Statement of

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Introduction

Chairman Gallego, Ranking Member Cook, and esteemed members of the House Subcommittee for Indigenous Peoples of the United States, it is my honor to testify before you on behalf of the Department of Health and Human Services (HHS) concerning the crisis of missing and murdered Indigenous women (MMIW) and girls. My name is Jeannie Hovland and I serve as the Commissioner of the Administration for Native Americans (ANA) within the Administration for Children and Families (ACF). I am a proud member of the Flandreau Santee Sioux Tribe located in South Dakota. Before my appointment, I served as Senior Advisor to the Assistant Secretary for Indian Affairs at the Department of the Interior (DOI) and, prior to joining the Administration, I worked for nearly thirteen years on Native American issues for Senator John Thune of South Dakota.

Our approach to addressing MMIW issues has been to engage with our stakeholders, partner with our sister agencies, and promote available resources while creating new opportunities to meet identified gaps. Since my confirmation, I have worked to improve collaboration within HHS and across the federal interagency with respect to issues concerning Native communities. In particular, I re-established and chair the Intradepartmental Council on Native American Affairs (ICNAA). This council, initially established under the Native Americans Programs Act, was designed to enhance collaboration across the HHS operating divisions when addressing policy and budget issues that affect Native Americans. The ICNAA has met three times and two of our focus areas include human trafficking and MMIW. Opioids and substance use disorders have had a grave impact on our nation, including Native communities, and represents another area of focus for the ICNAA.

Background

According to the Centers for Disease Control and Prevention (CDC), homicide is the third leading cause of death among American Indian and Alaska Native (AI/AN) women between 10 and 24 years of age, and the fifth leading cause of death for AI/AN women between 25 and 34 years of age.[1] Data from U.S. crime reports indicate that nearly half of female homicide victims in the U.S. are killed by a current or former male intimate partner.[2] According to the National Institute of Justice (NIJ), more than four in five AI/AN women, or about 84 percent, have experienced violence in their lifetime.[3] These statistics are staggering and expose the deep impact violence has in the lives of Native women, families, and communities.

I recently participated in the Department of Justice (DOJ), Office of Violence Against Women tribal consultation where a tribal leader stated that often the first responders to a domestic violence scene are the children in the home. We know from research that children who witness domestic violence suffer long-term consequences including changes to their mental and physical development, possibly resulting in worse health outcomes, learning disorders, and continuation

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1 Leading Causes of Death (LCOD) by Age Group, American Indian/Alaska Native Females-United States, 2013 and 2014. Numbers for 2015 vary slightly for these age bands but remain one of the leading causes of death for these ages. Accessed at: **https://www.cdc.gov/women/lcod/index.htm**

[2] Cooper, A., & Smith, E. L. (2011). Homicide trends in the United States, 1980–2008. Washington, D.C.: Bureau of Justice Statistics. NCJ 236018.
Petrosky, E., Blair, J. M., Betz, C. J., Fowler, K. A., Jack, S., & Lyons, B. H. (2017). Racial and Ethnic Differences in Homicides of Adult Women and the Role of Intimate Partner Violence - United States, 2003-2014. MMWR. Morbidity and mortality weekly report, 66(28), 741-746. doi:10.15585/mmwr.mm6628a1

[3]National Institute of Justice. Five Things About Violence Against American Indian and Alaska Native Women and Men. https://nij.ojp.gov/topics/articles/five-things-about-violence-against-american-indian-and-alaska-native-women-and-men

of a cycle of violence over generations.[4] Further, the long-term effects of adverse childhood events is that they create emotional scars that are reopened when people are exposed to traumas in adulthood leading to adult post-traumatic stress disorder.

Recently, I attended HHS Regional Consultations across the nation asking what HHS can do to address human trafficking and MMIW, and have continually heard that tribes do not want just more studies on this issue but also want action. In July, President Bordeaux of the Rosebud Sioux Tribe located in South Dakota issued a statement to his community that reads in part:

> *"We have had a number of tragic deaths in the past ten days. They were almost exclusively children. I know that we all grieve with the families and extend our condolences and prayers for comfort for the families impacted by these tragedies. No parent should have to bury their children.*
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> *It has become obvious that it is a dangerous time for our people. It is especially true of our young people and our young adults, who face many safety threats that were unheard of even fifteen or twenty years ago. We now find ourselves in a situation where we need to be more vigilant about protecting the up and coming generation. There are simply too many threats to their safety. Indian Country's struggles with alcohol, meth and opioids are well documented."*

[4] Child-Witnessed Domestic Violence and its Adverse Effects on Brain Development: A Call for Societal Self-Examination and Awareness, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193214/
Domestic Violence and the Child Welfare System. https://www.childwelfare.gov/pubPDFs/domestic-violence.pdf

Unfortunately what is happening in Rosebud is happening in many other tribal communities as well. This is why a multiagency approach is vital to making any kind of impact on these issues all of which are tied together.

On July 18, 2019, to ensure that Native Americans living in urban settings are included in strategies to address trafficking and MMIW, I co-hosted a virtual conference with urban Indian organizations and the National Council of Urban Indian Health to discuss MMIW. Twelve urban Indian organizations participated, as well as the DOJ, the Department of Housing and Urban Development, and my HHS colleagues from the Indian Health Service (IHS). Not surprisingly, what we heard from the urban Indian organizations is that the resources and collaborations needed to address these issues include prevention programs, housing, data, and technical assistance and capacity building to form strong partnerships locally to address the multiple service needs of their most vulnerable clients.

Primary Prevention

I am happy to share that HHS is leading efforts on primary prevention, intervention, recovery, and healing. Our efforts include a whole family approach that connects families to services that support the physical, mental, and spiritual health and wellbeing of individuals and families. Within ACF, programs such as the Tribal Maternal, Infant and Early Childhood Home Visiting (MIECHV), Head Start, Runaway and Homeless Youth, Family Violence Prevention and Services, and Healthy Marriage and Responsible Fatherhood are incorporating new practices to respond to trauma and domestic violence, raising awareness of the issue, and working to heal victims and their families.

For example, the Tribal MIECHV program supports the development of happy, healthy, and successful AI/AN children and families through a coordinated home visiting strategy that addresses critical maternal and child health, development, early learning, family support, and child abuse and neglect prevention needs. Tribal MIECHV conducted 72,326 home visits between 2012 and 2017 and in 2017, the program served 3,453 parents and children. In Maricopa County, Arizona, Native Health, one of our Tribal MIECHV grantees, is working to enable urban AI/AN enrolled in the program to experience increased safety through prevention of child abuse and neglect and domestic violence. This comprehensive services program provides the full range of physical and mental health medical services to participants including misdemeanor domestic violence offender treatment services.

The importance of mental health services in these communities that bear the weight of historic and contemporary trauma cannot be understated. Programs with a trauma-informed approach can help to establish competent, compassionate, and culturally appropriate responses. The Tribal Behavioral Health Agenda was created by the Substance Abuse and Mental Health Services Administration (SAMHSA) at the request of tribal leaders and examines the impact of trauma on current mental health outcomes. In partnership with Futures Without Violence, the Head Start program has developed trainings for grantees on trauma informed care, how to recognize and respond to disclosures about domestic violence, and how to partner with community domestic violence programs to address the issue.

I have heard from tribal leaders, service providers, and others about the importance of engaging with tribal community members to lead efforts in developing and implementing solutions. As President Bordeaux stated, it is a dangerous time for our youth. Towards this end, I am working to connect the tribal youth directly with federal leaders—to hear about their ideas and concerns and to empower them to become change agents in their communities. I strongly believe that youth need to be at the table when addressing these important issues. In July, I hosted the first-ever ICNAA Native Youth Town Hall in Albuquerque, New Mexico. At this town hall, leadership from SAMHSA, CDC, IHS, the ACF Office on Trafficking in Persons (OTIP), and I heard from over 100 Native youth from across the United States, including Guam, Saipan, and American Samoa. We provided these youth a number of resources, including our Native Youth Toolkit on Human Trafficking. Shortly after the town hall, I received an email from youth leaders asking if they could meet regularly with HHS leadership and work with us to address mental health and wellness issues including physical activity, nutrition, substance abuse, human trafficking, and MMIW. We held our first follow up call a few weeks ago.

Promoting and Developing Resources

HHS has created and funded resources that Native communities can access to serve populations vulnerable to human trafficking and MMIW. These populations include foster children; runaway and homeless youth; victims of domestic violence and children who witness it; homeless adults; lesbian, gay, bisexual, and transgender individuals; individuals with mental disabilities; and those struggling with substance abuse or addiction.

ACF's Family Violence Prevention and Services Act (FVPSA) formula grant is non-competitive and is mandated to allocate 10 percent of its appropriation to tribes and tribal organizations in an effort to increase public awareness and support services for victims of family, domestic, or dating violence. This funding is typically used to pay for domestic violence prevention advocates who can assist victims with creating a safety plan as well as crisis intervention, such as an emergency shelter. FVPSA also provides discretionary funds for several resources specific to tribes, such as the StrongHearts Native Helpline, the National Indigenous Women's Resource Center (NIWRC), and the Alaska Native Women's Resource Center (AKNWRC).

The StrongHearts Native Helpline is a confidential and anonymous helpline for Native peoples affected by domestic and dating violence, as well as responds to calls from victims of human trafficking, as needed. StrongHearts is currently a collaborative project of The National Domestic Violence Hotline and NIWRC whose legal counsel, Mary Kathryn Nagle, testified before you on the MMIW issue this past March. In operation for just over two years, StrongHearts has experienced an increase in call volume since expanding its service hours, demonstrating that there is significant demand for culturally specific services.

The NIWRC serves as the National Indian Resource Center Addressing Domestic Violence focused on providing national leadership to end gender-based violence through educational resources, training and technical assistance, and policy to enhance the capacity of tribes and tribal organizations. They have also developed materials to bring awareness and resources to Native communities on the issue of MMIW including a toolkit that can be accessed online.

The AKNWRC serves Alaska's 229 federally recognized tribes, regional corporations, and tribal consortia as a statewide resource focused on strengthening local tribal responses to domestic and gender-based violence. They are also meeting on MMIW in their communities to discuss and develop a plan for further outreach about this crisis in the Alaska Native communities.

Recently on the matter of MMIW, the Family Violence Prevention and Services program collaborated with NIWRC, StrongHearts, and AKNWRC to raise the visibility of this issue and growing epidemic at its 2019 Tribal Grantee Meeting, held August 13-15, 2019 in Seattle, Washington. Speakers from the NIJ, in partnership with the University of North Texas Health Science Center, presented on NamUs, the National Missing and Unidentified Persons System. NamUs is a centralized database and resource center that assists law enforcement, medical professionals, and public users in resolving cases of missing, unidentified, and unclaimed persons. Also, a member of the Puyallup Tribe of Indians Community Domestic Violence Advocacy Program presented on this issue from the perspective of a surviving family member. Risk factors, data, challenges, and policy changes related to MMIW, as well as what can be done as community members and individuals, were shared with meeting attendees.

The National Runaway Safeline (NRS) is another HHS resource that has pledged increasing outreach to AI/AN communities. The NRS supports and serves youth in crisis, runaway youth, and youth experiencing homelessness and their families. The NRS provides services such as free bus tickets home, and a way to leave messages for family and loved ones, if the youth feel that they are not safe contacting them directly. They also offer prevention resources to help minimize

running away incidents among vulnerable youth, including resources tailored for Native American youth.

Frontline Providers

Health care providers are often the first line of defense in identifying cases of domestic violence, intimate partner violence, teen dating violence, and human trafficking. Ensuring these providers are adequately trained to identify and address these cases is an important step in intervention. Through training efforts such as the Stop, Observe, Ask, and Respond (SOAR) to Health and Wellness Program administered by OTIP, providers learn how to identify cases of human trafficking. They study clinical contexts using trauma informed and culturally appropriate approaches. Recognizing the importance of culture, ANA has partnered with OTIP to develop a SOAR curriculum for Native communities. This training examines historic factors that contribute to the trafficking of Native populations, identifies indicators, and describes what human trafficking looks like in Native communities. Moreover, it provides existing resources for Native populations and service providers working on this issue and describes methods for honoring cultural practices while providing supportive services to individuals who have experienced human trafficking. We also created an online Native Youth Toolkit on Human Trafficking that is designed to raise awareness and prevent this issue through education and includes tips on how to stay safe.

In July, the CDC and IHS partnered on a National Conference on American Indian/Alaska Native Injury and Violence Prevention. The conference brought together tribal and federal stakeholders to discuss the links between violence and injury and how to intervene in instances

of intimate partner violence (IPV). The CDC offers a technical package of programs, policies, and practices to stop violence before it starts.[5] IHS regularly provides screening on IPV during appointments.

Other important programs that aim to be a means of primary prevention include ACF's Healthy Marriage and Responsible Fatherhood grant programs. These are part of HHS's community-based efforts to promote strong, healthy family formation and maintenance, responsible fatherhood and parenting. Grants such as these help strengthen healthy forms of relationship and parenting and can serve as a preventative measure against intimate partner violence.

ANA Approach

ANA funding is unique in the flexibility it provides to tailor projects to the needs of the community it is serving. Because of this, ANA funding can be used to address MMIW in a myriad of ways. This could include funding of training programs or helping tribes create codes and collect data for their response to disappearances or violence when they occur. ANA funding also prioritizes the preservation of Native cultures and languages which have been shown to stand as a strong protective and preventative factor. The Minnesota Indian Women's Resource Center recently completed a project Oshki Wayeshkad (New Beginnings) that illustrates how communities use ANA funds. This project provided emotional, cultural, and life skills coaching to women age 16 to 21, and during the course of the project, staff helped a woman living with an abusing partner move, find employment, and attend dialysis and medical appointments.

[5] https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf

In addition to promoting our funding opportunities, I seek ways to be "a visible advocate" on behalf of Native Americans, Alaska Natives, Native Hawaiians, and Pacific Indigenous communities. In order to strengthen my advocacy, I have been active in workgroups that are breaking down silos to address issues of great concern to tribes and Native communities. These include a White House Tribal Affairs Work Group, which has highlighted MMIW as well as substance abuse and economic development as priorities, a Federal Interagency Working Group on Women and Trauma, and an Interagency Ad Hoc Working Group on AI/AN trafficking. I have also formed partnerships with the Department of the Interior and Department of Justice focused on improving public safety. I recently joined the DOI Assistant Secretary for Indian Affairs, Tara Sweeney, and other federal and tribal representatives at a listening session focused on cold cases, violent crimes, human trafficking, and MMIW.

We will be following up on our consultations and listening sessions with additional in-person roundtables with legislators and federal partners focused on sharing data and formulating recommendations for victim protections. ANA has been developing a relationship with tribal epidemiology centers in cities across the country to have dialogue on MMIW data collection, the lack of which is problematic in identifying the scope of the problem.

Furthermore, ANA recently partnered with OTIP to establish the first-ever class of the Human Trafficking Leadership Academy where Native survivors of human trafficking and frontline professionals will have the opportunity to participate in monthly leadership training over a six month period while examining cultural protective factors aimed at prevention of human

trafficking of Native youth. This class is scheduled to begin in October and we look forward to their recommendations in the spring.

Conclusion

Tribal nations and native communities in urban areas are ready to act to address MMIW and HHS is ready to partner with them. We are thankful for the attention you are bringing to MMIW and the support of this Subcommittee in helping address this crisis.

I would be happy to answer any questions you may have.