MISSING AND MURDERED

INDIAN WOMEN IN MONTANA

by

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TRIBAL AFFILIATION

Chippewa Cree Rocky Boy Montana

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KEY WORDS

1. Indian, North American
2. Alaska Native
3. Domestic Violence
4. Rape
5. Homicide
6. Human trafficking
7. Education, continuing
8. Nurse Practitioner

OPERATIONAL DEFINITION OF TERMS

- First Nations- First Nations is a term used to describe Indigenous peoples in Canada (Gadocz, 2019).
- The Métis (/meɪˈtiː/) are a multicentral Indigenous group whose homeland is in Canada and parts of the United States between the Great Lakes region and the Rocky Mountains. The Métis trace their descent to both Indigenous North Americans and European settlers. Not all people of mixed Indigenous and Settler descent are Métis, as the Métis is a distinct group of people with a distinct culture and language. Since the late 20th century, the Métis in Canada have been recognized as a distinct Indigenous peoples under the Constitution Act of 1982; and have a population of 587,545 as of 2016 (*Canada, Government of Canada, Statistics 2013-05-08.)*Smaller communities self-identifying as Métis exist in the United States, such as the Little Shell Tribe of Montana (Peterson & Brown, 2001).
- Ojibway- Ojibwa, also spelled Ojibwe or Ojibway, also called Chippewa, self-name Anishinaabe, Algonquian -speaking North American Indian tribe who lived in what are now Ontario and Manitoba, Canada, and Minnesota and North Dakota, U.S., from Lake Huron westward onto the Plains. Their name for themselves means “original people” (*CDC American Indian Alaska Native Populations Racial Ethnic Minorities Minority Health”. 2 December 2012*)

ABSTRACT

Problem. Violence against women is more widespread and severe among American Indian women than among other North American women. Statistics reveal that American Indian and Alaska Native women experience ten times the murder rate of the national average and the highest lifetime rape (27.5%) prevalence in relation to all other ethnicities (14-21%). It is further estimated that three in five AI/AN women will be victims of domestic violence. There is a reason to believe that AI/AN women who are missing may be victims of human trafficking. Evidence suggests that chronic poverty, rape, homelessness, childhood abuse, and racism all play a part in human trafficking.

Purpose. Nurse practitioners are a critical workforce in screening and early intervention for AI/AN women as these high-risk women often live in rural and isolated places where the safety net of police, social workers, support groups and safe houses are limited. The purpose of this project was to 1) explore nurse practitioners' knowledge and perceived educational needs related to Montana murdered and missing Indian women, and 2) provide appropriate follow up education with participants based on the findings.

Methods. A convenience sample of ten Cascade County nurse practitioners with AI/AN women in their client panel participated in a semi-structured interview. A descriptive analysis of the transcribed interviews revealed gaps in what this sample of primary care providers knew about interventions for AI/AN women at risk for or who have experienced violence.

Conclusions. The study produced updated recommendations on screening and referrals for Cascade County nurse practitioners.to use with clients. The results also suggest a need for the State Board of Nursing to offer continuing education on Montana's missing and murdered Indian women. It was also suggested the importance of sharing information on missing and murdered Indian women at one of the nurse practitioners' conferences.

CHAPTER ONE

VIOLENCE AGAINST AMERICAN INDIAN WOMEN

The disproportionate rate at which indigenous women experience violence is a grave and persistent problem. It is a global phenomenon. For instance, Aboriginal women in rural areas of Australia are up to 45 times more likely to experience violence than non-Aboriginal women (Burnette, 2015). Likewise, violence against Aboriginal women in Canada is approximately 3.5 times the rate of non-Aboriginal women. In the United States, American Indian and Alaska Native women experience violence at 2.5 times the rate of non-native women (Burnette, 2015). According to Rosay (2016), three in five American Indian and Alaska Native women will be victims of violence and one in three will be raped. Indigenous women experience unique challenges that intensify the epidemic of violence against them that includes intimate partner violence, rape, murder, and human trafficking.

American Indian and Alaska Native (AI/AN) women are almost three times as likely to experience rape or sexual assault when compared to White, African, or Asian American women. These national estimates include AI/AN women residing both on and off tribal lands. Bachman, Zaykowski, Lanier, Peteyeva and Kallmyer (2008) reported the average annual rates of rape for women aged 12 and older as 0.5% (AI/AN), 0.2% (Whites), 0.2% (African Americans) and 0.1% (Asian Americans). The average annual percent of rape and sexual assault victimization against a female by race was as follows: AI/AN 91%, African American 78%, White 71%, and Asian American 62%. Sadly, AI/AN women face vulnerability due to the mere fact that they are Indian women (Rosay, 2016).

Intimate partner violence (IPV) is a significant public health concern. More than half of all female homicide victims are murdered by current or former intimate partners. The rate is estimated for AI/AN women at 4.4 per deaths per 100,000 (Petrosky, 2017). The most recent data, from the 2011 National Intimate Partner and Sexual Violence Survey, indicated that over 10 million women in the United States experience physical violence each year by a current or former intimate partner. Globally, 1 in 3 women will experience physical or sexual intimate abuse, partner violence or non-partner violence in their lifetime (World Health Organization, 2016). Kirk, Terry, Lokuge, and Watterson (2017) reported most of the violence against women is IPV, which includes physical or sexual violence occurring within an intimate relationship. In addition to the immediate impact, IPV has lifelong consequences. Studies have shown that beyond injury and death, victims of IPV are more likely to report a range of adverse mental and physical health outcomes that are both acute and chronic **(**Niolon, Kearns, Dills, Rambo, Irving, Armstead, & Gilbert, 2017).

Various national and regional studies have found that violence against women is more widespread and severe among self-identified AI/AN women than among other North American people (Crossland et al., 2013; CDC, 2017). For example, authors of the National Violence Against Women Survey found that self-identified AI/ AN women were significantly more likely than women from all other backgrounds to encounter violence at some point in their lifetime (Tjaden & Thoennes, 2006). Furthermore, according to estimates from the National Crime Victimization Survey, self- identified AI/ AN women experienced the highest rate of IPV (18.2%), when compared to White women (6.3%), African American women (8.2%), and Asian American women (1.5%) (Catalano, 2007). However, the results from these studies cannot

produce reliable estimates of violence against AI/AN women on or off the reservation (Crossland et al., 2013).

Although AI/AN women are less likely to be killed as the result of another felony (e.g., robbery), when compared to White (5%) and African American (4%) females, AI/AN are more likely (7%) to be murdered as the result of rape or sexual assault (Bachman et al., 2008). In the U.S., AI/AN women are murdered at a rate ten times the national average (Pember, 2016). Non-partner sexual violence is experienced by at least 7% of women in their lifetime (Abrahams, Devries, Watts, Pallitto, Petzold, Shamu, et al., 2014).

It is essential to include human trafficking in the analysis of violence against women. The International Labor Organization (2012) reported human trafficking, or "Modern Day Slavery", occurs when people are commodities and then victimized by force, fraud, or coercion for the purpose of physical or sexual exploitation. The International Labor Organization reported 20.9 million global trafficking victims, making human trafficking the third largest worldwide criminal enterprise (International Labor Organization, 2012).

Human trafficking in Indian Country is a significant problem, with AI/AN women and girls suffering disproportionately when compared to the general population. The federal agencies who investigated or prosecuted human trafficking in Indian Country are the Federal Bureau of Investigation, Bureau of Indian Affairs, Immigration and Customs Enforcement, and the United States Attorney's Office. These federal agencies reported 14 federal investigations and two federal prosecutions of human trafficking offenses in Indian Country from fiscal years 2013 through 2016. From fiscal years 2013 through 2015, there were over 6,100 federal human trafficking investigations and approximately 1,000 federal human trafficking prosecutions,

overall. In certain circumstances, state or tribal law enforcement may have jurisdiction to investigate crimes in Indian country; therefore, these figures likely do not represent the total number of human trafficking-related cases in Indian Country. Also, considering that human trafficking is known to be an underreported crime, it is unlikely that these figures, or any other investigative or prosecutorial data, represent the full extent to which human trafficking occurs (Goodwin, 2017).

American Indian and Alaska Native women experience risk factors that can lead to victimization more often than other groups. The number of murdered and missing AI/AN women has reached into the hundreds, but scant records have made tracking those cases difficult. According to the Federal Bureau of Investigation, AI/AN people disappear at twice the rate of Whites (Lutey, 2019). One explanation is that AI/AN women and girls are targeted by traffickers "for their exotic beauty" (St. Claire, 2017). Another explanation is that Indian Country is where predators can more easily get away with their crimes. An overview of the legal and law-enforcement environment is critical to further understanding the disparity.

Legal Environment and Law Enforcement Factors

Violence against AI/AN women is a critical public health and safety issue. The Violence Against Women Act recognized AI/AN women's unique vulnerabilities to violence (Violence Against Women Act of 1994 as cited by Crossland et al., 2013). Jurisdiction over law enforcement varies by the location of the offense (on or off-reservation), what parties are involved (the race/ethnicity of the victim and offender), and the nature of the crime (major crime or misdemeanor). American Indian advocates argue that the tribal government's inability to prosecute non-Indians attracts offenders of various crimes to Indian country (Deer, 2005).

Further, because of tribal government's inability to prosecute non-Indians, AI/AN women are more of a target, particularly the women who have addiction issues, post-traumatic stress disorder, and other kinds of sicknesses.

A study by authors from the University of Delaware and the University of North Carolina found that more than two-thirds of sexual assaults against AI/AN women were committed by White and other non-AI/AN people (Bleir & Zoledziowski, 2018). Yet non-AI/AN men who assault AI/AN women on reservations cannot be arrested or prosecuted by tribal authorities under a 1978 Supreme Court decision (*Oliphant v. Suquamish Indian Tribe, 435 U.S. 191*, 1978). The law states, "Indian tribal courts do not have inherent criminal jurisdiction to try and to punish non-Indians, and hence may not assume such jurisdiction unless specifically authorized to do so by Congress" (p. 195-212).

United States Department of Justice (2016) reported that there are many jurisdictional complexities and limitations in Indian Country. They stated:

> The confusing division of authority among tribal, federal, and state governments results in a jurisdictional maze that is complicated by the lack of tribal courts' criminal jurisdiction over non-Indians, the practical impact of Public Law 280, and other limitations on tribal criminal jurisdiction (p. 4).

As a result, non-Indians who commit acts of domestic violence that are misdemeanors on Indian reservations are virtually immune from prosecutions in most areas of the country. In *Oliphant v. Suquamish Indian Tribe*, followed by *Duro v. Reina*, the Court held that Indian tribes do not have the authority to criminally prosecute any non-tribal citizens. The Court held that the federal judiciary has the authority to divest aspects of Indian tribes' sovereign authority (for example, the power to prosecute non-Indians) if the court concludes that aspect of sovereignty is

"inconsistent with their status" as domestic dependent nations (*Oliphant v Suquamish Indian Tribe*, 435 U.S. 191, 1978).

Public Law 280 was a transfer of legal authority to make decisions from the federal government to state governments which significantly changed the balance of power among tribal, federal, and state courts (Tribal Crime and Justice: Public Law 280, May 19, 2008). The difficulty of determining jurisdiction, and providing for concurrent jurisdiction in some instances, can cause conflict and confusion for law enforcement, prosecution, courts, service providers, and crime victims in Indian Country. As a result of Public Law 280, tribal governments may not prosecute non-Indians who commit misdemeanor acts of domestic violence on Indian reservations (Tribal Crime and Justice: Public Law 280, May 19, 2008).

However, if the perpetrator is non-Indian and the victim is an enrolled member, only a federally certified agent has that right to make the arrest. If the opposite is true, a tribal officer can make the arrest, but the case still goes to federal court. Even if both parties are tribal members, a U.S. attorney often assumes the case, since tribal courts lack the authority to sentence defendants to more than three years in prison (Crane-Murdoch, 2013).

Lawmakers have made some incremental efforts in response to the unmitigated rates of violence against AI/AN women in the past twenty years. One is Savanna's ACT. This federal bill sponsored by Senator Murkowski of Alaska, (*Savanna's ACT*, *S.227*, 2020) would direct the Department of Justice to review, revise, and develop law enforcement and justice protocols to address missing and murdered AI/AN. Among other things, the Department of Justice would be obligated to provide training to law enforcement agencies on how to record tribal enrollment and gender for victims in federal databases. Documenting the tribal affiliation of each missing AI/AN

would help with appropriate documentation of where these women are from. The bill authorizing Savanna's Act passed the U.S. Senate unanimously but was held by the U.S. House of Representatives on March 12, 2020. Time will tell if this important piece of procedural legislation becomes a law. Mr. Hoeven (for himself, Ms. McSally, Mr. Barrasso, and Mr. Cramer) introduced the following bills which were read twice and referred to the Committee on Indian Affairs (Tribal Law an Order Reauthorization and Amendments Act of 2019). The two bills introduced were: 1) The Tribal Law and Order Act Reauthorization and Amendments (TLOA) Act, and 2) The Securing Urgent Resources Vital to Indian Victim Empowerment (SURVIVE) Act).

The aim of these bills was to enhance current law to ensure tribes have the necessary tools to combat crime and increase coordination between tribal, federal, and state law enforcement officials. The bills included $6.5 million for the Bureau of Indian Affairs (Murkowski, 2019). The authorization of funds to the Bureau of Indian Affairs was to purchase a comprehensive look at the issue of missing and murdered Indian women (MMIW) including funding for "cold case" work, background checks, equipment needs, and forensic training for Indian Health Service personnel (Murkowski, 2019).

The authorization further provided $502.5 million for Violence Against Women Prevention and Prosecution programs as well as funding for research related to the incidence of MMIW and girls in remote communities underserved by law enforcement resources (Murkowski, 2019). Additional line items included $38 million for Tribal assistance in state and local law enforcement and $30 million for Tribal resources under the Community Oriented Policing Services program, an initiative to increase the number of police officers and ensure

appropriate training. Finally, the budget included a 5% set-aside from Victims of Crime Act Fund for Tribes to address services for victims of domestic and sexual violence (Murkowski, 2019).

The second relevant piece of legislation is Hanna's Act or House Bill 21. The bill was named after Ms. Hanna Harris, a Lame Deer, Montana woman found murdered on the Northern Cheyenne Reservation in 2013. The emphasis of this legislation was to authorize the Department of Justice to assist with the investigation of all missing persons cases. It also required the employment of a missing persons specialist in new investigations. Montana Governor Bullock signed Hanna's Act into law on July 1st, 2019 (Dudik, 2019).

The third relevant piece of legislation is the Looping in Native Communities (LINC) Act. Senate Bill 312 was created to convene a missing indigenous persons task force to include a representative from each tribal government on Montana's seven reservations and the Little Shell Chippewa Tribe. The bill was passed in Spring of 2019 (Members of Legislature's Missing Indigenous Persons Task Force, 2019). The bill is important to the legislative environment because it requires them to prepare a written report of findings and recommendations for submission to the state tribal relations interim committee. This report is due no later than September 1, 2020 and is expected to draw new attention to the problem of MMIW and girls in Montana. The report must include a recommendation to the 67th legislature as to whether the task force should continue in existence.

A small group of AI/AN activists formed the Lakota People's Law Project in 2004. Unlike the federal and state laws discussed so far, the Lakota People's Law Project is a grassroots organization that advocates for laws important to AI/AN people. The Lakota People's

Law Project began its outreach campaign to tribes across the country after successfully getting the Standing Rock Sioux Tribe to endorse their first resolution letter calling for a Truth and Reconciliation Commission (TRC) on June 2016. The Lakota People's Law Project goal is to have as many tribes as possible sign on to the TRC as a way of showing Congress that it is time to act. The goal of the TRC is to help heal tribal members and families affected by the Federal boarding school policies that devastated Indians' life from late 1800's to mid-1900's. In 1876, the federal government decreed that all American Indian children must be removed from their families and confined in boarding schools (Charbonneau-Dahlen, 2015). It was not until 1978 with the passing and enforcement of the Indian Child Welfare Act that families had the authority to say, "No, their child was not going to boarding school" (History and Culture, n.d.). The 1869 "Peace Policy," known as the Indian Boarding School Policy, founded boarding schools focused on assimilating and "civilizing" AI/AN children. The intent was to "kill the Indian, save the man." This motto was coined by Richard Pratt who had modeled the first Indian Boarding School (Charbonneau-Dahlen et al., 2016). More than 100,000 children were forcibly removed from their families and distributed among 460 Bureau of Indian Affairs operated schools. The boarding school system shamed these children by using oppressive discipline and corporal punishment. "Neary every challenge Native Americans face today is traceable to intergenerational trauma" (LPLP, 2004**).** Much of the physical, emotional, and sexual violence against AI/AN women and girls today is in part caused by the unresolved grief and trauma AI/AN men and women embody.

These federal and state laws and grassroots movements represent initial efforts to address the chronic problem of violence against AI/AN women. By including specialists from law

enforcement and representatives from each sovereign nation, there are more opportunities for collaboration and mutual understanding. By addressing truth and reconciliation there is hope for the chronic cycle of violence to be disrupted as individuals, families and communities begin the healing process from chronic grief and trauma. The administrative and protocol changes made in S. 227 address some of the procedural shortcomings in current inter-jurisdictional investigations. Unfortunately, the inability of tribal courts to try and sentence non-Indian perpetrators continues to make Indian Country too attractive to violent offenders.

The Federal government agencies have provided a range of resources and training to improve responses to human trafficking. In more recent years, agencies have developed tribal-specific resources. The department of Justice's National Indian Country Training Initiative, the U.S. Department of Homeland Security's Federal Law Enforcement Training Center, and the Bureau of Indian Affairs' Indian Police Academy have developed training for federal and tribal law enforcement on human trafficking in Indian country. The focus of the practice is to appropriately identify victims, investigate cases, and working effectively with Native victims (Human Trafficking, 2017).

As of July 2018, few tribes have prosecuted human trafficking cases, and even fewer tribal judges have presided over these cases in their courtrooms. Nevertheless, as more law enforcement and prosecutors receive training on bringing these problematic cases, tribal judges will confront these cases on a more regular basis. This is especially true for those tribes that have enhanced sentencing authority under the Tribal Law and Order Act of 2010 (Goodwin, 2017).

Historical Trauma as a Contributing Factor

An important factor in understanding the problem of violence against AI/AN women is the role of historical trauma in the psyche of AI/AN men and women. Much of the abuse of AI/AN women can be traced to the colonization of Indigenous people by the Europeans. Before European colonization and missionization, American Indian traditions and practices effectively enforced moral codes and protocols that upheld American Indian women's status as highly valued members of the community (Pearce et al., 2015). These protocols supported American Indian women's status as graciously cherished and were destroyed due to aggressive Christianization, which rapidly transformed traditional American Indian gender relations and introduced the subjugation of Indian women's individual freedom and devaluation of female identity (Pearce et al., 2015).

Indigenous scholars refer to historical or intergenerational trauma as collective emotional and psychological injury over the life span and across generations (Pearce et al., 2015). There is increasing acknowledgment that the health, social, and economic impacts of colonization and residential schools have been far-reaching and intergenerational (Pearce et al., 2015). The traumatic influences have changed Indian people's moral codes, culture and language.

To understand historical trauma, one must first understand the concept of trauma. Historical trauma refers to a complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance (Mohatt, Thompson, Thai, & Tebes, 2014). Historical trauma can be understood as consisting of three primary elements: a "trauma" or wounding; the trauma is shared by a group of people, rather than an individually experienced; the trauma spans multiple generations, such that contemporary

members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing event(s). It is distinct from intergenerational trauma in that intergenerational trauma refers to the specific experience of trauma across familial generations but does not necessarily imply a shared group trauma. Similarly, a collective trauma may not have the generational or historical aspect, though over time may develop into historical trauma (Mohatt et al., 2014).

Historical trauma results from chronic cultural oppression and genocide and is often propelled by contemporary political or religious movements which quell awareness of legal and moral responsibility by the dominant group (Fenelon & Trafzer, 2014). The causes of historical trauma can be related to settler invasions, violated government trade agreements, and religious missions that forced cultural genocide (Lemkin, 1944). Increases in trauma-related events such as suicide, abuse/assault, substance abuse, and mental health issues are noted in those suffering from historical trauma. Historical trauma is chronic; the trauma continues to affect individuals, families, and communities (Heckert & Eisenhauer, 2014).

Four Typologies of Abuse

Studies have shown that many Indian people have experienced one or more of the four typologies of abuse (physical, sexual, emotional, and neglect). Many of these typologies are evident in substance abuse, poverty, unemployment, government dependency, interpersonal violence, suicide, social isolation, and trauma to cultural identity influenced by colonialism (Heckert & Eisenhauer, 2014).

Poverty, drug, and alcohol abuse contribute to several less than desirable environmental conditions that create increased stress and trauma. Over two-thirds (68%) of AI/AN female

sexual assault victim believed their attackers had been drinking or taking drugs before the offense (Heckert & Eisehauer, 2014).

Findings from several regional research studies also demonstrated high rates of victimization in the AI/AN population. In a relatively large study of a random sample of women (N = 1,368) from six American Indian tribes in the southwest, northwest, northern Plains and north-east, it was documented that 45% reported physical assault and 14% reported episodes of rape since turning 18 years old. In a study of a southwestern tribal community that included almost 600 individuals, Crossland et al. (2013) reported 91% of these women experienced some form of IPV. Verbal and physical violence in a relationship were experienced by approximately 75% of women, and 16% of women reported forced sex by a partner. Almost half of the women reported needing medical care from injuries sustained during an episode of IPV and a little more than one third reported incidents that involved their children. In another study on a southwestern reservation, among all assault injuries reported by ambulatory and emergency services, one in four was due to IPV (Crossland et al., 2013). These compelling numbers of sexual and intimate partner violence in AI/ AN communities indicate the problem merits serious attention.

Individual and Family Level Factors

There is considerable evidence that women from lower socioeconomic groups disproportionately experience IPV. In one study, more than half (53.9%) of AI/AN women were estimated to live below the Federal poverty level (Malcoe, Duran, &Montgomery, 2004). Malcoe et al. (2004) reported many American Indian women from lower socioeconomic experienced IPV. Malcoe et al. (2004) reported that 27.3% of AI victims were employed full time, 41.7%

were unemployed, 48.9% had received food stamps, and 18.3% had received Temporary Assistance to Needy Families (TANF).

Burnette and Figley (2016) reported that AI/AN women, who experienced child maltreatment, adverse childhood experiences, or teenage pregnancy were at high risk for IPV. Protective traits to cope with adversity include (a) being educationally oriented; (b) demonstrating affirming talents, abilities, self-sufficiency, and inner strength; (c) coping by helping others and expressing emotions; and (d) having faith, optimism, and a resilient perspective, such as learning and seeing growth from adversity (Burnette & Renner, 2016).

Community-Level Contributing Factors

All women deserve the right to live free from fear (President Obama, 2013; McConnell, 2015). For this to happen, it is essential to empower women legally, educationally, and financially. Empowerment can be achieved by emphasizing education and making sure girls receive good educations. Finally, communities need to be shaped so all women can experience economic independence and where they can be equal partners in economic development and prosperity (McConnell, 2015).

Racism is another aspect of violence to consider at the community level. Racism contributes to the elevated rates of violence against AI/AN women. American Indian/Alaskan Native women are victims of violence far more often than Whites, African Americans, and Asian women. American Indian/Alaskan Native women are targeted because of who they are as AI/AN women and what they represent (Lucchesi & Echo-Hawk, 2019).

We live in a society where portrayals of AI/AN women are often as victims of violence or hypersexualized. When the rest of the country only thinks of AI/AN women in terms of those

portrayals, it is easy to see AI/AN women in real life as women to victimize (Lucchesi & Echo-Hawk, 2019). American Indian/Alaskan Native women and girls are the least recognized and least protected population.

There has been extensive research on the legal environment and law enforcement capacity, the individual and family level factors, historical trauma, and the four typologies of abuse, which are all influential in the epidemic of MMIW. However, there have been a limited number of studies exploring the impact of the healthcare environment on this invisible problem. Specifically, there are too few studies on the level of knowledge primary care providers have about missing and murdered AI/AN women and their perceived role in reducing and preventing the prevalence of violence for this population.

Healthcare Environment

The current crisis of MMIW and girls is tied to the structural conditions and lived material realities that upend the lives of AI/AN peoples, rendering them disposable, unworthy, precarious, and even exposed to violent victimization and homicide (Monchalin, Marques, Reasons, & Arora, 2019). A critical aspect of the environment for AI/AN women and the focus of this paper is the healthcare environment and the 290,000 nurse practitioners who operate within it (More Than 290,000 Nurse Practitioners, 2020).

The health implications associated with human trafficking are varied, as victims commonly exhibit signs of physical, psychological, and sexual trauma. In one study Donahue and colleagues (2019) surveyed hundreds of trafficking victims and found that 88% reported that they received medical care during their captivity, and of those, 63% had been seen and treated in hospital emergency departments. In 2016, 5,712 AI/AN women and girls were reported missing

in the United States (Lucchesi & Echo-Hawk, 2017). Healthcare practitioners serve an essential role in the identification and assistance of victims many times; Nurse Practitioners are the first person a victim may encounter. Nurse Practitioners are in a unique position to interact with a person missing and seen in the clinical setting (Hachey & Phillippi, 2017). Healthcare providers get moments of privileged access to victims who often are out of reach to law enforcement (Donahue et al., 2019). There are nearly 6,000 hospitals in the country, but only an estimated 1.0% have policies for treating patients who are being trafficked. At present, only two states, Florida, and Michigan, require health care workers to complete some form of human trafficking training as part of their licensure (Donahue et al., 2019).

Statement of Problem

American Indian women are murdered at a rate ten times higher than the national average, and an estimated one third of American Indian women will be raped at some point in their lifetime (Cohen, 2018). American Indian women have long been considered invisible and disposable in society, and those vulnerabilities attract predators making AI/AN women at disproportionate risk for rape or murder (Deer, 2005). Homicide is the third leading cause of death among 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 (Heitkamp, 2017). There is also reason to believe that AI/AN women who are missing may be victims of human trafficking. Evidence suggests that chronic poverty, rape, homelessness, childhood abuse, and racism all play a part in human trafficking (New Report on Prostitution**,** n.d.).

Purpose Statement

Estimates suggest that between 75% (Green, 2016) and 87 % (Schwarz et al., 2016) of trafficking victims saw a healthcare provider while in captivity. Therefore, it is of utmost importance that Nurse Practitioners have a thorough understanding of Montana's epidemic of missing and murdered Indian women (MMIW). The purpose of this project was to 1) explore Nurse Practitioners knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated.

Significance of the Project to Nursing

Nurse practitioners are in a unique position to help human trafficking victims who walk through their doors. Since the life expectancy of a human trafficking victim is seven years, rescuing victims is of the essence. Estimates suggest that between 75% (Green, 2016) and 87 % (Schwarz et al., 2016) of trafficking victims saw a healthcare provider while in captivity.

Therefore, it is critical that Nurse Practitioners have a thorough understanding of Montana's epidemic of MMIW as many of these women may be victims of human trafficking. The purpose of this project was to 1) explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated.

CHAPTER TWO

REVIEW OF LITERATURE

The Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, Cochrane Library, and Urban Indian Health Institute databases were used to find peer-reviewed publications on violence against women and human trafficking. The following is the list of key terms used in conducting database searches:

- Indian, North American
- Alaska Native
- Domestic Violence
- Rape
- Homicide
- Human trafficking
- Education
- Nurse Practitioner
- Native American Women
- American Indian Women
- Missing and Murdered
- Indigenous
- Urban Indian
- Savanna's Act
- Montana
- Hannah's ACT
- Task force in Montana
- Colonization.

In addition to a key terms search, a hand search of the two most relevant journals was also conducted. The *Journal of Interpersonal Violence*, volumes 32-35 and *Violence Against Women*, volumes 23-26 were searched by viewing the table of contents of each issue for the years 2017 – 2020.

Missing and Murdered Indigenous Women and Girls

Studies have shown that AI/AN women face the highest rate of violent victimization, followed by Black, Hispanic, White, and Asian/Pacific Islander women (Monchalin et al., 2019). The rate of violent victimization for AI/AN women is almost twice that of Black women (Monchalin et al., 2019). In Canada, Indigenous females are six times more likely than non-Indigenous females to become homicide victims (Hansen & Dim, 2019). Of all women in Canada, Indigenous women experience the highest levels of violence, both in terms of severity and incidence (Oppal, 2012).

The actual number of missing or murdered AI/AN women is unknown; however, several estimates provided here are based on published research, internet databased, and by testimonies from affected families. In Canada, the Sisters in Spirit initiative documented 582 cases of missing and murdered Indigenous women over the 50 year period from 1960 to 2010 (Native Women's Association of Canada, 2010). Pearce (2013) recorded 824 cases of missing and murdered Indigenous women and girls between 1946–2013. A Royal Canadian Mounted Police report documented 1181 cases of missing and murdered Indigenous women from 1980 to 2012 (Royal Canadian Mounted Police, 2014). Most recently, community members from the Walk4Justice initiative estimated the number to be higher than 4000 and stated that they collected 4232 names of missing and murdered Indigenous women and girls along their walk (Yeung & Nair, 2017).

Lucchesi created an online database documenting 3,000 cases of MMIW in Canada and the United States. Lucchesi lamented the undercount of victims on her website, estimating that there are at least 25,000 to 30,000 more names that need attention (Aguilar, 2018). The Director

of the Urban Indian Health Institute took note of Lucchesi's work and as a follow-up to Lucchesi's database, the pair published a summary report of MMIW from 71 urban cities across the United States (Lucchesi & Echo-Hawk, 2018). The authors identified 506 cases of missing and murdered Indigenous women and girls. The authors cautioned that this was likely an undercount due to sparse surveillance in many cities.

Amnesty International (2014) stated there is "clear evidence" that Indigenous women are sought out as targets for attacks by men. These attacks are motivated both by racism and perpetrators' realization of the lack of importance placed on the protection and well-being of Indigenous women, which allows them to evade justice easier (p. 3). This reality was also noted by the *Missing Women Commission of Inquiry,* which investigated police response to the missing and murdered women from the Downtown Eastside of Vancouver B.C., who were victims of serial killer Robert Pickton. Many of his victims were Indigenous women. There were reports of highlighted critical police failures, citing their degrading or insensitive treatment of families (Oppal, 2012). When families reported a loved one missing, the police did not see the urgency in reporting. Their inquiry concluded that there was "systemic bias in the police response to the missing women investigations" and that faulty stereotyping of street-involved women had negatively impacted investigations of missing women (Oppal, 2012, p. 43).

When examining this MMIW crisis, one cannot separate it from the structural embeddedness of colonialism and the impacts of patriarchy. The disappearance and murder of AI/AN women and girls is an example of structural violence. As Laveel-Harvard (Wikwemikong First Nation) and Brant (Tyendiaga Mohawk Nation) stated:

> To understand the severity of the tragedy facing Indigenous women today, the history of settler colonialism is important to understand, a process deliberately and

> openly designed to eradicate the so-called "Indian problem" in North America by simply eliminating the "Indians" themselves (Riel-John, 2016, p. 3).

When colonizers came to North America, Indigenous women came under attack, as they were deemed "a threat to the development of a patriarchal society" (Riel-Johns, 2016, p. 37). In recognition that AI/AN women held prominence in their societies, Riel-Johns posited that colonizers sought to break this link and deliberately attempted to erase their presence.

Indigenous women were viewed as "savage or primitive" (Deer, 2015). They were shamed and marginalized as a result of patriarchal colonizers who advanced distorted narratives of Indigenous societies and peoples, as a means to exterminate or assimilate (Deer, 2015). Janice Acoose (Nehiowè -Metis-Ninahkawè Iskwèw) explained how Indigenous women have been sexualized and misrepresented within Canadian literature since early history in this place referred to as "Canada." Indigenous women were labeled as the "Indian princess," "easy squaw," or "whores whose only purpose is a sexual one" (Acoose, 1995, p. 39–45 cited by Monchalin et al., 2019). Métis scholar Emma LaRocque explained that the depiction of a "squaw" is dehumanizing, in that it represents a female who "has no human face, she is lustful, immoral, unfeeling and dirty" (Monchalin et al., 2019, p. 178).

Such representations create compelling images that in turn create stereotypes. The stereotypes foster dangerous cultural attitudes that affect human relations and inform institutional ideology (Monchalin et al., 2019). Depictions such as "squaw" persist. These representations of Indigenous women have become embedded and normalized within North American discourses, literature, media, institutions, and societal structures. These stereotypes are very apparent in popular culture today, whereby pop icons or models have dressed up as "sexy Indians" to deem themselves as more "erotic" or "exotic" perhaps without recognizing the dangerous, damaging

stereotypes they perpetuate. These images serve to perpetuate colonial narratives that Indigenous women are exotic “others” for disposable use. They unwittingly achieve the same objective that the early patriarchal colonizers set out to do (Monchalin et al., 2019).

Violence against Indigenous women is a sociological phenomenon that has been happening since colonization (Riel-Johns, 2016, p. 39–40). Colonial ideologies of women's sexuality, particularly Indigenous women's sexuality, underpin the violence Indigenous women faced throughout history into the present day. As Laveel-Harvard and Brant (2016) explained: “the issue of missing and murdered Indigenous women and girls in Canada and U.S., today must be understood within the context of these genocidal efforts” (p. 4).

The residential schools and Indian boarding schools also sought to erase Indigenous peoples. Children were stolen from families and forced into these institutions that were modeled off prisons. It has been well documented that children in these institutions faced horrible abuses. For instance, the final report of the Truth and Reconciliation Commission of Canada (2015) contained over two million words. It spanned six volumes and was based on the testimonies of over 6000 survivors. Survivor testimonies revealed that physical, emotional, and sexual abuses were persistent. As residential school survivor Fred Kelly (from Ojibway's of Onigaming First Nation) stated, “Many of us were physically beaten, sexually fondled, molested, and raped” (Monchalin et al., 2019). In addition to residential schools, Indigenous women were targets of forced sterilizations and child welfare apprehensions that were all aimed at destroying the power of women to carry on the next generations of Indigenous nations (Lavell & Brant, 2016).

Until recently, remnants of this erasure could also be seen in Canada's Indian Act. The purpose of this statue was to govern 'Indian' status, and the management of First Nation

communities in Canada, where before amendments in 1985 if an 'Indian' woman partnered with a non-Indian man, she and any children resulting from that union would lose their Indian status (Monchalin et al., 2019).

This socio-historical context cannot go unacknowledged when trying to understand the violence prevalent in AI/AN women's lives today. Intimate partner violence, rape, homicide, and trafficking are all expressions of structural racism and violence. Structural racism and violence are perpetuated from intimate partners as well as strangers—those invisible forces affect everyone. New processes of colonization have become entrenched. They have become endemic to society and institutions, and as such, put AI/AN women at a greater collective risk (Monchalin et al., 2019).

Human Trafficking

Human trafficking falls into two broad categories. The first is labor trafficking. Labor trafficking typically is for hard labor, usually in agriculture, textile sweatshops, or domestic workers, such as a nanny or house servant. The second is sex trafficking. Sex trafficking involves forced work in strip clubs, massage parlors, pornography production, or prostitution. It may also include mail-order brides (Green, 2016).

Sex trafficking is the most dominant form of slavery in the United States. An estimated 14,500 to 17,500 are trafficked into the U.S. annually, and the exploitation of minors in the United States is estimated to range from 100,000 to 200,000 (Green, 2016). The extremes of wealth and poverty in North America contribute to the problem of trafficking. Data support that women and girls are at a higher risk for sex trafficking than men or boys, both internationally and within the United States (Hachey & Phillippi, 2017).

Traffickers often target the emotional needs and vulnerability of others. Childhood sexual abuse nearly doubles the odds of later entry into prostitution and 80 - 90% of these youths become victims of human trafficking (Monchalin et al., 2019). Studies reveal that physical, emotional, and sexual violence were persistent factors leading to the sex trafficking of individuals.

The history of childhood sexual abuse of AI/AN children from the boarding schools had a chronic effect, which is evident today. The persistent impact of sexual abuse has made AI/AN women prey to traffickers. American Indian women and girls face ongoing exposure to abuse, exploitation, and violence in their families and peer networks. As an essential risk factor; the legacy of the boarding schools is described as one of the most devastating impacts of generalization of trauma (Pearce et al., 2015).

The Role of the Nurse Practitioner

Garcia-Moreno, Jansen, Ellsberg, Heise and Watts (2006) reported intimate partner violence is a serious medical and public health epidemic. Violence against women can lead to severe short-and long-term harm. Intimate violence partner survivors are at an increased risk of psychological concerns such as decreased feelings of self-worth, depression, post-traumatic stress disorder, and substance use (Ragavan et al., 2018). Physical and reproductive effects include increased risk of sexually transmitted infection, unwanted pregnancy, poor maternal outcomes, pain, and injury. All women who experience violence are at increased risk for repeated violence (Kirk et al., 2017). Furthermore, IPV survivors face challenges accessing health care services and developing trusting relationships with their health care providers (Ragavan et al., 2018). Women commonly use informal sources and health care systems for help.

However, formal institutions (counseling, legal) are still underutilized (Katerndahl, Burge, Ferrer, Becho et al., 2020)**.** However, screening for IPV is low, ranging from 1.5% to 18%, and varies by the type of health care provider (i.e., primary care, obstetricians, etc.) (Stoler, Verity, & Williams, 2020). Acting in IPV can take the form of leaving the relationship, seeking help with coping, or taking legal action (Katerndahl et al., 2020).

Public health interventions aimed to prevent or reduce violence against women can be divided into three types: primary, secondary, and tertiary. The goal of primary prevention is to prevent the disease or health event from ever occurring. Secondary prevention aims to detect the issue early and to avoid or delay its progression or reoccurrence. The aim of tertiary prevention is to prevent death and disability associated with the disease or health event (Kirk et al., 2017).

Primary prevention in the context of violence against women means reducing the number of new instances of IPV or sexual violence by intervening before any violence occurs (Harvey, Garcia-Moreno, & Butchart 2017). Primary prevention relies on identification of the underlying, or "upstream" risk and protective factors for IPV and sexual violence, and the actions needed to address those factors. The meaning of taking action upstream is explained as:

> There are some people fishing on the riverbank, and suddenly they see a person swept by in the current, half-drowned, and struggling to stay afloat and swim to shore. They wade into the water and grab hold of the person, who continues her way by land once she has caught her breath and dried off a bit. Just as they get her to shore, they see another person in trouble or hear a cry for help. All afternoon they continue saving people from drowning by pulling them out of the river until someone decides to walk upstream to find out what is causing people to be swept away in the river in the first place (Harvey et al., p. 5)

One example of a primary intervention is strategizing collaborative interventions to prevent child maltreatment and promote healthy development (Harvey et al., 2007). This includes a discussion of IPV and sexual violence in maturation and physical education courses.

Another example is lobbying policymakers so they are aware of the problems of IPV and sexual violence.

The public health approach to the primary prevention of IPV and sexual violence is accomplished by the Nurse Practitioner in four stages. First is to define IPV and sexual violence and document the scope and magnitude of the problem in their practice setting and among their panel of clients. Next, the Nurse Practitioner should identify the risk and protective factors for their panel. Third, they need to modify or tailor their intervenitons based on the developmental and edcational stage of their audience. Finally, the Nurse Practitioner must implement proven and promising strategies, including education, screening, and referral (Harvey et al., 2017). No single factor can explain why some people are at high risk while others are not or why violence is more common in some contexts than in others. This is why Nurse Practitioners must routinely include education about IPV and sexual violence in their interactions with their clients (Harvey et al., 2017).

Figure 1. The Ecological Model.

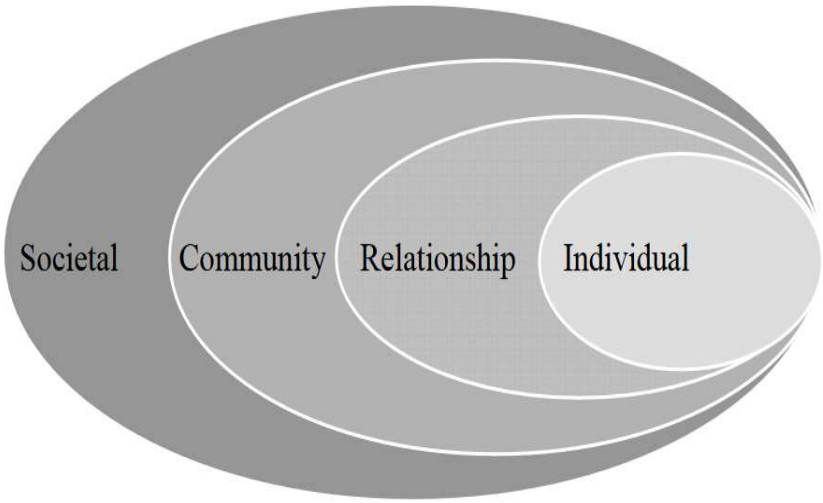


Figure 1 is an illustration of the Ecological Model for understanding this interplay of factors at various levels. The Ecological Model can be used to better understand the many and layered factors that impact the incidence and prevalence of any health matter (Heise et al., 1998; Krug et al., 2002). In this case, the model illustrates how an individual's exposure to violence can be influenced by factors at the individual, relational, community, and/or societal levels. The individual level of the model encompasses biological factors, beliefs and attitudes, and personal history factors that influence an individual's likelihood of becoming a victim or perpetrator. The relationship level reflects how an individual's close social relationships affect their risk for violence. The community level includes the characteristics of neighborhoods, recreational spaces and work environments that contribute to or protect against violence. Simple examples include well-lit walkways, police presence, and mixed-use neighborhoods. Societal level factors refer to those underlying conditions of society that either encourage or inhibit violence. Examples of societal level factors include the legal and policy landscape, structural racism, and the health promotion curriculum in public schools. The Nurse Practitioner must have ongoing knowledge of how these factors interact to confer risk with a wide variety of clients and across multiple settings (Harvey et al., 2007).

Primary prevention is critical for the long-term reduction of violence against women and girls. The Patient Protection and Affordable Care Act of 2010 required that providers integrate IPV screening into preventative care for all women of reproductive age (Ramachandran, Covarrubias, Watson & Decker, 2013). It is important to inform patients that violence is a health risk and can result in acute and chronic physical and emotional problems. The clinical relevance of understanding violence and other abusive relationship dynamics is increasingly evident; for

example, recognizing violence or reproductive coercion may enable providers to avoid prescribing contraceptive methods that could be subject to sabotage by an abusive partner (Daley & Polifroni, 2018). Screening for dating violence among adolescents can yield positive effects on both primary and secondary prevention activities (Phase, Sherwin, Harrison, Mitchell, Freeman, & Lichterberg, 2019).

Nurse Practitioners are in an ideal position to help identify women at risk, establish a trusting relationship with their patients and be advocates in ending the cycle of violence. Identifying women experiencing IPV must be a priority for Nurse Practitioners. The role of Nurse Practitioners requires a commitment to meet the evolving needs of society and advances in health care science (Scope of Practice, 2019). Nurse Practitioners serve as advocates by providing a much-needed voice for patients, their communities, and their profession. Specifically, these include protecting patients from harm, communicating patient preferences, fostering collaboration, providing essential information to inform decision-making, and supporting the voice of the patient regarding choices and care (Choi, 2015). Furthermore, it is suggested by survivors of IPV that the provider be nonjudgmental, listen, offer information, and resist pushing for disclosure (Chang et al., 2006).

Inquiring about past or current IPV can be done through direct questioning as part of the routine visit or through pattern recognition when signs and symptoms in the history and physical exam alert healthcare providers to explore the possibility IPV. Identifying IPV victims in the clinical setting can occur through spontaneous or prompted dialogue. Screening for IPV is not necessarily a standard part of every clinical encounter so primary care providers must be knowledgeable on risk factors and prepared to conduct and empathic inquiry and screening

assessment. Moran (2008) reported the importance of screening for IPV and the need to do so in a caring, confidential, and nonjudgmental manner. Nurse Practitioners are well versed in holistic care and are therefore likely to have the empathetic and therapeutic skills necessary to implement IPV and sexual violence screening with their clients (Miller, 2015).

Nurse Practitioners are the gatekeepers for identifying IPV. It is also evident that the medical community represents an opportune setting to prevent or interrupt violence against women and to identify and assist victims of trafficking (Schwarz et al., 2016). Research has also shown that victims tend to be more comfortable speaking with a health care provider than with police (Bauer, Brown, Cannon, & Southard, 2019).

Estimates suggest that between 75% (Green, 2016) and 87% (Schwarz, 2016) of trafficking victims saw a healthcare provider while in captivity. Sadly, sex trafficked victims sought treatment within the healthcare system while in captivity but were rarely identified or helped by health care practitioners (Donahue et al., 2019). There are tips to recognizing the signs of human trafficking during the assessment phase of the visit. Nurse practitioners with proper training have an increased likelihood of identifying victims.

Victims of trafficking often present with common health issues that may include sudden illness, drug overdose, toxic exposures, pregnancy, abortion, or untreated chronic disease, such as diabetes. A potential victims' assessment should consist of careful documentation of information about injuries that involve mouth, skin, or genital or anal areas (Leslie, 2018). Objective clinical findings indicative of potential risk includes a patient's poor mental health, poor physical health, abnormal behavior, and inability to speak for himself/herself due to a third

party insisting on being present and interpreting (Mason, 2018). Subjective assessment findings may include client report of multiple sexual partners.

In general, screening refers to empathic inquiry and may or may not include a standardized question set. O'Doherty, Hagerty, Ramsay, Davidson, Fender, and Taft (2015) reported there is no specific tool to assess for IPV as each victim's situation varies. However, evaluating the effectiveness of IPV screening where healthcare professionals either directly screened women face-to-face or through written or computer-based methods. Positive screening results would then be assessed by the healthcare provider who could exercise their own clinical judgement in how to respond to a positive result (O'Doherty et al., 2015). The review concluded that there is insufficient evidence to justify the implementation of intimate partner violence (IPV) screening for all women in healthcare settings. However, it would be more beneficial to train healthcare professionals in case finding for IPV as part of the routine social history (O'Doherty et al., 2015). Still, there is a need for studies evaluating universal screening to case finding for women's overall safety to inform IPV identification policies in a healthcare setting (O'Doherty et al., 2015). Basile, Hertz, and Back (2007) reported nearly three dozen IPV questionnaires available for health care providers to utilize in their clinical settings. The three with the highest predictive value are the 1) Computer Based IPV Questionnaire, 2) Abuse Assessment Screen, and 3) Two Question Screening Tool.

The Computer Based IPV Questionnaire

The Computer Based IPV questionnaire developed by Rhodes et al. (2002) screens for physical abuse, emotional abuse, and the patient's perception of safety in the current relationship. The fourteen-item questionnaire includes six specific questions related to violence:

1. Have you ever been physically hurt by someone close to you?
2. Are you worried that you might get physically hurt?
3. In the past 12 months, have you ever felt so low that you thought about harming yourself or committing suicide?
4. Have you ever been made to have sex when you did not want to?
5. Is there a handgun in your home or car?
6. Have you ever witnessed or taken part in any argument or fight where someone had a gun or knife?

These questions are typical of the screening items included in many of the most used instruments. They require that the client be able to read in English if the instrument is applied before the visit. Alternatively, the Nurse Practitioner can verbally screen their client during the exam.

Abuse Assessment Screen

The Abuse Assessment Screen (AAS) is one of the oldest short domestic screening tools still used today (Women's Health Education Center, 2009). The Abuse Assessment Screen is a five-item assessment focused on physical, sexual, and emotional abuse. It is not exclusive to IPV but on violence against the client perpetrated by anyone. The screening tool was validated with abused pregnant and nonpregnant, African American, Hispanic, and White women in health and prenatal clinics and emergency departments. A Nurse Practitioner might value this tool because it is only five items and because the test/retest reliability for pregnant women was 83%. The sensitivity was 93%, and specificity was 55% when compared to the gold standard Index of Spouse Abuse (Basile et al., 2007). The combination of high sensitivity and low specificity

means that the provider will have some false-positive results to sort out among their clientele. Due to the ethical implications of missing cases of violence, a screening tool with higher false-positives is preferable to one that could result in false-negatives.

Two Question Screening Tool

The purpose of the Two Question Screening tool developed by McFarlane, Greenberg, Weltge, and Watson (1995) is to rapidly assess for physical IPV and sexual violence. The screening tool was validated by African American, Hispanic, and white women in public and private emergency departments. A woman is considered abused if she gives a positive response to either question. A Nurse Practitioner might value this tool because it is only a two-item questionnaire asking the following questions:

1. Have you ever been hit, slapped, kicked, or otherwise physically hurt by your male partner?
2. Have you ever been forced to have sexual activities?

A safety plan should be discussed with women who have a positive screen, and they should receive information regarding abuse and community resources (McFarlane et al., 1995).

Leslie (2018) reported a different two-item scale she found useful for screening purposes. An alternative to McFarlane et al. (1995), these two items assesses the patient's living situation and if they exchange sex for resources such as food, money, or shelter. This approach is slightly different than McFarlane's approach which assess for IPV directly and does not consider the patient's living situation. A potential downside to this practical approach is the patient may display signs of depression or fear and answer questions in a vague manner. The use of open-

ended-questions concerning the patient's mental and physical health may help the provider learn of an abusive situation (Leslie, 2018).

The patient should be given the option to speak to a male or female provider and the provider must take the time to build rapport with potential victims (Leslie, 2018). Screening all clients with any risk factors is an ethical imperative for primary care providers. The process of changing deep-rooted societal beliefs with patients is never fast, and health care providers will have to go beyond screening and secondary prevention to work on resolving violence against women (Kirk et al., 2017).

Resolving violence occurs during tertiary intervention. Tertiary prevention begins with a positive screen and a disclosure by the client. In such a circumstance, time is of the essence and rescuing the victim is critical. Donahue et al. (2019) reported the average life expectancy of a trafficking victim is only seven years**.** There are two types of disclosures the NP may hear which can help in identifying IPV victims in the clinic. These two types of disclosures are "unintentional" and "prompted" which are explained in further detail.

Unintentional disclosure is when the patient discloses IPV in a chief complaint or during the history and physical exam; but also, can be done through a reliable third party such as police, emergency medical personal, or a friend. When IPV is identified in this way, it is a confirmed diagnosis of IPV.

Alternatively, prompted disclosure is an inquiry for past or current IPV by the provider due to assessment findings during the history and physical exam. The provider may notice risk factors in the client's social history or recognize a pattern of complaints consistent with IPV. When gently asked by the Nurse Practitioner, the patient may admit or deny IPV. When patients

disclose IPV, it is a confirmed diagnosis of IPV. However, when a patient denies IPV, the Nurse Practitioner may continue to suspect IPV or eliminate suspicion of IPV (Miller, 2015).

Nurse Practitioners should know that in two studies of women who were routinely screened by their primary care providers, the clients valued the assessment and the impacts from screening (Spranger, Koziol-McLain, Ruherford, & Zwi, 2019). The screening resulted in a tentative model for women's perceptions about the effects of screening, which included naming the abuse and gaining a sense of connection (see Figure 2). The authors showed that benefits were not restricted to those who disclosed their experiences (Spranger et al., 2019).

Figure 2. Pathways to Women's Decision to Disclose or Not Disclose.

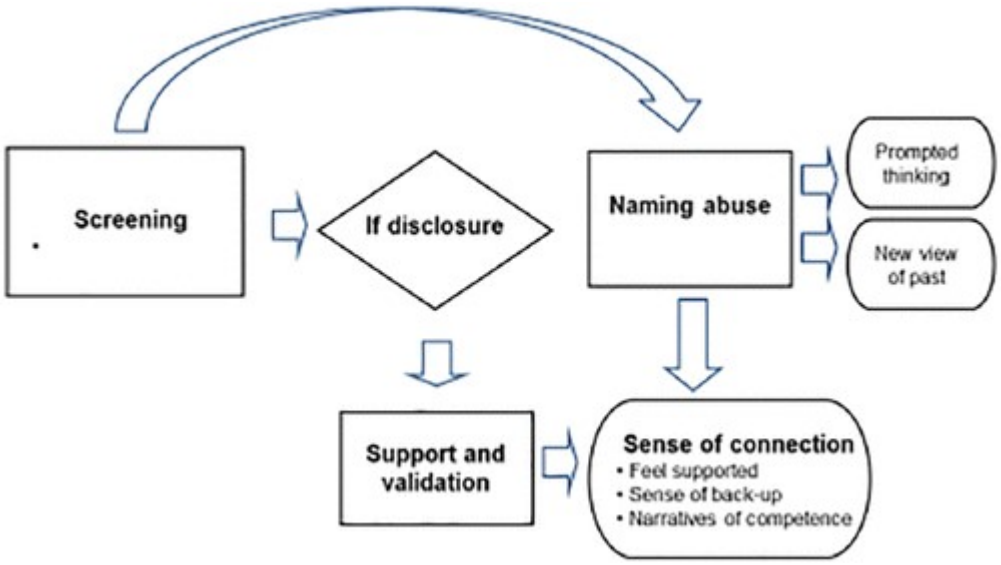


Figure 2 is a diagram of women's perceptions about the impact of screening for IPV. The diagram shows pathways to women's decisions to disclose or not disclose abuse in response to routine screening (Spangaro et al., 2016). Importantly, women who talked to their health care provider about abuse were four times more likely to use an intervention (McClosky, Lichter, Williams, Gerber, Wittenberg, & Ganz, 2006). Evidence suggests that when healthcare providers

connect their patients to an advocate, the patients are more likely to use an intervention (Feder et al., 2011). The assistance can be as simple as assisting the client with making a phone call. This is called a "warm referral" or "warm hand off" in practice. Before handing a client off, the Nurse Practitioner must do their utmost to document imminent danger to their client.

When addressing IPV, the best practices for directing the implementation of IPV counseling includes an integrated response with a healthcare delivery system including clients, health professionals (e.g., social workers, case managers), health system leaders and policymakers. Those exposed to IPV may seek care in a variety of health care settings. These settings need to have the capacity and motivation to identify support and connect patients to those services. The systems-based approach emphasizes not only health provider education but also policies, protocols, and institutional supports within the healthcare delivery system to facilitate routine IPV screening and counseling and connecting to advocacy service (Miller, 2015). In cases where the Nurse Practitioner is the only person the client trusts or in settings where there are not counselors or interventionists available to the client, the NP could use the Danger Assessment Tool as part of a plan of care to help the victim appreciate their level of danger.

The Danger Assessment Tool

The Danger Assessment Tool was designed to determine the level of danger an abused woman has of being killed by her intimate partner. The instrument was initially developed by Campbell (1986) who is nationally recognized as the preeminent scholar on intimate partner homicide in the U.S. (Messing & Thaller, 2012). The Danger Assessment Tool was refined with consultation and content validity support from battered women, shelter workers, law

enforcement officials, and other clinical experts on battering (Campbell, 2009). The tool is available in English and Spanish, and the population of study was with African American, White, and Hispanic women in the community, battered women shelters, prenatal clinics, and primary care clinics. There are two parts to the tool: a calendar and a 20-item scoring instrument (Basile et al., 2007).

The calendar method uses a diary methodology and where the victim marks the days the husband or partner beat them and the severity of the violence. The calendar gives the victim a picture of the seriousness of the violence, which has occurred over time. If slapping or pushing occurred with no injuries, the victim marks a “1” on the calendar. If punching, kicking, bruises, or cuts were sustained, or if the client is in ongoing pain, the victim marks a “2” on the calendar. If severe wounds, burns, or broken bones were sustained, the victim marks a “3" on the calendar. If threatened with a weapon, or sustained a head injury, internal injury, or permanent injury, the victim would mark a “4” on the calendar. The victim would mark the number “5” on the calendar if they received wounds from a gun. A drawback to the test is the length and time but a benefit is the visual data the patients sees on the occurrences of abuse over a month-long or months-long period (Basile et al., 2007).

When a health professional has positive screening for IPV there is a mandatory reporting system set in place. The mandatory reporting is a set of U.S. federal and state laws that require healthcare providers to report actual or suspected abuse to a legal or governmental agency (Jordan & Pritchard 2018). These laws address multiple types of abuse and harms, including crime-related injuries deriving from the use of a weapon, child abuse, neglect or exploitation, elder abuse, and domestic violence or sexual assault (Jordan & Pritchard 2018). Mandatory

Reporting laws influence survivors' ability to seek and receive support (Lippy, Jumarali, Nnawulexo, Williams, & Burk, 2020).

Media Coverage

There have been articles written about MMIW and stories about the families of victims in the media. In June 2018 Jermaine Charlo, a 23-year-old American Indian female, disappeared near a grocery store in Missoula and is still missing. Larson and Reilly (2019) reported Jermaine as the 13th AI woman to go missing in Montana since January 2018. Another case of MMIW was in 2017 when Ashley Heavy Runner of Browning, Montana, was reported missing (McLaughlin, 2019) with no trace of her whereabouts at the time of this writing.

In January 2020, the story of a young American Indian girl story went viral after Selena Not Afraid was reported missing. She was last seen at a rest area outside of Billings, Montana. A search and rescue searched the lands near the rest area for weeks. Selena's body was recovered three weeks later, one mile from the rest area (Healy, 2020).

Lucchesi and Echo-Hawk (2018) opined that media coverage of the MMIW issue is insufficient and explained that many cases occurring in urban areas fail to be covered by national media. The authors shared how this lack of reporting may lead the general public to have an inaccurate understanding of the issue, and over two-thirds of the cases that happen in urban areas are consequently rendered invisible (Lucchesi & Echo-Hawk, 2018). The lack of reporting at the national, state, and community levels prevents critical awareness of the problem and is also hurtful to victims' families and communities. The lack of media conversation perpetuates a dominant White narrative that continues to propagate the idea that Indian bodies do not matter, especially if these Indian women are killed by members of a dissociative American public.

Higher levels of dissociation were associated with increased violence in a diverse range of populations, including college students, military veterans, psychiatric patients, and perpetrators of sexual/domestic violence and homicide (Bourget, Gagne, & Wood, 2017).

Increased violence in diverse populations and a lack of representation from law enforcement limits engagement in a cross-cultural community dialogue on how to enhance safety--not just for Indian women and girls, but for all women who live in the cities in which they go missing or murdered (Lucchesi & Eco-Hawk, 2016). To enhance the safety of communities, there also needs to be more involvement at the community-level. The community-level includes the characteristics of neighborhoods, recreational spaces, and work environments that contribute to or protect against violence (Krug et al., 2002; Harvey et al., 2007).

Lutey (2019) reported the number of MMIW from urban areas, such as Billings, Great Falls, Butte, and Helena, Montana. This report did not include figures from tribal lands. Because of inadequate reporting collaborations, the cases of MMIW could be higher than what was cited. The "NamUs" clearinghouse is the result of national recognition by the Institute of Justice in 2003 that sharing information across jurisdictions was critical to pursuing justice for victims and families. In 2018 "NamUs" launched their software program and it remains to be seen if this data clearinghouse will be a tipping point in collaboration on cold cases. Take for example, the National Crime Information Center reported 5712 missing AI/AN women and girls in 2016. In contrast, "NamUs" listed 116 cases (namus.gov, 2016; Lutey, 2019).

American Indian women are missing/murdered at an alarming rate and are rarely found. American Indians make up 6.7% of Montana's population (U.S. Census Bureau, 2010), but they accounted for 26% of missing person reports from 2016 through 2018, the only years for which

comprehensive data on those cases were available from the state. Nearly two-thirds of those cases involved women or girls (Wilson, 2019). Although media support for U.S. & Canada indigenous populations has grown over the last year, decades of disproportionate murder and abduction rates among AI/AN women points to an unsettling trend of underlying disdain against AI/AN people (Petrova, 2018). Monchalin and colleagues (2019) suggested that the disappearance of AI/AN women is a by-product or extension of colonization by the European settlers and the resulting trauma experienced by AI/AN people. At a Senate oversight hearing on December 12, 2018, Senator John Tester (Democrat- Montana), and Senator Steve Daines, (Republican-Montana), reported that 24 AI/AN women in Montana disappeared in 2018. Only one was found alive, another was found dead, and the others remain missing (Lutey, 2019). The Montana Department of Justice reported an increase in missing persons, particularly in tribal communities in 2019.

Figure 3 illustrates the number of active cases of missing persons by race reported to Tribal police or the Bureau of Indian Affairs as of 12/31/2019 (Missing Persons Data, 2019). The histogram in Figure 3 does not include information for the Fort Belknap or Little Shell Tribe of Chippewa Indians. Fort Belknap works with the Blaine County Sheriff's Department and therefore the Bureau of Indian Affairs does not have that data in their files. When viewed together these figures help the reader to appreciate both the startling raw numbers of current cases of MMIW in Montana and the disproportionate percentage of overall MMIW cases for AI/AN. It is important to note from Figure 4 that AI/AN people are missing at more than four times their percentage of the general population (6.5%).

Figure 3. Total Number of Missing AI's entered by Tribal police/ BIA.

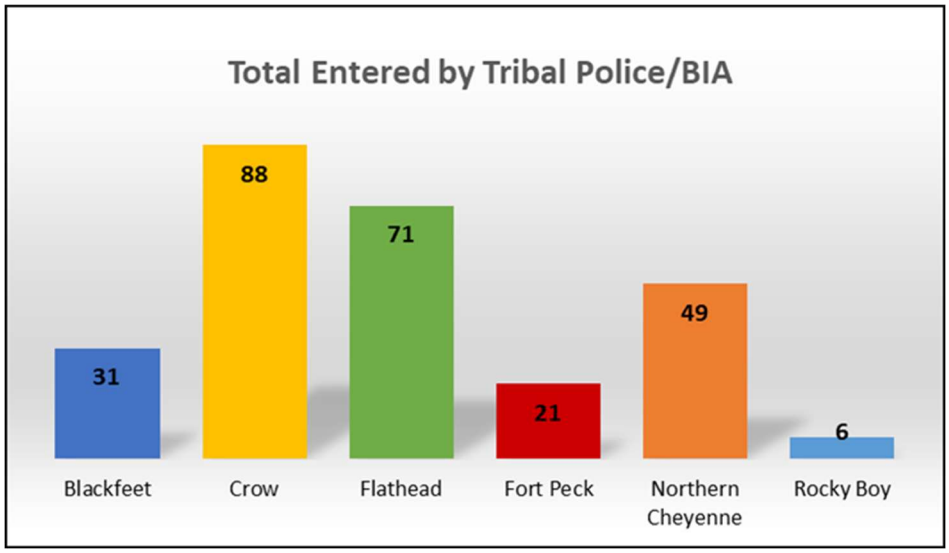
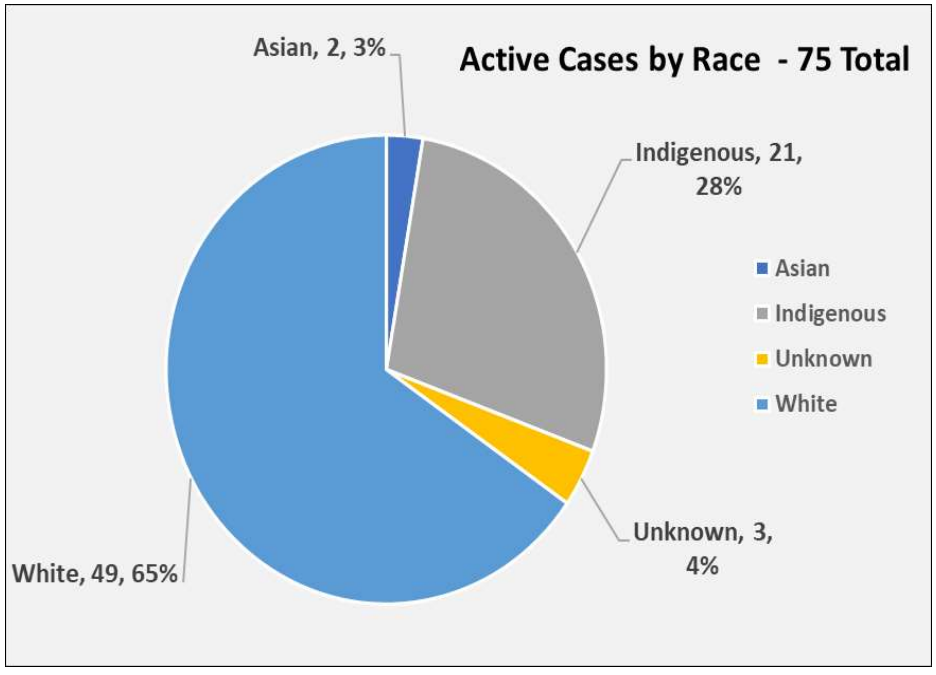


Figure 4. Active Missing Cases by Race.



The Urban Indian Health Institute, in consultation with key community leaders, reported cases of missing or murdered Indian women and girls from 71 cities across the United States.

The cities reviewed were those with 1) Urban Indian Health center, 2) a significant population of urban Indians, and 3) a large number of MMIW/girl cases. Lucchesi and Eco-Hawk, (2019) reported 506 deaths of AI/AN women and girls from 1900-2018 noting that two thirds of these 506 deaths were from the five-year period 2013-2018. These cases were linked to domestic violence, sexual assault, police brutality, and lack of safety for sex workers. Montana was noted as one of the top states with the highest numbers of MMIW/girls. The number of cases were from the following cities: 1) Billings with 29 cases, 2) Great Falls, with 5 cases, 3) Helena with 3 cases, and 4) Missoula with 4 cases. Billings and Great Falls are in the top 10 cities with the highest number of MMIW that have failed to be reported to national and local law enforcement (Lucchesi & Eco-Hawk, 2019).

Attorney General Eric H. Holder, Jr. declared the Department of Justice has both "a legal duty and a moral obligation to address violent crime in Indian Country and to assist tribes in their efforts to provide for safe tribal communities and most importantly to Indian women" (Rosay 2016, p. 6-7). Despite this declaration, there has been limited work done to understand disappearances and murders of AI/AN women, and limited studies exploring the knowledge Nurse Practitioners have about MMIW. Nurse Practitioners in Montana may have AI/AN women as their patients and should be able to recognize AI/AN women's unique risk profile. However, it is unknown what level of knowledge Nurse Practitioners have regarding MMIW.

Activists, in response to the lack of societal awareness of the disproportionate rate at which AI/AN women and girls go missing, created the Red Dress Movement depicted in Figure 5. Communities across Canada and the U.S. displayed the Red dress to remind a person that these dresses belonged to an Indian woman who has gone missing. They serve as stand-ins for

the potentially thousands of native women who go missing or are murdered each year (Ault, 2019).

Figure 5. Red Dress Movement.

The Hardin's girls' basketball team remembered Selena Not Afraid, a young AI girl who was found dead outside of Billings, Montana, near a rest area after being reported missing for three weeks. In remembrance of Selena, the team wore red shirts with the words “Hope for Sel” as a warm-up top before the game (Jay, 2020). The shirts were worn to show remembrance for Selena and to bring awareness to MMIW. The MSU Bobcat team followed suit and had special warmups made, and the MSU American Indian Center dancers performed at halftime in February 2020 to bring notice to MMIW.

A Northern Cheyenne artist Alaina Buffalo Spirit has set up a group of wooden silhouettes in a room at Chief Dull Knife College located near the Northern Cheyenne Indian Reservation in Lame Deer, Montana. The figures are for a new art piece by Buffalo Spirit called Spirit Women to honor missing and murdered American Indian women; each figure will be

decorated by family members to honor a loved one. The Spirit Women can bring together women to form a support group, a resource for grieving American Indian families; women can come together and express how they feel, bringing everyone together that have lost loved ones (Paige, 2020).

Theoretical Framework

Knowles Theory of Adult Learning

Knowle's Theory of Adult Learning has guided this project as a conceptual framework to learn what Nurse Practitioners know, what they need to know, and their recommendation for other Nurse Practitioners in relation to MMIW. Knowle's Theory of Adult Learning was known as one of the most influential learning theories during the late 1970s and 1980s and remains relevant today. The Theory of Adult Learning affirms that by applying six principles, new learning will occur. Nurse Practitioners can work towards the need to know and to understand for themselves why they should learn something. While these principles can be used in many diverse settings, their meanings, as defined by Knowles, do not change. The principles of the Theory of Adult Learning are applied to each adult learning situation which will be used in identifying what Nurse Practitioners need to know about MMIW (Knowles, 1980).

Adults have life experiences that serve as resources upon which they attach new learning. These life experiences are a significant source of an adult's self-identity. There are six principles of Knowles Theory of Adult Learning. The first is that adults need to know and to understand for themselves why they should learn something new. The second is that adults have a deep need to be self-directing. Self-directed learning means that adults oversee their education, the pace of their learning, the when, where, and how of their education. Adult learners need to be capable of

taking responsibility for themselves, and thus, their education. The third principle is that adults have a higher volume and different quality of experiences than children. Adults have life experiences that serve as resources upon which they attach new learning. These life experiences are a significant source of an adult's self-identity. The fourth principle is that adults become ready to learn when they experience a need to know. Not only must an adult understand the need for the learning, but the timing of the learning must also be right for the adult. If adults are not ready in their work, their home life, their setting, etc., new knowledge will not occur. Fifth is that adults enter a learning experience with a task-centered or problem-centered orientation to learning. Since adults have life experiences, they develop an understanding of their own learning style which is to learn around the application of newly acquired knowledge to the task or problem at hand. If adults are taught around this center, they will see how to apply the new knowledge. Finally, the sixth principle of Knowles Theory of Adult Learning is that adults are motivated to learn by both extrinsic and intrinsic motivators. Extrinsic factors (e.g., a problem or a task) motivate adult learning to a certain point and are needed. Intrinsic factors complement the extrinsic factors and are essential for the adult to increase self-esteem and to measure actual achievement. Extrinsic factors can be imposed upon the adult, such as the adult being told the learning must take place before a promotion is given. If the adult does not have the intrinsic motivations of also wanting to acquire the new knowledge, however, the learning will not take place. Both motivators are needed (Knowles, 1980). In the context of Nurse Practitioners acquiring knowledge around reducing the incidence and prevalence of violence against women, it is assumed that this scholarly project will help them gain the intrinsic motivation to acquire new knowledge as they improve their practice and expertise.

CHAPTER THREE

METHODS

Purpose Statement

American Indian/Alaskan Native women are murdered at a rate ten times higher than the national average, and an estimated one third of AI/AN women will be raped at some point in their lifetime (Cohen, 2018). American Indian/Alaskan Native women have long been considered invisible and disposable in society, and those vulnerabilities attract predators making AI/AN women at disproportionate risk for rape or murder (Deer, 2005). Homicide is the third leading cause of death among 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 (Savanna's Act Congress S.1942 -115th, 2017-2018).

There is reason to believe that AI/AN women who are missing may be victims of human trafficking. Evidence suggests that chronic poverty, rape, homelessness, childhood abuse, disparate educational opportunities, gender, prior abuse history, nationality, and poor physical and mental health are also regarded as vulnerability factors of human trafficking (Preble & Black, 2019). Many AI/ANs have experienced physical, sexual, emotional abuse, and neglect, which makes AI/AN women easy prey for predators (Amnesty International, 2020). Human trafficking is modern-day slavery and a public health issue that impacts individuals, families, and communities. Understanding the urgency and gaining knowledge about human trafficking could help Nurse Practitioners rescue AI/AN women.

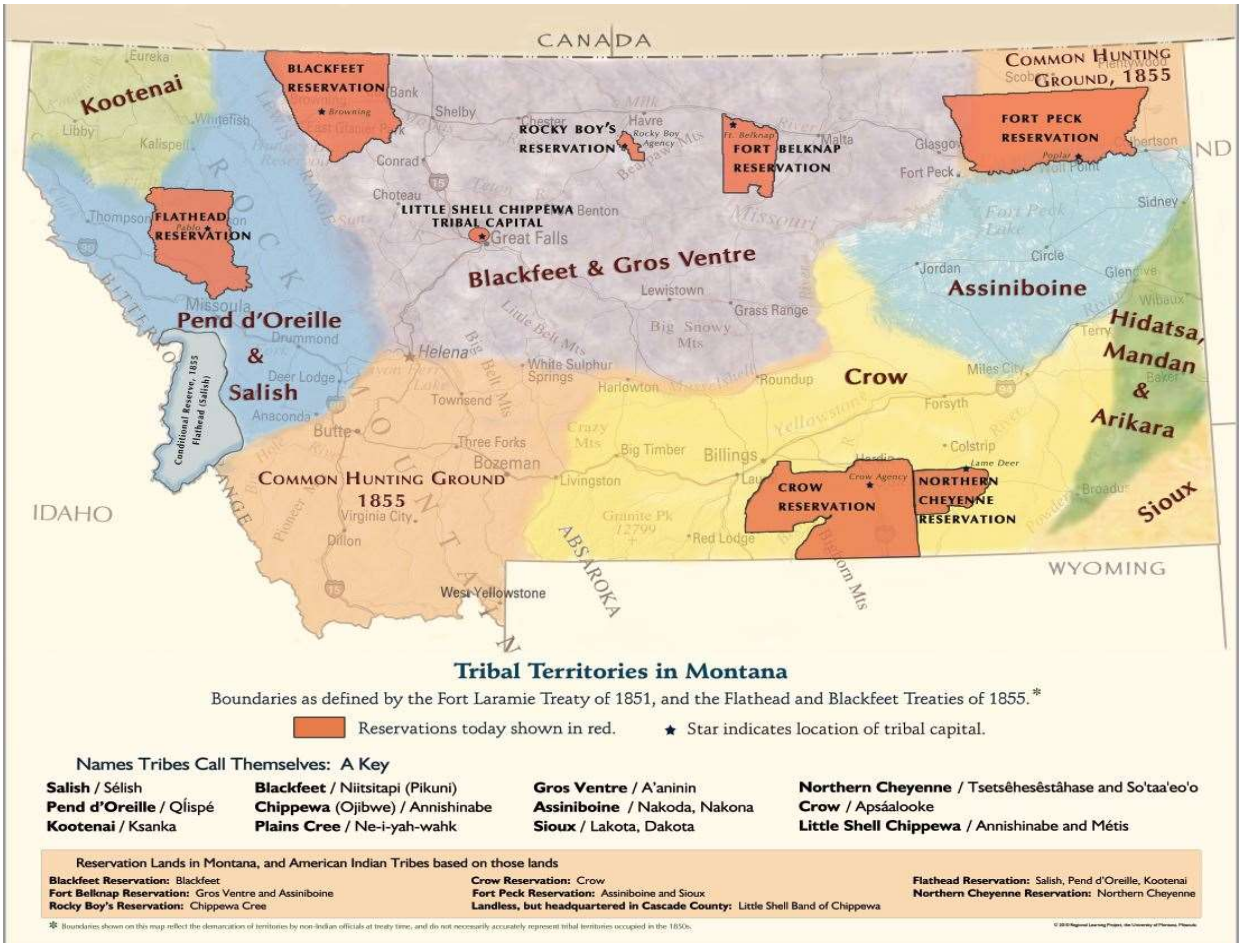
The objective of this project was to interview 10% of practicing Nurse Practitioners in Cascade County. The purpose of this project was to 1) explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated.

Setting

Montana State Board of Nursing lists 1145 active certified Nurse Practitioners, and 115 of them reside in Cascade County (Professional License List Download, 2019). The author chose to focus on Nurse Practitioners in Cascade county because AI/AN population was second to the White population in Cascade County (United States Census Bureau, 2018). The White population was 85%, and AI/AN was 5.5 % (United States Census Bureau 2018). Cascade County is home to the band of Little Shell Chippewa Indians who were Federally recognized as a tribe on December 2019. With the recognition the Tribe and each member are eligible for all services and benefits provided by the United States to Indians and federally recognized Indian tribes (Little Shell Tribe of Chippewa Indians Restoration Act of 2019, 2020**)**. Cascade County is also home to two surrounding reservations, which are the Rocky Boy and Blackfeet Nation. Members of all three groups utilize clinics and hospitals in this area.

Figure 6 identifies each of Montana's seven American Indian reservations, the Little Shell Chippewa Tribe, and the name of each of the tribes in those areas.

Figure 6. Tribal Territories in Montana.



Cascade County has reported seven MMIW cases and has failed to report cases to national and local law enforcement agencies despite having a high number of MMIW (Rosay, 2016). Native Americans make up 6.7 % of Montana's population, according to the U.S. Census Bureau but account for 26 % of missing person reports from 2016 through 2018, the only years for which comprehensive data on those cases were available from the state. Nearly two-thirds of those cases involved women or girls (Rosay, 2016).

Data Collection for Assessment

The principles of the Learning Needs Assessment helped guide the collection of data needed for this project. The Learning Needs Assessment is a systematic approach to assess what individuals or groups need to learn (Pilcher, 2016).

Learning is more likely to lead to change in practice when a Learning Needs Assessment has been conducted (Grant, 2001). The first step to the Learning Needs Assessment was to define the purpose. The first purpose of this project was to explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW. The second step was to identify parameters. Identifying parameters can also include the characteristics of the learner and the environment (Laxdal, 1982). The learner characteristics can consist of demographics, readiness to learn, what they already know, and how they learn best (Pilcher, 2016). The Nurse Practitioners characteristics included what they knew about MMIW and their readiness to learn about MMIW. Hence, the parameters were to complement their underlying knowledge, refresh their knowledge, and apply this new knowledge to the problem of MMIW in the AI/AN population.

The third step of the Learning Needs Assessment was to select the tool and conduct the investigation. Tools can include an expert review of the literature, observation, interviews, focus groups, surveys, critical incident review, self-assessment, and other strategies (Grant, 2002). In this case, three open-ended and one close-ended questions were administered by the interviewer to learn what Nurse Practitioners knew about MMIW.

The fourth step of the Learning Needs Assessment was to analyze the results of the interviews. A thematic analysis was used to identify, analyze, and interpret patterns of meaning within qualitative data collected from the interviews. The results of the analysis guided the planning and educational needs of Nurse Practitioners about MMIW in Montana. The fifth step

was an ongoing analysis. Ongoing analysis is a collection of immediate learning outcomes. The sixth step was the conclusion. During the conclusion, the author assessed what the Nurse Practitioners learning needs were pertaining to MMIW in Montana which provided the foundation for designing effective educational activities which were expressed by the Nurse Practitioners.

Pilcher (2016) explained that Learning Needs Assessments can fall into different categories, including formal gap analysis, analysis of organizational needs, analysis of learner, self-identified needs, and anticipation of future needs. Analysis of learner and self-identified needs were the foci of this assessment. Methods for assessing learner needs can include reviewing the literature, benchmarking, reviewing documents, seeking learner input, and other data collection methods. An open-ended and closed-ended interview process was selected for the formal assessment process to determine Cascade County Nurse Practitioners' needs about MMIW.

Interview Guide

Three open-ended questions and one closed-ended question were used to guide the interview with participants. The goal of asking these four items was to determine the participant's current knowledge of MMIW, what the participant wanted to know, and what the participant recommended for advancing awareness about MMIW among Nurse Practitioners. The four questions were: 1) In your practice, could you tell me what percentage of your patients are AI/AN Women, 2) As a Nurse Practitioner, what do you know about Montana's Missing and Murdered Indian Women, 3) What role do you see Nurse Practitioners having in policy, prevention, or recognition of Montana's Missing and Murdered Indian Women, and 4) What

information, if any, regarding the important and critical issue regarding Montana's Missing and Murdered Indian Women would you find helpful in delivering care in your practice? Additional questions were asked to ensure that the participant's meaning had been correctly understood, or to request elaboration of a point made by the participant. The content validity of the interview questions was confirmed by the doctoral committee.

Procedure

This study was approved by the Institutional Review Board (IRB) at Montana State University (JC012120-EX). The consent process began by briefly stating the purpose of the interview, sharing that participation was voluntary, and that no risks for participating were anticipated. The author explained that information related to age, practice experience, and participants' responses would remain anonymous. The participants received the author's telephone number and email address which they were invited to use if they had further questions concerning the interview questions or participation.

After the participants were briefed about the study and they signed their consent to participate, the interviews were conducted, recorded and transcribed. The audiotaped interviews occurred from January to February 2020 at a time that was convenient for the Nurse Practitioner. The interviews lasted less than 20 minutes.

Participants

The information from the interviews was collected from Nurse Practitioners practicing in a variety of clinical settings in Great Falls, Montana. The criteria for the samples were Nurse Practitioners working in clinical practice and willing to take part in this study. There were 10

Nurse Practitioner participants, one male, and nine females. Participants' mean age was 53.1 years (SD=13.1 years, range 28- 65 years) and participants' average years of experience was 15.9 years (SD= 10.21 years, range of experience 2-30 years).

Data Analysis

The most fundamental task of data analysis is to familiarize yourself with your data (Polit & Beck, 2017). In the qualitative approach used in this project, the words and sentences recorded in each Nurse Practitioner interview were the "meaning units" (Polit & Beck, 2017). In the review of each recorded interview, the "meaning units" that conveyed similar meaning, were identified and labeled with codes. The coding process allowed for interpretation of the Nurse Practitioner's responses and statements in their interview.

The interview questions were reviewed and analyzed using a method of "structural coding". Structural coding is a way to label passages with terms that are related to the research question (Belotto, 2018). The author labeled passages with terms that were related to the purpose of the project and used structural coding to sort and categorize the codes developed from the interview questions. After reviewing the transcripts and identifying themes, the author identified and assigned passages to one of the three codes: 1) Knowledge, 2) Educational needs and 3) Follow-up or recommendation. The codes allowed for enhanced understanding of the Nurse Practitioners knowledge level, educational needs, and follow-up or recommendations the Nurse Practitioners had of MMIW.

CHAPTER FOUR

RESULTS

The author conducted three face-to-face interviews and seven telephone interviews with practicing Nurse Practitioners in Cascade County to explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW. The first interview question was, "*In your practice, what percentage of your patients are AI/AN Women?*" The mean percentage of female AI/AN clients in the NP's panel (n = 9) was 15.4% (SD = 9.5%, range 5-30%). There was one outlier who stated her panel was 14% female but did not know how many of these women were AI/AN. Importantly, all Nurse Practitioners had AI/AN women in their client panel.

The second interview question was, "*As a Nurse Practitioner, what do you know about Montana's Missing and Murdered Indian Women?*" The most important finding from the interviews conducted with practicing Nurse Practitioners was that 20% of participants (n = 2) knew nothing of the subject of MMIW even though one who knew nothing on the subject recognized MMIW as an important topic. Eighty percent of the Nurse Practitioners interviewed (n = 8) knew there were American Indian women missing in Montana. Seventy percent of the Nurse Practitioners interviewed (n=7) reported hearing of MMIW on the television news or reading about the issue in the newspaper. The Nurse Practitioners expressed their awareness that these women are rarely found and that many cases go undocumented. The Nurse Practitioners also shared stories they heard from their patients who had a family member or knew of someone who had gone missing. One participant was knowledgeable on the subject and trusted their place of employment was very proactive concerning this issue,

> By bringing in outsides sources to speak on the issue of MMIW and human trafficking has helped bring the issue of MMIW and human trafficking to the forefront by educating health care providers that AI women are missing and rarely found.

The third interview question was, "*What role do you see Nurse Practitioners having in policy, prevention, or recognition of Montana's Missing and Murdered AI/AN*?" One participant commented, "As Nurse Practitioners we have a role to combat this issue by assessing for physical and emotional abuse, drug use and human trafficking. It is also important to listen to the patient as they can share important information through stories."

Nurse Practitioners thought their role in combatting the issue of MMIW would be enhanced if they had continuing education on the topic and if information was shared about MMIW at national conferences and discussed among Nurse Practitioner colleagues. The most important finding from the interviews conducted with practicing Nurse Practitioners was that 50% of participants (n = 5) recommended State Board of Nursing to offer Continuing Education Credits about MMIW, 60% of participants (n = 6) expressed the importance of having this information published in nursing journals and newspapers throughout Montana, 10% of participants (n = 1) expressed community involvement bringing awareness to MMIW and 30% of participants (n = 3) expressed the importance of listening to AI/AN stories to help bring light to recognizing signs of trauma training or signs to look for trauma.

In summary, the recommendations from the Nurse Practitioners were to recommend to the State Board of Nursing to offer continuing educational credits about MMIW, increase discussion of the topic between Nurse Practitioners at national conferences, and to see publication in nursing journals on the issues of IPV and MMIW.

The fourth interview question was, "*What information, if any, regarding the important and critical issue regarding Montana's Missing and Murdered Indian Women would you find helpful in delivering care in your practice?*" The Nurse Practitioners responses could be grouped into three general areas including: screening tools to assess and recognize danger, alerts to the victims' names and pictures, and a resource list to give to affected family members and friends. The most important finding from this question was 70 % of participants (n = 7) expressed the importance of knowing what screening tools are available to assess for IPV and MMIW. Fifty percent of participants (n = 5) shared that it would be helpful to have access to victims' names and pictures. Others (n = 4) thought it would be helpful to have a list of up-to-date resources available for both the Nurse Practitioner and family members.

Educational Needs

Eighty percent (n = 8) of the Nurse Practitioners interviewed felt that the topic of MMIW was receiving more recognition statewide and nationally. Organizing efforts from the grassroots to a national level have brought this issue to the public eye. As social justice continues to increase across tribal nations and communities, lawmakers and governments are being educated and held accountable for making proactive changes (Agtuca, 2019).

One of the Nurse Practitioners asked, "Why just AI women when there are other women missing too?" The author used this question as an opportunity to provide education about the disparity in IPV, missing and homicide rates to this participant.

Two of the Nurse Practitioners expressed concerns about the feasibility of screening for MMIW. One participant stated, "This is impractical! How do I know if an AI woman is missing or dead?" These Nurse Practitioners wondered if there was a database one could review to be

updated on MMIW. The author once again offered education by stating, “Currently there is the Indian task force and data bases available that Nurse Practitioners could search to see if a possible patient is missing.” Eight of the Nurse Practitioners shared MMIW is receiving more attention which is applauded but there continues to be AI/AN women missing daily. Six of the Nurse Practitioner’s recognized that is it possible many of the MMIW could be victims of human trafficking. Table 1 (page 58) is a list of resources to contact if one is needing information on human trafficking.

CHAPTER FIVE

DISCUSSION

According to Pilcher (2016) when assessing a group or individual it is essential to assess what the individual knows about a subject which will then lead you to what they need to know. The purpose of this project was to 1) explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated. The project utilized a qualitative interview to assess the knowledge of ten providers from the various clinical setting regarding MMIW.

Needs and Commonalities

Nurse Practitioners must understand human trafficking as many of the missing AI/AN women may encounter primary care providers. Research suggests that victims may seek treatment within the healthcare system when in captivity. Presenting to the healthcare system with injuries, evidence of neglect, sexually transmitted infections (STI), addiction disorders, pregnancy, and advanced disease states are potential signs of victims of trafficking or abuse but are often not identified by healthcare providers (Hachey & Phillippi, 2017). Nurses Practitioners can use their knowledge and experience with violence or trauma to identify and help trapped victims, regardless of age, race, or gender (Ramnauth, Benitez, Logan, Abraham, & Gillum, 2018).

In a study of health care providers in England (n = 792), 13% (n = 102) of the respondents reported actual or suspected contact with persons trafficked in a variety of clinical settings. Maternity ward providers reported suspected or prior contact rate of 20.4% (n =

28/137). While 91 % of the study respondents (n = 697) felt they had an obligation to assist alleged victims of trafficking, 80% (n = 613) cited lack of knowledge in their role in identifying and appropriately responding to human trafficking (Ross et al. 2015; Hachey & Phillippi, 2017).

Unfortunately, few health care providers have adequate education to identify victims and appropriately manage the care of a suspected victim (Hachey & Phillippi, 2017). All Nurse Practitioners are in the frontline position to prevent, identify, and treat victims of human trafficking with the appropriate education. Healthcare professionals often lack knowledge of the various referral services and the national hotline established for possible victims of human trafficking (Donahue et al., 2019).

Tribal advocates in South Dakota and northern Minnesota began alerting the healthcare providers at Minnesota Indian Women's Resource Center (MIWRC) and other urban Indian service providers in these areas any time a new case of abuse or missing person was noted. Advocates explained that adolescent Indian girls from their communities were being trafficked into prostitution, pornography, strip shows, and transported over state lines and internationally to Mexico (Pierce, 2012). Cascade County Nurse Practitioners indicated their interest in being alerted with names and pictures of MMIW/girls in their practice area. This is an opportunity for action by MMIW advocates in Montana. Cascade County Nurse Practitioners also expressed interest in a fresh list of helpful resources to distribute to affected families. Table 1 is a list of referral resources for human trafficking for use by primary care providers and nurses.

Table 1. Human Trafficking Resources.

Resource name	Information Provided	Contact
Coalition Against Trafficking in Women	NGO to combat trafficking of women and children	http://www.catwinterinternational.org
DHS	Legal assistance-visa, and victim support	1-866-347-2423
DHS Blue Champaign	Awareness, education, shoe cards, victim centered investigation	https://www.dhs.gov/blue-campaign/about-blue Champaign 1-866-347-2423
Department of Health and Human Services: Rescue and Restore Campaign	Toolkits including literature and posters	http://www.acf.hhs.gov/programs/endtrafficking/trafficking
ECPAT-USA	Leading anti-trafficking policy organization in the U.S.	https://www.ecpatusa.org
HEAL Trafficking	Interdisciplinary health professional connects to end trafficking through referral, education, advocacy, and support	https:// healtrafficking.org
Local police department	Immediate assistance for safety and protection	911 or local contact number
National Human Trafficking Resource Center Hotline	Education information, and local referral sites	1-888-373-7888
NHTRC SMS Short code for victims	Specialized Text Service confidential crisis support, referrals, tip reporting, and general information through SMS text message	https://polarisproject.org/services-hours TEXT "BeFree" (233733) 3 p.m.-11 p.m. EST (provide information to victims)
Polaris Project website and Resource Center	Online reporting, education, and information	www.polarisproject.org
S.O.A.P.	Outreach and education rescue victims trafficked at hotels, educate motels on trafficking signs	https://www.traffickfree.com/soap
SafeHorizon	Victims' service agency-Antitrafficking Program only for New York	http://www.safehorizon.org/page/human-trafficking-what-we-do-346.html

Note. DHHS = Department of Health and Human Service, DHS = Department of Homeland Security; ECPAT = End Child Prostitution and Trafficking; HEAL= Health, Education, Advocacy, Linkage; NGO = nongovernmental organization; NHTRC = National Human Trafficking Resource Center; SMS = Short Message Service; S.O.A.P. = Save Our Adolescents from Prostitution.

Data Bases

The following three programs include databases attended to by specialists who ensure that records of AI/AN missing persons are accurate: Hannah's Act, Savanna's Act, and Looping in Native Communities. Each one of these databases is open for all people to access as an MMIW resource.

The first database is House Bill 21, also known as the "Hanna's Act." House Bill 21 provided for a specialist from the Montanan Department of Justice to help law enforcement and families in the search for missing persons. The specialist oversees entries into the database of the national crime information center of the U.S. Department of Justice and other databases to ensure records of missing persons are accurate, complete, and made promptly (Drake, 2019).

The second is Savanna's ACT (*Savanna's ACT*, *S.227*, 2020). Savanna's Act directs the Department of Justice to review, revise, and develop law enforcement and justice protocols to address MMIW. The third is Looping in Native Communities (LINC) Act or Senate Bill 312, which created a missing AI/AN person task force that includes a representative from each tribal government on Montana's seven reservations and the Little Shell Chippewa Tribe (Missing Indigenous Person Task force, 2019). By statute, members must also include a representative from the Attorney General's Office; an employee of the Montana Department of Justice who has expertise in missing persons; and a member of the Montana Highway Patrol. SB312 creates a network for tribes to identify, report, and find AI/AN peoples who are missing. Cascade County Nurse Practitioners would benefit from an educational presentation at a state or national conference on these resources, their history, and their utility to the practicing Nurse Practitioners. Primary care providers are busy professionals and would benefit from knowing the key

informational clearing houses for information on MMIW rather than having to search for updates themselves or worse—being uninformed.

Why Just Indian Women?

An important conversation took place between the author and one of the providers when the Nurse Practitioner asked, "Why just AI women when there are other women missing too?" The author agreed by saying, "Yes, missing and murdered women in general, regardless of ethnicity remains a national issue." The author then explained, "American Indian women are disappearing at an alarming rate when compared to other races and many of these women are rarely found. This is an issue with urban American Indian communities as well as tribal communities."

This specific Nurse Practitioner's concern caused the author to wonder if the interview question as posed may have come across biased. The author appropriately reflected on the interview items and wondered, "Am I asking questions and presenting information in way that made my interviewees think that I only cared about AI women?" What the author learned from this sentiment was the importance of sharing her own understanding and consideration of all women that remain missing regardless of ethnicity. After this interview the author shared with the participant,

> I know women, men and young children are missing and rarely found. My heart goes out to those families and I pray the creator brings peace to all who have been inflicted by such horrible actions. This subject is close to me as I am an Indian woman, a mother, a grandmother, and an auntie. I have friends and relatives who have been affected by some of the horrific actions inflicted on Indian Women.

The question must be asked, “Why Indian women?” In November 2019, in Montana and Nebraska AI/AN girls represented 37% and 13% of all missing girls, respectively, even though AI’s represents 6% and 1% of the statewide population (Lucchesi, 2019). The disproportionate violence and homicide experienced by AI/AN women and girls, particularly in the Northern Plains states, is an urgent issue of injustice. Mobilizing Nurse Practitioners with facts and action steps is just one of many strategies that need to be used to address this unacceptable epidemic.

Another 20% of the Nurse Practitioner’s stated, “This is impractical. How do we know if an AI woman is missing? Surely, we would not know if they are murdered.” The interviewer prompted the participant by responding, “What can be done to make this issue more practical?” The suggestions were to create a database so that Nurse Practitioners could take note of gut feelings when they suspect patients to be hostages to give these women a formal identity, not just a number. The database could function to humanize the issue. By bringing in pictures of missing or murdered women, by providing this database with correct spellings of names, nicknames, and approximate ages, Nurse Practitioners and the corresponding communities could begin to give underrepresented statistics faces and names.

Eighty percent of the Nurse Practitioner’s surveyed felt that MMIW is receiving more recognition statewide and nationally. Montana Governor Bullock has referred to MMIW as an “epidemic”. 1.47 million dollars has been allocated to work with safety on the reservations (Lutey, 2019); however, the safety issues do not discuss how healthcare providers can become more involved in combating this epidemic. Furthermore, this dividend and the state's efforts have yet to address tragedies in relation to what can be done for those families who have missing family members. These families have yet to be provided with answers, solutions, or strategies.

What Was Surprising

Why Indian Women

An alarming question was asked by one of the participants, "Who is taking responsibility for these women?" The following statement is excerpted from an article which was published in the Billings Gazette by Tom Lutey. Mr. Lutey offered this explanation for who is taking responsibility:

> John Tester and Steve Daines say they will reintroduce a bill that would require the Department of Justice to overhaul law enforcement protocols and improve data collection regarding slain or missing Native Americans. For example, the National Crime Information Center cited 5,712 reports of slain or missing Native American women and girls in 2016, according to a recent report by the Urban Indian Health Institute. But only 116 of those cases were logged into a Department of Justice database (Lutey 2019, pp 3)

The Sovereign Bodies Institute (SBI) has documented a disturbingly high number of MMIW and girls' cases in the Northern Plains regions of the United States, including the Dakotas, Montana, and Nebraska. These cases total 411 MMIW or girls who went missing or were killed in these four states or came from tribal nations (reservations) in these four states. From 2017 through 2019, approximately 30-40 cases occurred annually (excluding claims in which the missing person was safely located). If the number of cases remained relatively constant, the estimated actual number of cases in the region would be closer to 3500 to 4700 since 1900 (Lucchesi, 2019).

This violence has a profound impact on AI children. American Indian girls are over-represented in missing and runaway child reports, as well as in cases of the homicide of girls, and AI children also disproportionately experience the trauma and cumulative impacts of losing their mothers, grandmothers, sisters, cousins, and aunts to trafficking, death, and disappearance.

This trauma can lead to chronic and acute physical and mental issues, and create a pipeline to poverty, incarceration, new experience of violence, and disappearance, creating an intergeneration ripple effect.

Lucchesi (2019) reported in over 50 cases, when there was an incidence of MMIW/girl, there was a probability the family had been traumatized with a previous instance of a family member who was either murdered or missing. When an AI/AN woman or girl is missing, evidence proves violence and murder can affect families over and over to produce chronic victimization, trauma, and unresolved grief. For example, Crow tribal member Harriet Wilson was murdered in Billings, Montana in 2013. Harriet's great-grandmother, Rose Old Bear, was murdered in Hardin in the 1950s. Harriet's great-aunt (also named Harriet Wilson) was murdered outside Hardin in 1970. These three deaths remain unsolved (Lucchesi, 2019).

There is difficulty in accessing accurate data on MMIW. Currently, there is Hannah's Act or House Bill 21, Savanna's Act and Looping in Native Communities Act Montana Missing people, and Freedom of Information Act, which all are an instrumental piece in addressing the issue of MMIW. The focus of the Savanna's ACT is to review, revise, and develop law enforcement and justice protocols to address missing and murdered Indians.

Considering the recognition MMIW is receiving in the news it is surprising that 20% of the NPs interviewed had limited knowledge on this subject. Montana is one of the top ten states in the nation with the highest number of MMIW. Billings, and Great Falls, Montana are of the top cities with the highest numbers of MMIW cases (Rosay, 2019). At a Senate oversight hearing on December 12, 2018, Senator Jon Tester, (Democrat-Montana), and Senator Steve Daines, (Republican-Montana), reported that 24 Native American women in Montana disappeared in

2018. Of those only one was found alive, another was found dead, and the others remain missing (Lutey, 2019).

Another theme identified among the responses that was surprising was the attitude that MMIW is a problem for tribal governments. It is important for healthcare providers and all citizens to understand that many of these women are missing from non-reservation communities. Great Falls, Montana is in the top 10 cities with the highest number of MMIW that have not been reported to law enforcement (Rosay 2016). Seventy-eight percent of the AI population in Montana lives off the reservation with 60% of those residing in an urban area (Lewis, 2019). Only 22% of AI/AN people live in reservation communities. This is more than the problem of the tribes; it concerns everyone and requires community involvement.

What Was Not Surprising

Several themes were identified among the Nurse Practitioners that were not surprising at all. It was reassuring to know that 70% of the Nurse Practitioners interviewed knew about MMIW, 10% were very knowledgeable on this issue and 20% knew nothing of MMIW. It was not surprising to hear that 50% of the Nurse Practitioners surveyed felt that many of the MMIW could possibly be victims of human trafficking. Perpetrators of trafficked individuals target vulnerable populations through force, violence and victimization (Coppola et al., 2019). American Indian women are a targeted, vulnerable population and have been victims of rape and murder. It is not surprising the Nurse Practitioners interviewed voiced MMIW could be victims of human trafficking. Raising awareness and providing information to all Nurse Practitioners may be one among many critical steps necessary to end human trafficking.

The increase of MMIW became known to the participants through a variety of avenues. Representatives of tribal government, families, activists and interested people began speaking out on this issue and bringing it to the forefront. Missing and Murdered Indian Women found itself as a movement first in Canada where the grassroots efforts to raise awareness found footing around 2015. Since this time, MMIW has grown and is gaining momentum still. It is because of the efforts of AI women and their families that awareness of this crisis is gaining momentum. American Indian women are finding innovative ways to sound their voices on this issue as it is profoundly affecting communities (Lewis, 2020). For example, Marita Growing Thunder for the third year is hosting a walk across the Flathead Reservation to bring awareness of MMIW. This year the walk is in honor of Jermaine Charlo, who went missing almost a year ago in Missoula (Mott, 2019).

The epidemic of MMIW has shaken the government; they are trying to put light on why so many AI/AN women are disappearing. At the federal level, the Not Invisible Act was introduced to the House and Senate. The Not Invisible Act is the first bill to be presented by four members of federally recognized tribes: Deb Haaland (Pueblo Nation of Laguna), Tom Cole (Chickasaw Nation of Oklahoma), Sharice Davids (Ho-Chunk Nation of Wisconsin), and Markwayne Mullin (Cherokee Nation). They are putting light on why so many AI/AN women are disappearing. The Not Invisible Act would bring together a committee of law enforcement, tribal authorities, federal partners, and more to study and discuss solutions to the crisis of murdered and missing Indigenous women and establish better coordination (S.982 Not Invisible Act of 2019).

Not only has the issue of MMIW shaken the Tribal and United States governments but also Nurse Practitioners. The interviews' results suggested the importance of MMIW and how this information should be put in every paper, newsletter, and presented at conferences nationally.

DNP Core Essentials

Clinical Scholarship and Analytical Methods for Evidence-Based Practice

Clinical scholarship and analytical methods for evidence-based practice focus on the DNP's role in assuring accountability of quality care and patient safety as well as critically examining ethical dilemmas inherent in-patient care, health care organizations, and scientific research (AACN, 2006). The author was able to critically examine ethical dilemmas of violence against women, mainly AI/AN women, and the long-term effects abuse has on AI/AN women and their families. It was also essential to bring to the attention of Montana State Board of Nursing the issue of MMIW to address continuing education units for licensure renewal on Montana's MMIW.

Organizational and Systems Leadership for Quality Improvement

The DNP core essential of leadership is part of the ongoing academic inquiry by identifying an essential issue in nursing. The author assumed leadership by identifying an essential issue in nursing pertaining to Montana's MMIW. Violence against AI/AN women is an important area for advocacy and leadership among the ranks of primary care providers from Cascade County as well as across the state and nation.

Clinical Prevention and Population Health for Improving the Nation's Health

Nursing theory has its foundation in health promotion, risk reduction and improving the health of both individuals and communities. By increasing the Nurse Practitioners' awareness of violence against women and the importance of identifying signs of abuse, this project emphasized health promotion, risk reduction and clinical prevention concerning violence against women.

Nursing Practice

Beside the DNP educational essentials, there are also professional standards set out by the American Academy of Nurse Practitioners that guide professional practice. The scope of practice is not setting specific standards but instead is based on the needs of the individual patient (APRN Consensus Model, 2008). This statement is especially relevant when working with IPV patients. It is essential to have empathy for these patients and speak with them in a nonjudgmental manner, letting them know you are their advocate.

The Nurse Practitioner facilitates patient participation in health care by providing evidence-based, culturally sensitive information needed to make decisions regarding promotion, maintenance, and restoration of health, appropriate utilization of health care resources, and potential for consultation with other proper health care personnel (AANP, 2016).

Implications for NP's Practice

The purpose of this project was to 1) explore Nurse Practitioner's knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated. The results of the project brought forth a variety of recommendations.

Four strategies were recommended by multiple participants. First, the Nurse Practitioner should appeal to the Montana State Board of Nursing to include content on MMIW and human trafficking for licensure. Secondly, the Nurse Practitioner should introduce the topic of MMIW to Montana's Healthcare Conference. This is important as Montana is home to 12 American Indian Tribes and the topic of MMIW is relevant (see Appendix B). The third recommendation was to make sure content on IPV and MMIW is included in graduate education. The fourth recommendation was requesting easy access to information on MMIW. The participants requested a brochure or flyer with missing Indian women names and faces would make it possible to put a face to those who are missing. One NP explained, "They can be my patient, but without needed information these women can fall through the cracks and continue to go unnoticed." Currently there is a data base available which shows pictures, names, ages and hometown of MMIW/girls (Montana Department of Justice, 2020**).**

Follow up Actions Taken by Student Based on the Findings of this Study

At the conclusion of this scholarly project, there were two follow-up interventions to pursue. The first was to contact the Montana State Board of Nursing to inquire about offering continuing education credit on MMIW available on their Website (see Appendix A). Second is to submit an abstract to Montana's Heath Care Conference when abstracts for the conference become available (see Appendix B).

Limitations

There were several limitations to the methods of this scholarly project. First, the project was limited to Nurse Practitioners in Cascade County. Cascade County was selected due to the

large number or urban-dwelling AI/AN women in and around Cascade County, but sampling from a broader geographic area would have made the findings more generalizable across the state. Including Nurse Practitioners from different areas of Montana would have given the study a broader view and perhaps greater insights on the issue of MMIW.

Initially the interviews with the Nurse Practitioners were to be a sit-down conversation. This proved to be more of challenge than originally anticipated because of their busy practice schedules. Due to the NP's schedules most were willing to do a telephone interview rather than a face-to face-interview. The informed consent forms were discussed and signed and faxed to the author prior to the interview.

Another limitation to this project was the lack of prior studies on Nurse Practitioner's knowledge of MMIW. The paucity of literature focused on violence against AI/AN women limited the scope of this authors' analysis. Still, with the limited studies available, it was possible to lay a foundation for raising awareness of the issue of MMIW.

Conclusion

The goal of the Doctor of Nursing Practice capstone project was to bring new knowledge and awareness to the healthcare arena. Implementing this capstone project and interviewing 10% of practicing Nurse Practitioners in Great Falls, Montana on MMIW has facilitated conveying new knowledge to Nurse Practitioners and is one forward step in raising awareness about the problem of violence against women particularly AI/AN women.

Knowles' Theory of Adult Learning was the theoretical framework that guided this project to learn what Nurse Practitioners knew, what they needed to know, and for the DNP student to learn their recommendations for future educational interventions with Nurse

Practitioners concerning the issue of MMIW. The most important recommendations from those Nurse Practitioners interviewed was to bring concerns of MMIW to the forefront. It is of utmost importance to share this information and raise awareness with Nurse Practitioners not only in Montana, but nationwide.

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APPENDICES

APPENDIX A

LETTER TO THE MONTANA STATE BOARD OF NURSING

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Melisa Poortenga:
Montana State Board of Nursing
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Ms. Poortenga:

I am a graduate student at Montana State University-Bozeman completing my doctorate in nursing. I am writing to see if there is a forum for professionals to bring recommendations to the State Board of Nursing (SBON). My suggestion is to bring the issue of Montana's Missing and Murdered Indian Women (MMIW) to the forefront for all nurses to understand this issue as some of these women could be potential patients.

The epidemic of MMIW has shaken the government; they are trying to shine a light on why so many Indian women are disappearing. At the federal level, the Not Invisible Act was introduced to the House and Senate. The Not Invisible Act would bring together a committee of law enforcement, tribal authorities, federal partners, and more to study and discuss solutions to the crisis of murdered and missing Indigenous women, and to establish better systems of coordination (Lewis 2020).

At a Senate oversight hearing on December 12, 2018, Senator John Tester, D-Montana, and Senator Steve Daines, R-Montana, reported that twenty-four Native American women in Montana disappeared in 2018. Only one was found alive, another was found dead, and the others remain missing. Montana is one of the top ten states in the nation for the highest numbers of Missing and Murdered Indian Women. (MMIW).

My recommendation is to implement CEU's for nurse practitioners in Montana to understand the epidemic of MMIW. The CEU's would cover how NP's can identify possible MMIW victims and how to report a case without compromising the safety of their patient. The CEU's should be one of the requirements for licensure and renewal for all NP's.

Thank you for your time and consideration in this manner.

Joyce Cleavenger (DNPs)-FNP-BC

APPENDIX B

ABSTRACT FOR SUBMISSION TO THE MONTANA'S HEALTH CARE CONFERENCE

ABSTRACT

Title: MISSING AND MURDERED INDIAN WOMEN (MMIW)

Authors and Affiliations: Joyce Cleavenger FNP-BC
Montana State University, Bozeman Montana

Objectives: Describe the importance of Hannah's Act, Savannas Act, Looping Native Communities Act, and the influence these acts are to MMIW.

Background: According to the National, Intimate Partner and Sexual Violence Survey findings for lifetime rape prevalence comparing women from different racial/ethnic groups, 27.5% of American Indian/Alaskan Native women have been raped compared to 14% of Hispanic women, and about 21% of White and black women (Rosay 2016). Existing research indicates that violence against AI/AN women is a problem. According to Rosay (2016), three in five Indian women will be victims of domestic violence. Violence against women is more widespread and severe among AI/AN women than among other North American people. Statistics reveal AI/AN Indian woman experience the highest lifetime rape prevalence in relation to all different ethnicities (de Heer & Jones 2017). Native American/Alaskan women have long been considered invisible and disposable in society, and those vulnerabilities attract predators, making AI/NA women especially easy targets for rape or murder (Deer 2005).

Case Description: The purpose of this project was to 1) explore NP’s knowledge and perceived educational needs related to MMIW, and 2) advocate for continuing education and follow up as indicated.

Conclusion: Overall, it was evident that 20% of the NP's surveyed showed a knowledge deficient related to MMIW. Studies have depicted that victims may seek treatment within the healthcare system when in captivity. Very few NP's understand how to identify victims and manage the care of a suspected visit.