

Protecting the Public Health of Indian Tribes: the Indian Child Welfare Act

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For thousands of years, Indian tribal governments developed the community environments that created healthy lives for American Indian and Alaska Native children.^{4,23,27,29} To support that mission,

Congress passed the 1978 Indian Child Welfare Act, which establishes minimum federal standards states must follow when an American Indian or Alaska Native (AI/AN) child is removed from her home. Courts and child welfare agencies are mandated to comply with a framework that prioritizes the placement of an AI/AN child within the child's Indian tribe or community, and requires heightened assistance for their families.¹⁵ This premier child welfare law is

at risk due to a number of legal attacks in federal court.^{1,16,25,32} This essay posits a unique framework that identifies these legal attacks on ICWA as not just attacks on a gold standard law in the child welfare system, but rather as an attack on the public health of Indian tribes.⁶ Any success of these legal threats could lead to the same adverse health outcomes produced by long-time Indian child removal policies.

In 2013, the Supreme Court decided the case *Adoptive Couple v. Baby Girl*.² The Court found against a biological father in an

adoption case, and after that decision, the Obama Administration put a high priority on enforcing the Indian Child Welfare Act (ICWA) through administrative actions – a shift in public policy that had until then, at best, ignored violations of the Act.^{8,9,17,33,34} In response, states' rights and adoption industry groups, like the Goldwater Institute and the National Council for Adoption, are funding a series of new legal attacks on ICWA to challenge the sovereign authority of tribal governments over the wellbeing of their children and the constitutional validity of ICWA.^{1,7,11,16,25,31,32} These cases make claims that are contrary to long-settled issues of federal Indian law, and violate the trust responsibility the federal government owes to all Indian tribes and citizens due to the history of Indian child removal by the government.¹³

Missionaries began the forcible removal of Indian children under the pretext of education, which the U.S. federal government endorsed and intensified between the 1800's and 1970's by devising the Indian boarding school system. Compulsory attendance at boarding schools, predominately on active or decommissioned military sites, was "designed to separate a child from his reservation and family ... and

prepare him for never again returning to his people.”³⁵ Rampant physical, sexual, and emotional abuse, disease, malnourishment, overcrowding, and lack of health care in boarding schools are well-documented.^{24,30,36} Children were punished for using their native language, cultural practices, and religion to compel them to adopt western practices and Christianity.^{24,30,36}

Research demonstrates that childhood trauma experienced in boarding schools, “*at a minimum, the separation from family,*” contributed to poor health impacts on attendees as adults.⁴⁰ For example, a 2017 study confirmed that “[c]ombined direct and indirect results (beta = -0.39 , CI = -1.20 , $.42$) show American Indians who attended boarding school have lower health status (beta = -1.22 , CI = -2.18 , $-.26$, $p \leq .01$) than those who did not.”³⁰ Other studies demonstrate that adult attendees experience increased risk for PTSD, depression, and unresolved grief.⁴⁰ As a result, a “prevailing sense of despair, loneliness, and isolation from family and community are often described.”³⁰

State child welfare agencies later took over the Indian child removal policy. Between the 1950’s and 1970’s, AI/AN children experienced pervasive foster care and adoption placement with non-Indian foster or adoptive homes or institutions. Studies demonstrated that approximately 25-35 percent of Indian children were forcibly removed from their families, often unwarranted, and over 85 percent of Indian children were placed in non-Indian homes.³⁵ The disparity between Indian and non-Indian removal was stark. For example, in Minnesota the foster care or adoption placement rate of Indian children was 5 times

greater than the non-Indian rate; in Washington the adoption rate was 19 times greater and the foster care rate was 10 times greater; in Montana the foster care rate was 13 times greater; and in South Dakota the foster care rate was 16 times greater.³⁵ These staggering numbers led to extraordinary activism on the part of Indian tribes, and particularly American Indian women, to prompt a policy solution.¹⁸

Indeed, by 1978, Congress determined the “wholesale separation of Indian children from their families is perhaps the most tragic and destructive aspect of American Indian life today.”³⁵ In turn, Congress enacted the Indian Child Welfare Act. Ahead of its time, ICWA requires prevention-based measures to restore wellness for Indian children, their families, and Indian tribes. The Act codifies the opportunity for an AI/AN child to become exposed to the distinct protective factors for AI/AN child and adolescent health: cultural and family connectedness.^{15,17}

A protective factor is “a characteristic at the biological, psychological, family, or community level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes.”²⁶ Because protective factors are independently capable of having a direct behavior effect and positive health effects are recognized to influence the entire community, protective factor enhancement is considered a medical best practice.^{5,14,,22,26} Key protective factors for general child and adolescent health include connecting with adults beyond family, self-regulation, defined as the deliberate control of emotions, attention, and behaviors to achieve a goal, and academic achievement.²⁶ However, research suggests that signature protective factors for Indian

child health are *unique* from factors supporting non-Indians.¹⁴ Factors such as cultural connectedness and family connectedness are of particular relevance for Indian children.

AI/AN health trends demonstrate the need for protective factor enhancement. For example, the suicide rate of AI/AN ages 15-24 is more than double the national rate (14.1 and 5.8 respectively).¹⁰ Markedly, studies reveal that both cultural and family connectedness positively influence Indian child and adolescent resilience, emotional health including depression, suicide attempt, academic success, alcohol, tobacco, and substance use, and delinquent and violent behavior.^{3,20,22,28} For example, a 2012 study determined that among high-risk, low-protection groups, the loss of protective factors was associated with a larger increase in reported suicide attempts in Indian youth than in non-Indian youth (from 20%-46% and from 17%-26% respectively).²²

Moreover, studies examining AI/AN adult adoptees spotlight poor health outcomes associated with Indian adoption and placement in non-Indian homes. Although many adoptees received socioeconomic advantages by virtue of their adoption, adoptees experienced increased rates of depression, low self-esteem, and suicide.¹⁸ For example, a 2017 study revealed that AI/AN adult adoptees are more likely than White adoptees to report depression (M=88%, M=82% respectively), alcohol addiction (M=28%, M=7% respectively), and drug addiction (M=14%, M=6% respectively).²¹ Many adult adoptees continue to struggle with identity and report feelings of loneliness and isolation.^{18,19} Negative child welfare-associated health outcomes are avoidable

because ICWA protects identity-building systems and opportunities.^{15,17}

ICWA enhances protective factors by requiring court and agency compliance in child welfare proceedings with two cutting-edge provisions: active efforts and placement preferences. Congress deliberately created a higher standard for Indian child welfare proceedings requiring state agencies to provide active efforts to AI/AN families compared to non-Indian proceedings – which require use of reasonable efforts. Active efforts are defined as “affirmative, active, thorough, and timely efforts intended primarily to *maintain or reunite an Indian child with his or her family.*”^{15,17}

This active efforts provision requires agency assistance to help the AI/AN parent(s) or custodian(s) execute the state’s child welfare case plan and access or develop the resources to satisfy the case plan, reinforcing the maintenance or reunification with the child’s biological family.¹⁷ Importantly, ICWA orders engagement with the Indian child’s tribe and culturally appropriate and cross-system services including housing, financial, transportation, mental health, substance abuse, and peer support services.^{15,17} Thus, public health considerations are an inherent ICWA function.

ICWA also requires certain preferences for an Indian child’s placement. Because the preferences reflect “[f]ederal policy that, where possible, an Indian child should remain in the Indian community,” the provision determines the future of an Indian child when he cannot return home.^{15,17} When a child must be removed from her parent(s) or guardian(s), courts must place an Indian child in placements tiered by the statute, depending on the child’s best interest and

availability of the placement. These placements include: extended family, other members of the child's Indian tribe, other Indian families, and other preferences authorized by the child's Indian tribe.^{15,17} These placements help ensure the public health benefits for an Indian child of remaining with her culture and tribe.

The full power of the Indian Child Welfare Act must be realized for American Indian and Alaska Native children to achieve authentic health and wellbeing. As interest groups attempt to erode tribal governments' jurisdiction over Indian children, remembering the history of Indian child removal and those public health consequences will prevent a repetition of that history. To protect the public health of Indian tribes and AI/AN children, federal and state courts and policymakers, and the public health field must advocate for full ICWA compliance and prompt new research that highlights the positive impact of the law on AI/AN health.

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