

## **Child Abuse and Neglect in Indian Country Definitions and Incidence**

### **Objectives:**

1. To provide participants with an overview of child abuse and neglect.
2. To provide an overview of the current statistics of child abuse and neglect.
3. Participants will better understand child abuse and neglect indicators and incidents in Indian Country.
4. Participants will learn the difficulties of accurate recordkeeping and statistical information for Indian child abuse and neglect.

### **Activities:**

Lead participants in large or small group discussion of:

- 1) What is child abuse and neglect and how does it affect your community?
- 2) What can you (your agency) do to prevent further incidences of child abuse and neglect?
- 3) What protocol is in place to report child abuse and neglect? Are community members aware of how to report and who to report to?
- 4) Are mandated reporters aware of who they are and who they report to?

### **Discussion Questions:**

1. What can our community do to prevent further cases of child abuse and neglect?
2. What services do families need when a child has been abused/neglected?
3. Is our community prepared to take a stand against child abuse and neglect?
4. What resources does our community currently have and/or need to help families who are victims of child abuse and neglect?
5. What traditional resources are available for use with children who are victims of child abuse and/or neglect?
6. Is our tribal leadership prepared to take a stand against child abuse by passing resolutions in support of prevention efforts?
7. How do the statistics differ between American Indians and other populations in the U.S. in regards to child abuse and neglect?
8. How can we better keep statistics on child abuse and neglect in our communities?

Related Training Presentations (Power Point):

[Definitions, Incidence, Indicators and Effects of Child Abuse and Neglect](#)  
[Child Abuse Statistics in Indian Country](#)

## Definitions of Child Abuse and Neglect

There are five major types of child maltreatment: physical abuse, neglect, sexual abuse, medical neglect and emotional abuse. While definitions may vary, operational definitions include the following:

- **Physical Abuse** is characterized by the infliction of physical injury as a result of punching, beating, kicking, biting, burning, shaking or otherwise harming a child. The parent or caretaker may not have intended to hurt the child; rather, the injury may have resulted from over-discipline or physical punishment.
- **Child Neglect** is characterized by failure to provide for the child's basic needs. The ultimate form of neglect is abandonment. Many referrals of neglect concern children living in filth, lack of proper clothing, unattended and malnourished. It is important not to confuse neglect with poverty. Many times a family is so poor that they cannot provide for the basic needs of their children. This is not neglect, but requires services from social services to provide the essential basics for the family, i.e., food, clothing, heat, housing, etc.

Neglect can be physical, educational, or emotional. *Physical Neglect* includes refusal of, or delay in, seeking health care; abandonment; expulsion from the home or refusal to allow a runaway to return home; and inadequate supervision. *Educational Neglect* includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need. *Emotional Neglect* includes such actions as marked attention to the child's needs for affection; refusal of or failure to provide needed psychological care; spouse abuse in the child's presence; and permission of drug or alcohol use by the child. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty.

- **Sexual Abuse** includes fondling a child's genitals, intercourse, incest, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials. Many experts believe that sexual abuse is the most under-reported form of child maltreatment because of the secrecy or "conspiracy of silence" that so often characterizes these cases.
- **Emotional Abuse (*psychological/verbal abuse/mental injury*)** includes acts or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. In some cases of emotional abuse, the acts of parents or other caregivers alone, without any harm evident in the child's behavior or condition, are

sufficient to warrant child protective services (CPS) intervention. For example, the parents/caregivers may use extreme or bizarre forms of punishment, such as confinement of a child in a dark closet. Less severe acts, such as habitual scapegoating, belittling, or rejecting treatment, are often difficult to prove and, therefore, CPS may not be able to intervene without evidence of harm to the child.

- **Medical Neglect** is the failure of a caregiver to provide appropriate health care for the child, resulting in harm to the child's health, even though the caretaker was financially able or offered the financial or other means to do so. This may include prenatal exposure to drugs.

Although any of the forms of child maltreatment may be found separately, they often occur in combination. Emotional abuse is almost always present when other forms are identified.

### INDICATORS OF ABUSE AND NEGLECT

	<b>Physical Indicators</b>	<b>Behavioral Indicators</b>
Physical Abuse	<ul style="list-style-type: none"> <li>• Unexplained bruises (in various stages of healing)</li> <li>• Welts, human bite marks, bald spots</li> <li>• Unexplained burns, especially cigarette</li> <li>• Unexplained fractures, lacerations or abrasions</li> </ul>	<ul style="list-style-type: none"> <li>• Self-destructive</li> <li>• Withdrawn and aggressive – behavioral extremes</li> <li>• Uncomfortable with physical contact</li> <li>• Arrives at school early or stays late as if afraid to go home</li> <li>• Chronic runaway (adolescents)</li> <li>• Complains of soreness or moves uncomfortable</li> <li>• Wears clothing inappropriate to weather, to cover body</li> </ul>
Physical Neglect	<ul style="list-style-type: none"> <li>• Abandonment</li> <li>• Unattended medical needs</li> <li>• Consistent lack of supervision</li> <li>• Consistent hunger, inappropriate dress, poor hygiene</li> <li>• Lice, distended stomach, emaciated</li> </ul>	<ul style="list-style-type: none"> <li>• Regularly displays fatigue or listlessness, falls asleep in class</li> <li>• Steals food, begs from classmates</li> <li>• Reports that no caretaker is at home</li> <li>• Frequently absent or tardy</li> <li>• Self destructive</li> <li>• School dropout (adolescents)</li> </ul>

<p>Sexual Abuse</p>	<ul style="list-style-type: none"> <li>• Torn, stained or bloody underclothing</li> <li>• Pain or itching in genital area</li> <li>• Difficulty sitting or walking</li> <li>• Bruises or bleeding in external genitalia</li> <li>• Venereal disease</li> <li>• Frequent urinary or yeast infections</li> </ul>	<ul style="list-style-type: none"> <li>• Withdrawal, chronic depression</li> <li>• Excessive seductiveness</li> <li>• Role reversal, overly concerned for siblings</li> <li>• Poor self-esteem, self devaluation, lack of confidence</li> <li>• Peer problems, lack of involvement</li> <li>• Massive weight change</li> <li>• Suicide attempts (especially adolescents)</li> <li>• Hysteria, lack of emotional control</li> <li>• Sudden school difficulties</li> <li>• Inappropriate sex play or premature understanding of sex</li> <li>• Threatened by physical contact</li> <li>• Promiscuity</li> </ul>
<p>Emotional Abuse</p>	<ul style="list-style-type: none"> <li>• Speech disorders</li> <li>• Delayed physical development</li> <li>• Substance abuse</li> <li>• Ulcers, asthma, severe allergies</li> </ul>	<ul style="list-style-type: none"> <li>• Habit disorders (sucking, rocking)</li> <li>• Anti-social, destructive</li> <li>• Neurotic traits (sleep disorders, inhibition of play)</li> <li>• Passive and aggressive – behavioral extremes (especially adolescents)</li> <li>• Developmentally delayed</li> </ul>
<p>Medical Neglect</p>	<p>Signs of Medical Neglect include:</p> <ul style="list-style-type: none"> <li>• Adults does not use emergency services at all, even with severe injury or illness</li> <li>• When medicine is prescribed the prescription is not filled</li> <li>• Dental needs go untreated</li> <li>• Regimens recommended for treatment of chronic illness not followed</li> <li>• Prescribed psychological help not obtained</li> <li>• Failure to thrive: a significantly underweight child, usually under 18 months old.</li> </ul>	

## **Child Abuse and Neglect Statistics**

### **Current Indian Country Statistics**

In the U.S. from 1992-1995, American Indians and Asians were the only racial or ethnic groups to experience increases in the rate of abuse or neglect of children under age 15, as measured by incidents recorded by child protective service agencies.

Non-Hispanic American Indians accounted for just under 2% of the victims of child abuse/neglect in reports collected nationwide in 1995. There is evidence that their share has been increasing. Non-Hispanic American Indians, who accounted for just under 1% of the population age 14 or younger, were over represented twofold as victims of child abuse.

On a per capita basis, 1995 data indicate about 1 substantiated report of a child victim of abuse or neglect for every 30 American Indian children age 14 or younger.  
(American Indians and Crime, DOJ, 1999)

Currently, there are some, mostly federal, sources available for data on child abuse and/or neglect among American Indian/Alaska Native children, and most of these are based on one source, the National Child Abuse and Neglect Data System of the federal Department of Health and Human Services (DHHS), Children's Bureau. The Bureau of Indian Affairs (BIA), the Department of Justice (DOJ), and the Indian Health Service (IHS) collect limited data as well. Reports from these federal agencies portray serious problems of child abuse and neglect in Indian Country, with rates of abuse and neglect higher than those reported for the general population. These figures include the following:

- American Indian/Alaska Native children represent 1.6% of substantiated or indicated child abuse and/or neglect cases yet are only 1% of the population (Child Welfare League of America, 1999).
- The victimization rate for American Indian and Alaska Native children is 20.1 victims per 1,000 children of the same race, compared to a rate of 10.6 for White children (DHHS, 2001).
- There is about 1 substantiated report of a child victim of abuse or neglect for every 30 American Indian/Alaska Native children age 14 or younger, a rate about double the national rate (DOJ, 1999).

### **Who Collects Data for American Indian/Alaska Native Child Abuse and/or Neglect?**

Guidelines and funding to provide oversight of the abuse and neglect reporting system in Indian Country have been lacking to date (Cross et al., 2000). However, there have been a limited number of reports and sources of data regarding the abuse and/or neglect of American Indian/Alaska Native children generated over the past few years. These reports have been generated by private foundations and organizations, universities, and federal agencies.

## **Federal Agencies**

Data from the federal level are generally collected as part of a funding stream. By reviewing funding streams, it may be possible to identify potential sources of data on child abuse and/or neglect. United States federal responsibility for ensuring the protections provided by law to American Indian/Alaska Native children rests with the BIA in the Department of the Interior and the Administration for Children and Families (ACF) in DHHS. As part of their responsibility to American Indian/Alaska Native children, these agencies are expected to monitor compliance with the Indian Child Welfare Act of 1978 (ICWA) and the Indian Child Protection and Family Violence Prevention Act.

## **Role of the Bureau of Indian Affairs**

The Bureau of Indian Affairs (BIA) has been the central oversight agency for tribes for the past 180 years. The establishment of the BIA in 1824 under the U.S. War Department originally led to the use of army medical personnel to oversee the health care of American Indians and Alaska Natives on reservations, setting a negative tone for American Indian/Alaska Native-federal relationships that has been difficult to overcome (Attneave, 1984). The BIA was transferred from the War Department to the Department of the Interior in 1849 and has maintained its oversight of tribes since that time with continuing mixed reviews from the tribes.

The BIA is a complex bureaucracy headed by a Commission of Indian Affairs who reports directly to the U.S. Department of Interior. While the Washington, DC office is the central location for the BIA, the 12 area offices have an unusually great degree of decision-making authority. About 80 offices under the direction of area offices are located on one or more reservations.

The BIA collects data on the services it oversees through its regional offices, but there is currently no direct requirement for reporting of data on child abuse and neglect. The major responsibility of the BIA is the provision of education through the BIA-run boarding and day schools and the management of tribal resources. Much of the funding for child welfare programs is provided through the BIA either directly, through BIA-administered tribal services, or indirectly through ICWA, the Indian Self-Determination Act, or the Snyder Act. The Snyder Act ("Authorization of Appropriations and Expenditures for Indian Affairs") was passed in 1921. While the law appropriated no funds, it has been used as the basis for appropriating money for the administration of Indian Affairs by the BIA (Canby, 1998).

Some of the Snyder Act funds are passed to self-governance tribes, which receive a share of funds in a lump sum (instead of by category) to administer all of their tribal programs. Self-governance tribes allocate these funds to programs, including child welfare programs, as they choose. In addition, some of the BIA administered funds go to tribes that have contracted to obtain services through another provider. Further, the Snyder Act funds are allocated based on need; so funding formulas are based on prior years and current spending (Chet Eagleman, Indian Child Welfare Specialist, Tribal Services Division, BIA, personal communication, April 3, 2000).

All tribes and agencies that receive federal money are required to report on how that money is spent. Each consortium, tribe, and BIA agency is supposed to submit a form to the BIA Regional Office that lists the total child abuse and/or neglect referrals, the type of referral (sexual abuse, physical abuse, neglect); substance abuse involvement, incident characteristics (recurring case, siblings involved); results of investigation (substantiated, unsubstantiated, under investigation); and action taken (referral to court, referral to social services or other agency, no action). Cases can only be counted as one abuse type, so a case can be counted, for example, as physical abuse or neglect but not both. Instructions for which category to pick if there is more than one type of abuse or neglect occurring are provided. The regional offices compile the tribal, consortium, and agency reports into one annual report for the region and send it to the BIA Central Office. However, because of complex legal and policy issues, reporting is incomplete.

Several issues complicate child abuse and/or neglect reporting to the BIA. Tribes are sovereign nations. Currently, the BIA has no penalties that can be applied to a sovereign nation for non-compliance with child abuse and neglect reporting. Only programs that receive Snyder Act funds are required to report, as their funding is need-based and has to be justified. Snyder Act funds can be withheld for non-reporting. Self-governing tribes may not report to the BIA as their self-governance status affords them broad sovereignty. Those tribes that contract services probably do not have the data to report. For example, tribes where the state or county is responsible for investigations do not report. If a state has responsibility for child protective services, the tribe can't send the data to the BIA because the tribe doesn't have it.

### **Role of the Department of Health and Human Services (DHHS)**

DHHS also provides indirect funding to tribal programs. Within DHHS, the Children's Bureau, Administration on Children and Families (ACF) supports state and tribal programs to provide child welfare, foster care, adoption and family preservation services under three titles of the Social Security Act: Titles IV-E, XX, and IV-B. These funds are primarily funneled through the states, and tribes must enter into a state agreement in order to obtain money to provide services (Cross et al., 2000).

Although the national data collection and analysis system for child abuse and neglect, NCANDS, receives data on child abuse and/or neglect from all 50 states, data from American Indian/Alaska Native tribes or nations appear to be incomplete (Earle, 2000). Data on American Indian/Alaska Native children are included only if provided by the states, and this requires some state/tribal coordination and trust.

Earle, K.A. PhD, and Cross, A., (2001); Child abuse and neglect among American Indian/Alaska Native Children: An analysis of existing data. NICWA, Portland, OR.

## Indian Health Service Role

IHS provides health and mental health services to enrolled members of federally recognized American Indian tribes and Alaska Natives. As of March 1996, the federal IHS administered 37 hospitals, 64 health centers, 50 health stations, and 5 school health centers located on or near the lands of the approximately 573 recognized tribal organizations in the United States. IHS provides services at these sites to all enrolled members of a federally recognized American Indian/Alaska Native tribe/nation within each geographic area in which they are located. Health related data are collected by IHS but are not necessarily directly related to allegations of child abuse and/or neglect.

The IHS Mental Health and Social Services Program Branch's decentralized automated information system, the Resource Patient Management System (RPMS), includes codes in an abuse category that lists child abuse and neglect as possible reasons for a visit to an IHS mental health program. However, these abuse-coded data are not publicly accessible or currently available other than in an aggregate form that subsumes child abuse and neglect within other categories.

Earle, K.A. PhD, and Cross, A., (2001); Child abuse and neglect among American Indian/Alaska Native Children: An analysis of existing data. NICWA, Portland, OR.

## U.S. Statistics

- In 2000, there were 70.4 million children under age 18 in the United States, or 26% of the population, down from a peak of 36% at the end of the baby boom. Children are projected to remain a stable percentage of the total population, comprising 24% of the population in 2020.
- The ethnic diversity of America's children continues to increase. In 2000, 64% of U.S. children were white, non-Hispanic; 15% were black, non-Hispanic; 4% were Asian/Pacific Islanders; and 1% were American Indian/Alaska Native. The number of Hispanic children has increased faster than that of any other racial and ethnic group, growing from 9% of the child population in 1980 to 16% in 2000.
- The poverty rate for children living with family members continued to decline from 18% in 1998 to 16% in 1999. The poverty rate for children has fluctuated since the early 1980s: it reached a high of 22% in 1993 and has since decreased to the lowest rate since 1979.
- The decrease in poverty is apparent for children living in female-headed families and is more pronounced for black children. Among black children in female-headed families, about two-thirds lived below the poverty line from 1980 to 1993, but by 1999 just over half were in poverty.
- The percentage of children who had at least one parent working full-time, all year continued to increase in 1999 to 79% from 77% in 1998.
- Unintentional injuries continue to be the leading cause of death for children and youth ages 1 to 19, with motor vehicle crashes being the most common reason for those injuries. Overall, deaths to adolescents ages 15 to 19 have fallen significantly since 1991. One major reason for the decrease in deaths is a drop in mortality due to firearm injuries.

- In 1999, the adolescent birth rate was at a record low, at 29 births per 1,000 young women ages 15-17.

### The Good News

- Fewer children live in poverty.
- Teen births are at a record low.
- Teen death rates are at all-time lows.
- Most young people have at least one parent who works full time.
- 85% of children have health insurance.
- The number of fully immunized babies is increasing.
- Teen deaths from firearms are going down.
- Violent crimes by, and against, youth are down.
- More students are taking advanced placement courses.
- Math scores are up a little.
- More people are getting college degrees.

### The Bad News

- Many children are poor even though they have at least one parent who works full-time all year.
- 14% of children don't have health insurance.
- Car crashes are the most common reason for child and adolescent death.
- Adolescent drinking and illicit drug use have stayed about the same.
- Reading scores aren't getting any better.

### Also of Note....

- About a quarter of the U.S. population is under age 18.
- U.S. kids are a diverse bunch: 64% white, 16% Hispanic, 15% black, 4% Asian/Pacific Islander, and 1% American Indian/Alaskan Native.
- The percent of children who don't speak English well has nearly doubled in the last 20 years.
- Female headed families are the poorest, and two parent families the least likely to be poor.
- Well over half of 16 year olds work as well as go to school.

(To obtain a full copy of this report, contact the Institute for Educational Leadership, (202) 222-8405.)

## **Referrals and Reports**

As referrals of possible child maltreatment come to the attention of child protective services (CPS), they either are "screened in" or "screened out". For those reports screened in, a future determination is made about whether to investigate. The role of the CPS agency is deciding whether to take further protective actions on behalf of a child.

- Of the estimated 2,974,000 referrals received, approximately three-fifths (60.4%) were transferred for investigation or assessment and two-fifths (39.6%) were screened out.\*

- More than half of child abuse and neglect reports (54.7) were received from professionals. The remaining 45.3 percent of reports were submitted by nonprofessionals, including family and community members.\*
- Most states have established time standards for initiating the investigation of reports. The average response time to initiate investigating reports was 63.8 hours.\*
- Slightly fewer than one-third of investigations (29.2%) resulted in a disposition either substantiated or indicated child maltreatment. More than half (54.7%) resulted in a finding that child maltreatment was not substantiated.\*
- The average annual workload of CPS investigation and assessment workers was 72 investigations.\*

### **Child Maltreatment Victims**

Victims of maltreatment are defined as children who are found to have experienced substantiated or indicated maltreatment or are found to be at risk of experiencing maltreatment.

- There were an estimated 826,000 victims of maltreatment nationwide. The 1998 rate of victimization, 11.8 per 1,000 children, decreased from the 1996 rate of 12.6.\*
- Almost three-fifths of all victims (58.4%) suffered neglect, while one-fifth (21.3%) suffered physical abuse; 11.3 percent were sexually abused. More than one-third (35.9%) of all victims were reported to be victims of other or additional types of maltreatment.\*
- The highest victimization rates were for the 0-3 age group (13.9 maltreatment per 1,000 children of this age in the population), and rates declined as age increased.\*
- Rates of many types of maltreatment were similar for male and female children, the sexual abuse rate for female children (1.6 female children for every 1,000 female children in the population) was higher than the sexual abuse rate for male children (0.4 male children per 1,000).\*
- Victimization rates by race/ethnicity ranged from a low of 4.4 Asian/Pacific victims per 1,000 children of the same race in the population to 25.2 African American victims per 1,000 children of the same race in the population.\*
- Children who had been victimized prior to 1999 were almost three times more likely to experience recurrence during the 6 months following their first victimization in 1999 than children without a prior history of victimization.\*

### **Perpetrators**

A perpetrator of child abuse and/or neglect is a person who has maltreated a child while in a caretaking relationship to that child.

- Three-fifths (61.8%) of perpetrators were female. Female perpetrators were younger than their male counterparts – 41.5 percent of female perpetrators were younger than 30 compared with 31.2 percent of male perpetrators who were younger than 30.\*

- Almost nine-tenths (87.3%) of all victims were maltreated by at least one parent. The most common pattern of maltreatment was a child victimized by a female parent acting alone (44.7%).\*
- Female parents were identified as the perpetrators of neglect and physical abuse for the highest percentage of child victims. In contrast, male parents were identified as the perpetrators of sexual abuse for the highest percentage of victims.\*

## **Fatalities**

Child fatality estimates are based on data recorded by CPS agencies and/or other agencies.

- An estimated 1,100 children died of abuse and neglect, a rate of approximately 1.62 deaths per 100,000 children in the general population.\*
- Slightly more than 2 percent (2.1%) of all fatalities occurred while the victim was in foster care.\*
- Children younger than a year old accounted for 42.6 percent of the fatalities, and 86.1 percent were younger than 6 years of age.\*
- Maltreatment deaths were more often associated with neglect (38.2%) than with any other type of abuse.\*
- Slightly more than one-tenth (12.5%) of the families of child fatalities had received family preservation services in the 5 years prior to the deaths, while only 2.7% of the child fatality victims had been returned to the care of their families prior to their deaths.\*

## **Services Provided**

CPS agencies provide services to prevent future instances of child abuse and neglect and to remedy harm that has occurred as a result of child maltreatment. Preventive services are provided to parents whose children are at risk of abuse or neglect. Remedial or post-investigative services are offered to families that have experienced a child maltreatment episode.

- Nationwide, an estimated 1,563,000 (22.3 out of every 1,000 children in the population) received preventive services.\*
- The average time from the start of an investigation to provision of service was 47.4 days.\*
- Nationally, 55.8 percent of child victims (an estimated 461,000) received post investigative services, and an additional 14.2 percent of children with unsubstantiated reports (an estimated 217,000) also received services.\*
- Nationally, an estimated 171,000 child victims were placed in foster care. An estimated additional 49,000 children who were not victims (i.e., children with unsubstantiated reports) were placed in foster care.\*
- About one-fifth (21.2%) of victims had received family preservation services within the previous 5 years, while more than 5.1 percent of victims had been reunited with their families in the previous 5 years.\*

- Court actions were initiated for an estimated 26.1 percent of maltreatment victims. Four-fifths of these victims were provided with court appointed representatives.\*

\* *Findings required by the Child Abuse Prevention and Treatment Act, as amended, to be included in all annual state data reports to the Secretary of Health and Human Services. Because this is only the third year that many of these data have been required, not all states were able to provide data on every item.*

Source: U.S. Department of Health and Human Services. *Child Maltreatment 1999: Reports from the States to the National Child Abuse and Neglect Data System* (Washington DC: U.S. Government Printing Office, 2001).

There appear from the analysis of the National Child Abuse and Neglect Data System (NCANDS) data, to be significantly lower rates of sexual and physical abuse among non-Hispanic American Indian/Alaska Native children than among non-Hispanic White children.

The victimization rate for American Indian/Alaska Native children is 20.1 victims per 1,000 children of the same race, compared to a rate of 10.6 for White children (DHHS, 2001).

There is about 1 substantiated report of a child victim of abuse or neglect for every 30 American Indian/Alaska Native children age 14 or younger, a rate about double the national rate (DOJ, 1999).

- American Indians make up 1.5% of the total population in the United States.
- There are 4.1 million U.S. residents who reported as American Indian and Alaska Native alone or in combination with one or more races in Census 2000. The 2.5 million who reported as American Indian or Alaska Native alone represented 0.9% of the population.
- The American Indian population increased 26%, faster than the total population between 1990 and 2000.
- Four out of 10 American Indians live in the West (43%), 31% in the South, 17% in the Midwest, and 9% in the Northeast.
- Over one half of all people who reported to be American Indian lived in 10 states (CA, OK, AZ, TX, NM, NY, WA, NC, MI, AND AK).
- \$31,799 is the median household income for American Indians and Alaska Natives, based on a 1998-2000 average. This is higher than for African Americans (\$28,679), not statistically different from Hispanics (\$31,703) and lower than for non-Hispanic Whites (\$45,514).
- The poverty rate for American Indians and Alaska Natives is 25.9%, based on a 1998-2000 average. This rate was not statistically different from the rates for African Americans and Hispanics, but was higher than those for non-Hispanic Whites, and Asians and Pacific Islanders.
- There are 701,000 American Indians and Alaska Natives below the poverty line, based on a 1998-2000 average.

- 26.8% of American Indians and Alaska Natives lack health insurance coverage. Their rate is significantly higher than the rates of African Americans (19.5%), Asians and Pacific Islanders (18.8%), and non-Hispanic Whites (10.1%), but lower than that of Hispanics (32.8%).
- There are 5 tribes with 100,000 or more members that account for 42% of all American Indians; Cherokee, Navajo, Choctaw, Sioux, and Chippewa.
- There are 187,000 American Indians and Alaska Natives who were 65 or older in Census 2000. This number represented 7% of the total American Indian and Alaska Native population nationwide.

*Source: 2000 Census*