DECLARATIONS

- Currently receive research funding from research councils/charities

- Former (unpaid) member of the UK Government Advisory Council on the Misuse of Drugs (ACMD) (2011-2019); currently (unpaid) co-opted member of ACMD WG assessing medicinal cannabis rescheduling

- Scientific Advisory Board (unpaid) MIND Foundation

- Former (unpaid) Board Member/Past President of the European Society for Prevention Research (EUSPR)

- (Unpaid) Editorial Board member Journal of Prevention, Addictive Behaviors

FOCUS OF THIS TALK

- What is an evidence-based approach in drug demand reduction (DDR)?

- What is the relationship between research evidence and policy in the drugs field?

- Complexities of knowledge exchange processes

- Quality standards + guidelines

- Some thoughts on ethics and professional cultures in DDR

WHY DO WE NEED AN EVIDENCE-BASED APPROACH IN DDR?

- Alcohol and other drug use are important contributors to **global disease burden**

- Substance use disorders are **complex** health conditions with multiple determinants, which require comprehensive and public health orientated responses delivered by many different institutions

- There are still many **outdated and stigmatising views** about substances and the people who use them

- Many responses are **ineffective**, not cost-effective, and in some cases can even be harmful

- **Under-developed evidence base** in some areas of practice

- **Variable implementation quality and scale**, concerns about workforce competencies

- Its is morally and ethically the right thing to do

WHAT IS EVIDENCE-BASED POLICY/PRACTICE?

- *". . .informed by research rather than, for example, rumour, prejudice or unexamined assumptions."*

- *". . .an approach that helps people make well-informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation"*

- *"a 'narrow' approach, whereby high-quality research evidence is viewed as being systematically translated into guidelines for good practice, to a 'broader' approach, which is a more flexible view of how research can inform people and the types of knowledge that constitute evidence."*

- Is there a single, useful definition?

Bridges et al., 2008; Davies, 2004; Nutley et al., 2007

An approach that emphasises the importance of consistent and cost-effective decision-making that moves away from action based on anecdotal evidence or intuitive assumptions about effective practice and policy

WHAT DOES 'HIGH QUALITY' DDR LOOK LIKE?

AN ACADEMIC PERSPECTIVE?

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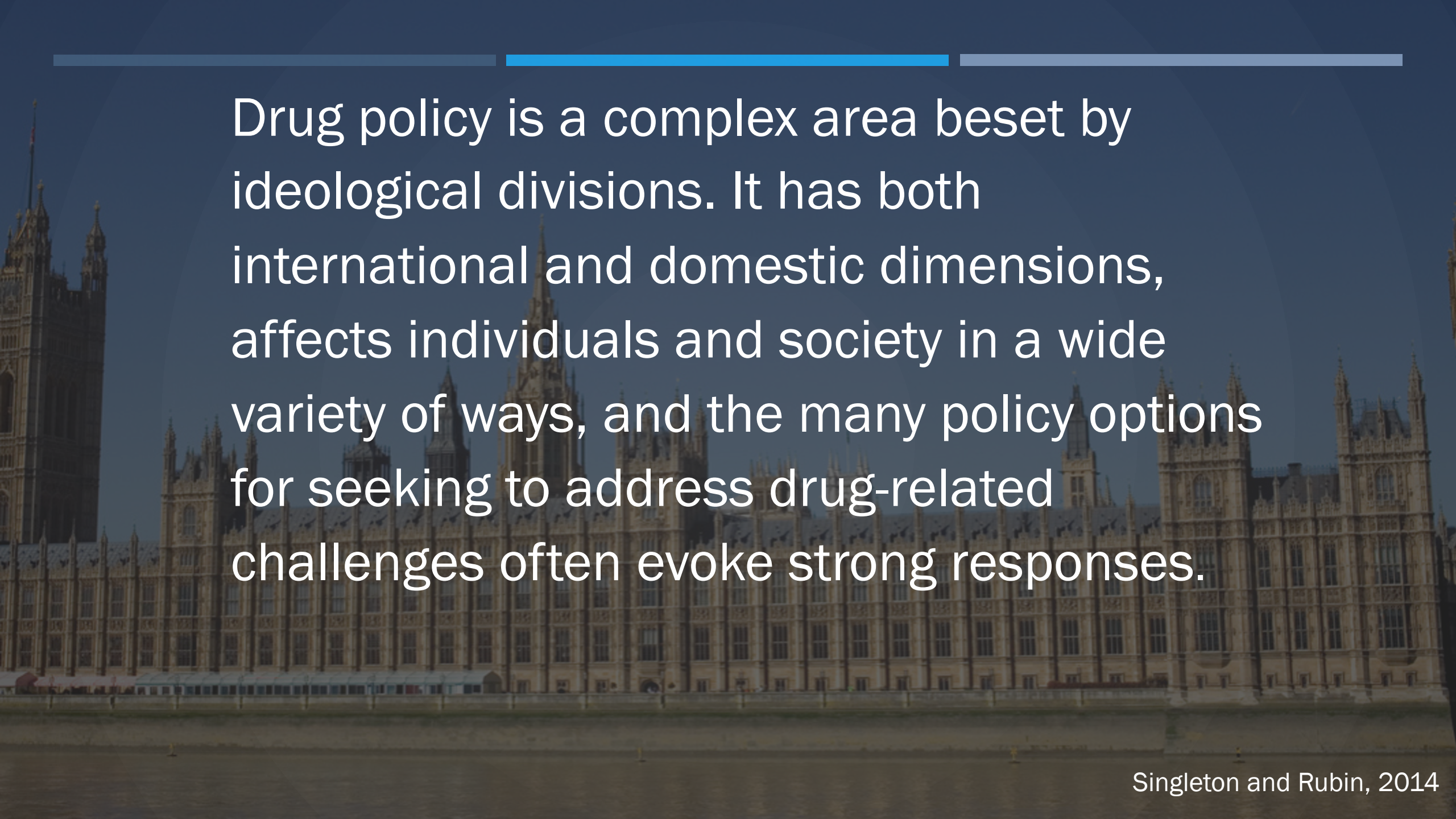- Sustained for as long as the target population requires it

A POLICY/PRACTICE PERSPECTIVE?

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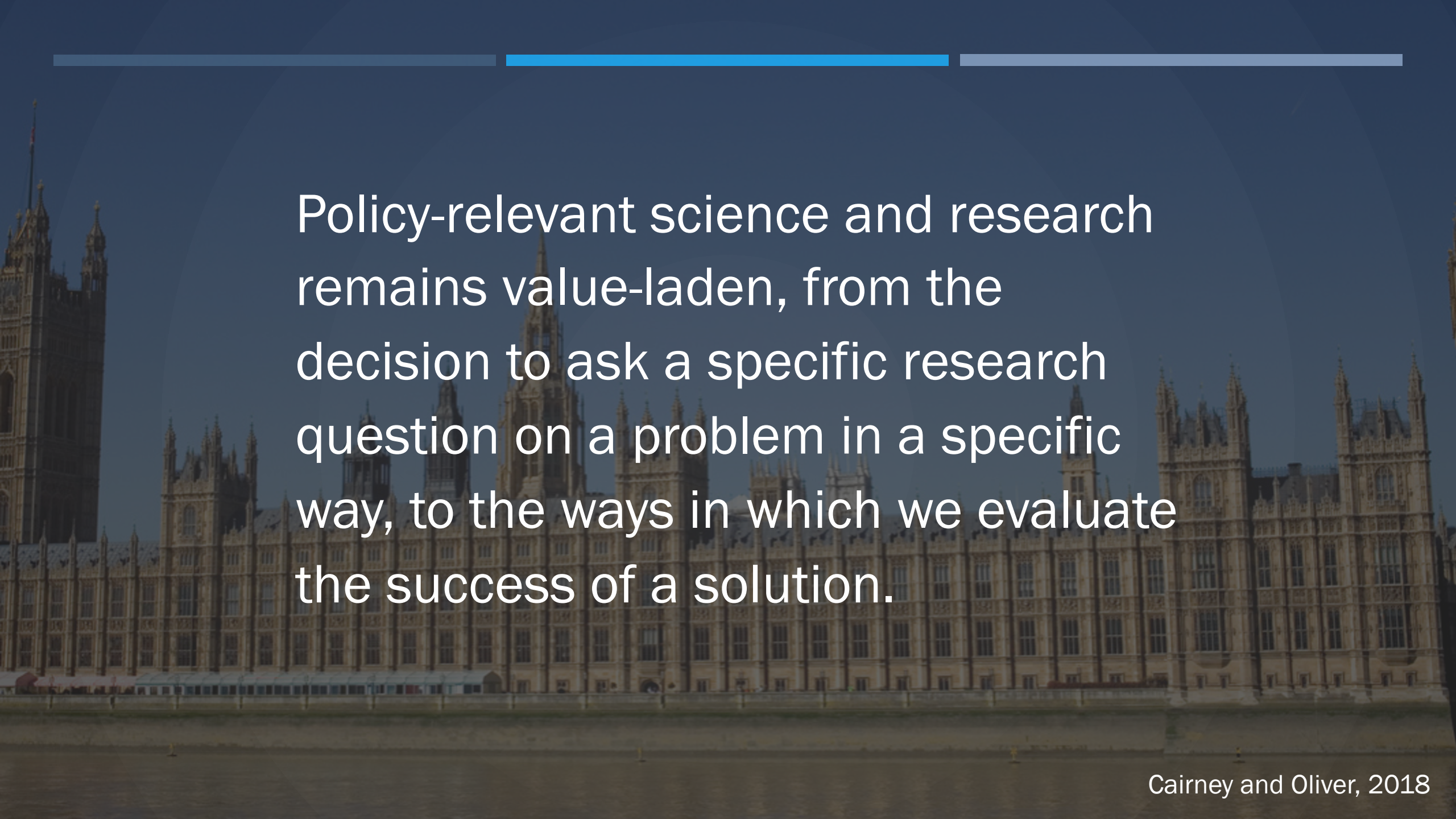- Sustained for as long as funding allows

What is evidence? A traditional 'evidence pyramid'

Many high-quality studies don't tell us about important factors such as reach, effectiveness in routine practice, adoption, adaption and sustainability
or variation in influence of social contexts and social and system dynamics

We also need other research designs to understand what actions have been implemented and how well they have been delivered.

Drug policy is a complex area beset by ideological divisions. It has both international and domestic dimensions, affects individuals and society in a wide variety of ways, and the many policy options for seeking to address drug-related challenges often evoke strong responses.

Singleton and Rubin, 2014

Policy-relevant science and research remains value-laden, from the decision to ask a specific research question on a problem in a specific way, to the ways in which we evaluate the success of a solution.

Cairney and Oliver, 2018

WHAT COUNTS AS EVIDENCE TO DECISION MAKERS?

- 'academic' evidence

- polling

- public opinion

- key informants

- epidemiological data

- narratives of historical developments

- qualitative data

- knowledge gained through interpersonal interaction

- practice-based knowledge of influential individuals

Oliver & de Vocht, 2017
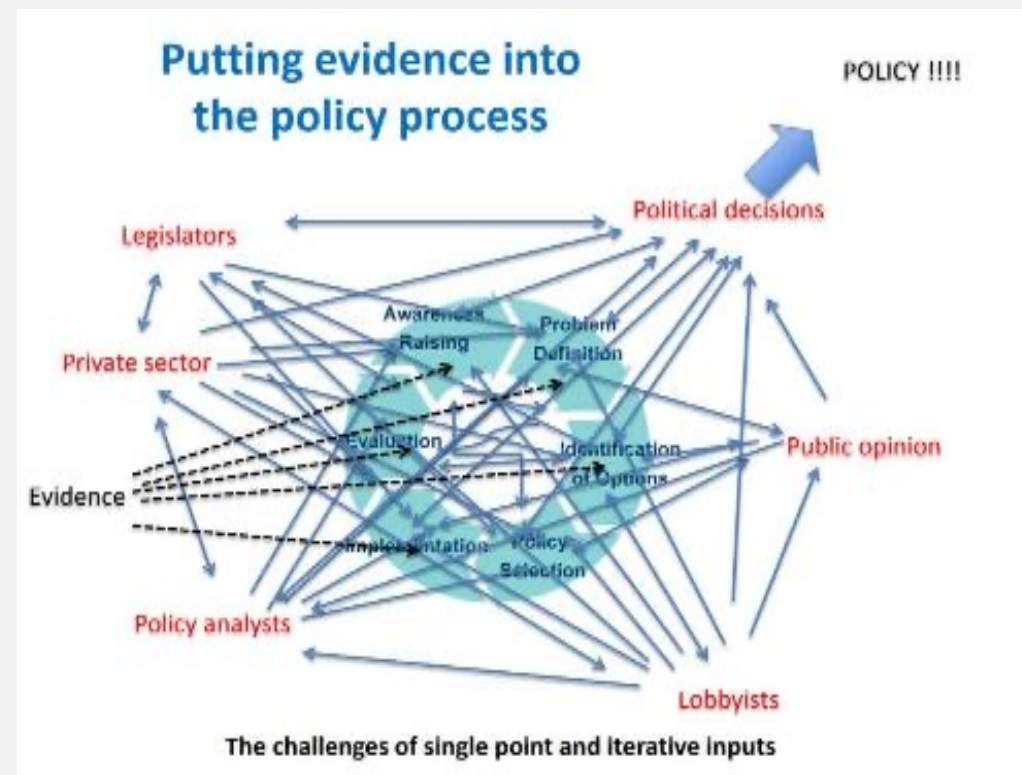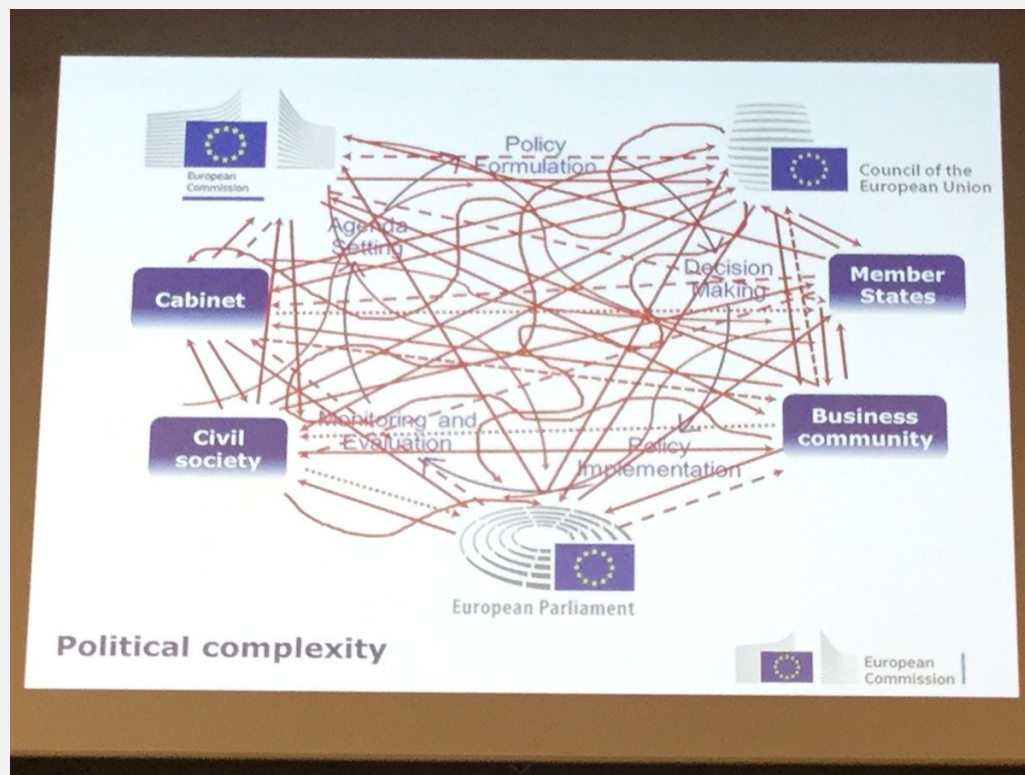
REALITY CHECK – CAN RESEARCH EVIDENCE CHANGE POLICY?

Yes it can, but:

- Politics (and public opinion) almost always trumps evidence

- Influencing policy is a specialist, time-consuming activity

- Much research has no policy relevance

- Much research supports the policy status quo

- The more research evidence available on a topic, the less likely consensus will be reached

- Policymaking can be chaotic

PLAYING THE LONG GAME?

- It has been estimated that it takes an average of 17 years for 14% of research to translate into practice

Balas et al., 1998

ADVOCATING FOR EBP CHANGE 1

- Rather than just presenting solutions to societal problems, advocates must work to shift awareness to these problems, and present reasons for [the public and] policy makers to prioritise [and care about] them

After Cairney and Oliver, 2018

# ADVOCATING FOR EBP CHANGE 2

- Successful advocacy combines relevant scientific evidence with emotional appeals that put a 'human face' on a story, and intelligently exploits emerging opportunities by framing suggested responses to be consistent with the **political and personal beliefs and values of decision makers,** and what is already known about what they care about.

After Cairney and Oliver, 2018

# ADVOCATING FOR EBP CHANGE 3

Lessons learned:

- Don't focus on bombarding policymakers with evidence.

- By the time policymakers pay attention to a problem it's too late to produce a solution.

- When your environment changes, your strategy changes.

After Cairney and Oliver, 2018

Idealised knowledge transfer process

After EMCDDA, 2012
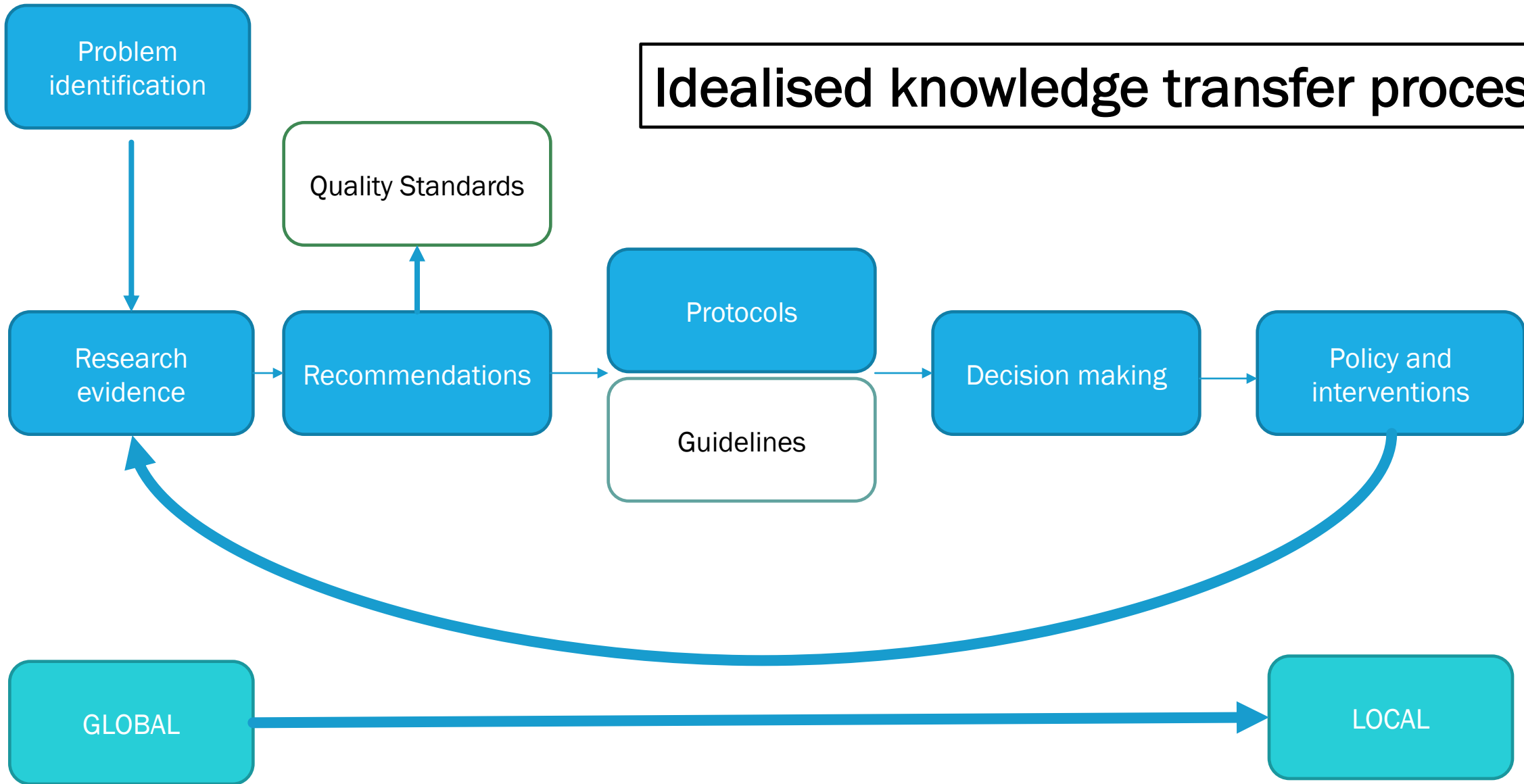
KNOWLEDGE TRANSFER: REALITY

- Takes place within a system of activity

- Dynamic, interactive and multidirectional processes involving many different actors and activities.

- Affected by wider **socio-political and professional** climates, the characteristics of target audiences and the system into which it is going to be delivered, and the positive and negative consequences of successful implementation and uptake.

- Delivery of an action can change the system into which it is introduced

(Greenhalgh et al. 2004; Ward et al. 2009)
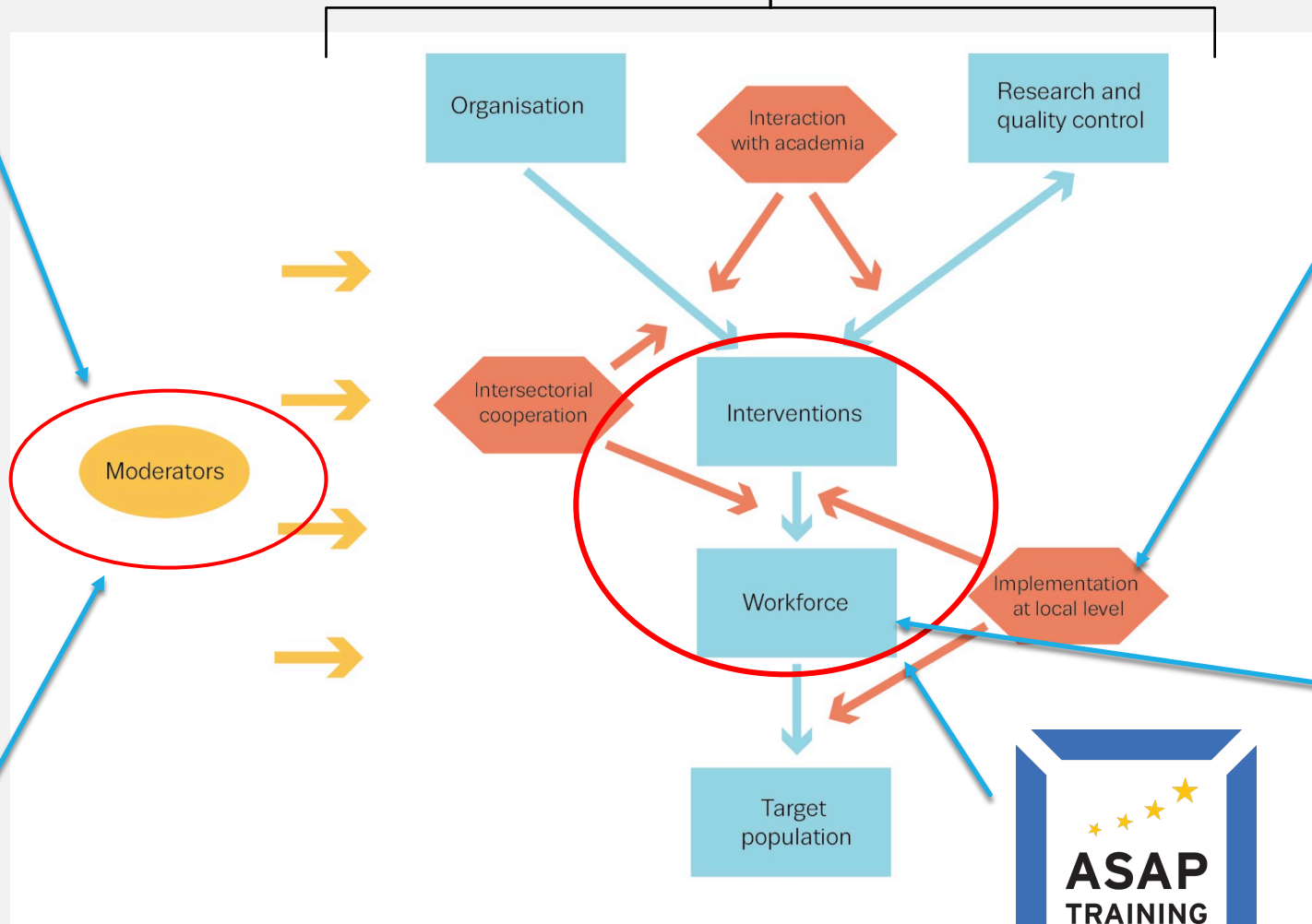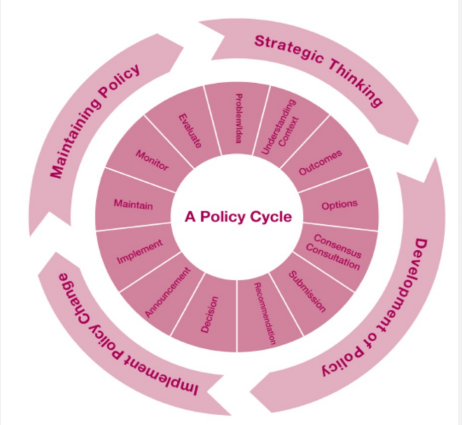
Components of an idealised prevention system (EMCDDA, 2019)

IMPLEMENTATION OF INNOVATION REQUIRES BEHAVIOUR CHANGE

- Normalising evidence-based practice depends on changing **behaviour** – *at individual, organisational, and systems levels*

- **Within systems, this includes the behaviour of** managers, service commissioners and providers, civil servants, policy-makers, politicians...

- Emphasis on organisations and policy environments, corresponding with diffusion models, or individual professional differences

International standards for the treatment of drug use disorders

REVISED EDITION INCORPORATING RESULTS OF FIELD-TESTING

World Health Organization

UNODC United Nations Office on Drugs and Crime
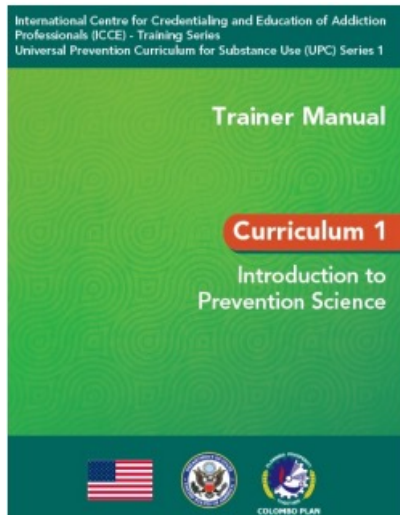
UNODC
United Nations Office on Drugs and Crime
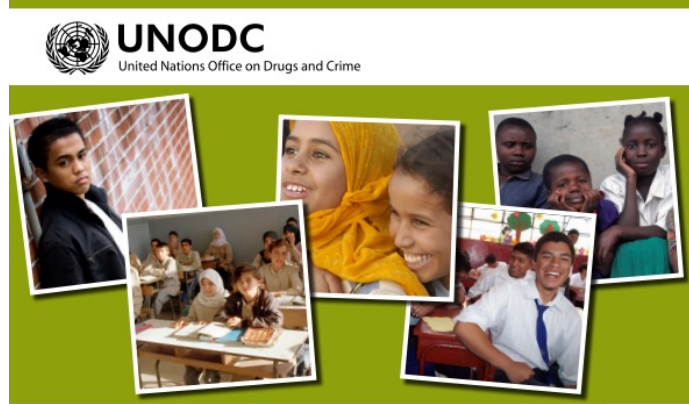
International Standards on Drug Use Prevention

Colombo Plan Drug Advisory Programme (DAP)
The Universal Treatment Curriculum for Substance Use Disorders (UTC)

Trainer Manual

Course 1

Physiology and Pharmacology for Addiction Professionals

3rd Edition, 2017

International Centre for Credentialing and Education of Addiction Professionals (ICCE) - Training Series
Universal Prevention Curriculum for Substance Use (UPC) Series 1

Trainer Manual

Curriculum 1

Introduction to Prevention Science

COLOMBO PLAN

NICE National Institute for Health and Care Excellence
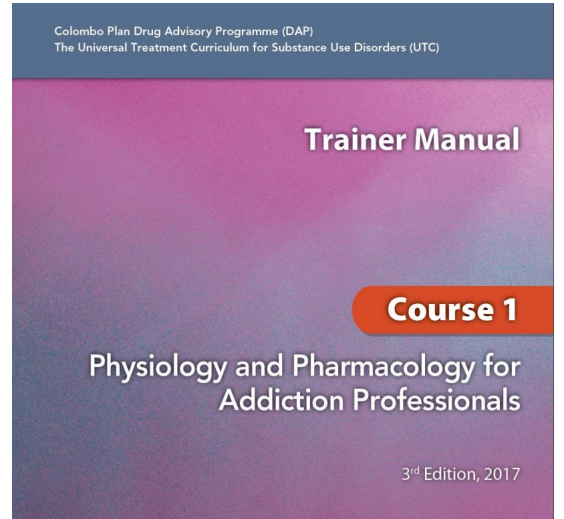
HEALTH BEHAVIOUR CHANGE COMPETENCY FRAMEWORK

Low Intensity Interventions	**Foundation Competences: examples**	**Behaviour Change Competences: examples**
	knowledge of professional and ethical guidelines	ability to take a generic assessment
Medium Intensity Interventions	ability to foster and maintain a good intervention alliance	capacity to select and apply the most appropriate intervention method
High Intensity Interventions	capacity to adapt interventions to client need	capacity to implement models in a flexible manner

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 standards developers
- Can standardise language but not standardise practice
- Do not necessarily lead to improvements in outcomes
- There may be resistance to change
- Without incentive, organisations may work to achieve the minimum and no more

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

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?
- Often too many guidelines!
- Do guidelines and decision support tools take into account who will use them, for what purposes, and under what constraints?

ETHICAL PRACTICE AND POLICY

- Work that is characterised by an ethical and lawful conduct of the provider, with orientation towards participants' rights, autonomy, and needs.

- Important in DDR as many target groups are young, or have been (systemically) marginalised or (deliberately) excluded from participation in society (inequality/inequity)

- Ethical imperative to understand inequality, and to ensure DDR activity, systems and policy addressed the root causes of inequity

- Approaches to DDR are underpinned by judgements about what is 'good' or 'bad' for participants

- There may be conflict between societal values and preferences, policies and laws, normative definitions of health and wellbeing, and evidence-based guidance:

ETHICAL CONSIDERATIONS FOR DDR SERVICES/SYSTEMS

- **Development and monitoring of a code of ethics**
- Adherence to legal requirements
- Respecting participants' rights and autonomy
- **Activities provide real benefits for participants**
- Causing no harm or substantial disadvantages for participants
- Providing transparent, truthful and comprehensive information

- Obtaining participants' consent
- **Coercion vs autonomy**
- Treating participant data confidentially
- Tailoring support to participants' needs
- **Involving participants as partners and developing positive relationships**
- Protecting participants' and staff members' health and safety.

Brotherhood and Sumnall, 2011
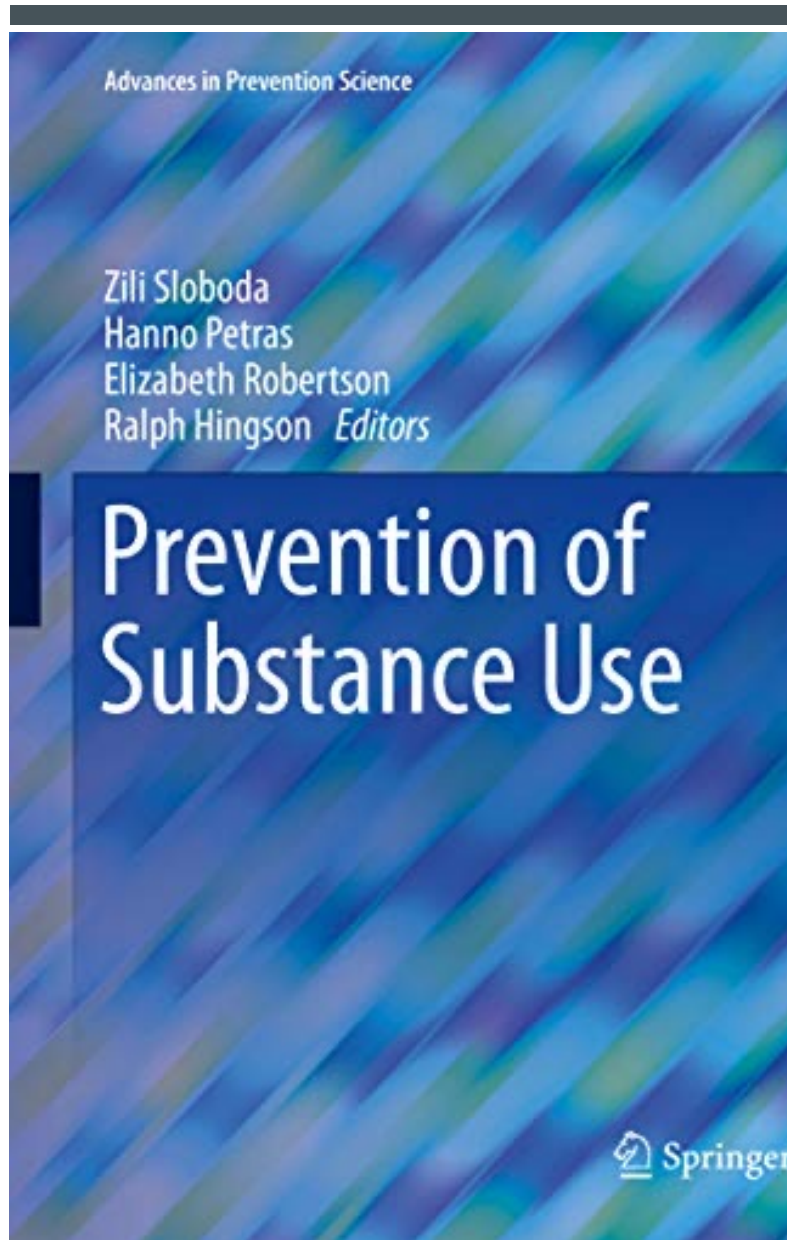
WHAT IS PROFESSIONAL CULTURE?

No normative definition

The product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine commitment, style and proficiency

- Professional 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

- Cultural change is a slow and dynamic process involving small changes on many different aspects over a longer period

(Sumnall, 2020)

"Core beliefs that maintain the unity of the 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 programmes that seek to promote organisational concentrate only on the superficial or visible aspects of a culture. Unless the central paradigm changes, long-lasting [organisational] change will not occur."

Kuhn, 'The Structure of Scientific Revolutions' 1962

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 too often remain aspirational

- Gap between research findings and recommended guideline actions

- Symbolic value of 'evidence-based' approaches vs reality

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

A framework for change
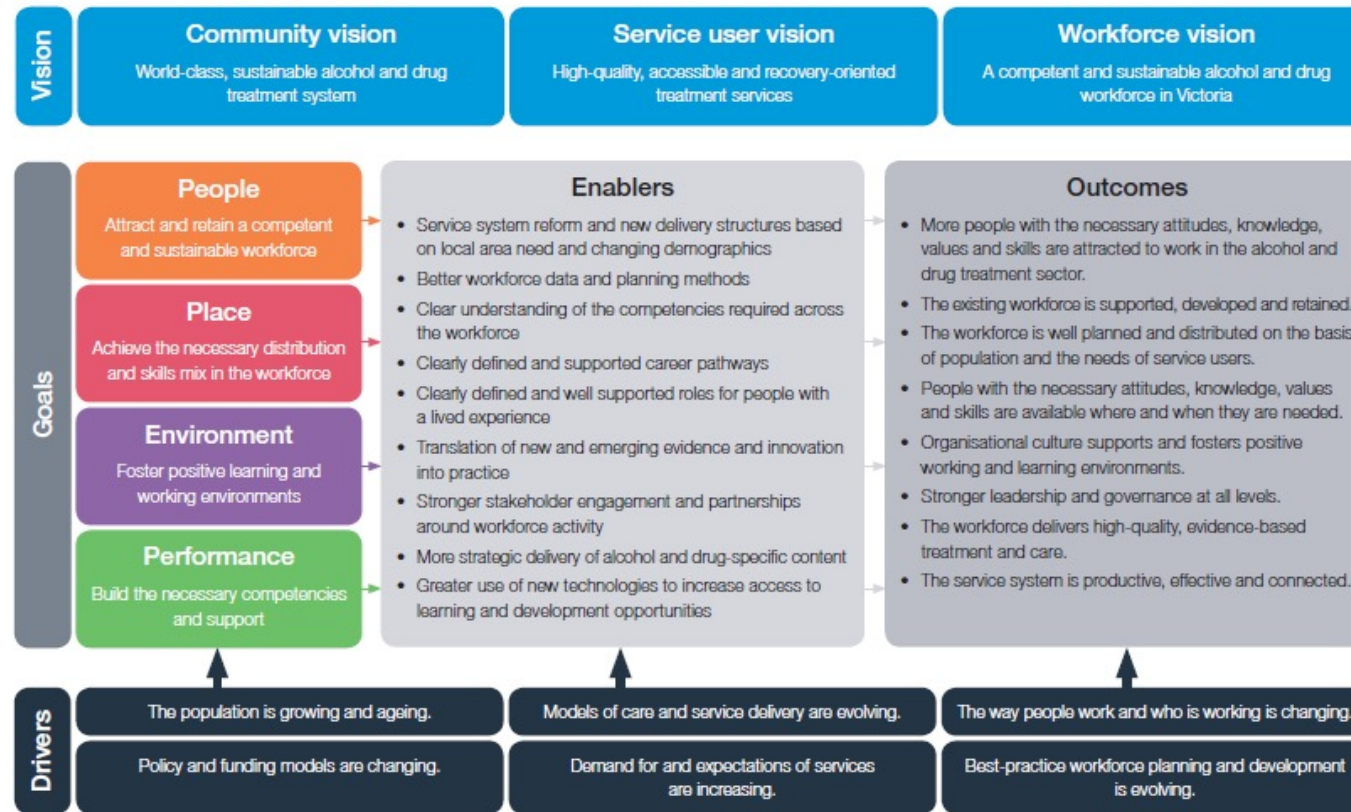
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