



# Building Trust in Communities:

## *The Narragansett Indian Tribe and the State of Rhode Island*

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The Narragansett Indians are descendants of the aboriginal people of the State of Rhode Island, where they have existed for more than 30,000 years.<sup>1</sup> According to the 2005–2007 American Community Survey estimates, the state of Rhode Island was home to more than 3,900 Native Americans, about 0.4% of the total population. While Native Americans living in Rhode Island report belonging to dozens of tribes, the Narragansett Indian Tribe, with more than 2,000 members, represents the largest tribe in the state.<sup>2</sup>

The Narragansett people have had long-standing disputes with the State of Rhode Island. In 1975, the tribe filed suit against the state and individual landowners in order to reclaim land the tribe asserted rightfully belonged to them. An out-of-court settlement in 1978 concluded with the return of 1,800 acres of land, where the tribe established its reservation. Finally, in 1983, the tribe was given federal recognition of its sovereignty and has participated in federal programs funded by the Bureau of Indian Affairs and the Department of Indian Health Services.

Through the Federally funded programs the tribe is able to service many of its Tribal Body members in all aspects of life. The mission of the Tribe is to continue to promote and develop awareness among Tribal members [of] the importance of education, culture, and family life within their own tribal community.<sup>3</sup>(Nationhood section)

A number of public health issues face the Narragansett people. The median age for the Native American population is 26 years, whereas the overall state median is 38 years. Over 92% of the Native American population is age 65 or younger, while 86.2% of the overall state population is age 65 or younger.<sup>2</sup>

**Socioeconomic Indicators:** The percentage of Native Americans living below poverty is over three times higher than the overall state population, and almost five times higher than the white population. The median household income for Native Americans is \$22,800; this is \$31,300 less than the state median and \$35,400 less than that of the white population. A lower percentage of Native Americans graduate from high school compared to the overall state and the white populations. A greater percentage of Native Americans is unemployed compared to the overall state population and the white population.<sup>4</sup>

**Behavioral Risk Factors:** Native Americans have a higher percentage of both overweight and obese adults compared to the white and the overall state populations. This is especially pronounced for obesity—28.0% of Native American adults are obese, compared to 20.8% for Rhode Island as a whole. The percentage of Native Americans who smoke cigarettes (35.5%) is nearly two times higher than that of the white (19.5%) and the overall state (19.4%) populations.<sup>4</sup>

**Maternal and Child Health:** The overall state and the white populations have more favorable maternal and child health outcome indicators than the Native American population in Rhode Island. Native Americans are about twice as likely to receive delayed prenatal care as are the white or the overall state populations. The percentage of Native American teens (ages 15–19) who give birth is more than four times greater than it is for the overall state or the white populations. Over 13% of Native American infants are low birth weight, compared to approximately 8% for white infants and for infants across all racial and ethnic groups.<sup>4</sup>

**Access to Health Care:** Most samples are too small to draw reliable conclusions regarding Native Americans and access to health care. One-third of Native American adults said there was a time in the past year when they could not afford to see a doctor; a statistic over three times that of the overall state population and over four times that of the white population. The percentage of Native Americans having no health insurance is more than double that of the overall state population and nearly four times that of the white population.<sup>4</sup>

**Environmental Concerns:** A number of environmental issues are being addressed by the tribe, including surface and groundwater pollution; “incremental non-point source pollution from surrounding residential development and Tribal development;”<sup>5</sup>(Environmental Concerns section) air pollution; hazardous waste; highway run-off; illegal dumping; lead paint; radon; and “biological and chemical contamination of drinking water.”<sup>6</sup>(Environmental Concerns section)

#### RHODE ISLAND PLAN FOR MINORITY CARE

In order to address the public health needs of minorities, the Rhode Island State Department of Health facilitated the development of a community action plan, which was informed by a community assessment and feedback process begun in 1998. This was followed by an internal assessment conducted in 1998 and three state breakout sessions of the New England Region Conference for the Elimination of Health Disparities that took place in 1999, 2001 and 2003.<sup>7</sup>(para 1)

The vision from the action plan was to allow for all racial and ethnic minorities in Rhode Island to have an equal opportunity “to live safe and healthy lives in safe and healthy communities.”<sup>7</sup>(para 2) The minority community set as its mission to reduce health risks and improve health outcomes by disseminating health education materials and engaging the community in healthier behaviors.<sup>7</sup>

To support this mission, minority communities in Rhode Island were asked to participate in the development of policies, plans, and tracking systems to ensure that their community’s needs are integrated and addressed within all state health department programs. Specific goals of the plan were: (1) racial and ethnic health disparities would be eliminated by 2010; and (2) racial and ethnic minority populations would “have equal access to high quality health services.”<sup>7</sup>(para 4)

In order to achieve these outcomes, six goals/priorities were identified; the plan was to implement them within a 3-year period:

1. “All HEALTH [Rhode Island Department of Health] programs meet the needs of racial and ethnic minority populations.
2. Establish uniform guidelines and procedures regarding the collection, use, analysis and dissemination of data on racial and ethnic populations.
3. Establish policies and procedures ensuring meaningful and productive minority community involvement and participation in all planning, monitoring and evaluation of health activities.
4. Improve work force diversity within HEALTH and promote the need for diversity in all health care institutions.
- 4a. Ensure that all LEP [limited-English-proficiency] individuals receive the same quality health services (Title VI of the Civil Rights Act).
5. Build community capacity to provide health education, health promotion, and disease prevention activities that are aligned with HEALTH overall priorities targeting racial and ethnic minority populations.
6. Facilitate and develop public/private partnerships at the state, regional and national level to eliminate racial and ethnic health disparities.”<sup>7</sup>(Introduction)

While not specifically developed for the Narragansett people, the tribe has used the plan as a blueprint for addressing and evaluating its own process for improving health outcomes for its people. This action follows a trend among Native American tribes to take more control over their own healthcare planning and implementation. Ongoing studies suggest that various models are available for Native American tribes to use to either enhance or in some cases replace care provided through the Indian Health Services. While the federal government is responsible, through law and agreements, to provide care to Native Americans, many Native American tribes elect to run their own programs with funding from the federal government.<sup>8</sup> One model includes development of an independent

public health department, which would function as the public healthcare leader in the tribal community. The Gila River Indian Community has already implemented this model and other Native American tribes are following their lead.<sup>9</sup> Currently, their programs are limited to providing health education materials, referrals, and training, but they also include specific educational interventions for diabetes, since American Indians and Alaskan Natives are more than twice as likely as non-Hispanic whites to have type 2 diabetes.

Even with plans, either independent of the Indian Health Services or in collaboration with it, Native American tribes have competing interests with some public health issues, in this instance tobacco use and sales.

In July of 2003, the Narragansett Indian Tribe, a federally recognized tribe that maintains a government-to-government relationship with the United States of America, began selling cigarettes from a shop on tribal lands to promote economic development. The state and tribe have disagreed on certain rights on the reservation. The sale of cigarettes without the state-required tax took place over the objections of Rhode Island Governor Donald L. Carcieri, who did not believe the tribe could legally sell cigarettes without charging state taxes. On July 14, 2003, the Governor Donald Carcieri ordered a raid on the tribe's tax-free smoke shop, which devolved into a physical confrontation between Rhode Island state troopers and Narragansett tribal members, including several members of the tribal leadership. Following the conflict, seven tribal members were charged with misdemeanors, including simple assault, disorderly conduct, and resisting arrest. The tribal leadership contended that their sovereignty was under attack and demanded that state troopers be held responsible for the force used during the conflict. However, no state troopers were charged as a result of their behavior in the raid. After the raid, Chief Sachem Matthew Thomas of the Narragansett Indian Tribe and Governor Carcieri issued statements.

Thomas said, "The Narragansett Tribe did what it's always done; it stood to protect its land. ... It's unfortunate [we had to do this] because it's 2003."<sup>10</sup>(para 4)

Carcieri supported the state by saying, "Today's actions were precipitated by the Narragansett Indians and their flagrant violation of state law."<sup>11</sup>(para 4)

In 2005, a three-judge panel of the U.S. First Circuit Court of Appeals declared the raid a violation of the tribe's sovereignty, but reversed the decision during a hearing by the full court. The decision held that the raid was not a violation of

the tribe's sovereignty because of an agreement signed by the Narragansett tribe that agreed the tribe would adhere to state laws, even on its own land.<sup>12</sup>

In a separate federal civil rights lawsuit, the tribe charged the police with the use of excessive force during the 2003 raid on the smoke shop. The jury was asked to decide if Trooper Kenneth Jones used excessive force when he broke the ankle of the plaintiff Adam Jennings. Police contend that Jennings resisted arrest, however Jennings testified that he did not resist arrest and that when the officer attempted to handcuff him, he complied.<sup>13</sup>

On April 4, 2008, a Superior Court jury found Chief Thomas and two other elected tribal members guilty of misdemeanor charges while clearing four others. Upon his conviction, Chief Thomas stated, "I didn't expect anything really different. I was waiting to get it over."<sup>14</sup>(para 11)

While acquitted of all the charges against her, Ms. Bella Noka, a former tribal councilor and wife of Randy Noka, first councilor, was quoted as saying, "We are reminders of their awful past and we are constant reminders of everything they've done and they won't stop until we no longer exist."<sup>15</sup>(para 4)

Meanwhile, Governor Carcieri's spokesperson issued the following statement, "With the conclusion of this trial, Governor Carcieri hopes that the Narragansett Indian Tribe and the State of Rhode Island can put the smoke-shop incident behind us and move forward into a more cooperative future."<sup>16</sup>(para 20)

Moving forward would be difficult for members of the Narragansett tribe. Abuse at the hands of government agents, government entities, and even those working to improve the lives and health of Native Americans was still a real fear for many tribal members. These abuses were not just about sovereignty, land rights, and cultural identity, but also about questionable studies conducted on Native Americans under the guise of health research.

For many Native Americans, experiences with public health researchers, governmental or institutional, have been negative, and as a result, have severely impacted trust. Mistrust was not limited solely to those institution(s) conducting the research; it affected the individuals conducting the research as well. "Too often, research has been conducted 'on' rather than 'with' American Indian communities, resulting in their being stigmatized or stereotyped."<sup>17</sup>(p 1399)

Research activities such as those on Navajo flu, the Barrow alcohol study, and the collection of blood samples, con-

sented for one study but then used for other studies without consent, are but a few of the unethical behaviors by researchers that caused deep mistrust in the Native American community.<sup>18</sup> Other minorities have similar issues of mistrust based on past public health initiatives; African Americans experienced similar health research deception in the Tuskegee syphilis study,<sup>19</sup> and stories have been passed down from times of slavery regarding experiments being conducted on their ancestors and the sale of their bodies for medical experiments following their death.<sup>20</sup> Today, one third of African Americans believe that HIV/AIDS was introduced into their community by the federal government. Other recent scandals have generally undermined the general public's trust in community organizations, businesses, and public figures, including the Clinton-Lewinsky scandal, the Enron bankruptcy scandal, and the legal troubles for American icon Martha Stewart.<sup>21</sup>

Signs of distrust can be found in each of these situations. Broken promises, leaders acting in their own best interest, individual rights sacrificed for expediency or lack of compassion, and the desire to advance research at any cost illustrate the need for more accountability.<sup>22</sup> But accountability alone cannot build public trust. There must be transparency of action and decision making; a consensus-building process that includes community members; dissemination of materials and information that provide for informed consent; a reason for the community to participate; and finally, incentives to facilitate participation.<sup>23</sup>

Following graduation from her public health training, Jennifer moved to the state of Rhode Island to begin working as a public health analyst at the Rhode Island Department of Health (a state-affiliated agency). Jennifer was asked to head a prevention and community health team that would design a comprehensive health program to address medical, behavioral, and preventive care needs of the Narragansett people, including prevention of heart disease, diabetes, and cancer. In addition, she would need to specifically address tobacco and alcohol use among the Narragansett people. Jennifer's activities would include researching public health issues within the minority communities of Rhode Island, iden-

tifying programs that work in these communities for possible use with the Narragansett Indian Tribe, designing prevention and primary care programs that consider the culture of the Narragansett people, developing a health promotion campaign in collaboration with the community, and reviewing currently available evaluation tools to assess the effectiveness of current initiatives and the possible use of these tools in her program design.

As a first step, Jennifer and her team were asked to meet with the Narragansett tribal leadership to gauge their interest, ask for their ideas, get buy-in for the collaboration, and identify their counterparts in the tribe. Jennifer and her team had less than a month to develop an agenda, including detailed information about each agenda item, prepare for the meeting, and run their ideas past the department's senior management.

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