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LIVERPOOL JOHN MOORES UNIVERSITY

DEVELOPING A CULTURE OF QUALITY IN PREVENTION

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ACKNOWLEDGEMENTS

- Angelina Brotherhood & EDPQS Prevention Standards Partnership; Gregor Burkhart

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ABOUT THIS TALK

More questions than answers

- Researchers need to listen to professionals!

Feedback and discussion points welcomed

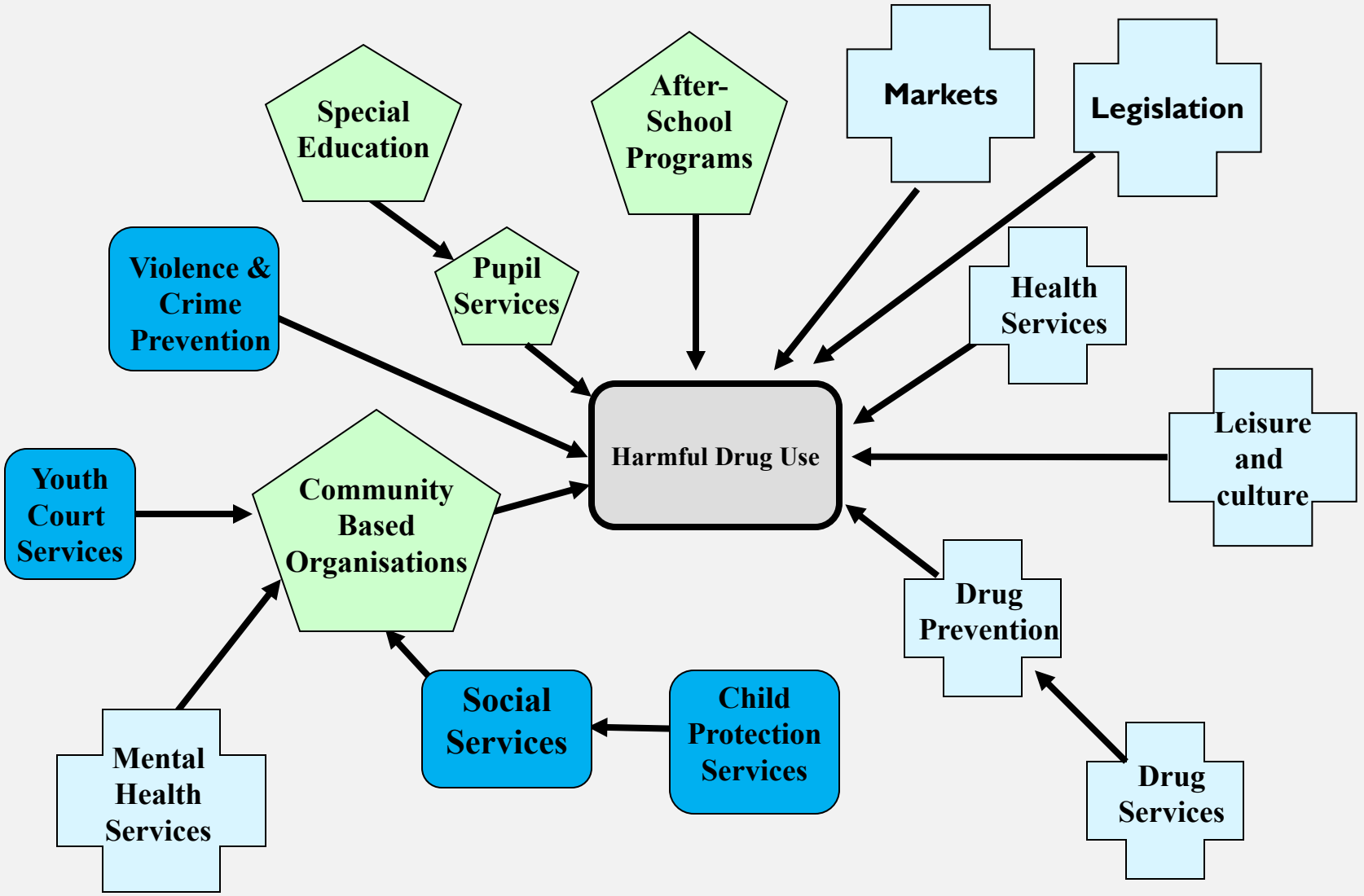
Based on experiences of undertaking the EDPQS project 2008-2015, and participation in projects such as SPAN, UPC, EUSPR, and domestic drug policy development

Background in substance use, but relevant to other fields…?

(SOME) CURRENT CHALLENGES FOR EU (DRUG) PREVENTION

Null effects or small effect sizes	Lack of evaluation and logic in most approaches	Evidence based repositories & 'Gold Standard' programmes	Diminishing effects of 'big name' programmes
Scaling up and embedding in routine practice	Austerity & lack of funding	Prioritisation of outcomes	Multiple risk behaviour approaches

Fragmented Policy ⟷ Fragmented Practices



Adapted from: *Health is Academic: A guide to Coordinated School Health Programs* (1998). Edited by E. Marx & S.F. Wooley with D. Northrop. New York: Teachers College Press.

KEY QUESTIONS

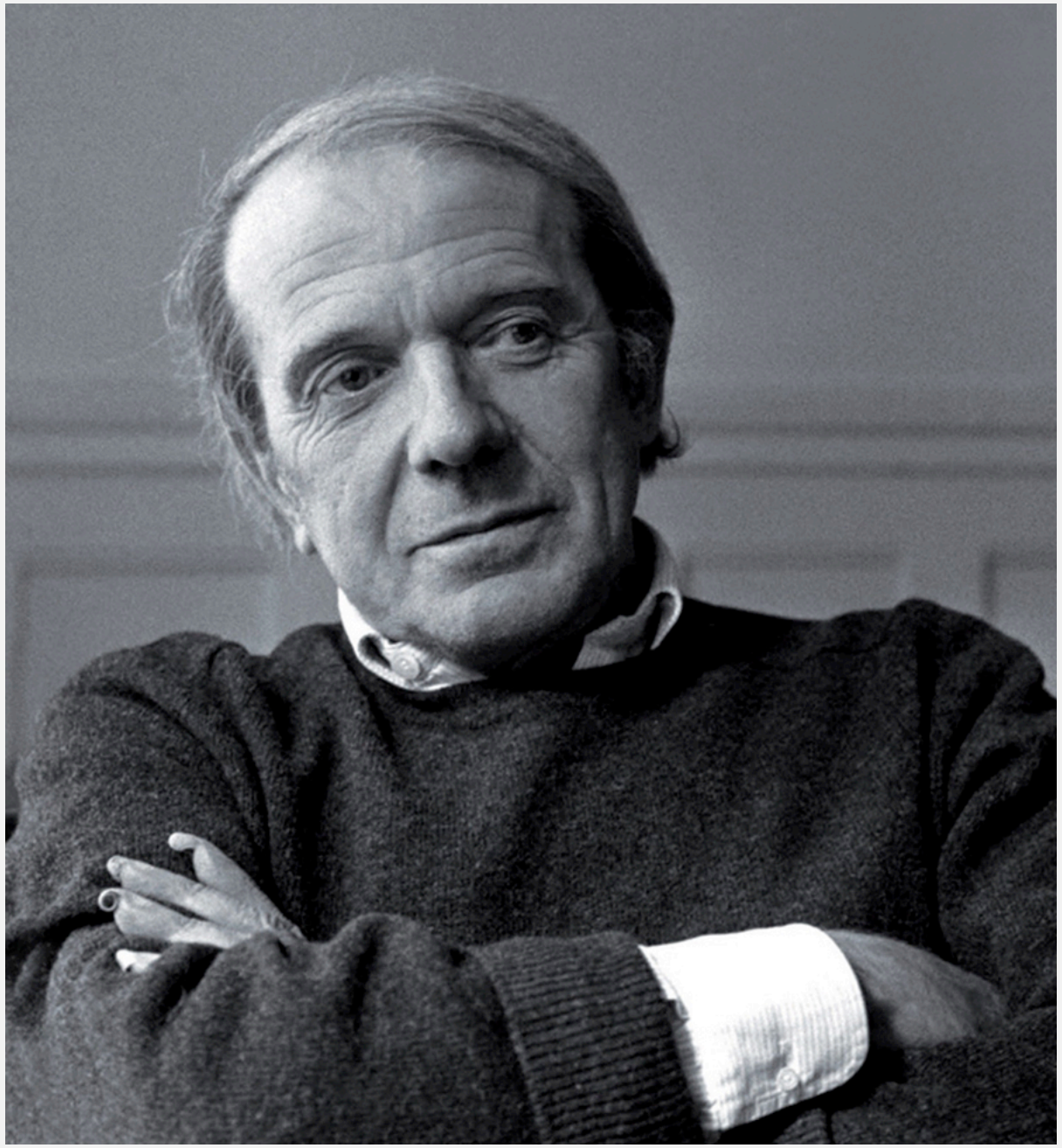
- **What is prevention culture?**
- **What is 'quality'?**
- Who are relevant actors in delivering change (professionals? target group? community?)
- What is a prevention system?
- **How might we begin to change culture?**

WHAT IS PREVENTION CULTURE?

No normative definition

→

"The product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that can determine the commitment to, and the style and proficiency of a workforce prevention system"



HOW HAS PREVENTION BEEN 'CONSTRUCTED' ?

- Prevention as an ideological 'litmus test' (Edman, 2012)
- Health and social problems to be handled by 'experts' and intervention, rather than political action (Roumeliotis, 2013)
- Structural forces vs individual responsibility in decision making
- Prevention as a way of governing society, defining problems (and 'problem people'), and reinforcing existing ways of acting (gendered and classed) (Farrugia, 2016)

Core beliefs maintain the unity of culture. Stories, rituals and routines, symbols, control system, and power and/or organisational structures are the manifestations of culture that result from the paradigm.

Most actions that seek to promote change concentrate only on the superficial or visible aspects of culture. Unless the central paradigm changes, long-lasting change will not occur.

Kuhn, 'The Structure of Scientific Revolutions' 1962

- Prevention culture is not just those standards, actions, and goals to which stakeholders attribute intrinsic worth, but also reflects broader and dynamic societal perspectives on health and social behaviour and how those individuals and groups that engage in such behaviours should be viewed and managed

- Professional cultures (or groups) can be targeted directly, but cultural change is better understood as a slow and dynamic process involving small changes on many different aspects over a longer period of time (including changes which may be outside of the control of prevention professionals and organisations)

(Brotherhood & Sumnall, under review)

WHAT DOES 'HIGH QUALITY' PREVENTION LOOK LIKE

IN EDPQS

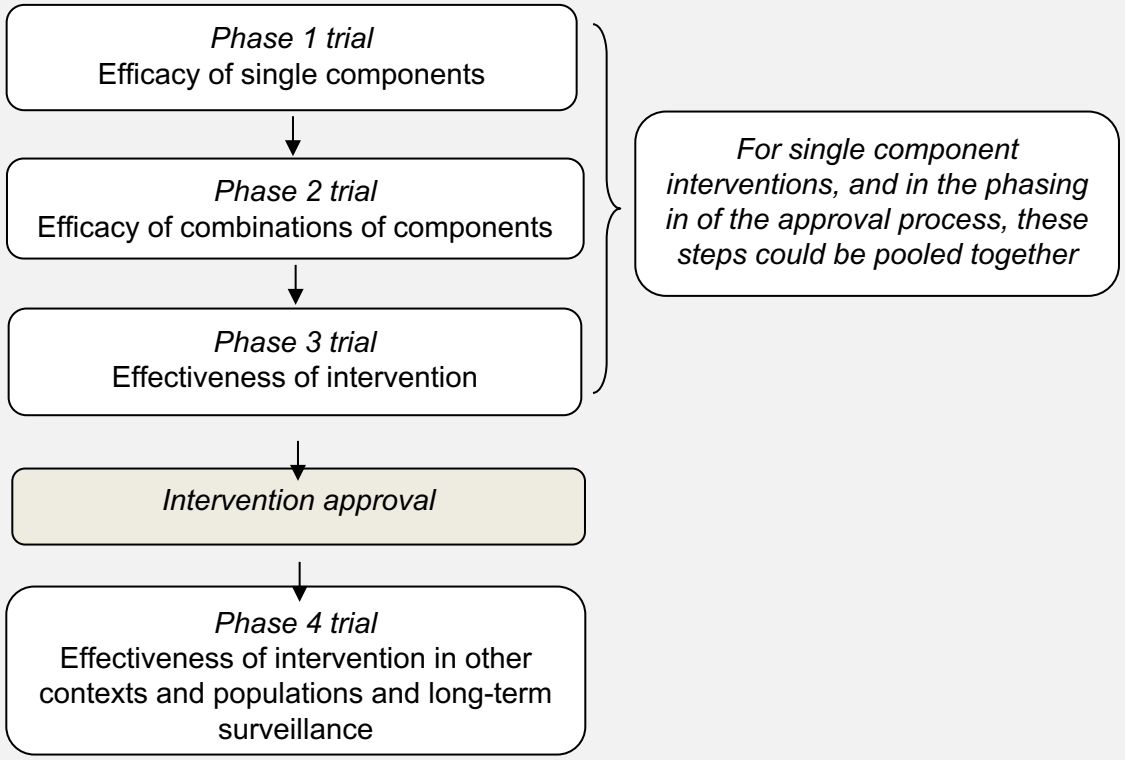
- Relevant to target populations;
- Make reference to relevant policy;
- In line with principles of ethical conduct;
- Make use of the best available scientific evidence;
- Generate evidence;
- Achieve specified objectives;
- Practically feasible;
- Sustained for as long as the target population requires it

DIFFERENCES IN WIDER PRACTICE?

- Relevant to acutely presented needs
- Help to achieve secondary outcomes
- Make reference to funding & commissioning priorities
- Responsive to public and political priorities
- Achieve monitoring objectives
- Utilise and value a range of (difference) evidence sources
- Sustained for as long as funding allows

MODEL FOR APPROVAL OF PREVENTION INTERVENTIONS

Figure 1 - Proposal for a four-step evaluation and approval process of prevention interventions for health-compromising behaviours



Faggiano et al., 2014

COMPONENTS OF 'QUALITY'

	Criteria							
List of registries	Evidence of efficacy	Quality of evaluation	Quality of programme goals	Quality of programme rationale	Quality of programme content and appropriateness	Quality of programme implementation methods	Educational significance[a]	Usefulness and replicability
Blueprints	Yes	Yes	Yes	N/A	N/A	N/A	N/A	Yes
Drug strategies: Making the Grade	Yes	Yes	Yes	N/A	N/A	N/A	N/A	N/A
ED List	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Maryland Report	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A
NIDA Guide	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A
SAMHSA National Registry of Evidence-Based Programs and Practices	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Youth Violence: A Report of the Surgeon General	Yes	Yes	Yes	N/A	N/A	N/A	N/A	Yes
EMCDDA Best Practice Portal	Yes	Yes	Yes	No	Yes	Yes	No	No
Dutch Recognition System	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes

Faggiano et al., 2014

SPAN

C. Professional development of the prevention workforce should be promoted across Europe, in multiple sectors, to bridge the significant gap between available and required knowledge, skills and competencies

- Institutions and organisations that employ the prevention workforce and give a high value to prevention science knowledge and skills should be recognised nationally and across Europe for their contribution
- Amongst the prevention workforce, in multiple sectors, there is a strong need to invest in comprehensive and recognised professional development activities and programmes.

SPAN SURVEY: COMPETENCES OF PREVENTION WORKFORCE

- Seniors assessing their colleagues:
  - 87%: basic knowledge on theoretical background and research findings
  - 64% to 75%: problem analysis / needs assessment, programme implementation quality and evaluation, ethics
  - 50%: advocacy for quality prevention
  - Significant gaps in all areas of prevention work, especially in **advocacy**, funding, management, and **prevention programme development** (Ostaszewski et al. 2017)

Slide courtesy of G.Burkhart

Training background (social work vs. psychology)?
Training level?
Professional bias
- regulation = "prohibition"
- norms = "fascism"
- evaluation = "unnecessary"
- evidence = "doesn't exist"
- nudging = "manipulation"
- manualisation = "evil"
- indicated prevention = "medicalisation"
- problem behaviour = "need for treatment"

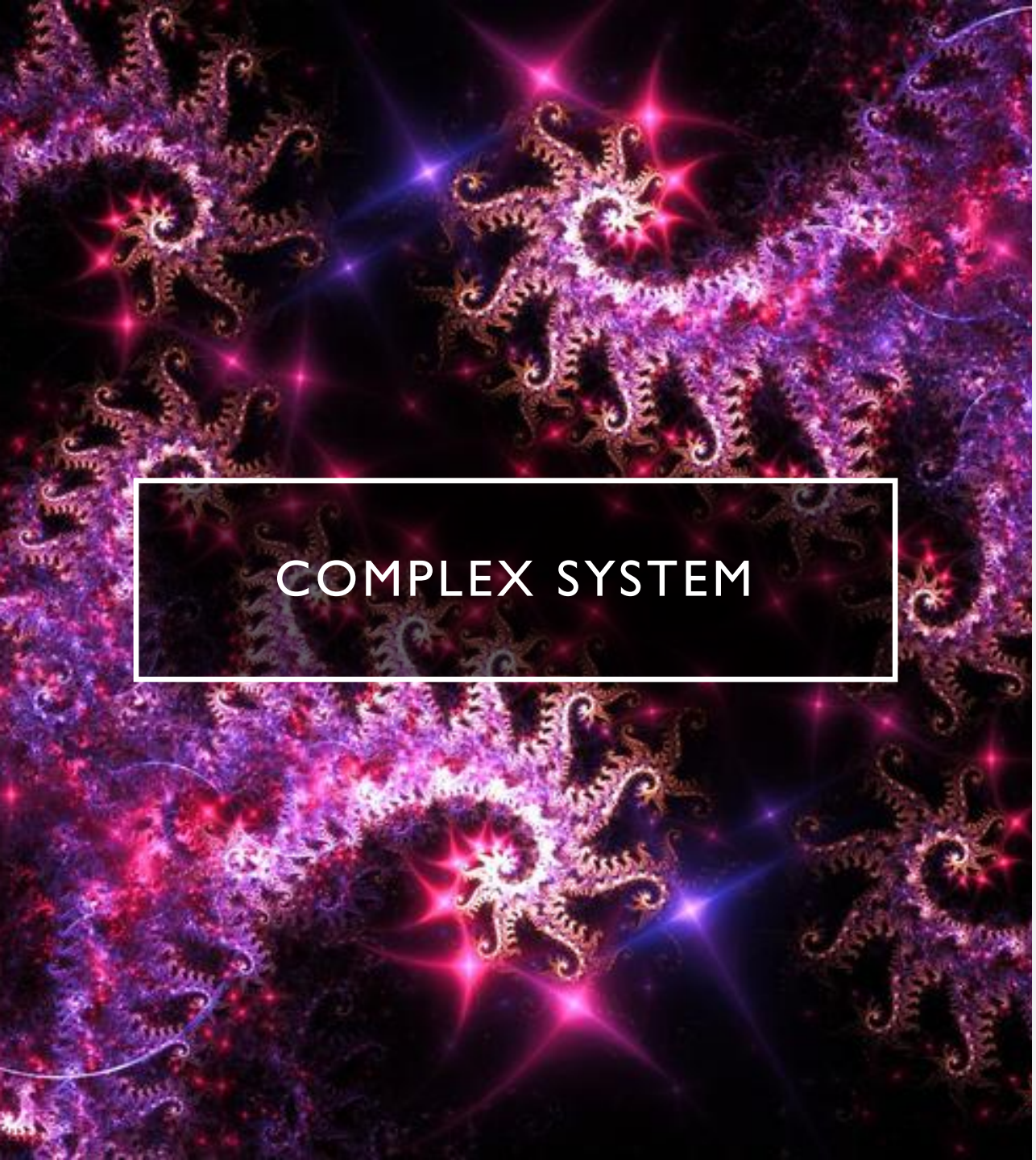
Graphic courtesy of G.Burkhart

STAKEHOLDER PERSPECTIVES

- Politics!
- Scientists often believe that science provides evidence based solutions for complex health issues
- Differences in understanding and value placed on traditional forms of 'evidence' for decision making and practice
- In the real world, many public health policies (and by extension prevention policies) are not 'evidence-based' in the sense that would be understood by scientific researchers
- The use and selection of 'evidence' in contested policy areas such as illegal drugs is rarely a neutral decision
- Policy making process itself defines what is acceptable as evidence, what disciplines and outcomes are eligible to be considered, and what research questions should be prioritised
- What has been implemented, and how it has been delivered?

Faggiano et al., 2014; Gottfredson et al., 2015; McKay et al., 2015; Oliver et al., 2015


CONNECT
BE ACTIVE
TAKE NOTICE
KEEP LEARNING
Give
TALK & LISTEN, BE THERE, FEEL CONNECTED
DO WHAT YOU CAN, ENJOY WHAT YOU DO, MOVE YOUR MOOD
REMEMBER THE SIMPLE THINGS THAT GIVE YOU JOY
EMBRACE NEW EXPERIENCES, SEE OPPORTUNITIES, SURPRISE YOURSELF
Your time, your words, your presence



COMPLEX SYSTEM

- A large number of nested, inter-connected elements, some of which are unknown; non-linearity of inputs, interactions and outcomes, including delayed, unexpected and unpredictable outcomes; self-organisation;
- 'Intervention points' that can be identified and influenced, but not necessarily controlled
- 'Counter-balancing' and 'reinforcing' loops
- Even if the system is not fully understood then there may be critical intervention points:
  - E.g. policy levers (e.g. national policy, standards), purchasing levers (e.g. funding mechanisms, accreditation and certification), data (e.g. evidence of effectiveness, available prevention activities), manualised programmes, prevention stakeholders, training structures, and professional networks

Hassmiller Lich et al., 2016


Media and culture
Police and criminal justice
Whole school policies
Alcohol prevention/ education
Pricing and marketing
Responses to alcohol
Treatment and intervention
Families and communities
Licensing
Environmental design

DO WE NEED CULTURAL CHANGE?

- Failure to translate research knowledge into policy and practice wastes resources and means that high risk populations are unable to receive the interventions and care that might most benefit them
- Lack of well-developed treatment and prevention systems to support the integration of scientific evidence with relevant policy, and delivery of services and actions, also presents significant barriers
- Quality standards and guidelines in the health field are aspirational
- Gap between research findings and recommended guideline actions
- Symbolic value of ‘evidence based’ approaches vs reality

EDPQS THEORY OF CHANGE

Input	Time, money, expertise regarding quality and quality standards, support from partner organisations and potential users of standards, supportive structures (prevention systems, professional cultures, political context)

⇩ ⇧

Activities	Development, translation and effective dissemination of quality standards, activities to support quality in prevention at the systems level

⇩ ⇧

Output	Quality standards and materials/workshops to support their uptake and use in practice

⇩ ⇧

Reach	Those involved in funding, managing, developing, implementing, evaluating or otherwise supporting drug preventive work

⇩ ⇧

Outcomes	Increased awareness, motivation and skills relating to quality and quality standards, as well as use of standards to develop and improve prevention activities

⇩ ⇧

Impact	Increased quality of preventive work, changes in professional prevention culture (i.e. poor quality no longer acceptable), better outcomes for target populations

PROFESSIONAL CULTURAL CHANGE - 3 STEP MODEL

Unfreeze
- Present equilibrium destabilised

Change
- Old behaviour discarded

Refreeze
- New behaviour adopted

Schein, 1996; Kim et al., 2016

ORGANISATIONAL CULTURE CHANGE: UNFREEZE–CHANGE–REFREEZE

- 'Unfreezing' difficult step
- Refreezing thus includes the development of a new self-concept and identity and the establishment of new interpersonal relationships
- 'Refreezing' misnomer – should be a dynamic process
- Is it a top down process – reduces acceptability
  - Pressure for change

Burnes, 2004; Kim et al., 2016

OPPORTUNITIES FOR CHANGE

- Research may *inform* change by:
  - Providing the necessary *evidence*,
  - *Trigger* change by providing a solution to a recognised problem,
  - ***Drive* change by directly involving those responsible for change.**
- Practice may *drive* change through:
  - A felt need (typically resulting from *crisis*);
  - Shared ownership of expertise – threats to the status quo and negating professional expertise and identity
  - Compatibility of existing structures; and/or
  - Effective stakeholder networks.

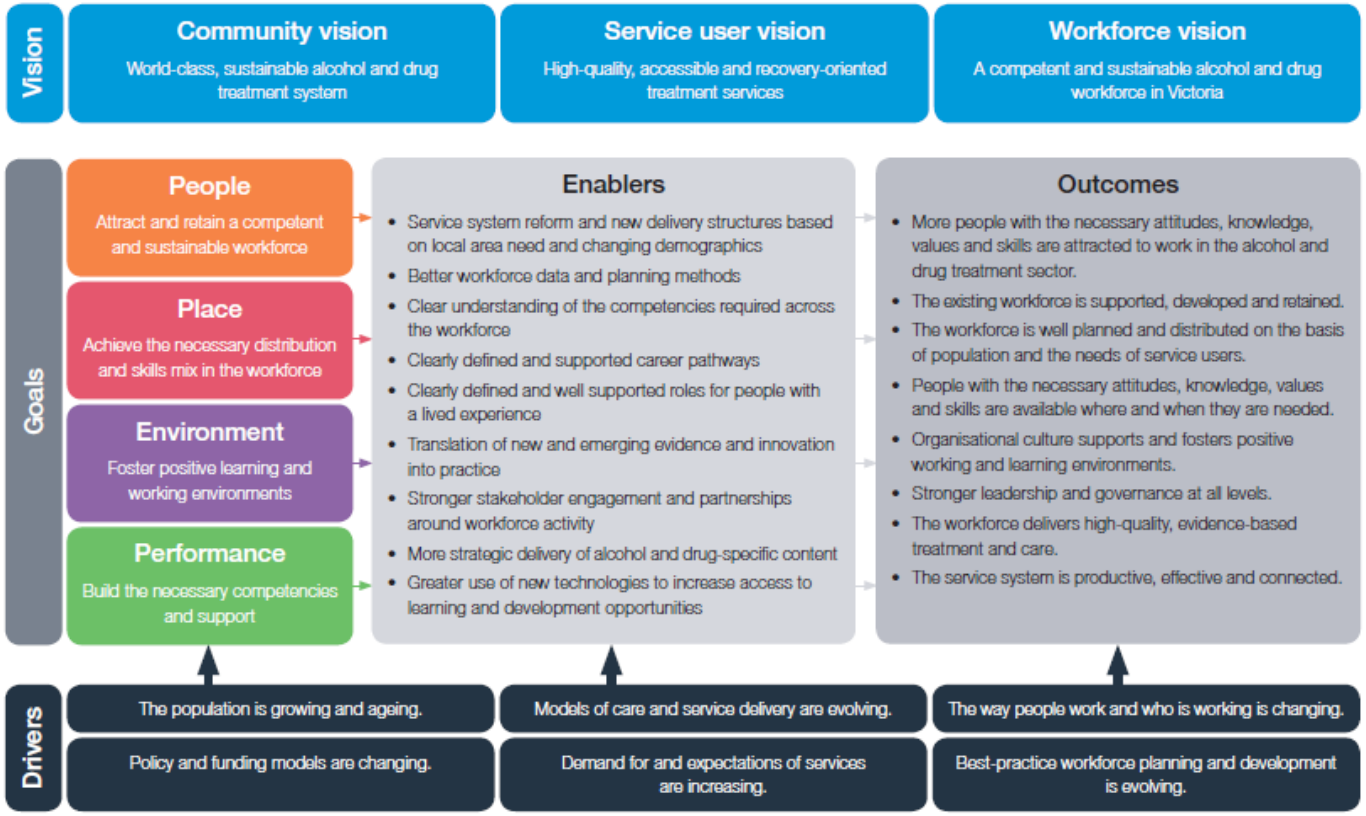
Bammer, 2015; Burnes, 2004

CONSIDERATIONS

- National & Local Drivers differ between sectors
- Little understanding of wider prevention systems (cf micro-systems and complex intervention systems)
- Researchers very rarely have a complete picture of the conditions and 'reality' of working in practice (and vice versa!)
- 'Time' is a luxury of academia that does not exist in practice
- Narrow operationalisation of change often limited to professional attitudes and beliefs

GOVERNMENT OF VICTORIA, 2012

A framework for change



QUALITY STANDARDS

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- Support organisations to work to the same outcomes
- Reduce unnecessary variability in delivery
- Useful evaluative tool
- Helps organisations demonstrate commitment to ‘quality’
- Supports decision makers in funding

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- Acceptability of developers
- Standardise language but don’t standardise practice
- Do not necessarily lead to improvements in outcome
- Resistance to change
- Without incentive, organisations work to achieve the minimum and no more

EMCDDA, http://www.emcdda.europa.eu/best-practice/guidelines

GUIDELINES

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- Usually based on high quality evidence – systematic reviews
- Powerful political tool
- The best have stakeholder involvement in development
- Can be applied at individual → community level
- The best leave space for professional judgement

-

- Inflexibility of evidence
- Vested interests
- How is efficacy established?
- Too many guidelines!
- Do guidelines and decision support tools take into account who will use them, for what purposes, and under what constraints?

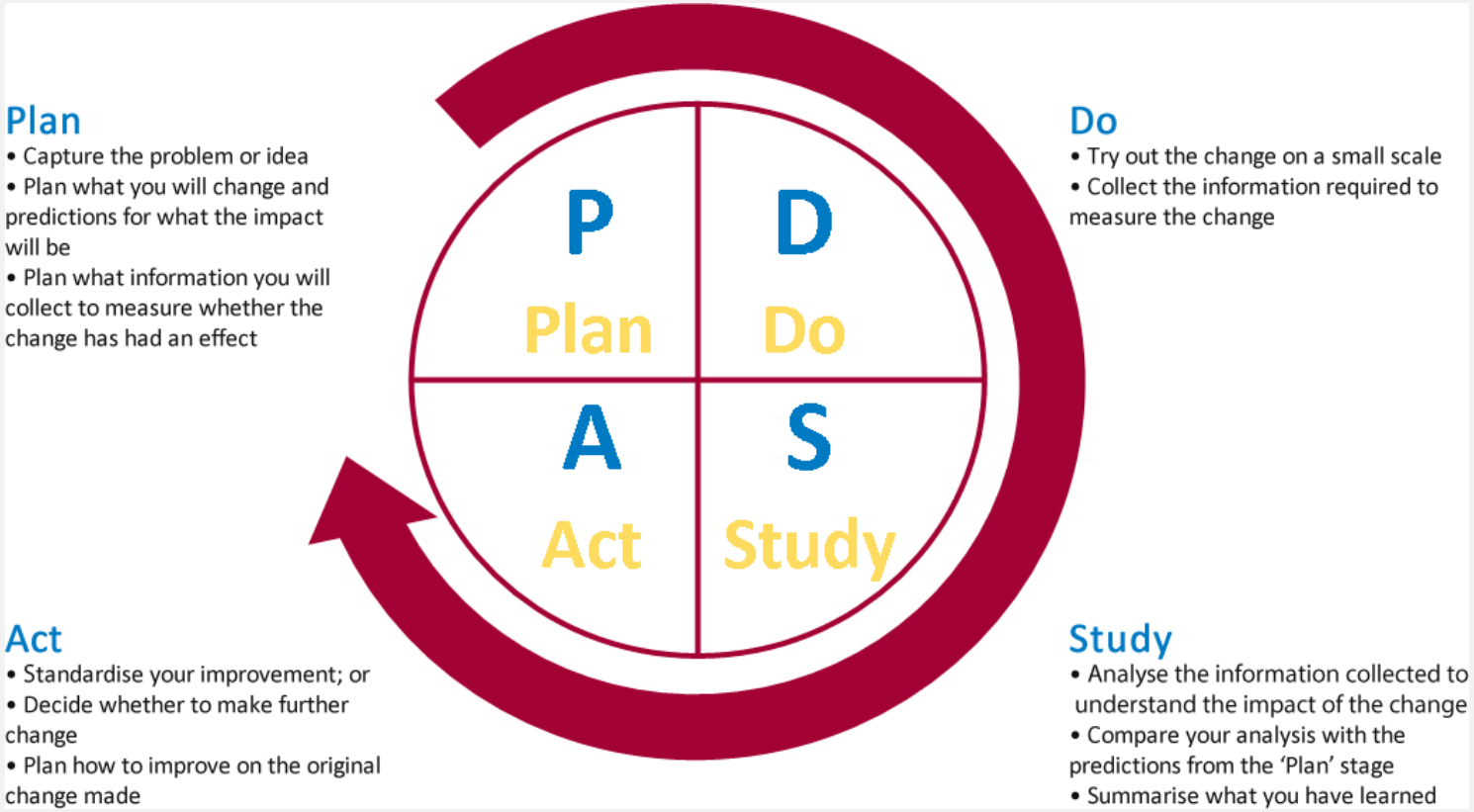
e.g. Greenhalgh, 2014

KNOWLEDGE TRANSFER

- Theory:
  - Problem identification and communication;
  - Knowledge/research development and selection;
  - Analysis of context;
  - Knowledge transfer activities or interventions; and
  - Knowledge/research utilisation
- Dynamic, interactive and multidirectional processes involving many different actors and activities.
- Wider socio-political and professional climates, the characteristic of the system and target audience into which it is going to be delivered, and the positive and negative consequences of successful implementation and uptake.

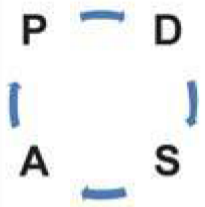
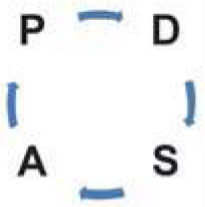
(Greenhalgh et al. 2004; Ward et al. 2009)

CONTINUOUS QUALITY IMPROVEMENT



(Deming 2000)

E.G. GETTING TO OUTCOMES PROGRAMME

Study Activities	Nov 06-Mar 07	April 07	April-Sept. 07	September 07	Sept 07-March 08	May 08
CQI Activities	**Workshop Planning** Planning committee = GTO staff and directors from ten participating programs ○ Planned CQI Workshops ○ Developed CQI tools ○ Recommended programs complete tools prior to workshops	**First QI Action Plan Workshop** Analyze data, develop CQI Actions to improve one program aspect	**Implementation Period 1** 	**Second QI Action Plan Workshop** Analyze data, develop and revise CQI actions to improve one program aspect Train new staff about CQI	**Implementation Period 2** 	**Third QI Action Plan Workshop** Analyze data, develop CQI actions to improve ○ cross program referrals ○ one program aspect
Technical assistance	Provided through investigator participation in monthly staff meetings; quarterly phone calls and periodic, ad hoc meetings and emails					
Research Activities		Workshop Evaluation	Interview Wave 1 (July 07)	Workshop Evaluation	Interview Wave 2 (November 07) Interview Wave 3 (February 08)	Workshop Evaluation

Feasible, but does it lead to improvements in outcomes?

(Chinman et al. 2008)

ACTION PLANNING OBJECTIVES

PEOPLE

- A workforce that has the size, skill mix and distribution to meet projected population growth and need.
- Engage with local and national workforce planning agencies to ensure that the long-term requirements are considered.
- Improve the attraction and recruitment of students and new graduates.
- Strengthen the design and delivery of consumer leadership, carer leadership and peer support roles

ORGANISATIONAL CULTURE

- Create a more positive perception of working in the sector
- Build the competency of the workforce to provide high-quality care and organisational leadership.
- Support workplace cultures that are responsive to new ways of working that enhance recovery.

After Government of Victoria, 2012

PRACTICAL ACTIONS

- Funding criteria graded on demonstration of adherence to QS/guidelines or commitment to undertake training (e.g HR and CR)
- Embedding QS in national policy (e.g. EDPQS in UK Drugs Strategy 2017)
- Development of professional communities of practice that include evidence based working in the ToR (e.g. Mentor-ADEPIS in UK; Swedish 3 Cities project
- Training curriculums (e.g. SPAN; UPC-ADAPT)

SUPPORTING UPTAKE OF RECOMMENDED ACTIONS

EXAMPLES

- Provides clear and succinct messages, with simple, focussed objectives that require small practical changes
- Tailors information so that it is personalised and can be modified to the local setting without disrupting the overall aims of the strategy
- Highlights the relevance of information (i.e. guidelines) to the practitioner and their client needs
- Includes clear identification of roles and activities
- Includes assessment of, and focus on barriers to change
- Addresses changes at multiple levels, including the individual practitioner behaviour, organisational structure and culture, and health system policy
- Identifies organisational changes that require practitioners to respond or take action (e.g., automatic prompts and obligatory responses)

Bywood et al., 2008

SUMMARY THOUGHTS

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