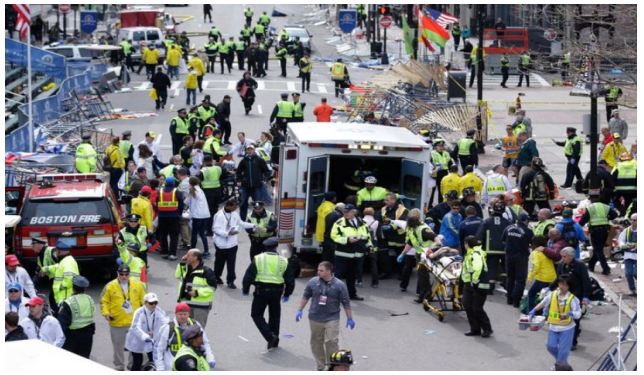
Ancestral Medicine and Community Transformation

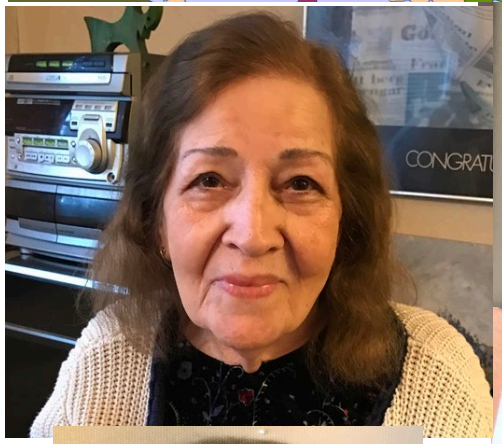
JoAnne Riegert, Caroline Ortiz, Noshene Ranjbar, Thomas A. Chavez, Emily Shoteen Si'al


Gaa-waabaabiganikaag
White Earth Nation


N
E
S


Armenia
Azerbaijan
Caspian Sea
Turkmenistan
Tabriz
Lake Urmia
Mashhad
Iraq
Tehran
Qom
IRAN
Esfahan
Birjand
Afghanistan
Yazd
Kuwait
Shiraz
Saudi Arabia
Persian Gulf
Pakistan


BOSTON FIRE




به امید صبح آزادی


AP
TODAY IN HISTORY
Rep. Gabrielle Giffords Shot in AZ

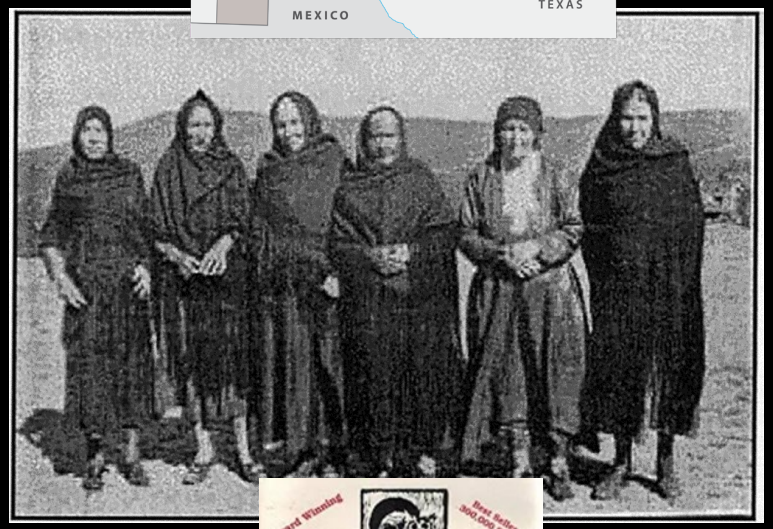

EARTH

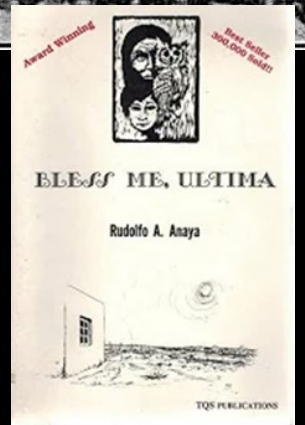
EARTH Initiative: Empowering All Relatives to Heal

- RWJ Culture of Health Strategic Initiative formed in 2020
- Serving those who work to transform trauma, keep wisdom and peace, and protect life on the ground
- Developed through the cultivation of service to Indigenous communities, at CMBM, and healing journey
- Ongoing support for MBM trained individuals among Indigenous and Iranian communities
- Mind-body-spirit medicine,
- Storytelling Initiative
- Relational wellbeing, support and spiritual nourishment
- Sharing our voice is precious medicine

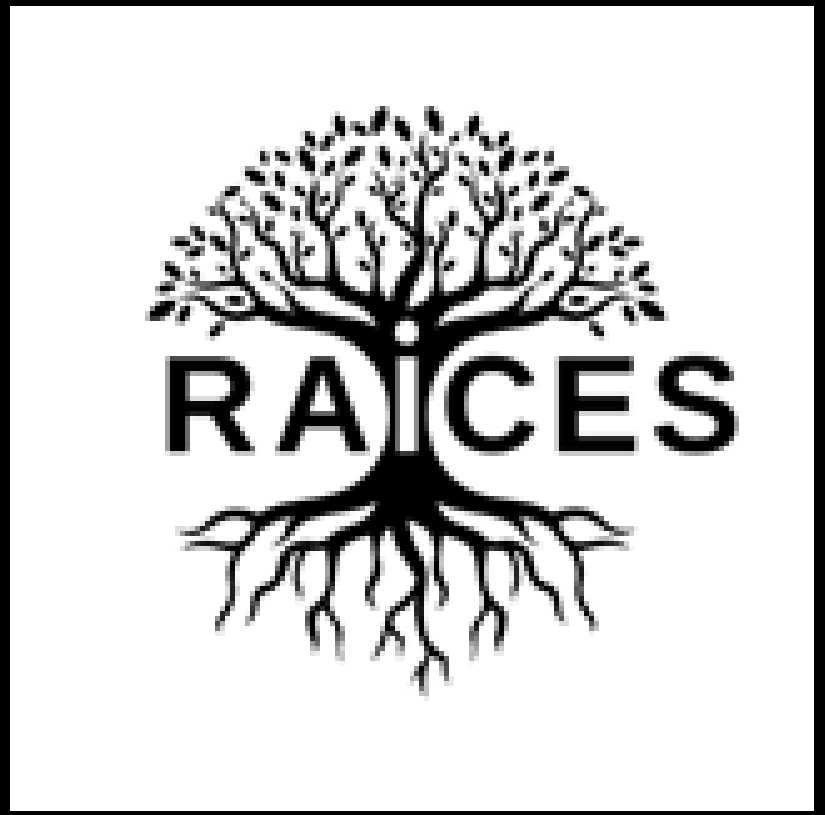

CURANDERA HILDA
ESPECIAL DEL MES
SE LEEN LAS CARTAS
O LA MANO Y UNA LIMPIA
CONSULTA
$20

My Cultural Roots





Returning to the Medicine



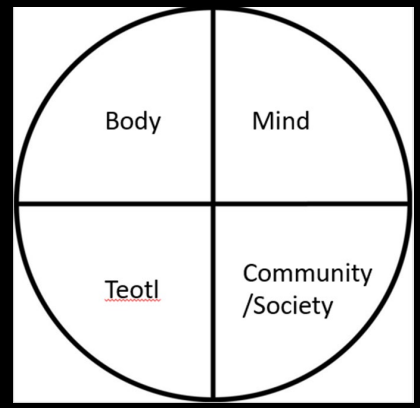
Decolonizing and Indigenizing: A Mesoamerican Worldview

A World in Motion
"slick and slippery"

The metaphorical idea behind the Nahua understanding of [goodness] and "truth"… **is that it is a matter of being rooted like a tree, as opposed to sliding about on our slippery, slick earth**.

The goal, **the solution to our human problems, then, is to find rootedness**

4 overlapping dimensions

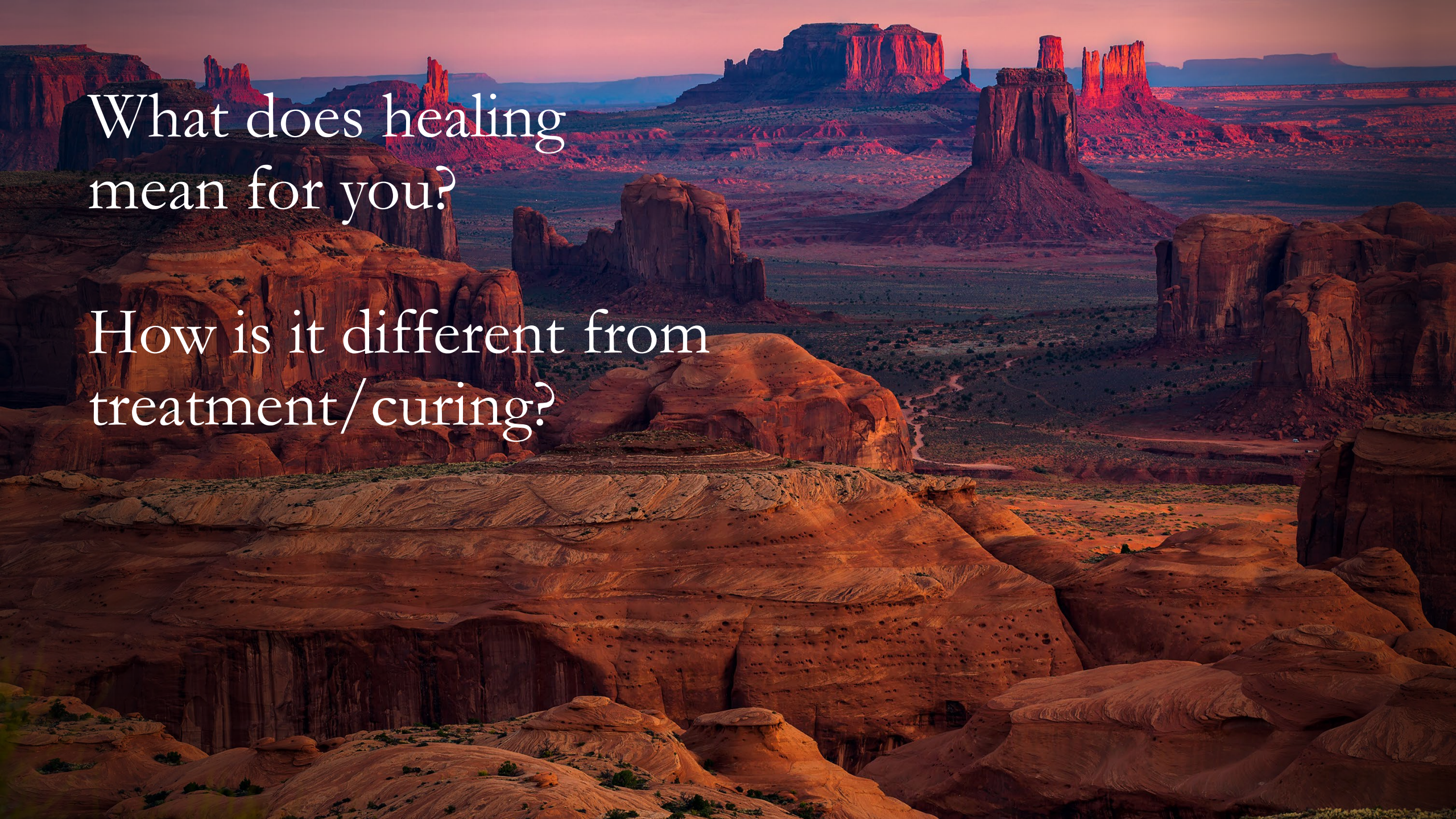


Copalli or copal = Resin or Incense


Intention and Invitation

What do you remember about your own ancestral healing wisdom/ways?

What ancestral medicine do you carry today?


What does healing mean for you?
How is it different from treatment/curing?


Gifts

Resources

- Herb List, RAICES Community
- Respectful Harvesting Guidelines, Kaayani Sisters Council
- 2024 Summer Curanderismo Course: https://curanderismo.unm.edu/
- University of Arizona Integrative Psychiatry Program
- The Center for Mind-Body Medicine (www.cmbm.org)
- *The Transformation: Discovering Wholeness and Healing After Trauma* by James Gordon, MD

References

- Martinez, K., Callejas L., and Hernandez, M. (2010). Community-Defined Evidence: A Bottom-Up Behavioral Health Approach to Measure What Works in Communities of Color. *Emotional & Behavioral Disorders in Youth.*

RAICES Community HERB LIST

***********Consult with an expert herbalist and your doctor regarding contraindication***********

***********Use may vary by cultural groups***********

***********Availability of herbs vary by region**********

Sorted by: Common name, Spanish, Scientific name

- **Aloe, Sabila name, Aloe spp**.: Anti-arthritic, Antibacterial, Anti-diabetic, Antifungal, Antirheumatoid, Anti-tumorigenic, Supports digestive and immune systems and skin. Caution: Hypersensitivity can develop at high doses and long-term use resulting in liver injury.

- **Angelica, Angelica, Angelica officinalis:** Analgesic, Anticoagulant, Anti-carcinogenic, Anti-inflammatory, Antimicrobial, Antioxidant, Antitumoral, Hepatoprotective, Nephroprotective.

- **Basil, Albahaca, Ocimum basilicum:** Anti-inflammatory, Antioxidants, Aphrodisiac, Energetic Cleansing. Caution: Avoid large doses and long term use during pregnancy.

- **Calendula, Calendula, Calendula officinalis:** Anti-carcinogenic, Anti-diabetic, Antifungal, Anti-inflammatory, Antioxidant, Heptoprotective, Supports immune system and skin.

- **Catnip, Hierba Gatera , Nepeta cataria:** Antibacteial, Antifungal, Anti-inflammatory, Antimicrobial, Antioxidant, Antiseptic, Anti-spasmodic, Anxiolytic, Insecticidal, Nervine Relaxant, Sedative, Supports digestive system. Caution: Consult a physician before talking during pregnancy.

- **Chamomile, Manzanilla, Matricaria Recutita:** Anti-inflamatory, Anti-spasmodic, Anxiolytic, Nervine relaxant, Supports digestive system and sleep.

- **Chaparral/Creosote Bush, Gobernadora, Larrea divaricata tridentate:** Anti-carcinogenic, Antifungal, Anti-inflammatory, Supports respiratory system. Caution:

Use in moderation due to side effects (stomach, digestive, weight loss, fever, rash, liver and kidney damage).

- **Chokecherry, Capulín, Prunus virginiana:** Anti-inflammatory, Antimicrobial, Supports respiratory system. Caution: Seeds may be poisonous.

- **Cinnamon, Canela, Cinnamomum verum:** Anti-carcinogenic, Anti-diabetic, Anti-inflammatory, Antimicrobial, Antioxidant, Hypoglycemic, Neuroprotective, Supports cardiovascular and digestive systems.

- **Cistus Purple Rockrose, Cistus purpureus:** Antibacterial, Antifungal, Antioxidant, Antiviral (flu), Supports digestive and respiratory systems.

- **Comfrey, Consuelda, Symphytum spp.:** Antibacterial, Anti-inflammatory, Antiviral, Supports skeletal system and skin. Caution: Hepatotoxic, Liver failure, Carcinogenic potential

- **Copal, Copal, Protium copal (Burseraceae):** Antibacterial, Anti-carcinogenic, Antifungal, Anti-inflammatory, Anti-oxidant, Energy cleansing, Insecticidal, Larvicidal.

- **Cottonwood, Alamo, Populus spp.:** Antifebrile, Anti-inflammatory, Antioxidant, Antiseptic, Supports skeletal sytem. Caution: May cause a skin allergy

- **Echinacea, Equinacea, Echinacea purpurea:** Antibacterial, Anti-fungal, Anti-inflammatory, Antiviral, Supports immune and respiratory system. Caution: Lupus, Multiple Sclerosis, Rheumetoid Arthritis, Tuberculosis, cancer, HIV/AIDS, auto-immune disorders. Do not use with catnip.

- **Fennel, Hinojo, Foeniculum vulgare:** Supports digestive, endocrine, reproductive, and respiratory systems. Caution: Pregnancy

- **Feverfew, Santa Maria, Tanacetum Parthenium:** Anti-cancer, Anti-inflammatory, Antiemetic (nausea/vomiting), Antispasmodic, Energetic Cleansing, Vasoconstriction (migraines).

- **Four O'Clock, Maravilla, Mirabilis multiflora:** Antibiotic, Antifebrile, Anti-inflammatory, Supports digestive system. Caution: Narcotic properties at high doses.

- **Garden Sage, Salvia, Salvia officinalis:** Anticarcinogenic, Anti-inflammatory, Antimicrobial, Antioxidant, Supports cognitve function and digestion. Caution: Pregnancy, lactation

- **Ginger, Jengibre, Zingiber officinale:** Analgesic, Anticarcinogenic, Antiemetic (nausea/vomiting), Antifebrile, Anti-inflammatory, Antimicrobial, Antioxidant, Carminative (reduces flatulence), Food source, Hypoglycemic, Indigestion, Supports cardiovascular system.

- **Grayfeather, Cachana, Liatris punctate:** Anti-inflammatory, Antiviral, Diuretic.

- **Green Ephedra, Cañutillo del Campo, Ephedra nevadensis:** Antibacterial, Digestive, Diuretic, Energizing, Supports urinary tract system. Caution: High blood pressure, Heart disease. Avoid high doses and long-term use.

- **Hawthorne, Espino, Crataegus:** Anti-inflammatory, Hepatoprotective, Supports cardiovascular system.

- **Hens & Chicks, Siempre Viva, Sempervivum spp.:** Antimicrobial (ulcers), Supports ear, digestive and respiratory systems.

- **Hibiscus, Flor de Jamaica, Hibiscus cv.:** Antibacterial, Anti-cholesterol, Antioxidant, Diuretic, Hepatoprotective, Nephroprotectve, Refreshing, Supports cardiovascular system.

- **Horsetail, Cola de Caballo, Equisetum hyemale:** Antibiotic, Antifungal, Anti-inflammatory, Antimicrobial, Antioxidant, Diuretic, Supports kidneys and urinary tract, Supports skeletal system. Caution**:** Pregnancy, Breastfeeding, Heart or kidney disorders, Diabetes, Gout

- **Hummingbird Mint, Agastache, Agastache spp.:** Anti-inflammatory, Anxiolytic (reduces anxiety), Nervine, Refreshing beverage, Supports cardiovascular system.

- **Jade, Siempre Viva, Crassula ovata:** Antibacterial, Anti-diabetic, Antimicrobial, Antioxidant, Antiviral. Caution: Avoid high doses and long-term use.

- **Juniper, Enebro/Tascate, Juniperus spp.:** Plant: Antibacterial, Antifungal, Antimicrobial, Antioxidant, Insecticidal, Supports immune and respiratory systems. Pitch: Antibiotic, Antifungal. Caution: Pregnancy. Overdosing may cause kidney damage and inflammation

- **Lavender, Alhucema, Lavandula angustifolia:** Analgesic, Antibiotic, Anxiolytic, Nervine Relaxant, Sedative. Caution: Allergy.

- **Lemon balm, Toronjil, Melissa officinalis:** Anti-inflammatory, Anti-microbial, Antioxidant, Anxiolytic, Nervine relaxant, Supports digestive system and sleep. Low dose supports cognitive function. Caution: Pregnancy, lactation, thyroid disorders.

- **Lizard's Tail (Swamp Root), Yerba Mansa(o) , Anemopsis californica:** Antibacterial, Anti-carcinogenic, Antifungal, Antimicrobial, Antiseptic, Antiviral. Contraindications: Anesthesia. Consult a doctor before taking during pregnancy or breastfeeding.

- **Madagascar Vinca / Periwinkle, Vinca, Cataranthus roseus:** Anti-carcinogenic, Antidiabetic, Antidiarrheal, Antimicrobial, Antioxidant, Anti-ulcer, Nervine. Caution: Avoid very high doses.

- **Mallow, Malva, Malva officinalis:** Antifungal, Antioxidant, Antimicrobial, Decongestant, Supports digestion, urinary tract and respiratory system.

- **Monarda "Bee Balm", Oregano de la Sierra, Monarda fistulosa:** Analgesic, Antibacterial, Anti-febrile, Anti-fungal, Anti-inflammatory, Anti-tussive, Supports digestive system. Caution: Pregnancy.

- **Mugwort, Estafiate, Artemisia vulgaris:** Analgesic, Antibiotic, Anti-inflamatory, Hepato-protective, Supports sleep.

- **Mullein, Punchón, Verbascum Thapsus:** Anti-inflammatory, Anti-tumorigenic, Supports the respiratory and digestive systems. Caution: Not to be used while breastfeeding. Can irritate skin.

- **Oak, Encino, Quercus spp.:** Antibiotic, Antifungal, Antimicrobial, Antioxidant, Antiviral, Supports digestive system. Caution: Limit use to four days. Can cause serious side effects such as stomach and intestinal problems, kidney and liver damage at high doses and long term use.

- **Passion Flower, Passiflora, Passiflora spp.:** Analgesic, Anxiolytic, Nervine relaxant, Supports digestive system and sleep. Caution: High doses and long term use may cause dizziness, drowsiness, confusion, hepatotoxicity, pancreatic toxicity. Do not use during pregnancy or breastfeeding.

- **Red-Berry Mahonia, Algerita, Mahonia haematocarpa:** Antibacterial, Anti-tumorigenic, Food source, Supports digestive system.

- **Rose, Rosa, Rosa spp.:** Anti-bacterial, Anti-inflammatory, Anti-microbial, Antioxidant, Digestive, Energy cleansing, Nervine. Rosehips: Oxidative, Supports eyes and immune system (vitamin C).

- **Rosemary, Romero, Rosmarinus officinalis:** Analgesic, Antiseptic, Anti-inflammatory, Antimicrobial, Antioxidant, Anti-tumorigenic, Energy cleansing,

Neuroprotective, Oxyginator, Supports cognitive function. Caution: Avoid very high doses.

- **Rue, Ruda, Ruta graveolens:** Analgesic, Antibiotic, Anticoagulant, Anti-inflammatory, Energy cleansing, Insecticidal. Caution: Pregnancy, Abortifacient, Menorrhagia. Can cause serious side effects and toxicity in multiple organs.

- **Spearmint, Yerba Buena, Mentha spicate:** Antibacterial, Antidiabetic, Antifungal, Anti-inflammatory, Antioxidant, Antispasmodic, Antiviral, Carminative (reduces flatulatence), Diuretic, Hepatoprotective, Supports digestive system. Caution: A related species, mentha pulegium (pennyroyal), is an abortifacient and hepatotoxic.

- **St. John's Wort, Hierba de San Juan, Hypericum spp.:** Antibacterial, Anti-inflammatory, Anti-tumorigenic, Antiviral, Nervine, Neuroprotective, Regulates mood. Caution: Possible drug interactions with birth control, and medications to treat blood clots, HIV and transplant rejection.

- **Stinging Nettle, Ortiga, Urtica dioica:** Anti-inflammatory, Anti-hyperglycaemic, Antirheumatic, Supports immune system and provides relief from allergy. Caution: Allergy, Contact Dermatitis

- **Texas Sage, Cenizo, Leucophyllum spp.:** Anti-inflammatory, Anti-microbial, Antioxidant, Nervine, Supports cardiovascular and digestive systems.

- **Thyme, Tomillo, Thymus vulgaris:** Analgesic, Anti-arthritic, Antibiotic, Antifungal, Anti-inflammatory (insect bites, rheumatism, swelling), Antimicrobial, Anti-spasmodic, Antioxidant, Antiseptic, Antitussive, Antiviral, Carminative (reduces flatulence), Disinfectant, Supports respiratory system.

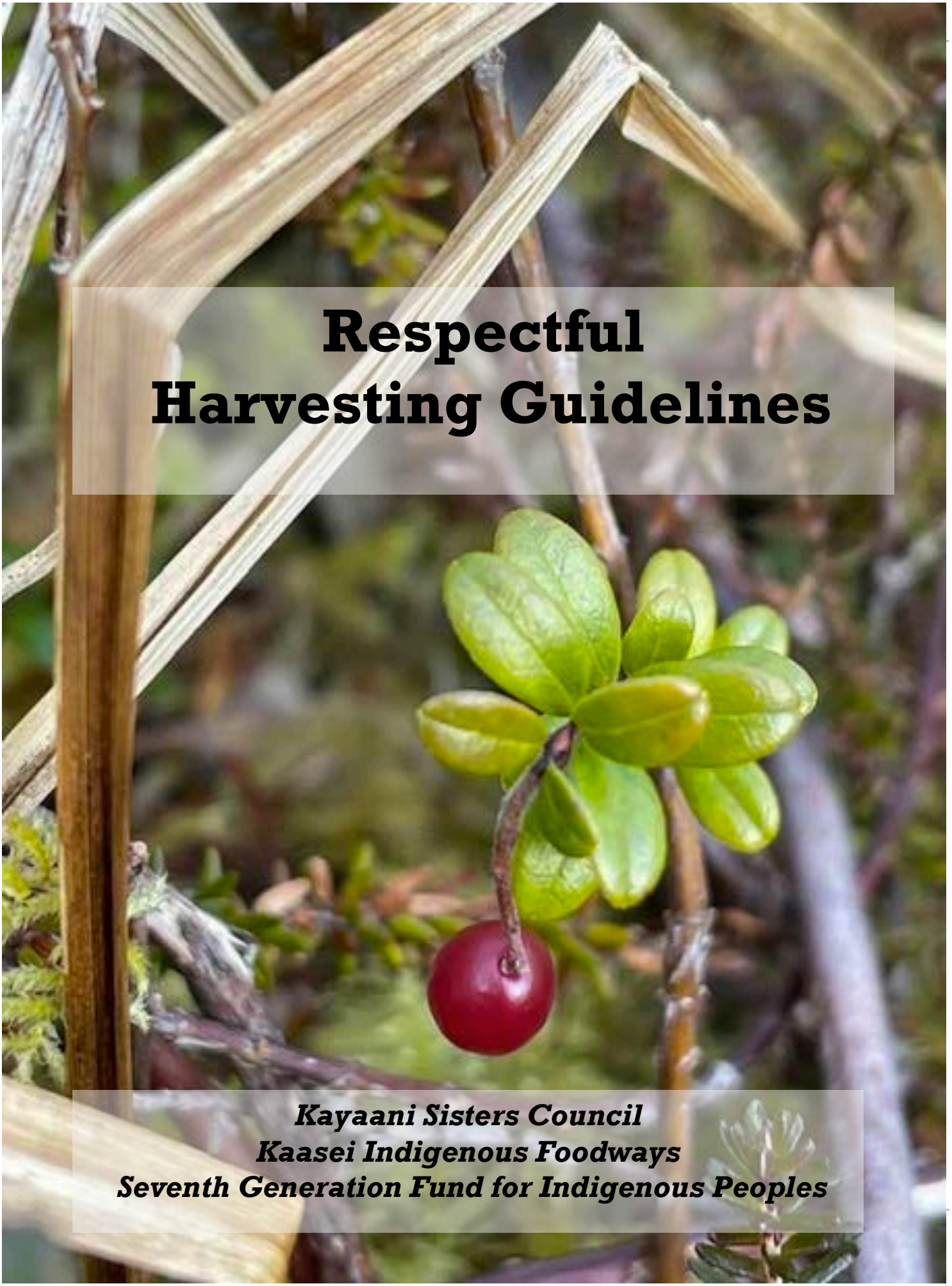
- **Valerian, Valeriana, Valerian officinalis:** Anxiolytic, Spasmolytic (relieves spasms), Supports sleep. Caution: Do not use during pregnancy

- **Vitex, Agnocasto, Vitex agnus-castus**: Analgesic, Antifebrile, Anti-inflammatory, Antioxidant, Endocrine regulatation of menstruation and menopause, Hypoglycemic, Nervine Relaxant, Supports sleep. Caution: Not to be used with pregnancy or birth control

- **Wild Tea/Greenthread, Cota, Thelesperma megapotamicum:** Antibiotic, Antiviral, Diuretic, Refreshing beverage, Supports urinary tract system.

- **Yarrow, Plumajillo, Achillea millefolium:** Analgesic, Antibacterial, Anti-inflammatory, Antimicrobial, Antiseptic, Antiviral, Diuretic, Expectorant, Insect repellant, Supports digestion. Caution: High doses not recommended during pregnancy.

- **Yucca, Amole, Yucca spp.:** Anti-arthritic, Antimicrobial, Antioxidant, Antiviral, Supports digestive system.



Respectful Harvesting Guidelines

Kayaani Sisters Council
Kaasei Indigenous Foodways
Seventh Generation Fund for Indigenous Peoples

Welcome to Respectful Harvesting Guidelines

Kaasei
INDIGENOUS FOODWAYS

Dear Reader,

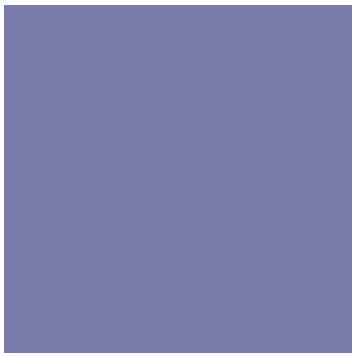
Respectful Harvesting Guidelines was prepared by the Kayaani Sisters Council, a group of Indigenous women across Alaska, and by Kaasei Training & Consulting, who are offering it to you as a gift. Many people have asked us individually and collectively for harvesting guidelines to help educate and inform those who want to learn about Indigenous cultures and want to gather local plants.

In preparing these guidelines, the women met as part of a Kayaani Sisters project supported by the Seventh Generation Fund for Indigenous Peoples. Much thought and care went into the preparation of these guidelines to address concerns of elders and individuals about overharvesting, ignorance of local practices, the need for sustainability and the need for healing in our Indigenous communities.

We hope that in following these guidelines we can maintain for the next seven generations the land on which we live and the foods and plants that sustain us. We also hope that local tribes, schools, communities, businesses and individuals will use these guidelines as a starting point for developing additional practices needed to sustain our lands and peoples. We believe that everything is connected. We are all interconnected with the plants, lands and each other. By further developing ways of protecting our resources, we are also healing ourselves and our lands.

"I want to learn more about plants because they help us and we need to help them too."

-Xein Tlaa, Kalani White, Age 6



Social justice, equity and food sovereignty are also connected. Many individuals currently living in Alaskan communities no longer have access to their traditional foods and plants. This lack of access contributes to poverty, inequity, and a wide variety of social issues.

By sharing the importance of maintaining and strengthening connections with our cultures, local plants and foods, and the importance of preserving our lands and resources, we believe it is an act of love and healing from the effects of colonization and violence against our peoples. We believe plants are our teachers. By learning about them, preserving them, respecting them in the ways we go about gathering and harvesting, we are leaving behind a legacy for the next generations. The Indigenous wisdom and teachings about our connections to our lands and resources is important for all.

By working together to better understand, preserve and respect our local resources, we are creating a better world and learning how to honor one another.

Our goal is that these guidelines encourage you to engage with your own local and cultural plant traditions. We believe that precious knowledge, wisdom and medicine exist within each of us and all around us. Our gift of these guidelines is meant to encourage thoughtful discussion, honesty and hard work to help solve the issues of inequity and develop more sustainable ways to preserve and care for our resources.

Naomi Michalsen
Kaasei Indigenous Foodways
87 Chacon Street
Ketchikan, AK 99901
907-617-1852

Kayaani Sisters Council

Respectful Harvesting Guidelines

Here are some suggestions that will support building relationships:

Build a deeper understanding and connection to the People on whose land you are harvesting.
The gifts of the land are the legacy of those who came before us. Express gratitude to the first stewards of the land by acknowledging and taking the time to explore the history of the Indigenous peoples in the area in which you are harvesting, including traditions, values and knowledge. Understand the history of colonization and its continued impacts today.

Prepare yourself spiritually.
Being honorable involves preparing yourself to go in a good way to make a connection with Creator, the land and the plants. This process strengthens your relationship with the earth. Make a connection to the spirit of the plant through offering a blessing, songs, prayer, smudging, meditation, talking to the plant, dreams, or other mindfulness practices. Listening and learning from the elders' stories can help you prepare and develop your own practices.

Choose your words carefully.
The heart is like a box and language is the key. Language provides connection to the land and to the ancestors. It is important for Indigenous and non-indigenous peoples to engage with local Alaska Native language by learning words, phrases, plant names and place names and also how to express gratitude in Indigenous languages. Many videos and stories are available at the local library and online. Consider taking a language class. For those whose ancestors are from the land, introduce yourself in your own language. This brings every one of your ancestors with you and gives you strength and connects you to the land. This practice will develop your skills and confidence to talk about plants and foods in a positive and respectful way that brings honor to the Indigenous people.

Honor and respect your teachers.
The connection to your teachers is as important as the connection to the land. Avoid relying *solely* on books and online resources such as Facebook posts because many of those resources may not provide a close connection to important and critical local knowledge and may be inaccurate for your area. Some plants may be usable in certain places, but poisonous or not usable at all in others. Local Indigenous knowledge can clarify these issues and help create a spiritual connection to the land and resources. Hands-on learning and gathering with an experienced person, elder or expert is critical for safe, sustainable harvesting. Where possible, seek guidance from elder women, as they are the traditional gatherers. This may take several visits or even several years. Express gratitude for your ancestors' knowledge and for the knowledge your teachers share. Name the lineage of your teachers when appropriate and respect oral traditions. It is customary to bring sacred plants, foods and other gifts to your teachers as a way of showing your appreciation and as a way of honoring them. Understand that some knowledge is intended to be shared while some knowledge is meant to be protected.

Honor and respect your plant teachers.
Plants are also your teachers, so take the time to observe closely and get to know them well. Practice reciprocity by considering what you can give back. Offer good intentions to the plants and the place where you are harvesting. Some may offer a gift (such as tobacco, a strand of hair, cedar), song, or prayer in gratitude for the gifts of the plants. Others may pick up garbage or remove invasive plant species.

Ask for permission.
Find out who's land you're planning to harvest on and then ask for permission to harvest there.

Harvest safely.
Plants can potentially transfer toxins to us so it is not safe to harvest everywhere. Avoid harvesting from roadsides, near railroads, old military sites, mining and oilfield sites, agricultural areas, and any other places that may be contaminated or sprayed with herbicides or pesticides. Out of respect, do not harvest at or near cemeteries or other sacred places. Be aware of wildlife in the area and other safety concerns.

Harvest carefully.
Plants contain powerful medicine so we must be careful in handling them. Make sure you absolutely know what you are harvesting before touching it. Know how to identify the plant by its characteristics such as color, texture, scent, where it's growing, and other indicators throughout all the seasons. Know what parts and what times of the growing season are appropriate to harvest. Learn how to identify plants that are poisonous and how to tell the difference between look-alikes. If in doubt, do not harvest because some plants can look similar. Misidentification can lead to illness or even death. Be aware of safety concerns for children, elders, people with pre-existing conditions, nursing or pregnant women. Some medicine plants should only be used for a short period of time, as cumulative effects can be harmful.

Harvest thoughtfully with gratitude.
Plants provide essential foods for animals. Their roots interact with fungal mycelia in the soil. They also play a critical role in relationship to the rest of the ecosystem, so take only what you need and not more. Be aware of how much of the plant is available and harvest only where there is abundance. Some harvesters take up to 10-20% of the plants and leave the rest for other humans and living beings. Be respectful to elders by leaving more easily accessible plants for their gathering. Plan ahead of time for how you will process the plant, and calculate how much time it takes to clean, prepare or preserve so there is no waste. Recognize that while you may only pick something in one season, this plant has its own life cycle and it takes time to grow. Be aware of how your harvest will affect the plant's growth and give appreciation to this process.

Practice reciprocity and leave no trace.
Make sure you share your harvest with elders or others who are not able to gather for themselves, as generosity is a core value and practice in Indigenous ways of being. When harvesting wild foods, clean up the area and make it better than when you arrived. Part of giving back is taking care of the land and protecting what we were given.

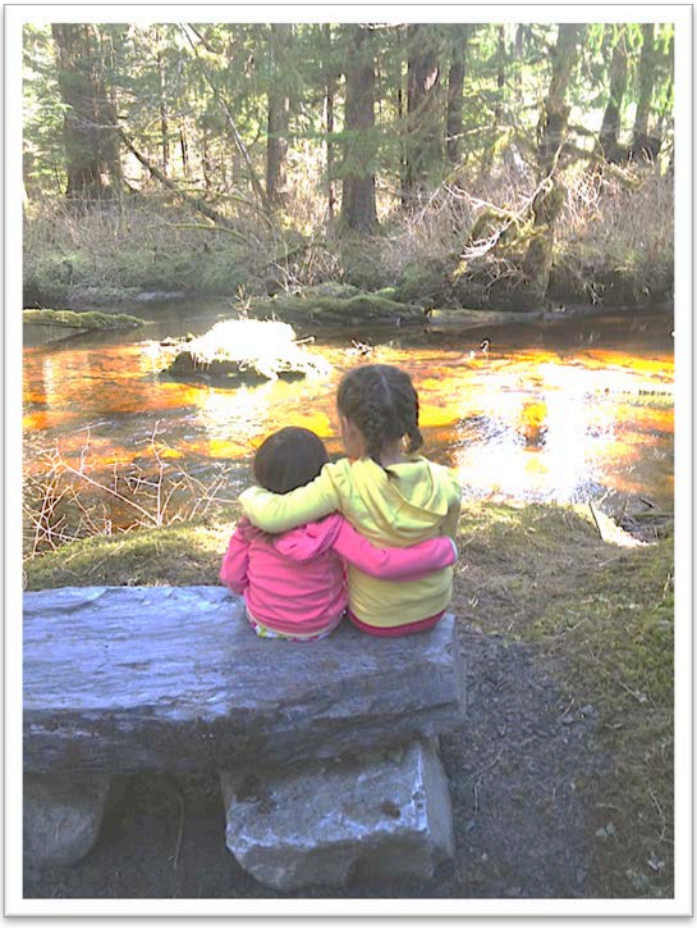
The above list of guidelines is not meant to solely represent every community and culture. Please use this list as a starting point for collaborating with your own community members to develop guidelines that honor your local Indigenous knowledge and the unique needs of your peoples.

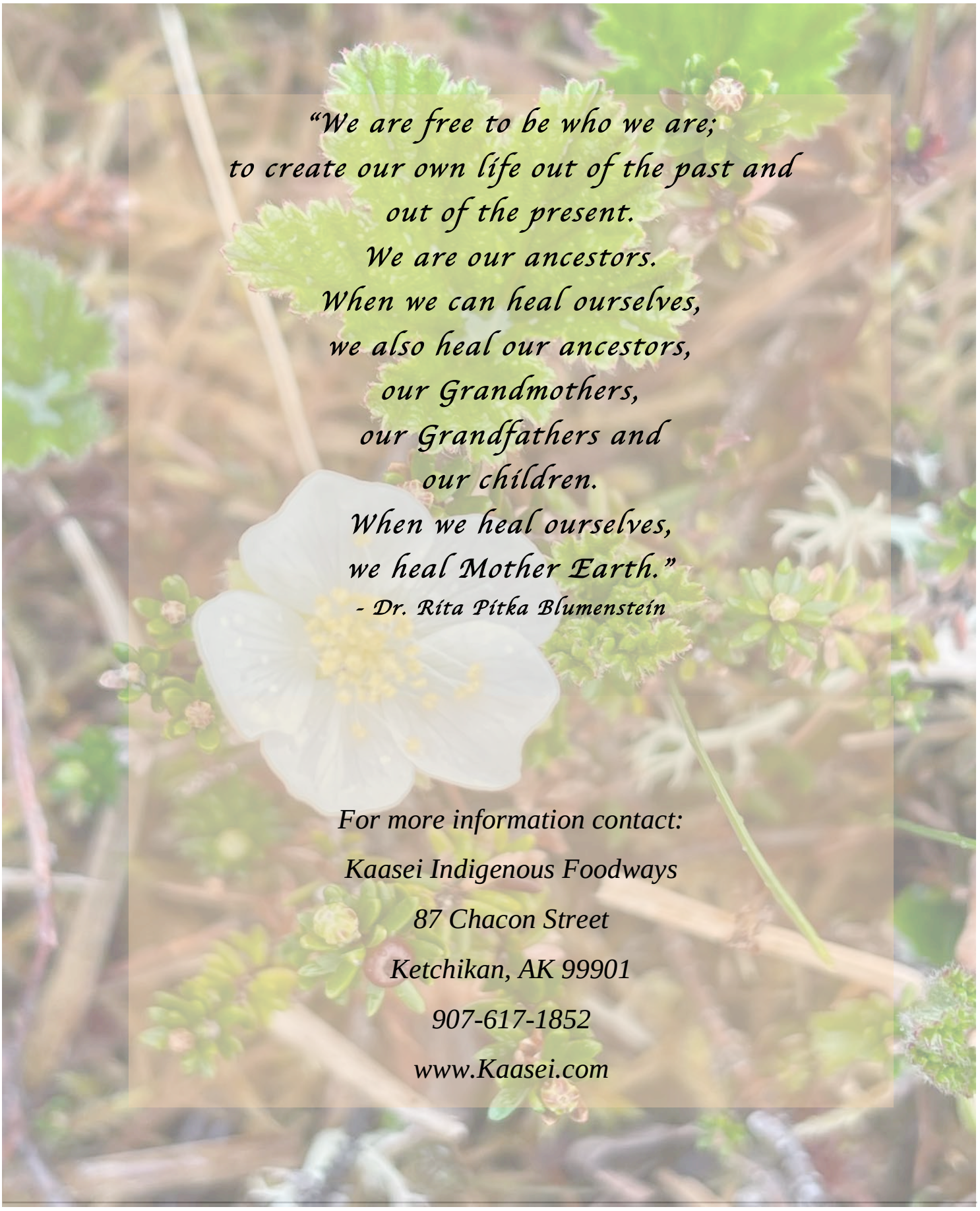
2021 Kayaani Sisters Council Members

Thank you to the 2021 Kayaani Sisters Council Members for sharing their time, expertise and dedication for this project and for all you do in your families and communities.
Thank you also to the Seventh Generation Fund for Indigenous Peoples for your support in making this project possible.

Trixie Bennett, Ketchikan, Alaska
Louise Brady, Sitka, Alaska
Eva Burk, Nenana, Alaska
Tia Holley, Soldotna, Alaska
Naomi Michalsen, Ketchikan, Alaska
Gloria Simeon, Bethel, Alaska
Disney Williams, Juneau, Alaska

Seventh Generation Fund
for Indigenous Peoples, Inc.





"We are free to be who we are;
to create our own life out of the past and
out of the present.
We are our ancestors.
When we can heal ourselves,
we also heal our ancestors,
our Grandmothers,
our Grandfathers and
our children.
When we heal ourselves,
we heal Mother Earth."
- Dr. Rita Pitka Blumenstein

For more information contact:

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Community-Defined Evidence: A Bottom-Up Behavioral Health Approach to Measure What Works in Communities of Color

by Ken Martinez, Linda Callejas, and Mario Hernandez*

This article describes the rationale for and components of the Community Defined Evidence Project (CDEP), which offers an important and exciting opportunity to advance the current body of knowledge on community-based practices that "work" for populations of color and to address behavioral health disparities in these communities. By developing an evidence base that uses cultural and/or community indices, the project seeks to evaluate the implementation and effectiveness of innovative community-based practices in Latino/Hispanic communities to reduce disparities and improve availability, quality, and outcomes of behavioral health care for all individuals and families.

Addressing Disparities in Communities of Color With Evidence-Based Practices

In continuing efforts to address growing behavioral health disparities and to ensure that individuals—including children, youth, and families in need of mental health services—receive the best treatment available, policymakers, researchers, and funders have promoted the use of evidence-based practices (EBPs; see Huang, 2002; Juszczak et al., 2003; Novins et al., 2000; U.S. Department of Health and Human Services, 2001; Walkup et al., 2000; Wang et al., 2000). In the literature, EBPs usually refer to well-defined, manualized interventions and treatments that show evidence of positive impact in randomized controlled trials (RCTs). Implicit in this framework is an emphasis on *empirical* support, which limits the definition of "evidence" and restricts the epistemology or worldview within which "evidence" is conceived to a strict form of empiricism.

The problem with relying solely on empirical evidence is twofold. First, empiricism itself is culturally rooted, and although empiricism may be compatible with the worldview of a substantial number of European Americans and Western Europeans, it is often not compatible with the worldview of many indigenous (e.g., Native American) and non-Western groups around the world.

Second, a reliance on empiricism often excludes the use of other forms of evidence in defining "evidence-based practices." For example, indigenous, non-Western European, and even some "nontraditional" European American and Western European practitioners, rely on other forms of "evidence" to support their use of treatments that are based on epistemologies that are not as compatible with empirical approaches to establishing evidence. More important, some scholars have expressed concern that an over-reliance on empirically supported interventions has the potential to become "an ideological and economic monopoly" in its advocacy for the sole use of empiricism and its methods (Slife et al., 2005).

Predominant methods for conducting research and defining evidence pose a problem for Latinos, currently the largest ethnic group in the country, as well as other diverse groups, in a number of ways. Traditionally, Latinos and other diverse populations have not been adequately included as subjects in services research (Miranda et al., 2005). They are typically not asked to participate in the conceptualization and design of treatments and interventions. As a result, the vast majority of EBPs were not designed for or appropriately standardized on populations of color. Therefore, these should not be used or promulgated for use in Latino communities without additional culturally appropriate and informed standardization, testing, or adaptation.

There are some empirically supported treatments that have been adapted or designed for specific cultural communities. For instance, Guiando a Niños Activos (GANA) is an adaptation of Parent Child Interaction Therapy (PCIT) for Mexican-American children (McCabe et al., 2005). McCabe used a sophisticated approach that included studying and documenting the values, customs, and beliefs of Mexican-American families so as to incorporate them into a PCIT adaptation that would be fundamentally based on the culture and values that are relevant and authentic to Mexican-American families.

The vast majority of EBPs were not designed for or appropriately standardized on populations of color.

Modification and adaptation of EBPs typically, but not always, focuses on incorporating the service user's values; on ethnic matching of providers and consumers; and on the incorporation of family, community and/or other informal support resources within a cultural community (Griner & Smith, 2006; Isaacs et al., 2008; Jackson-Gilfort et al., 2001; Martínez & Eddy, 2005). Some "adaptations" rely only on translations that are insufficient to qualify as adaptations because they do not fundamentally address the core values, beliefs, traditions, rituals, and historical contexts of the diverse populations they are meant to serve.

Recent evaluations of research on culturally adapted EBPs suggest promising results with regard to efficacy and effectiveness of interventions (Griner & Smith, 2006; Miranda et al., 2005). However, a number of questions still remain, including whether the adaptation of a practice compromises the fidelity of a

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particular intervention (Isaacs et al., 2008). Other concerns include the degree to which researchers and practitioners adapting EBPs consider specific ethnic/cultural factors relevant to subgroups within heterogeneous populations such as Latinos (Dumka et al., 2002), as well as the continued exclusion of traditional, spiritual, or other culturally relevant practices used within communities of color (Espiritu, 2003; Isaacs et al., 2008).

Looking beyond culturally adapted EBPs, there have been a few interventions that were designed specifically for, and normed on, a specific ethnic population such as Latinos. Two notable examples are the Family Effectiveness Training program (FET; Szapocznik et al., 1989) and Brief Strategic Family Therapy (BSFT; Szapocznik & Williams, 2000). Both FET and BSFT were designed for, standardized on, and replicated with Latino families in Florida. Since then, both practices have been studied for use with other populations such as African-American and white youth and families. FET and BSFT are, however, unusual examples; it is not common to find an EBP that has been designed, standardized, and replicated with youth and families of color.

Alternatives to Evidence-Based Practices

With the growing emphasis on EBPs by policymakers and funders of services, some community-based providers have felt the pressure to abandon practices that have been viewed as effective but that have not been formally established as EBPs. Although accountability is essential, forcing providers to abandon practices that have worked for children, youth, and families can have negative effects, including reliance on practices that may be inappropriate or irrelevant to the needs or priorities of families and youth of color. In addition, family and youth "voice and choice" is a critical element to consider (Osher, 2003). Even if a practice or set of practices meets the "gold standard" of being an established EBP, an alternative intervention based on the family's context and prioritized needs may be a better option.

Practice-Based Evidence. As a result of growing concern over repeated calls on the part of funding agencies and policymakers for exclusive use of EBPs in behavioral health, the concept of "practice-based evidence" (PBE) has emerged in the research literature. Isaacs, Huang, Hernandez, and Echo-Hawk (2005) defined PBE as "a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions." Results associated with the use of culturally specific community-based interventions, including traditional healing practices, are a common example of PBE. Such practices typically lack empirical support through formal research and are created and improved through the experiences of an organization actually offering the practice to the community (Isaacs et al., 2008). Over time, the term "practice-based evidence" has come to signify the "practice to science" complement to the "science to practice" paradigm, both of which were endorsed by the President's New Freedom Commission (2003). Over the past decade, however, PBE has come to mean many things. There are now attempts to further refine it as a concept and model that can be used to generate "evidence" of what works in communities (Martínez, 2008b).

Community-defined evidence is the knowledge accumulated through the ongoing successful implementation and/or evaluation of practices developed locally with significant community input.

Community-Defined Evidence. Practice-based evidence is probably the most widely recognized term used to describe the need to look beyond traditional empirically based models of examining practice effectiveness and to consider models that value the role of culture in determining effectiveness. Community-defined evidence (CDE) is a further refinement of the original PBE concept. Community-defined evidence emphasizes the inherent knowledge, experience, and expertise of communities themselves, based upon their history, prior success, and community-sanctioned use of certain practices, including those considered culturally related or not. Community-defined evidence is a response to the growing need to recognize and test community-based practices, culture specific or not, that "work" and the need to establish a means for documenting their positive effects using culturally appropriate and accepted methods of investigation. Community-defined evidence not only seeks to refine the concept and definition of PBE, it also seeks to provide a validating research model to determine "evidence" from the community perspective.

Community-defined evidence is the knowledge accumulated through the ongoing successful implementation and/or evaluation of practices developed locally with significant community input. The working definition of community-defined evidence to date has been that:

> [Community-defined evidence is] a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community (Martínez, 2008a).

Whereas there may be no consensus that "evidence" is defined as a set of practices, evidence in community-defined evidence supports the identification of specific practices by highlighting practices the community finds to be successful, rates highly, or speaks highly of, or that the community has assisted to develop or discover. Community-defined evidence emphasizes the critical role of a particular "service user community" (consumer) in determining whether a practice "works" for the community through acceptance and continued utilization of the practice, as well as evidence for demonstrating positive outcomes as defined by the service user within her or his cultural context.

In this working definition of community-defined evidence, "community" has purposely not been specifically defined because every population group, entity, or geographic area defines itself differently and should be properly defined by the group itself. Examples of "community" might include the neighborhood/barrio, the ethnic community in a city, the community-based organization, and the community it serves. "Community consensus" has also not been specifically defined because communities may have varying ways of measuring success, based upon

their particular parameters and priorities of what constitutes success.

A basic tenet of community-defined evidence is that people in the service user community themselves have knowledge based upon life experience and learned expertise that is rarely tapped to inform scientific study, especially in developing behavioral health practices. People in communities know who they are, the historical roots from which they come and the trauma that may be related to that history, and, many times, what works for them. Community-defined evidence is a paradigm that includes and values this knowledge in the discovery and study of those practices that have never, and may never, be studied through a controlled trial, yet are essential to include in our practice repertoire.

The Community Defined Evidence Project

The CDEP was initiated in response to the growing concern for increased recognition and acceptance of community-based practices and the need to establish a means for documenting their positive effects within communities of color by using culturally relevant, appropriate, and accepted methods of investigation. The CDEP is a partnership between the National Latino Behavioral Health Association and the National Network to Eliminate Disparities, and aims to discover and develop a model for establishing an evidence base using cultural and/or community indices that identify community-defined and based practices that "work." Community-defined evidence can encompass, in addition to treatments, a broad array of practices that include effective outreach and engagement strategies that increase retention and use of services, as well as multi-service assistance such as legal aid, housing, employment, and nutrition services. The CDEP focuses on identifying and documenting such practices within Latino/Hispanic communities across the country in order to develop a framework that might later be used with other cultural communities.

CDEP Design and Methodology

To study practices that might constitute community-defined evidence, the following criteria for selecting practices for the project were developed.

Clear Articulation of Practice(s) Used. Practices that were accepted for possible inclusion should be clearly articulated and include a description of the development and implementation process. Service providers/agency staff should be able to:

- Clearly articulate the practice and how it is used with the population of focus;
- Articulate how practices were arrived at, developed for, and/or adapted, to meet the needs of particular segments in the community; and
- Indicate whether the identified practice(s) derives from traditional or other culturally indigenous practices within the community.

Demonstrated Knowledge of the Population(s) Served. Service providers/agency staff should be able to:

- Clearly describe the population(s) of focus;
- Identify key demographic and/or cultural indicators; and
- Provide data (anecdotal or empirical) related to the proportion of service users who use Latino-focused practice(s).

Utilization of Specific Practice(s) by and for the Latino/Hispanic Community. Practices should demonstrate some evidence, anecdotal or otherwise, that consumers were indeed using these practices. Service providers/agency staff should be able to:

- Provide information related to utilization and retention rates associated with the identified practice(s); and
- Indicate how utilization helps, if rates are measured, to shape development, refinement, or implementation of the identified practice(s).

Potential for Demonstrating Outcomes. Service providers/agency staff should be able to:

- Provide information indicating whether the population(s) of focus value and are satisfied with the identified practice(s) and/or other services provided;
- Provide, where available, information on the effects of using the identified practice(s) among the population of focus—such information may range from anecdotal information and traditional or indigenous knowledge generated over time to experimental studies, if applicable and available;
- Identify factors, where available, that are associated with outcomes such as outreach, engagement, and other practices that can support continued use of practices or services; and
- Provide other data that indicate the practice(s) "works" with Latino service users.

In clinical work with victims, an effort is made to raise consciousness regarding their rights, abilities, and potential, as well as awareness about the impact of domestic violence on all of society.

Potential for Sustainability of Practice(s). Service providers/agency staff should be able to:

- Describe how the identified practice(s) is sustained by their agency;
- Identify whether they have specific funding sources for the identified practice(s); and
- Provide information, where available, about whether practices have been replicated with different populations and the process they used.

A nomination and review process identified organizations and programs that use innovative practices successfully with Latino and Hispanic communities across the country. A total of 56 organizations and programs and their practices were nominated (through a self- and third-party nomination process), representing 27 states. Nominated sites were then asked to participate in a one-hour screening interview designed to elicit information on key site characteristics (e.g., access indicators, outreach strategies, practice utilization, program and satisfaction evaluations, and clinical outcome measures that focus on functional and relational behavioral health and well-being outcomes), as well as the degree to which consumers and family members were involved in the development, implementation, and/or evaluation of an identified practice. Interview responses were then reviewed separately by two researchers

using a scoring sheet that calculated a total score given the degree to which consumers' input was incorporated at every stage of practice development. A mean score was then calculated for each site and these were ordered from highest to lowest. The 16 practices with highest scores were selected to participate in the study.

Data collection for the 16 sites consisted of in-depth interviews with a cross-section of each organization's stakeholders, including consumers, family members, providers, and community partners. Each site was also asked to submit demographic information for the practice of focus, as well as perceptions of community needs and barriers to mental health services. A total of 246 interviews were completed and are undergoing analysis to document the essential components of practices and factors important to their continued successful implementation.

Community-defined evidence would supplement EBPs that are already being used effectively with populations of color, therefore improving access by having more culturally appropriate and relevant options.

Cross-site findings will be used to further refine the parameters for defining and identifying community-defined evidence through distilling the "essential elements" that the sites have in common and that have been deemed critical to their success as defined by the local communities in which they are implemented.

Examples of Innovative Practices Selected for Study

Practices that were identified for in-depth study were categorized for the purposes of analysis. These categories are identified and defined below, and an example is provided for each.

Practices That Build Capacity and Consciousness in Local Communities. Generally, the practices identified in this category focused on building community capacity and/or raising the political consciousness of individuals (in various age groups) to prevent negative behaviors or improve behavioral health or well-being. An example is a domestic violence program in the U.S. Southwest that provides a holistic and comprehensive approach to addressing domestic violence among Latinas in the community by emphasizing these women as political beings. In clinical work with victims, an effort is made to raise consciousness regarding their rights, abilities, and potential, as well as awareness about the impact of domestic violence on all of society.

Practices That Increase Service Accessibility. Practices that increase service accessibility focus specifically on increasing access to services for children, youth, and families. An example is a community partnership working to increase access to a wide range of services and changing the way services are delivered to families in a southeastern state through a network of local providers, community health workers, and a grassroots community resident organization that identifies community needs and concerns and feeds these back through the network.

Practices That Raise Awareness About Mental Health. These practices focus on raising awareness within Latino communities about a range of mental health issues and services in formats that are widely available and culturally relevant. An example is an association affiliated with a county mental health department in a southeastern state that promotes information and education about mental health and available services specifically for Latinas. The association provides community workshops and has produced educational brochures and a CD series addressing mental health issues specifically for local Latina women.

Innovative Engagement Practices. Innovative engagement practices focus on engaging Latino consumers to establish rapport and increase provider acknowledgement of consumer values and preferences. An example is a health education and prevention organization in a western state that uses an engagement technique that incorporates art and storytelling to allow each consumer to express her or his individual identity and consider how it relates to health and well-being.

Community Outreach Practices. Community outreach practices focus on reaching out to the potential consumers in a variety of ways, to increase service reach, identify needs, or provide follow-up services. An example is a mental health clinic in the U.S. Midwest that works to "integrate immigrant and refugee families into the American society" through the services the clinic provides. The clinic conducts a great deal of outreach by relying on home visitors to develop relationships of trust with consumers, especially with the undocumented population.

Organizational Infrastructure Practices. Organizational infrastructure practices are implemented within organizations to enhance their administrative functions and/or other aspects of their organizational infrastructure in support of a program developed specifically for the local Latino/Hispanic population. An example is a multicultural relational approach that has been developed by a community-based mental health organization in a northeastern state to recognize, explore, and ascertain consumers' expectations with regard to treatment, to develop culturally relevant treatment methods, and to diminish cultural misunderstandings in the development of programs.

Interventions and Treatments. Locally developed interventions or therapies have been developed specifically to address the behavioral health needs in local Latino/Hispanic populations. An example is a therapeutic drumming approach that has been developed by a community-based mental health treatment center in California to address anger management and violence in adolescent males.

Locally Adapted Evidence-Based Practices. Local adaptations of EBPs have been modified to address behavioral health needs in local Latino/Hispanic communities. An example is a local adaptation of Cognitive Behavioral Therapy (CBT) in a U.S.-Mexico border community in Texas to address the mental health needs of a largely Mexican immigrant population.

Implications for the Field

Community-defined evidence can be viewed as a complementary option in a growing tool box of epistemologies and methodologies to define "evidence," especially in diverse communities. The knowledge gained through the CDEP can contribute to the field by documenting the way in which the traditional or indigenous knowledge that exists within communities has been used to develop and implement

successful practices for the residents of these communities. Community-defined evidence is not meant as a substitute for evidence-based practices that have benefited from the "gold standard" of controlled research. It is offered as an alternative model to describe how evidence can be defined from another paradigm, and as a method for including and validating practices that have emanated from communities from years of outcomes deemed successful by the community—a bottom-up approach. Although the empirical model seeks to confirm or disconfirm hypotheses using methods such as randomized control trials, and then accumulate knowledge of interventions from research conducted under such controlled conditions, community-defined evidence is predicated on the community members as a whole providing information about what works and what does not work in the community. Within this paradigm, worldview, cultural context, and personal interpretation are critical to the success or failure of an intervention or practice.

Community-defined evidence is more likely to take into consideration several critical variables that many times are not addressed when the intended population comes from an ethnic or racial group, including:

- Historical trauma;
- Current trauma related to racism/ethnocentrism/white privilege;
- Worldview;
- Immigration status;
- Generation in the United States;
- Preferred language;
- Socioeconomic status; and
- The presence and practice of traditional beliefs, values, and rituals, including spirituality and communication styles.

These variables contribute to the success or failure of any intervention or practice because they influence the ways in which children, youth, and families interpret them.

Whereas the CDEP studied practices in the Latino community as a start to define the "essential elements" that would constitute community-defined evidence, the long-term goal is to share the knowledge gained to determine its application to other major populations of color. Community-defined evidence would supplement EBPs that are already being used effectively with populations of color, therefore improving access by having more culturally appropriate and relevant options. It would also improve quality by using what has been shown, although maybe not documented by methods such as randomized clinical trials, to work in diverse communities.

From a practical perspective, community-defined evidence seeks to positively influence academicians/researchers, governmental entities, and public and private funders to include the use of appropriate culturally and community-defined evidence criteria when addressing the needs of populations of color. Examples include using CDE criteria alongside EBPs in requests for proposals (RFPs) and contract language so that funders/policymakers give grantees the option of using practices supported by community-defined evidence as well as practices tested in randomized controlled trials in their service delivery repertoire. The intention is to support development of knowledge and expertise of communities of color and to expand our knowledge of and study of existing community practices with populations of color that are perceived to be of value to the community. An additional aim is to influence future legislative and policy efforts so that funding is prioritized for culturally based research on racial/ethnic behavioral health disparities and to advocate for practice "effectiveness" measures that are culturally and community appropriate.

A research and evaluation agenda for the implementation and use of community-developed and based practices as well as EBPs that are effective with populations of color is essential. A long-term goal of defining a paradigm such as community-defined evidence is the elimination of disparities in behavioral health. Research conducted using the community-defined evidence model represents one major step toward achieving that goal by discovering and developing measurement criteria by which to assess what really works with populations of color within the context of their own communities and culture.

Conclusion

The wide support for EBPs on the part of policymakers and key behavioral health funding agencies has been promoted as a solution to the poor outcomes that ethnically/racially diverse populations have encountered in the behavioral health system. However, a number of limitations with regard to the use of EBPs with ethnically/racially diverse populations have been raised within the research literature (Bernal & Scharrón-del-Río, 2001; Isaacs et al., 2008; Manderscheid, 2006; Mays & Albee, 1992; Miranda et al., 2005). Specifically, these limitations relate to the lack of participation from communities of color in the development and testing of EBPs, as well as the degree of cultural relevance their outcomes may have for ethnic and racial communities (Isaacs et al., 2008; Miranda et al., 2003, 2005; Nagayama Hall, 2001; Sue, 1998). Further, as Isaacs et al. (2008, p. 622–623) note:

> [Theory development is] stymied by the complexity of the relationships between culture and mental health, as well as the many important related factors that would need to be considered (e.g., acculturation, language, socioeconomic status, regional effects, family variables, community variables).

EBPs could therefore exacerbate and deepen existing inequities if they are implemented without sufficient attention to factors that may differ between specific communities.

So the question is: By what method do we define "evidence" for a cultural community? The hegemonic paradigm suggests evidence should be collected by external researchers using an empirical epistemology. This approach negates alternative forms of "knowing" that may exist in communities of color and ill-prepares interventions for implementation within their communities (Zayas et al., 2004). EBPs could therefore exacerbate and deepen existing inequities if they are implemented without sufficient attention to factors that may differ between specific communities. Native American communities, in particular, have expressed concern that government mandates requiring use of EBPs not only ignore the impact of traditional spiritual ceremonies or rituals in behavioral health, but may also constitute "another form of oppression" (Isaacs et al., 2008, p. 623).

There is contemporary evidence of many effective and culturally appropriate

practices in diverse communities that have never been formally measured empirically or documented in any manner (Callejas et al., 2009). The CDE paradigm is an important opportunity to advance the current body of knowledge of community-defined and community-based practices that "work" for populations of color and to increase knowledge and awareness of these innovative practices among researchers, policymakers, and funding agencies. By developing an evidence base that uses cultural and/or community indices of success, the goal is to influence the research and evaluation agenda, as well as policymakers and funders, to implement and use community-defined and community-based practices to reduce disparities and improve availability, quality, and outcomes of behavioral health care for all individuals and families.

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