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Editors' Introduction

Growing Roots: Native American Evidence-Based Practices

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Is love an evidence-based practice, or prayer? What constitutes evidence? How do you operationalize love or prayer? What are the expected outcomes, and how are they measured? What constitutes evidence where there are fundamental differences in worldview? How can we reconcile western science with Indigenous knowledge? These are the type of issues that the authors address in this collection of articles.

This special issue of the *Journal of Psychoactive Drugs* explores evidence-based practices for Native Americans. It looks at contemporary behavioral health and substance abuse treatment and prevention practices of Native Americans in a context that is both historical and aware of Native American ways of knowing.

The first article by Holly Echo-Hawk discusses the trials and tribulations of evidence building in nonwestern cultures and the development of an alliance of Native Americans in the United States with other Indigenous people of Canada, New Zealand, Australia and around the world. In the second article, R. Dale Walker and Douglas A. Bigelow give a practical example of an effective alternative model derived by and for Indian people that was adopted by the state of Oregon.

Next, Maria Yellow Horse Brave Heart, Josephine Chase, Jennifer Elkins and Deborah B. Altschul present concepts, research and clinical considerations regarding historical trauma to inform community-based interventions. Joseph P. Gone and Patrick E. Calf Looking explore the issue of culture as treatment and present a culturally-grounded intervention for substance abusers on the Blackfeet Indian reservation.

Janet King follows with an overview of the Mental Health Services Act, designed to transform the behavioral health system in California, and describes conflicts between mainstream and Native approaches to behavioral

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health. Ethan Nebelkopf and Serena Wright provide a ten-year perspective on the Holistic System of Care for Native Americans in an Urban Environment, a model used in the San Francisco Bay Area, and present data on its effectiveness in reducing substance abuse.

Dolores Subia BigFoot and Beverley W. Funderburk present an excellent example of a Native American adaptation of Parent-Child Interaction Therapy called Honoring Children—Making Relatives. Esther Lucero demonstrates an imperative to liberate behavioral health practices from a western colonial framework and to honor Indigenous practices based on principles of self-determination.

R. Dale Walker, Douglas A. Bigelow, Jessica Hope LePak and Michelle J. Singer demonstrate the process of community innovation embodied in the Indian Country Methamphetamine Initiative. Bree Desmond presents the evolution of Urban Trails, a project that developed a culturally-appropriate, family-driven, child-guided system of care for children of Indian families decimated by substance abuse and mental illness in Oakland and San Francisco. Daniel L. Dickerson and Carrie L. Johnson describe how traditional healing and cultural activities are integrated into a youth substance abuse and mental health treatment program in Los Angeles.

Kurt Schweigman, Claradina Soto, Serena Wright and Jennifer Unger analyze data from a sample of Native California youth to demonstrate the link between participation in cultural practices and the development of ethnic identity. Kyle Nelson and Nazbah Tom evaluate the outcome of a Center of Substance Abuse Prevention funded intervention to prevent substance abuse, HIV/AIDS, and hepatitis in the San Francisco Bay Area.

Sandra E. Larios, Serena Wright, Amanda Jernstrom, Dorthy Lebron and James L. Sorensen use qualitative methodology to examine attitudes toward evidence-based treatments in minority-serving substance abuse treatment programs.

The cover art is a painting created by the youth of the Native American Youth Center in Oakland, California in a 2003 workshop guided by a Native American artist from the Red Lake Band of Chippewa Indians, Sam English. In March 2011, Sam English unveiled a new painting in Washington D.C. commissioned by the Substance Abuse and Mental Health Association (SAMHSA) to help raise awareness about substance abuse and behavioral health. Mr. English has been clean and sober for 30 years, which is evidence of the effectiveness of 12-Step programs (English & Dallman 2009). This community leader was honored by the San Francisco Bay Area Native American Community at the Tenth Annual Gathering of the Lodges, a recovery celebration held by the Native American Health Center, and attended by 300 American Indians and Alaska Natives in July 2011.

EXAMINING EPBS

Government funders have mandated that behavioral health care providers observe the same evidence-based practice (EBP) standards that are expected in health care. Funding is tied to the delivery of EBPs. Policy makers require the delivery of EBPs without providing support for the substantial effort and costs to convert programs and systems to new standards of practice (Miller, Zweben & Johnson 2005; Isaacs et al. 2005).

Cognitive behavioral therapy (CBT) and motivational interviewing (MI) are two of the most widely used EBPs. In the late 2000s, since funding depended on the use of EBPs, many Native programs considered using motivational interviewing for the tribal population. Motivational interviewing, an offshoot of Carl Roger's client-centered therapy, is clearly a western model. Two manuals were written documenting Native adaptations of MI (Venner, Feldstein & Tafoya 2006; Tomlin et al. 2005). Dee BigFoot successfully developed cultural adaptations of trauma-focused cognitive behavioral therapy and parent-child interaction therapy.

The Gathering of Native Americans (GONA) was the most widely used EBP developed by and for Native Americans. This practice was developed by a consensus of Native American professional educators and clinicians. This group was convened by the Center for Substance Abuse Prevention (CSAP) in the early 1990s to support community efforts to reduce and prevent alcohol and other drug abuse in American Indian communities. The GONA manual was updated in 1998, and widely distributed by the Indian Health Service (IHS) and Center for Substance Abuse Prevention (CSAP). As one of the agencies in the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAP was also the major funder, along with IHS, for tribes and urban Indian organizations. The GONA curriculum recognizes the importance of Native American values, traditions, and spirituality in healing those suffering from historical trauma, and it includes both cultural activities and talking circles (Kauffman & Associates 1999; Macro International 1994). GONA is not listed in any EBP registries because outcome research is scant.

The EBP movement contends that the most effective practices should occur through consideration of the results of carefully controlled scientific experiments, which assess the causal efficacy of these practices. The need for randomized clinical trials is based on the premise that reliable attribution of cause and effect relationships, especially in the convoluted context of human behavior, is difficult to render. Having embraced the methodological advantages of randomized clinical trials, the EBP movement aspired to relocate professional practice from the realm of clinical experience to the realm of scientific evidence (Gone & Alcántara 2007).

The designation of RCT as the gold standard for evaluating pharmacological interventions in medicine cannot be meaningfully extended to the evaluation of interventions in behavioral health; the active causal ingredients of a behavioral intervention are difficult to isolate empirically. Furthermore, the specific treatment procedures or techniques employed do not account for the therapeutic change as much as the kind and quality of the therapeutic relationship. Officially sanctioned lists of EBPs are controversial because behavioral health practitioners are accustomed to providing services derived from their professional training, theoretical orientation, experience, and clinical intuition (Gone & Alcántara 2007).

The increasing reliance on EBPs leaves many Native communities at a disadvantage. Indigenous communities are faced with having to select an EBP that is rooted in non-Native cultural contexts, and which possess no known effectiveness in the indigenous community. Much of the evidence used to document the basis for an effective intervention springs from quantitative research and randomized controlled clinical trials. These procedures and designs do not necessarily fit well with the circumstances of Native groups. The EBP movement was promoted by academic researchers working with nondiverse populations. The limitations of EBPs include inadequate inclusion of ethnic and cultural groups in study samples, limited resources devoted to the research of culturally-specific practices, lack of theory about the relationships between culture, behavioral health disorders and treatment, and limited involvement of culturally diverse researchers. Another contributor to the slow pace of indigenous evidence building is confusion generated by the different definitions of evidence that correspond to a differing range of practices. These include promising practice, exemplary practice, best practice, practice-based evidence, community-defined evidence, and EBP (Echo-Hawk 2011).

In the early 2000s, the Substance Abuse and Mental Health Services Administration (SAMHSA) engaged in a large funding effort, partly based on the findings of the Surgeon General's *Report on Mental Health: Culture, Race and Ethnicity* (US DHHS 2001). This breakthrough document pointed out that culture counts, emphasized the strengths of community-based organizations, and called for the inclusion of consumer input into behavioral health programs. As a result, new resources flowed down to tribes, urban tribal organizations, and other community-based groups funding innovative grassroots programs.

By the mid-2000s, however, there was reaction by the academic institutions and scientific research establishment, resulting in SAMHSA mandating the use of EBPs, thus linking the usage of EBPs to funding. Maybe this was a reaction to the faith-based movement, favoring scientific evidence over faith-based evidence. Nevertheless, this action rolled back the progress that community-based and culturally-based programs had made in securing SAMHSA funding. The National Registry of Effective Programs and Practices (NREPP) was established, inclusion in which often verifies a practice as an EBP. American Indian Life Skills Development/Zuni Life Skills Development (LaFramboise & Howard-Pitney 1995), a curriculum focusing on suicide prevention in a classroom setting, was the first Native American program accepted into NREPP, with its ultra-rigorous western academic standards. One other Native program is currently listed in NREPP; Red Cliff Wellness School Curriculum, developed by Eva Petoskey, is a substance abuse prevention intervention based on Native American tradition and culture (Petoskey et al. 1998).

NREPP relies heavily on the outcomes of clinical trials, such as those employed by the National Institute of Drug Abuse (NIDA) in the Clinical Trials Network. Academic institutions were demanding that only programs with their scientific imprimatur would receive funding.

Verification of an intervention as an EBP depended on the gold standard of randomized controlled or comparison studies, the same standard used by the pharmaceutical companies and U.S. Food and Drug Administration (FDA). Those individuals and groups who had the dollars to organize and implement these experimental conditions were called "developers." Community-based and tribal organizations already strapped for resources did not have the capacity to do this, thus the development of EBPs was limited to large universities and private for-profit businesses. Ironically, although SAMHSA still demanded consumer input into the development of proposals for new funding, in thousands of opportunities listening to consumer input over the years, the authors have never heard one consumer call for the adoption of an EBP.

In 2005, *The Road to Evidence: The Intersection of Evidence Based Practices and Cultural Competence in Children's Mental Health* was published, defining and justifying the use of practice based evidence (PBE) for cultural minority groups (Isaacs et al. 2005). PBE was defined 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. They are accepted as effective by the local communities, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework (Isaacs et al. 2005). Much of this practice-based evidence includes cultural practices that have worked to rebuild Native communities from the devastating effects of the "Indian Wars" in the United States a century ago and the historical trauma that has affected Native American families for generations (Brave Heart 2003; Nebelkopf & King 2003).

In 2007, one of the agencies within SAMHSA, the Center for Substance Abuse Prevention (CSAP), for its

Strategic Prevention Framework State Incentive Grant (SPF-SIG) program required the adoption of EBPs, but broadened the definition of EBP to entail (1) inclusion on NREPP; (2) being reported with positive effects in peer-reviewed journals; or (3) documented effectiveness supported by other sources of information, including a consensus among informed experts. Informed experts may include key community prevention leaders, and elders or other respected leaders within Indigenous cultures. The advantage of inclusion of documented evidence of effectiveness was the ability to select innovative, complex interventions to meet the needs of individual communities, and include culturally-based evidence (SAMHSA/CSAP 2007).

The CSAP SPF-SIG program acknowledged that complex interventions may exhibit certain characteristics that make them difficult to evaluate and measure:

- A multifaceted approach with interacting components;
- A philosophy that values adaptation in response to unique community needs and opportunities.

In the late 2000s community-defined evidence (CDE) emerged as a significant factor in the debate. CDE was defined as 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 (ICF Macro 2011; Martinez, Callejas & Hernandez 2010). The concept of CDE is reminiscent of the struggle for self-determination waged by minority communities in the sixties and seventies. This special issue presents CDE from the Native American community.

There are political and cultural factors that need to be considered in this discussion. In many Native communities, the contemporary status of American Indian mental health remains significantly caught up in a history, culture, and spirituality challenged by the devastating context of European American colonialism. The medical model for addressing the behavioral health problems of Native Americans seems irrelevant given that epidemic rates of distress and dysfunction clearly originated in the historical moment of United States colonial conquest and domination (Gone & Alcántara 2007).

There may be an inherent bias against Native American cultural communities expressed by making it a requirement to use EBPs to get funding. EBPs are not tested in cultural communities so their results cannot be applied with the expectation of success. Mandated use of EBPs discriminates against community-defined best practices that are rooted in culture. Communities facing larger disparities in health care need interventions that focus on the community, not the single individual. This bias has found its way into the behavioral health field and mirrors many of the racist assumptions that prevailed in the past, such as that improvement of quality of life means being deprogrammed from one's cultural identity.

The focus on individual outcomes that characterizes most EBPs is too narrow and does not aid in reducing disparities in behavioral health services; this also cannot be achieved through the evidence-based research process. The cumulative and interactive nature of disparities is more complex and multifaceted than an approach that isolates single variables. Disparities cannot be addressed through a single intervention. Scientific processes have yet to develop research designs or tools to accommodate this level of complexity (ICF Macro 2011).

What works in small sample-controlled settings does not necessarily work in community settings. The personnel, training and fidelity testing capacity to implement EBPs are rarely available to tribes. From a political standpoint, this EBP mandate is in conflict with principles of tribal sovereignty, consultation, and government-to-government relations. Compilations such as *Oregon Tribal Evidence Based and Cultural Best Practices* (developed by the state of Oregon) and *Compendium of Best Practices for Indigenous American Indian/Alaska Native and Pacific Island Populations* by the First Nations Behavioral Health Association are pioneering efforts to define EBPs by and for American Indians (Echo-Hawk 2011; Cruz & Spence 2005).

Evidence-based practices are reliant upon documentation through established statistical and epidemiological methods. In the publication process a discussion of limitations of the use of these methods to assess and determine outcomes is customary. Although the possible flaws in these methods are seemingly accepted without question, these limitations are very real. Despite these flaws, results of epidemiological trials are held up as proof of a fundamental and universal truth.

Statistical methods are fraught with limitations; they simply cannot prove everything. Outliers—data points that diverge greatly from the bulk of information—are often thrown out of data sets as they skew analytic results away from a normal distribution (Gladwell 2008). But what if you, a real live person, happen to be that outlier? Your information does not inform the whole, policy decisions are not made with regard for your reality, and cycles of alienation continue. Small populations are frequently omitted or lumped together into a disparate "other" category. If only five American Indians are included in a larger dataset, how can anything meaningful be said about this population? And how can appropriate interventions and policies be created to address the needs of this small but meaningful community? Statisticians and epidemiologists are well aware of these limitations. That their methods are continually used to uphold customary norms of the majority and continue cycles of alienation for disenfranchised populations is regrettable.

Native communities do not have a "one size fits all" for each individual best practice. Communities use a combination of Indigenous culture-based approaches and western practices to tailor and fit each community's unique and changing need. Addressing co-occurring disorders, historical trauma, and poverty are key factors and are needed to restore wellness balance.

From the standpoint of culture-based knowledge systems, randomized controlled clinical trials cannot encompass significant moderating and mediating variables of local context and culture. Choice is a powerful factor that the experimental scientist cannot randomize or control. Complex webs of interrelated and reciprocal factors are not readily reducible to simple, linear models (see Walker & Bigelow in this issue).

From a cultural worldview that perceives everything in terms of relationships, reliance on the reductionism inherent in western behavioral research is absurd. Methodology that is used to verify evidence must be broadened to include a consensus of elders, participant satisfaction, and cultural knowledge. An understanding of science entails a systematic observation of events and a spirit of empirical inquiry, and much more than anecdotal evidence. For many cultures, the quality of the relationship with the healer is primary, not the curriculum. How could western science make this mistake? Looking at the whole picture, dealing with the effects of slavery and immigration, as well as historical trauma, are essential in preventing substance abuse and fostering mental health for people of color.

Indigenous peoples have a tradition of unity with the environment and that tradition is reflected in song, custom, approaches to healing, birthing, and the rituals associated with death. Indigenous knowledge is dynamic, derived from original instructions given to particular Peoples and reflected in Creation stories. It results from a continuous scientific process—observation, experimentation, documentation, evaluation, education, and adaptation. It has the capacity to blend with western scientific knowledge and should be considered complementary to current scientific and technological efforts to solve problems in today's world. Indigenous knowledge storage and retrieval systems include ceremony: song, dance, food preparation, herbal wisdom, and storytelling. Indigenous knowledge is handed down orally and through art forms from generation to generation.

Community-defined and practice-based evidence can record relevant community outcomes from indigenous perspectives in a culturally appropriate manner. The requirement to use EBPs is seen as an infringement of AI/AN sovereignty and a violation of Indian self-determination. The use of scientific methods in the rationalization of AI/AN oppression has resulted in AI/AN resistance to science-based systems.

We recommend a holistic approach to verification of evidence as we move into the twenty-first century. Health care reform means the medicalization of substance abuse treatment and behavioral health. The relationships of body, mind, spirit, and emotion are way too complicated for current western science to measure or comprehend. We stretch our minds to document evidence of this complexity, shout out our prayers to make a better world for our children and grandchildren, and give from the heart to help people who are going through hard times. Love heals.

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