SAMSHA Proposal

Comment Period Ends October 25

SAMHSA's National Registry of Effective Programs and Practices (NREPP): Overview and Agency Context

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Presentation to
Drug-Free Communities (DFC)
2004 Training Meet
November 16, 200

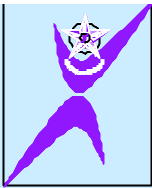
THE AOD FIELD RESPONDS TO NREPP

CAADPE Urges Action by AOD Field

Response prepared by Joan E. Zweben, Ph.D.

What is NREPP?

- National Registry of Effective Programs and Practices
  - formerly the National Registry of Effective Prevention Programs
- Began in 1998 within SAMHSA’s CSAP as a system for identifying & promoting interventions that are:
  - Well implemented
  - Thoroughly evaluated
  - Produce consistent positive and replicable results
  - Able to assist in dissemination and training efforts
- www.modelprograms.samhsa.gov



SAMHSA Model Program

NREPP Scientific Review Process

Identification

Identify programs through:
1) Published scientific literature;
2) Final grant reports;
3) Other organizations' lists of exemplary programs;
4) Submissions from field.

Contact Developers

Send program developer:
1) SAMHSA solicitation letter;
2) NREPP rating criteria.

Review Initiation

Determine priority of review (expedited etc).

Developer Initiation

Upon receiving evaluation materials, NREPP contacts developer to:
1) Confirm receipt;
2) Verify completeness of materials;
3) Request additional data when available.

Triage

Triage program based on evaluation rigor.

Review

Assign and distribute program to NREPP reviewers.

Achieve Consensus

Confirm scores with reviewers as to status of program.

Assign Status
Once review is complete, based on compiled scores, program categorized as:

Effective
(4.0 or >)

Promising
(3.33 to 3.99)

Insufficient Current Support
(3.32 or <)

Vision for NREPP Expansion

- NREPP becomes the leading national resource for practical, contemporary and reliable information on scientifically-proven treatment and prevention services
  - Every clinician, prevention specialist, purchaser, administrator, consumer, family member and advocate in America has a good working knowledge of, and/or direct experience with NREPP

Goals for Expansion

- Goals are a comprehensive and transparent system
- Comprehensive
  – Outcomes based
  – Application/Self-assessment
- Transparent
  – Posting of evaluative scores and criteria summaries from scientist reviewers
  – Posting of utility scores and criteria summaries from stakeholder reviewers

NREPP Expansion in Progress

- Began reviewing programs in SA treatment, and MH promotion and treatment in Fiscal Year 2004
- Consolidation of core NREPP functions in single contract in Fiscal Year 2005
  - Review of all programs/practices by scientific team for integrity
  - Re-review of interventions on the NREPP five or more years
  - Review of "threshold" programs by stakeholder review teams for disseminability and utility
- Development of framework for inclusion of community coalitions
- Redesign website - www.nationalregistry.samhsa.gov
  - Highly visible
  - User-friendly (e.g. self-assessment, posting of program reviews, database searchable by outcomes)
  - Potential for policy guidance in the use of the NREPP

“Branding” NREPP

- NREPP becomes a signature SAMHSA activity/product
  - www.nationalregistry.samhsa.gov
- SAMHSA becomes widely known as the place to:
  - Identify effective, evidence-based programs and practices – including successful coalition efforts
  - Receive – or be linked with - “implementation assistance” to implement a model program/practice
  - Seek – or be linked with - “development assistance” to build a program or practice evidence-base

Bridging Science and Service

	Science “Ideal” Conditions	Service “Real” World
Population	- Homogeneous - Exclusionary criteria	- Heterogeneous - Comorbid, Complex, etc.
Design	- Methodologically rigorous - Maximize internal validity	- Influenced by constraints - Don’t deny intervention
Setting	- Controlled	- Naturalistic
Exposure	- Time limited	- As long as needed
Financing	- Grant funded - Limited need for more $$	- Grant and contract funded - Blended – need more $$
Goals	- Prove efficacy and effectiveness	- Demonstrate safety and positive change

NREPP Can Facilitate Bridging

- Rooted in stakeholder needs – “what works”
- Multiple levels encourage initial entry and promote quality improvement
- Movement toward stakeholder inclusion in review of “Model Program” candidates
- Identification of successful coalition efforts
- Plans to redesign web site to increase visibility and usability – (i.e., search by outcomes)
- SAMHSA’s Service to Science orientation
  - Technical assistance to program developers
  - Potential for Service to Science grants

Aligning Technical Assistance with NREPP Expansion

- Coordinating SAMHSA TA with NREPP
  - "Center-driven" technical assistance to promote:
  - Implementation of NREPP model programs (science-to-service support to organizations and practitioners)
  - Development of evidence base for new programs (service to science support to program developers)

NREPP Policy Relevance

- Influence SAMHSA discretionary and block grant investments
- Serve as a resource for states and communities seeking to implement evidence-based MH and SA prevention and treatment services
- Provide an important tool for both public and private purchasers in selection of effective services

Revised NREPP Process

Rating Programs by Outcome

0 = Insufficient Current Support

1 = Program or Practice of Interest

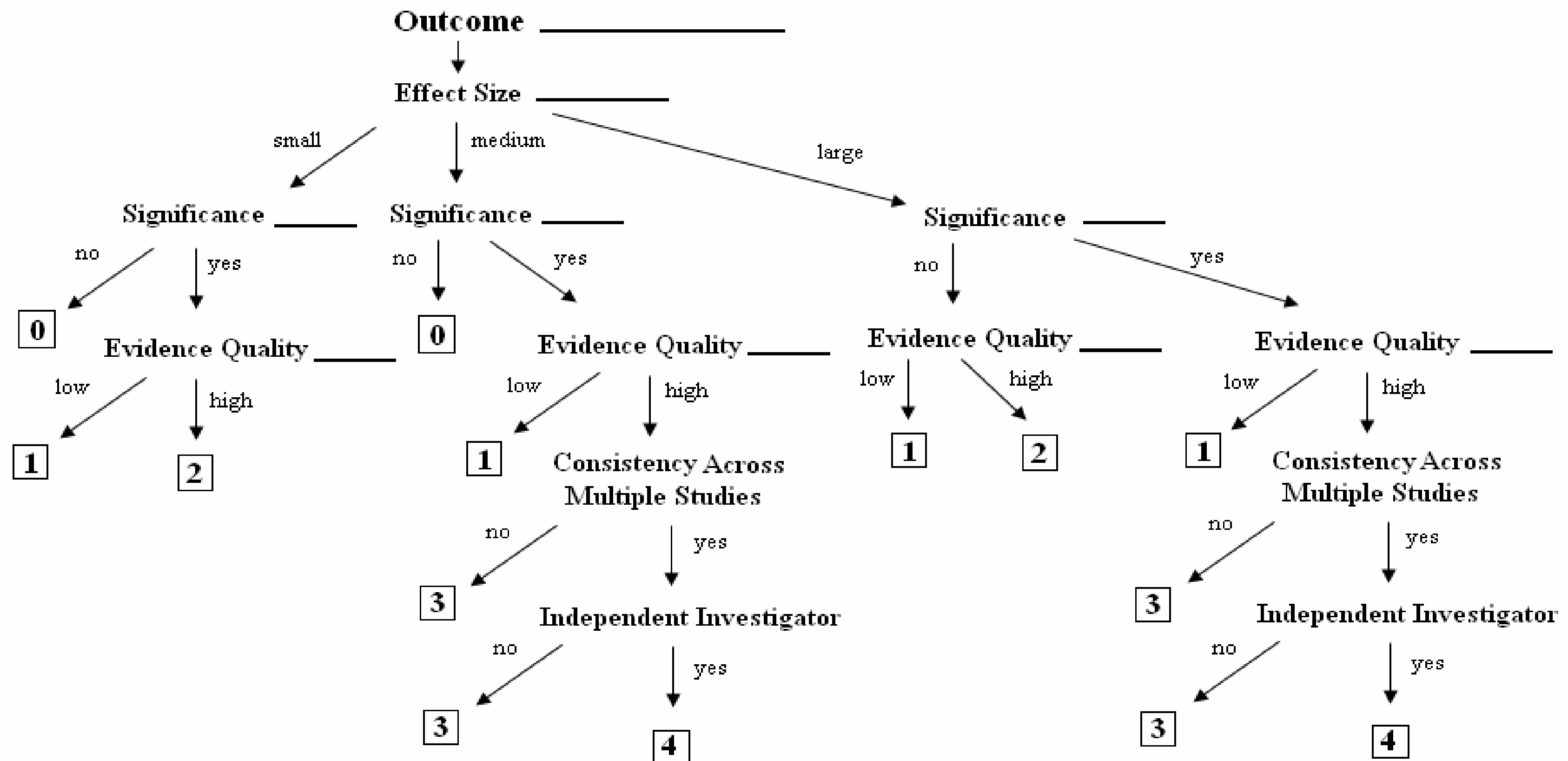
2 = Promising Program or Practice

3 = Conditionally Effective Program or Practice

4 = Effective Program or Practice

Rating Programs by Outcome

For each reported outcome, use the decision tree below to aid program categorization:



What is the NREPP process?

- Identify programs through self nomination and proactive literature searches
- Screen and triage programs to ensure there is sufficient material for review
- Assign programs to review teams, based on expertise and workload
- Reviewers independently rate programs
- Achieve consensus – post-review debriefings
- Synthesize program effects by outcome
- Assign status by outcome – Effective, Conditionally Effective, Promising, Program of Interest, Insufficient Current Support
- Notify developer and give feedback

Current NREPP Criteria Developed from…

- Original NREPP criteria
- Ongoing reviews of other evidence grading systems
- Suggestions made by expert panels convened to inform NREPP expansion
- Review of the evidence quality literature

NREPP Rating Process and Criteria

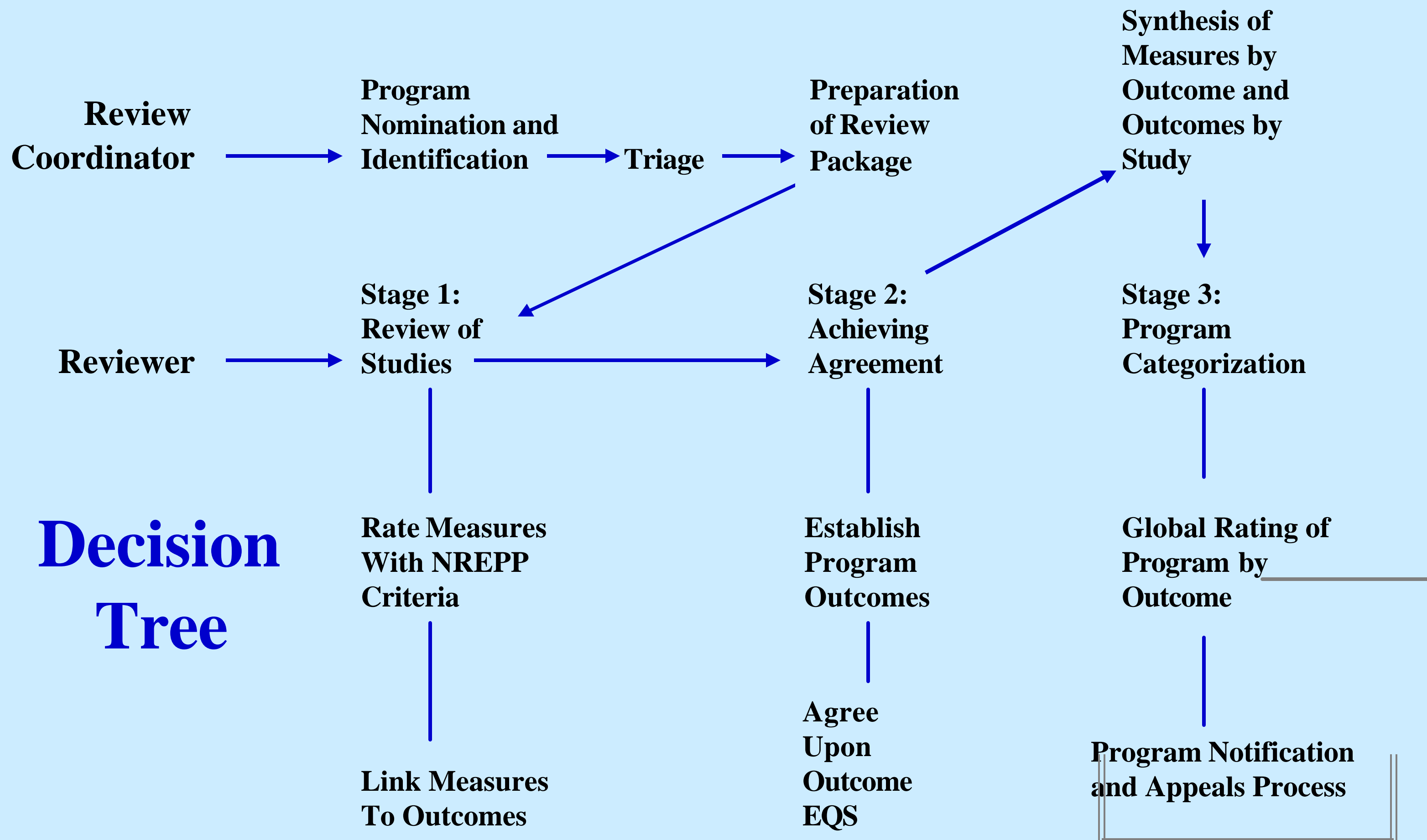
Stages of NREPP Reviewer Ratings

Stage 1: Applying NREPP criteria to individual studies

Stage 2: Achieving agreement between Reviewers

Stage 3: Rating a program's effectiveness for each reported outcome

Flow Diagram of Rating Process



NREPP Rating Criteria: Evaluative Criteria

1. Adjustment of Outcome Measures for Alpha Inflation
2. A Priori Identification of Outcome Measures
3. Reliability of Measures
4. Validity of Measures
5. Intervention Fidelity
6. Comparison Fidelity
7. Comparison Condition
8. Informing Subjects Appropriately
9. Subject Awareness of Treatment Received
10. Standards for Data Collection
11. Data Collector Bias
12. Selection/Assignment Bias
13. Subject Attrition
14. Missing Data
15. Analysis Meets Assumptions
16. A Priori Identification of Analytic Methods
17. Anomalous Findings
18. Replications of Findings

NREPP Rating Criteria: Evaluative Criteria

5. Intervention Fidelity

0 = There is evidence intervention implemented was substantially different from one proposed

1 = Only narrative evidence that applicant or provider believes intervention implanted with fidelity

2 = Evidence in the form of judgment's) by experts based on observation and administrative data

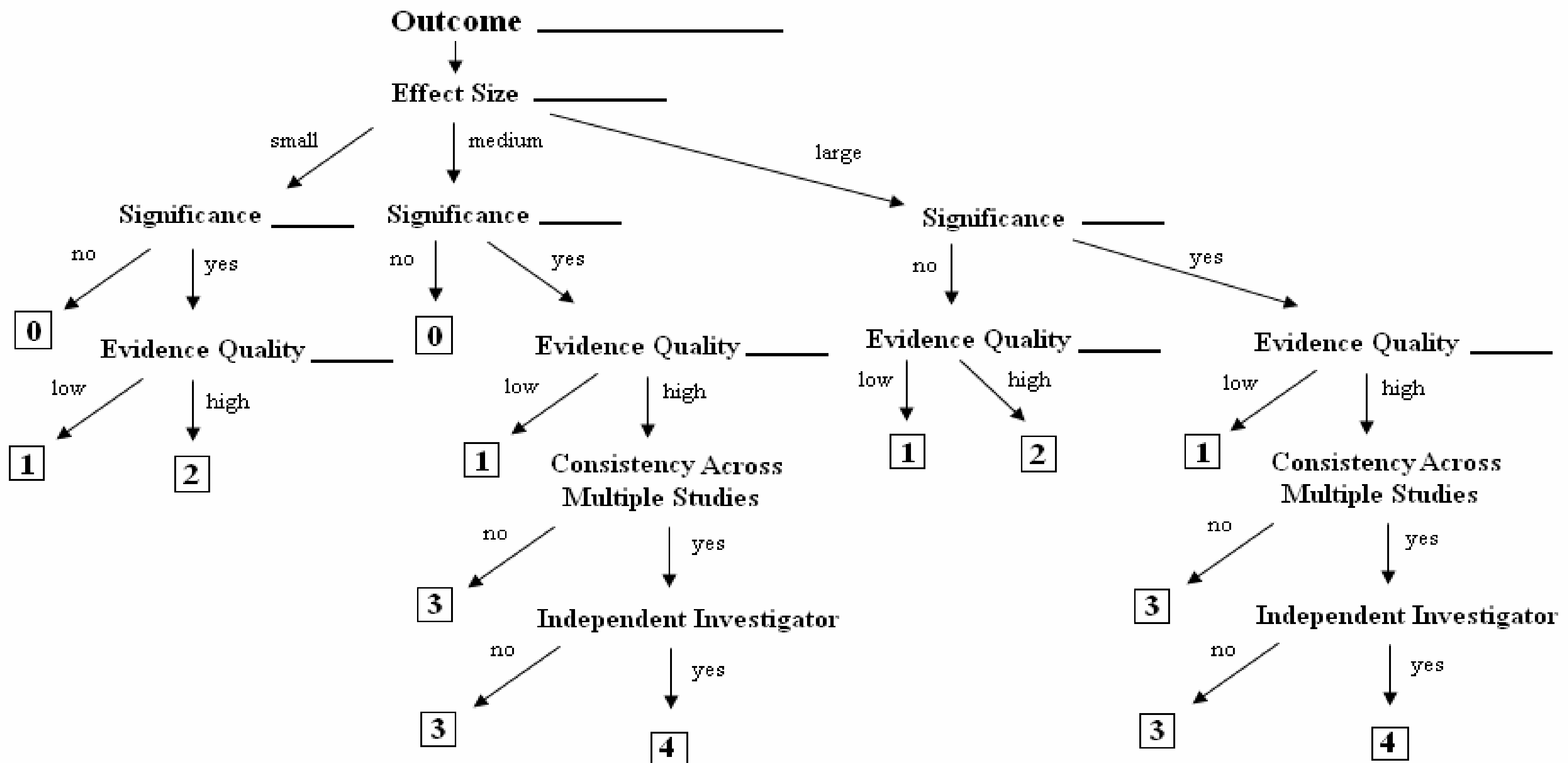
3 = Extensive evidence in the form of data on things like dosage, time spent in training, adherence to guidelines or manual, or a fidelity measure with unspecified or questionable psychometric properties

4 = Evidence from a tested fidelity instrument shown to have reliability and validity

99 = No or insufficient information

Rating Programs by Outcome

For each reported outcome, use the decision tree below to aid program categorization:



Rating Programs by Outcome

What rating are you most confident giving to this program or practice for this outcome, taking all studies of the program and measures of the outcome into account?

0 = Insufficient Current Support: A small to medium effect size with statistically non-significant findings.

1 = Program or Practice of Interest: Small or medium effect size that is statistically significant with low-quality evidence (from 2.0 to 2.5), or large effect size that is not statistically significant with low-quality evidence (from 2.0 to 2.5).

2 = Promising Program or Practice: Small effect size that is statistically significant with high-quality evidence (above 2.5), or large effect size that is not statistically significant with high quality evidence (above 2.5).

3 = Conditionally Effective Program or Practice: Medium or large effect size that is statistically significant with high-quality evidence (above 2.5). Can be single study, or multiple studies with inconsistent findings.

4 = Effective Program or Practice: Medium or large effect size that is statistically significant with high-quality evidence (above 2.5). Includes multiple studies including one by an independent investigator with no inconsistent findings across the studies.

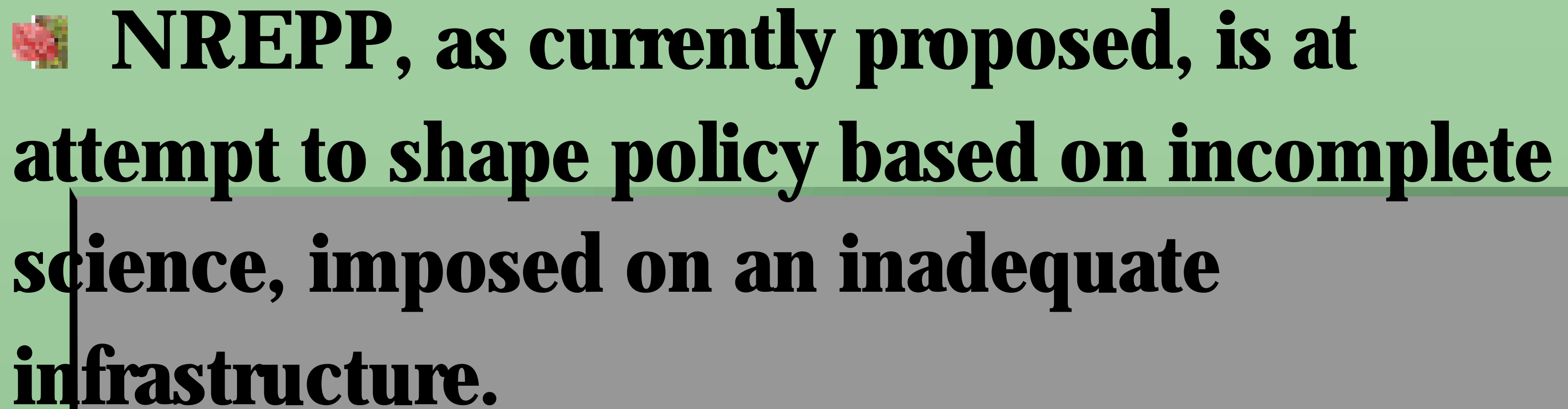
NREPP Utility Criteria

NREPP Rating Criteria: Draft Utility Criteria

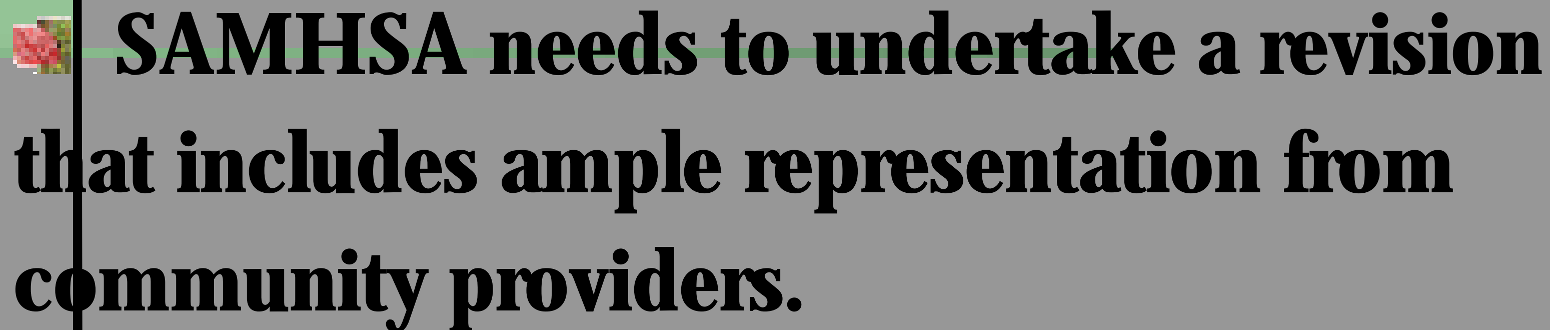
- U.1 Dissemination Readiness: Materials
- U.2 Dissemination Readiness: Training
- U.3 Dissemination Quality Control Procedures
- U.4 Analysis: Clinical Significance
- U.5 Global Safety
- U.6 Population Coverage
- U.7 Available Translated Languages
- U.8-U.10 Consumer Involvement
- U.11 Real World Applicability*:* Generalizability
- U.12 Real World Applicability: Cost

SAMHSA end

THE AOD FIELD RESPONDS TO NREPP



- NREPP, as currently proposed, is at attempt to shape policy based on incomplete science, imposed on an inadequate infrastructure.



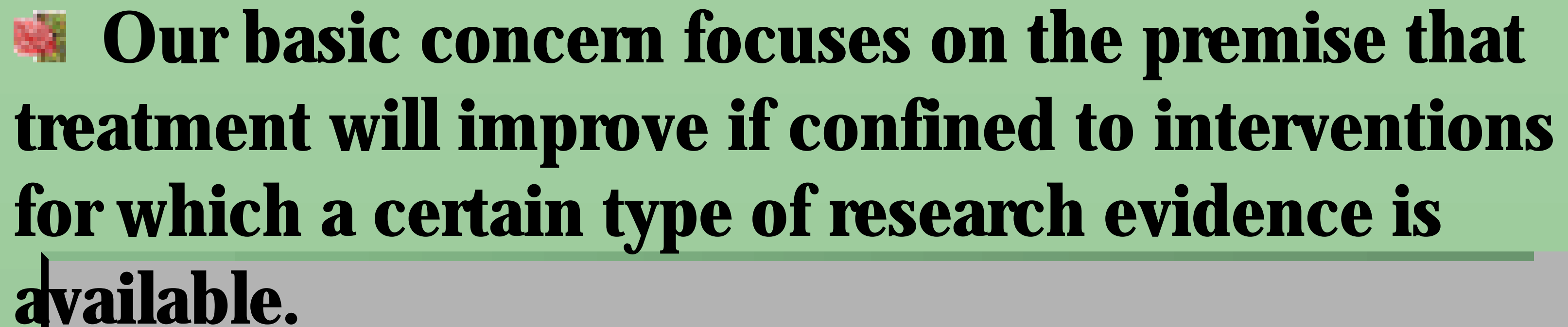
- SAMHSA needs to undertake a revision that includes ample representation from community providers.

Treatment providers need to be at the table when decisions are made about the criteria and process for evaluating programs.

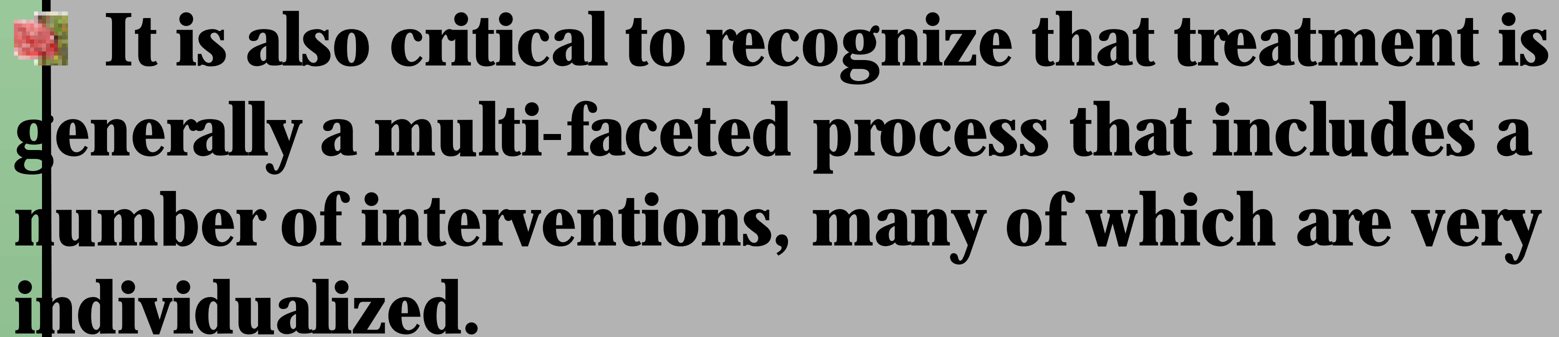
TALKING POINTS

NREPP is a significant federal initiative, and it is important that those involved in treatment weigh in on its likely impact. Please review the notice from the Federal Register (8/26/05) and form your own opinions.

Your opinions must be communicated during the public comment period ending on 10/25/05. Following are some talking points that you may wish to consider. They were synthesized from comments by both researchers and treatment providers



- Our basic concern focuses on the premise that treatment will improve if confined to interventions for which a certain type of research evidence is available.



- 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.

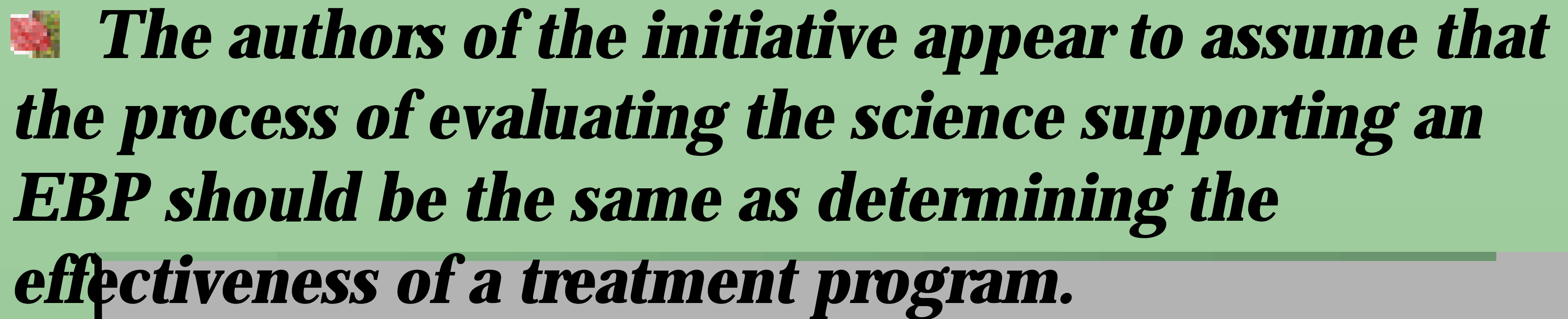
- Evidence-based practices are important modifications to treatment but must be recognized as a piece of a much larger scenario.

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.



The authors of the initiative appear 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 EBP's?**

  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 EBP's, compared with client factors, extra-therapeutic factors, therapeutic alliances, and strategies for engagement and retention?**

- **How well do the EBP's 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 EBP's, we will never know.

Achieving fidelity takes a very labor- intensive supervision, and most states don't fund supervision.

- ? Is the concept of fidelity, as implemented in a research study, appropriate for a community-based treatment program?
- ? 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 EBP's.**

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.

- **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.

- **How does SAMHSA intend to protect opportunities for innovation?**

  Funders are already issuing lists of EBP's worthy of funding, and narrowing what they will reimburse.

? 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 EBP's that meet our standards and make sure these activities are the only thing we fund."

SAMHSA PowerPoint presentation adapted by the California Association of Alcohol & Drug Program Executives

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