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Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration

# THE BRIDGE

Linking Science and Service

Volume 3, Issue 1, Spring 2013

## Introduction to This Issue of The Bridge

By Paul Roman, PhD, Editor

Improving the quality of the treatment of substance use disorders (SUDs) is the theme of a multifaceted campaign that has touched nearly every treatment provider organization and individual treatment professional for more than two decades.

In 2011, the National Institute on Drug Abuse (NIDA) formed a workgroup to consider how to best improve the scope and quality of “implementation science,” a relatively new name for a specialty area of research and practice centered on behavior change among organizations and individuals. In late 2012 the workgroup produced a report with recommendations, [\*Adoption of NIDA's Evidence-Based Treatments in Real World Settings: A National Advisory Council on Drug Abuse Workgroup Report\*](#). (Read the complete report in PDF format.) In this issue of The Bridge we present reactions to the report from six professionals working in different sectors of SUD treatment and research.

*The Bridge* is published to educate and especially to stimulate debate and discussion. As the reader will see, the reactions to the report offer very diverse perspectives, and in some instances controversial opinions are included. The discussion also reveals long-term dilemmas that affect the long-term effort for better quality treatment of SUDs.

The commentaries that are offered are notably diverse. Several note that the recommendations in the report do not reflect the empirical realities of treatment. The issue of cost and financing is raised in several of the commentaries. Some are supportive of the report while others are not. The ongoing dilemmas of the SUD treatment field are reflected across all of the commentaries.

We invite readers to respond to these materials, including the workgroup report itself. To the extent they are appropriate, these reactions may be included in future issues of *The Bridge*. Please address your comments to Paul Roman at the University of Georgia ([proman@uga.edu](mailto:proman@uga.edu)).



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## Payment Mechanisms Drive Service Modalities

Michael Boyle, University of Wisconsin

The National Advisory Council on Drug Abuse Workgroup report, *Adoption of NIDA's Evidence-Based Treatment in Real World Settings*, identifies one of the barriers to the adoption and implementation of evidence-based practices as:

“The “individual-based” approach of most evidence-based behavioral treatments is an obstacle for most public and private treatment services which are “group-based”. Even as substance use services become integrated in primary care, it is likely that these services will continue to be group-based treatments by primary care teams, as is the case for behavioral treatments for other health conditions.”

I believe this issue deserves further exploration.

As a former CEO of a behavioral healthcare treatment organization, I first wish to explore why substance abuse treatment is predominantly group-based. I start with the simple premise that providers deliver what they are paid to deliver. The payment system for substance use disorders usually rewards group treatment over individual or family sessions. For example, the state where my organization was located paid for treatment through fee-for-service. The individual hourly rate from Medicaid or state payments was \$60.32. The group rate was \$22.80 per hour. Thus, when we provided a group session with eight patients, the revenue per hour of clinician time was \$182.40, representing a three-fold increase over the payments for a typical individual treatment session.

Insurance and managed care contracts offer similar incentives for provision of group treatment. One managed care company we worked with paid \$121 for an individual session and \$45 for a 90-minute group. The financial benefits of providing group services were clear. Executive leaders face a dilemma even if they support using evidence-based treatments (EBPs): “How can I afford to reduce our revenues by two-thirds and remain in business?”

In addition, research shows that training alone does not support widespread adoption of EBPs. (Glasner-Edwards & Rawson, 2010). Ongoing supervision including the review of taped sessions is required to achieve high fidelity. Consequently, adopting EBPs reduces income, and supporting adoption increases expenditures. In the current financing environment, senior leaders are unlikely to champion changing treatment approaches to adopt EBPs. And without support from senior leaders, widespread change is even less likely.



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I do not know why the group approach was originally adopted for substance use treatment. I suspect it evolved from the 12-step orientation of the early alcohol treatment organizations and was a key component of the therapeutic community approach for treating drug addiction. Groups remain an efficient means to providing services. Regardless of the evolution of the group approach, it is time for a revolutionary change to individual and family therapy modalities. I am not advocating that groups never be utilized. They can serve a supporting role in skill training, role-playing, and problem solving activities. Treatment manuals are available for implementing evidence-based cognitive behavioral treatments in group settings. Still, it is challenging to provide truly individualized, tailored, and adaptive treatment in a group setting. Most groups are still “one size fits all” and fill the time with less effective treatment approaches such as lectures and general group counseling.

New funding methods may and hopefully will replace the current fee-for-service or grant payment mechanisms. These may include episode of care payments, bundled payments to the newly formed accountable care organizations, or capitation. These contracts will likely include pay-for-performance clauses tied to both performance measures and outcomes. Such new payment systems will reward achieving better results more efficiently; they should be an incentive to providing individualized care that focuses on adaptive treatment and utilizes evidence-based practices.

I disagree with the report’s premise that primary care will adopt the group treatment approach as substance use is integrated into these settings. First, I think physical health care is oriented toward science and research rather than being tied to someone else’s tradition. Primary care physicians will look toward implementing the most effective practices in their approaches to substance use disorders (SUDs).

Second, primary care settings are already providing individual treatment for behavioral health problems, particularly for mental health issues. At a SAMHSA/HRSA Invitational Conference on integrated treatment in 2008, virtually all the examples of behavioral health treatment in primary care utilized individual therapy. Of interest, the majority utilized a 15-30 minute session rather than the traditional one-hour approach that dates back to early psychoanalytic treatment. The sessions in primary care clinics were focused on progress, further assessment, and tailoring of next steps rather than “free association” or finding something to talk about to fill the hour, again “someone else’s” tradition.

A third reason why I believe primary care will not adopt the group treatment approach again regards the payment mechanisms. Integration is likely to occur first in Federally Qualified Health Centers (FQHCs), mandated by their Federal funding to address behavioral health problems. The FQHC patient population usually includes a high percentage of Medicaid patients, a group that will increase under the Affordable Care Act.



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The individual states' Medicaid programs have discretion on coverage for group treatment of behavioral health disorders; according to a report from the National Association of Community Health Centers (2011), group services are almost never covered. FQHCs have no financial incentive to address substance use illnesses through group interventions. Individual treatment is reimbursed at a cost-based encounter rate. Whether a service lasts for 15 minutes or an hour, the reimbursement is the same—a compelling incentive to deliver the focused individual sessions previously noted.

If brief, individual-based treatment in primary care becomes commonplace, and if studies show that a new approach produces better results, the existing specialty addiction treatment system may be in jeopardy of extinction. The “real world” of treating substance use illnesses will change dramatically from what exists today.



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## **Connecting the NIDA Workgroup Report to Clinical and Organizational Realities** **Gregory Brigham, PhD, Maryhaven Research Institute**

The NIDA Workgroup report, *Adoption of NIDA's Evidenced-Based Treatments in Real World Settings* addresses a topic of great importance to many stakeholders: persons suffering with addictions and those who love them, policy makers, researchers, healthcare providers, and addiction specialty care providers.

Much of the report relates to the desire for special funding and handling for implementation research and a redesign of the effectiveness research endeavor. The intention seems to be to bring implementation and effectiveness research more in line with healthcare reform and the vision of expanding the impact of substance abuse care into more traditional medical settings. Healthcare reform, with the promise of expanding the impact of healthcare on substance use problems, makes this an exciting and important time in the substance abuse treatment and research field. History will judge the degree to which this vision becomes a reality. I will restrict my comments to the areas with which I have firsthand experience: assessment of the current reality, in which most addiction care is delivered in the context of community treatment programs, and the assessment of the NIDA Clinical Trials Network (CTN).

The workgroup's description of the use of science in practice seems to be a rehash of some well-worn criticisms of the addiction treatment system supplemented with some SAMHSA survey data. It fails to give any serious consideration of research that has failed to replicate those results or of evidence that does not support its conclusions. The report criticizes the NIDA CTN for not doing a better job of promoting the adoption of specific interventions it has evaluated. From my view, as a clinician and researcher working in a community treatment program environment, I see a very different picture. Setting aside the fact that the CTN was not created for the purpose of dissemination, it has actually had a remarkable impact in this area. In my experience, both in my own setting and through my connection with hundreds of treatment providers in my state and across the country, the NIDA CTN has done as much to advance the use of evidence based practices in addiction care as all of NIDA's previous and concurrent dissemination efforts combined.

The goal of the CTN is to use science to improve drug abuse treatment. Achieving that goal cannot be fully appreciated or measured by a linear approach to adoption of a single or even multiple products (i.e., CTN studied treatment X and CTPs did or did not adopt treatment X). Using science to improve treatment represents a culture change as well as a practice change that should result in the adoption of the best available science to improve treatment, regardless of whether or not it was specifically studied within the CTN. I'll use my own practice setting as an example.



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Maryhaven has participated in a number of clinical trials both within the CTN and working with other NIDA sponsored investigators and has also adopted a number of empirically supported treatments. There is not a high correlation between the treatments studied and those adopted, but should that matter? For example, we have adopted Community Reinforcement Approach (CRA), Adolescent CRA, Multi-dimensional Family therapy (MDFT), Motivational Stepped Care, and agonist (methadone), partial agonist (buprenorphine) and antagonist (Vivitrol) therapies for opioid dependence. All patients admitted to our center are offered some form of empirically supported treatment. None of the treatments mentioned here were the subject of any of the clinical studies we participated in to date and none of them were in use in our center before the CTN was implemented. I should mention that Maryhaven did adopt, and has treated over 10,000 patients using, the first intervention studied in the CTN: Buprenorphine Taper Treatment for medically management withdrawal, and is in the process of adopting other CTN tested interventions.

While my view differs from that expressed in the report on the current status of adoption of evidence based practices in the "real world," I agree that considerable improvement is needed. One of the problems is that NIDA's limited budget simply isn't able to support all of the research that is needed. For example, there is a growing acceptance among researchers of the view, long held by addiction care providers, that addiction is a chronic condition and should be treated as such. Unfortunately, nearly all of NIDA's research portfolio is dedicated to research of acute interventions while addiction care centers treat patients who repeatedly relapse and return to treatment repeatedly over extended periods of time. While some approaches to managing chronic addiction have been tested there are no empirically supported chronic disease management approaches for drug dependence that meet the gold standards of science for effectiveness and this seriously limits the practical utility of much of addiction treatment science. Of course there are structural barriers in the way research is funded that make it difficult to study chronic care approaches, just as there are similar barriers in the funding of treatment that promote the continuance of an acute care treatment approach.

The report recommends that the effectiveness research endeavor be adapted to an addiction healthcare environment that does not currently exist. Even if healthcare reform is fully implemented in all 50 states, there will remain a need for a CTN-like system to develop and test treatments for severe drug addiction treatment treated in specialty care settings. Shifting resources away from conducting gold standard multi-site effectiveness research in addiction care will further limit the production of science than can be used to treat those most severely affected by addictive disease. If implemented this would, in my opinion, be a sad outcome for an endeavor which has carried the banner of bridging the gap between research and practice.



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## **An Outstanding Report from NIDA's Workgroup**

**Holly Hagel, PhD, Institute for Research, Education, and Training in Addictions (ATTC)**

The National Institute on Drug Abuse (NIDA), like all other National Institute of Health (NIH) institutions, “has the responsibility to ensure that a significant proportion of its research will result in broadly applied interventions with public health value and economic sustainability.” This is a compelling statement of purpose and sets the tone of the resulting sections of *Adoption of NIDA's Evidence-Based Treatments in Real World Settings: A National Advisory Council on Drug Abuse Workgroup Report*.

The workgroup rightly mentions the research-to-practice gap and the limited use of evidence-based practices (EBPs) in real world settings. They state, “Research evidence can be useful in promoting and encouraging change but is rarely by itself sufficiently powerful to change behaviors or systems.” The purpose of the workgroup was nicely articulated and is relevant not only in light of the research-to-practice gap but also in light of changes to the US healthcare system due to the passage of the Affordable Care Act (ACA). The workgroup's stated five recommendations are listed with specific goals where needed and accompanied by detailed action items. Overall, I agree with all of the five recommendations and have written a short commentary for each. I am glad the workgroup stated both NIDA and Substance Abuse and Mental Health Services Administration (SAMHSA) missions in relation to their recommendations, since each entity plays an important role in research and service delivery. Both of these entities have roles in translation activities for evidenced-based substance use disorder and addictions treatment. I compliment the workgroup on using a systems-level approach to their recommendations and references.

The workgroup's general introduction to the problem illustrates a central concern for the addictions field: the infrequent use of EBPs for addiction treatment. The workgroup expresses a valid and true criticism of the field. The Institute of Medicine (IOM) highlighted this concern in multiple reports, which state that “the challenge of the health care system is to provide safe, effective, patient-centered, efficient, equitable, and timely services.” With the passage of the ACA, that challenge has never been more important. In light of these changes to the healthcare system, it is vital to reduce the gap between research and practice in real world settings. Consequently the workgroup's recommendation that “validated research protocols and treatment manuals that improve identification and treatment of substance use disorders have impact only if they are scalable, translated, widely implemented in practice, and sustainable” has never been more true.

The workgroup highlighted the deficiencies of the current addiction treatment system. They correctly identified problems such as poor integration with health care systems, poor uptake of best practices, and inadequate records and reporting systems.



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The five recommendations that the workgroup outlines are necessary to further the up-take of evidence-based practices in a more seamless and timely manner so as to address the goals outlined by the IOM, “to provide safe, effective, patient-centered, efficient, equitable, and timely services”. These recommendations followed by action items are encouraging.

### Recommendation 1: Create a New Entity for Translation and Implementation Science Within NIDA to Help Bring Its Scientific Findings on Treatment Efficacy Into Broad Practice

On its face value the recommendation seems to restate the essential purpose of NIDA. However, as the workgroup points out, translating scientific research into broadly applied treatments and services differs significantly from bench research. While NIDA has expertise in the important and necessary basic research and clinical trials, purposely seeking new expertise in translation and implementation is a worthy pursuit. The action items the work group suggests mix NIDA’s current strengths with new expertise that should tackle the current gap in research to practice.

### Recommendation 2: Establish NIDA Guidelines for Funding Consideration of Treatment Development Research Projects that Consider the Potential for Implementation, Adoption, Scalability, and Sustainability in Various Practice Settings

This is an essential recommendation in that it is important to “put your money where your mouth is.” We must dedicate resources to specifically fund translation and implementation research in and of itself. The workgroup outlined a harsh truth, “some interventions that have strong scientific support have little or no chance of being adopted in the real world, in part because there has been insufficient consideration of implementation potential.” I think that providers feel this the most when considering implementing an EBP. Most providers have the authentic desire to help the people they serve and have a willingness to serve them better, but at times the very interventions that would achieve this are not only costly to implement but maybe cumbersome in the day-to-day operations of a facility. Facilities are often pulled in a million directions with administrative requirements, shrinking funding streams, and an underpaid and aging workforce.

### Recommendation 3: Establish Systems-Based Research Networks within Naturalistic Settings to Evaluate Intervention Effectiveness, Adoption and Sustainability in Practice

This is a forward-thinking recommendation that will allow for new ideas and innovations to come into the process, especially with an evolving healthcare system. This recommendation also addresses an absent consideration in the current research environment. All too often a major barrier to the uptake of an EBP is



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the very system that is trying to adopt it. Therefore, systems-based research networks seem like an essential recommendation. It is laudable to include a revamping of the way NIDA addresses implementation to include evaluation that could look specifically at adoption, scalability, and sustainability of EBPs within real world settings. The action items of including networks that shift from traditional addiction treatment programs is not only needed but necessary in the ACA environment, since the current treatment systems only address a fraction of the people who could benefit from services. I applaud the recommendation to seek new more naturalistic settings such as FQHCs, EAPs, Accountable Care Organizations, college campuses, and schools, as outlined in the action item section to create service networks that can learn from one another.

### Recommendation 4: Target Funding to Expand the Grant Portfolio for Implementation Science

As I mentioned in my response to Recommendation 2, to move ahead with a translational and implementation science research portfolio, NIDA has to dedicate financial resources in order to advance the knowledge base and develop practical mechanisms to shorten the research to practice gap and bring effective treatments to scale. The workgroup members write that the operational definition of implementation science is to “establish a knowledge base about the ways evidence-based substance use disorder treatments are being utilized in practice settings and systems as well as the optimal methods to promote adoption into healthcare policy and practice”. The recommendations put forth in this report indeed set a path for NIDA to realize this definition, especially if NIDA is explicitly funding an implementation portfolio.

### Recommendation 5: Establish a Recurring NIDA-Based Peer Review Panel Charged with Evaluating Research Applications that Focus Specifically on Advancing Rapid Adoption of Evidence-Based Interventions

The fifth and final recommendation is again essential if NIDA is serious about shortening the research to practice gap. This recommendation, if fully realized, would represent an innovation in substance use research. The workgroup committee recommends that a “specific science of rapid translation and adoption of evidence-based findings for drug use disorders” is pioneering.

I found this report to be a forward thinking piece, a document that I have on my desk for the purposes of citing in my own writing or to guide my thinking. Most of the recommendations are meaningful and relevant to the current state of addictions research and treatment. In fact these recommendations are essential in light of the changes to healthcare as a result of the ACA. The recommendations are visionary of the future direction of addiction research and treatment, a direction that we must progress towards for the next decade and beyond. Finally, the action items that the workgroup proposes are measureable and most are accomplishable.



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## **A Vision for Implementation Science at NIDA: Questions of Gain and Loss**

**Hannah K. Knudsen, PhD, University of Kentucky**

The recent report, *Adoption of NIDA's Evidence-Based Treatments in Real World Settings*, makes clear that the reach of interventions developed and tested with funding from NIDA has been limited. It is important to realize that this "implementation gap" is not unique to NIDA-funded research. The implementation gap is ubiquitous across a range of health conditions and delivery contexts, as evidenced by the standing program announcements across a range of NIH institutes for dissemination and implementation research.

In thinking about the translation of evidence-based practices into routine use, one important distinction may be useful to consider before examining the recommendations contained within the report. Because NIDA is not a funder of drug abuse services (roles largely housed within the Substance Abuse and Mental Health Services Administration and the Center for Medicare and Medicaid Services), it would seem that its focus should be on the science of implementation, rather implementation as an end unto itself. It strikes me that the critical issue is less whether NIDA has succeeded or failed at achieving implementation of evidence-based interventions developed with its funding, but rather whether NIDA is supporting research on strategies for increasing implementation and studies of the barriers that are blocking greater implementation. It is through this lens of implementation science that I approached the recommendations within the report. Of the five recommendations, I was most struck by three of the recommendations upon which I would like to focus:

- Recommendation 1: Establish a new entity for translation and implementation science within NIDA to help bring its scientific findings on treatment efficacy to broad practice.
- Recommendation 2: Establish NIDA guidelines for funding consideration of treatment development research projects that consider the potential for implementation, adoption, scalability, and sustainability in various practice settings.
- Recommendation 5: Establish a recurring NIDA-based peer review panel charged with evaluating research applications that focus specifically on advancing rapid adoption of evidence-based interventions.

Large complex organizations, such as NIDA, necessitate the subdivision of the organization into units consisting of specialty areas, and thus, it is logical to consider the value of a new entity within NIDA as the locus of its translational research (Recommendation 1). The establishment of such an entity would also signal to the field that NIDA values translational research that seeks to advance our scientific understanding of implementation processes. There is also pragmatic value in that it signals that such research is a funding



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priority. It may be useful to look to other NIH institutes and how they have approached developing entities to oversee this type of research. The National Cancer Institute (NCI) has clearly embraced translational and implementation science for both its focal disease and by leading efforts to broaden the field of implementation science regardless of specific disease. NCI houses an abundance of online resources related to noteworthy dissemination and implementation science: <http://cancercontrol.cancer.gov/is/>.

Establishing guidelines for funding that include implementation potential may be more challenging than it initially appears (Recommendation 2). Consider this question: If this approach had been taken in the late 1990s, what research would not have been funded? Some of the significant research on pharmacotherapies may not have been funded if implementation potential had been required. With the exception of methadone maintenance programs, treatment at that time was largely delivered in specialty facilities that often lacked access to physicians. The legislative changes in the DATA Act of 2000 had not yet occurred, so physicians in private practice were limited in their ability to prescribe medications to treat opioid dependence. By the implementation potential criterion, there is a real question whether, for example, clinical trials of buprenorphine would have met this threshold based on the legal context and service delivery system at the time. Sometimes treatment innovations may be ahead of the delivery system, making it difficult to anticipate which interventions can be taken to scale.

It is also an open question whether implementation science itself is advanced enough that we can reasonably predict whether a novel intervention will be implemented. Implementation science itself as a discipline is relatively young, with a major edited volume on this emerging science being published last year (Brownson, Colditz, & Proctor, 2012). Rigorous tests of the effectiveness of implementation strategies (i.e., specific approaches to promote the use of evidence-based practices) remain relatively rare in the NIH portfolio. Implementation science is a nascent field, which will make it difficult to predict with much certainty and specificity the implementation potential of interventions. It seems to me that guidelines, if they are too rigid, may be premature, but that program announcements could convey to investigators that they should be reasonably attentive to implementation and scalability when describing the significance of their research.

At the same time, I can appreciate that the development of interventions without any consideration of the realities of the treatment system may not represent the most prudent investment of limited funding resources. There may be benefits in bringing health economists and experts in human engineering to the table earlier in the intervention development process. The challenge is that those experts, and the resulting data collection activities needed to support their analytic work (e.g., cost-benefit analyses, etc.), come with their own costs and may mean making trade-offs for the overarching research design. A related question is whether current funding mechanisms, which have not been adjusted for inflation in many years, can support both the scientific



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resources needed to rigorously test the effectiveness of the intervention under development and this broader scope of work within the same project. My experiences as a grant reviewer suggest that it is possible but can be challenging.

Finally, there is intuitive appeal to the notion of establishing a NIDA-based peer review committee. NIDA has a lengthy history of such review panels, although they have been less common in recent years. Such a panel would give NIDA more oversight over the review process and may address concerns that substance abuse-related implementation research has struggled within the standing Dissemination and Implementation Research in Health study section managed by the NIH's Center for Scientific Review (CSR).

At least two key questions should be further considered. First, does the drug abuse field have the depth of expertise in the theories and models of the emerging field of implementation science to fill such a panel? This is a question for which I do not know the answer. Second, do we risk reinforcing the ongoing silo-ing of drug abuse as something that is not viewed as a disease like the others? Will perspectives from the broader field of implementation science (i.e., theories and methods being tested for other conditions and other service contexts) be lost, resulting in our scientific contributions having less impact?

These are just a few of the questions that arose when I was considering these recommendations. From my perspective, it can be a useful thought exercise to consider how different the research landscape would look if these recommendations had been implemented in the past, as well as what may be gained or lost if these recommendations are implemented in the near future. I can appreciate the desire to have NIDA's research make the largest possible public health impact. Implementation science may be an important vehicle for maximizing these public health benefits, particularly if our research in drug abuse is engaged in the broader scientific discourse about strategies for improving the quality of care through greater use of evidence-based practices.



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## Lost Hope for Dissemination and Implementation Research in the NIDA Clinical Trials Network

Steve Martino, PhD, Yale University

I read with great interest the National Advisory Council on Drug Abuse Workgroup Report, *Adoption of NIDA's Evidence-Based Treatments in Real World Settings*. In particular, I was curious about what the workgroup members had concluded about the Clinical Trials Network's (CTN) success in moving the results of its trials into the hands of community treatment programs, thereby serving as an entity for evidence-based practice dissemination. Indeed, this was one of the CTN's original primary aims. The workgroup concludes that the CTN "was not positioned to conduct system-level implementation research nor can it be repositioned or reorganized to do so, given its history, structure, and personnel (p. 10)".

There had been two potential avenues for the dissemination and implementation of evidence-based practices in the CTN – one hopeful and one hoped-for. The hopeful avenue began in 2001, in large part through the CTN's participation in the National Institute on Drug Abuse (NIDA) - Substance Abuse and Mental Health Services Administration (SAMHSA) Blending Initiative and its close involvement with the Center for Substance Abuse Treatment's (CSAT) Addiction Technology Transfer Centers (ATTC). The hoped-for avenue was that the CTN would provide a program network ripe for dissemination and implementation research—the desire of many of the participating investigators and program directors. What happened?

*The sudden disappointment of a hope leaves a scar which the ultimate fulfillment of that hope never entirely removes.* – Thomas Hardy

Developed in 2001 by NIDA and SAMHSA and directed by NIDA's Office of Science Policy and Communications, the Blending Initiative melded science and practice together to improve substance use disorder treatment (see Condon, Miner, Balmer, & Pintello [2008]). Its primary goal was to accelerate the adoption and implementation of research findings from the CTN trials and other NIDA-funded treatment studies into community-based practice through the development of blending products and accompanying training programs. In brief, a systematic process was used for this purpose in which blending teams consisting of researchers, program providers, and ATTC technology transfer experts developed the products and executed associated strategic dissemination plans. Strategic plans involved making blending product materials widely available through the ATTCs, training regional trainers for some products, and launching interactive websites as resources for continued learning, technical assistance, and information exchange.



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The bulk of the work occurred largely through the ATTCs, in collaboration with the CTN's Research Utilization Committee, the latter functioning as the formal locus for blending product implementation activities solely within CTN-participating programs (see Martino et al., 2010).

To date, blending products based on interventions tested in the CTN have promoted the adoption of buprenorphine for illicit and prescribed opiate treatment, motivational incentives (also called contingency management), motivational interviewing, and program-based HIV rapid testing. Hence, in 14 years since the CNT began, only four blending products have materialized from the 32 CTN research protocols that have been completed, a relatively small return on the investment made in the CTN and relatively little to show for the transfer of research results from its trials to community program providers and their clients.

Adding salt to this wound is the lack of information about the degree to which these products are utilized across the country, or if those trained as trainers of the products continue to provide training and technical assistance in the field. Moreover, there is no data that demonstrates the blending products result in adoption of evidence-based practices or the faithful implementation of them in real-world settings. While some efforts are underway to address these shortcomings (e.g., our NIDA-funded trial testing the effectiveness of the blending product to support the implementation of motivational interviewing [R01 DA023230; PI: Martino]), there is no current evidence that blending products are being used or improving the transfer of evidence-based practices into community treatment programs.

Finally, funding for the Blending Initiative has been substantially reduced over the years, diminishing the resources and personnel now devoted to this effort and the ability to address the shortcomings noted above. Moreover, the responsibility for the Blending Initiative now resides within the CTN rather than directed by NIDA's Office of Science Policy and Communications and formally shared with SAMHSA/CSAT/ATTC. This shift has weakened the NIDA/CTN-SAMHSA/CSAT/ATTC partnership that was the hallmark of the Blending Initiative. These structural changes stands in contrast to the tenets of well-respected implementation models of evidence-based practice that the CTN had once largely embraced (e.g., Dean Fixsen and colleagues' [2005] synthesis of the implementation research, Dwayne Simpson's [2002] program-based technology transfer approach, and Everett Rogers' [2003] diffusion of innovations theory).

*He that lives upon hope will die fasting. – Benjamin Franklin*

The CTN originally aimed to conduct pharmacological and behavioral treatment trials to determine the effectiveness of drug abuse interventions within diverse community treatment programs and patient populations. A large national network of community treatment programs arose, including an infrastructure for developing protocols in a bidirectional manner between community-based researchers and service providers.



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Participants in the CTN quickly saw the opportunities the network afforded for dissemination and implementation research trials. Access to multiple sites, diverse provider and client groups and organizational structures and processes, and existing collaborations with community program partners to facilitate research practices were just a few of the many attractive features.

In contrast to the Workgroup's recent conclusions about the CTN's current state of affairs, the CTN had been very well positioned to conduct system-level implementation research, and it missed its opportunity to do so. Several efforts were made to put forth proposals to study how best to train providers or identify and address organizational issue that might influence the rate and quality of evidence-based practice adoption. However, the NIDA CTN leadership clearly defined these types of studies as outside the scope of the CTN and told investigators to look for funding to support dissemination and implementation proposals elsewhere. Rather than moving the CTN in the direction of effectiveness to implementation science research (two steps forward), it began to use the network of programs to test the efficacy of new treatment options in addition to the effectiveness of already established ones (one step back). The potential for the CTN to systematically study processes and factors that could lead to the widespread use of evidence-based practices was lost.

Despite the strategic decision to exclude dissemination and implementation research in the CTN, hope springs eternal for dissemination and implementation research elsewhere in NIDA via its Health Services Research Branch. It is a relatively young discipline and ripe for the influx of early career scientists who might build and sustain the field (Stamatakis, Stirman, Melvin, & Brownson, in press). Most recently, NIDA issued a Request for Information seeking "comments from a broad range of stakeholders on the research and information needed to support the widespread use of evidence-based drug abuse treatment interventions and practices" (<http://grants.nih.gov/grants/guide/notice-files/NOT-DA-13-014.html>). Bridging the gap between research and practice was the original impetus to the formation of the CTN (cf. IOM, 1998). The CTN dropped this important ball of its mandate. We are now back to the future. Hopefully, this time NIDA will invest in an alternative structure to the CTN that establishes a research network where dissemination and implementation research is welcomed and will flourish.



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## **42 CFR Part 2 as a Major Legal Barrier to Implementation Research at NIDA**

**Dennis McCarty, PhD, Oregon Health & Science University**

**Tim Hartnett, CODA of Portland, Oregon**

The Affordable Care Act can be a catalyst for integrating addiction treatment into patient-centered primary care medical homes. The NIDA workgroup report, *Adoption of NIDA's Evidence-Based Treatments in Real World Settings* therefore, encourages implementation research to address the unique needs within medical care settings. At the same time, the report cautions that the federal alcohol and drug confidentiality regulations (42 CFR Part 2) inhibit the integration of addiction treatment into medical settings and asserts the need for modification to support implementation of treatment interventions for substance use disorders (SUDs) into routine medical care.

The confidentiality regulations were initially promulgated in 1970 to implement protections required in the Comprehensive Alcoholism Prevention, Treatment and Rehabilitation Act (also known as the Hughes Act). The Comprehensive Act authorized the creation of the National Institute on Alcohol Abuse and Alcoholism, created the National Advisory Council on Alcohol Abuse and Alcoholism, required the identification of a state alcoholism authority, established federal formula grants for states, required state plans for treatment and prevention, encouraged hospitals to admit alcoholics, and funded research. Finally, it protected the confidentiality of patient records, with these protections designed to encourage individuals struggling with alcoholism to seek care with the assurance that the treatment would be confidential. 42 CFR Part 2 prohibits disclosure that an individual is in care or has been in care unless the patient signs a consent authorizing the release of the information for a specific reason and to a specific person. The regulations effectively prohibit routine release of information to physicians, inhibit inclusion of addiction treatment information in electronic medical records, and isolate addiction treatment programs.

Although the health care system has changed dramatically since 1970, 42 CFR Part has not been amended to reflect current electronic technology and did not adequately anticipate today's efforts toward increased integration with medical care. This barrier is of great significance for at least in theory, electronic health records can alert medical practitioners to a history of alcohol and drug use disorders, facilitate better care, and reduce adverse events related to medication interactions with buprenorphine and naltrexone prescriptions. Further, the Health Insurance Portability and Accountability Act (HIPAA) substantially increased the confidentiality of all medical records and arguably eliminated the need for a separate confidentiality standard for addiction and alcohol problem treatment records.



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A casual assessment of the landscape for healthcare reform, however, finds little potential for legislation or litigation to change 42 CFR Part 2. Specialty addiction treatment centers are segregated from medical settings and the complexities of complying with the confidential regulations discourage integrated care. The standards promote the status quo and inhibit change. Specialty addiction treatment centers seem to use the regulations to resist evolution and change. Unfortunately, they also miss the opportunities created within the Affordable Care Act. Oregon provides a case study.

## Oregon Case Study

The innovative Oregon Health Plan (Medicaid) is a national leader in healthcare reform. State legislation (passed with bipartisan support) authorized Coordinated Care Organizations (CCOs) to manage care for Medicaid recipients. CCOs (similar to the Accountable Care Organizations in the Affordable Care Act) integrate physical and behavioral health care in a single point of accountability (a patient centered primary care medical home) to increase access to care, control healthcare costs and improve health outcomes. Global budgets and shared savings promote quality of care rather than quantity of care. The locally governed, regional coalitions of health care providers and community stakeholders assume financial risk. Medicaid resources, previously separated for behavioral health and primary care services, are merged. Integration with primary care promotes access to and utilization of services for alcohol and drug use disorders. Integrated funding fosters incentives for primary care teams to incorporate behavioral health specialists to address alcohol, drug and mental health disorders. Healthcare organizations and practitioners share cost savings. CCOs are accountable to their membership and include consumers in the organizational governance. Financial performance standards and quality of care metrics monitor CCO performance.

Beginning in August 2012, the Oregon Health Authority authorized 15 regional CCOs (see website for details <http://www.oregon.gov/oha/OHPB/Pages/health-reform/certification/index.aspx>). A review of the applications suggests little change in the organization and delivery of addiction treatment services in Oregon. Most CCOs plan to subcontract with local addiction treatment services and purchase care on a fee-for-service basis. A few propose integrated behavioral healthcare specialists who triage patients with suspected alcohol, drug and mental health disorders into specialty care. In interviews, CCO leaders report concerns about 42 CFR Part 2 as a barrier to more integrated care.

As a result, few of the addiction treatment centers are major players in their regional CCOs. They miss the opportunity to manage population-based care, promote screening and brief intervention, and develop services to help patients manage chronic alcohol and drug use disorders. As long as care is provided on an episodic fee-for-service basis, addiction treatment centers are unlikely to share in savings achieved through reductions in utilization of emergency and inpatient services. There is little incentive to change.



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Oregon has also implemented an All-Payer All-Claims database to provide a population-based perspective on access to and utilization of care among residents and to enhance system management to reduce disparities. The database could provide a comprehensive analysis of the population burden of alcohol, tobacco, and drug use disorders. Currently, however, because of concerns with 42 CFR Part 2 some health plans have refused to submit claims for alcohol and drug treatment and the Oregon Health Authority has excluded those claims from the public use data file. Oregon is missing the opportunity for a more complete understanding of how alcohol and drug use disorders interact with other health problems and the burdens they impose on systems of care.

## Implementation Science Proposal

If 42 CFR Part 2 is a barrier to system evolution, what are the options? Implementation science and implementation research may be part of the answer. Integrated care for alcohol and drug use disorders may be the leading implementation research challenge facing the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. The NIDA workgroup report recommended creation of a systems-based research network to study intervention effectiveness, adoption and sustainability. The first challenge for the network is an assessment of the impact of integrated electronic health records. Within the context of a research protocol it may be feasible to integrate addiction treatment data into the patient health record. Research can investigate the positive (e.g., better health care) and negative (e.g., loss of confidentiality) results associated with the integrated electronic health record. The research could document the continued need, if any, for 42 CFR Part 2 protections and delineate the benefits and risks of integrated health records.

The NIDA workgroup recommended construction of a new research network. The National Drug Abuse Treatment Clinical Trials Network (CTN), they felt, was not structured and staffed to support implementation science. The CTN, however, has matured into an adaptable infrastructure with multiple linkages to service systems. They can rapidly recruit investigators and study sites and conduct a large scale test of electronic health records within integrated systems of care.

The leadership to challenge the continuing need for 42 CFR Part 2 is not going to come from the Substance Abuse and Mental Health Services Administration, the Legal Action Center, existing treatment providers, or patient advocacy groups. NIDA can support the research that could be the basis for modification of these standards (perhaps in partnership with NIAAA, SAMHSA, and major foundations) and assure an unbiased analysis of the data. The addiction treatment field needs to know – do the safeguards created by 42CFR Part 2 enhance or inhibit access to care, utilization of care, quality of care, coordination of care and confidentiality of care? Answering this question must be a priority for NIDA's portfolio of implementation science research.



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## Repeating the Mantra in Splendid Isolation

**Paul M. Roman, PhD, University of Georgia**

The report, *Adoption of NIDA's Evidence-Based Treatments in Real World Settings* (September 2012) generated by a NIDA-appointed workgroup (WG) is an ironic document. It offers what appear to be extremely valuable “micro-observations” about needed change within the various operating Divisions of NIDA, but in its principal recommendations consist of suggestions that I believe would move both research and practice in a backward direction. A further irony is that it uses the theme of integration repeatedly in multiple contexts, and ends up promoting segregation and isolation. Thus I conclude that the report ultimately contributes little to progress in that part of health services research concerned with the organizational changes entailed in the adoption and implementation of new treatment practices.

Like many such government “reports” it is in a twilight zone of publication: not “really” published as a printed document, and presently not known to be advertised on lists of Government Documents available to inform the public or the research community. Being “not quite” a statement of policy, it nonetheless reflects the received knowledge of a distinguished group, and evidently was screened in some manner for legitimacy before becoming available. Nonetheless, with the context of current Internet technology, it is readily available to anyone who wants to find it. In such a context, its short or long term influence is unknown.

As such, the document is another in a long line of castigations of the organizations and personnel in the US involved in the treatment of substance use disorders (SUDs). If one wants to believe that this specialty is rife with incompetence and mismanagement, this report joins a multitude of others, some with the imprimatur of highly prestigious sources. The critical visions of nearly all of these documents are clouded by a failure to understand at least three key facts:

- The relative newness of the SUD treatment specialty in the health care delivery system (together with its current marginality in that system)
- The lack of understanding of treatment within the general population and among potentially supportive constituencies;
- The importance to nearly every treatment organization of effective cost management on a day-to-day basis in order to survive as an organization (otherwise known as the absence of “organizational slack”)

In addition, there is the unchallenged premise that there is not “enough” quality in SUD treatment.



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Compared to what? Compared to whom? Compared to when? Yardsticks are practically never offered. And indeed, when a few boundary-spanners have looked closely at conformity with evidence-based practices (EBPs) in other medical specialties, they almost invariably find parallels with the alleged “backwardness” of SUD treatment.

The basic premise of the WG is based in a very significant social movement to gain bureaucratic control over the practice of medicine in the US. Over the past decade or so, an extremely effective campaign has almost institutionalized the idea that in order to achieve excellence in quality, health care delivery must consist of the best EBPs that the provider can identify. It is not a new idea, but an activation of what was formerly a passive assumption.

Certain sets of needed services in human societies have long been delegated to specialists who receive from society the status of professionals. Core to the professionals’ societal assignments are their particular “mandates,” definitions of the content and boundaries of their fields of practice. Within the boundaries of their mandates, it has long been assumed that professionals had complete autonomy in their choice of strategy and tactics and of tools and techniques. Rules for making such choices were enveloped in professionals’ training and acquired talents, but composite judgments based on experience and knowledge rather than recourse to rules. Nonetheless, use of and payment to these professionals was centered largely on this core of decision-making, which could not be replicated by the “laity,” including everyone who did not have the particular professional mandate.

In this context, there were only two categories of “deviance.” First was when those without a mandate posed as members of a profession and were punished when their fraud was detected. Second is malpractice, nearly always defined by an injurious outcome that is linked to negligence or misconduct. Malpractice is not defined by rules, but by a complicated combination of implied standards subject to negotiation and judgment in the context of litigation.

The walls around the professional mandates of the various practitioners of medical care have been breached. Standards for practice are yielding to measurement, which is the core technique of bureaucratic social control. Without measurement, bureaucratic rules cannot be enforced. The insistence on the use of EBPs is transforming from an assumption about behavior “inside” the professional mandate into an active standard that will have external bases for judging conformity and thus defining quality.

This is more than a principle; it is a pervasive ideology, the effects of which have spread into every sector of health care practice. Institutionalization is best described when a norm or practice seems “natural,” is “taken for granted,” or if challenged, generates surprise. Institutionalization usually takes a long time. Our best example



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is right in front of us, namely the institutionalization of the idea that “addiction” to potent substances requires or deserves the response of medical care. It is easy to see that (at least in the US) treatment for SUDs is not yet fully institutionalized. A great deal of what most researchers and practitioners are doing every day in this specialty is more or less geared toward further institutionalization of “the treatment response” to SUDs.

But, as a sort of supreme irony, while SUD treatment itself is not institutionalized in the larger society, the expectation of the presence of EBPs in SUD treatment has indeed come close to reaching that level within the SUD treatment and research specialties, as is well demonstrated by the WG report. The mantra about inadequate use of EBPs in SUD treatment is sustained by the WG report, oddly using a descriptive overview from SAMHSA’s N-SSATS survey rather than reviewing the substantial literature on diffusion and adoption developed by NIDA’s grantees. This oddity derives from the fact that the WG evidently sees itself exempt from its own admonitions about using an evidence-base as a guide for quality practice, in this case using a survey from a semi-commercial vendor rather than peer-reviewed research in their attempt at advocating for a change in NIDA policy.

The WG’s core recommendation is that NIDA set up its own shop to study adoption and implementation. In many ways, this fits the cliché of re-inventing the wheel, although in this case it would come at a substantial expense, borne by the research community who are now in a zero-sum game in competition for scarce NIH funding. This supports a subtle admonition for the continued isolation of the SUD research and treatment enterprise, isolation reflected in the struggle for SUD treatment to become mainstreamed into overall health care. Instead of attempting to draw upon what others have done and are doing, the WG recommends that NIDA “go it alone” in developing its own highly specific portfolio of research on implementation. One might observe that if SUD treatment does not or cannot adhere to the principles involved in the delivery of other health care, what is the point of mainstreaming it?

In addition to giving almost no attention to the work of NIDA’s health services research grantees, the WG shows little recognition of the existence of theoretical and research specialties focused on communication, dissemination, and organizational change found in universities, libraries, journals and within NIH itself. Indeed, as the report implies, one will find a relatively sparse set of conclusions if one looks through the published literature for implementation studies focused solely on SUDs. That’s where the art of generalization and conceptualization comes in.

There is an abundance published literature relevant to questions related to implementation and sustainability of change and new practices within organizations. It will take substantial effort to review that literature from the lens of SUD treatment, but such an effort would seem to be the clear starting point rather than attempting to re-invent a new research subspecialty with a singular application to issues related to SUD treatment.



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Perhaps of even greater concern is the understatement of how the SUD research and treatment enterprise within NIDA could effectively link with and become integrated into what appears to be a massive enterprise in translating research from bench to bedside throughout the NIH. Not only is this found within the National Center for Advancing Translational Sciences which is essentially a new NIH institute centered on clinical translation across all disorders of interest to NIH, but which houses a massive national project guiding the 60+ Clinical and Translational Science Awards. While the WG makes mention of NIDA “interacting” and “partnering” with efforts on implementation that are already Federally funded, its core recommendation is to set up a new organization within NIDA, with its own NIDA-oriented expertise and its own NIDA-based grant review committee, by definition “siloes” from these other endeavors and consistent with the isolationism that has long characterized the SUD research and treatment specialty.

The research work of interest here has been partly addressed by NIDA-funded scientists, which the WG decides for some reason to ignore. Perhaps more importantly, the research that needs to be done is best addressed by those in the scientific specialties of communication and organizational change, which is not directly related to research on SUDs. The WG is suggesting that NIDA move beyond its core technology of conducting high quality research on SUDs and recruit its own personnel for developing a specialty brand of “implementation science.” When the parent organization of NIH is already investing so heavily in these issues and when resources are already scarce without even considering the impact of extant and future Federal budget cuts, the WG’s recommendations seem far out of step with reality. That the recommendations are driven by a culture of insularity and isolation is only an hypothesis, but an hypothesis that is remarkably credible in light of the scope of research activity relevant to the focal production that is already underway and doubtlessly accessible within NIH itself as well as in the literatures of organizational management and communication.

As mentioned, the extent of adoption and use of EBPs in SUD treatment may be seen as very slow, or very fast, but without a clear standard, neither conclusion makes any sense. On the basis of my own research experience, I believe that the WG largely neglects three other considerations that are vital to future implementation of new ideas.

First, while in many ways remarkable, the EBPs offered to the SUD specialty are not blockbusters in the sense of offering revolutionary cures to suffering people. Many of the clinical trials oriented toward SUD treatment find only marginal effects of EBPs. As introductory methods classes always tell us, statistical significance does not equal substantive significance. Many of these clinical trials, if not most of them, find a robust effect of “treatment as usual” that is the control condition.

This can be read as saying that conventional practice may be close if not equal in effectiveness to new practices. Emphasizing this point here is not to “put down” the new practices, but to empathize with practitioners



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who, viewing these findings or their honest translation, are not going to be easily convinced that the cost of change (in the broad sense) is really worth it.

Second, and closely related, NIDA has offered the field very few high quality cost-benefit and cost-effectiveness studies regarding EBP adoption and use. Generally, when managers of treatment programs are considering a minimal or large scale adoption of an EBP, they have no tools to answer the questions of whether this adoption will “pay off.” Instead it seems that managers are offered value statements that imply a greater research base equals “better,” or offering “more” is better. In contexts of severe economic strain, these arguments are often not adequately compelling to lead to change. Little is found in the WG’s report to support attention to this crucial barrier to change.

Third, adoption of new ideas in the marketplace is driven by demand. While there seems to be more than enough documentation that treatment providers are not demanding many of the proffered EBPs, or are not demanding them enough, what about the wishes of treatment clients, their families, and their significant others? While huge sums are invested in educating about the adverse effects of drug and alcohol use, close to nothing is invested in education about treatment. Again, we have more than enough documentation that people who seem to need SUD treatment will not use it, but this is blamed on “stigma” or the unavailability of care. Is treatment attractive? Is it credible? When clients do eventually get to treatment, are they adequately educated to ask for what specialists call EBPs? Will they accept a treatment that they do not understand? Will they accept using a substance to deal with the substance that got them into trouble in the first place? These are core questions, and only those with expertise in SUD research and treatment are equipped to address them, but again this key issue receives no attention from the WG.



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