Tribal Behavioral Health Expert Panel Meeting
Portland, Oregon
May 2008

Summary Report

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Background

American Indian and Alaska Native populations suffer inordinately from mental health disparities and access to culturally appropriate care. Studies have found rates of depression among American Indian and Alaska Native people that range from 10% to 30% of the population. The prevalence of suicide for American Indian and Alaska Natives is 1.5 times the national rate. American Indian and Alaska Native males age 15 to 24 accounts for two-thirds of all tribal suicides. Violent deaths – unintentional injuries, homicide, and suicide – account for 75% of all mortality in the second decade of life for American Indian and Alaska Natives. Historical trauma, exacerbated by re-traumatization of the community by ongoing death and loss, continues throughout Indian Country today. Ongoing trauma is one factor that directly impacts a tribal community's ability to plan and implement effective behavioral health services.

Despite the United State policy "to meet the national goal of providing the highest possible health status to Indians and to provide existing Indian health services with all the resources necessary to affect that policy" (Public Law 94-437), actual Congressional allocations to Indian Health Service meet only 52% of health care needs and less than 7% of Indian Health Service budget dedicated to behavioral health care (mental health and substance abuse services).

Meeting Purpose

The Center for Mental Health (CMHS) seeks to increase knowledge about mental health issues in American Indian and Alaska Native populations and to develop culturally appropriate strategies to engage tribal consumers in system and service delivery systems. CMHS also seeks to increase the federal-tribal partnership that can ultimately lead to an increase in service provision to American Indian and Alaska Native communities.

In this effort, the Center for Mental Health Services supported the convening of a panel of American Indian and Alaska Native behavioral health experts in Portland, Oregon on May 3-4, 2008. The meeting was held at Portland State University, Office of the Regional Research Institute.

Meeting Participants

The panel participants and guests included tribal psychologists, tribal social workers, tribal parents and foster parents, and other tribal representatives. Each participant had significant field experience in the delivery of American Indian and Alaska Native behavioral health services. Self-introductions by each participant revealed their tribal experiences and provided deep cultural context to their involvement and leadership in the tribal behavioral health field. Brief biographies of the panel participants are attached (Appendix A).

Meeting Agenda

During the course of the two-day meeting, the panel participants explored a series of critical issues related to the behavioral health needs of American Indian and Alaska Native communities. The agenda for the American Indian and Alaska Native Behavioral Health Expert Panel meeting is attached in Appendix B.

Topical areas discussed included:

- Neo-colonial Subversion on Local Tribal Thought and Practice;
- Field observations of the emerging social issues to the complex tribal behavioral health picture;
- Barrier reduction strategies;
- Culture-based engagement strategies; and
- Field observations of tribal service arrays, including how tribal traditional approaches to healing have successfully or unsuccessfully intermixed with mainstream clinical approaches.

The meeting discussion format was also designed to address each topic area from rural reservation, Alaska Native, and Urban Indian perspectives. In addition, special attention was paid to the impact of the degree of acculturation with tribal communities and tribal families, as well as ways to address and/or build upon the generational differences within tribal families.

Other special presentations by panel members included an overview of the tribal behavioral health status, tribal traditional and mainstream clinical service arrays, and an update on a tribal behavioral health financial sustainability study. The following report summarizes the recommendations that emerged from the expert panel meeting.

Impact of Neo-Colonial Subversion on Local Tribal Thought and Practice

Dr. Joseph P. Gone, an American Indian clinical and community psychologist and assistant professor in the Department of Psychology at the University of Michigan, provided an overview of the role that tribal behavioral health might play in the neo-colonial subversion of indigenous thought and practice. Beginning with a discussion of epistemology, also known as philosophical ways of knowing, Dr. Gone discussed the absence of attention in contemporary psychology to local ethno-psychological influences on healing and the therapeutic. In the treatment process, what would happen if we first started with an examination of the local ethno-psychological underpinnings of wellness? From that vantage point, what would the therapeutic process look like?

Based on recent research in a Native-controlled treatment setting, Dr. Gone discussed the western approach to expressive psychotherapy which is based on the therapeutic value of talk. This western approach assumes that the way to heal painful emotional burdens is through verbal disclosure of authentic but painful feelings, resulting in catharsis. In this treatment setting, talk therapy was seen to start the healing journey for Native clients.

However, many Native traditional approaches to treatment and healing are not based on the cathartic power of talk. For example, in historical Gros Ventre society, healing had nothing to do with “talk”. For many tribal people, the traditional approach to healing is based on prayer and cultural rituals, sometimes through the use of a medicine person and other ceremonial leaders. Today, both western and tribal behavioral health programs have increased their efforts to provide culturally competent care to American Indian and Alaska Native youth. Even with this sincere intent to address the cultural orientation of tribal youth, we can at times end up with treatment imported from western popular psychology, packaged in superficial aspects of Native culture. For the most part, the behavioral health field in Indian Country continues has depended on talk therapy.

Tribal programs that emphasize talk therapy should consider the possibility that such approaches actually serve to promote ongoing Native cultural assimilation in the guise of "help." Fueled by higher education and behavioral health training, therapeutic assimilation results as a by-product of being educated within western therapy approaches. Western therapy approaches are also reinforced by state and national accreditation standards and behavioral health financing structures. All of this can result in an almost invisible western cultural proselytization through tribal services. Dr. Gone suggests that tribal providers need to de-familiarize themselves with what they learned in school and re-assess the relevance of traditional therapeutic approaches that may work best for tribal communities. Culture matters and tribal communities often know what works for their community.

In closing, Dr. Gone left the group with the observation that very few of the behavioral health clients in our communities seek psychotherapy voluntarily. Because so many are court-ordered, or pressured by social services, to obtain counseling, we have a special obligation to ensure that we offer the most helpful services possible. In contrast what will result if we only dress up conventional therapy in beads and feathers? Has this been effective? What are the alternatives?

Panel members then discussed the unique goal of tribal behavioral health services as preserving the essence of cultural strengths while strengthening the tribal person's ability to respond to changing external factors.

Evidence Based Practice and Tribal Alternatives

The tribal expert panel discussed the evidence based practice (EBP) movement and the disconnection between EBP and tribal traditional healing practices.

Evidence-Based Practice is derived from scientifically designed research projects that consistently show evidence of health care improvement for those who receive the test treatment. Often referred to as the gold standard, clinical trials are the most arduous of the research methods to establish new evidence based treatments. Evidence-Based Practices, supported by data and scientific literature, have demonstrated effectiveness in controlled environments. However, the world is not a controlled environment (*One Sky Center News*, 2005).

Panel members suggest that evidence based practice promotes western European "treatment as usual". Treatment as usual harbors the potential to hurt, not help, tribal communities. At best, an evidence based practice approach can alienate tribal people; at worst, it can promote forced assimilation. Other practitioners believe that evidence based practices can serve as the starting place for treatment, but that the evidence based practice should be adapted for culture.

Panel members felt strongly that the evidence based practice movement is not compatible with the need for culture based treatment. They argued that in culture based treatment, one does not add culture into an existing mental health practice. Culture is not an afterthought or an add-on to a western European therapeutic approach. Rather, the panel members felt that the opposite must occur. That is, *one must integrate mental health into the tribal culture*. In other words, culture is the starting place.

The panel also discussed traditional healing and evidence based practices. Panel members were opposed to any effort to merge the two vastly different worlds of EBP and traditional practices. Although traditional practices can be broadly defined and are specific to each different tribal group, they are spiritual in nature and are difficult to evaluate scientifically. Some feel that any attempt to package a traditional healing practice into an EBP framework devalues the traditional practice. Panel members also discussed the ethics involved with any pursuit of an evidence base for traditional practices. Hypothetically, another danger is that should a tribal traditional practice ever become a widely accessible evidence based practice, the traditional practice could be unwittingly misused in the public domain. All traditional practices have specific tribal or regional roots and are not intended for use by other populations. Other panel members feel that the full array and mix of available tribal services (ranging from clinical services to traditional practices) may warrant further examination

Culture matters and the current EBP movement is lacking in its knowledge of the role of culture in intervention and healing. Some approaches to tribal healing, especially in the realms of tribal client engagement and culturally competent treatment, could provide useful information to tribal behavioral health programs. Other efforts in community accepted healing approaches (also know as Practice Based Evidence or PBE) have recently emerged. Several efforts across the country have been working on ways to build the evidence base of the community-driven or Practice-Based Evidence work. Work in this area can benefit from tribal and tribal-experienced research partners.

Field Observations: Emerging Influences on Tribal Behavioral Health

The tribal behavioral health experts brought significant working experience in rural reservation states, southwest pueblo communities, Alaska Native communities, urban Indian communities, Oklahoma tribal nations, and tribal boarding school communities to the discussion table. Some of the changing social and economic factors that affect today's tribal families, and that have implications for behavioral health services, include:

- Unique generational issues when tribal parents are not able to pass traditions on to their children;
- Negative tribal community environments that informally sanction lecture, shame and ridicule;
- Tribal humor that at times is masking community and/or family pain;
- Lines of discontinuity (e.g., what happens when tribal communities lose the rigidity required to maintain traditional values and protocols?);
- Tribal youth gang involvement as a new way for Tribal youth to feel connected;
- Impact of desire for pop culture (Nike brand, rap music, iPods, Xbox, etc.) on tribal youth values and tribal youth purchasing ability;
- U Tube influence and de-sensitization of negative behaviors (e.g., fights, huffing, gang rape, etc.)
- Salary disparity between the tribal gaming industry and tribal social services;
- Impact of caretaker gambling on family wellness (e.g., children sitting in cars outside casinos waiting for their parent or caretaker);

- Fetal alcohol syndrome (FAS) and fetal alcohol effected (FAE) youth now coming into adulthood;
- Drug and alcohol abuse occurring at younger ages, sometimes as young as eight year olds;
- Increased tribal abuse of prescription narcotics;
- Increased rates of tribal suicide attempts and suicide completions;
- New levels of resignation characterized by tribal community members who watch the community or youth fall apart with little or no intervention;
- Tribal youth "forgetting" of past dangers and exemplified by young tribal adults who are indulging in social drinking;
- Tribal enrollment and descendency issues, sometimes referred to as the "blood quantum divide" (e.g., a growing number of today's tribal grandchildren may not be eligible to become enrolled tribal members due to rolling impact of intermarriage with non-Indians or intermarriage with other tribes); and
- Risk to tribal community stability if the line between physical and spiritual worlds is reduced.

Barrier Reduction Strategies

Panel members discussed the broad diversity of tribes and tribal populations and the challenges for many in accessing behavioral health services and supports. The challenge for tribal behavioral health is to use the essence of tribal traditions and belief systems as the foundation of today's modern tribal behavioral health system. This use of the cultural familiar increases the comfort level for families or individuals to seek help. However, some may continue to be hesitant to seek help because they fear that confidentiality may be broken within their tight-knit community environment. Panel members discussed ways to reduce barriers to tribal behavioral health services. Following are factors in barrier reduction to consider for tribal communities:

- ✓ Developing a tribal workforce that are trained in behavioral health interventions and approaches, but who also understand and respect the cultural nuances of the tribal community;
- ✓ Ensuring that the physical work settings for behavioral health services do not breech confidentiality;
- ✓ Providing additional emphasis on confidentiality in small town settings for all direct service staff;
- ✓ Ensuring that staff supervisors remain vigilant and sensitive to community concerns about confidentiality;
- ✓ Working to provide the best match possible between assigned behavioral health provider and the individual or family to be served, paying attention to conflict of interest areas such as family members serving family members, or rivalries within the community;
- ✓ The "wrap-around" model of family counseling does accommodate the support system beyond the nuclear family members;
- ✓ Marketing behavioral health to the community using a strength-based approach that relies on local language, local values and local communication methods;
- ✓ Using the power of Native language to reinforce the value of physical health, emotional balance, spirituality, and problem solving

skills as ways to strengthen families and the tribal collective; and
- ✓ Determining ways to reach those in need but who may be geographically or socially isolated.

Considerations for Culture-based Engagement Strategies

Panel members discussed the importance of respecting tribal autonomy as a key to tribal engagement. This means that any effort to engage tribal communities must lead with tribal values (specific to each tribal community). In some communities, this could mean finding ways to engage within a culture of non-interference, using indirect communication and story telling as the communication norm. In summary, culture based engagement must be tied to the local tribal cosmology.

It is also important to tailor strategies specifically to the sub-segments that together comprise Indian Country. These include attention to nuances particular to rural reservations, Alaska Native communities, Urban Indian communities, degrees of acculturation, and the tribal generational divide. Panel members shared their perspectives on considerations for each of the following sub-segments of Indian Country:

Some Urban Indian Considerations:
- ✓ *Multiple tribes means multiple tribal belief systems*
- ✓ *Federal relocation process, initiated in 1952, resulted in tribal families spread out across designated urban geographic areas in a way that there is not a single "community" to access*
- ✓ *Urban Indian health programs typically rely on federal resources, not State resources*
- ✓ *Urban Indian people are conscious on a daily basis of interconnectedness between the urban and rural of tribal communities*
- ✓ *Urban Indian program staff are often youthful and expert in their behavioral health knowledge of tribal urban life*

Some Alaska Native Considerations:
- ✓ *Alaska Native people comprise the largest block of federally recognized tribes in the United States*
- ✓ *Many Alaska Native communities had early influences by non-Native organized religion (Christian, Russian Orthodox, etc.) which have now become integral parts of their communities*
- ✓ *Alaska Native regional and village corporations are owned by Alaska Native people through privately owned shares of corporation stock (resulting from the Alaska Native Claims Settlement Act, 1971) which often serve as the economic backbone of the communities*
- ✓ *Remote isolation of some Alaska Native communities can be a factor in behavioral health*

Some Rural Reservation Considerations:
- ✓ *Increased tribal youth suicide on some reservations is alarming and a significant prevention and intervention focus*
- ✓ *Most rural reservations are economically deprived and face workforce challenges for credentialed staff*
- ✓ *Oklahoma has no reservations, but home to 37 federally recognized tribes and their individual tribal governments*

Some Acculturation Considerations

- ✓ *Tribal people live in multiple worlds with multiple world views*
- ✓ *Contact with mainstream American results in a mix of cultural behavior and multi-cultural thinking*
- ✓ *Some tribal people have identity confusion characterized by the statement "when you don't know the land and the land doesn't know you"*
- ✓ *People who leave their tribal community may lose knowledge, over time, of how to seek help through their traditions and rituals*

Some Generational Divide Considerations

- ✓ *Many tribal parents may want their children to connect with their traditions but the youth may not, especially during adolescence when they are more influenced by mainstream culture*
- ✓ *Conversely, due to past assimilation policies, tribal youth may want to learn more about their cultural identity, but their parents "weren't brought up that way", and may not know how to access these kinds of supports, and may not value them*
- ✓ *Loss of culture by younger generations is a serious fear in some tribal communities*
- ✓ *Survey of tribal youth in the Denver area asked "who do you talk to about problems?" and the most common response was "no one"*

Other Considerations:

- ✓ *Christian influence for many American Indian and Alaska Native people is significant*
- ✓ *Many tribal traditional ceremonies of today reflect a co-existence with Christian influences*
- ✓ *Indian churches abound, including Indian Baptist Church, Indian Methodist Church, Indian Catholic churches, and others*
- ✓ *Many tribal people are proud to be both Christian and Indian, and each life area contributes to strengths, coping skills, and resilience*

Tribal Best Practice Elements

A series of discussions occurred on the topic of best practice elements of clinical and traditional services that result in best practices. That is, what are the key elements that contribute to Tribal behavioral health programs that can successfully engage, treat, and support the emotional well-being of tribal communities?

Discussion first focused on how one tribal community "re-claimed" their healing. In this instance, the community first consulted with their tribal elders and traditional healers to listen to their knowledge of how their tribal community functioned historically and the historical behavior expectations of tribal children, youth, parents and families. Tribal culture served as the foundation of community functioning. This included behavior protocols, traditions, and rituals which shaped the community and were reinforced by the community adults. Building on this foundation, the tribal community then developed a local definition of wellness, developed a training curriculum on tribal behavioral health (based on the belief system for their tribal particular community) for both tribal and non-tribal behavioral health providers, created tribal diagnostic categories that served as a cultural parallel to DSM-IV diagnostic categories, established treatment approaches in which tribal traditional practices serve as the core and clinical practices serve as supplemental supports, and implemented an continuum of care in which cultural self and

tribal traditions served as a key component of restoring balance and wellness.

Other critical elements of Tribal best practices discussed by the Tribal panel stressed the importance of:

- Reclaiming the local traditional process;
- Maintaining unconditional respect for local process of communication and decision making;
- Determining the elements that make tribal communities feel comfortable to accept treatment;
- Incorporating the power of Native language into the overall program and marketing efforts for increased access;
- Ensuring that program approaches are viewed as judgment-free;
- Paying attention to helping people rejoin the community without shame;
- Realizing that community consensus on best practices may be difficult to reach because of acculturation issues;
- Integrating traditional approaches with community approval and in a manner that protects the practice integrity;
- Incorporating indirect therapy (e.g., story telling) as treatment modality;
- Using tribal values as cultural touchstones and incorporating values into treatment;
- Linking local tribal art and social influences into the treatment process;
- Maintaining a focus on utilizing tribal creativity as a part of the treatment process;
- Building rituals of celebration that reinforce wellness and the pride in cultural self;
- Determining ways to counter community resistance that can take the form of cultural challenges (for example, "that's not how we do it here") and remaining focused on the essence of the practice or intervention while being simultaneously alert to the role of community resistance; and
- Recognizing that some Native coping strategies were developed in the context of times of extreme hardship or during times of war, and reliance on the same practices for the sake of tradition may not have the same effect.

Traditional and Clinical Service Arrays

Panel members discussed their experiences with the range of treatment and service approaches used within tribal communities. In general, the panel members called attention to a need for an open door approach for services to tribal children, youth and families. This means that tribal clients may come and go as they move toward wellness and are not likely to come to treatment for 10 sequential sessions.

Also discussed were most effective treatment approaches. These were discussed in terms of steps of access, engagement, assessment, diagnosis, and treatment or service arrays. The summary included:

Providing Comfort. Panel members discussed the emotional and spiritual wounds of tribal people. Recognizing that the client is wounded and needs to initially be comforted and nurtured, prior to the beginning of any treatment. Comfort is offered through food, ceremony, humor or any other means that provides comfort.

Relationship Building. The client-therapist relationship in Indian Country is reciprocal relationship building. A panel member describes this relationship building process between the tribal client and therapist as tidal in nature, that is "you tell me some and I'll tell you some" as the relationship builds.

Relationship Building Within the Cultural Framework. Knowledge of the cultural roles and social expectations of behavior for the tribes (or tribes) of the client during relationship building is therapeutically helpful. For example, knowledge of Clan relationship can place the sense of belonging within a cultural context.

Assessment.

In addition to standard approaches to clinical, risk, require additional assessments. These include an assessment of loss, trauma and displacement in the tribal child's life, a cultural assessment to determine cultural health and ease with their cultural self, and an assessment of strengths and resiliency. Every movement (or non-movement) that the child makes is part of the observed assessment.

Diagnosis.

Clinical diagnosis alone is insufficient for most tribal people. Many tribal treatment programs consult with traditional practitioners to determine if spiritual or ancestral wounds also need to be addressed. In some tribal programs, the traditional practitioner and the clinician work in partnership, each contributing their area of expertise, to the diagnosis and treatment process.

Service Arrays.

Service arrays within tribal communities vary and may combine both Native traditions and clinical treatment approaches. Indian Health Service and credentialing and funding bodies require the use of evidence based assessments and treatments, viewed by some tribal people as perpetuating neo-colonial modalities. Tribes contracting to provide their own behavioral health services are able to use Native traditions as the core of services, and to view Western clinical approaches as important, but supplemental. Depending on the regional or tribal cultures, tribal programs adapt the match between culture and need in many ways:

- For children with attachment issues, some may use *Making Relative* ceremonies as part of treatment;
- Some Tribal approaches to child welfare protection do not remove the child from the home (which re-traumatizes the child), but rather removes the alleged adult offender;
- Equine therapy is growing in popularity as a treatment option and reinforces the horse culture of many tribes (some use medicine wheel teachings in equine therapy and referred to by some as spirit of the horse);
- Incorporating the strength of Native language and Native perspective into treatment (for example, determining the local term for well being, or viewing archeological ruins not as "ruins" but as something that was left by our ancestors to show how they survived through harsh situations); and
- Developing assessment, diagnosis and treatment approaches that address the cultural aspects of behavioral health and reinforcing the belief that cultural health can be followed by spiritual and physical health.

Remaining Challenges

Although much progress has been made in designing culture-driven services for tribal communities, serious challenges remain. The available behavioral health workforce for tribal communities continues to be seriously lacking. Funding for tribal behavioral health is not a priority for communities who have more pressing health and economic survival needs. The lack of warrior spirit that calls tribal men to services contributes to high numbers of tribal men leaving local communities for military service leaving voids in local male role models.

High rates of suicide attempts, suicide completions, and suicide clusters continue to haunt tribal communities. Panel members discussed results from a recent reservation-wide survey which asked tribal junior high and high school students about reasons for tribal youth suicide. The youth responses included:

1. No spirituality, we don't know God
2. Bullying
3. No involvement of parents in their lives
4. Relationship with girlfriend, boyfriend, and peers
5. Extreme poverty with no hope

The panel members noted that the common theme in the responses were variances of "relationships".

Summary

Panel members recognized that there are a multitude of factors that influence the emotional, spiritual, and physical health of tribal people. Tribal people seek supports that have a tribal flavor and respond best if the provider understands the community context in which they live. Conventional, western therapy as a stand-alone approach is a misfit for many tribal people. Some consider that conventional treatment only approach to be dangerous as it undermines the cultural re-claiming process that builds a strong sense of cultural self.

Several tribal organizations have developed lists of tribal best practices which offer a treasure trove of information. Two sources of tribal best practices include the One Sky Center (www.oneskycenter.org) and an emerging national organization of tribal behavioral health providers called First Nations Behavioral Health Association (www.fnbha.org). Although finding ways to share best practices with American Indian and Alaska Native programs is critical, it is important to note that tribal best practices that work well for one tribal community may not fit the cultural context of other tribal communities. In summary, culture matters and just as culture evolves, so does the field of tribal behavioral health.

Appendix A: Meeting Participants

Shannon Crossbear (Ojibwe)

Holly Echo-Hawk (Pawnee)

Jill Shepard Erickson (Dakota/Athabaskan)

Joseph P. Gone (Gros Ventre)

Jeff J. King (Muscogee Creek)

Joanne Canillo Lee (Pomo)

Jackie Mercer

Deb Painte (Arikira)

Alan Rabideau (Ojibwe)

Catherine Reimer (Inupiaq)

Paulette Running Wolf (Blackfeet)

Pamela Jumper Thurman (Cherokee)

Appendix B: Brief Biographies of Meeting Participants

SHANNON CROSSBEAR

Mental health issues within her family of origin and community cement her commitment to improving conditions for the children. As a parent survivor of a child who completed a suicide, her sensitivities to the needs of families are paramount in her work. She seeks, through her skills and experience, to create partnerships. Moving policy to practice through the use of evaluation and research that accurately reflects the voices of families and communities is a part of her personal and professional mission.

Shannon CrossBear is employed with the Federation of Families for Children's Mental Health and her current work through her business, Strongheart Resource Development, includes facilitating and consulting with the National Indian Child Welfare Association, Georgetown University, the Surgeon General's Conference on Children's Mental Health, and the Aboriginal Healing Strategy. Shannon has worked with the National People of Color Leadership Institute in the development of cultural competency and the celebration of the strength inherent in diversity. She was a co-founder of the Holistic Health in the Heartland Midwest Conference that laid the foundation for the bridge between western modalities and complimentary medicine. Ms. CrossBear is a member of the federal Children's Mental Health Outcomes Roundtable.

HOLLY ECHO-HAWK, MS

Holly Echo-Hawk is the founder of Echo-Hawk and Associates, an organizational behavior and management consulting firm specializing in the field of children's mental health. Born and raised in Pawnee Oklahoma, she is a member of the Pawnee Tribe and holds a Masters degree in organizational behavior. During the past twenty five years, she has served as the executive director of three children's service organizations and has been responsible for clinical staff and services to thousands of children and families. Services under her leadership ranged from therapeutic group care for child sex offenders to leadership development for minority youth. Holly completed three gubernatorial appointments as a trustee of Clark College in Washington State in 2002.

Through her current work with the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), and the National Indian Child Welfare Association, she has worked with numerous tribal mental health programs throughout the country and is co-author of *Cultural Strengths and Challenges in Implementing a System of Care Model in American Indian Communities, The Role of Traditional Practices in Native American Mental Health,* and *The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children's Mental Health.* In 2003, she facilitated a symposium on tribal perspectives and issues around research which resulted in the on-line monograph: *AIRPEM Work Group on American Indian Research and Program Evaluation Methodology.*

JILL SHEPARD ERICKSON, MSW, ACSW

Jill Erickson currently serves as Executive Director of First Nations Behavioral Health Association. She is enrolled in the Santee Sioux Tribe through her mother, and her father was born in the Eyak Village of Alaska. She retired from the Center for Mental Health Services in 2006, after serving eight years as

Program Director for the Circles of Care grants for tribes and urban Indian programs, and Project Officer for grants to tribes and states to transform their systems of care for children with serious emotional needs. Prior to that, she worked for Indian Health Service in both direct service and at the Headquarters West Mental Health Program Office, in Rosebud, SD, Albuquerque NM, Pendleton OR, and Phoenix Az.

JOSEPH P. GONE, PHD

Dr. Joseph P. Gone is assistant professor in the Department of Psychology (Clinical Area) and the Program in American Culture (Native American Studies) at the University of Michigan in Ann Arbor. An enrolled member of the Gros Ventre tribe of Montana, Gone enlisted in the U.S. Army for two years before obtaining his A.B. in psychology at Harvard University in 1992. Following a year of living and working on the Fort Belknap Indian reservation in north-central Montana, Gone pursued his doctorate in clinical and community psychology at the University of Illinois in Urbana-Champaign. During his graduate training, he served as the Charles A. Eastman Dissertation Fellow at Dartmouth College before accepting an Internship in Clinical Psychology at McLean Hospital/Harvard Medical School. Gone earned his Ph.D. in 2001 and commenced his academic career with a brief faculty appointment in the Committee on Human Development at the University of Chicago before relocating to Ann Arbor.

As a cultural psychologist, Gone addresses through his research a key dilemma confronting mental health professionals who serve Native American communities, namely how to provide culturally appropriate helping services that avoid the neo-colonial subversion of local thought and practice. He has published articles and chapters concerning the ethno-psychological investigation of self, identity, personhood, and social relations in American Indian cultural contexts vis-à-vis the mental health professions.

JEFF KING, PHD

Jeff King received his M.S. and Ph.D. in Clinical Psychology from Pennsylvania State University and the B.A. in Psychology from the University of Oklahoma. Dr. King is an Associate Professor at Western Washington University, Department of Psychology, where he is also Assistant Director for the Center for Cross Cultural Research. He is a licensed clinical psychologist and has provided clinical services to primarily American Indian populations for the past 20 years. He was Director of Native American Counseling in Denver, Colorado for 13 years. During this time, he also taught graduate courses in multicultural counseling for several universities in Denver. Before coming to Western Washington University, Dr. King worked for two years among the Taos and Picuris Pueblos in New Mexico through Indian Health Service. He is currently the President of the First Nations Behavioral Health Association and an active member of the National Alliance of Multi-Ethnic Behavioral Health Association. Both organizations advocate at the national level for cultural competence and the reduction in disparities in mental health care for Native Americans and other ethnic minority populations. Dr. King is a tribally-enrolled member of the Muscogee (Creek) Nation of Oklahoma.

JACQUELINE A. MERCER

Jackie Mercer is CEO of Native American Rehabilitation Association of the N.W. (NARA), Inc., Portland, Oregon. She has worked in the field of mental health and addiction for over 30 years and has provided leadership at NARA to expand services to Indian people and others who are in need. She is an adjunct faculty member of the Departments of Psychiatry and Nursing at Oregon Health Sciences University. Other affiliations include the Oregon Legislative Commission on Indian Services, Oregon Indian Counselors Association, Indian Health Services, Portland Area Alcohol and Drug Managers Association, and serves on the Boards of the Oregon Primary Care Association, the National Council of Urban Indian Health, and the Coalition of Communities of Color.

DEBORAH PAINTE, MPA

Deborah Painte, MPA, is a member of the Three Affiliated Tribes (Mandan, Hidatsa, & Arikara Nation) of North Dakota and is the Project Director for the Medicine Moon Initiative to Improve Tribal Child Welfare Outcomes through System of Care. The Medicine Moon Initiative is administered through the Native American Training Institute, a North Dakota inter-tribal child welfare training consortium. Ms. Painte has over twenty-five years experience working with Tribal Nations in program, community and systems development and has nine years direct experience in developing Tribal Systems of Care. She served as the former Project Director and Evaluator for the *Sacred Child Project*, a Center for Mental Health Services (CMHS) children's mental health System of Care grantee. Deborah has assisted the Standing Rock Sioux Tribe in securing a State-Tribal Youth Prevention Grant and will be involved in the initial program design implementation and development of the evaluation research design.

Ms. Painte has significant experience in state-tribal relationships, state-tribal policy development & legislation, advocacy and Native American issues and was appointed as a State Cabinet member under two Governors as the Executive Director for the North Dakota Indian Affairs Commission. Ms. Painte continues to provide technical assistance, training and consultation to Tribal Nations and First Nations across the United States and Canada in a multitude of areas related to tribal best practices. Deborah has co-authored or provided input for numerous articles, studies, and reports on System of Care, wraparound process, tribal culture, Native children's mental health and Indian Child welfare issues and has made numerous conference and workshop presentations on these topics. Ms. Painte was instrumental in the development of a wraparound training certification process and manual for tribal communities and the establishment of the Native American Training Institute (formerly known as the Native American Children & Family Services Training Institute) in Bismarck, ND.

ALAN R. RABIDEAU

Alan "Jawenodee Inini" Rabideau is a member of the Sault Ste. Marie Tribe of Chippewa Indians in Sault Ste. Marie Michigan. He provides consultation and technical assistance on various issues of development and integration of Anishinabek (Ojibwe) cultural values in Human Services agencies and organizations. Mr. Rabideau has conducted training for parents, foster/adoptive parents, kinship parents, educators, social service staff and tribal youth in positive behavioral support, strength based supervision, effective leadership skills and developing "Family Driven" Systems. Mr. Rabideau has over 15 years of experience working with youth and families.

Mr. Rabideau considers his greatest accomplishment to have been given the chance to parent and provide treatment/specialized foster care to eight adolescent males with behavioral, emotional and educational disabilities for the past eight years. He has also served in many other roles which include substance abuse counselor in tribal co-ed group home and public school settings, live-in program manager for a medium secure juvenile sex offender group home, parent trainer for court ordered parents, cultural competency consultant to youth and families treatment programs, and consultant to state and tribal communities who are part of the federal Systems of Care Initiative for Children's Mental Health and the Child and Adolescent State Infrastructure grant program.

CATHERINE SWAN REIMER, EDD

Dr. Catherine Swan Reimer is an Inupiaq Eskimo who received her doctorate from the George Washington University in Counseling Psychology. She has worked in the field of education, counseling, suicide prevention, addiction, and Voice Dialogue training. She owns her own consultant business and does workshops and training for both education and mental health agencies; she is also does private therapy. Author of *Counseling the Inupiat Eskimo,* she is currently writing a book called *Native and White in One Breath*. Dr. Reimer has been a National trainer, evaluator, and curriculum writer for various organizations in the Washington D.C. area. She taught graduate studies for the University of Alaska and just finished research in the area of suicide, alcoholism, and spirituality among the Inupiat Eskimo for the University of Alaska, Fairbanks and NIAAA. Currently, she is presenting conferences on Best Practices in Native American Counseling for Mental Health Workers.

PAULETTE RUNNING WOLF, PHD

A Blackfeet/Cree enrolled tribal member raised and educated on her reservation in Montana, Dr. Running Wolf has focused her career energies on serving tribal communities. Her research interests are directed in exploring tribal values – identifying similarities and determining differences from main stream society and their application in effective behavioral health treatment.

Dr. Running Wolf is the founding Executive Director of the First Nations Behavioral Health Association and is a private consultant serving tribal communities across the country in the areas of social service training, program evaluation/research and assisting states in planning/implementing culturally competent systems of care. She is a also past project manager for a national AI/AN suicide prevention project funded by SAMHSA entitled *Native Aspirations* to promote suicide and violence prevention planning in nine tribal communities nationally with Kauffman & Associates.

PAMELA JUMPER THURMAN, PHD

Pamela Jumper Thurman, PhD, (Western Cherokee), Center for Applied Studies in American Ethnicity, Colorado State University. Dr. Thurman is a Senior Research Scientist with the International Center for Community Readiness: Research and Enrichment and the Project Director for the CDC funded *Advancing HIV/AIDS Prevention in Native Communities* a project working nationally to decrease the rising rates of HIV in Native communities. She is co-developer and co-author of the Community Readiness Model and has applied the model in over 1500 communities throughout the lower 48 and Alaska, as well as in Italy, Israel, Canada, and numerous other countries. She has worked with cultural issues related to alcohol, tobacco, and other drugs, violence, and victimization, rural women's concerns, HIV/AIDS prevention, and solvent abuse. She has served as Principle Investigator for federally funded projects addressing intimate partner violence, methamphetamine prevention, rural drug use, American Indian substance use and epidemiology and solvent use among youth. Funding sources have included the Center for Disease control and the Office of Juvenile Justice and Delinquency Prevention. She has served as evaluator for grants to tribes funded by the Center for Mental Health Services, SAMHSA. She has served as a member of the Center for Substance Abuse Treatment (CSAT), SAMHSA Advisory Council, is a member of SAMHSA's Data Committee, Roslyn Carter's Caregiving Panel, and is chairing the new Treatment Improvement Protocol on American Indians and Alaska Natives. She is also a published photographer, and an award winning artist and jeweler.

R. DALE WALKER, MD

Dr. Walker is Professor of Psychiatry and Public Health and Preventive Medicine and Director of the Center for American Indian Health, Education and Research at Oregon Health and Science University. Dr. Walker was the Founding President of the Board of Directors, First Nations Behavioral Health Association. Currently, he is chair of the Governor's Council on Alcohol and Drug Abuse Programs for the State of Oregon. He and his staff were initially funded by SAMHSA for a National Resource Center for American Indian and Alaska Native Substance Abuse Services called the *One Sky Center*. The Center was one of the first national resource center dedicated to improving prevention and treatment of substance abuse among native people. Dr. Walker chaired a state task force for the Department of Health and Human Services that focused on co-occurring addictions and mental illness problems. He is working on three major research projects, drawing attention to best practices for the treatment of addictions disorders.

Throughout his career, Dr. Walker has served nationally and locally as an advocate and activist for access to healthcare and the elimination of the stigma of mental illness. A major focus of his research has been on addictions and mental health issues of American Indians. Over the past 30 years, the American Indian Research Group has studied the prevalence and natural history of addiction disorders, risk and protective factors relating to addiction disorders, the relationship between mental and addictive disorders and treatment strategies. Dr. Walker has consulted and lectured throughout North America on American Indian issues.

Appendix C: Agenda for Expert Panel Meeting

American Indian and Alaska Native Behavioral Health Expert Panel Meeting

May 3-4, 2008
Portland, Oregon

Agenda

Friday, May 2, 2008

6:00 – 7:30 pm	Informal Networking

Saturday, May 3, 2008

8:00 – 8:45 am	Continental Breakfast/Networking
8:45 – 9:00 am	Welcome and Introductions
9:00 – 9:15 am	Tribal Behavioral Health Overview and Impact of Neo-Colonial Subversion of Local Thought and Practice
9:15 – 9:15 am	Field Observations: New Additions to the Tribal Behavioral Health Picture
9:30 – 10:30 am	Culture-Based Engagement Strategies • Rural Reservations • Alaska Native • Urban Indian • Impact of Degrees of Acculturation • Addressing the Generational Divide
10:30 – 10:45 am	Break
10:45 – 12:00	Barrier Reduction Strategies • Rural Reservation • Alaska Native • Urban Indian • Impact of Degrees of Acculturation • Addressing the Generational Divide

Noon – 12:45	Lunch
12:45 – 1:30 pm	Lunch Presentation • Traditional and Clinical Service Array-Best Practice Elements • Tribal Reservation and Urban Indian Perspectives
1:30 – 3:00 pm	Field Observations: Traditional and Clinical Service Access and Utilization-Best Practice Elements
4:00 – 4:00 pm	Day One Summation

Sunday, May 4, 2008

8:30 – 9:00 am	Continental Breakfast/Networking
9:00 – 10:00 am	Implementation Strategies for Dissemination of Tribal Behavioral Health Best Practices • Tribal Communication Venues and Strategies • Tribal Elected Officials • National Tribal Health and Advocacy Organizations • Tribal Family Organizations • Tribal Youth Organizations and/or Websites • Other National Tribal Websites
10:00 – 10:15 am	Break
10:15 – 11:00 am	Tribal Behavioral Health Frequently Asked Questions (FAQ's) and Expert Panel Responses
11:00 – 11:50 am	Sustainability Partnerships for Behavioral Health
11:45 – 11:50 am	Day Two Summation