Four Considerations for Dissemination of Intervention Innovations
Bruce F. Chorpita, University of Hawaii at Mānoa, Hawaii Department of Health
Brad J. Nakamura, University of Hawaii at Mānoa

The current paper offers four considerations related to Stirman, Crits-Cristoph, and DeReubis’s (this issue) insightful review on general theories relevant to the dissemination of psychological interventions and major obstacles associated with the dissemination effort. Readers are asked to consider (a) the notion that the dissemination of a psychological intervention is not equivalent to unidirectional product delivery, (b) the importance of examining local uncontrolled evidence alongside controlled research evidence, (c) design strategies to facilitate adapting evidence-based interventions for community settings, and (d) fostering working partnerships between laboratories and the communities.

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CONSIDERATIONS FOR DISSEMINATION OF INTERVENTION INNOVATIONS

The proliferation of well-designed, empirically tested psychological treatment manuals over the past 15 years has had a profound influence on research and training. However, the effects of these innovations on clinical practice have been disproportionately modest (e.g., Addis & Krasnow, 2000; Backer, 2000; Weisz, Donenberg, Han, & Weisz, 1995). Stirman, Crits-Cristoph, and DeReubis (this issue) provide a thoughtful and timely review of general theories relevant to the dissemination of psychological intervention technologies, and they point out some of the major obstacles that dissemination efforts face today. In so doing, the review by Stirman et al. serves as an important bellwether for further practice development in psychological service delivery. To complement their important contribution, the current paper offers four considerations related to the implementation of new practices.

**Consideration 1: Dissemination is Not Product Delivery**

Contemporary discussion of dissemination in the research and policy arenas often involves a metaphor of delivery, in which a new intervention technology is developed, tested, and subsequently “pushed out” to the practice setting. It is worth questioning whether this conceptualization might constrain our thinking in ways that ultimately are misleading or counterproductive. The ubiquitous notion that practicing clinicians need to be informed about evidence-based practice techniques might carry the inadvertent implication that clinicians are “empty vessels,” with little or no knowledge of effective practice. Although research generally does not support the effectiveness of usual care in clinical practice settings (e.g., Bickman, Lambert, Andrade, & Penalooza, 2000; Weisz et al., 1995), less is known about why these practices have failed to demonstrate positive outcomes. Possibilities include the following extremes: (a) clinicians use approaches wholly different from those supported by the evidence base, and (b) clinicians use the same techniques as those supported by the evidence base, with client or other context factors limiting outcomes. They also include such intermediate positions as (c) clinicians use largely the same techniques as those supported by the evidence base, but have made changes or adaptations (sequencing, timing, use of homework) that have attenuated their effectiveness, and (d) some clinicians use evidence-based treatments and get positive outcomes, while others use different approaches and get poor or negative outcomes, with a net result being a small or no effect size. At present, the research on the components of usual care practices is too limited to assume that position (a) is the correct stance for researchers and intervention developers to assume. Were we to discover that practices employed in the community somewhat resembled common strategies of evidence-based treatments, the implications are that training and dissemination could be quite different. For example, training might include a baseline assessment of current practices used in a system, with attention being focused mainly on supplementing or adding in the
missing features of evidence-based practices. As Stirman et al. point out, “training in the basic principles of a particular type of therapy and demonstrating its applicability to a variety of diagnoses may be more efficient and more clinically relevant than providing training for only one particular diagnosis” (p. XXX).

Overall, it is important to question the assumptions that technology and expertise flow only one way and that evidence-base practices should replace rather than supplement, or co-develop with, existing practices (e.g., Chorpita, 2002; Weisz, in press). Given that some positive but untested practices likely do exist in clinical settings, dissemination efforts should be considered in the context of a broader conceptualization of the evidence base, which balances both local practice evidence as well as the clinical literature. Weisz (in press) has recently written about this idea, outlining a model whereby clinicians and researchers pool their complementary expertise in a dialectical progression of intervention design. If nothing else, this approach is probably a healthy way to engage those who ultimately deliver services.

Consideration 2: There Are Two Kinds of Evidence
A second issue concerns the identification of whether and when dissemination of a new technology is warranted. The assumption that evidence-based practices should be disseminated into practice systems on a grand scale may represent an oversimplification of the problem of human service delivery and an overemphasis on one type of knowledge. Addressing this issue, Chorpita and Donkervoet (in press) articulated one example of the development of evidence-based strategies in a statewide mental health service system. This model emphasized the important balance between local, uncontrolled evidence (i.e., practice and system outcomes) and generalized, controlled evidence (i.e., scientific clinical trials), stating that the local outcomes can often take precedence over the research literature.

The implications can be illustrated with a specific example. Suppose a behavioral health system chooses to invest in the dissemination of evidence-based practice in its system. That system serves several thousand individuals with “usual care” services. A portion of those being served would be expected to demonstrate some clinical progress, perhaps 40% or more (Borkovec, Echemendia, Ragusea, & Ruiz, 2001; Eysenck, 1952). The system then switches its funding strategy to reimburse only three evidence-based treatments that it chooses to import and for which it can sponsor clinician retraining. Given that roughly 20–30% of individuals receiving evidence-based practices do not improve (e.g., Chambless, 2002), the odds are that some individuals who were previously improving in the system would be switched to the new evidence-based protocol and not improve. The odds are even greater that another portion of the individuals being served previously would now have no service available to address their specific problem area, given that the three newly imported evidence-based practices would not cover an exhaustive set of clinical targets. Thus, dissemination of innovative and promising treatments might not represent a true gain for the system.

Chorpita and Donkervoet (in press) argued that from a system perspective it is often important to consider the local evidence first and to turn to the research evidence second. That is, the careful and organized assessment of individual clinical progress provides a critical source of evidence. Only after that capacity has been developed is the question of dissemination worth raising, ideally with efficient direction of those practices supported by the controlled, generalized evidence at individuals that the system has reliably identified as failing to improve. Stirman et al. (this issue) raise similar points regarding the measurement of outcomes.

Consideration 3: Adaptation Should Be Possible
Rogers (1995) argues that adaptation or “re-invention” is a common part of the incorporation of an innovation. Arguments weigh in on both sides regarding the issue of adapting evidence-based protocols for clinical settings (Kendall, Chu, Gifford, Hayes, & Nauta, 1998; Chorpita & Donkervoet, 2001; Weisz, in press; Wilson, 1996). Whether and what type of adaptations might be needed to facilitate the dissemination of evidence-based practices probably cannot be answered given the current state of the literature. However, it is clear that the current models for intervention design do not produce interventions that can be easily scaled or modified to fit their eventual context, if such adaptations are in fact warranted.

Weisz (in press) articulated a model that carefully balances both sides of this argument. This Deployment
Focused Model posits that interventions should be subject to a cycle of repeated modifications and tests when implemented in a clinical context in order to “tune” the intervention for optimal results and compatibility with the system. This type of approach is likely to describe many of the future efforts to disseminate and re-engineer interventions as they move from the lab to the clinic. However, given the design structure of most evidence-based manuals, potential adaptations might pose significant challenges.

In response to this concern, Chorpita, Daleiden, and Weisz (2004) recently offered one model for intervention design—modularity—that would allow for the preservation of standardized protocol instructions when necessary but could also allow their efficient scaling or adaptation as needed. In general, this model or other innovative models of intervention design are needed, as they have the potential to facilitate the kinds of technological evolution that is a common part of diffusion and dissemination (Rogers, 1995). In other words, as Stirman et al. (this issue) point out, “innovations inevitably will change as they disseminate throughout a system” (p. XXX). In the case of manualized treatments, principles underlying pure-form psychotherapy protocols might need to be modified to accommodate such challenges as irregular attendance with therapeutic treatment sessions, managed-care limitations on the number of billable treatment sessions, patients’ reading or education levels, and other factors (Stirman et al., this issue).

Consideration 4: Homophily is Good; Partnership Even Better

Rogers (1995) suggested that aside from properties of the innovation (e.g., treatment manuals), properties of the change agent are critical moderators of the speed and extent of innovation diffusion. Primary among these dimensions is homophily, or the degree to which the change agent is similar to the dissemination target. We need not write here about all the ways in which academic intervention developers are different from community practitioners, as those differences are well known and often extensive. The field does need to be content with this issue, however, as no matter how appealing evidence-based technology is to practitioners (and it largely is not; Addis & Krasnow, 2000; Norcross, 1999), dissemination efforts will be enhanced if developers and users of practice technologies can begin to speak a common language.

Kendall (2002) offered an important illustration about the nature of social influence and working partnership in connecting research with the community. In that story, a new Ph.D. presented data to a school in order to solicit its participation in research. Another new Ph.D. met with a school, but presented less data and allowed for a casual discussion on the local community’s pastime of trout fishing. As the story turns out, the latter Ph.D. was invited to conduct research in the school, and the former was not. Whether fact or fable, Kendall’s illustration is clear about the importance of informal social networking and of establishing trust. Although a portion of intervention developers do successfully maintain such partnerships and connect their research with the community (e.g., Borkovec et al., 2001; Henggeler & Randall, 1999; Weisz, in press), more effort is needed to create a common understanding of shared ideas and values.

CONCLUSION

These considerations are meant to serve as a stimulus for thought and to supplement the excellent review of Stirman et al. (this issue). The exciting developments in practice technologies over the last 15 years have yielded a promising array of tools to promote human competency and alleviate suffering. To date, the collective efforts of clinical researchers in this regard represent a true technological marvel: We stand at a point in history where many effective strategies have been designed, tested, and catalogued. Nevertheless, much of the work to realize the impact of these important developments still lies ahead. Building on a solid theoretical framework such as that outlined by Stirman et al. is likely the place to which we should next turn our attention.

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REFERENCES


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