Author's response to reviews

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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Dr. Anne Sales and the Implementation Science Editorial Team

Implementation Science

Dear Dr. Sales and Editorial Team Members:

RE: 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

Thank you for considering the enclosed resubmission to Implementation Science. We want to thank Drs. Gone and Walrath for their thoughtful reviews of our manuscript. We have attempted to address their comments and suggestions in this revised manuscript while being mindful of your charge not to lengthen it substantially. Our specific responses to our Reviewers’ comments and suggestions and our corresponding revisions to the manuscript are described below with changes noted through Track Changes.

Dr. Gone’s Comments and Suggestions

We felt Dr. Gone’s comments were closely linked to one another, thus before we address each suggestion individually, below, we would like to note the vast majority of our revisions to the text in response to these suggestions may be found in two places in the manuscript: Lines of Tension Around Substance Abuse Services [starting on page 12, paragraph 2] and Specific Concerns Regarding the use of Evidence-Based Treatments in Programs Serving AI/AN Communities: Characteristics of the Innovation [starting on p. 14., par. 1].

1. ... 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.

Dr. Gone asks us whether our Advisory Board discussions allow us to untangle attitudes towards and use of EBTs that are related to scientific legitimacy (e.g., belief in the value of experiments such as randomized clinical trials) from those related to pragmatic considerations (which we take to mean issues such as clinical and cultural appropriateness as well as staffing requirements). Our discussions do allow us to do both, though Dr. Gone is correct that our original manuscript focused largely on pragmatic considerations. In terms of scientific legitimacy, our Board’s assessment is that while some key stakeholders (administrators, clinicians, community members) reject the scientific process outright, others believe there is value in harnessing the scientific process for the benefit of American Indian and Alaska Native (AI/AN) people. We have noted these issues briefly in our Introduction [page 5, paragraph 1] and review of Community Contexts [p. 7, paragraph 2] with a more extensive
discussion in our description of the “Lines of Tension Around Substance Abuse Services” [starting on p. 12, par. 2].

2. … 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… In sum, the authors might consider promising AI strategies of resistance to EBT mandates alongside their interest in finding common ground.

We agree that the Practice-Based Evidence movement is an important response to the EBT movement that deserves to be highlighted in this paper. Indeed, the Practice-Based Evidence movement has not only had important impacts at SAMHSA, but a comparable effort by tribes, tribal organizations, and academics in Oregon has led to the creation of a special review process for culturally-based services. We believe this issue fits nicely in “the range of responses” to the scientific legitimacy of experimental research (#1 above) and have included these issues in our additions to the text regarding this issue [p. 12, par. 2].

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.

We agree with Dr. Gone that cultural adaptation is by no means a simple process, that developers of EBTs often have concerns about how changes to their interventions for any reason, including cultural adaptation, may diminish their effectiveness because of reduced fidelity. Indeed, NIDA’s Clinical Trials Network has included cultural adaptation in its research to practice efforts. Likewise, AI/AN communities are often very concerned about the explicit incorporation of what is often closely-held tribal knowledge into a treatment manual, or may be unable to do so because such an approach would irreparably damage the power of their traditional healing. While Dr. Gone notes that there have been some successful cultural adaptations, there have also been some apparently unsuccessful adaptations as well (see for example Lau et al., 2006). We have expanded our discussion of this issue to describe the very real challenges in such approaches [p. 14, par. 1].

4. …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 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...

We appreciate Dr. Gone’s thoughtful exposition of these issues. Indeed, we have framed our response to comment #1 to underscore that the questioning of scientific legitimacy of experimental research is strongly related to its external imposition on AI/AN communities [starting on p. 12, par. 2]. Our Board also discussed the belief of some AI/AN people that the scientific enterprise of which the EBT movement is built clashes with traditional AI/AN ways of knowing. However, we also noted in our discussions that other AI/AN people have advocated for an alternative perspective suggesting there are strong parallels between the scientific process and how AI/AN communities traditionally developed an understanding of themselves and the world around them. We have added this aspect of the debate to the manuscript [p. 13, par. 1]. We are less confident than Dr. Gone that these are inseparable concerns (indeed those who argue that systematic description and investigation is part of AI/AN traditions suggest that the two issues should be separated), though it is certainly true, as we note on p. 12, par. 2, that questioning the legitimacy of the scientific process is one of the ways that some AI/AN communities have argued against the external imposition of EBTs on the substance abuse treatment programs that serve them.

**Dr. Walrath’s Comments and Suggestions**

1. … it might be helpful if there was more “methodological” information provided on how the advisory group was formed, in what way they contributed, etc. Similarly, the "methodology" around the expert opinion group - the process they used to review the literature, categorize into factors and reach consensus would be helpful.

This paper was written by a subset of the membership of our Advisory Board drawing on the notes from our September 2008 meeting. We have expanded our description of both the meeting and the preparation of the manuscript [p. 6, par. 1] and revised the list of authors to note that this paper was authored on behalf of the full Advisory Board [p. 1].

2. … Is this increase to SAMHSA funding to AI/AN communities relevant to the SA treatment field, or is that increase in SAMHSA funding largely coming through CMHS?

We appreciate Dr. Walrath’s request that we be more specific in our description of Substance Abuse and Mental Health Services Administration (SAMHSA) funding. The real-dollar decrease in IHS funding has affected all health services, including substance abuse services, and one of the major sources for addressing this decline in funding for substance abuse services has been pursuing funding opportunities through SAMHSA’s Center for Substance Abuse Treatment (CSAT). We have revised the text accordingly [p. 9, par. 1].

3. … This reviewer’s question, however, is how these factors (and conclusions) compare and contrast to factors in non-AI/AN …this is mentioned in the closing paragraphs, but for this to be truly useful to the field it seems a more detail compare and contrast would be helpful.
We agree with Dr. Walrath that our closing statements regarding programs serving non-AI/AN communities would be stronger if the issue was addressed more explicitly in the text regarding the factors affecting the dissemination process. We have added a description of the likely similarities and differences in these factors [p. 20, par. 2].

4. *... has anything been learned with regard to Mental Health EBP implementation that can be applied or integrated into this piece?*

We agree with Dr. Walrath that there are strong parallels with the EBT dissemination and implementation process for substance abuse and mental health services in AI/AN communities, not the least is the trend towards the integration of the two administratively (and to some extent clinically) in behavioral health programs. Also, the funding mandates from the Center for Mental Health Services (CMHS) are comparable to that for CSAT as are those from some state Medicaid programs. If we were to transfer our discussion of “lines of tension” to mental health services we could easily replace 12-step traditions with psychotherapeutic approaches that are widely used but have a limited evidence base (e.g., psychodynamic therapy). There are some rigorous cultural adaptations of mental health EBTs (e.g., trauma-focused cognitive behavioral therapy for AI children with PTSD by Dee Bigfoot at the University of Oklahoma). Similarly, the Practice-Based Evidence movement is taking a behavioral health perspective on their drive for locally-developed evidence. Similar issues have also arisen in the treatment of chronic health conditions that rely on cognitive behavioral techniques for supporting behavior change (e.g., the Healthy Heart Program for reducing the risks of diabetes-related cardiovascular disease). However, while there is surely a “cross-pollination” of these issues and suggested solutions, we could not think of clear examples in which innovations from mental health or primary care are leading the way for substance abuse services. We have therefore noted that similar tensions are affecting mental health and primary care services in AI/AN communities [p. 20, par. 2], but feel a full explication of these issues is beyond the scope of this paper.

5. *The co-authors use the terms systems, services, and treatments interchangeably. If indeed these terms are interchangeable in this context then it should be specified - if there are distinctions in meaning when those various terms are used, that would be helpful for the reader to know.*

We have carefully reviewed the text to assure that we are using these terms in a clear and consistent manner as follows [a number of minor revisions throughout the text]:

- **System** – a group of health care programs that serves the health care needs of a target population (in this case for AI/AN communities).
- **Services** – a set of treatments/interventions offered by a health care program (or programs) to address a health condition (in this case substance abuse problems).
- **Treatment** – a specific intervention for addressing a health condition (in this case substance abuse problems), though we occasionally use treatment in a compound noun, as in substance abuse treatment community, but we have limited its use in this manner as much as possible.

We have not added a glossary of terms but would be happy to do so if you feel it would strengthen the manuscript.

Thank you again for considering this submission. The text of the new manuscript is 2 pages longer than our original submission. We hope that this modest increase in length is within the acceptable range you had requested. Finally, we would again like to thank our Reviewers for their thoughtful assessments of our
manuscript. We believe the changes we have made in response to their comments and suggestions have allowed us to strengthen it considerably.

Sincerely,

Douglas K. Novins, M.D.