DEVELOPING A CULTURE OF QUALITY IN PREVENTION

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ACKNOWLEDGEMENTS

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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…?
<table>
<thead>
<tr>
<th>Null effects or small effect sizes</th>
<th>Lack of evaluation and logic in most approaches</th>
<th>Evidence based repositories &amp; ‘Gold Standard’ programmes</th>
<th>Diminishing effects of ‘big name’ programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling up and embedding in routine practice</td>
<td>Austerity &amp; lack of funding</td>
<td>Prioritisation of outcomes</td>
<td>Multiple risk behaviour approaches</td>
</tr>
</tbody>
</table>
Fragmented Policy ↔ Fragmented Practices

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

WHAT DOES ‘HIGH QUALITY’ PREVENTION LOOK LIKE
MODEL FOR APPROVAL OF PREVENTION INTERVENTIONS

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

Phase 1 trial
Efficacy of single components

Phase 2 trial
Efficacy of combinations of components

Phase 3 trial
Effectiveness of intervention

Intervention approval

Phase 4 trial
Effectiveness of intervention in other contexts and populations and long-term surveillance

For single component interventions, and in the phasing in of the approval process, these steps could be pooled together

Faggiano et al., 2014
### COMPONENTS OF ‘QUALITY’

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

- Senior 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)
Training background (social work vs. psychology)?
Training level?
Professional bias

  regulation = "prohibition"
  norms = "fascism"
  evaluation = "unnecessary"
  evidence = "doesn't exist"
  nudging = "manipulation"
  manaulisation = "evil"
  indicated prevention = "medicalisation"
  problem behaviour = "need for treatment"
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
Talk & listen, be there, feel connected

Be Active
Do what you can, enjoy what you do, move your mood

Take Notice
Remember the simple things that give you joy

Keep Learning
Embrace new experiences, see opportunities, surprise yourself

Give
Your time, your words, your presence

http://wellbeinginfo.org
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
Responses to alcohol
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

<table>
<thead>
<tr>
<th>Input</th>
<th>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)</th>
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</thead>
<tbody>
<tr>
<td>Activities</td>
<td>Development, translation and effective dissemination of quality standards, activities to support quality in prevention at the systems level</td>
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<tr>
<td>Output</td>
<td>Quality standards and materials/workshops to support their uptake and use in practice</td>
</tr>
<tr>
<td>Reach</td>
<td>Those involved in funding, managing, developing, implementing, evaluating or otherwise supporting drug preventive work</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Increased awareness, motivation and skills relating to quality and quality standards, as well as use of standards to develop and improve prevention activities</td>
</tr>
<tr>
<td>Impact</td>
<td>Increased quality of preventive work, changes in professional prevention culture (i.e. poor quality no longer acceptable), better outcomes for target populations</td>
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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
A framework for change

**Vision**

- **Community vision**: World-class, sustainable alcohol and drug treatment system
- **Service user vision**: High-quality accessible and recovery-oriented treatment services
- **Workforce vision**: A competent and sustainable alcohol and drug workforce in Victoria

**Goals**

- **People**: Attract and retain a competent and sustainable workforce
- **Place**: Achieve the necessary distribution and skills mix in the workforce
- **Environment**: Foster positive learning and working environments
- **Performance**: Build the necessary competencies and support

**Enablers**

- Service system reform and new delivery structures based on local area need and changing demographics
- Better workforce data and planning methods
- Clear understanding of the competencies required across the workforce
- Clearly defined and supported career pathways
- Clearly defined and well supported roles for people with a lived experience
- Translation of new and emerging evidence and innovation into practice
- Stronger stakeholder engagement and partnerships around workforce activity
- More strategic delivery of alcohol and drug-specific content
- Greater use of new technologies to increase access to learning and development opportunities

**Outcomes**

- More people with the necessary attitudes, knowledge, values and skills are attracted to work in the alcohol and drug treatment sector
- The existing workforce is supported, developed and retained
- The workforce is well planned and distributed on the basis of population and the needs of service users
- People with the necessary attitudes, knowledge, values and skills are available where and when they are needed
- Organisational culture supports and fosters positive working and learning environments
- Stronger leadership and governance at all levels
- The workforce delivers high-quality, evidence-based treatment and care
- The service system is productive, effective and connected

**Drivers**

- The population is growing and ageing
- Models of care and service delivery are evolving
- The way people work and who is working is changing
- Policy and funding models are changing
- Demand for and expectations of services are increasing
- Best practice workforce planning and development is evolving
QUALITY STANDARDS

+ 
• 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

− 
• 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
GUIDELINES

+ 
  • 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

Plan
- Capture the problem or idea
- Plan what you will change and predictions for what the impact will be
- Plan what information you will collect to measure whether the change has had an effect

Do
- Try out the change on a small scale
- Collect the information required to measure the change

Act
- Standardise your improvement; or
- Decide whether to make further change
- Plan how to improve on the original change made

Study
- Analyse the information collected to understand the impact of the change
- Compare your analysis with the predictions from the ‘Plan’ stage
- Summarise what you have learned

(Deming 2000)
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

- Awareness of funding and political environment
- A deficit model of influence is not appropriate
- Charismatic leaders and orators key
- Diffusion initiatives embedded in an organisational implementation strategy
**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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