Reviewer's report

Title: Use Of The Evidence Base In Substance Abuse Treatment Programs for American Indians and Alaska Natives: Pursuing Quality in the Crucible Of Practice And Policy

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Reviewer: Joseph P Gone

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It has been a pleasure to review Novins et al.’s manuscript (ms) exploring the tensions between treatment paradigms in substance abuse programs for American Indian and Alaska Native (AI/AN) clients. The authors’ analysis of the many complex issues that converge around the implementation of evidence based treatments (EBTs) for substance abuse in “Indian country” is timely, cogent, elegant, and insightful. Indeed, the authors warrant special acknowledgment for their sophisticated engagement of thorny conceptual material at the outset of what promises to be an indispensable empirical project. In the spirit of respectful intellectual engagement with the authors and their project, I offer the following brief comments.

Major Compulsory Revisions
None.

Minor Essential Revisions
None.

Discretionary Revisions
1. As a Native psychologist who has conducted mental health research in eight reservation or urban American Indian (AI) communities over 15 years, I have never met an AI administrator, service provider, or engaged community member who expressed enthusiasm for an EBT on the basis of its rigorous scientific evaluation. Instead, the most common reaction I have observed from AIs who live and work in these communities is incredulity that researchers would bother to invest such time and energy in such resource-intensive evaluation efforts. Indeed, even among other AI psychologists—all of whom have received training in research design and scientific methodology—it is difficult to identify a single proponent of randomized clinical trials (RCTs) as the ideal means to assessing the therapeutic efficacy of a given intervention. Thus, I think the ms would be strengthened if the authors could provide a few brief but unambiguous examples of the “considerable range of responses” they have observed among AI professionals and/or community members to the dissemination of EBTs, especially as these pertain to issues of scientific legitimacy as opposed to pragmatic concession.
2. Although I have not typically encountered unbridled enthusiasm for scientific vetting in these community contexts, I have certainly witnessed tribal leaders, administrators, and providers who have struggled with the externally imposed mandate to adopt EBTs in their programs and services. In the face of such challenges, some agree to adopt and promote an EBT, not because they accept it as the superior choice but because they require agency support for their efforts. As the authors allow, others attempt to culturally adapt EBTs. Additionally, some seek to obtain evidence for locally-valued interventions (often culturally grounded), while others probably choose not to apply for such funds at all. In this regard, it is interesting to note that the national First Nations Behavioral Health Association (http://www.fnbha.org/) has recently undertaken a campaign alongside other national ethnic minority behavioral health advocacy groups to promote so-called Practice-Based Evidence (in contrast to Evidence-Based Practice) as a legitimate alternative to mandated EBTs. Surprisingly, in response, SAMHSA has revised its policy and now will fund some exceptions to EBTs in light of longstanding alternative community therapeutic traditions. My point here is that one promising strategy for resolving these issues is to harness political power for changes in government policy irrespective of the “evidence” for efficacy per se. Exercise of tribal sovereignty seems like one significant means to achieve this. In sum, the authors might consider promising AI strategies of resistance to EBT mandates alongside their interest in finding common ground.

3. As the authors mention, one area of common ground may be cultural adaptations to established EBTs as these are implemented in “Indian country.” Indeed, there is emerging evidence that such adaptations yield better outcomes in comparison to standard (or un-adapted) EBTs for communities of color (Griner & Smith, 2006). One set of concerns about such adaptations, however, pertains to the fidelity to the EBT—for which the efficacious components are often unknown—as well as fidelity to the cultural practices and processes that are incorporated into the EBT. With regard to AI therapeutic traditions and substance abuse EBTs in particular, there are in many cases a clear set of divergences, some of which the authors allude to (e.g., sacred-secular, mystical-rational, and relational-technical; see Gone, 2010b). Brief additional attention to the dilemmas and trade-offs in adapting or integrating culture and EBT would be welcome.

4. Finally, in my professional experience, the primary reason offered by AI program administrators, providers, and consultants for resisting the local programmatic adoption/ implementation of EBTs is often expressed in a single word: culture. The ms addresses this under the subheading Characteristics of the Innovation by suggesting the “lack of fit with the values of providers,” “lack of flexibility” relative to desired cultural adaptation, and “lack of a spiritual component” as limitations of most EBTs. My sense is that the prevalence of culture as an express rationale for AI resistance to EBTs extends well beyond these particular limitations. For example, I would suggest two additional domains of significance that are implicitly indexed by this term: postcoloniality and epistemology. By postcoloniality, I refer to the impact of the enduring legacy of Euro-American conquest and colonization that frames contemporary AI community life, and the desire of many in these communities to chart
self-determined futures that remain distinctively indigenous in important ways (which I believe the authors are getting at when they make reference to tribal sovereignty). By epistemology, I refer to the a diversity of established and authorized ways of knowing that characterize human communities, and the interest of many AIs to cite and celebrate indigenous knowledges as viable and valuable in the modern world. These domains are inseparably linked, such that the external—even hegemonic—promotion of EBTs by funding agencies is grounded in the assumption by powerful outsiders that scientific knowing through the application of RCTs is the best way to determine whether an intervention truly works. But anthropologists have documented that, for many AI communities, first-hand personal experience is the ultimate arbiter of authoritative knowledge. I have reviewed these issues more in-depth elsewhere (Gone, 2010a); my point here is simply to encourage the authors to enter more deeply into these sources of divergence for competing treatment paradigms.

References

Level of interest: An article of outstanding merit and interest in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interests.