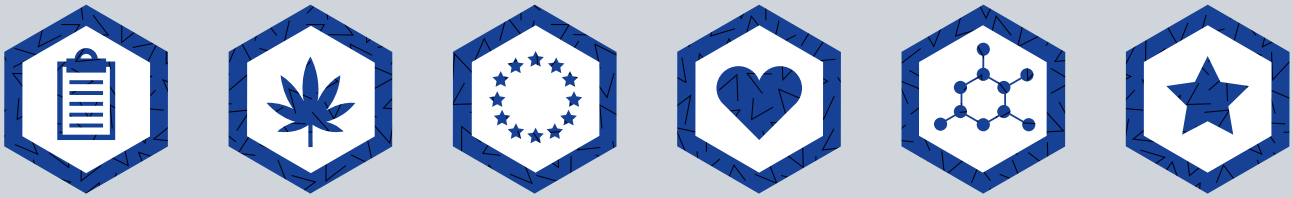

EDPQS Toolkit 4: Promoting quality standards in different contexts (Adaptation & Dissemination Toolkit)

Step 4: Promoting quality standards

European
drug prevention
quality standards

Authors

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Acknowledgements of further contributors can be found in a separate document of this toolkit.

Suggested citation

Brotherhood A, Sumnall HR & the European Prevention Standards Partnership (2015) EDPQS Toolkit 4: Promoting quality standards in different contexts ("Adaptation and Dissemination Toolkit"). Step 4: Promoting quality standards. Liverpool: Centre for Public Health.

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Funding statement

This publication has been produced with the financial support of the Drug Prevention and Information Programme of the European Union (Project name: "Promoting Excellence in Drug Prevention in the EU - Phase II of the European Drug Prevention Quality Standards Project"). The contents of this publication are the sole responsibility of the authors stated above and can in no way be taken to reflect the views of the European Commission.

About this toolkit

This document is part of the EDPQS Toolkit 4 on Adaptation and Dissemination. This toolkit consists of the following documents:

- **Introduction & Key messages** – helps to understand what the toolkit is about. Introduces the overall toolkit and highlights key aspects concerning each step of the process.
- **Step 1: Deciding what to do** – helps to decide what type of adaptation or dissemination to undertake. Describes what an 'EDPQS Champion' is, introduces the adaptation process and distinguishes three types of adaptation (translation, formal content adaptation, flexible content adaptation). Includes Exercises A and B as well as Figures 1 and 2.
- **Step 2: Identifying potential barriers and facilitators** – helps to estimate the required resources, and to anticipate potential problems as well as sources of support. Highlights the role of written materials, supportive people, sufficient time and money, as well as prevention systems and professional cultures. Includes Exercises C-F as well as Figure 3.
- **Step 3: Undertaking the adaptation** – helps to think through the actual adaptation process from setting up a working group to publishing the project outputs. Explains how to achieve a good translation of the EDPQS, and what changes to avoid when adapting the layout or contents of the EDPQS. Includes Exercise G and Table 1.
- **Step 4: Promoting quality standards** – helps to plan follow-up activities that will ensure uptake of the standards by end-users. Includes an evidence review of dissemination strategies, distinguishes 'dissemination' and 'implementation' and suggests evaluation indicators that can help assess the impact of activities to promote quality standards. Includes Exercises H-J.
- **Example projects** – helps to understand how EDPQS have been adapted and disseminated in practice. Describes eight example projects from across Europe, including contact details of the persons responsible for these projects.
- **Acknowledgements** – list of people who contributed to the development of this toolkit.
- **Translation and adaptation checklist** – a checklist of the most important points to consider when translating or adapting any EDPQS materials.

Throughout the toolkit, the following two symbols are used to indicate:


'Lessons learnt' from the example projects


Practical exercises

Please note: This toolkit refers to "Example Projects" throughout. Full details regarding the example projects, including links to reports and project web pages, are provided only in the Example Projects document. The examples are included to illustrate how people have gone about introducing quality standards using the EDPQS. Inclusion of the projects should not be interpreted as official endorsement or promotion of the projects by the Prevention Standards Partnership. More examples of projects that have used the EDPQS to promote quality in prevention can be found on **www.prevention-standards.eu**

This toolkit may be used, in whole or in part, to guide the development/revision of quality standards and other quality assurance tools. Endorsement by the Prevention Standards Partnership of such derived products may not be stated or implied by toolkit users unless explicitly agreed with the Partnership.

Feel free to share your own experiences of using the EDPQS by contacting the European Prevention Standards Partnership at **http://prevention-standards.eu/contact/**

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Step 4: Promoting quality standards

Top tips for promoting quality standards

- Position the standards as a way of **identifying existing strengths of preventive activities** as well as areas that can be developed further. Remember that people don't like feeling that they are being judged or assessed. Emphasise that the ultimate goal of introducing standards is to ensure that target populations are offered the best prevention activities possible.
- **Consider from the beginning** how you will disseminate the standards. Invite other organisations working towards quality in prevention to join your project. Obtain support from opinion leaders (such as policy makers, professional associations, or others) by involving them in the process early on. To produce a strong and credible product, **create an alliance including researchers, policy makers and practitioners**.

In the final part of this toolkit, we focus on the dissemination and implementation of quality standards. Dissemination can be defined as:

> "[…] the active and targeted distribution of information or interventions via determined channels using planned strategies to a specific public health or clinical practice audience. […] In contrast to diffusion, which is a passive, informal process, dissemination is a formal, planned process with the intent of spreading knowledge and associated evidence-based interventions to stimulate adoption and enhance the integration of the evidence, information, intervention (or combinations of these) into routine practice" (McCormack et al. 2013: 5)

This is where the actual work of improving the quality of preventive work begins. As highlighted in the EDPQS Theory of Change (see **http://prevention-standards.eu/theory-of-change/**), quality standards are **not a goal in themselves, but a tool to improve the quality of prevention** with a view to producing better outcomes for ultimate target populations (e.g. young people). Any project to introduce quality standards must therefore also consider from the beginning how their uptake will be supported.

Quality standards help to establish a shared vision of 'high quality drug prevention' that different members of the prevention community can work towards. However, it is important to recognise that **publication of quality standards is not sufficient to produce change in the prevention field**. Along the way to improved quality, your target audiences need to:

i) become aware of the need for high quality in prevention and find out how to access the quality standards (referred to in the EDPQS Theory of Change as 'awareness');

ii) agree that the quality standards are important and useful, become motivated to comply with the quality standards and form intentions to use them ('motivation'); and

iii) fully understand the contents of the quality standards and develop the skills necessary to successfully and confidently apply quality standards in their work ('skills').

Simply publishing the quality standards offers little incentive for this kind of in-depth engagement.

Why it's not enough to send a newsletter about the standards to target audiences

Murthy and colleagues (2012) identified three conditions under which mass mailing a printed bulletin with evidence summaries may improve practice by health system managers, policy makers and healthcare professionals: if there is a single clear message; if the change is relatively simple to accomplish; and if users are aware that a change in practice is required. Assuming these conditions apply also to the dissemination of quality standards, it seems unlikely that just publicising the existence of the standards will be sufficient to produce behaviour change, as quality standards are potentially complex, and target audiences may be initially unwilling to accept the need for them. Consequently, more sophisticated dissemination strategies are needed.

If you involved key stakeholders from the prevention field as well as target audience representatives in the adaptation and development of quality standards, then you have already taken an important first step towards raising your target audience's awareness of the standards and readiness to use them – however, additional work will be required to **ensure your efforts are sustained**.

The Prevention Standards Partnership has also produced a range of materials that can help to support dissemination efforts. You can access these under **www.prevention-standards.eu**

Note that where we refer to the EDPQS in Step 4, the recommendations are likely to apply also to quality standards in general, including standards adapted from the EDPQS.

4.1. Ensuring impact – Example strategies to promote quality standards in drug prevention

Let us start by considering how successful different dissemination strategies are likely to be, and under what conditions. At the time of preparing this toolkit, there was no scientific evidence available on EDPQS-specific dissemination strategies. For this section, we therefore drew upon available research findings on the dissemination of evidence-based practice more generally[1], as well as the practical experiences of the Prevention Standards Partnership and existing EDPQS champions.

The overview below outlines potential strategies to promote the use of quality standards in drug prevention, describing the effectiveness of strategies in general, supplemented with practical insights from EDPQS-related work. We based the categorisation of approaches on existing reviews, adding approaches that could be relevant to the dissemination of quality standards as well as EDPQS-specific examples[2]. Nevertheless, the list (including the examples) should not be considered exhaustive.

Educational materials

Key message	**Can be a low-cost strategy, but unlikely to produce behaviour/practice change unless combined with other strategies**
EDPQS-specific examples	• Publication of Manual, Quick Guide and supporting materials on relevant websites • Sending hard copies of the EDPQS Manual to selected members of the prevention community (e.g. Heads of Reitox National Focal Points, within countries to regional prevention coordinators) • Distributing EDPQS-related information to a broad audience e.g. via newsletters, social media, relevant websites (e.g. best practice portals), press releases, professional publications, leaflets
Example projects	Poland, Hungary, Croatia, Sweden, NEWIP, EQUS, UK (all in conjunction with other strategies)

General evidence of effectiveness and practical considerations	Although the costs of educational materials depend on the format, dissemination channel, and quantity/size of materials, educational materials are generally considered a low-cost strategy (Bywood et al. 2008b). They can be easily disseminated to large groups of people, especially if this is done via the Internet. However, the evidence is mixed on whether distributing educational materials without employing another dissemination strategy is effective (Bywood et al. 2008a; Grimshaw et al. 2012). Fixsen and colleagues (2005) conclude that access to information alone has little impact on behaviour. Bywood and colleagues (2008a) report minimal effects in few outcomes for prescribing, but no effects for preventive care. The findings for electronic educational resources were similar. Bywood and colleagues (2008a) found one primary study investigating the effectiveness of mailing guidelines by post; with no effects on GP's referral behaviour. To successfully reach a broader audience, educational materials should be relevant, credible, well-designed and concise (Bywood et al. 2008a). Repetition of key messages, for example by disseminating a series of related bulletins, has also shown promise (Bywood et al. 2008a). Overall, it is recommended that educational materials are used in conjunction with another dissemination strategy rather than in isolation.
EDPQS-specific considerations	Our own experience has been that educational materials work well with already-motivated people who are used to self-learning. This group of people can also engage with longer materials (such as the EDPQS Manual). We have also found that obtaining the endorsement of an influential organisation and including their logo on the materials increases the likelihood of materials being read. A potential disadvantage of disseminating materials is the lack of personal contact with target audiences, precluding feedback and knowledge of who uses the materials and in what way. The EDPQS project has produced educational materials such as short summaries and self-reflection questionnaires, which can be used for this purpose (see www.prevention-standards.eu).

Educational meetings (continuing professional development [CPD])

Key message	**Interactive educational meetings are likely to be effective but may be resource-intensive and have limited reach**
EDPQS-specific examples	• Launch event upon publication of standards • Presentation of EDPQS at conferences and seminars • Offering training on EDPQS through bespoke workshops • Integrating training on EDPQS into existing structures (e.g. University courses, refresher courses for practitioners)
Example projects	Poland, Hungary, Croatia, Sweden, NEWIP, EQUS, UK
General evidence of effectiveness and practical considerations	Estimating the effectiveness of this strategy is challenging because the format and contents of educational meetings vary greatly across research studies. For example, in existing research, meetings have lasted between a single 10-15 minute session and multiple hour-long sessions over an extensive period (Bywood et al. 2008a). Bywood and colleagues (2008a) report small effects in most outcomes for the majority of clinical areas studied, and recommend interactive educational meetings as an effective strategy. Inclusion of interactive elements prompting participant interaction increases the effectiveness of educational meetings (Fixsen et al. 2005; Bywood et al. 2008a; Grimshaw et al. 2012). Effective training workshops appear to consist of "presenting information (knowledge), providing demonstrations (live or taped) of the important aspects of the practice or program, and assuring opportunities to practice key skills in the training setting (behaviour rehearsal)" (Fixsen et al. 2005: 41). Fixsen and colleagues (2005) conclude that training can increase knowledge, motivation and skills, and even lead to adoption of written policies, but is unlikely to lead to actual behaviour change unless combined with other strategies (such as personal coaching). Bywood and colleagues (2008a) report a study indicating that practitioners with poorer knowledge or skills at baseline benefit most from an educational intervention. A challenge can be that practitioners are unable to take time off work to attend educational meetings. In addition, the costs of educational meetings must be considered. However, there is evidence to suggest that educational meetings can be cost-effective (Bywood et al. 2008b).

EDPQS-specific considerations	Educational meetings allow presenting quality standards in a more practically relevant way than is possible through educational materials alone. Such meetings also offer the chance to correct wrong assumptions about quality standards and to highlight their benefits. Interactive elements (e.g. asking participants to undertake a self-reflection using the quality standards) can introduce participants to using quality standards. We suggest that didactic delivery formats with little participant interaction (e.g. lectures) are more suitable to raise awareness about quality standards across the prevention community, whereas interactive meetings (e.g. small-group workshops) are better suited to increase the motivation and skills of targeted groups. It is important, however, that the trainer has the appropriate communication skills as well as knowledge on quality standards. The EDPQS support materials include PowerPoint slides that can be used for presentations, as well as a resource pack to help deliver interactive training workshops on the EDPQS (Toolkit 3; see **www.prevention-standards.eu**).

Local consensus processes

Key message	**Lack of scientific evidence of effectiveness - anecdotal evidence suggests that involved stakeholders may be more likely to use/promote quality standards at no extra cost**
EDPQS-specific examples	• Involving stakeholders in the development or adaptation of quality standards with a view to making them locally relevant
Example projects	Poland, Hungary, Sweden, NEWIP, EQUS, UK
General evidence of effectiveness and practical considerations	We could not identify any scientific research on this question, as studies reported by Bywood and colleagues (2008a) explored a related albeit different issue (i.e. the effectiveness of locally adapted guidelines versus standard national guidelines).
EDPQS-specific considerations	In our experience, involving stakeholders is not only crucial in producing relevant and credible materials, but can also aid dissemination. It is plausible to assume that those who were involved as stakeholders during the development process will be more likely to accept and use the resulting materials, as well as promote them among their peers. To use consensus processes as a starting point for dissemination, we suggest identifying and involving potential opinion leaders (see below). A challenge in such processes is the inability to incorporate and act upon all feedback and suggestions received. This must be managed carefully, as dissatisfied stakeholders can become negative opinion leaders and dissuade others from using the final product. Since uptake of the standards by involved stakeholders would be a by-product of local consensus processes (whose costs are covered as part of the standards development), there are no additional costs associated with this dissemination strategy.

Local opinion leaders (including product champions)

Key message	**Likely to be effective if opinion leaders meet certain criteria but challenge to identify suitable individuals/organisations**
EDPQS-specific examples	• Use and recommendation of EDPQS by influential individuals • Endorsement of EDPQS by government or leading prevention agencies (e.g. EMCDDA, national drugs agency, major charities, professional associations) • Government policy emphasises importance of high quality prevention and refers to quality standards • Any dissemination activity not undertaken by the original standards developers

Example projects	Poland, Hungary, Croatia, Sweden, EQUS, UK
General evidence of effectiveness and practical considerations	A Cochrane review (Flodgren et al. 2011) concluded that opinion leaders alone or in combination with other strategies may successfully promote evidence-based practice. However, it was challenging to judge the effectiveness of this approach because primary studies differed greatly and described rarely what opinion leaders actually did. The role and purpose of opinion leaders will differ depending on target audience needs (e.g. promoting awareness vs. promoting skills; Bywood et al. 2009). It is important that opinion leaders meet certain criteria, such as being appreciated by their peers, having good interpersonal skills, being knowledgeable about and committed to evidence-based practice, and so on (Bywood et al. 2008a, 2009).
EDPQS-specific considerations	As it is not possible to undertake all necessary dissemination activities on your own, it is crucial to identify potential opinion leaders and to 'delegate' some of the dissemination work to them. Our experience suggests that endorsement of quality standards by opinion leaders can help to persuade target audiences that quality in prevention is an important issue, and that quality standards are a useful tool to achieve quality in prevention. Some opinion leaders will be able to take a more active role and become EDPQS champions. Ideally, quality standards can be disseminated in a cascading way, whereby the successful efforts of EDPQS champions motivate others to become EDPQS champions. A challenge in using this strategy is to identify suitable opinion leaders. In existing studies, opinion leaders were typically individuals nominated by their peers as 'influential' (Flodgren et al. 2011). In practice, we have found that EDPQS champions volunteer to take on this role as it helps them pursue their goal of increasing the quality of preventive activities. Furthermore, it seems that individuals as well as organisations can be successful opinion leaders. We suggest that the criteria specified in Exercise A (Step 1) of this toolkit can be used to judge the suitability of future opinion leaders. Ideally, opinion leaders will have already been involved in the project (e.g. as stakeholders, see above). It is nevertheless important to provide adequate support and guidance to EDPQS champions to help them understand their role, as well as to maintain their commitment and help them address any barriers.

Educational outreach visits (academic detailing)

Key message	**Likely to be effective if focussing on key messages and simple changes but there may be cheaper ways to achieve similar results**
EDPQS-specific examples	• A trained person visits prevention practitioners to introduce EDPQS, to discuss how EDPQS apply to their project, and may help them undertake a guided self-reflection
Example projects	Croatia; also trialled as part of EDPQS Phase II project ('case studies')
General evidence of effectiveness and practical considerations	Educational outreach or academic detailing involves a trained person visiting a healthcare provider at their workplace. During a meeting that typically lasts 10-15 minutes, the detailer informs the provider about a new healthcare approach and motivates the provider to adopt the new approach (Grimshaw et al. 2012). Research suggests that this strategy is effective in changing relatively simple behaviours (e.g. prescribing practice) but its effectiveness in changing complex behaviours is less certain (Grimshaw et al. 2012; Bywood et al. 2008a). The literature recommends that educational outreach should have clear objectives, identify and repeat key messages, address barriers to change, be tailored to specific contexts, use an interactive format (i.e. involve practitioners), use trained, credible educators, and be combined with additional strategies (e.g. feedback, follow-up) (Bywood et al. 2008a, 2008b). As costs can be relatively high, there is mixed evidence with regard to the cost-effectiveness of educational outreach (Bywood et al. 2008a; Grimshaw et al. 2012). Bywood and colleagues (2008b) recommend identifying the most appropriate level of intensity or complexity (e.g. in terms of location, frequency and duration of visits) required to achieve the desired level of change.

EDPQS-specific considerations	As part of the EDPQS Phase II project a slightly different strategy was used (Brotherhood et al. 2014). Prevention providers in Austria, Italy, Hungary, Greece and Germany were visited for one day, and educational outreach was combined with audit and feedback (see below). In those cases where providers had the possibility to amend their projects in the future (i.e. they were not obliged to follow a protocol), providers reported that they found it useful to review their own project using the EDPQS. In Croatia, educational outreach was also combined with audit and feedback with similarly positive feedback. In both cases, results on changes in prevention practice were not yet available at the time of preparing this toolkit.

Audit and feedback

Key message	**Likely to change the behaviour of 'poor performers' but currently no systematic approach available to assessing compliance with EDPQS**
EDPQS-specific examples	• Providing feedback on project strengths and weaknesses according to EDPQS
Example projects	Croatia; also trialled as part of EDPQS Phase II project ('case studies')
General evidence of effectiveness and practical considerations	Audit and feedback involves giving a healthcare provider information about how their performance compares with that of their peers or best practice guidelines, in the hope that the comparison will motivate providers to change their behaviour (Grimshaw et al. 2012; Bywood et al. 2008a). Data can be collected from medical records, electronic databases, or patient observations. Research suggests that audit and feedback is an effective strategy to produce professional behaviour change, especially if baseline adherence to recommended practice was low (Grimshaw et al.2012; Bywood et al. 2008a). A targeted approach could therefore focus on those practitioners with low levels of compliance. The literature indicates that providing feedback verbally rather than in writing, and combining feedback with other strategies, is likely to produce better results (Bywood et al. 2008a).
EDPQS-specific considerations	Our own experience (Brotherhood et al. 2014) suggests that to be well received, audit and feedback should focus on areas which the practitioner has control over. Practitioners may dismiss the standards as irrelevant if the audit highlights weak areas which they cannot influence. We also suggest acknowledging strengths (i.e. where providers do comply with the quality standards) as part of the audit to help providers develop positive attitudes towards quality standards. A challenge can be to formally assess provider's compliance with quality standards. However, we have found that prevention providers are more likely to engage with a broader discussion of their project in relation to quality standards rather than a very detailed assessment.

Prompts and reminders (including decision support)

Key message	**Prompts and reminders are generally effective at producing behaviour change but no evidence available on EDPQS-specific prompts and reminders**
EDPQS-specific examples	• Including items relating to quality standards on grant application forms, in routine project management forms, in database templates
Example projects	Hungary, Croatia, Sweden

General evidence of effectiveness and practical considerations	Prompts and reminders ask healthcare providers to recall information about evidence-based practice. For example, a prompt which automatically pops up on a doctor's screen may ask them to record certain medical information or to perform a certain action when seeing a patient. Research suggests that simple prompts and reminders are effective in changing professional behaviour, whilst the evidence concerning complex decision-support systems is less clear (Grimshaw et al. 2012). It has been suggested that prompts and reminders are more likely to be effective if they appear automatically, a response is obligatory, and they are combined with other strategies (Bywood et al. 2008a).
EDPQS-specific considerations	Target audiences would need to receive EDPQS-related prompts and reminders when planning their activity, rather than when interacting with target populations. In the Swedish Three Cities project (Example 5), the EDPQS were used as a template to describe each of the 14 sub-projects. Feedback indicated that this encouraged sub-project leaders to reflect on aspects of their work which they might not usually consider, but it was not clear whether this led to actual improvements in preventive practice. We suggest that EDPQS-related prompts and reminders could be integrated in funding applications, routine project management forms and similar templates, but our experiences with this strategy are limited.

Recognition as 'best practice' (including formal accreditation)

Key message	**May increase motivation but unknown effectiveness to change behaviour, and currently no systematic approach available to assessing compliance with EDPQS**
EDPQS-specific examples	• Inclusion of providers or activities meeting quality standards in databases of recommended programmes • Quality certificates issued to providers or activities meeting the EDPQS
Example projects	Poland, Hungary, Croatia (planned), UK (planned)
General evidence of effectiveness and practical considerations	Being formally recognised as delivering 'best practice' prevention may act as an incentive for providers to improve their activities. This approach was not reviewed by Bywood and colleagues (2008a) or Grimshaw and colleagues (2012), and so the literature does not permit conclusions regarding its effectiveness.
EDPQS-specific considerations	Our own experience suggests that such schemes can only work if there is real value to what is being offered. The scheme (e.g. best practice database) should be recognised and hold value in the prevention community. Experiences in the UK and other countries suggest that practitioners will be motivated to obtain a formal accreditation if it can be used as a selling point in negotiating contracts with buyers of prevention programmes (e.g. schools). It can be challenging, however, to develop a transparent and systematic procedure for determining whether a particular provider or activity meets the criteria to receive the quality certificate.

Financial incentives

Key message	**Available evidence not applicable to EDPQS and conditional funding may have unintended consequences**
EDPQS-specific examples	• Linking receipt of funding for prevention activities with fulfilment of minimum quality criteria or obligatory training on quality in prevention
Example projects	Croatia

General evidence of effectiveness and practical considerations	Existing research has examined the effectiveness of performance-based financial incentive schemes remunerating individual healthcare practitioners for specific clinical actions. Bywood and colleagues (2008a) report that evidence concerning the effectiveness of these approaches was inconclusive. The authors noted several factors that could impact on (cost-) effectiveness, including the magnitude of the financial incentive, concurrent competing incentives or disincentives, mode and frequency of payments (Bywood et al. 2008a). In addition, differences between national healthcare systems must be taken into account when considered financial incentive schemes.
EDPQS-specific considerations	Our own discussions with practitioners on linking funding receipt with fulfilment of quality criteria have highlighted the potential for unintended consequences (e.g. increased bureaucracy, fulfilment of standards on paper but not in practice, putting small organisations at a disadvantage) (Brotherhood & Sumnall 2010). In a pilot project, the Office for Combating Drugs Abuse in Croatia (Example 3) took an innovative approach whereby it was not required that projects meet the quality criteria from the beginning. Within its regular activities, the Office organises an annual Call for Tender for projects by non-governmental organisations. In recent years, this Call for Tender explicitly encouraged applicants to consider existing quality standards in the preparation of their applications. In addition, recipients of government funding committed to attending training on quality in prevention. Feedback indicated that this approach was well received by the practitioners, but at the time of preparing this toolkit it was unknown whether it led to improvements in preventive practice.

Statutory requirement

Key message	**Effectiveness depends on quality of the accreditation process and level of enforcement**
EDPQS-specific examples	• Only accredited providers (i.e. those fulfilling quality criteria) are allowed to deliver prevention activities in schools
Example projects	In Hungary, such a system is in place based on national quality criteria. EDPQS have been suggested as a means to support achievement of the mandatory criteria.
General evidence of effectiveness and practical considerations	This approach is similar to the previous one but in this case fulfilment of quality standards is a condition for undertaking any prevention work (in the given setting), rather than a voluntary choice. This approach was not reviewed by Bywood and colleagues (2008a) or Grimshaw and colleagues (2012), and so the literature does not permit conclusions regarding its effectiveness.
EDPQS-specific considerations	The challenges relating to this approach are similar to those described for the previous two approaches. In addition, the effectiveness of this approach will depend on how well it is enforced (e.g. whether non-accredited providers are actually rejected by school directors).

Multi-faceted interventions

Key message	**Likely to be effective if strategies complement each other but effect size doesn't necessarily increase with number of strategies**
EDPQS-specific examples	• Combination of any of the strategies mentioned above
Example projects	All of the above

General evidence of effectiveness and practical considerations	Combining several dissemination strategies may be more effective as it can address a greater number of barriers and reach different populations. Fixsen and colleagues (2005) concluded that implementation strategies were more effective in combination and if conducted over a longer period of time. McCormack and colleagues (2013) identified multicomponent strategies as the most effective approach in their review, especially if they included 'reach', 'motivation' and 'ability' components. Bywood and colleagues (2008a) found mixed evidence of effectiveness, with small improvements in most outcomes for preventive care but minimal or no effects in other clinical areas. Research suggests that the effect size is not proportional to the number of strategies (i.e. combining more strategies will not necessarily produce better results) (Grimshaw et al. 2012; Bywood et al. 2008a). Bywood and colleagues (2008a: 4) conclude that "a small number of well-chosen strategies targeted to the behaviour and tailored to the setting" may be sufficient to improve practice. Due to the heterogeneity of studies, authors were unable to identify which combinations of strategies were particularly effective. However, in order to effectively combine different strategies, it seems important to select strategies based on an assessment of target audience needs (including barriers to change), and to be clear about how strategies will work together to achieve the desired results (e.g. targeting different populations) (Bywood et al. 2008a; Grimshaw et al. 2012; McCormack et al. 2013).
EDPQS-specific considerations	Feedback received over the course of the EDPQS projects suggests that 'top-down' approaches (e.g. promotion of quality standards through policy) should be combined with 'bottom-up' approaches (e.g. involvement of practitioners in the development of standards, training activities) to ensure that the same understanding of 'quality in prevention' is shared across all levels.

4.2. Choosing appropriate dissemination strategies

So, which strategy to pursue?

The selection of dissemination strategies depends on specific circumstances, and thus we are unable to recommend any strategies that would guarantee uptake of the standards by your target audiences. However, the overview in the previous section should allow you to consider the pros and cons of different strategies and to make an informed choice. Remember that **no single strategy will meet all the desirables**, which is also why a combination of different strategies is preferable.

In the previous section, different dissemination strategies were presented alongside evidence of effectiveness and practical considerations. Your choice of dissemination strategies, however, will have to take into account the particular circumstances of your work context. Therefore, factors to consider will include:

- *Effectiveness* (Based on previous research and experiences, how likely is it that this strategy will work well to produce the desired changes in target audiences [e.g. motivate them to use the standards in practice]?)
- *Coverage* (How big is your target audience vs. How many people can you reach with this strategy? Will it systematically exclude any important professional groups?)
- *Acceptance* (What are the preferences of your target audience? How familiar is your target audience with this strategy? How likely are they to find it appealing and useful?)
- *Intensity* (Does the strategy allow superficial or in-depth engagement with the standards?)
- *Fit* (Does the strategy correspond to target audience characteristics [e.g. their level of expertise]? Does it address major barriers currently preventing uptake of quality standards?)
- *Costs* (What resources does this strategy require from you as well as from the target audiences [e.g. time, money, know-how, delivery structures]? Are these resources available?)
- *Sustainability* (Could the strategy be implemented and sustained over a longer period of time?)

You will also want to consider how the different strategies will help to achieve the different outcomes specified in the EDPQS Theory of Change (awareness, motivation, skills, adoption, and implementation). McCormack and colleagues (2013) suggest that different dissemination strategies focus primarily on one aspect. For example, according to their categorisation, mailing information would be a 'reach' strategy; use of opinion leaders would be a 'motivation' strategy; and training would be an 'ability' strategy. However, it could also be argued that dissemination strategies can (and should) incorporate elements concerning several aspects. As Grimshaw and colleagues (2012) note, educational materials usually focus on improving knowledge and skills, but if written persuasively they may also increase people's motivation to take action.

It is likely that you won't have the resources available to undertake all relevant dissemination activities. There are different **possibilities to prioritise resource allocation**:

- Identify the most critical barriers which you can actually influence, and choose dissemination strategies addressing these (Grimshaw et al. 2012) (see also Exercise H below).

- Take a 'stepwise' approach to dissemination, initially using less costly strategies with a broad target audience, followed by more resource-intense strategies aimed at specific groups (e.g. those who did not respond to the less costly strategy) (Bywood et al. 2008a).

- Following our distinction of 'awareness', 'motivation' and 'skills', you may wish to i) use less costly strategies to increase awareness concerning quality standards across the prevention community (including practitioners, policy makers, researchers) to help establish a shared vision and vocabulary concerning quality in prevention; and ii) use more resource-intense strategies to develop the motivation and skills among those who would benefit most from using quality standards.

Learning from Rogers' "Diffusion of Innovations" theory

Rogers' "Diffusion of Innovations" theory describes how, over time, innovations (e.g. an idea, behaviour or product) can naturally become part of routine practice. He distinguishes five stages in this process (knowledge, persuasion, decision, implementation, and confirmation), which correspond to stages found in other behaviour change theories (for a comparison of different theories, see Bywood et al. 2008c). What distinguishes Rogers' model from other theories, however, is his categorisation of individuals based on how quickly they adopt an innovation (referred to as "adopter categories"):

- *innovators* are in a position to introduce an innovation into the system;
- *early adopters* have been waiting for this kind of innovation and so will soon start using it and act as opinion leaders in convincing others of its benefit;
- momentum for diffusion of the innovation gathers as the *early majority* adopts the innovation as its benefits become evident;
- followed by the more sceptical *late majority*; and ultimately
- the *laggards* who oppose the innovation for as long as possible.

Although the theory did not originate in public health, it can be helpful to consider these categories when trying to characterise your current situation as well as the stakeholders and intended target audiences for your project. If your context is still in the early stages of developing quality in prevention, you should try and engage the early adopters as these will show greater readiness to engage with your project and its products even if these are not yet widely used. Conversely, laggards will need to see that the innovation has become routine practice before they too decide to adopt it, so although you may involve them from the beginning, you should grant them more time to adapt to change. Dissemination strategies will vary accordingly (e.g. in terms of the arguments used)[3].

Exercise H: Matching dissemination strategies with barriers to standards uptake

The purpose of dissemination strategies is **to overcome potential barriers that hinder adoption and implementation of evidence-based practice**. Dissemination strategies are more likely to be successful if they address the prevailing barriers to knowledge transfer in a given context (Grimshaw et al. 2012). In Step 2, we considered different barriers and facilitators, as well as the readiness of prevention system(s) and professional culture(s) with regard to quality standards.

Return to Step 2, and review your answers to Exercise E as well as Figure 3. Which of the red boxes described the prevention system(s) or professional culture(s) in your context? What could be appropriate dissemination strategies to improve the situation? For example, if your target audience doesn't know about the existence of quality standards, you may want to disseminate information about them. How would you do this, and how might this be followed up to achieve actual improvements in preventive practice?

Use the box below to note your initial ideas. *Refer also to the overview tables in the previous section to consider different dissemination strategies and to refine your ideas.*

4.3. General recommendations for promoting quality standards

Regardless of what strategies you choose, it may be helpful to keep in mind the **following key elements of successful dissemination strategies**, as identified by Bywood and colleagues:

- Clear and succinct message, with simple, focussed objectives that require small practical changes
- Reliable and credible source, with accurate, evidence-based information
- Interactive format that is appealing, persuasive and encourages participation
- Tailored information that is personalised and modified to the local setting
- Relevance of information to the practitioner and their client needs
- Clear identification of roles and activities
- Systems or procedures that are accessible and easy to use, with little effort required to comply
- Assessment of, and focus on barriers to change
- Address changes at multiple levels, including the individual practitioner behaviour, organisational structure and culture, and health system policy
- Organisational changes that require practitioners to respond or take action (e.g., automatic prompts and obligatory responses)
- Reinforced messages, with additional materials and support
- Sustainability of strategy over a prolonged period (from Bywood et al. 2008a: 6).

Besides these points, our own experience suggests it is extremely important to highlight the **practical benefits of quality standards for your specific target audience**. Although target audiences will soon agree that quality standards can be beneficial to the prevention community overall, in order to motivate them to use quality standards in their own work, you will have to highlight the specific benefits for them. It will be helpful if you can show how the quality standards complement (and differ from) existing resources already used by your target audience.

★ EDPQS Champions from Croatia (*Example 3*) recommended assessing what the target audience knows, thinks and feels about prevention, quality and standards, and to start a discussion from there[4]. **Target audiences should be treated as partners in the process of achieving quality** in prevention. Asking practitioners to justify their past actions and to demonstrate how they meet the standards can put them in a defensive position and thus reduce their willingness to engage with quality standards. Any dissemination activity should seek to support target audiences in developing their prevention activities further, rather than take a punitive approach.

It can also be necessary to correct potential misperceptions about quality standards when communicating with target audiences. Target audiences may feel that quality standards devalue existing experiences and practices, and worry that existing activities will be no longer funded if they don't meet all standards. In such cases, it will be useful to clarify that quality standards are primarily a tool to help improve existing activities, and that practitioners should aim to meet all the standards that are relevant and feasible within the confines of a given project. To start with, it will be sufficient if activities are informed by the standards, even if it is not (yet) possible to meet the standards. Or, for example, the standards may be perceived as over-emphasising written documentation. It must be clear that actions are more important than words, and that the standards refer to documentation primarily as a proxy because actions can be difficult to observe[5].

Exercise I: Practical benefits of using quality standards

Take a moment to consider potential practical benefits of using quality standards – not from your point of view, but **from your target audience's point of view**. Consider how the standards can help them in their everyday work. What problems does your target audience encounter on an everyday basis? Can using the standards help to solve any of these problems? How do the standards link up with existing guidance (e.g. government policy, legislation) that target audiences are obliged to follow? Can they support achievement of existing requirements? What is the added value of the standards over existing materials? If you involved stakeholders in Step 3, it is likely that they will have given some opinions on these questions.

Use the box below to note your ideas. These could form the basis for what to highlight during dissemination activities. If you are unsure what to write, you can check the box below or the EDPQS PowerPoint presentation as it also describes ways in which quality standards can help with everyday practice (see **www.prevention-standards.eu***).*

What can be the benefits of using EDPQS from the end-user's point of view?

Here are some examples of potential benefits mentioned by prevention professionals during discussion groups in the EDPQS Phase II project (Prevention Standards Partnership 2014: 19):

- EDPQS offer guidance where official standards are not yet available or where drug prevention guidance more generally is scarce
- EDPQS help to achieve other (binding) aims, such as those defined by national/local strategies, targets or other standards; and/or the broader aims of education, public health, crime prevention, and so on
- EDPQS help to clarify what prevention is trying to achieve beyond monitoring indicators and performance targets set by commissioners
- EDPQS offer a common communication code among stakeholders belonging to different professional categories, allowing them to share a common view and approach on project designing and managing
- EDPQS offer a common project structure
- EDPQS offer planning and decision making tools
- EDPQS offer safety and reassurance in the implementation phase by helping to avoid mistakes

4.4. Assessing the impact of introducing standards

While considering possible dissemination activities to promote the standards, it is also important that you think about **how you will know whether you are achieving your aims** of promoting quality in prevention (e.g. whether the standards are being taken up by your target audiences and leading to improvements in preventive practice). Some aspects of monitoring and evaluation may also be a requirement if you received external funding for your work on quality standards.

★ Out of the *Example Projects* included in this toolkit, only Mentor ADEPIS in the UK (*Example 8*) formally assessed the impact on their work. The charity conducted a short online survey and qualitative follow-up interviews with local government, schools, teachers, and NGOs working in schools. The survey was publicly accessible and was advertised through social media and other channels. The aim was to better understand if and how resources produced through the project were being used by primary and secondary target audiences. Data collected included, inter alia, whether target audiences were aware of and using ADEPIS resources; how the standards were used or implemented; and how the standards impacted on the delivery of alcohol and drug education, as well as general service provision. A report on the findings was being written at the time of preparing this toolkit.

The example above demonstrates that it is feasible also in a non-academic context to gather relevant information that will help you understand if and how the standards are being used by your target audiences.

Who to collect data from, and how?

Research may target any member of your target audience (as in the example above) and/or the specific individuals who you reached through your adaptation and dissemination activities (e.g. stakeholders participating in consultations, recipients of educational materials, training participants). Depending on the circumstances, data may be collected through telephone or face-to-face interviews, online surveys, printed questionnaires (e.g. at the end of training sessions), observations (e.g. during training sessions), and similar means.

Although the actual impact of the standards can be measured (e.g. increases over time in % of grant applications meeting quality standards), this is likely to be challenging, not least because of the potentially long time-spans between introduction of the quality standards and emergence of notable changes in the quality of prevention work, in the professional culture, and target populations. Focussing on the immediate and intermediate outcomes is more feasible.

Similarly to how process and outcome indicators can be distinguished when evaluating interventions, we can consider process and outcome indicators relating to dissemination of quality standards. **Process indicators** are likely to explore reach/coverage of your target audiences, acceptability of the standards and the strategy, and use of resources. Examples of relevant indicators could include:

- Number of training sessions or presentations delivered, and context (e.g. invited speech?)
- Number of participants at training events
- Feedback following training events (+/-)
- Number of people participating in stakeholder consultations, and context (+/-)
- Number of educational materials disseminated
- Number of visits to website
- Number of downloads of materials from website
- Number of contact and information requests, and context (+/-)
- Number of references in documents not written by your own group, and context (+/-)
- Total number of people reached
- % of target audience reached

- % of respondents reporting no barriers to using/implementing standards
- Costs of dissemination strategy

Outcome indicators can be organised according to the five categories provided in the "Outcomes" box of the EDPQS Theory of Change (see **http://prevention-standards.eu/theory-of-change/**). Examples of relevant indicators could include:

- *Awareness* – % of respondents who believe that quality standards are important; % of respondents able to describe what the EDPQS are and where to access them; % of grant applications making reference to the EDPQS in a general way

- *Motivation* – % of recipients of educational materials requesting additional information; % of respondents agreeing that EDPQS are 'useful' or 'very useful'; % of respondents intending to use EDPQS; % of providers applying for quality certificates

- *Skills* – % of respondents stating they have read the Manual or Quick Guide; % of respondents being able to describe specific ways in which the EDPQS could be used in their organisation; % of respondents stating they would feel 'confident' or 'very confident' to apply EDPQS in their own work; % of respondents able to describe key concepts within the EDPQS; % of respondents able to discuss strengths and weaknesses of prevention projects in relation to the EDPQS

- *Adoption* – % of respondents who have used the EDPQS to plan/review a prevention activity; case studies of how standards have been used by members of prevention community; % of involved stakeholders who have become EDPQS champions; % of funders who have revised their funding criteria in line with EDPQS; % of prevention providers stating they routinely use the EDPQS when planning prevention activities; % of externally delivered training courses referring to EDPQS

- *Implementation* – % of respondents stating they have made changes to their activity as a result of using the EDPQS; case studies of changes made; % of funded projects meeting EDPQS

Although the indicators above are mostly quantitative, qualitative indicators are equally valuable. Note also that the above examples are suggestions rather than firm recommendations, as other questions may be more relevant in your case (consider also your answers to Exercise B, Step 1).

The EDPQS training pack includes questionnaires that can be used to assess participant needs and their progress towards adopting quality standards (Toolkit 3; **www.prevention-standards.eu**).

With regard to **when information should be collected**, there is no single answer. For example, if you wish to collect data from training participants, observations may already take place during the training (e.g. are participants able to discuss the strengths and weaknesses of a project using the quality standards without difficulty?), a questionnaire at the end of the training may collect information on motivation and skills, whereas a follow-up phone call a few weeks after the training may ask training participants about adoption and implementation. This also highlights the overlap between dissemination activities and activities to measure dissemination, as a follow-up phone call may actually increase the effectiveness of the initial training in producing behaviour change (Bywood et al. 2008a).

★ In the Mentor ADEPIS project (*Example 8*), the impact assessment was undertaken nearly a year after the quality standards had been published. At the time of undertaking the assessment, a number of dissemination activities had already taken place to promote the quality standards.

Longer-term follow-up can also help you understand if initial interest in the quality standards is subsiding, and whether any additional activities are required to sustain the momentum.

4.5. From dissemination to implementation

At the beginning of Step 4, dissemination was defined as "the active and targeted distribution of information or interventions" (McCormack et al. 2013: 5). In contrast, implementation can be defined as: "The process of putting a defined practice or program into *practical effect*; to pursue to a conclusion" (Fixsen et al. 2005: 82, emphasis added). In the context of the EDPQS, this would mean ensuring that prevention practice is actually amended as necessary to be in accordance with the EDPQS.

It is therefore useful to **distinguish between dissemination and implementation strategies** (Bywood et al. 2008a; McCormack et al. 2013). In the context of the EDPQS, dissemination strategies typically aim at engaging target audiences with quality standards. In other words, many dissemination strategies focus on the first three outcomes listed in the EDPQS Theory of Change (awareness, motivation, skills; see **http://prevention-standards.eu/theory-of-change/**). It is assumed that if target audiences have been successfully engaged (i.e. they have the necessary awareness, motivation, and skills), then they will adopt the quality standards and try using them when they next plan/review prevention activities. It is then **up to them** to devise appropriate implementation strategies (i.e. to identify ways of changing their prevention practice so that the quality standards are achieved). In some cases, it will be possible to implement the standards immediately by making small changes at no extra cost; in other cases, additional preparatory work will be required before the standards can be met. If changes are not possible while the intervention is ongoing, it may be necessary to wait until the intervention starts with a fresh cohort of participants.

Implementation of quality standards can be **challenging because it requires applying something general and abstract to a very specific context** (Brunsson & Jacobsson 2002). End-users may struggle to understand what a particular standard means in the context of their specific project, or even if it is applicable (Brotherhood et al. 2014). An overly rigid reading of the standards may frustrate users and mean that standards are wrongly dismissed as 'not applicable', while a very broad interpretation may render the standards meaningless. The task for end-users is to understand the underlying 'function' of the standard (i.e. why is this important for a high quality project? Why has it been included?). They will then be able to consider it in the context of their own work, keeping in mind that there is 'flexibility in form' regarding its achievement (i.e., in practice the same standard may be achieved through different means; Brotherhood et al. 2014)[6].

> Since implementation of quality standards must take into account the specific circumstances of the project and its local context, we are unable to offer specific suggestions for implementation strategies[7]. Your target audience should be able to successfully devise implementation strategies in relation to most standards.

However, there can also be **structural barriers** that prevent target audiences from acting on their good intentions and achieving change (Bywood et al. 2008a; Grimshaw et al. 2012). For example, even if target audiences are motivated and skilled to use the standards, they may be unable to do so because there is never enough time, or their manager may not support use of the quality standards because they are not mentioned in government policy. And even if quality standards are adopted in everyday practice, it is yet another thing to actually implement them[8]. Assume a practitioner finally had a chance to review an existing project using the EDPQS Quick Guide, identifying lack of an outcome evaluation as a weakness that they would like to address. Yet, if there is no funding available to undertake an outcome evaluation, then the standard is not implemented, even though it was adopted by the practitioner. We touched upon this issue in Exercise E (Step 2), when you were asked to consider potential barriers to standards uptake among your target audiences.

- The Polish EDPQS champion described the situation in Poland (Example 1) as follows: *"It is difficult to implement the standards in practice. Due to the decentralised system in Poland, we can only recommend them, but we can't make them obligatory. It requires additional work and new ways of thinking, whereas commissioners make decisions based on their own experience and they don't have a reason to change their working approach. Even if commissioners have read the standards*

> *and agree with them, it can be difficult to use them in practice. […] If the EDPQS are used for funding decisions, it may mean that none of the local projects will qualify for funding because they don't meet the standards. There are local traditions of which programmes are implemented, how things are done, and which NGO's are active locally. There is an established 'market' of prevention providers and programmes in Poland. It is not easy to change this. That is why non-evidence-based programmes continue to be offered".*

So while many dissemination strategies focus on the readiness of prevention providers to use quality standards, there can be other kinds of barriers that are more difficult (but equally important) to address. Even if all members of the prevention community agreed on the importance of conducting, for example, outcome evaluations, it would not be possible to do so unless the necessary structures and resources were in place (e.g. funding, expertise). Consequently, the dissemination strategies described in the previous sections will have limited impact if achievement of quality is not facilitated by appropriate prevention structures.

The **achievement of some standards may be outside the control of individual providers**, and may require action from higher-level policy-makers and other influential groups. Below, the final Exercise J, addresses this point.

Exercise J: Strategies to support implementation of quality standards

While members of your target audience need to consider implementation strategies only in relation to their own projects or organisations, your task as EDPQS champion is more complex than this. As you are hoping to improve the quality of prevention in a wider professional context, your implementation strategies will need to address wider structural barriers (including at the systems level) to the delivery of high quality prevention.

Whether or not you – as an EDPQS champion – will undertake implementation strategies in addition to dissemination strategies depends, inter alia, on how much influence you have over the prevention system in your professional context. If you are based in a government agency or other influential organisation, you may be in a good position to review the suitability of the prevention system for delivering high quality prevention. Are there any areas which need to be developed further before your target audiences are able to meet the quality standards? What would need to be done to improve these areas? If you are not in a position from which you can directly influence the prevention system, you may still be able to start or further this process by advocating for the required changes. It is likely that any such activity will require an entirely new project, independent (although following on) from your project to adapt and disseminate quality standards.

This is the final exercise in this toolkit, so it also serves to help you think about your next activity to improve the quality of preventive work in your professional context.

Use the box overleaf to note aspects of your prevention system that do not support high quality prevention, and how the situation could be improved. Try and formulate an action plan and highlight the tasks which you would like to tackle next.

How to support quality in prevention at the structural/systems level?

Checklist: Tracking the progress of your adaptation

During the adaptation process, you can use the following checklist to monitor your progress. Have you:

- ☐ Planned appropriate dissemination activities?
- ☐ Considered how you will measure the impact of your work?
- ☐ Developed first ideas about what to do next to support quality in prevention?

You've completed Step 4

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Notes

1 We identified four broad reviews summarising the available literature on the effectiveness of dissemination strategies. All four reviews covered the broader health field rather than the substance use field. Studies relating specifically to the dissemination of quality standards were not highlighted in any of the four reviews. Fixsen and colleagues (2005) sought to synthesise research in the area of programme implementation and replication. They distinguished experimental studies (including reviews) based on whether these presented ineffective or effective strategies related to different implementation components (staff selection, training, coaching, evaluation); correlational research was discussed separately. Bywood and colleagues (2008a, 2008b, 2008c) published three related reports reviewing dissemination strategies in health, with a specific focus on their applicability to the alcohol and drugs field. Results were distinguished according to the clinical areas in which the primary studies had been conducted (i.e., disease/pain management; prescribing and test ordering; preventive care; counselling/communication; diagnosis; adherence to guidelines; referrals; general medicine). The costs and cost-effectiveness of dissemination strategies were also explored, but the evidence was limited (Bywood et al. 2008b). The Cochrane Effective Practice and Organisation of Care (EPOC) group undertakes reviews of interventions to improve healthcare systems and healthcare delivery. Grimshaw and colleagues (2012) summarised the results of key Cochrane EPOC reviews on knowledge transfer strategies. Most recently, McCormack and colleagues (2013) published a review in which dissemination strategies were categorised into the domains of 'reach', 'motivation' and 'ability' in line with their (assumed) primary purpose. However, these authors were unable to draw clear conclusions using this categorisation, and in the following we therefore refer primarily to the other reviews. A fifth review (Flodgren et al. 2011) reviewed the effectiveness specifically of using local opinion leaders in dissemination efforts. As this section is necessarily brief, interested readers are referred to these reviews for more detail.

2 The labelling of dissemination strategies was adapted from the taxonomies used by Grimshaw and colleagues (2012) as well as Bywood and colleagues (2008a), with modifications. With regard to the EDPQS-specific examples, dissemination activities have also taken place elsewhere but we only listed those countries and projects which are also included in the Example Projects document in this toolkit. The COMIQS.BE project in Belgium (Example Project 7) is not mentioned here, as its dissemination strategy had not yet been finalised at the time of preparing this toolkit.

3 We thank our German colleague Frederick Groeger-Roth for highlighting this point.

4 In the EDPQS training materials (Toolkit 3; **www.prevention-standards.eu**), Units 1/1A outline a training activity for exploring these concepts in a group setting.

5 For further guidance, refer to the EDPQS Questions and Answers: **http://prevention-standards.eu/questions-and-answers/**

6 A similar argument concerning core components of preventive interventions can be found in the review by Fixsen and colleagues (2005: 25).

7 Bywood and colleagues (2008a) review a number of 'organisational interventions' which could also help to implement quality standards at the organisational level (not covered here, see their review for further details).

8 This includes the problems of "paper implementation" and "process implementation", whereby written policies or procedures are adopted but actual practice is not changed (Fixsen et al. 2005: 6) (further discussed in the EDPQS Position Paper).

European
drug prevention
quality standards