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In memoriam

Dale Shimizu

October 17, 2005

Substance Abuse and Mental Health
Services Administration
c/o NREPP Notice
1 Choke Cherry Road
Rockville, Maryland 20857

Dear Madam/Sir(s):

Subject: COMMENTS REGARDING THE NATIONAL REGISTRY OF
EVIDENCE-BASED PRACTICES (NREPP)

Federal Register Volume 70, No. 165

CAADPE, the California Association of Alcohol and Drug Program Executives, is a professional association of community-based nonprofit alcohol recovery and other drug abuse services treatment agencies, providing substance abuse services at over 300 sites throughout California. Established in 1989, it is the only statewide association representing all modalities and the full continuum of substance abuse treatment services. Its membership constitutes the infrastructure of the state's substance abuse treatment delivery system. CAADPE members are the front-line providers, leading the California's initiative for reclaiming lives from the devastation of substance abuse.

As such, CAADPE has grave concerns about NREPP as it has been proposed. The central concerns involve the focus on the premise that treatment will improve if confined to interventions for which a certain type of research evidence is available; the issue of "branding," which could lead to some of our most innovative and effective small scale providers eliminated from funding considerations; and, the "process" heavy and burdensome "decision tree".

CAADPE recognize that a number of treatment approaches are efficacious. While it is important to identify and implement specific techniques that may enhance treatment success, it is also critical to recognize that treatment is generally a multi-faceted process that includes a number of interventions, many of which are very individualized. Evidence-based practices (EBP) are important modifications to treatment but must be recognized as a piece of a much larger scenario. NREPP, as currently proposed, imposes unproven science on an infrastructure of providers whose treatment effectiveness would be compromised by the very effort designed to improve it.

CAADPE recommends that SAMHSA undertake a major revision of NREPP that balances the desire for data collection with the needs of individuals in treatment. The following points offer a detailed outline of CAADPE's concerns.

- **Programs vs. Practices.** The description in the Federal Register moves back and forth between evidence-based practices and evidence-based programs. The term “practices” is easier to understand and appears to refer to specific techniques with clear evidence of efficacy. What exactly is a program? Is it a specific treatment protocol with multiple elements for a specific population (e.g., Matrix Model for methamphetamine users)? Is it the services of a particular organization, delivered to a heterogeneous group of substance abuse patients? Within such a “program,” there may be several “practices” with varying degrees of evidence-based credentials. By themselves, however, none of the “practices” represent the entire program.
- SAMHSA’s NREPP proposal appears to assume that the process of evaluating the science supporting an EBP should be the same as determining the effectiveness of a treatment program. A treatment program is an amalgam of interventions that may or may not be delivered like the research that established the efficacy of the intervention. Adaptation is both inevitable and useful for the success of dissemination. Thus, this proposal fails to deliver its primary promise - to inform consumers and the general public about effective programs. There's a huge difference between a program delivering one or more effective interventions (as determined by science) and an effective program as determined by program or funder evaluation of its own outcomes, whether achieved by the use of “proven” interventions or not.
- NREPP is based on an assumption that evidence-based practices account for a major contribution to outcomes. What is the magnitude of treatment effects of the currently recognized EBPs? Effect sizes are currently not reported in a public, consistent manner that permits comparison by funders and practitioners. In many cases, the effect sizes appear to be modest and possibly not worth the transition costs. What is the contribution of EBPs, compared with client factors, extra-therapeutic factors, therapeutic alliances, and strategies for engagement and retention? How well do the EBPs work outside of the context of comprehensive care?
- The NREPP initiative does not address the fact that the effectiveness studies are absent or inadequate for interventions supported by efficacy trials. The initiative promises “utility descriptors” at a later time, but does not discuss this key issue. Do evidence-based practices work in a community-based organization with ordinary resources? (E.g., staffing, supervision, data collection.) Do we know? If we move to funding only EBPs, we will never know. Lastly do they have any real application in residential settings?
- Is the concept of fidelity, as implemented in a research study, appropriate for a community-based treatment program? Achieving fidelity takes a very labor- intensive supervision, and most states don't fund supervision. What is the downside of emphasizing fidelity to the model? What about the “boredom” factor? Do these manualized treatments still “work” 2-3 years later? Are there any studies of this? Counselors do become bored and their ability to tinker keeps them engaged. They are also often aware that some modifications will be more effective with varying population groups served.

- What is the tradeoff between fidelity and the need to adapt interventions for specific populations? Providers are expected to offer culturally competent interventions. These expectations may conflict.
- What about the huge gaps in the research literature (e.g., group interventions). With the current and proposed changes, studies addressing these gaps are unlikely to be funded, precisely because they are not EBPs.
- The existing treatment infrastructure cannot handle the expectation for data collection. It is currently unlikely that most community based treatment programs could meet the standard to be listed on the Registry. How can the infrastructure be strengthened? What funding streams is SAMHSA promoting to accomplish this? Management information systems and clinical supervision are obvious gaps. The initiative promises technical assistance, but this is no substitute for missing infrastructure. The financial resources to support such efforts has always been absent, yet the expectations and demands continue to be placed upon under funded community based service providers, driving some out of business and requiring others to reduce services to many to survivor.
- How is SAMHSA planning to protect providers from exploitation? Already there are examples of large sums of money being asked for training materials on interventions developed with tax dollars. Consultants representing particular practices are charging fees of \$3000 per day. This is not something most nonprofits can afford.
- Funders are already issuing lists of EBPs worthy of funding, and narrowing what they will reimburse. How does SAMHSA intend to protect opportunities for innovation?
- Competitive grant writing becomes more and more a challenge to community providers who struggle to address the EBP without adequate infrastructure to do so. CBO's who have made strides to address EBP have significant hardships trying to implement such activities without adverse impact on agency staff and services to others.
- What are SAMHSA's plans to anticipate possible misunderstanding on the part of funders and address them proactively? Funders are already assuming that the way to improve treatment is to confine interventions to items on a list. What began as an effort to promote adoption of research-based interventions has become "let's list all the EBPs that meet our standards and make sure these activities are the only thing we fund."

The evaluation of interventions, practices, and programs must begin with consensus by treatment providers, local and state agencies, and professional networks. Treatment providers must be represented in all phases of the development of NREPP. Only with the provider perspective will NREPP be both effective and accepted.

CAADPE is anxious to contribute its collective experience and expertise to the process.

Sincerely,



Albert Senella
President, California Association of Alcohol and Drug Program Executives