Use of Evidence-based Prevention Programmes in Communities.
A Practice-based Taxonomy of Barriers and Possible Solutions

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Frederick Groeger-Roth
Crime Prevention Council of Lower Saxony,
Ministry of Justice of Lower Saxony, Germany
frederick.groeger-roth@mj.niedersachsen.de
Prevention Council on State Level:

- intra-gouvernemental coordination

- support of local prevention coalitions:
  - training
  - providing networking opportunities
  - on-site technical assistance
  - allocate subsidies
  - advice of specific prevention interventions (registry of EBP)
  - needs assessment through state-wide youth surveys

We are promoting Communities That Care – CTC as a model for effective prevention planning on the local level
My Perspective?

“Hey, no problem!”
EUSPR Discussion, examples:

- Dr Nick Axford (Dartington Social Research Unit, UK) – Are evidence-based programmes dead?

- How do we support a professional culture of quality in prevention? – Prof Harry Sumnall (Liverpool John Moores University, UK)

- Health system dynamics – Prof Peter Hovmand (Washington University in St. Louis, USA)

- Rethinking the dynamics of primary prevention: mobilisation, implementation, and embeddedness in open systems – Prof Carl May (University of Southampton, UK)
### Table 4: Steps included in each reviewed framework

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<td><strong>Phase One: Initial considerations</strong></td>
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<td>1. Needs and resources assessment</td>
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<td>2. Fit assessment</td>
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<td>3. Capacity/readiness assessment</td>
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<td>4. Possibility for adaptation</td>
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<td>5. Buy-in; supportive climate</td>
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<td>6. General org. capacity building</td>
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<td>7. Staff recruitment/maintenance</td>
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<td>8. Pre-innovation training</td>
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<td><strong>Phase Two: Structure for implementation</strong></td>
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<td>9. Implementation teams</td>
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<td>10. Implementation plan</td>
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<td><strong>Phase Three: Ongoing support strategies</strong></td>
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<td>11. TA/coaching/supervision</td>
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<td>12. Process evaluation</td>
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<td>13. Feedback mechanism</td>
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<td><strong>Phase Four: Improving future applications</strong></td>
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<td>14. Learning from experience</td>
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**Phase One: Initial considerations**

1. Needs and resources assessment
2. Fit assessment
3. Capacity/readiness assessment
4. Possibility for adaptation
5. Buy-in; supportive climate
6. General org. capacity building
7. Staff recruitment/maintenance
8. Pre-innovation training

**Phase Two: Structure for implementation**

9. Implementation teams
10. Implementation plan

**Phase Three: Ongoing support strategies**

11. TA/coaching/supervision
12. Process evaluation
13. Feedback mechanism

**Phase Four: Improving future applications**

14. Learning from experience
Shifting the Focus from Programmes to What?

Reframing the Dissemination Challenge: A Marketing and Distribution Perspective

A fundamental obstacle to successful dissemination
Matthew W. Kreuter, PhD, MPH, and Jay M. Bernhardt, PhD, MPH


Building infrastructure for prevention interventions is key – but mostly we have invested only in single programmes
Let Us Think About Cars and Mobility:
Training and User Licence
Availability:
Usability:
Usability:
Usability:
Customizing To Your Needs:

...without violating the model integrity!
What Has Been Done So Far:

- Optimizing programmes (cars) without optimizing infrastructure:
  - easy available? – more than single programme strategies
  - trained and liscenced users? – more than programme specific
  - coordinated strategies by broader system? – more than advocating for single programmes
  - support for local implementers? - more than a single programme provider can do
  - etc.
What’s Standing in the Way of the Spread of Evidence-based Programs?

A look at one critical link in the chain—the organizations responsible for disseminating.

By Alex Neuhoff, Eliza Loomis, and Farhana Ahmed

Chart 2: Percent of purveyors surveyed who conduct each activity (N=43)

- **Increasing effectiveness**
  - Improving the program: 96%
  - Strengthening evidence: 75%

- **Ensuring fidelity**
  - Training: 98%
  - Supporting: 89%
  - Monitoring fidelity: 51%
  - Tracking outcomes: 40%

- **Proactively expanding reach**
  - Marketing: 71%
  - Advocacy: 47%
  - Recruiting new sites: 46%
  - Setting growth goals: 25%
  - Recruiting participants: 23%

**Note:** All respondents did not answer all questions.
**Exploration**
- Create a team
- Assess needs
- Explore evidence
- Examine usability of interventions
- Consider implementation drivers
- Assess fit and feasibility

**Installation**
- Acquire resources
- Prepare organizations
- Prepare implementation drivers
- Select and prepare staff
- Make administrative changes

**Initial Implementation**
- Assess and adjust implementation drivers
- Manage change
- Assess fidelity
- Deploy data systems
- Initiate improvement cycles

**Full Implementation**
- Monitor & improve implementation drivers
- Achieve fidelity & outcomes
- Monitor organization and system supports

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2 - 4 Years
# Practice-based Taxonomy of Implementation Barriers for EBP

<table>
<thead>
<tr>
<th>Type of Barrier</th>
<th>1) Academic</th>
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<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Refusal of EBP because of caveats against underlying methodological standards.</td>
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</tbody>
</table>
| **Typical Statements** | “There is more than one type of (scientific) knowledge”  
“RCT’s are not the Gold Standard” |
| **Actual Reasons for Refusal** | local support for programmes or practices with other / lower / no scientific evidence behind them |
| **Typical Representatives** | Professionals with scientific education who have strayed into practice contexts, middle management level |
| **Estimated Prevalence in Real World Settings** | 5 % |
| **(100% = all persons with EBP rejection)** | |
| **Promising Strategies** | - sometimes better to ignore in discussions in front of audiences of practitioners  
- claim scientific pluralism also for EBP |
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<th>Type of Barrier</th>
<th>2) Culturalistic</th>
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<tr>
<td>Definition</td>
<td>Refusal of EBP because of conflicting norms, values and attitudes</td>
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<tr>
<td>Typical Statements</td>
<td>“EBP are not relevant for our target groups because of the foreign origin” (also called the “Not Invented Here - Syndrom”)</td>
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<td>“EBP are too directive and in contradiction to our working style”</td>
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<tr>
<td>Actual Reasons for Refusal</td>
<td>EBP are in competition with existing programmes and practices</td>
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<td>Negative experiences with EBP implementation (the “Dark logic” of failed implementation experiences)</td>
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<td>Typical Representatives</td>
<td>Middle administrative level, some front-line staff</td>
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<td>Estimated Prevalence in Real World Settings</td>
<td>20%</td>
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<td>(100% = all persons with EBP rejection)</td>
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<tr>
<td>Promising Strategies</td>
<td>- talk about positive implementation experiences in their settings</td>
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<td>Definition</td>
<td>Refusal of EBP because of scarce resources and capacities</td>
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<tr>
<td>Typical Statements</td>
<td>“We do not have enough resources available to implement this programme”</td>
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<td>Actual Reasons for Refusal</td>
<td>Sometimes camouflage of academic or culturalistic reasons, could be also refusal of change in general, but mostly actual lack of resources</td>
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<td>Key leaders, front-line staff</td>
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<td>Estimated Prevalence in Real World Settings (100% = all persons with EBP rejection)</td>
<td>75%</td>
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<td>Promising Strategies</td>
<td>- mobilize additional resources</td>
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<td>- implement low-resource interventions</td>
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<td>- develop local infrastructure</td>
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Community Coalitions

...have the potential for building infrastructure for EBP (and for advocating for infrastructure on larger system levels):

- coordinated demand for programmes that fit to local population needs, norms and resources
- shared responsibility for implementation and results
- build up programme-specific and generic implementation knowledge

... but need support for this work
Communities That Care:

Community Planning System

- to prevent multiple juvenile problem behaviours, including violence
- by tackling common risk and protective factors
- through community coalitions and evidence-based programmes
- with a public-health approach
  (e.g. Hawkins, Catalano et al. 1992, Hawkins et al. 2002)

Implementation Model:

- providing instruments, training and technical assistance for community prevention coalitions to adopt a prevention science approach

https://www.communitiesthatcare.net/
CTC – Implementation Strategy:

- mobilizing community stakeholders and empowering community coalitions for strategic prevention planning (Phase 1 and 2)

- need and resource assessment: measuring profiles of risk and protection at community level (CTC - Youth Survey), focus on the most pressing r/p factors and assessment of existing resources and services (Phase 3)

- matching of effective prevention programmes to community needs, developing measurable goals, community action plan (Phase 4)

- monitoring and evaluation of results of programme implementation, adjustment of action plan (Phase 5)
Community Coalitions

...have the potential for building infrastructure for EBP (and for advocating for infrastructure on larger system levels):

- coordinated demand for programmes that fit to local population need, norms and ressources
- shared responsibility for implementation and results
- build up programme-specific and generic implementation knowledge

... but need also scientific support for this work
Thank you very much for your attention!

www.ctc-network.eu