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SCIENCE-BASED STRATEGIC APPROACHES TO DISSEMINATION

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There has been a widespread reluctance to aggressively assemble, analyze and disseminate what is, in fact, known. . . . Leaving local initiatives to painstakingly make these discoveries on their own, or to never make them at all, has been a wasteful process and will interfere with further progress in spreading these initiatives. . . . Most wasteful of all has been the absence of well-funded, concerted attempts to learn systematically from current experience and to disseminate that learning to those responsible for community-change initiatives, to those who make relevant policy in the private and public sector, and to the general public. (Schorr, 1997, p. 370)

Many currently available, science-based drug abuse treatment approaches are not yet widely used by community-based treatment agencies, yet, if effectively disseminated, these research-based technologies have the potential to improve the quality and impact of treatment services, especially in a time of tight resources and increasing demand.

In all areas of health and human services there is a substantial gap between research and practice. This has been documented for various types of

drug abuse treatment programs, such as those for methadone maintenance (D'Aunno, Folz-Murphy, & Lin, 1999; D'Aunno & Vaughn, 1995; Etheridge, Craddock, Dunteman, & Hubbard, 1995; Higgins, Budney, Bickel, & Badger, 1994; McLellan et al., 1994; Silverman et al., 1996; Simpson, Joe, & Brown, 1997; Widman et al., 1997). It is equally true for science-validated drug abuse prevention methods (Backer, 2000b). Examinations in virtually every other field of education, social service, and community development reveal similar types of gaps, as the opening quote by social and public policy analyst Lisbeth Schorr makes clear.

Lamb, Greenlick, and McCarty's (1998) study, which was conducted for the Institute of Medicine, identified some important dimensions of this gap specific to drug abuse treatment: structural barriers, such as regulations constraining what treatment approaches may be used in publicly funded programs, financial barriers, insufficient training and education of practitioners to implement new practices, and inadequate attention by researchers to the complex challenges of dissemination. Research-based dissemination strategies from various fields can help identify and close these and other gaps. Such methods have been well discussed in the drug abuse literature (Backer, 1991; Backer, David, & Soucy, 1995; B. Brown, 1998) but often are not used to maximum impact.

SCIENCE-BASED PRINCIPLES OF DISSEMINATION

Dissemination of innovations in any field is inherently a social phenomenon, influenced by the real and perceived characteristics of the innovation (including the cultural beliefs and prejudices of particular groups—such as drug abuse treatment counselors or their clients), the methods by which dissemination occurs, and the organizational or community environment in which the effort to introduce the innovation occurs (Rogers, 1995). More than 80 years of empirical study about how to promote dissemination of innovations, leading to change at the individual, organizational, and community levels, has confirmed four basic principles that underlie successful dissemination efforts (this literature has been summarized by Backer, 1991, and Backer et al., 1995):

1. *User-friendly communication.* Information about the innovation and its relevance to potential adopters must be communicated effectively, in user-friendly, easily accessible formats.
2. *User-friendly evaluation.* Evidence must be available indicating that the innovation is effective, works better than available alternatives, and doesn't have significant side effects; this information must also be communicated effectively to potential adopters.

3. *Resource adequacy.* Sufficient human and financial resources must be available to implement the innovation effectively in new settings.
4. *Addressing the complex human dynamics of change.* Potential adopters must be able to handle the human dynamics of change associated with innovation adoption, by rewarding change activities and involving those who will have to live with change in designing how the innovation will be implemented and by helping adopters overcome their fears, resistances, and anxieties.

These fundamental principles have been confirmed in research specific to drug abuse treatment. For example, Sorensen et al. (1988) demonstrated through a 6-year empirical study funded by the National Institute on Drug Abuse (NIDA) that site visits and conferences are more effective than print materials and other traditional forms of education in promoting dissemination of innovations in drug abuse treatment facilities; their impact is enhanced through creating lively partnerships with state drug abuse authorities (Lipton & Appel, 1984).

Treatment-focused dissemination efforts must also address the perspectives typical of treatment personnel. For instance, Backer, Brown, and Howard (1994) highlighted the importance of constructing dissemination efforts for treatment personnel that respect their personal experiences with addiction. V. B. Brown and Backer (1988) identified a number of active-directive teaching methods that drug abuse personnel prefer for learning about new technologies.

Shortfalls between knowledge and action in the adoption of worthwhile treatment innovations occur for reasons quite similar to those that make it difficult to change individual behavior related to substance abuse or other types of health-related behavior. Incentives to change; resistance to change; and many other technological, organizational, and human factors significantly influence the outcome of efforts to change behavior. This is true whether the behavior is avoidance of street drugs by a recovering cocaine user or adoption of a new treatment technology by a community-based program for heroin addicts.

PRACTICAL DISSEMINATION STRATEGIES DERIVED FROM THESE PRINCIPLES

The complexity of change needed to successfully introduce an improved drug abuse treatment method into one or more treatment settings and communities suggests that scientists, practitioners, and community leaders need to work together in disseminating science-based drug abuse

treatment strategies to the treatment field. The four science-based principles for effective dissemination just cited provide a conceptual base from which to design such collaborative interventions, but the knowledge base also provides some more specific strategies for dissemination, which I present here with some briefly stated current examples.

1. *Interpersonal contact.* To get an innovation used in new settings, there needs to be direct, personal contact between those who will be adopting the innovation and its developers or others with direct knowledge about the innovation. For instance, in November 2000, NIDA and the Robert Wood Johnson Foundation (along with local sponsors) cosponsored a conference in Los Angeles, "Blending Clinical Practice and Research: Forging Partnerships to Enhance Drug Addiction Treatment," which brought together some 800 researchers and practitioners to discuss these issues face to face over several days (this is in contrast to most professional conferences, which draw only one audience or the other). A similar conference—"Common Ground, Common Language, Common Goals: Bringing Substance Abuse Practice and Research Together"—was held in April 2001 (also in Los Angeles), cosponsored by the Robert Wood Johnson Foundation; the University of California, Los Angeles's (UCLA's) Integrated Substance Abuse Programs; and the Center for Substance Abuse Treatment (CSAT). Both conferences appeared to be successful in promoting an exchange between drug abuse researchers and practitioners about issues in dissemination (M. Douglas Anglin, personal communication, May 16, 2002).
2. *Potential user involvement.* Everyone who will have to live with the results of the change that adopting an innovation requires needs to be involved in planning and implementing the adoption effort. Inclusion of all players is needed, both to get a range of suggestions for how to undertake the adoption effectively and to facilitate "felt ownership" of the new program or activity (thus decreasing resistance to change). For example, Richard Rawson at the UCLA Integrated Substance Abuse Programs helped to organize a consortium of researchers and practitioners who have worked for several years on the dissemination issues specific to drug abuse treatment in south central Los Angeles, including those related to African American culture (M. Douglas Anglin, personal communication, May 16, 2002).
3. *Planning and conceptual foresight.* A well-developed strategic plan for how an innovation will be adopted in a new setting,

including attention to possible implementation problems and how they will be addressed, is essential to meet the challenges of innovation adoption and sustained change. Part of the work of the south central Los Angeles consortium just mentioned has been to create such plans for disseminating and implementing science-based treatment programs in this community.

4. *Outside consultation on the change process.* Consultation can provide conceptual and practical assistance in designing the adoption/change effort efficiently and can offer useful objectivity about the likelihood of success, costs, possible side effects, and so on. PROTOTYPES, a comprehensive service program for drug-abusing women and their children in southern California that includes several residential treatment facilities (see chapter 15), organized a Systems Change Center that has identified science-based treatment strategies (targeting multiply vulnerable women) and now regularly brings in consultants who can help PROTOTYPES and its community partners wrestle with the complex issues of getting these programs implemented (Vivian B. Brown, personal communication, May 16, 2002).
5. *User-oriented transformation of information.* That which is known about an innovation needs to be translated into language potential users can understand readily—abbreviated so that attention spans are not exceeded and are made to concentrate on the key issues of “Does it work?” and “How can I replicate it in my setting?” The Drug Abuse Treatment Outcome Study Web site (<http://www.datos.org>), for instance, presents findings from this comprehensive research program in interactive-friendly formats not only for scientists but also for students, treatment counselors, and the general public. Practitioner-oriented videos on science-based treatment methods created by NIDA and CSAT serve as good examples of user-oriented transformation; so do print and online documents such as CSAT’s Treatment Improvement Protocols and Technical Assistance Publications (M. Douglas Anglin, personal communication, May 16, 2002).
6. *Individual and organizational championship.* An innovation’s chances for successful adoption are much greater if influential potential adopters (“opinion leaders”) and organizational or community leaders express enthusiasm for its adoption. Championship can also be provided by what Rogers (1995) referred to as “change agents”—individuals who are actively involved in promoting the process of dissemination itself. The ongoing efforts to introduce levo-alpha-acetylmethadol (LAAM) into treatment programs for heroin addicts contain many examples

of both positive and negative championship. Treatment program administrators often have resisted efforts to disseminate this science-based treatment innovation because they fear that its administration will be burdensome or that their counselors or clients will resist because of inaccurate but widespread misbeliefs about LAAM (Rawson, Hasson, Huber, McCann, & Ling, 1998). On the other hand, one clinic director successfully forced a switch to LAAM after his clinic was raided by the police because clients were selling their methadone on the street, and his "championship" ultimately proved effective (M. Douglas Anglin, personal communication, May 16, 2002).

Drug abuse researchers and their collaborators in communities (practitioners, clients, and community leaders) can explore together how these six practical strategies might be applied for a particular treatment innovation in a particular setting. For additional inspiration they can also look beyond methods already validated by the science on dissemination and beyond the drug abuse treatment field itself.

NEW AREAS FOR EXPLORATION

In addition to the science-based principles and strategies just presented, there are some emerging areas of science and community practice that could open new avenues for closing the gap between research and practice in the drug abuse treatment field.

- There is a growing knowledge base about how to create and sustain *partnerships* to promote effective dissemination and create change (Backer & Norman, 1998, 2000)—such as the researcher-practitioner partnerships emphasized in Lamb et al.'s (1998) study.
- The increased availability of *capacity-building* services and grant programs for nonprofit organizations (Backer, 2000a) provides opportunities for nonprofit drug abuse treatment agencies to strengthen their human, physical, and technological infrastructures in ways that make adopting new programs easier and their sustained success more likely.
- Recent behavioral and management science research offers a range of strategies for assessing and increasing the *readiness* of groups, organizations, and communities to participate in change (such as introduction of a new drug abuse treatment method); other research examines the opposite end of the adoption

spectrum, looking at ways to increase the *sustainability* of innovations, such as through early planning for long-term financing and ability to adjust to changing external circumstances.

- Dissemination strategies are being developed and tested in *other fields*—such as drug abuse prevention (Backer, 2000b), the larger field of health care (Sechrest, Backer, Rogers, Campbell, & Grady, 1994), the corporate world (Howard & Backer, 1998), and the work of private foundations (Backer, 1995, Backer & Bare, 1999)—that can themselves be transferred to encourage similar efforts in drug abuse treatment.
- The transition to *managed health care* in drug abuse treatment opens new options for financing and service systems change that could support dissemination of innovative treatment programs.
- Drug abuse research, such as that sponsored by NIDA, is concentrating increasingly on *applied research* methods that can be used to test and refine the application of evidence-based principles of dissemination to drug abuse treatment (e.g., clinical trials research, services research, and a new program focused directly on dissemination).

PARTNERSHIP STRATEGIES

Lamb et al. (1998) especially highlighted the critical importance to dissemination of creating and sustaining partnerships between researchers and community-based providers. They assessed a number of models for partnership in substance abuse research that have been tried in geographic areas (e.g., Iowa and the Navajo Nation), identified roles that funders of research and services can take to stimulate such partnerships both directly and indirectly, and addressed some of the challenges to making partnerships work (e.g., they seldom work if treatment agencies want to collaborate on research simply to obtain funds for expanding clinical services).

Lamb et al. (1998) also urged drug abuse research funders (such as NIDA) to look beyond substance abuse for learnings about how to create research–treatment partnerships. They give as an example of such “cross-fertilization” the National Cancer Institute’s Community Clinical Oncology Program.

An even larger perspective, on which Lamb et al.’s (1998) report touched but did not treat centrally, is to address the fundamental question of “What factors in its development and operation maximize the chances that a partnership will be successful over time?” Increasing evidence from research studies in substance abuse (Backer & Rogers, 1993), health care (Kreuter & Lezin, 1998), and many other fields (Backer & Norman, 1998, 2000) make it

clear that creating and sustaining partnerships is a complex process and that many partnerships fail.

For instance, in a recent study of multicultural coalitions in California (Backer & Norman, 1998), two of the most common threats to long-term sustainability of these partnerships were the failure to (a) address the frequent occurrence of burnout and departure of a coalition's charismatic leaders and (b) handle underlying racial and ethnic stereotypes within the leadership group of the coalition. Research-based innovations in substance abuse treatment need to be analyzed and custom tailored to fit different racial and ethnic groups (Alegria et al., 1994) as well as other special groups, such as people with disabilities (Backer & Newman, 1995), whose communities will be part of the partnerships.

Other evidence about factors that encourage partnership success comes from a recent study of collaboration strategies used by foundations with their nonprofit grantees, including drug abuse agencies' (Backer, 1999). This study concluded that funders need to provide training and technical assistance to grantees about the basic process of building and sustaining a partnership. They also need to issue clear guidelines for how a partnership should be set up and direct resources to sustain the collaboration process itself; it is not cost free.

Encouraging a well-crafted infrastructure to support partnerships among researchers and community treatment programs also is imperative. Two examples of infrastructure from related health service fields might be explored for their relevance to substance abuse treatment:

1. *San Francisco Bay Area HIV/AIDS Prevention and Evaluation Initiative*. This multiyear initiative brings together community-based AIDS prevention agencies; evaluation researchers from the University of California, San Francisco; and a consortium of 17 foundations for a team effort to develop, implement, and empirically evaluate AIDS prevention interventions. An evaluation of the initiative suggests that this three-way infrastructure works, but that its partnerships take time and are expensive, and that careful selection of partners and honest discussion among them help improve the quality of partnership (Northern California Grantmakers AIDS Task Force, 1998).
2. *Substance Abuse and Mental Health Services Administration (SAMHSA) Community Action Grant Program*. This funding initiative makes up to \$300,000 of federal funding available to plan and then implement a systems change intervention that will bring a validated innovation (including those in substance abuse treatment) into community practice. It begins by initiating a large-scale community planning process, with careful attention to issues of community readiness. Out of this

planning phase a partnership is formed to take responsibility for implementing the innovation. (For more information on this program, consult the funding agency's Web site: <http://www.samhsa.gov>.)

Such carefully designed, systems-level interventions are especially helpful when difficult innovations are being implemented, for example, those that face an unusual amount of either community resistance or professional skepticism. Methadone maintenance and LAAM (also discussed briefly earlier) are two research-based innovations in drug abuse treatment that seem to fit this profile, and they are discussed in chapter 7 of this volume.

Finally, the longer term success of dissemination transfer in drug abuse treatment will in part be dependent on introducing preservice (i.e., university-based) as well as in-service training on these strategies for drug abuse treatment personnel and for drug abuse researchers. This can be done through universities; through professional associations, such as the College on Problems of Drug Dependence; and through programs offered directly by NIDA or other funders.

NONPROFIT ORGANIZATIONAL CAPACITY BUILDING

Capacity building to strengthen the staff and infrastructure of community-based nonprofit organizations can significantly increase the chances of successful operation (Backer, 2000a). An increasing number of American communities have capacity-building services available to local nonprofits, supported primarily by private foundations. These include technical assistance on uses of technology for information management, building community partnerships, working with boards of directors, managing confidential information, fund raising, and so on. I (Backer, 2000a) identified a number of these programs, many of which provide comprehensive, assessment-based interventions that could also help nonprofits become more capable of addressing planned change efforts, such as those needed to identify, implement, and sustain an innovation.

Awareness of and direct contact with these capacity-building resources has yet to filter down to specific-focus nonprofits, such as the many nonprofit drug abuse treatment facilities in the United States. Yet research on dissemination suggests strongly that one main reason organizations fail to engage—or at least fail to engage successfully—in significant change based on innovations in practice they have identified is that they are too fragile, too disorganized, and too much preoccupied with day-to-day survival matters to engage strategically in change efforts. More systematic access by drug abuse treatment facilities to nonprofit capacity-building resources could help meet this challenge.

Capacity-building efforts are part of a national system for improving nonprofit management, including the ability to innovate and to respond to the demands of systems change. Elements of this system include 83 graduate-level nonprofit management training programs in universities, many additional undergraduate programs, more than 300 management service providers (community-based organizations that offer capacity-building services), and national and state associations ranging from state nonprofit associations to the national Alliance for Nonprofit Management.

READINESS AND SUSTAINABILITY

Oetting et al. (1995) emphasized that substance abuse innovations often fail not because they are inadequate but because communities are not ready to accept and implement them effectively. Therefore, assessing readiness, and intervening with communities to enhance readiness for the kinds of changes required by an important innovation such as a drug abuse treatment program, are action steps that can greatly increase the actual effectiveness of these programs. For instance, even the very best science-based treatment program may fail to get implemented if it encounters low readiness on the basis of not in my backyard resistance from the community. If community residents' fears about physical dangers or drops in property values are responded to effectively, then readiness for change can be increased.

Oetting et al. (1995) proposed a nine-stage model of community readiness for substance abuse programming. I (Backer, 1995) reviewed the larger literature in behavioral and management sciences on readiness for change and its implications for the drug abuse field. Kumpfer, Whiteside, and Wandersman (1997) developed a model of readiness assessment and enhancement specific to the substance abuse prevention field; most of its elements also could be used successfully by treatment agencies.

Sustainability of innovations is an issue that has been little explored in substance abuse or other fields, yet it is clear from both research and the "wisdom of practice" that many innovations do not last over time (Backer & Rogers, 1999), and if they do not, then the investment in dissemination strategy that led to adoption of these innovations may be largely wasted.

The existing empirical literature is mostly based on case studies. Glaser and Backer (1977, 1980) conducted two intensive investigations, both of which used case studies based on site visits of long-lasting, successful innovations (a program evaluation method and a community-based mental health service model). The results indicated that key factors in long-term sustainability were (a) adaptation of the innovation due to changing community circumstances or service needs and (b) availability early in the life cycle of technical assistance on enhancing long-term survival strategies.

In the drug abuse field, Gager and Elias (1997) tested a resiliency model for helping substance abuse programs survive in high-risk environments, using interventions focused on the resiliency factors similar to those found in children who thrive in high-risk environments. Goodman, McLeRoy, Steckler, & Hoyle (1993) described several efforts to develop measures of sustainability for health promotion programs. Studies such as these could readily be used to develop guidance for drug abuse treatment facilities about how to promote sustainability of innovations they adopt.

DISSEMINATION STRATEGIES FROM OTHER FIELDS

Expertise and methods of dissemination in other fields may be applied to improving such efforts in the drug abuse treatment field. Some of these applications include the following.

Applications From Drug Abuse Prevention

Strategies for implementing prevention innovations in high-risk environments (Gager & Elias, 1997), already discussed, are an example. This work suggests that evidence-based innovations can succeed even in challenging environments (troubled school districts in this case) but that strategically designed implementation is the key: linking the innovation to the mission and operations of school districts and schools, making programs visible and part of the culture, and having programs carried out by well-trained personnel using well-crafted materials. Approaches to diagnosing and enhancing organizational and community readiness, and a number of other dissemination-related strategies, all have been developed in the prevention environment and could be readily adapted to the treatment field.

Dissemination infrastructure in drug abuse prevention (see also Backer & Rogers, 1999) may also be reviewed both for its learning value and for some possible direct use to communicate treatment innovations. The on-line information systems of Join Together, a project funded by the Robert Wood Johnson Foundation, is just one prominent example. (For more information, visit the Join Together Web site at <http://www.jointogether.org>.)

NIDA funded Danya International and the Human Interaction Research Institute to develop an "action community" for promoting drug abuse prevention research dissemination. After issuing a publication summarizing innovations in a particular area—environmental approaches to substance abuse prevention—this effort's dissemination phase involves developing and operating an interactive Web site specially targeted to support the action community and providing funding support to four communities to implement environmental innovations, using the Web site and technical assistance to support their efforts. (For more information, visit <http://www.danya.com>.)

Applications From Health Care

Examples of dissemination strategies from the field of general health care include (a) computer-based decision support systems for new medical technologies, (b) communications about innovations disseminated through local opinion leaders in the medical community, (c) informal study groups for medical practitioners, and (d) site-based education in doctors' offices based on successful approaches developed by pharmaceutical companies (Bero et al., 1998; Davis, Thomson, Oxman, & Haynes, 1995; Greco & Eisenberg, 1993; Hunt et al., 1998; Oxman et al., 1995; Soumerai & Avorn, 1990; Soumerai et al., 1998). A review of literature by the VERDICT program (1998a), described further later in the chapter, summarizes the scientific evidence supporting the value of each of these approaches. In another VERDICT review (1998b), guidelines also were given for evaluating and understanding systematic reviews as a part of dissemination. The drug abuse treatment field also could take advantage of many of these programs now that they have been created by foundation and other sponsors.

Applications From the Corporate World

"Best-practices" systems (Howard & Backer, 1998) provide one example. Corporations such as Hewlett-Packard, Arthur Anderson, and Chevron have created computer networks with extensive best-practices databanks. These interactive systems (many of which are based in Lotus Notes software) permit employees worldwide to exchange information and opinions about best practices in a large number of subject fields. Some of these systems are quite extensive; for instance, Arthur Anderson's best-practices system has an annual budget of \$8 million for research alone (Howard & Backer, 1998). Best-practices systems also are being developed with increasing frequency in the nonprofit world (Backer & Bare, 1999).

Commercial consumer information systems also can be explored both for direct use and possible adaptation in the drug abuse treatment field. For instance, Medscape is an Internet startup company that provides free weekly online updates in summary form of the latest medical research and practice worldwide (see <http://www.medscape.com>). A searchable database is available for individuals who want the full text of articles or other details. Its membership includes more than 130,000 physicians and 150,000 laypersons. WebMD (<http://www.webmd.com>) is a similar consumer-oriented service with a large number of users. These systems already include information on drug abuse treatment research but could be modified to address dissemination issues more directly. Even more helpful would be a Web site specifically oriented to providing information on science-based treatment to practitioners, clients, and the public.

Applications From the Work of Foundations

Philanthropic organizations have developed several innovative programs, such as the Kaiser Family Foundation's approaches to creating health policy change through targeted dissemination of information to both policymakers and the general public, or the Dana Foundation's integrated system for promoting application of brain research findings (Backer, 1995). Another example, from the best-practices systems alluded to earlier, is the Robert Wood Johnson Foundation's Closed Grant Report System, which provides online access to well-written, concise summaries of final reports from the foundation's many grant projects, including a number of substance abuse projects (Backer, 1999). This system is accessible to both foundation staff and the public.

MANAGED CARE AND SERVICE SYSTEMS CHANGE

As drug abuse treatment evolves in a managed care environment, there are some advantages for future dissemination efforts. One is that the cost containment ethic of managed care can often overcome the traditional resistance to change such as that just described, *if* there is research evidence on cost advantage. Moreover, dissemination efforts in drug abuse treatment can through managed care systems be tied more directly to parallel efforts in the larger health care system (Sechrest et al., 1994).

The U.S. Department of Veteran's Affairs' VERDICT research brief (1998a) on this topic contains much from which professionals in the drug abuse field can learn—and much that can be used to convince skeptics within drug abuse treatment, because it comes from controlled studies in the medical field. For instance, in nine controlled trials, printed materials were found to have no significant effect in promoting actual change in clinical practice. Six randomized, controlled studies showed that traditional continuing medical education activities similarly had no impact on clinical practice change. Thus, the VERDICT brief concluded that the two most commonly endorsed approaches to disseminating new medical knowledge simply don't work—if actual practice change is the criterion. There is no reason to believe that drug abuse treatment is any different.

On the other hand, there is growing evidence in medical technology transfer that practice change does happen if there are changes in financing strategies; what is paid for tends to get used (Sechrest et al., 1994). The evolution of managed care may also afford new opportunities for testing and using this principle in drug abuse treatment, in part through collaborations with managed care organizations. The managed care initiatives of both CSAT and the Center for Substance Abuse Prevention may provide helpful

input on this topic (see SAMHSA's Web site, <http://www.samhsa.gov>, for more information).

Dissemination of drug abuse treatment innovations may also succeed by exploring applications that involve service systems integration, given the high rate of people with multiple vulnerabilities in the public system (Backer & Howard, 1998). Impact may be increased by developing dissemination strategies that attend to the larger context of ongoing change in communities and health care. *Information fatigue syndrome*, a new field of medical research, is just one sign that too much change can affect the capacity of a system to absorb a new technology, regardless of its merits or evidence of efficacy (Backer, 1998).

NIDA'S FUTURE RESEARCH PORTFOLIO

In the end, NIDA and other funders of research have a responsibility to address the issues of dissemination raised here through funding more research about how this complex process works in drug abuse treatment. I have suggested a good number of outside-the-box approaches in this chapter, but their application to widespread systems change in drug abuse treatment can be confirmed only through good research. Here are three examples:

1. NIDA's clinical trials program can address the issues of dissemination, perhaps using as an analogy CSAT's recently funded seven-site methamphetamine treatment research program, whose coordinating center is based at UCLA's Integrated Substance Abuse Programs. The coordinating center will explore dissemination approaches that can be woven into the research effort from its beginning.
2. NIDA's services research program can address issues of research-treatment provider partnership, within the larger frame of service systems change.
3. NIDA's own dissemination research program can examine new frontiers—such as the transfer of approaches from other health and social service fields, as discussed here. The power of the Internet in this realm also needs to be studied, with some of the themes identified by recent NIDA-sponsored projects, such as the Danya effort, mentioned earlier. It also can look at existing NIDA efforts, which seem to have been successful but have not been empirically evaluated.

NIDA's 1997 publication, *Preventing Drug Use Among Children and Adolescents*, is a prime example of a more user-friendly publication and one that has been extremely popular in the field. According to Susan David at NIDA (personal communication, October 6, 1998), it has been distributed

to more than 200,000 people and institutions—amidst much favorable reaction—or *buzz*, to use the Hollywood term. It is a success, but it is a limited success at this point, because no evaluation has been done of its effectiveness, and there is no strategically designed community campaign to extend its impact. Technology transfer research could help to address some of these unmet needs and provide confirmation that such an approach ought to be used more frequently in the future.

A modest first step, to help mobilize these new forces for promoting more effective dissemination of drug abuse treatment innovations, would be to gather together both treatment practitioners and scientists for a brainstorming conference that also would include representatives from each of the “other worlds” just mentioned. Ideas for further action generated from this conference could be pursued using existing funding sources (NIDA, SAMHSA, and foundations interested in substance abuse issues, such as the Robert Wood Johnson Foundation). Fundamental to the success of this or any other effort to close the research–practice gap is the creation of a truly equal partnership between researchers and practitioners, with two-way communication to identify challenges and opportunities related to effective dissemination.

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