthen cultural identity and connectedness.

Family preservation case managers, while not providing mental health interventions (which are instead provided by Native psychologists associated with DIFRC), use a trauma-informed approach in their work within the DIFRC FPM. This includes recognizing and respecting the trauma that families have experienced and the historical trauma they may bring up in narratives about their family background. Furthermore, in weekly supervision, case managers are educated about trauma responses frequently seen among American Indians, encouraged to recognize and assess ways in which trauma responses may be creating barriers to fulfillment of family service plan components, and trained to discuss with CPS workers the role that trauma may be playing in client behaviors or responses.

The systemic interventions of the model take place between DIFRC and the child welfare system and/or a network of community-based service providers. These systemic interventions ensure that CPS and others involved with Native families are culturally aware and responsive, and they encourage multidisciplinary collaboration between service providers, CPS, tribes, DIFRC, and families. At the foundation of these interventions is the goal of identifying Native children and families at their first contact with a CPS department and quickly referring them for services at DIFRC. The model encompasses strategies that assist CPS workers in helping Native children remain with their families whenever possible—or, if out-of-home placement becomes necessary, using kinship placements. Training is offered to increase CPS workers' understanding of Native culture and families, and to provide skills that increase workers' engagement with the families and awareness of both their resource needs and their cultural needs.

Table 1
Direct Practice and Systemic Interventions of the DIFRC Family Preservation Model

Direct Practice Interventions

- Component 1: Team decision-making or other early-intervention meeting to identify family strengths, challenges, and needs, as well as develop an initial plan for child safety
- Component 2: Strengths-based, culturally appropriate, and trauma-informed intake and family assessments
- Component 3: Educational sessions for families to increase knowledge and awareness of child welfare system, court processes, and treatment plan timelines, etc.
- Component 4: Concentrated and family-focused case management services
- Component 5: Referrals for material resources (e.g., housing, food, legal, transportation, etc.)
- Component 6: Referrals for evaluations and treatment services (e.g., mental health, substance abuse)
- Component 7: Referrals to DIFRC programs/groups (e.g., parenting skills, Alcoholics Anonymous, cultural connectedness/identity development and strengthening)

Systemic Interventions

- Component 1: Establishment of protocols for early identification of American Indian families and children within the child welfare system and for referral of these families to DIFRC for culturally appropriate family preservation services
- Component 2: Collaboration between DIFRC and county CPS departments on family preservation efforts
- Component 3: Service integration and cooperation between DIFRC and community-based service providers
- Component 4: Training for child welfare staff on culturally responsive services and family engagement strategies and creating of awareness of the impact of historical events, governmental policies, and intergenerational trauma on contemporary Native families
- Component 5: Support for child welfare caseworkers to assist them to engage in active and on-going efforts to maintain and strengthen each child's cultural and kinship connections
- Component 6: Commitment within CPS to kinship placements when out-of-home care is necessary
- Component 7: Collaboration with tribal courts and ICWA departments
- Component 8: Development of a network of culturally responsive treatment providers

Evaluation of the DIFRC Family Preservation Model

Projects Utilizing the Model

DIFRC evaluated its family preservation model through funded projects focused on two specific populations. The first project, in conjunction with the Rocky Mountain Quality Improvement Center (RMQIC), worked to prevent removal and out-of-home placement, or to promote timely return home, of Native children who had become involved with the child welfare system due to parental substance abuse and child neglect or maltreatment. The underlying assumption driving the program was that by providing culturally appropriate services to American Indian families referred by CPS, families would be strengthened and out-of-home placements would be avoided.

The project used both direct practice and systemic interventions, as shown in Table 1, and built upon DIFRC's ongoing Indian Child Welfare efforts by adding more intensive case management services for substance-abusing parents/caregivers. In addition, the program offered clients a pre-treatment support group to increase the readiness of substance-abusing family members to enter an appropriate level of treatment. In the three years of service provision under the grant, the program served 49 families (referred to in the next sections as RMQIC families), with 106 children.

The second project, funded by a grant from the Colorado Department of Human Services' Statewide Strategic Use Fund (SSUF), focused on serving TANF-eligible Native families (who are the majority of DIFRC clients, including those served by the earlier RMQIC program) working toward self-sufficiency while also experiencing family stressors that could put them at risk of child welfare involvement. The SSUF project sought to stabilize families, support family members in acquiring a new repertoire of behaviors and attitudes for responding to family stressors, and build communication skills necessary for working with non-Indians when accessing needed resources and services. Concentrated case management services would help to move the family from simply responding to a continuing cycle of crises to a more empowered stance in which members

would work purposefully on addressing stressors prior to their crisis points. In addition to intensive case management, services also included team decision making meetings, working collaboratively with mental health, substance abuse, and other community providers, and group provision of culturally-appropriate parenting and relationship skills. This two-year project served 24 families (referred to in the next sections as SSUF families) with 73 children.

Evaluation Methods

From its inception, DIFRC has seen the benefit of evaluating its programs and services and conducting community-based research that would contribute to the understanding of urban American Indian families. Both the outside evaluators and DIFRC's administrators and program heads were aware of the legacy of past research abuses in Indian Country, as well as the need to conduct evaluations and collect data in ways that were not only ethical, but that produced findings that were relevant and useful for the community in which the evaluation was conducted (Bubar & Jumper-Thurman, 2004). Thus, all program evaluation activities requested by DIFRC have incorporated strategies for culturally-responsive evaluation with American Indian communities, and have been aimed at improving practice while also generating knowledge that could be shared with its community and other Native programs. In addition, the university-based evaluators who conducted these evaluations had an established and long-term relationship with DIFRC, were committed to learning about the urban American Indian community the agency serves *from members of that community*, and interacted with community members by attending meetings and events within the community, as recommended by Stubbins (2001). Moreover, the evaluation of the DIFRC FPM discussed herein was in alignment with Stone (2002) in its use of a participatory action approach with input and oversight at all stages from DIFRC program and agency directors and community-based advisors. This evaluation incorporated a variety of measures, including pre-post assessments of family functioning, direct measures of child safety and child permanency, and qualitative interviews with clients and staff; these measures will be outlined in the sections that follow.

Assessment of family functioning. All family functioning instruments used for the RMQIC project were first reviewed, discussed, and modified (if needed) by a focus group process that brought together American Indian service providers and counseling professionals, family members, and community elders. The group met six times, and after considering a variety of published instruments, chose to modify items from the North Carolina Family Assessment Scale (NCFAS) (Kirk & Reed-Ashcraft, 1996). The revised NCFAS American Indian version (NCFAS-AI) was used by DIFRC case-workers at intake, periodically throughout the open case, and at case closure. For a family self-assessment survey, the group modified items from the Family Assessment Device (FAD) (Epstein, Baldwin, & Bishop, 1983), the Parent Behavior Inventory (PBI) (Lovejoy, Weis, O'Hare, & Rubin, 1999), a Spirituality Scale (SS) used by the National Center for American Indian and Alaska Native Mental Health Research, and the Multigroup Ethnic Identity Measure (MEM) (Phinney, 1992). The American Indian Family Survey (AIFS) consisted of items from the FAD, PBI, SS and MEM, as well as the environmental subscale of the NCFAS-AI, modified to reflect a family's perception of their home and neighborhood environment, and was filled out by family members at intake and case closure.

All scales modified were in the public domain, but wherever possible the evaluation team made contact with the scale's creators to let them know about the modifications. Examples of modifications included moving away from what reviewers perceived as problem-oriented language toward more strength-based terminology. Other changes were made to accommodate the *reality* of American Indian life as seen by the focus group members, and, for measures of spirituality, to drop references to specific religions, as a means of recognizing the importance to many families of practicing their tribe's traditional spirituality.

Screening for substance use problems was made initially by the case manager, and, if further evaluation was indicated, by a formal substance abuse evaluation. Progress toward substance abuse goals was measured by case managers, using one item in the Caregiver Capabilities subscale of the NCFAS-AI, and by parent self-report.

With the focus of the SSUF project on improving family resources and self-sufficiency, two additional scales were modified and used with families, the Family Resource Scale and Caregiver Stress Survey. Additionally, in 2010, because DIFRC was aware that Native adults served by their programs commonly had experienced multiple traumatic life events, a self-report instrument on trauma, Green's Trauma History Questionnaire (Green, 1996), validated across a variety of populations (Hooper, Stockton, Krupnick, & Green, 2011), was modified for use with the families in the SSUF program, resulting in an American Indian version of the instrument (THQ-AI).

Direct measures of child safety and permanency. Child safety was measured directly by noting any re-reports to CPS and indirectly through improvement on the Family Safety subscale of the NCFAS-AI. Child permanency was measured by categorizing the child's home at time of case closure as either with parents or other extended family members (which under ICWA provisions is also considered family preservation), in a tribally-approved Native home, or in a non-Native foster or adoptive home.

Client and staff interviews. Client interviews with SSUF families were conducted by a member of Denver's American Indian community who was not connected with DIFRC. All families were still residing in Denver in the year following services were contacted, and nine families agreed to be interviewed. Staff interviews were done by DIFRC's program evaluators, and for the RMQIC project included three case managers, the project manager/clinical supervisor, and several American Indian mental health professionals. Staff interviews for the SSUF program included the two family preservation case managers, the project manager, the clinical supervisor, and a psychologist.

Evaluation Results

Family Demographics and Needs at Intake

Parents in the RMQIC project ranged in age from 20 to 53 (average 35), and families had 1 to 6 children (average 2). Sixty-seven percent were referred by CPS (primarily for neglect), 11% by community agencies, and 17% were self-referred. By project criteria,

these families had high rates of substance abuse. In addition, families also had very high rates of domestic violence (67% in their current relationship and 85% across all relationships), and mental health/health needs (over 80%). The families also had critical needs for basic resources, as 88% were unemployed.

Parents in the SSUF families ranged in age from 20 to 57 (average 35), and families had from 1 to 7 children (average 3). Seventy-one percent were referred by CPS, 21% were self-referred, and the remaining 8% were referred by their tribe. These families were not as affected by substance abuse problems, with 46% having one or more members with an identified problem, but they had very high needs for basic resources (85%), as well as mental health concerns (67%), domestic violence (46%), and trauma histories (93% of those completing the THQ-AI). The high prevalence of trauma seen on the THQ-AI (and noted but not formally assessed in the RMQIC families) is consistent with Greenfield and Smith's 1999 finding that American Indians, whether urban or tribal, are the most highly victimized of all ethnic groups in the U.S. in a number of categories, and Evans-Campbell et al. (2006) finding that interpersonal violence rates are particularly high for urban American Indian women.

Changes in Family Functioning

Using t-tests to compare scores at intake and case closure on the NCFAS-AI, significant positive change ($p < .05$) was seen in the area of Caregiver Capabilities for families in the RMQIC program. A positive trend ($p < .10$) was seen in Family Safety for these families. Families in the SSUF program showed significant positive change in the area of Environment, and positive trends in the areas of Caregiver Capabilities, Family Safety, and Child Well-Being.

Child Safety

There were no re-reports during program services or within six months for any of the 49 families served by the RMQIC project, and one new report within six months after services for the 24 families served by the SSUF project. This compares favorably with national re-report rates (of substantiated cases within six months) ranging

from 1.5% to 12.2% for 2009, and 4.2% for Colorado (U.S. Department of Health and Human Services, 2009). This 2009 data does not report rates by race/ethnicity; earlier national data for 2004 showed general re-report rates of 8.1% and a re-report rate for American Indian/Alaska Native children of 15.5% (Leake, 2007).

Child Permanency

In the RMQIC project, 81% of families had their children preserved in the home, returned (if out-of-home care was used), or placed with extended family members. Due to the severity of substance abuse and mental health issues among these parents/caregivers, and because 39% of the RMQIC families started services with children placed in non-kinship out-of-home care, there was a higher number of cases in which children did not return home than among the SSUF families. These percentages are consistent with national placement trends for any children reported for abuse or neglect whose parents have a substance abuse problem, who experience higher rates of out-of-home placement, longer stays, and lower rates of reunification (Oliveros & Kaufman, 2011). The reduction in children in out-of-home care from 39% to 19% for the RMQIC families is an important one when compared with data showing that, at a national level, 54% of children from families with parental substance abuse were placed outside the home, compared with 23% of children from families without parental substance abuse (U.S. Department of Health and Human Services, 1997). While these national figures are for all children, not differentiated by factors such as family ethnicity or poverty, it is also known that American Indian children have higher placement rates compared to white children (see references in earlier section on history) and that poverty is correlated with lower rates of reunification (Brook, McDonald, Gregoire, Press, & Hindman, 2010).

In the SSUF project, 96% of families were preserved with children either at home with parents (the most common result) or with extended family members. For one family with an older teen, the final foster placement was not with an American Indian family but it was in a home approved by the family's tribe.

Staff Perspectives on Services

Staff serving RMQIC clients focused on the high level of needs they saw in the families—not just for substance abuse treatment, but to stabilize crisis situations; provide basic resources such as housing, health, food, and transportation assistance; and provide mental health services. Staff could see by working with the families that while the goals of the project centered around achieving sobriety, families had many things to work out before, or simultaneously with, entering substance abuse treatment. Most of the mothers with a substance abuse problem had a history of early trauma. There were also high levels of domestic violence, particularly when the mother was American Indian and the father was of a different ethnicity, leading one case manager to recommend that a way be found to create an empowerment group for young American Indian women. Her vision was that the group would not be modeled after assertiveness training, but instead would bring in cultural values and pride to help the women build inner strength and thus model that strength for their own young children. Case managers felt that most of the mothers they worked with would like to be in an empowerment group, but preferred individual counseling for mental health issues. Finally, several case managers noted that the clients told them they felt comfortable talking with service providers who were also American Indian, even if they came from different tribes.

Staff serving SSUF families also reflected on the high level of concrete needs in the families served, and on the value of prioritizing the needs to address the most pressing ones first, then using coaching and modeling to help families build skills and work toward self-sufficiency. Some of the SSUF families started off homeless; after case managers were able to help these families find stable housing, the workers were satisfied to see them take the next steps on their own, such as getting a GED, working community service hours to fulfill TANF requirements to get on-the-job training, and attending DIFRC's parenting classes (in some cases taking the classes twice).

There were three other important themes for the family preservation work. One was the importance of the training in Motivational Interviewing that all DIFRC staff received in 2010. Case managers

felt it helped them open up a dialog with parents about many life issues and focus on families' intrinsic values and hopes for the future. Using Motivational Interviewing also made all conversations, even those in the car as the worker was driving a family to an appointment, more "intentional."

The second theme was addressing mental health needs. As one worker commented:

Sometimes it's the root of the family problems and they're not aware that it's the root of the problem. If someone is bipolar, for instance, and not diagnosed until age forty, it strains the relationships in the family. Once cured, often things start to change.

A third and very important theme mentioned by two case managers who worked with the RMQIC families and everyone who worked with the SSUF families was the centrality of trauma in clients' lives—and that an understanding of this trauma contributed to the client's insight and motivation to change. This quote, referencing a client who had a high level of traumatic experiences but hadn't connected that to her current depression, exemplifies the impact of this understanding: "One mother filled it out, the Trauma History Questionnaire, and was amazed at some of the questions. She became reflective on it—'this is why I'm depressed' [she realized]."

FPM case managers also discussed historical trauma:

It was really helpful to get at historical trauma. I think historical trauma is the driving force with alcohol, other substance abuse, domestic violence, and everything else...Healing can be strengths-based...If we can make people proud of who they are and where they came from and where they can go, those are ways you can really help heal people. The Boarding School era stripped people of that.

Client Perspectives on Services

Clients interviewed in 2011 highlighted the concrete help they received with basic resources, what they gained from the parenting classes, and how a cultural match with DIFRC caseworkers helped them. When asked about what services they had received and

whether the issue they sought help for had improved or been resolved, all clients interviewed had positive things to say. Some of those comments included:

It has improved a lot. We have a place of our own now. I wanted to finish school and I did, and I got to spend more time with my kids.

Yes. [DIFRC staff] helped take us to an apartment, helped to get our social security, birth certificate, to help us get housing or jobs. He took us to a house, talked to the lady, and we ended up getting the apartment. They helped get the kids enrolled and they helped get the kids financial assistance through the tribe.

Yes, definitely. It helped us, and walked us through everything and it taught us by going to classes, and it just really gave us good feedback and direction. Our lives are probably way better than they were before.

Yes, I got furniture, clothing, bus passes, gas vouchers, domestic violence classes for my husband, Fatherhood program. [The worker] helped with getting into alcohol rehab. I remember he was extremely, extremely patient and extremely friendly. He helped me get on my feet like big time.

The interview asked specifically about any classes clients had taken; overall, clients felt the classes had helped them greatly. One client shared, in this regard,

When I went to fatherhood classes, that was wonderful. Sometimes you think you're a good father, until you go to these classes you find you can do more than what you're doing. You can be a better father. And it's nice. I wish a lot of people went to those classes. Before the classes we thought we were good parents but after we realized we could do more for our kids. We did Nurturing Parenting twice . . . Keep the same teachers. We always come back to what we were taught in those classes.

Another client commented about a class that she had taken by reflecting, "We took Healthy Relationships. [What I remember most

is] listening, cues from the person you were listening to, and good frame of mind.”

Finally, the interview asked if clients felt that DIFRC had provided services in a culturally sensitive way. Clients were very positive about this aspect of the DIFRC FPM, as well. Several interviewees mentioned feeling comfortable, and they added specific feedback, including:

It feels comfortable there because you feel the culture there. You see it all around, and then you feel it come through the teachers as well. And then there’s certain topics and issues that we talk about that we all can relate to because we’re the same culture . . . It was a big relief when I found out [the worker] was going to be on our case and work with my family. Not only was [the worker] Native American too, I felt like she was going to do a really good job with our family.

DIFRC is extremely awesome—especially since our heritage is so lost. So to bring it back like that, and to show that we still have it, that we have the support that we need, it makes it all worth it... I would recommend them getting more resources, because there are so many Natives out there that don’t even know what DIFRC is, and they’re wandering these streets, thinking there’s no help for them. When I tell Natives about them and when they go over there [to DIFRC], I see them the next week and you see their hair’s clean and their hair’s braided, and you know they’re proud again. God bless you and thank God for you, that’s all I would say.

Yes, I’m glad that they’re there and able to help Native families. It’s hard to be an Indian in society today. It’s difficult to maintain your identity and to also blend and cope with the rest of the culture—or the rest of society I should say. So it [provides] very good services, and I would urge them to continue to reach out to Natives.

Discussion and Conclusion

There is growing recognition of the need for child welfare practice models that can provide a framework to guide agencies and workers in providing services that not only promote child safety and well-being, but that are family focused, strengthen the capacity of parents/caregivers, provide services at a community level, and are culturally responsive (National Child Welfare Resource Center for Organizational Improvement & NRCFCPP, 2008). Few practice models for child welfare services for American Indian families currently exist, although tribes and other stakeholders identify these models as an important element that could improve services to Native children and families (Leake, Lucero, Walker, & McCrae, 2011). The collaborative and trauma-informed DIFRC Family Preservation Model discussed in this article is a practice model developed for use with urban-based American Indian families; evaluation of the model suggests that it shows promise in preventing out-of-home placement of Native children, while at the same time improving parental capacity, family safety, child well-being, and family environment.

Unique to this child welfare practice model is the incorporation of an extensive assessment process using instruments developed or modified specifically for use with urban American Indians. In practice, this has frequently resulted in the first-time identification of parental and/or child level challenges (especially untreated trauma and mental health conditions) that are playing a large part in creating the family instability that has brought the family to the attention of CPS. Feedback from families who have received services through the model indicated that family engagement with services, including mental health, trauma, and substance abuse treatment, was heightened due to the thoroughness of the case management they received and their ability to obtain services in their own community from an American Indian caseworker who was perceived as culturally similar.

Ten years of development and refinement of the DIFRC FPM has led to the understanding that successful preservation of urban American Indian families involved with the child welfare system requires not only effective direct practice interventions, but

commitment by CPS departments to implementing policies and practice protocols that support the ICWA's aim of preventing the breakup of the American Indian family. The system-level components of the DIFRC FPM represent examples of these types of policies and protocols; forming their foundation is the development and on going maintenance of collaborative partnerships between CPS and community-based agencies serving American Indian families. These partnerships then provide avenues for implementing within CPS systems other elements essential to preserving Native families, including: (a) identifying Native children at the earliest possible stage of their involvement with CPS; (b) developing a network of culturally informed service providers; (c) improving relationships with tribes; and (d) training CPS workers to not only provide services that are more culturally responsive, but to better understand the historical processes and policies, as well as the contemporary contextual elements, that may put American Indian children and families at risk for child welfare involvement.

In conclusion, the DIFRC Family Preservation Model provides an example of a much-needed framework for child welfare practice in Indian Country. The model was developed for use with American Indian families residing in an urban area, yet it may also have potential for modification and use in tribal settings. Although the two contexts are different, tribally-based and urban American Indian families often face similar challenges, such as parental/caregiver substance abuse, domestic violence, unaddressed trauma and other mental health conditions, housing instability, and the effects of poverty. Tribal families who become involved with the child welfare system often also find themselves working with both a tribal child welfare worker and a worker from the state or county CPS system. And moreover, both groups, as American Indians, share the history of troubling interactions with the child welfare system and a continuing legacy of widespread loss of their children to foster and adoptive placements with non-Indian families. Regardless of setting, use of a child welfare practice model such as the DIFRC FPM—which incorporates both systemic and direct practice components to promote system-level collaboration, increase family engagement, and improve child

and family well-being—has the potential to increase the number of American Indian children who will remain safely with parents and extended family members. In this way, these children have a greater opportunity to remain culturally connected and a part of the future of their tribes and tribal cultures.

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