

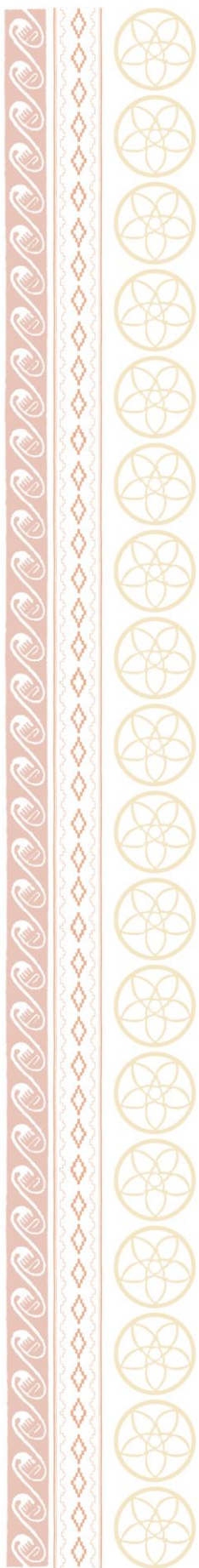
MARCH 2018

DOMESTIC VIOLENCE PREVENTION INITIATIVE

IHS DIVISION OF BEHAVIORAL HEALTH
YEAR 2 NATIONAL EVALUATION REPORT
September 30, 2016 – September 29, 2017



Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board



REPORT PREPARED BY:

Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board, Inc.
5015 Prospect Ave NE
Albuquerque, NM 87110

Kevin English, DrPH - Director
kenglish@aaihb.org
P: 505-764-0036 or (800) 658-6717

TABLE OF CONTENTS

PURPOSE	1
ABOUT DVPI	1
EVALUATION METHODS	3
SECTION 1: POPULATION SERVED	
DVPI Programs by IHS Administrative Area	5
DVPI Programs by Purpose Area	6
Target Population	7
SECTION 2: SERVICE TYPES	
Type(s) of Services Provided	9
Evidence-Based Practices	13
Practice-Based Practices	14
Holistic Approaches to Service	15
SECTION 3: PROGRAM OPERATIONS	
Partnerships	18
Staffing	19
SECTION 4: ACCOMPLISHMENTS & BARRIERS	
Program Accomplishments	22
Program Barriers	25
APPENDIX – PROGRAMS REPORTING	28



PURPOSE

The purpose of this report is to provide findings from the national program 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, 2016 through September 29, 2017. Findings are aggregated from DVPI Programs 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, IHS federal facilities, 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

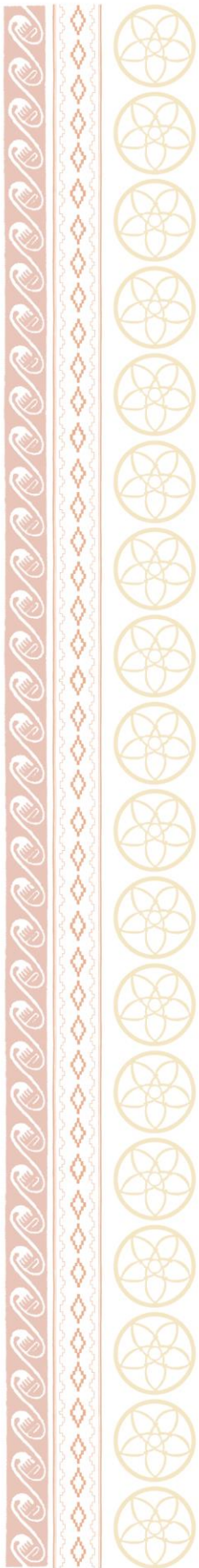
DVPI Purpose Area 1 awardees focus upon domestic and sexual violence prevention, advocacy, and coordinated community responses. Funded projects address the following eight broad objectives:

- 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;

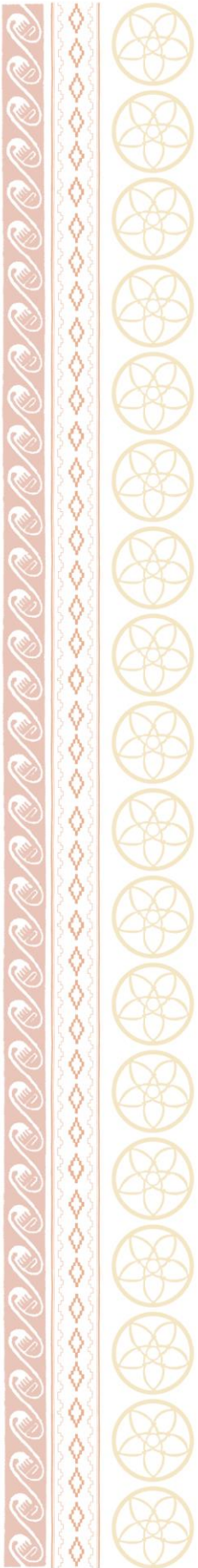
- 
- Improve health system organizational practices to improve medical forensic services and care coordination among victim services;
 - Establish local health system policies for sexual assault, domestic violence, and child maltreatment;
 - Integrate culturally appropriate treatment services throughout 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 program 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 2 period from September 30, 2016 to September 29, 2017. 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 were 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.

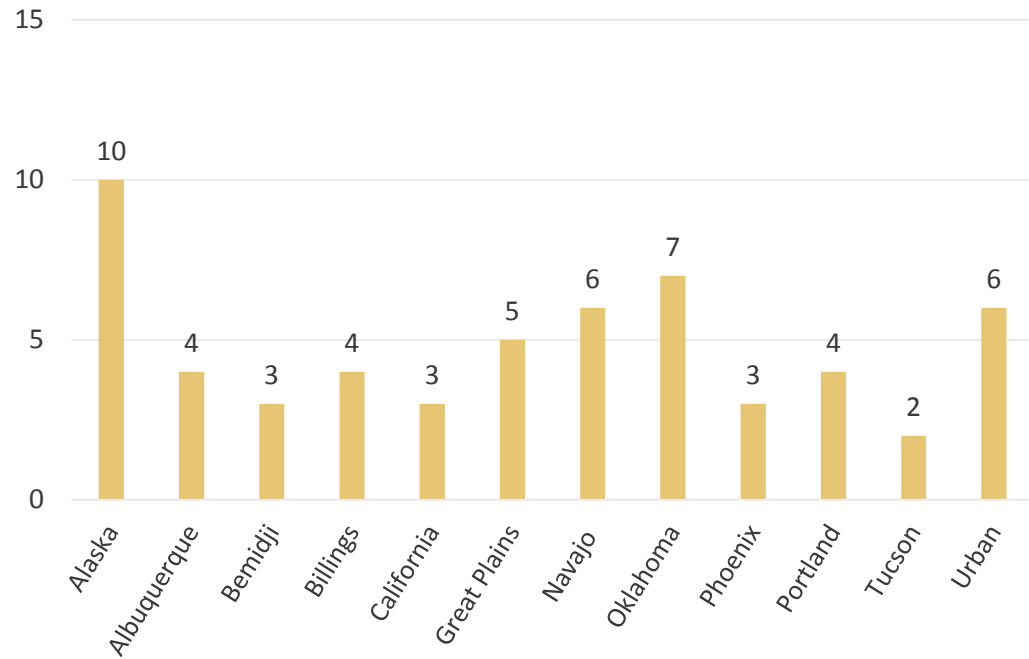


SECTION 1: POPULATION SERVED

POPULATION SERVED

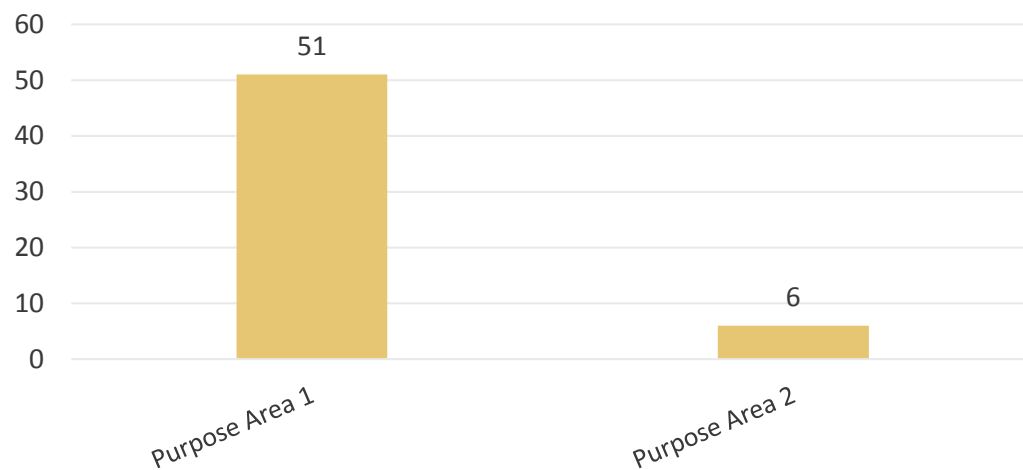
DVPI PROGRAMS BY AREA

Figure 1: Number of DVPI Programs by Indian Health Service (IHS) Administrative Area, 2016-2017



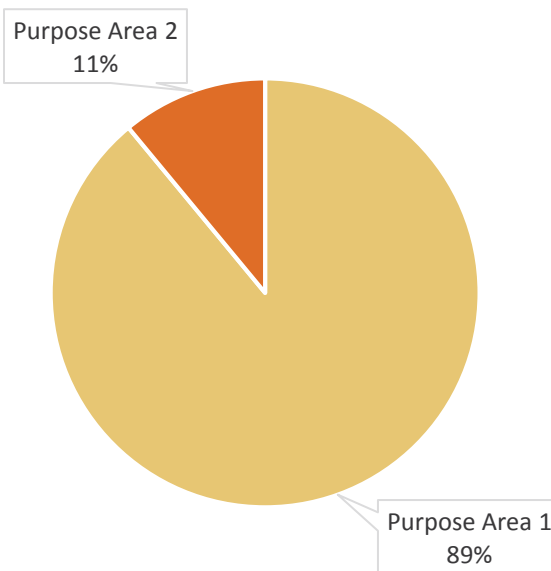
PURPOSE AREA

Figure 2: Number of DVPI Programs by Purpose Area, 2016-2017



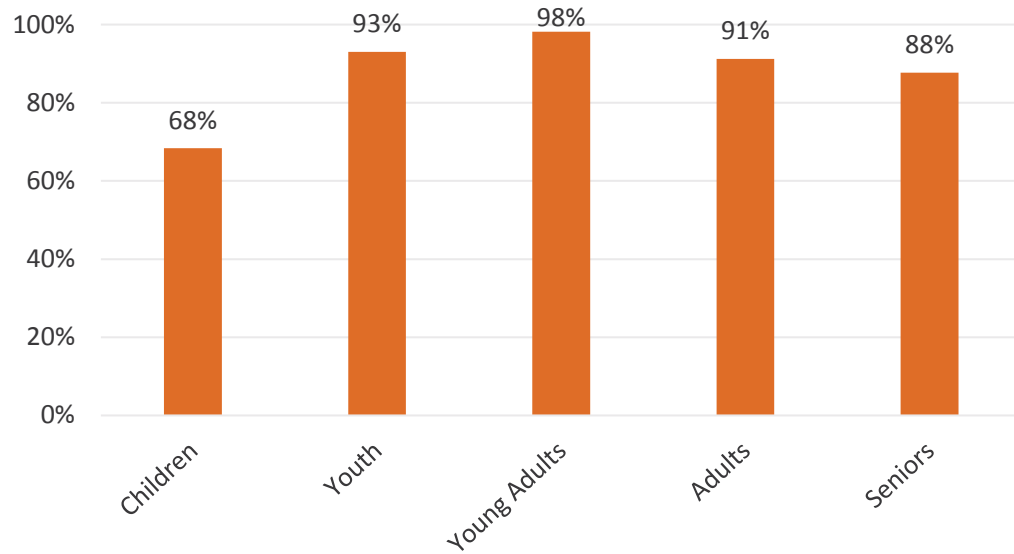
- Purpose Area 1: Domestic and Sexual Violence Prevention, Advocacy, and Coordinated Community Responses
- Purpose Area 2: Provide Forensic Healthcare Services

Figure 3: Percentage of DVPI Program by Purpose Area, 2016-2017



TARGET POPULATION

Figure 4. Target Population Served by DVPI Programs, 2016-2017*

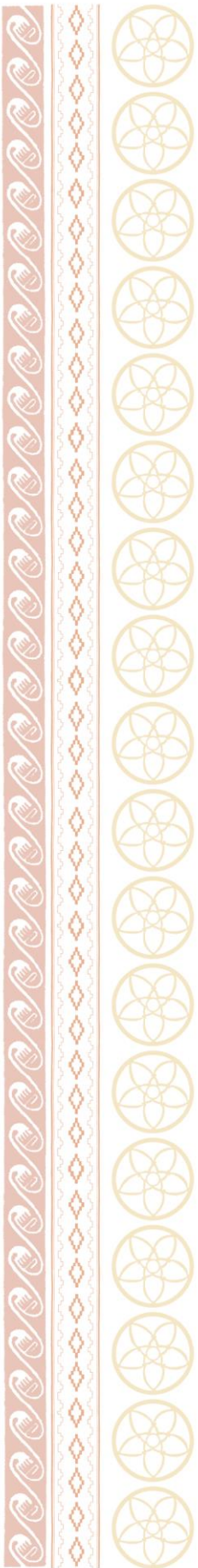


**Programs were able to select multiple target populations.*

As evidenced in [figure 4](#), DVPI programs serve a wide ranging age group within their respective communities.

TARGET POPULATION DEFINITIONS

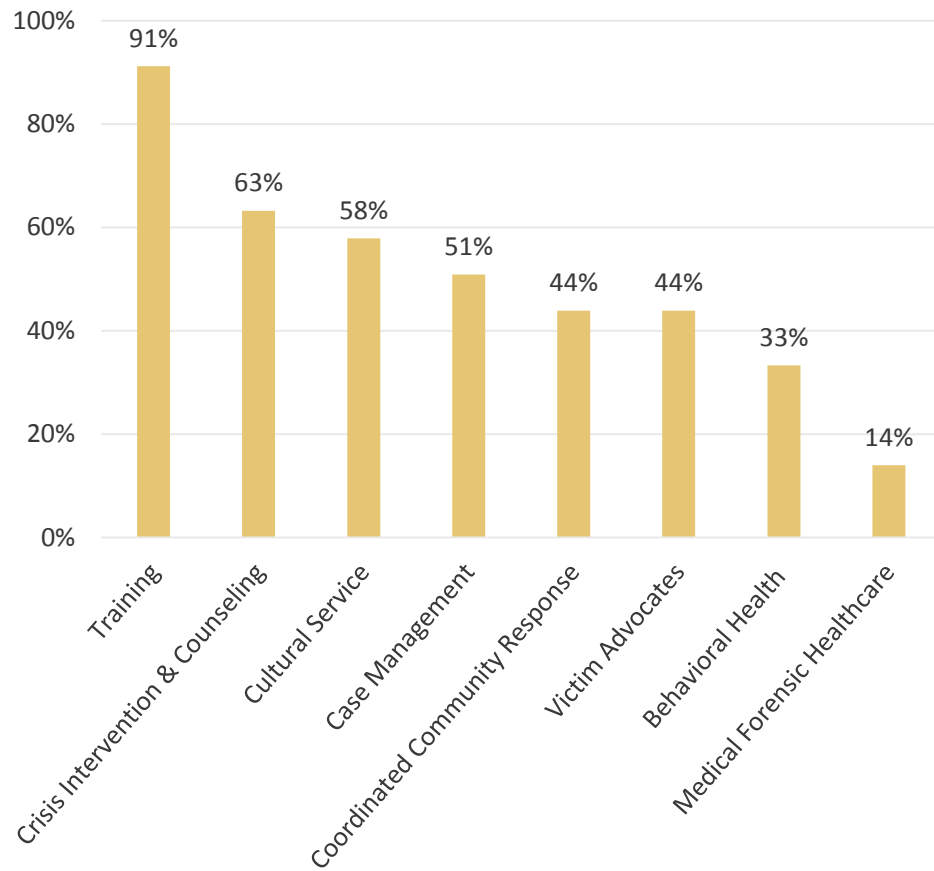
- Children (up to age 11)
- Youth (age 12-17)
- Young Adults (age 18-24)
- Adults (age 25-54)
- Seniors (age 55+)



SECTION 2: SERVICE TYPES

SERVICE TYPES

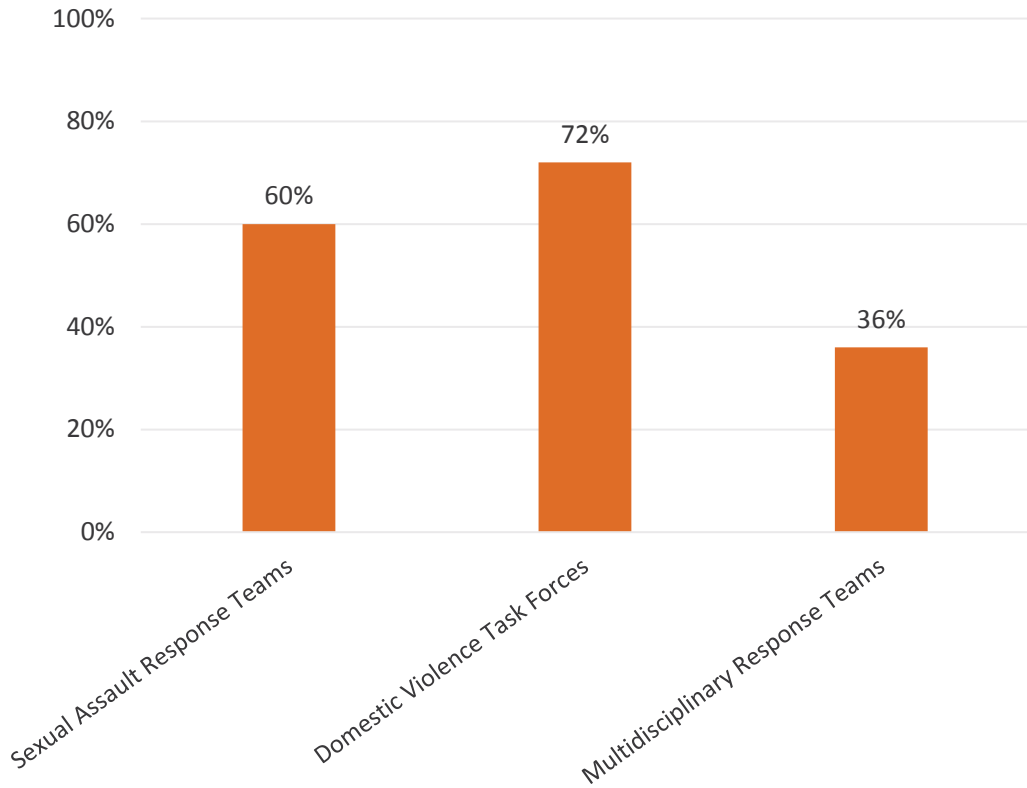
Figure 5. Type(s) of Services Provided by DVPI Programs, 2016-2017*



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

As evidenced in [figure 5](#), the most common service types offered by DVPI programs were training (91%), followed by crisis intervention/counseling (63%) and cultural service (58%).

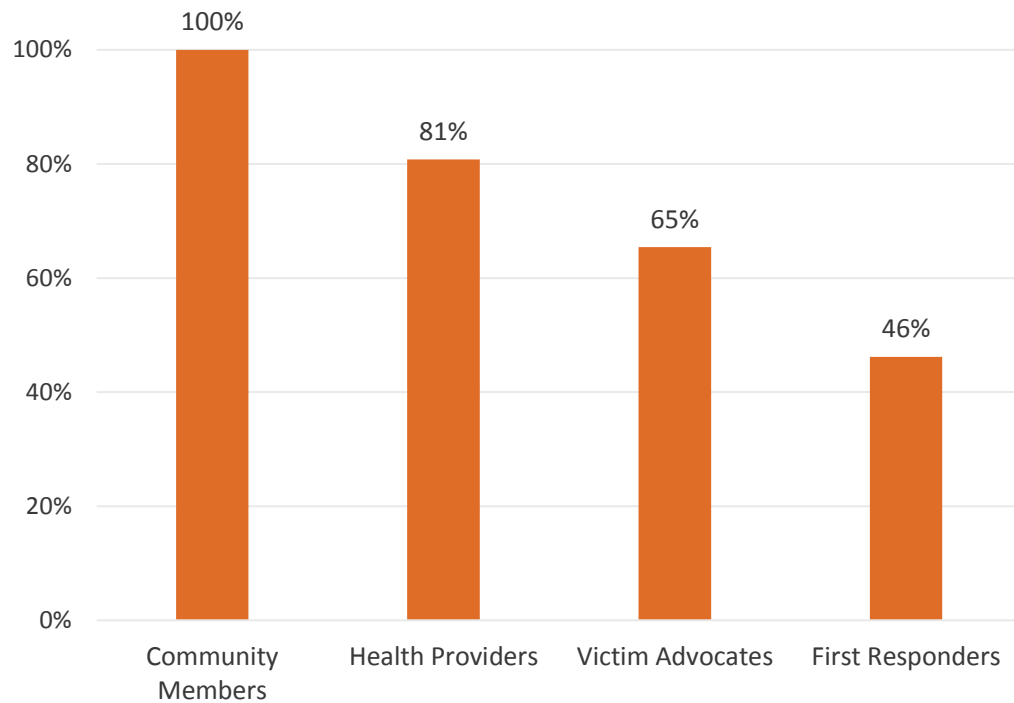
Figure 6. Type of Coordinated Community Response among DVPI Programs Reporting this Type of Service Delivery, 2016-2017*



**Programs 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 programs reporting this type of service delivery (n=25) was domestic violence task forces (72%) followed by sexual assault response teams (60%).

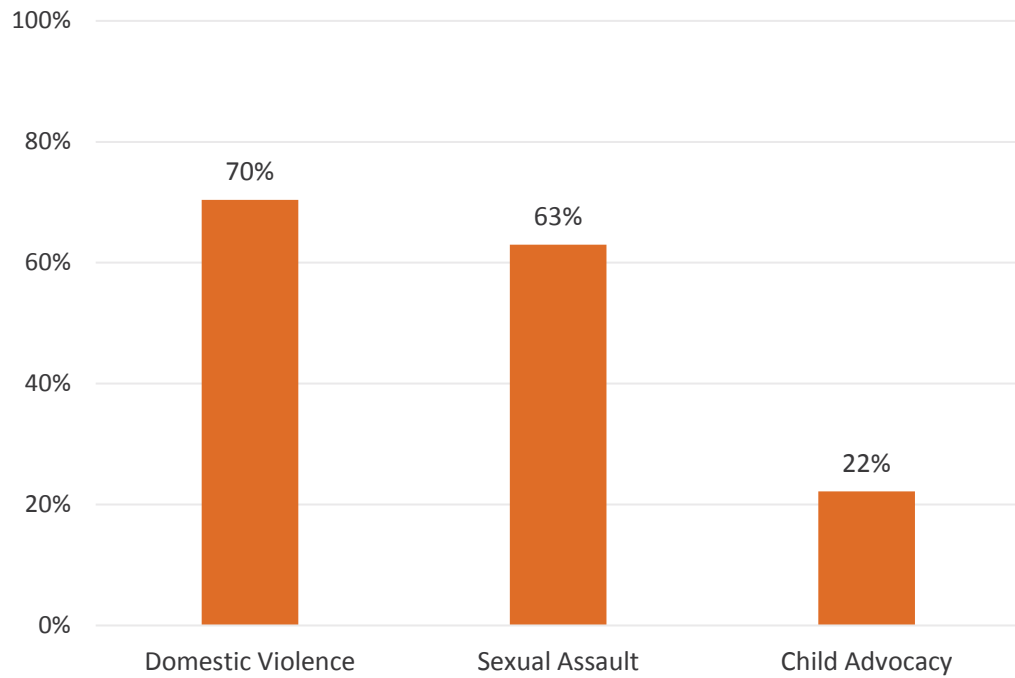
Figure 7. Target Population for Trainings Delivered by DVPI Programs, 2016-2017*



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

As evidenced in [figure 7](#), the most common target population for DVPI programs providing trainings (n=52) was community members (100%) followed by health providers (81%).

Figure 8. Areas of Focus among DVPI Program Victim Advocates, 2016-2017*

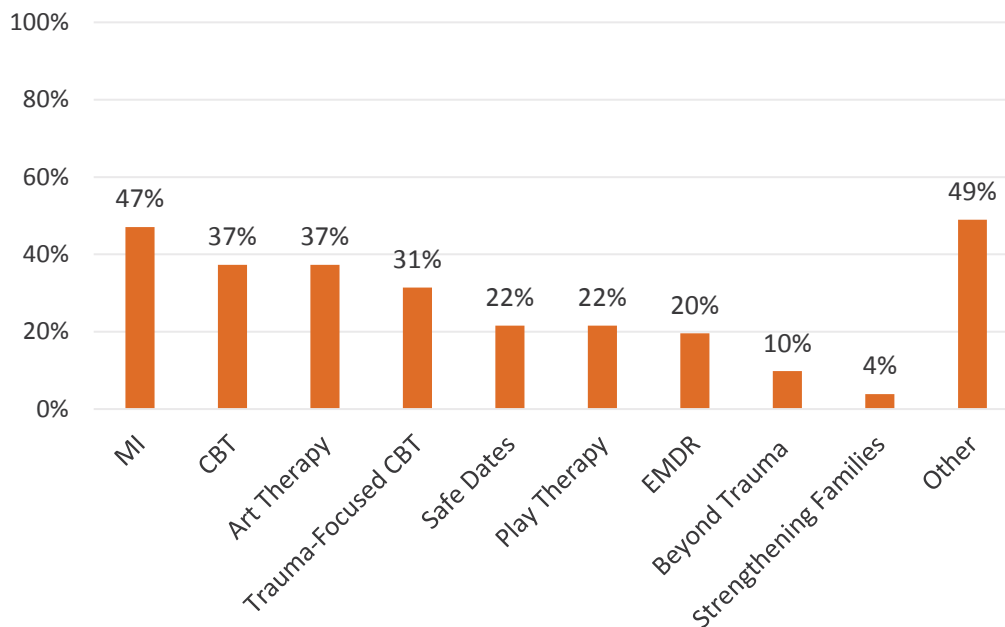


*Programs were able to select multiple types.

As evidenced in [figure 8](#), victim advocates supported by DVPI programs primarily focused on domestic violence (70%) and sexual assault (63%) victims.

EVIDENCE-BASED PRACTICES

Figure 9. Type of Evidence-Based Practices Utilized by DVPI Programs, 2016-2017*



*Programs were able to select multiple types.

As demonstrated in [figure 9](#), the most common Evidence-Based Practices utilized among DVPI programs were Motivational Interviewing (47%), Cognitive Behavioral Therapy (37%), and Art Therapy (37%).

“Other” evidence-based practices reported included: American Indian Living Skills; Brain Change Curriculum; Break the Cycle; Clothesline Project; Cognitive Processing Therapy (CPT); Expect Respect; experiential therapy; Family Spirit Home Visiting; Fatherhood/Motherhood is Sacred; Futures without Violence; Healing the Trauma of Domestic Violence; Healthy Relationships Curriculum; In Her Shoes Kit; John Hopkins University Respecting the Circle of Life; KANA's Behavioral Health Department; Kid's Club; Mental Health First Aid; Moral Reconciliation Therapy; National Indigenous Women's Resource Center Criminal Justice Institute; Native Life Skills Curriculum; OLWEUS (Bullying Prevention); Partners in Parenting; Positive Indian Parenting; Pregnant Moms Empowerment Program; SAMHSA's Anger Management; Strengthening Relationships curriculum; The Duluth Model; The Self Esteem Workbook; and Traumatic Incident Reduction.

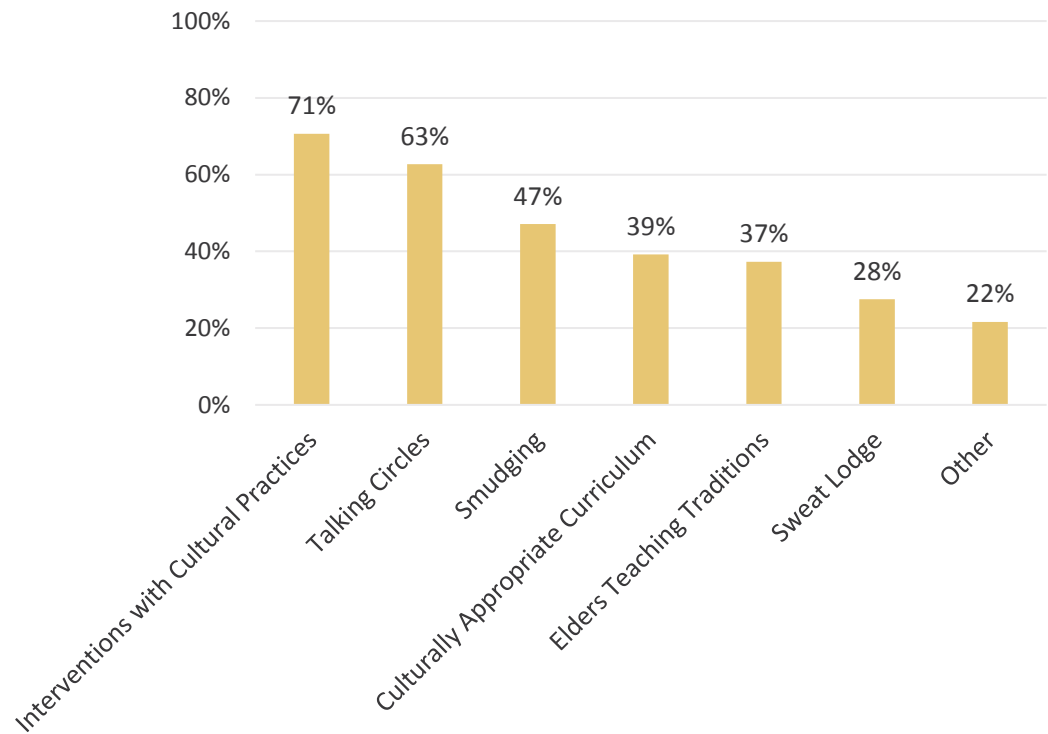
KEY:

CBT = Cognitive Behavioral Therapy

EMDR = Eye Movement Desensitization and Reprocessing

MI = Motivational Interviewing

Figure 10. Type of Practice-Based Practices Utilized among DVPI Programs, 2016-2017*



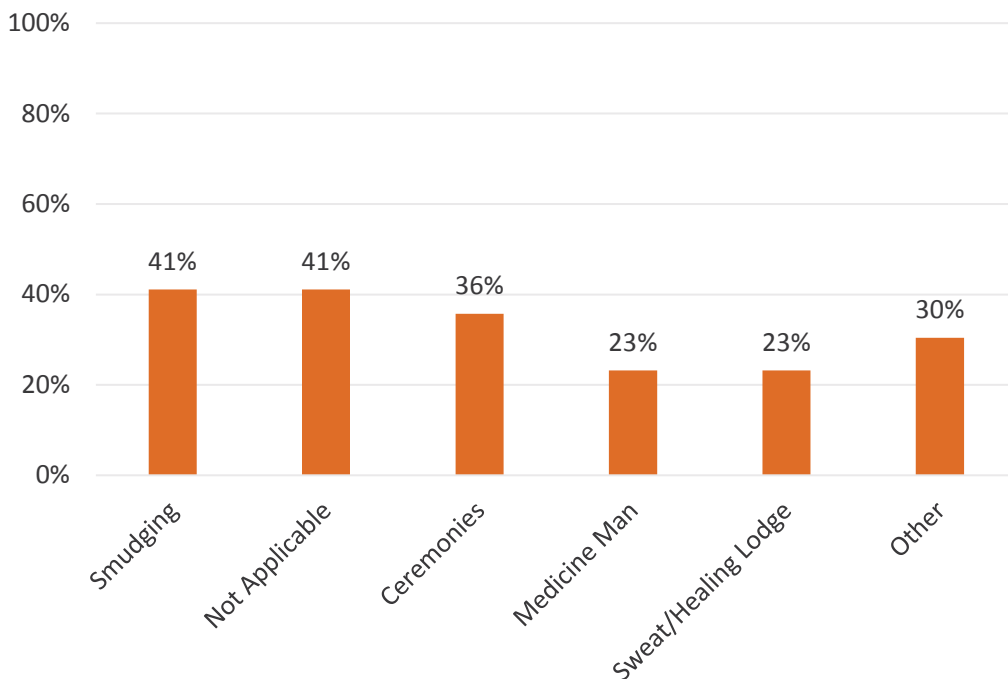
*Programs were able to select multiple types.

As demonstrated in [figure 10](#), the most common Practice-Based Practices utilized among DVPI programs were interventions that include cultural practices (i.e., beading, drumming, etc.) (71%), Talking Circles (63%), and smudging (47%).

“Other” practice-based practices reported by DVPI programs included: Adapted Native Wellness Institute Curriculum; Cultural Youth Camp; Faith-based Practices; Gathering of Native Americans; Native American Culture Practice/Intervention; Positive Indian Parenting; RezRIDERS Curriculum; Strengthening the Spirit Journal; Teen Dating Violence Prevention Curriculum; and Trauma Stewardship.

HOLISTIC APPROACHES TO SERVICES

Figure 11. Percentage of DVPI Programs Integrating Traditional Healing, by Practice Type, 2016-2017*



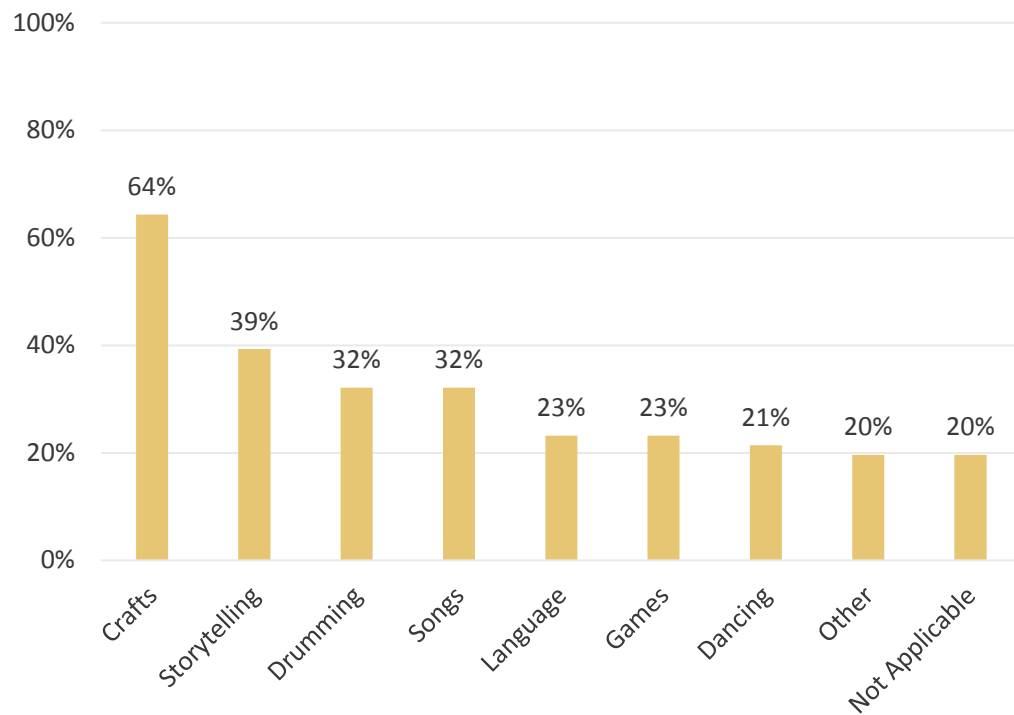
**Programs were able to select multiple types.*

Figure 11 demonstrates that the most common traditional healing related practices incorporated into DVPI activities included smudging (41%) and ceremonies (36%).

“Other” traditional healing practices included: Coming of Age; Cultural Crafting Groups; Cultural Praying Sites; Discussions with Community Elders; Equine Therapy; Mind Body Medicine; Talking Circles; Traditional Women's Teachings; and Women's Gatherings.

Overall, nearly two-thirds (63%, n=36/57) of DVPI programs reported integrating at least one of these traditional healing practices into their program services. Programs that did not use traditional healing practices selected "Not Applicable."

Figure 12. Cultural Practices Offered in DVPI Program Services, 2016-2017*

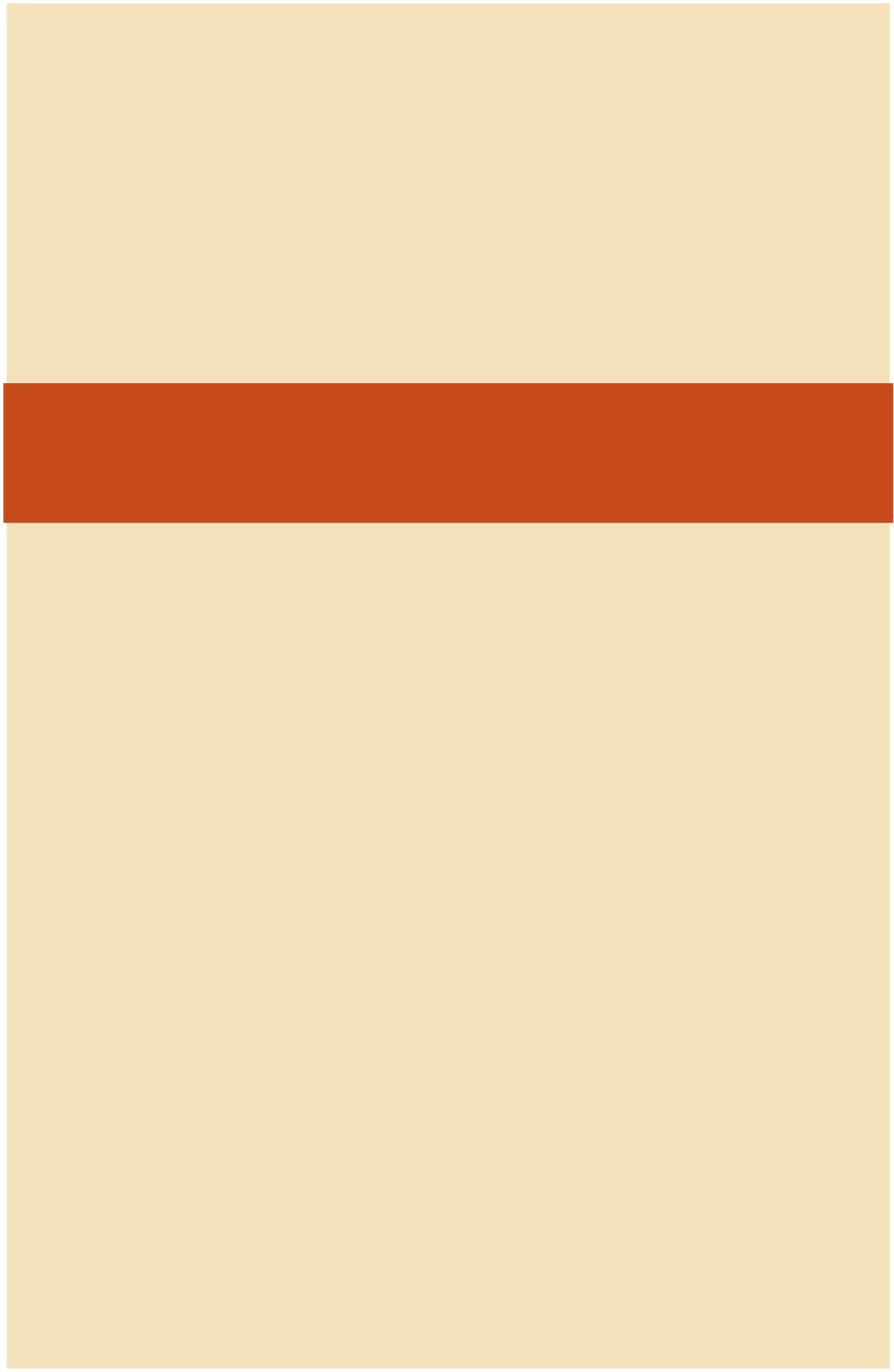
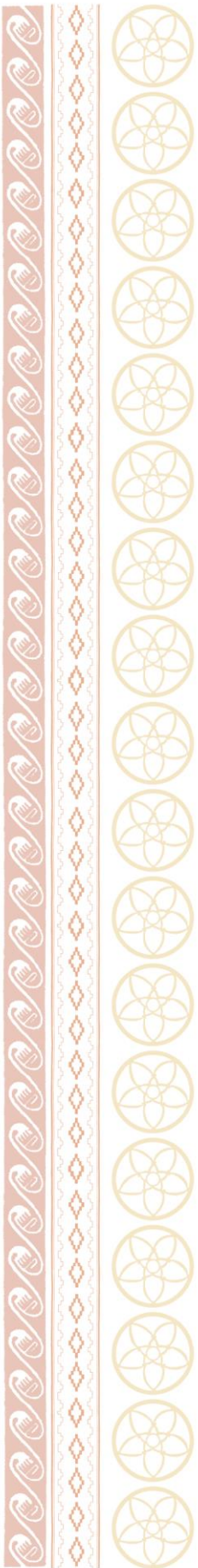


*Programs were able to select multiple types.

As evidenced in [figure 12](#), the most common cultural services included in DVPI programs were crafts (64%) and storytelling (39%).

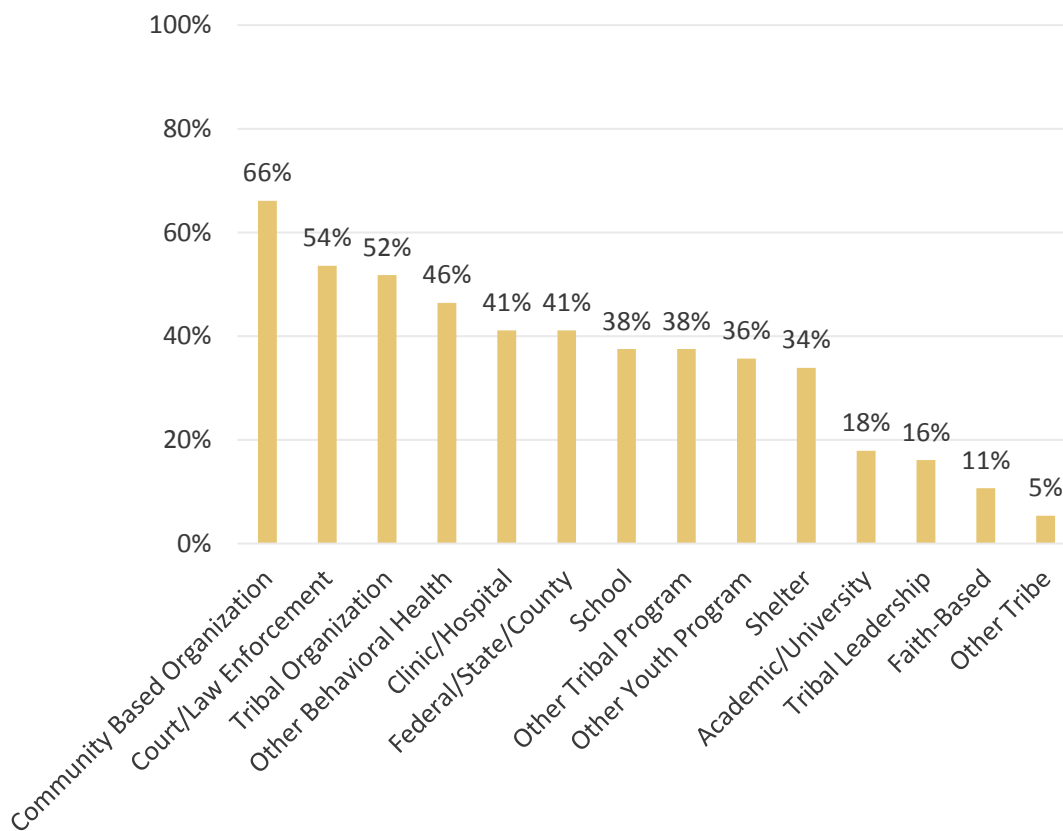
“Other” cultural practices cited included: Cultural Camps; Cultural Community Trauma-focused Programs; Cultural Mentorship; Home Visit; Mending Broken Hearts; Referral to Services (e.g., hospital chaplain, local cultural experts); Talking Circles; The Compass Program; Traditional Kayak Building; Traditional Prayers; and Women’s Teachings.

Overall, the majority of DVPI programs reported integrating at least one of these cultural practices into their program services (79%, n=45/57).



PARTNERSHIPS

Figure 13. Most Common Types of Partners Enlisted among DVPI Programs 2016-2017*



*Programs were able to select multiple partner types.

Table 1. Number of Partners and Memorandum of Agreements (MOAs) Reported among DVPI Programs, 2016-2017

	N
Total Partners (All Programs)	491
Average per program	8.8
Range	1 – 39
Total Memorandum of Agreements (MOAs)	99

STAFFING

Figure 14. Percentage of DVPI Programs that Experienced Staff Turnover, 2016-2017

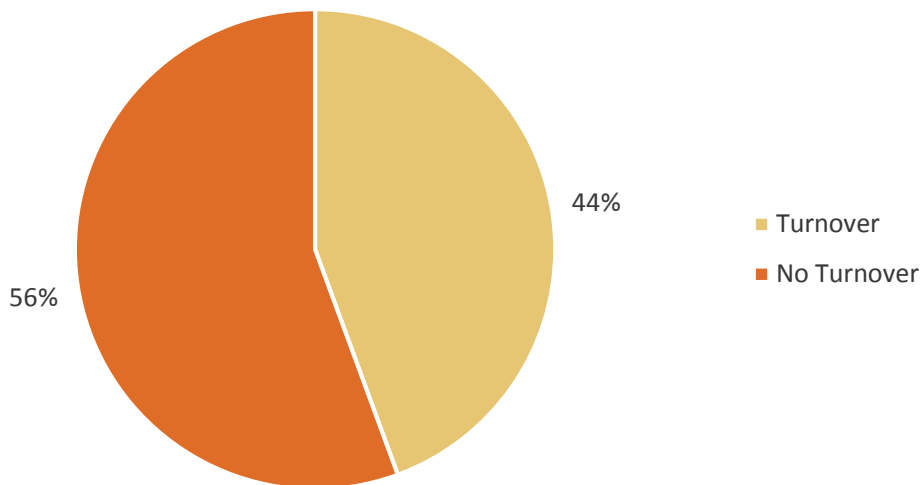


Figure 15. Percentage of DVPI Programs that Have Been Able to Recruit, Hire, and Onboard Staff, 2016-2017

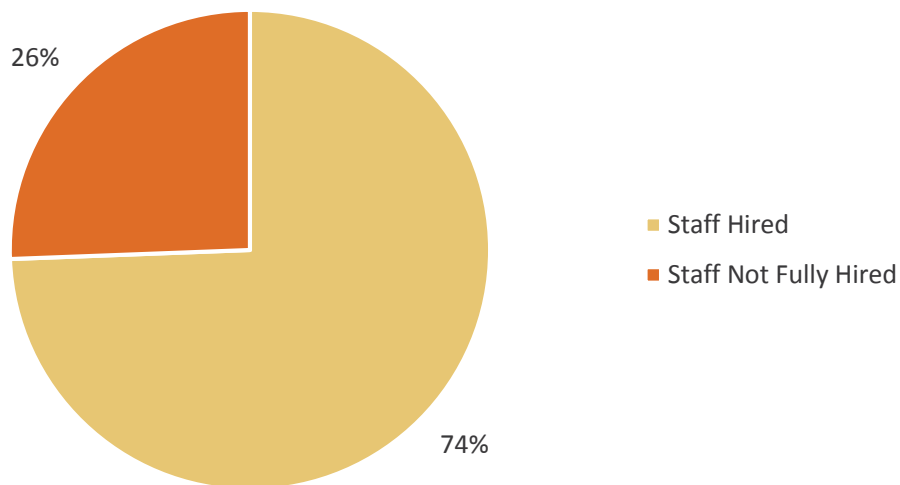
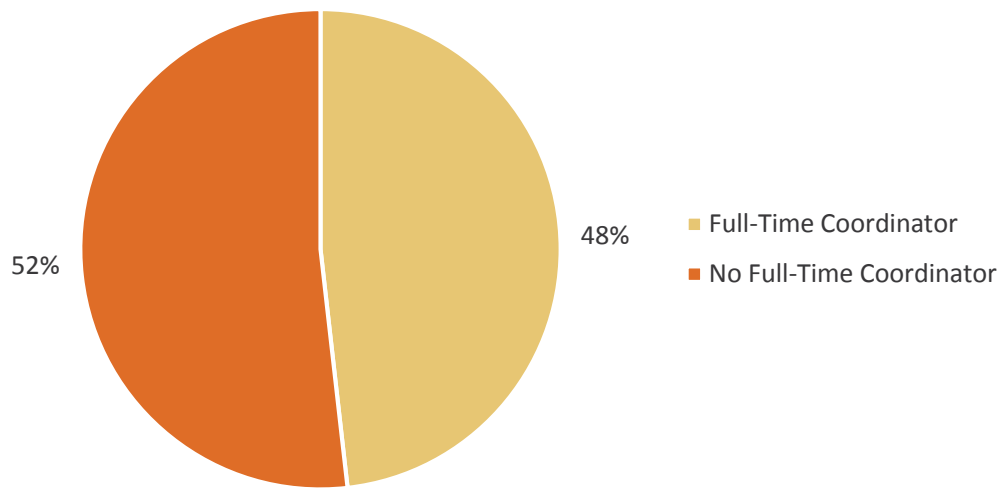
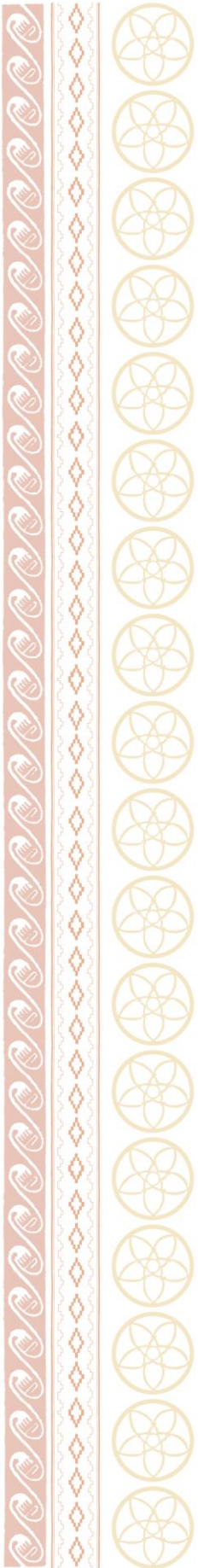


Figure 16. Percentage of DVPI Programs with a Full-Time Program Coordinator, 2016-2017



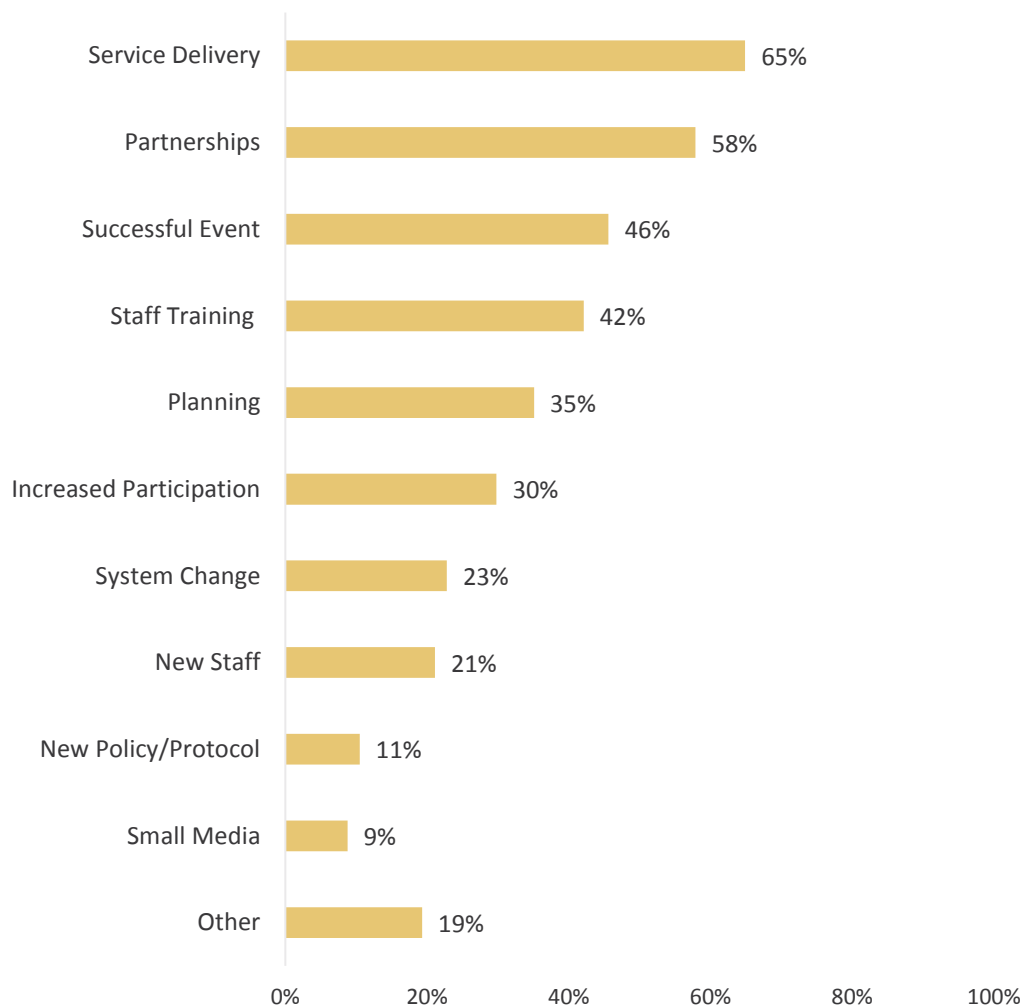


SECTION 4: PROGRAM ACCOMPLISHMENTS & BARRIERS

PROGRAM ACCOMPLISHMENTS AND BARRIERS

PROGRAM ACCOMPLISHMENTS

Figure 17. Types of Program Accomplishments Reported by DVPI programs, 2016-2017



As evidenced in [Figure 17](#), the most commonly reported DVPI program accomplishments in project year 2 included service delivery (65%), establishing one or more new partnerships (58%), implementing successful community events (46%), and completion of staff training (42%). Definitions and examples for each success category are provided on the following pages of this report.

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

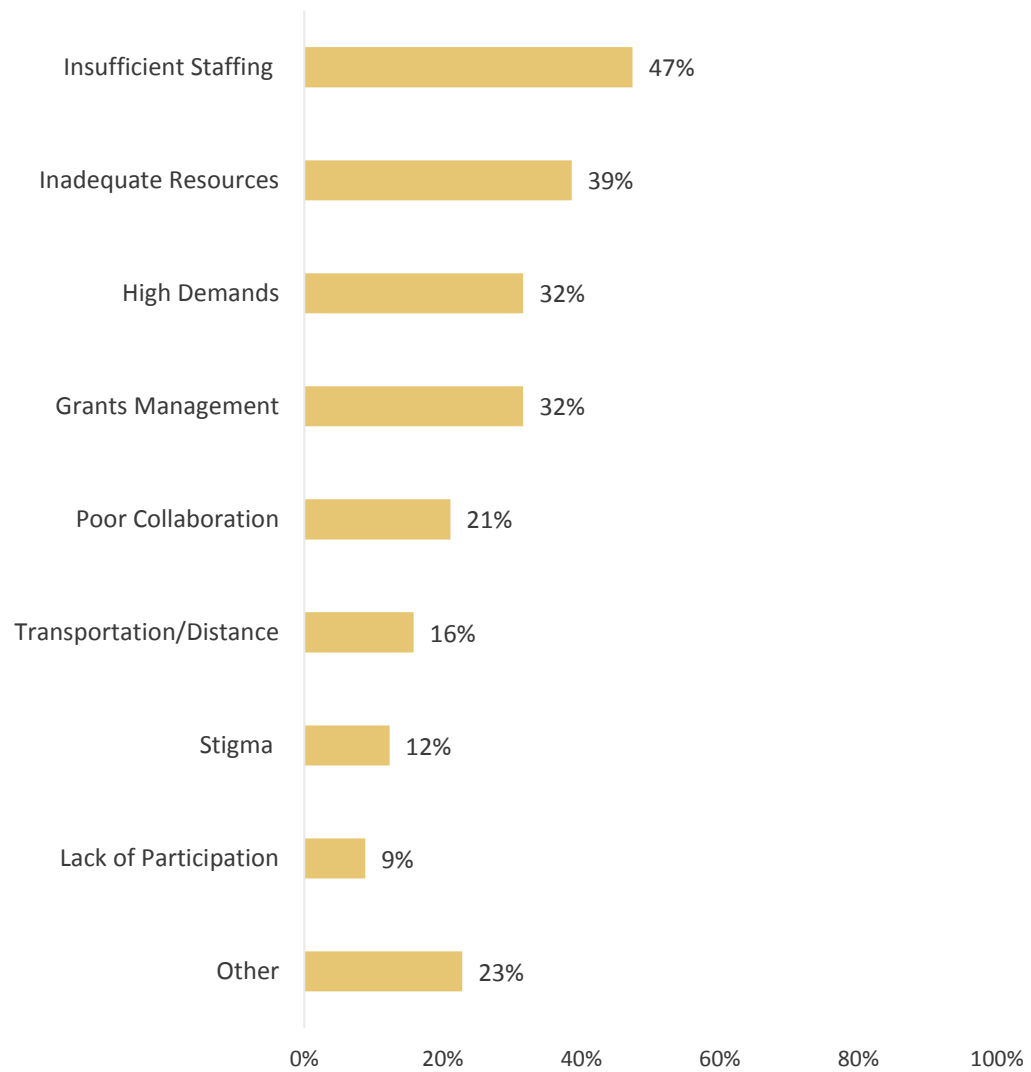
Table 2: DVPI Program Accomplishment Definitions

ACCOMPLISHMENT	DEFINITION
NEW PARTNERSHIPS	Program 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	Program has listed at least one community event sponsored by the DVPI program 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	Program has identified the access to and 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	Program 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 program 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	Program has noted an increase in community participation in DVPI sponsored activities and/or an increase in referrals to its services.
NEW STAFF	Program has identified at least one new staff person (part-time, full-time or contractual) joining its DVPI program during the reporting period.
SMALL MEDIA	Program has implemented a small media-related activity during the reporting period. Examples include: billboards, public service announcements (PSAs), brochures, newsletters, handouts, digital stories, and social media (e.g. Facebook).
NEW POLICY or PROTOCOL	Program 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	Program 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 programs during the reporting period. These included: program recognition, community awareness, successful programming, enhanced collaboration, grants management, and new office space.

PROGRAM BARRIERS

Figure 18. Types of Program Barriers Reported among DVPI programs, 2016-2017

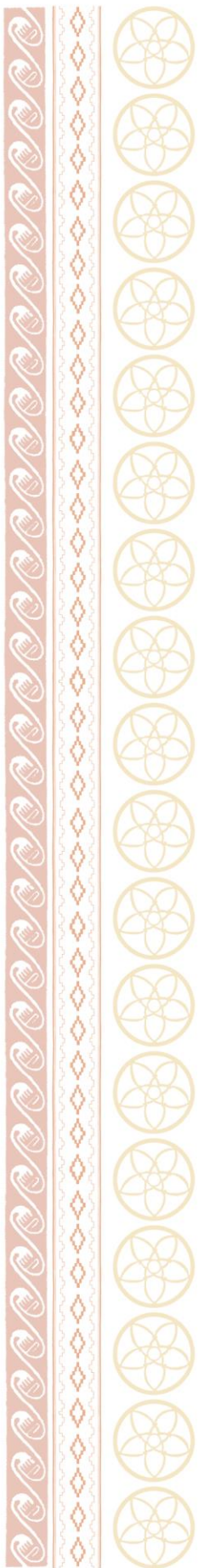


As evidenced in [Figure 18](#), the most commonly reported DVPI program barriers included insufficient staffing (47%) and inadequate resources (39%). Definitions and examples for each barrier category are provided on the following pages of this report.

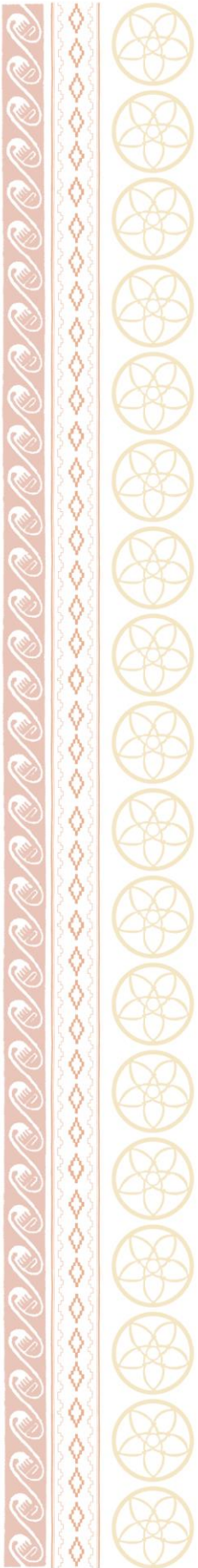
Note: This data were gathered through program narratives. There were no limits on the number or type of barriers that each program could report.

Table 3: DVPI Program Barrier Definitions

BARRIER	DEFINITION
INSUFFICIENT STAFFING	Program identified a lack of staff within its DVPI program 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	Program cited a lack of funding or poor local 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	Program 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	Program cited insufficient community participation in program services and/or activities as a significant challenge.
HIGH DEMANDS	Program 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	Program identified rurality, insufficient transportation, large geographic service areas, and/or excessive travel times as major challenges to the delivery of program services and patient access to these services.
GRANTS MANAGEMENT	Program 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.



<p>STIGMA</p>	<p>Program cited the ongoing stigmatization of domestic violence and/or sexual abuse issues among community members as a program barrier. In some instances, programs noted that stigma also limits open discussion about these topics in community settings.</p>
<p>OTHER</p>	<p>The other category included unique barriers reported by two or fewer DVPI programs during the reporting period. These included: participant mistrust of authorities, internal and/or external policy issues, difficulties inherent to the target population, lack of available meeting spaces, and the danger of homelessness.</p>

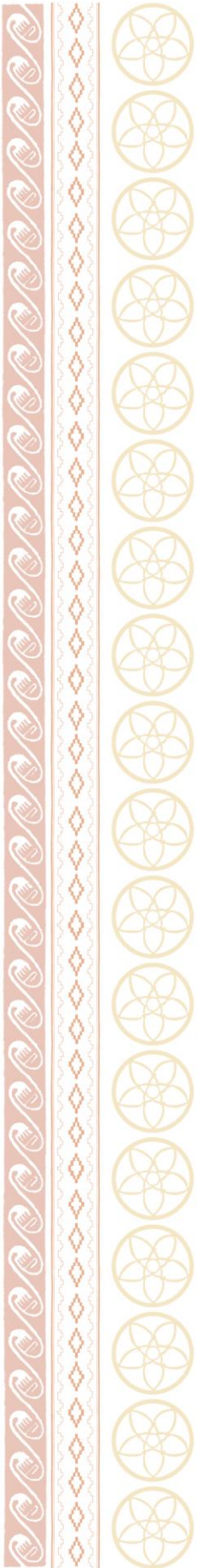


APPENDIX: PROGRAMS REPORTING

DVPI PROGRAMS REPORTING 2016-2017

Purpose Area 1

Alaska Native Tribal Health Consortium
 Aleutian Pribilof Islands Association, Inc.
 American Indian Health Service of Chicago, Inc.
 Blackfeet Tribal Health
 Bristol Bay Area Health Corporation
 Burns Paiute Tribe
 Cherokee Nation
 Chinle Comprehensive Health Care Facility
 Chippewa Cree Tribe
 Choctaw Nation - Project Homakbi Ribbon
 Chugachmiut
 Citizen Potawatomi Nation
 Confederated Salish and Kootenai Tribes
 Copper River Native Association
 Crow Tribe
 Eight Northern Pueblos Council, Inc.
 First Nations Community Health Source
 Fort Thompson Service Unit
 Gallup Indian Medical Center
 Hualapai Indian Tribe
 Indian Health Care Resource Center-Tulsa
 Indian Heath Council, Inc.
 Kodiak Area Native Association
 Leech Lake Band of Ojibwe
 Lower Elwha Klallam Tribe
 Minnesota Indian Women's Resource Center
 Native American Community Health Center, Inc.
 Native American Health Center, Inc.
 Oklahoma City Indian Clinic
 Pascua Yaqui Tribe
 Pinon Health Center
 Pokagon Band of Potawatomi Indians
 Ponca Tribe of Nebraska
 Quileute Tribal Council
 Ramah Navajo School Board, Inc.
 Rosebud Sioux Tribe
 Santa Clara Pueblo
 Shiprock-Northern Navajo Medical Center



South Dakota Urban Indian Health, Inc.
Southcentral Foundation
SouthEast Alaska Regional Health Consortium
Southern Indian Health Council, Inc.
The Healing Lodge of the Seven Nations
Tohono O'odham Nation
Tuba City Regional Health Care Corporation
Turtle Mountain Band of Chippewa Indians
United Indian Health Services, Inc.
Ute Indian Tribe
Ute Mountain Ute Tribe
Washoe Tribe of Nevada and California
Wiconi Wawokiya, Inc.

Purpose Area 2

Cass Lake Hospital
Chickasaw Nation
Chinle Comprehensive Health Care Facility
Choctaw Nation - Project Strong
Maniilaq Association
Norton Sound Health Consortium



Albuquerque Area Southwest Tribal Epidemiology Center
Albuquerque Area Indian Health Board