



EVERY CHILD IS SACRED



Comments Regarding the Development of a Clearinghouse of Evidence-Based Practices in Accordance with the Family First Prevention Services Act of 2018

(Published in the [Federal Register](#) on June 22, 2018)

First Kids 1st and the Indian Country Child Trauma Center jointly submit these comments regarding the Federal Register Notice, Decisions Related to the Development of a Clearinghouse of Evidence-Based Practices in Accordance With the Family First Prevention Services Act of 2018, published on June 22, 2018 (Volume 83, No. 121, pages 29122–29124). Our comments pertain to issues impacting American Indian and Alaska Native populations. We generally support the development of criteria for establishing evidence-based services for American Indian/Alaska Native children, parents, and relative caregivers that strengthen tribal families and are culturally appropriate and responsive to the conditions that contribute to and prevent child maltreatment in tribal communities.

The First Kids 1st initiative is a national collaborative effort and is comprised of leading Native American organizations, allies, and partners from all backgrounds, focused on changing national, tribal, and state policy to create conditions in which American Indian/Alaska Native children can thrive. We are working to build strategies and policies that strengthen local supports for vulnerable American Indian/Alaska Native children in their communities. The core partners include the National Indian Child Welfare Association, National Congress of American Indians, National Indian Health Board, and National Indian Education Association.

The Indian Country Child Trauma Center (ICCTC) was established to develop trauma-related treatment protocols, outreach materials, and service delivery guidelines specifically designed for American Indian/Alaska Native children and their families. The ICCTC was originally funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2004 with the goal to develop and deliver training, technical assistance, program development, and resources on trauma-informed care to tribal communities. It is housed at the University of Oklahoma Health Sciences Center in the Center on Child Abuse and Neglect. The ICCTC has been awarded the Project Making Medicine grant from the Children's Bureau to provide training to clinicians in Indian Country in the Honoring Children, Mending the Circle curriculum, which is the cultural enhancement of trauma-focused cognitive behavioral therapy. ICCTC is also the grantee for the Office of Juvenile Justice and Delinquency Prevention, Tribal Youth Training and Technical Assistance program.

General Comments

The Family First Prevention Services Act (Division E in the Bipartisan Budget Act of 2018—H.R. 1892) provides a much-needed reorganization of child welfare finance systems and policy priorities. Increasing federal resources to prevent removal of children while keeping them safe at home and strengthening their families will reduce trauma to children and reduce out-of-home placements of children overall. American

Indian/Alaska Native children and families, who have experienced the trauma that accompanies high removal rates and disparate treatment, know firsthand the need for a shift in the focus of child welfare policy and practice, and we welcome the opportunity to work with tribal governments and the Administration for Children and Families (ACF) to make the implementation of this law a success with American Indian/Alaska Native children and families.

There are two key opportunities in the statute to increase benefits and participation by American Indian/Alaska Native children, parents, and relative caregivers. The first is the secretary's discretion to establish specific criteria for evidence-based prevention services and programs provided for eligible American Indian/Alaska Native children, parents, and relative caregivers. The discretion is derived from a provision in the law that requires the secretary "shall allow programs adapted to the tribal culture and community" and that tribal standards must mirror state standards only "to the extent practicable" (H.R. 1982, Section 50711[e][1][A][ii]). This allows the development of alternative criteria to approve evidence-based services and programs reflecting the needs of tribal cultures and communities that take into account all of the reasons why strictly complying with the evidence-based standards is not "practicable."

Given the unique realities in tribal communities, sovereign nation status of tribes, and limited access to research-based studies and funding, we believe that the secretary has an opportunity to craft criteria for evidence-based practices with American Indian/Alaska Native families that will meet the overall goals of the law, but provide reasonable access to the law's resources and support the provision of culturally appropriate services that will have the greatest possibility of impacting positive change and avoiding harm from the imposition of ill-fitting prevention services or programs. Significantly, criteria for evidence-based practices with American Indian/Alaska Native families should be applied not just to direct funded tribal IV-E programs who decide to use IV-E dollars to fund prevention services, but also to state IV-E programs serving American Indian/Alaska Native populations directly or passing IV-E funds on to tribal governments through state/tribal IV-E agreements, which more than 100 tribes have.

Also, because of the barriers tribes have faced to direct Title IV-E funding and implementation, the secretary should use his discretion to support tribes with approved IV-E plans who may not yet be administering IV-E to begin IV-E implementation with prevention services. Because prevention services do not require a cost allocation methodology or have income eligibility requirements, they will be less burdensome to implement than other portions of the program. With only 10 approved tribal Title IV-E plans since 2008 and not all of the approved plans being implemented, the secretary should not constrain tribal problems any more than the prescriptive law already does. Allowing approved Title IV-E plan tribes to begin IV-E implementation with prevention services could be a gateway for more tribes to secure and implement Title IV-E programs.

Another key opportunity exists in the understanding that state and tribal government collaboration is key to American Indian/Alaska Native children, parents, and relative caregivers receiving the benefits that Congress intended for all populations within the scope of this law. The law requires states to consult with other state child- and family-serving agencies and other private and public agencies with experience in administering child and family services. We think this includes tribal governments and Indian organizations that serve urban American Indian/Alaska Native populations. Critical issues that states will need help with include accurate and culturally appropriate assessment of American Indian/Alaska Native children, parents, and relative caregivers who are potentially eligible for prevention services; effective coordination strategies to leverage resources and knowledge; development of appropriate outcome measures; and development of culturally relevant evaluation and data collection strategies that include American Indian/Alaska Native populations and interpret findings accurately. Successful implementation at the local, tribal, state, and federal levels will require tribal knowledge and skills to succeed, especially in an era when American Indian/Alaska Native children are one of the most disproportionately represented groups of children in state foster care systems across the country.

Below are our specific comments with regards to the issues on which ACF has requested comments. Formal tribal consultation will allow for the opportunity to discuss these issues in more detail and provide additional context and examples.

Program or Service Prioritization Criteria (2.2)

HHS cannot review all eligible programs in detail due to timing and resources, and therefore prioritizes the following:

Types of Programs and Services (2.2.1)

HHS intends to limit eligibility to:

- Mental health and substance abuse prevention and treatment services
- In-home parent skill-based programs (i.e., parenting skills training, parent education, individual and family counseling)
- Kinship navigator programs¹

HHS requests comments on:

- ***The scope of programs and services and topic areas of interest within the above categories (mental health and substance abuse prevention and treatment services, in-home parent skill-based programs) that should be prioritized for inclusion***

The statute specifies these program areas as eligible for reimbursement while not constraining the particular scope of these programs and services. We would urge ACF to consider that these service or program categories are broad in themselves and would benefit from a scope that provides the greatest flexibility in determining the particular services or programs that will be eligible for reimbursement. For American Indian and Alaska Native children and families it will be important that the scope is broad enough to include culturally based and culturally adapted services and programs to provide the maximum benefit. For example, mental health prevention and treatment services or programs in Indian Country can look different from the talk therapy models common in most mainstream clinics but yield superior results for American Indian/Alaska Native clients. In addition, alcohol and substance abuse are common presenting factors in a large majority of child welfare referrals involving American Indian/Alaska Native families, and culturally based treatment methodologies are often more effective with this population than mainstream interventions.

The Kinship Navigator program is a separate program under the law and distinct from the evidence-based prevention services and programs in the law in important ways. Kinship Navigator programs serve a broader population than do the eligible prevention services and programs under the law, which only serve children, parents, and caregivers where there is a risk of removal of the child. In addition, Kinship Navigator programs are not subject to the requirement for states and possibly tribes that 50% or more of the evidence-based services they seek reimbursement for must be well-supported evidence-based services. Another important distinction is the plan requirements for states planning to seek federal reimbursement for evidence-based prevention programs and services for candidates of foster care do not apply to Kinship Navigator programs.

Little data has been collected on this set of services and programs even though it is widely accepted in the field as an important and successful service for improving access to services and supporting positive outcomes for children in care. The Kinship Navigator is also different in that it is a service that helps individuals and families improve access to other services as opposed to a direct intervention. We recommend that the links and similarities between the Kinship Navigator program and other eligible prevention services be considered in terms of data collected and evidence of effectiveness (e.g., in fidelity and outcome measures).

Target Population of Interest (2.2.2)

HHS prioritizes:

- Programs or services that are developed or used to target children and families involved in the child welfare system

HHS requests comment on:

¹ A kinship caregiver cares for a child that is not their own, usually a grandchild or niece/nephew. Kinship navigators assist these caregivers by providing information on financial assistance, legal information and referrals, and other types of issues that caregivers face when raising children, in order to provide permanency and stability in the home (www.nysnavigator.org).

- **Populations that may be considered “similar” to those involved in the child welfare system for the purpose of prioritizing programs and services**

Many of the families that come to the attention of the child welfare system are or have been involved in other child- and family-serving systems. Juvenile justice systems, Temporary Assistance for Needy Families programs, behavioral health systems, and alcohol and substance abuse prevention and treatment systems all have as goals the prevention and treatment of issues that put at risk child and family well-being, such as child abuse and neglect, and the promotion of child and family well-being. Child welfare families often are either referred to these other systems for services or are enrolled in their services concurrently to supplement child welfare agency interventions.

The statute specifies which types of services may be eligible for reimbursement, including services that are often developed and offered in other child and family serving systems, such as mental health, but the statute does not require that the eligible evidence-based services may only come from child welfare systems.

The Systems of Care principles, which ACF supports and utilizes in their grant programs and technical assistance and training centers, recognizes the importance of child welfare systems partnering with other child and family serving systems to meet the multiple needs of children and families (<https://www.childwelfare.gov/topics/management/reform/soc>). Key Systems of Care principles include cultural competence, accountability, and interagency collaboration, which are important to achieving positive outcomes for children and families in child welfare.

We urge ACF to consider the important relationships these other systems and their evidence-based programs and services have to preventing the removal of children from their homes and stabilizing families, and allow evidence based-services from these systems to also be considered under this law.

Target Outcomes (2.2.3)

HHS intends to prioritize:

- Programs with target outcomes that “prevent child abuse and neglect and reduce the likelihood of foster care placement by supporting birth families and kinship families and improving targeted supports for pregnant and parenting youth and their children” (section 471(e)(4)(C) of FFPSA)
- Outcomes may include “important child and parent outcomes, such as mental health, substance abuse, and child safety and well-being”
- Access or referral to programs/services and satisfaction with programs/services will not count as “target outcomes” but the definition of what target outcomes should be considered will be partially based on suggestions in public comment

HHS requests comment on:

- **Which types of mental health, substance abuse, and child and family outcomes should be considered as “target outcomes” and what research is there to support recommendation of “target outcomes”**

We recommend that target outcomes include not only the primary target outcomes but also proximal outcomes that may show changes more quickly. Primary target outcomes might include the prevalence of specific mental health or substance use diagnoses, such as depression, active substance use disorder, or suicidal ideation/attempt. Prior research has shown the prevalence of these outcomes can take years to change after an intervention or prevention program is implemented (Sahota & Kastelic, 2012). As such, prior research and policy papers have recommended that funders and the federal government examine proximal outcomes, meaning those that can be measured in the short term and are associated in the research literature with longer-term improvements in mental health, substance abuse, and child and family well-being. Proximal outcomes can be viewed as a shorter-term proxy for the ultimate target outcomes. For American Indian/Alaska Native communities, proximal outcomes are often related to connection with cultural identity (Baldwin, Brown, Wayment, Nez, & Brelsford, 2011; Jones & Galliher, 2007; Kulis, Hodge, Ayers, Brown, & Marsiglia, 2012; LaFromboise, Albright, & Harris, 2010; LaFromboise, Hoyt, Oliver, & Whitbeck, 2006; Mohatt, Fok, Burkett, Henry, & Allen, 2011; Rieckmann, Wadsworth, & Deyhle, 2004; Wolsko, Lardon, Mohatt, & Orr, 2007). These cited studies have shown that the connection with culture is associated with a

host of longer-term target outcomes for American Indian/Alaska Native youth, such as reduced substance use, reduced mental health problems, and improved youth well-being in American Indian/Alaska Native communities. Measures of cultural connection as a proximal outcome could include cultural identity rating scales, some of which are tribally specific and others of which are for American Indian/Alaska Native people as a whole. Other measures might include self-reported social support and social engagement, which are related to both cultural connection and improved mental health outcomes (Baldwin et al., 2011; Stumblingbear-Riddle & Romans, 2012). Another set of proximal outcomes could include measures of whether individuals and families are pursuing treatment. This would be distinct from “access to services,” which we understand will not count as target outcomes. For example, treatment measures would include: (1) rates of attendance at therapy or medication sessions, (2) completion of substance use intervention programs, (3) proportion of individuals or families referred for services who engage in and complete treatment plans for a certain timeframe, etc. These kinds of measures are also more likely to be feasible in tribal communities than longer-term target outcomes such as prevalence of mental health or substance use disorder diagnoses. Many tribal communities have small sample sizes in their service populations because of overall smaller populations than states. Developing statistically significant findings for diagnostic prevalence outcomes therefore may be difficult for tribal communities.

Number of Impact Studies (2.2.4)

HHS intends to prioritize:

- Programs/services with at least two studies (with non-overlapping samples and distinct implementations examining effectiveness/impact)

Whether in Use/Active (2.2.5)

HHS intends to prioritize:

- Programs currently in use in the U.S. will be prioritized (those no longer in use or without current information about effect will not be prioritized)

Implementation and Fidelity Support (2.2.6)

HHS intends to prioritize:

- Programs/services with implementation training and staff support and/or fidelity monitoring tools/resources available to all U.S. implementers

Trauma-Informed (2.2.7)

HHS may also prioritize:

- Programs/services that have been implemented using a trauma-informed approach.

HHS requests comment on:

- **The feasibility of prioritizing programs and services based on past implementation in accordance with trauma-informed principles**

With regard to 2.2.4, it may be difficult for tribes and American Indian/Alaska Native populations to meet this criteria, given that programs are often (1) locally developed and (2) have small sample sizes (see comment above). As such, we recommend expanding the criteria here for tribal communities to include unpublished studies, such as local evaluation reports.

With regard to 2.2.7, the research on trauma-informed care is at an early stage in its evolution, especially in child welfare. There exists no widely adopted definition of what constitutes trauma-informed services that has broad consensus within the field. In addition, the statute provides broad parameters with regard to what is considered trauma and what trauma informed means within the context of this law. Specifically, the law requires that trauma-informed services and programs are “provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to all types of trauma and in accordance with recognized principles of a trauma-informed approach....” This language provides a specific mandate that the approach respond to all types of trauma but does not go so far as to specifically mandate what type of approach must be utilized other than one that is provided under an organizational structure and treatment framework that uses recognized principles of trauma-informed care.

We recommend that the criteria for trauma-informed services be established with broad parameters for the approaches used in providing trauma-informed care and allow for the use of culturally based variations in developing and delivering trauma-informed services in different cultures. For example, American

Indian/Alaska Native communities have long experienced historical trauma that is critical; an approach that accounts for this is critical to a proper and accurate understanding of how trauma impacts American Indian/Alaska Native children and families. Historical trauma is a response to the loss of tribal lands, forced removal of large numbers of American Indian/Alaska Native children from their families and communities and mistreatment in private and government run boarding schools, and other forced assimilation policies resulting in loss of language and culture (Brave Heart & Debruyn, 1998). These traumas continue to reverberate in Indian Country today while adding to the modern-day traumas that affect American Indian/Alaska Native children and families. Treatment approaches need to reflect these unique contexts; and in Indian Country, trauma-informed services and programs must be developed with a strong cultural basis in the approach and delivery. As such, the meaning of “trauma-informed” needs to be considered within different populations’ unique contexts.

Delivery Setting for In-Home Parent Skill-Based Programs and Services (2.2.8)

HHS intends to prioritize:

- In-home parent skill-based programs and services (where the primary service delivery strategy takes place in the caregivers’ place of residence) will be prioritized

While many in-home services would make the most sense to be provided within the home of the clients, this is not always the case for services such as parent training. Parent training can be more beneficial for parents when done in group settings within their community where peer-to-peer learning approaches can be applied. In addition, in many low-income communities, having parent services be prioritized to those applied within the home may create barriers for parents or relative caretakers where affordable housing is limited and the homes of parents, especially those who are victims of domestic abuse, may not be the most appropriate environment for providing services. We agree that services should be encouraged to be provided in-home whenever possible, but evidence-based services that are still in-home in focus but provided outside the home should be allowable.

We would also point out that the statute does not require that the category of in-home services must be delivered within a home. The statute only specifies the types of eligible in-home services, not the delivery location.

Study Eligibility Criteria (2.3)

HHS will search databases, websites, existing literature reviews, and meta-analyses to identify relevant studies for programs and services, and intends to limit eligibility based on:

Impact Study (2.3.1)

HHS intends to limit eligibility:

- To studies included in government reports and peer-reviewed journal articles that assesses impact (effectiveness) using quantitative methods

The statute does not require published studies and is silent on the breadth of government reports that could be used, providing ACF with flexibility to recognize all forms of government reports. We support the approach of utilizing not only peer-reviewed journal articles, but also government and private funder reports, including unpublished reports. Smaller tribal governments do not typically have the resources or the numbers of potential clients to do adequately powered, statistically robust studies, limiting possible inclusion in peer-reviewed journals. With regard to government reports, we recommend including studies that have been included in federal, state, local, and tribal government reports. This would include local evaluator reports (which are commonly used in tribal communities).

Target Outcomes (2.3.2)

HHS intends to limit eligibility:

- To studies that examine at least one target outcome (from section 2.2.3)

HHS requests comment on:

- **Specific outcomes in accordance with FFPSA statutory language that should be considered “target outcomes” and requests research evidence to support recommendations of “target outcomes”**

Please see text under 2.2.3.

Location (2.3.3)

HHS intends to limit eligibility:

- To studies conducted in the U.S., U.K., Canada, New Zealand, or Australia

Limiting studies to only those conducted in the U.S., U.K., Canada, New Zealand, or Australia will unnecessarily narrow the number of studies that can support evidence-based services for American Indian/Alaska Native children and their parents and relative caregivers. The critical body of studies for Indigenous populations comes from many different countries. Some, like South America, are not English speaking or included in the list of countries that would be considered eligible for consideration under this approach. We believe these criteria will only make it more difficult to qualify evidence-based services for Indigenous populations that already receive a disproportionately lower amount of research funding.

Language and Time Frame (2.3.4 and 2.3.5)

HHS intends to limit eligibility:

- To studies published in English, in or after 1990

Please see text under 2.3.3 above. We would also recommend that studies published before 1990 be eligible for inclusion. There is a dearth of research in Indian Country on effective practices, and so even older studies may provide valuable data.

Usual Care or Practice Setting (2.3.6)

HHS intends to limit eligibility:

- Whether the study was carried out in a usual care or practice setting

HHS requests comment on:

- **The definition of “usual care practice setting”**

“Usual care practice settings” in tribal communities are likely to be defined differently than in Western biomedical clinical settings. Many tribal communities use community-based and culturally based interventions, as we have learned both in reviewing literature (Donovan et al., 2015; Whitbeck & Parsells, n.d.) and in our work with tribal Systems of Care grantees. Just a few examples include equine therapy (working with horses outside or in a barn), Canoe Journey (a Northwest practice of travel to neighboring communities via ocean-going canoes), and cultural ceremonies and events (sweat lodge; drumming, dancing, and singing; and pow-wows). The “usual care practice setting” should be defined broadly to include the community as a whole in order for tribes to account for culturally specific practices.

Studies Prioritization Criteria (2.4)

HHS requests comment on criteria that can be used to prioritize eligible studies for rating.

Implementation period (2.4.1)

HHS requests comment on:

- **Whether studies with program or implementation periods of longer than 12 months should be considered for review and if so, whether any other implementation periods cutoff should be included as a study prioritization criterion**

While we agree that studies (or unpublished government reports, funder reports, and local evaluation reports) with implementation periods of 12 months should be included, we also recommend including reports with follow-up periods of longer than 12 months. The long-term target outcomes mentioned above under 2.2.3 will likely require longer follow-up periods to see an impact, although some of the proximal outcomes we recommend can be feasibly measured for potential benefit in shorter time frames, like 12 months.

The statute only allows for prevention services to be eligible for reimbursement for up to 12 months, but the statute does not constrain the use of evidence-based services that have longer implementation periods. Furthermore, the law amended Title IV-B, Subpart 2 to allow use of these grant funds to support similar types services for longer periods—more than 12 months. This indicates that Congress was thinking not just about

reimbursement of prevention services under Title IV-E in the law, but also the longer term support of prevention services beyond 12 months.

Sample of Interest (2.4.2)

HHS intends to prioritize:

- Studies that include samples of children and families involved in the child welfare system (or similar populations)

HHS requests comment on:

- **Populations considered “similar” to children and families involved in the child welfare system**

See 2.2.2 comments above.

Study Rating Criteria (2.5)

Favorable Effects (2.5.1)

HHS intends to rate studies based on:

- Whether they demonstrate at least one favorable effect on a target outcome²

HHS requests comment on:

- **Whether and how ratings should consider the number or magnitude of favorable effects**

We agree with looking for favorable effects on target outcomes. We recommend including proximal outcomes within the definition of target outcome as noted above under 2.2.3. We recommend that the criteria for a “favorable effect” take into account community and cultural contexts for American Indian/Alaska Native people. Favorable effects in quantitative studies meeting a trend level of statistical significance, or even those showing a numerical difference in an outcome but not meeting the threshold of statistical significance, may still indicate efficacy in American Indian/Alaska Native communities because many have small populations, without adequate sample sizes for power analyses that would detect significance at a $p < 0.05$ level.

Unfavorable Effects (2.5.2)

HHS intends to rate studies based on:

- The number of unfavorable effects on target or non-target outcomes (from sec. 2.3.2)

HHS requests comment on:

- **Whether and how studies should also be rated on the number of null effects on target outcomes and on whether and how rating should consider the number or magnitude of unfavorable effects**

See 2.5.1 comments above.

Sustained Favorable Effect (2.5.3)

HHS intends for studies:

- With at least one favorable effect on target outcome (from sec. 2.5.1) and whether favorable effects are sustained, and for how long

Rigorous Study Design (2.5.4)

HHS intends to rate studies based on:

- Whether studies have low, moderate, or high rigor and appropriateness of their study design³

HHS requests comment on:

- **Threats to internal validity that should be considered and appropriate thresholds for evaluating and assigning a rating to a study design**

² Defined using conventional standards of statistical significance (i.e., two-tailed hypothesis test and a specified alpha level of $p < .05$)

³ Based on the use of control and RCT or quasi-experimental design

Similar to our comments above under 2.5.1, we recommend that the standard of evidence on which studies or reports are rated for American Indian/Alaska Native communities be culturally and community specific. Small sample size studies that are feasible in Indian Country may not be adequately powered to examine threats to internal validity. In addition, study designs considered “rigorous” in terms of avoiding internal validity, such as randomized controlled trials (RCTs), are often difficult to conduct in Indian Country for both cultural and logistical reasons. RCTs are culturally anathema to some communities because the “placebo” or “comparison” group does not receive the potential benefit of the intervention being tested, which does not fit cultural values commonly found in communal societies. Furthermore, the small population sizes of many tribal communities mean that tribes may not have the financial resources or sample sizes to sustain an RCT. The definition of “rigorous” in studies conducted with American Indian/Alaska Native communities should thus be culturally tailored, and we suggest should include community-based participatory research (CBPR) designs.

Rigorous Study Analysis (2.5.5)

HHS intends to rate studies based on:

- Whether studies have low, moderate, or high rigor and appropriateness of analysis⁴

HHS requests comment on:

- **The rigor of the study analysis including appropriate thresholds for evaluating and assigning a rating to a study analysis, and assigning a rating to the reliability, validity and administration of target outcome measures**

Please see our comments above under 2.5.4. Our comments regarding rigor and sample size also apply to ratings for reliability and validity of target outcome measures, as sample sizes in studies conducted in Indian Country may not be adequately powered for such statistical analyses. In addition, some rating scales may be developed specifically for particular tribes or communities (Rieckmann, 2004; Wolsko, 2007), and so “rigor” could also be viewed in qualitative terms. That is, if an outcome measure or rating scale is culturally specific and reflects local, community-based knowledge, it can be viewed as having cultural “rigor,” which we posit is as valuable, and in some cases, more valuable, than traditional psychometric statistical measures of rigor. Instruments or rating scales developed using a true community-based participatory research (CBPR) design are more likely to be culturally rigorous in Indian Country than instruments developed for non-American Indian/Alaska Native populations (Sahota, 2010).

Reliability, validity, and systematic administration of outcome measures (2.5.6)

HHS intends to rate studies:

- As either high, moderate, or low on extent to which target outcomes measures are reliable, valid, and were administered consistently and accurately across all those receiving the practice in accordance to FFPSA or appropriate comparison practices⁵

HHS requests comments on:

- **Appropriate thresholds for evaluating and assigning a rating to the reliability, validity, and administration of target outcome measures**

Please see comments in 2.5.5 above.

Program or Service Rating Criteria (2.6)

- **HHS requests comment on approaches for determining that promising, supported and well-supported practices do not constitute a risk of harm**

We recommend careful consideration of the definition of “a risk of harm” and specifically how this may vary across cultural contexts. For American Indian/Alaska Native communities, evidence-based practices developed in non-American Indian/Alaska Native populations may have a risk of harm if implemented without cultural tailoring (Sahota & Kastelic, 2012). Evidence-based interventions that are not consistent with

⁴ Based on whether they account for sample attrition, clustering, baseline equivalence, etc.

⁵ Based on whether results are repeatable and measure what they intend to measure and whether treatment is applied consistently and accurately to all program participants

American Indian/Alaska Native culture or values (e.g., those that require individual treatment and do not consider the family context) may risk harming individuals but also the community as a whole. As such, we recommend defining “a risk of harm” in consultation and collaboration with target populations in a way that is specific to them, including American Indian/Alaska Native populations.

Recommendations of Potential Candidate Programs and Services for Review (3.0)

- ***HHS requests comment on potential candidate programs and services to consider for the systematic evidence review and how recommended programs and services meet the criteria specified in Sections 2.1, Program or Service Eligibility Criteria and 2.2 Program or Service Eligibility Criteria (3.0).***

Consider the statute’s authority for the secretary to allow reimbursement for services and programs that are in the process of collecting data to meet the evidence-based criteria. Allow for the collection of data as services are being implemented.

We recommend considering culturally specific practices in Indian Country such as the Gathering of Native Americans (GONA) (<https://store.samhsa.gov/shin/content/SMA16-4994/SMA16-4994.pdf>), Healing of the Canoe (Donovan et al., 2015), American Indian Life Skills Curriculum (LaFromboise, 1996) Positive Indian Parenting (<https://www.nicwa.org/training-institutes>), Child-Adult Relationship Enhancement (CARE) (Gurwitch et al., 2016), Parent-Child Interaction Therapy (PCIT) (Chaffin et al., 2004), trauma-focused cognitive behavioral therapy (Cohen, Mannarino, Kliethermess, & Murray, 2012), and SafeCare (Chaffin, Bard, Bigfoot, & Maher, 2012). These examples have not all been validated in American Indian/Alaska Native communities, and so should be considered within a cultural and community-consultation framework. These are just a few examples and are not a comprehensive list; individual American Indian/Alaska Native communities may also have their own culturally based practices that should be considered.

We also strongly suggest that the secretary allow reimbursement for culturally and community-based programs in Indian Country that may not have been yet evaluated in peer-reviewed papers, as we note above, given the unique challenges for tribes to do so, as discussed above. Given the thousands of years of accumulated knowledge of American Indian/Alaska Native communities, there are been examples of contemporary rigorous processes to allow for the consideration of culturally based practices as evidence-based practices. In the state of Oregon, American Indian/Alaska Native leaders in mental health and substance use advocated for the state to use a culturally specific review process when determining which practices counted as evidence based (Sahota & Kastelic, 2012). The Oregon Addictions and Mental Health Division agreed to collaborate with tribes, and a separate review and documentation process for tribally based practices was developed (see <https://www.oregon.gov/OHA/HSD/AMH/Pages/EBP.aspx>). The criteria were developed in close consultation with tribal communities. We recommend a similarly close consultation process be conducted to define culturally specific criteria for which programs are eligible for funding under the FFPSA.

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