JANUARY 2018

DOMESTIC VIOLENCE PREVENTION INITIATIVE

IHS DIVISION OF BEHAVIORAL HEALTH
YEAR 1 NATIONAL EVALUATION REPORT
September 30, 2015 – September 29, 2016

Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board

REPORT PREPARED BY:

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PURPOSE

The purpose of this report is to provide findings from the national evaluation of the Domestic Violence Prevention Initiative (DVPI) funded by the Indian Health Service (IHS) Division of Behavioral Health. The data included in this report is from the period September 30, 2015 through September 29, 2016. Findings are aggregated from DVPI Projects that submitted annual progress at the end of the reporting period.

ABOUT DVPI

The Domestic Violence Prevention Initiative (DVPI) is a congressionally mandated, nationally coordinated grant and Federal award program for Tribes, Tribal organizations, federally operated programs, and Urban Indian organizations providing violence prevention and treatment services. The DVPI promotes the development of evidence-based and practice-based models that represent culturally appropriate prevention and treatment approaches to domestic and sexual violence from a community-driven context. The DVPI expands outreach and increases awareness by funding projects that provide victim advocacy, intervention, case coordination, policy development, community response teams, sexual assault examiner programs, and community and school education programs.

In 2015, the DVPI became a grant and federal award program with a five year funding cycle. At this time, IHS awarded 57 grants and federal program awards to meet the following goals:

- Build tribal, Urban Indian Health Programs and federal capacity to provide coordinated community responses to American Indian and Alaska Native victims of domestic and sexual violence;
- Increase access to domestic and sexual violence prevention, advocacy, crisis intervention, and behavioral health services for American Indian and Alaska Native victims and their families;
- Promote trauma-informed services for American Indian and Alaska Native victims of domestic and sexual violence and their families;
- Offer health care provider and community education on domestic violence and sexual violence;
- Respond to the health care needs of American Indian and Alaska Native victims of domestic and sexual violence; and,
- Incorporate culturally appropriate practices and/or faith-based services for American Indian and Alaska Native victims of domestic and sexual violence

Two DVPI purpose areas have been established to help meet these goals:

1. Purpose Area 1: Domestic and Sexual Violence Prevention, Advocacy, and Coordinated Community Responses
2. Purpose Area 2: Provide Forensic Healthcare Services

Purpose Area 1

DVPI Purpose Area 1 awardees focus upon domestic and sexual violence prevention, advocacy, and coordinated community responses. Funded projects address the following eight broad objectives:

- Expand crisis intervention, counseling, advocacy, behavioral health, and case management services to victims of domestic and sexual violence;
- Foster coalitions and networks to improve coordination and collaboration among victim service providers, healthcare providers, and other responders;
- Educate and train service providers on trauma, domestic violence, and sexual assault and its impact on victims;
- Promote community education for adults and youth on domestic and sexual violence;
- Improve organizational practices to improve services for individuals seeking services for domestic and sexual violence;
- Establish coordinated community response policies, protocols, and procedures to enhance domestic and sexual violence intervention and prevention;
- Integrate culturally appropriate practices and/or faith-based services to facilitate the social and emotional well-being of victims and their children; and,
- Implement trauma informed care interventions to support victims and their children.

Purpose Area 2

DVPI Purpose Area 2 awardees focus upon the provision of forensic healthcare services. Funded projects address the following eight broad objectives:

- Expand available medical forensic services to victims of domestic and sexual violence;
- Foster coalitions and networks to improve coordination and collaboration among forensic healthcare programs to ensure adequate services exist either on-site or by referral for victims of domestic and sexual violence 24/7 year round;
- Educate and train providers to conduct medical forensic examinations;
- Promote community education on available medical forensic services;

- Improve health system organizational practices to improve medical forensic services and care coordination among victim services;
- Establish local health system policies for sexual assault, domestic violence, and child maltreatment;
- Integrate culturally appropriate treatment services throughout the medical forensic examination process; and,
- Implement trauma informed care interventions to support victims and their children.

EVALUATION METHODS

DVPI projects submitted an annual progress report on the measures relevant to their scope of work. Data was collected through a web-based reporting system. Findings reported here are aggregated for the entire year 1 period from September 30, 2015 to September 29, 2016. A total of 57 IHS DVPI projects submitted an annual progress report during this reporting period.

The data in this report are presented in figures and tables. Where applicable, annotations are provided following the figures and tables to share additional information related to a given topic. Missing data was handled by omitting those cases with missing data and running the analysis on what remained. Data analysis was conducted by the Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC) one of 12 Tribal Epidemiology Centers serving the American Indian/Alaska Native population across the country.

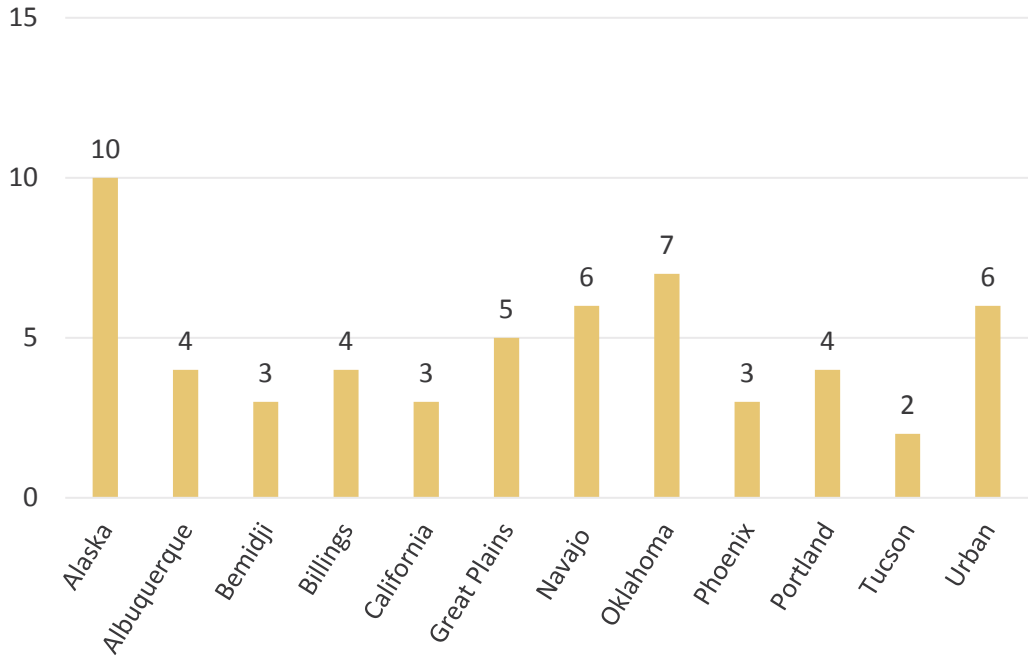
Assistance with interpretation of this report is available from AASTEC staff at 1-800-658-6717.

SECTION 1: POPULATION SERVED

POPULATION SERVED

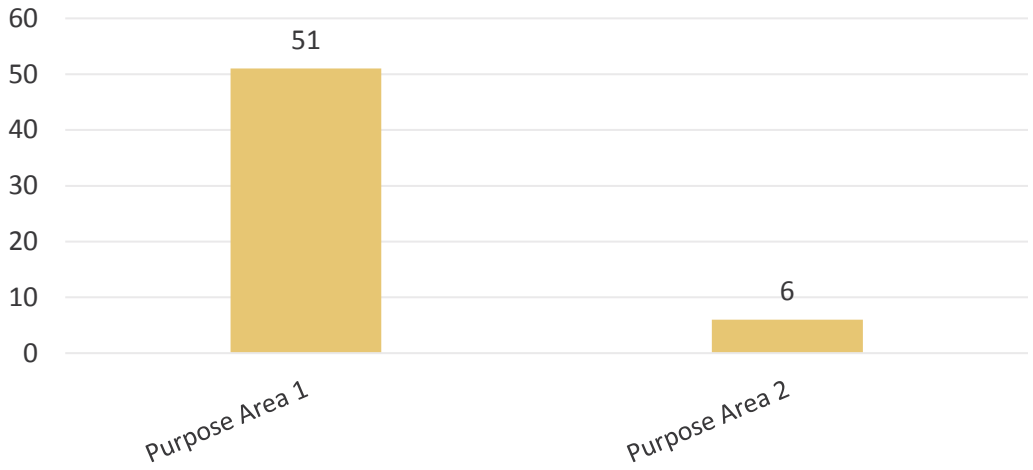
DVPI PROJECTS BY AREA

Figure 1: Number of DVPI Projects by Indian Health Service (IHS) Administrative Area, 2015-2016



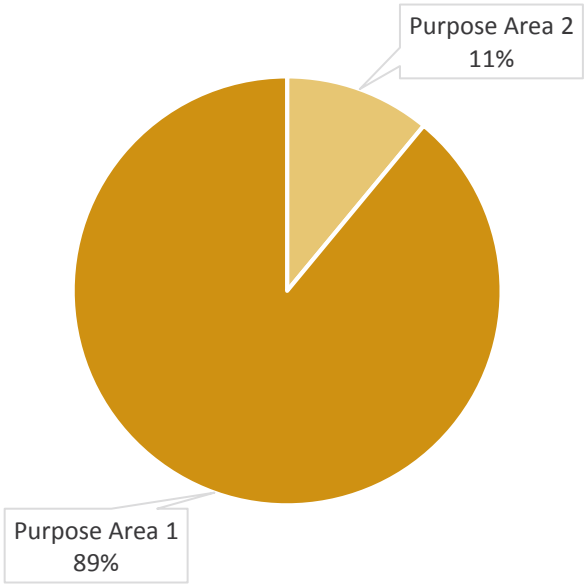
PURPOSE AREA

Figure 2: Number of DVPI Projects by Purpose Area, 2015-2016



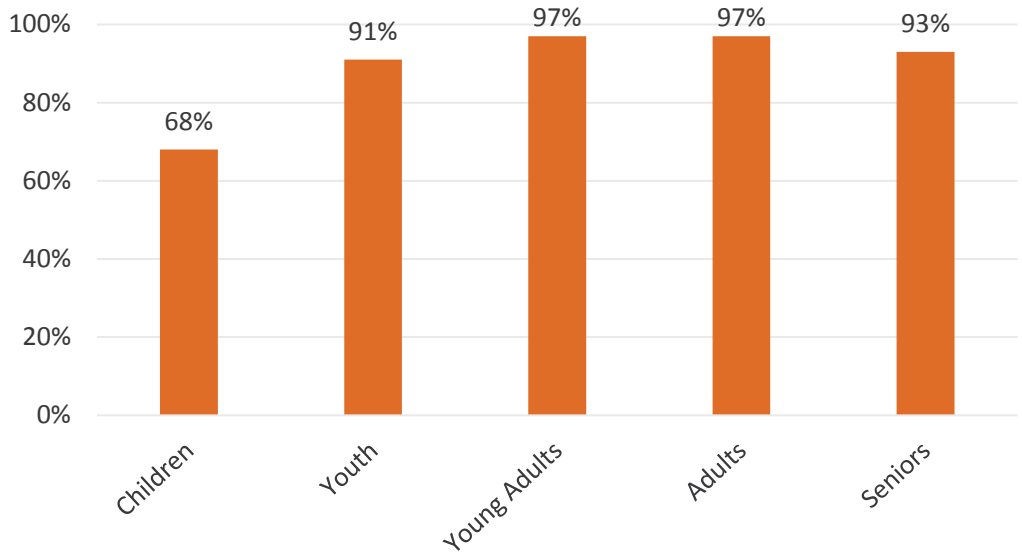
- Purpose Area 1: Domestic and Sexual Violence Prevention, Advocacy, and Coordinated Community Responses
- Purpose Area 2: Provide Forensic Healthcare Services

Figure 3: Percentage of DVPI Project by Purpose Area, 2015-2016



TARGET POPULATION

Figure 4. Target Population Served by DVPI Projects, 2015-2016*



**Projects were able to select multiple target populations.*

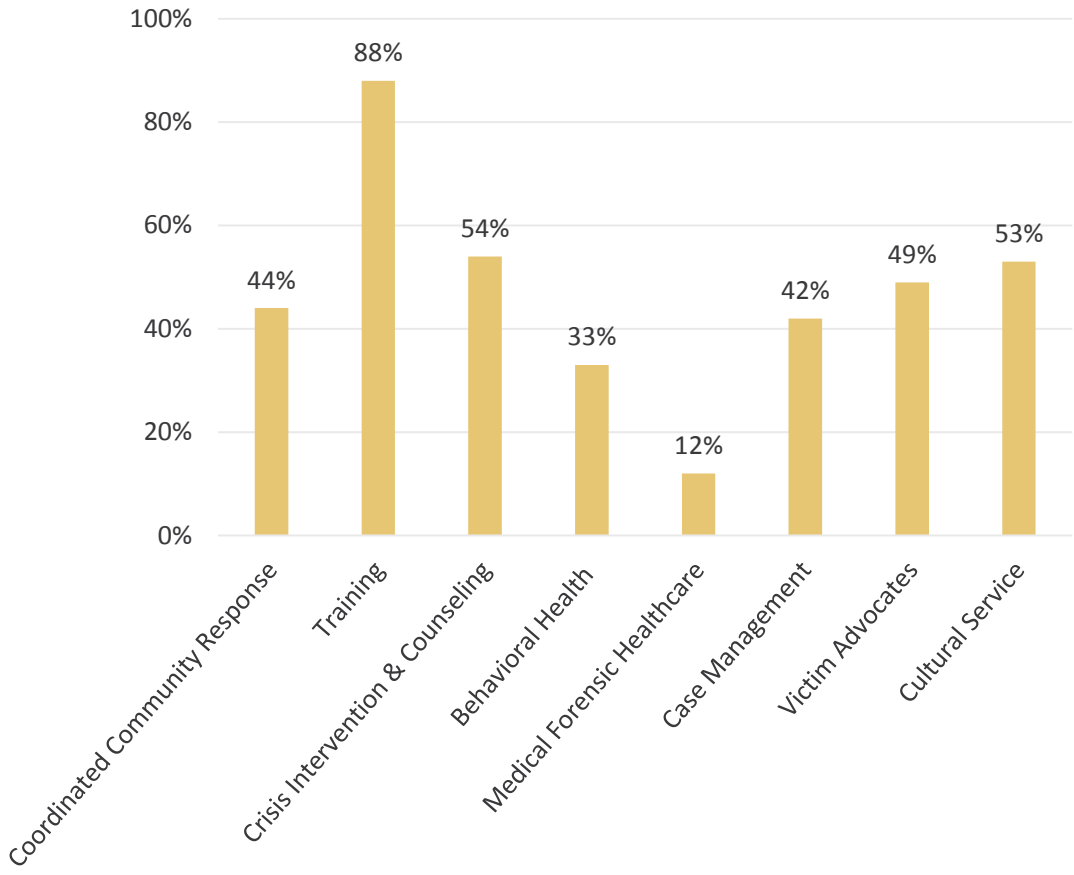
As evidenced in Figure 4, DVPI projects serve most of the population in their respective communities.

TARGET POPULATION DEFINITIONS
Children (up to age 11)
Youth (age 12-17)
Young Adults (age 18-24)
Adults (age 25-54)
Seniors (age 55+)

SECTION 2: SERVICE TYPES

SERVICE TYPES

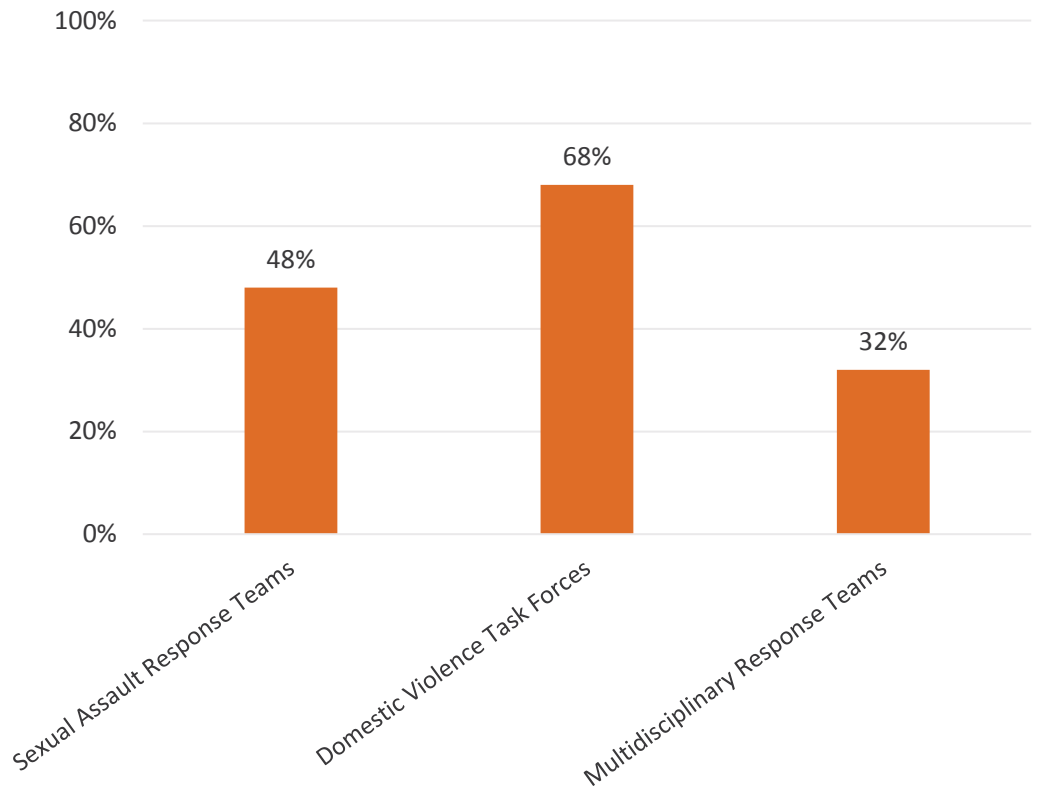
Figure 5. Type(s) of Services Provided by DVPI Projects, 2015-2016*



**Projects were able to select multiple types of service provision.*

As evidenced in Figure 5, the most common service types offered by DVPI projects were training (88%), followed by crisis intervention/counseling (54%) and cultural service (53%).

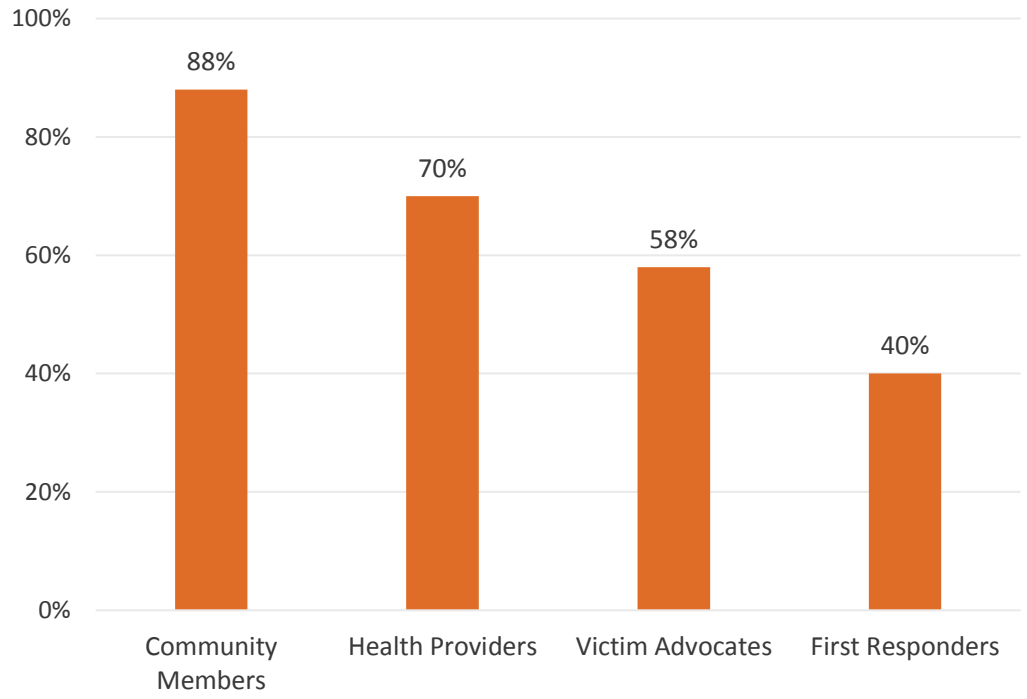
Figure 6. Type of Coordinated Community Response among DVPI Projects Reporting this Type of Service Delivery, 2015-2016*



**Projects were able to select multiple types of community coordinated response.*

As evidenced in Figure 6, the most common type of coordinated community response among DVPI projects reporting this type of service delivery (n=25) was domestic violence task forces (68%) followed by sexual assault response teams (48%).

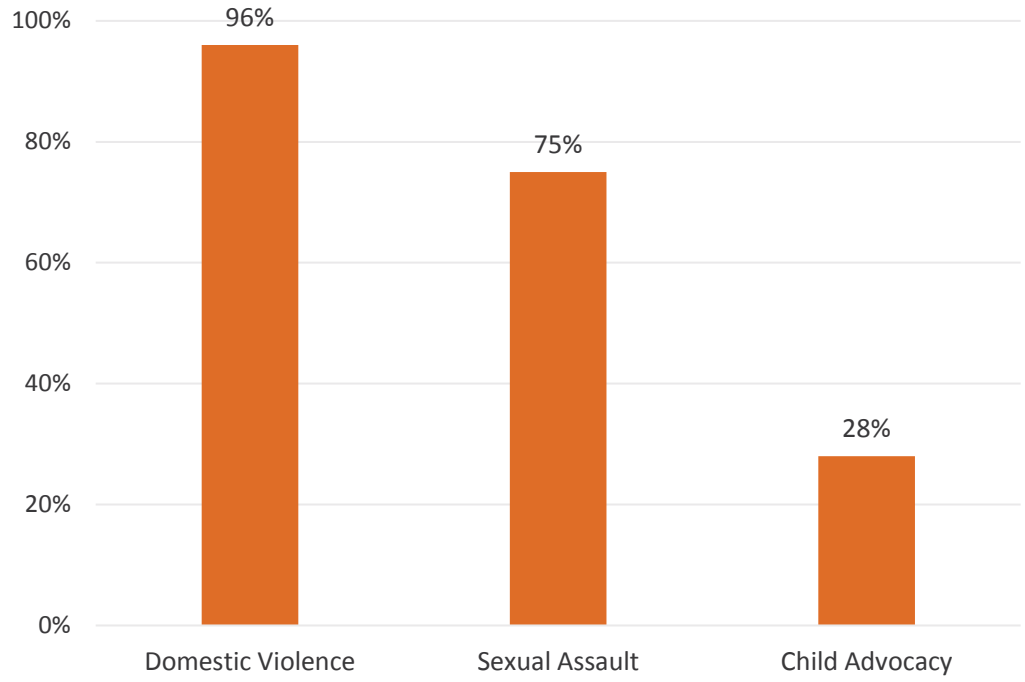
Figure 7. Target Population for Trainings Delivered by DVPI Projects, 2015-2016*



**Projects were able to select multiple target populations.*

As evidenced in Figure 7, the most common target population for DVPI projects providing trainings (n=50) was community members (88%) followed by health providers (70%).

Figure 8. Areas of Focus among DVPI Project Victim Advocates, 2015-2016*

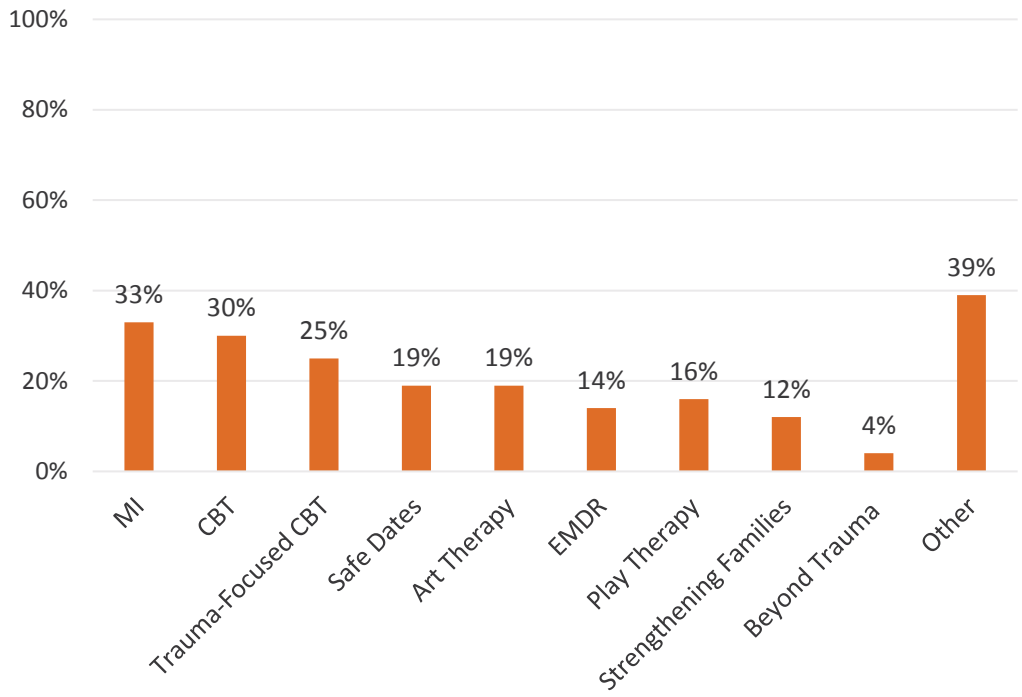


**Projects were able to select multiple types.*

As evidenced in Figure 8, victim advocates supported by DVPI projects primarily focused on domestic violence (96%) and sexual assault (75%) victims.

EVIDENCE-BASED PRACTICES

Figure 9. Type of Evidence-Based Practices Utilized by DVPI Projects, 2015-2016*



**Projects were able to select multiple types.*

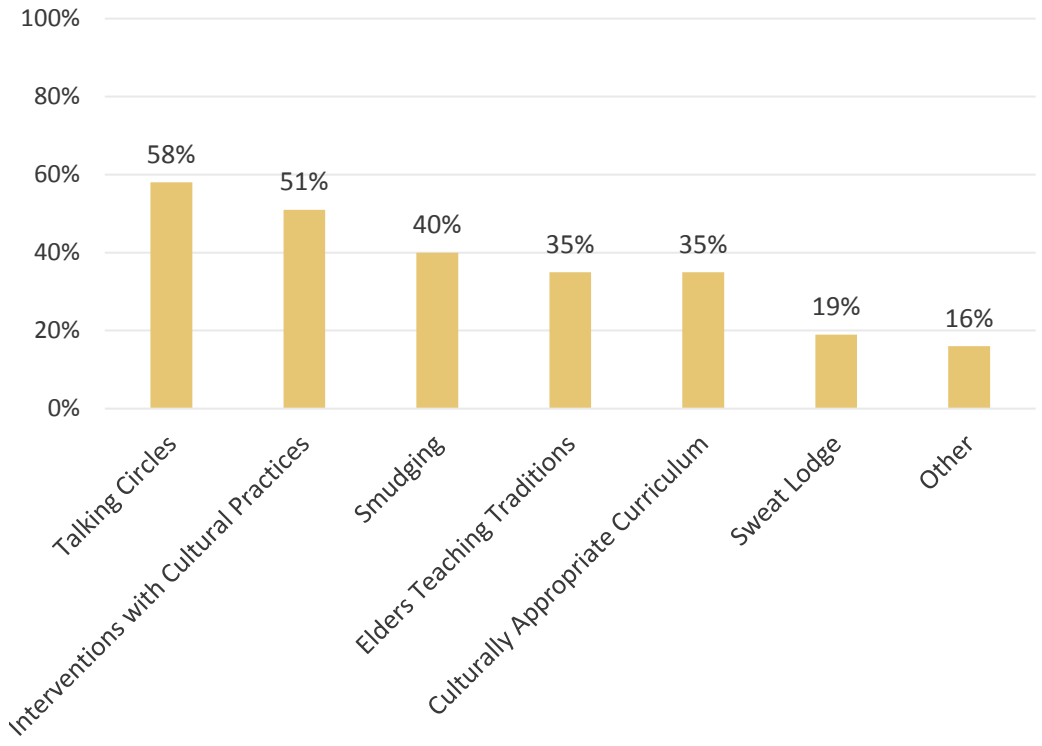
As demonstrated in Figure 9, the most common Evidence-Based Practices utilized among DVPI projects were Motivational Interviewing (33%), CBT (30%), and Trauma-Focused CBT (25%).

"Other" evidence-based practices reported included: Native HOPE, White Bison, AI Life Skills, Mental Health First Aid, SART, Duluth Model, SBIRT, and Domestic Violence Moral Reconciliation Therapy (DV MRT).

KEY:

MI = Motivational Interviewing
CBT = Cognitive Behavioral Therapy
EMDR = Eye Movement Desensitization and Reprocessing
SBIRT = Screening, Brief Intervention, and Referral to Treatment

Figure 10. Type of Practice-Based Practices Utilized among DVPI Projects, 2015-2016*



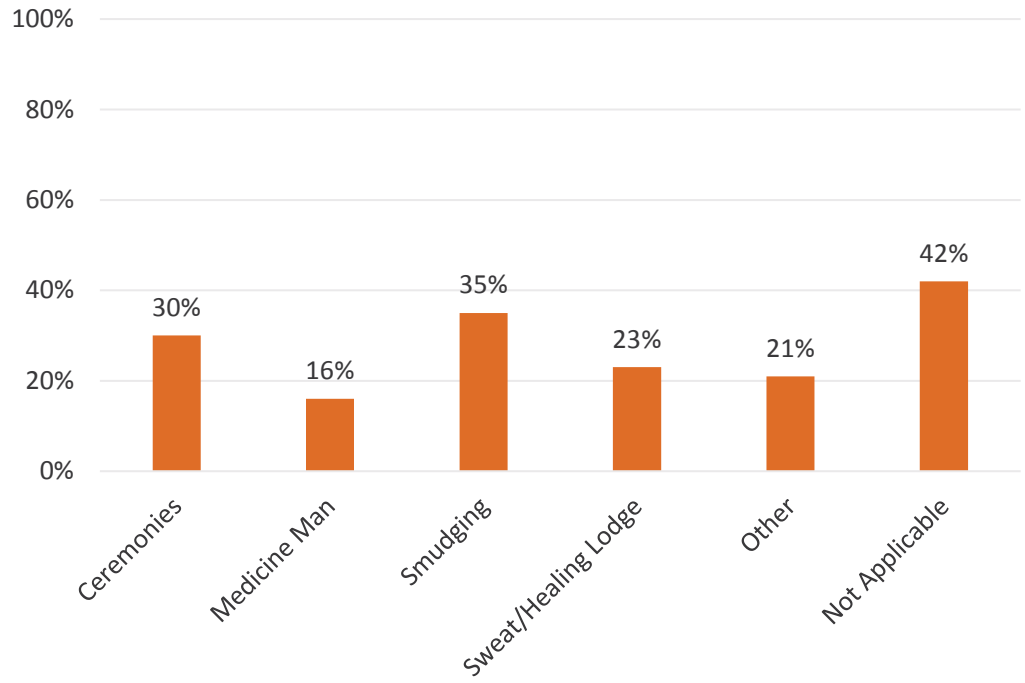
**Projects were able to select multiple types.*

As demonstrated in Figure 10, the most common Practice-Based Practices utilized among DVPI projects were Talking Circles (58%), interventions that include cultural practices (i.e., beading, drumming, etc.) (51%), and smudging (40%).

"Other" practice-based practices reported by DVPI projects included: Red Shawl Project, Love is Not Abuse, Navajo Wellness Model, Sand Tray Therapy, RezRiders, Say it Straight, Fatherhood and Motherhood is Sacred, Positive Indian Parenting, Hands are Not for Hitting, Brain Change, Clothesline Project, and In Her Shoes.

HOLISTIC APPROACHES TO SERVICES

Figure 11. Percentage of DVPI Projects Integrating Traditional Healing, by Practice Type, 2015-2016*



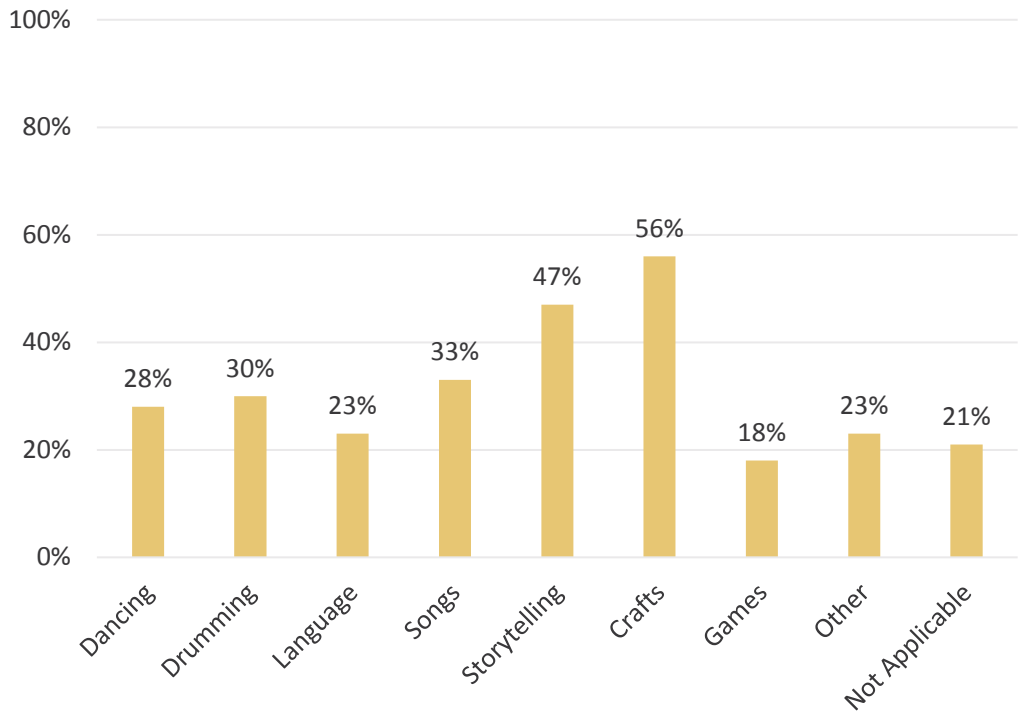
**Projects were able to select multiple types.*

Figure 11 demonstrates that the most common traditional healing related practices incorporated into DVPI activities included smudging (35%) and ceremonies (30%).

"Other" traditional healing practices cited included equine therapy, camps, Red Shawl, and traditional medicines.

Overall, approximately one-half (52.6%, n=30/57) of DVPI projects reported integrating at least one of these traditional healing practices into their project services.

Figure 12. Cultural Practices Offered in DVPI Project Services, 2015-2016*



**Projects were able to select multiple types.*

As evidenced in Figure 12, the most common cultural services included in DVPI projects were crafts (56%) and storytelling (47%).

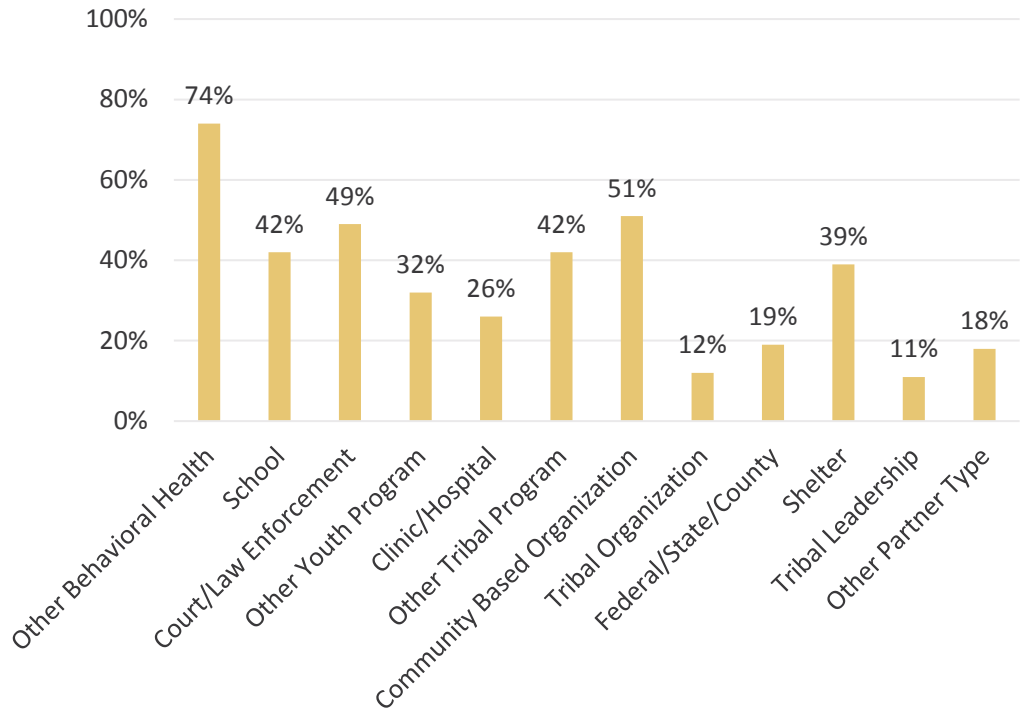
"Other" cultural practices cited included elder blessings, cultural mentorship, summer camps, traditional kayak building, and prayer.

Overall, the majority of DVPI projects reported integrating at least one of these cultural practices into their project services (73.7%, n=42/57).

SECTION 3:
PROJECT OPERATIONS

PARTNERSHIPS

Figure 13. Most Common Types of Partners Enlisted among DVPI Projects 2015-2016*



**Projects were able to select multiple partner types.*

"Other" partner types included other tribes, churches and faith based organizations.

Table 1. Number of Partners and Memorandum of Agreements (MOAs) Reported among DVPI Projects, 2015-2016

	N
Total Partners (All Projects)	439
Average per project	7.8
Range	0 – 24
Total Memorandum of Agreements (MOAs)	58

STAFFING

Figure 14. Percentage of DVPI Projects that Experienced Staff Turnover, 2015-2016

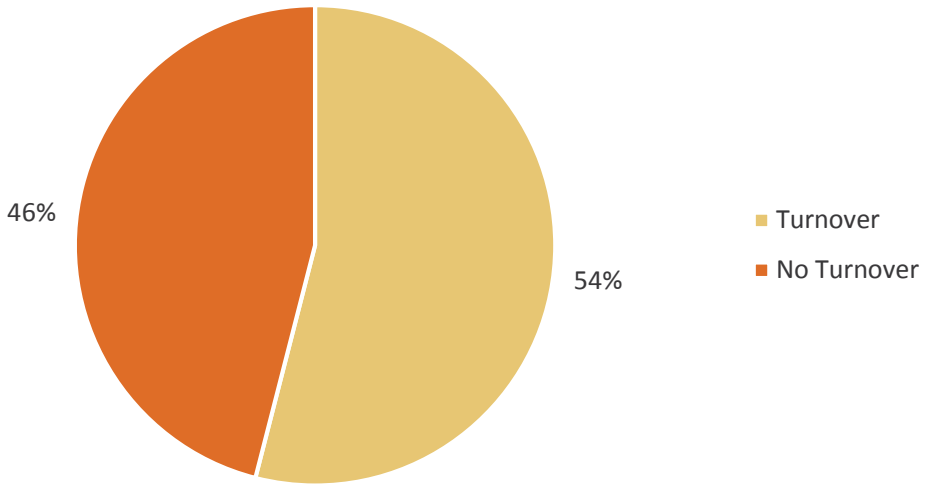


Figure 15. Percentage of DVPI Projects that Have Been Able to Recruit, Hire, and Onboard Staff, 2015-2016

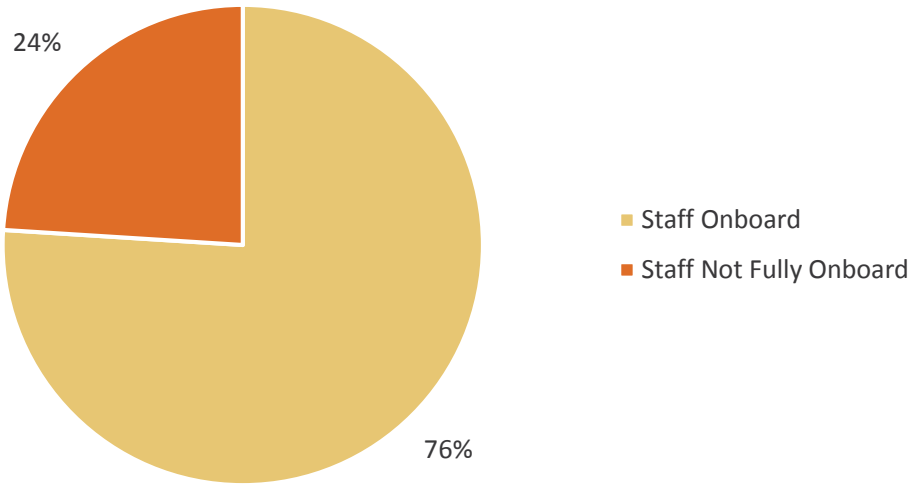
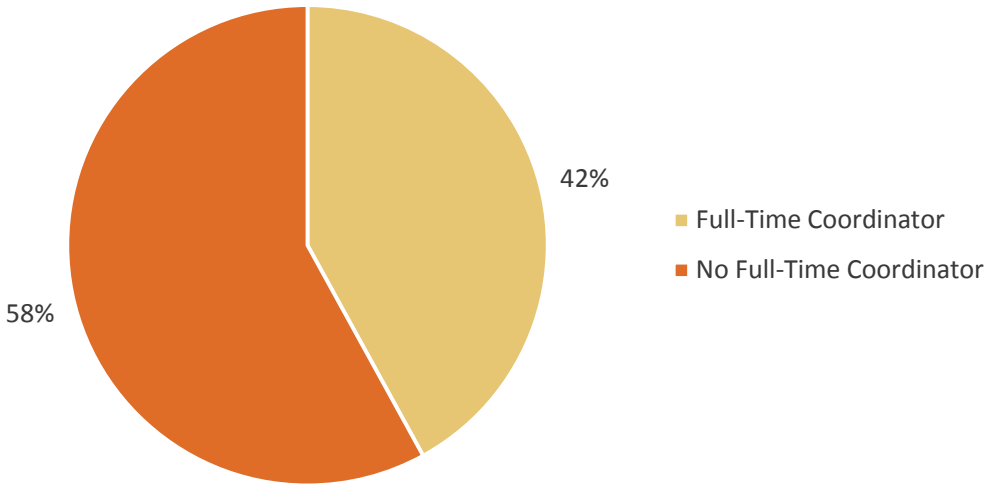


Figure 16. Percentage of DVPI Projects with a Full-Time Project Coordinator, 2015-2016

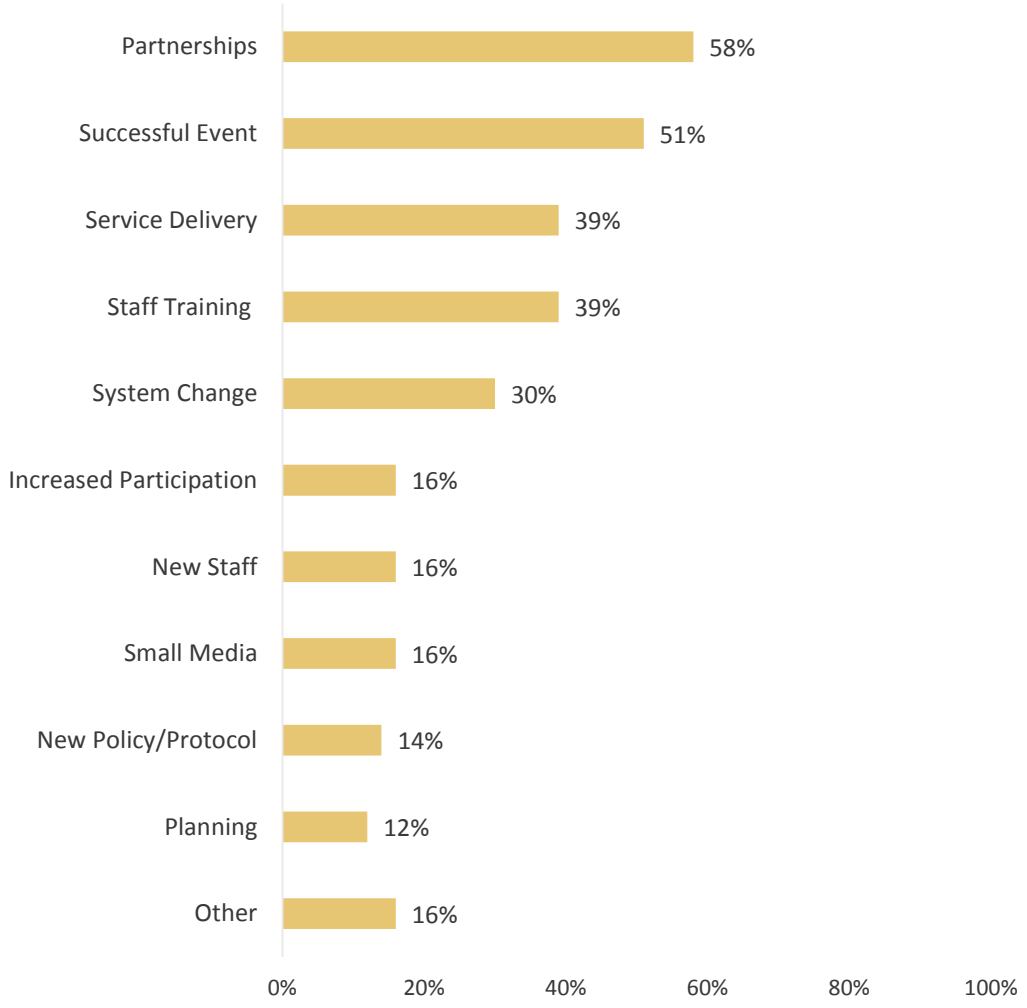


SECTION 4: PROJECT ACCOMPLISHMENTS & BARRIERS

PROJECT ACCOMPLISHMENTS AND BARRIERS

PROJECT ACCOMPLISHMENTS

Figure 17. Types of Accomplishments Reported by DVPI projects, 2015-2016



As evidenced in Figure 17, the most commonly reported DVPI project accomplishments in project year 1 included establishing one or more new partnerships (58%), implementing successful community events (51%), and completion of staff training (39%). Definitions and examples for each success category are provided on the following pages of this report.

Note: This data was gathered through project narratives. There were no limits on the number or type of successes that each project could report.

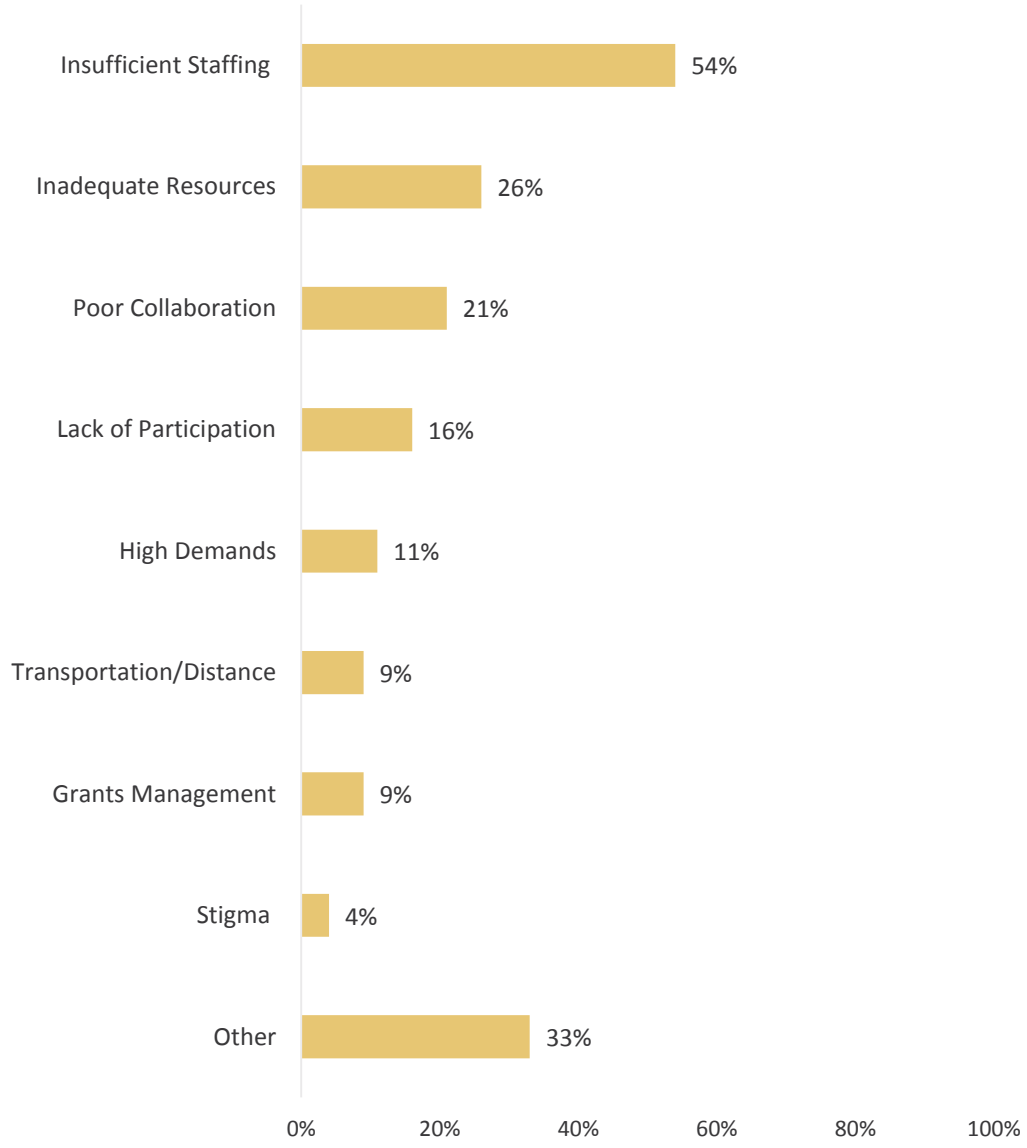
Table 2: DVPI Project Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
NEW PARTNERSHIPS	Project has identified at least one new partner during the reporting period as a measure of success. These new partnerships may be formal (as evidenced through MOUs or MOAs) or informal. Common new partner categories included: schools, law enforcement, courts, hospitals/clinics, social services, other tribal agencies/departments, and external partners (non-profit organizations, referral sites, universities, churches, and shelters).
SUCCESSFUL EVENT	Project has listed at least one community event sponsored by the DVPI project as a success during the reporting period. Common community event types included: school education events (healthy relationships, bullying, prevention, and safety planning), health fairs, community presentations/workshops, camps, community training, and fun runs/walks.
SERVICE DELIVERY	Project has identified the delivery of services to clients as a key accomplishment during the reporting period, such as case management, forensic care, victim advocacy, trauma-informed care, etc.
SYSTEM CHANGE	Project has identified at least one new or expanded service that it offers as a success during the reporting period. Examples include: support groups, traditional ceremonies/practices, extended hours, aftercare/follow-up, new/expanded counselling and case management services, expanded referral networks, classes (self-defense, parenting, self-care, stress management, art therapy), emergency assistance, i.e., providing temporary lodging, food, clothing and essentials to DV victims and their families.
STAFF TRAINING	At least one project staff member attended at least one domestic violence related training, conference or workshop during the reporting period. Common training topics included: domestic violence, sexual assault, healthy parenting, motivational interviewing, sexual assault examiner training, sex trafficking, pediatric sexual abuse, and sexual assault response team training.

INCREASED PARTICIPATION	Project has noted an increase in community participation in DVPI sponsored activities and/or an increase in referrals to its services.
NEW STAFF	Project has identified at least one new staff person (part-time, full-time or contractual) joining its DVPI project during the reporting period.
SMALL MEDIA	Project has implemented a small media-related activity during the reporting period. Examples include: billboards, public service announcements (PSAs), brochures, newsletters, digital stories, and social media (e.g. Facebook).
NEW POLICY or PROTOCOL	Project identified the implementation of at least one new or updated policy or protocol related to domestic violence prevention during the reporting period. Examples include: updated domestic violence policy, tribal code for domestic violence, multidisciplinary strangulation guidelines (protocol), sexual assault response protocol, updated system intake, and new IPV screening protocol.
PLANNING	Project planning activities were identified as a key accomplishment during this reporting period.
OTHER	The other category included unique successes reported by two or fewer DVPI projects during the reporting period. These included project recognition, less domestic violence in community, more domestic violence reporting, tribal resolutions, new curriculum development, new office space, positive communication, and increase in community awareness of project.

PROJECT BARRIERS

Figure 18. Types of Project Barriers Reported among DVPI projects, 2015-2016



As evidenced in Figure 18, the most commonly reported DVPI project barriers included insufficient staffing (54%) and inadequate resources (26%). Definitions and examples for each barrier category are provided on the following pages of this report.

Note: This data was gathered through project narratives. There were no limits on the number or type of barriers that each project could report.

Table 7: DVPI Project Barrier Definitions

BARRIER	DEFINITION
INSUFFICIENT STAFFING	Project identified a lack of staff within its DVPI project as a barrier during this reporting period. This barrier included staff turnover, difficulty recruiting for vacant positions, lack of qualified applicants (education, certifications, AI/AN), and understaffing, where existing staff are burdened with excessive job duties due to insufficient staffing.
INADEQUATE RESOURCES	Project cited a lack of funding or poor infrastructure as barriers to meet high local demand for services and activities. This category also included a lack of shelters, safe houses or transitional housing as well as insufficient legal resources and law enforcement.
POOR COLLABORATION	Project identified gaps or challenges in collaboration with other agencies/departments as a significant barrier during this reporting period. The most commonly entities cited as collaboration challenges included schools, law enforcement, and IHS clinics/hospitals.
LACK OF PARTICIPATION	Project cited insufficient community participation in project services and/or activities as a significant challenge.
HIGH DEMANDS	Project identified high demands (staff and partners) as a barrier to optimal service delivery and routine meeting/coalition participation. High demands encompass competing priorities, busy schedules, excessive workload, difficulties coordinating schedules with partners, and situations where the need for services exceeds local capacity.
TRANSPORTATION/ DISTANCE	Project identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of project services and patient access to these services.
GRANTS MANAGEMENT	Project noted challenges with grants management including local bureaucracies, new directives from tribal administration, long delays in securing procurement and contract approval, poor record keeping, and challenges in procuring needed equipment and training.

STIGMA	Project cited the ongoing stigmatization of domestic violence and/or sexual abuse issues among community members as a project barrier. In some instances, projects noted that stigma also limits open discussion about these topics in community settings.
OTHER	The other category included unique barriers reported by two or fewer DVPI projects during the reporting period. These included lack of forensic training opportunities, data sharing challenges, weather, lack of community trust, delayed tribal approvals, change in leadership, organizational restructuring, and “no barriers”.

APPENDIX: PROJECTS REPORTING

DVPI PROJECTS REPORTING 2015-2016

Alaska Native Tribal Health Consortium
Aleutian Pribilof Islands Association, Inc.
Bristol Bay Area Health Corporation
Copper River Native Association
Chugachmiut
Kodiak Area Native Association
Maniilaq Association
Norton Sound Health Consortium
Southcentral Foundation
SouthEast Alaska Regional Health Consortium
Eight Northern Pueblos Council, Inc.
Ramah Navajo School Board, Inc.
Santa Clara Pueblo
Ute Mountain Ute Tribe
Cass Lake Hospital
Leech Lake Band of Ojibwe
Pokagon Band of Potawatomi Indians
Blackfeet Tribal Health
Chippewa Cree Tribe
Confederated Salish and Kootenai Tribes
Crow Tribe
Indian Heath Council, Inc.
Southern Indian Health Council, Inc.
United Indian Health Services, Inc.
Fort Thompson Service Unit
Ponca Tribe of Nebraska
Rosebud Sioux Tribe
Turtle Mountain Band of Chippewa Indians
Wiconi Wawokiya, Inc.
Chinle Comprehensive Health Care Facility
Chinle Comprehensive Health Care Facility
Gallup Indian Medical Center
Pinon Health Center
Shiprock-Northern Navajo Medical Center
Tuba City Regional Health Care Corporation
Cherokee Nation
Chickasaw Nation
Choctaw Nation - Project Homakbi Ribbon
Choctaw Nation - Project Strong

Citizen Potawatomi Nation
Indian Health Care Resource Center - Tulsa
Oklahoma City Indian Clinic
Hualapai Indian Tribe
Ute Indian Tribe
Washoe Tribe of Nevada and California
Burns Paiute Tribe
The Healing Lodge of the Seven Nations
Lower Elwha Klallam Tribe
Quileute Tribal Council
Pascua Yaqui Tribe
Tohono O'odham Nation
American Indian Health Service of Chicago, Inc.
First Nations Community Health Source
Minnesota Indian Women's Resource Center
Native American Community Health Center, Inc.
Native American Health Center, Inc.
South Dakota Urban Indian Health, Inc.

Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board