Public awareness, school-based and early interventions to reduce alcohol related harm

A TOOL KIT FOR EVIDENCE-BASED GOOD PRACTICES

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on behalf of Joint Action RARHA's *Work Package 6*

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PUBLIC AWARENESS, SCHOOL-BASED AND EARLY INTERVENTIONS TO REDUCE ALCOHOL RELATED HARM
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Recension

Some years ago, the Commission introduced the concept of Joint Action as part of the European Union (EU) Health Programme. The idea was to get a better output from EU-financed research projects through involving health authorities of the Member States (MS) more directly in the cooperation linked to concrete research issues. One aim was to achieve a faster implementation of proposals brought forward through those EU-financed research projects. The working method is to involve the governments in recruiting the so-called associated partners from the research institutions to form working parties within the EU for specific issues. The idea is that this working method will bring governments and the research community closer. Since the beginning of Joint Action system, the MS have been invited to participate in specific Joint Action programmes covering a variety of disciplines.

The Commission presented a concept for a joint action on alcohol to the Committee on Alcohol Policy and Action (CNAPA) during the summer of 2012. The Joint Action concept was new to most of the CNAPA members, but nearly all members had joined this Joint Action when Reducing Alcohol Related Harm (RARHA) was launched in February 2014.

Three operational work packages (WP4, WP5 and WP6) were introduced. The first two were covering issues, which had been frequently on the CNAPA agenda for years; *monitoring* methods and drinking *guidelines*. They were difficult issues for different reasons, but issues that would be of interest for the governments.

The WP6 "Best practises" was not difficult, but many doubted that one would get much out of such a broad concept. Best practises do not address cross-border policies including EU regulations etc. It is a classical theme for practical intergovernmental cooperation without any political obligations connected to the work. One other concern was that a report on ongoing good projects would soon be outdated. Therefore, this WP got more attention at the beginning by the RARHA advisory board (where the MS representatives participate) than the other operational work packages.

In the end, the WP6 turned out as a very useful and most relevant tool kit for national authorities.

The general population level approach measures for prevention such as taxation, availability regulations etc. are not covered here. They have been high on the agenda in the past years and the knowledge base is generally well known.

Measures addressing the individual behaviour change directly have not had the same attention in international cooperation on alcohol related harm. Some programmes have even gained a reputation as popular programmes with little effect. Another reason for little interest is a common understanding that such measures must have a strong focus on local or national particularities, hence are not so easy to transfer to other countries.

The methods chosen to address best practises in this report strongly defend the choice of this theme as one of the three work packages.

WP6 gives a presentation of three types of prevention programmes addressing the individuals with different methods of implementation, but also different level of knowledge base.

Public awareness is covering the area of public communication programmes and social marketing. With an increased political interest for behavioural economy, these presentations fit well into that paradigm.

School based programmes have a long history, with a large number of different setups throughout Europe. Many have not satisfied a design that can be evaluated and measured; many more have shown little or no effect on reducing the harm caused by alcohol.

Early intervention programmes have, over a short period of years, gained a strong support for being cost effective measures.

I would like to point out four elements in the WP6 that may be of special interest for governmental bodies involved in planning policies for reducing harmful alcohol use.

1. The systematic description of each of the three types of measures addressing individual behaviour.
2. The recommendations for methods of choosing good practice approaches. The presentation of projects of good practice is in itself a very useful tool kit for measuring projects also at national level.
3. A very good summing up of early intervention's position as a cost-effective measure.
4. There are interesting projects to consider for use at home in the three lists of projects being screened as good practices.

There has been a worry that the actuality of the lists of good practises will not last long. I hope that both the MS and the Commission would see the usefulness of the method used to choose the good practices. One proposal is to establish a permanent setup for screening projects of good practices in reducing harmful alcohol use and let it be available for MS to consider in their national programmes. Since we now have the methods, this should not be a costly endeavour. Engaging three to five experts to go through projects and present them in the format we see in this WP6 every second year and provide them with some administrative support, would be quite cost-effective.

The WP6 has shown us a way to do it simply, yet professionally.

Bernt Bull
Senior advisor
Ministry of Health and Care Services, Norway
Department of Public Health

Executive Summary

"What should we do about alcohol?" Michael Marmot asked in 2004 (1). In his frequently cited editorial to the British Medical Journal "Evidence based policy or policy based evidence?", he was referring to the situation in the United Kingdom, characterised by a rate of alcohol consumption that had risen by about 50 % in the previous 30 years. Conversely, average consumption in Europe reached its lowest point in 2012 since 1961 (1, 2). Such averages may, however, disguise the underlying heterogeneity. Indeed, while the highest consumption countries have seen a drop, some of the countries with lower alcohol consumption rates have actually seen a rise in the same 50 year period.

Despite this diversity of epidemiologic developments in Europe, there is a shared concern, which brought together partners in Joint Action on RARHA. Europe remains the world region with highest alcohol consumption rate. The significant harm associated with consumption of alcohol at this level creates a need for identifying the most effective measures to counter the harm and it was this need, which motivated the creation of this tool kit.

At the core of the document are criteria, which were used to qualify the evidence base of submitted interventions. In alcohol prevention, a wide chasm exists between expectations of prevention scientists who are rarely content with anything other than andomised-controlled trials (RCTs) and the reality of prevention in practice – a reality in which the majority of interventions are not evaluated at all. To bridge this divide and provide practitioners and policymakers with hands-on advice, we adapted a Dutch classification system of the National Institute for Public Health and the Environment (3). The system is described in the country report of the Netherlands of Joint Action Chrodis (4). It rates interventions along a continuous scale of evidence levels, ensuring that a number of minimum requirements are met. With this approach, we were able to identify and classify interventions other than RCTs. Using this methodology, 26 out of a total of 43 assessed interventions were accepted.

Sometimes, the same evidence can lead policymakers to different conclusions, depending on the underlying values, as Marmot convincingly argued. It is the purpose of this document to inform policymakers about the tools for the assessment of available evidence.

For the tool kit, three areas for preventing alcohol related harm were chosen: early interventions, public awareness interventions and school-based interventions.

Some authors (5, 6) advocate the so-called "best buys" for reducing alcohol related harm: increasing taxes, restricting access to alcohol and banning advertising. While the debate on the exact mechanism of average aggregate consumption and alcohol related harm is ongoing, there is ample evidence that the law of demand applies to alcohol and that aggregate alcohol demand drops when prices go up (modest price elasticity).

Among the three approaches we assessed, "early interventions" (e.g. motivational interviewing) have long been held in higher esteem due to comprehensively demonstrated efficacy and effectiveness, than school programmes or public awareness campaigns. Why then did we limit our selection of measures to a number of activities that are sometimes considered relatively ineffective compared to regulatory measures?

RARHA is a joint initiative of EU MS as well as Iceland, Norway and Switzerland. But taxation and many regulatory measures are the prerogative of national governments and go beyond the mandate of Joint Action. Furthermore, stakeholders place great importance on education, in schools and through public awareness campaigns. Governments have an ethical mandate to inform all citizens about health risks. Public awareness campaigns may stimulate public debate and prepare the implementation of new policies. While interventions in some areas may be less effective than regulatory measures overall, the effectiveness of an individual intervention is ultimately not determined by the category it belongs to (school, public awareness, early intervention, etc.). Although a certain category may generally not provide much favourable evidence of effectiveness, an individual intervention may work well (as proven by the examples in the tool kit). Conversely, a methodological approach with proven effectiveness in general public may have less empirical backing in certain populations, as in a case of brief interventions conducted in school settings (7). The effect of public awareness campaigns may be small but their reach is large and interventions in schools offer easy access to a target population, in other words to "get up close and personal."

Working as a multi-national team, we have learned that values, ethics and context all matter and that there is no "one-size–fits-all" approach to effective alcohol prevention. Epidemiological developments differ between and within countries and so do value systems and cultures. This should be taken into account. At a minimum, this tool kit will help choosing a highly evaluated and effective intervention over a poorly evaluated and ineffective one.

Additionally, it will make readers aware of the importance of values in alcohol prevention: rather than clouding rational thinking, values help us to select an appropriate intervention. The same applies to context: if epidemiology differs, governmental responses should take this into account when designing policies.

Ultimately, this tool kit is not so much about saying what approach is "the best" in a certain context. Science simply cannot make that decision for us. The scientific method just helps us to tell apart good evidence from bad.

As in penal law, the most drastic sanctions may often be the most effective ones. In European liberal democracies, however, a range of subtler non-regulatory measures should be included in the portfolio of governmental responses and factors such as effectiveness and cost-effectiveness should not be the only guidance. Or as Michael Marmot would put it: "Scientific findings do not fall on blank minds that get made up as a result. Science engages with busy minds that have strong views about how things are and ought to be" (1).

If the goal is to reduce alcohol related harm it is necessary to build up a cultural norm where drinking little and avoiding drunkenness and binge drinking is the normal thing to do. To reach that goal it is necessary to use a combination of methods. Laws and regulations are the strongest signals to the population, prices and taxes are strong economic incentives as well as restrictions on marketing, whereas mass media campaigns (including drink-driving campaigns), if repeated for many years, can be a tool to point out negative health and social effects of alcohol and problems and thereby support healthy norms. In the same way norm setting from health or social professionals through brief interventions is helpful, and education can as part of this whole strategy be helpful. At last a qualified alcohol treatment system is necessary for the families where a person is drinking. So there is no choice of a single effective method which can make a country reach the goal. It is the combination of methods in a strategy for all levels in society which are important. Or as Babor said in his famous book *Alcohol: no ordinary commodity*: "A complementary system of strategies that seek to restructure the total drinking environment is more likely to be effective than single strategies ... Full spectrum interventions are needed to achieve greatest population impact." (6).

Science asks what is, not what ought to be and it would thus be fallacious to derive political decisions from scientific evidence (8). To highlight that values not only influence our perception, but that they may guide our decision-making, we included a chapter on ethics in the annex, which sets out a number of empirical findings about effectiveness that need to be

counterbalanced with value-based considerations of social justice, personal freedom and proportionality. The chapter also includes a brief introduction to a framework for ethical evaluation, which has recently been developed (9).

Recently, there has been increasing interest in the creation of frameworks that attempt to integrate empirical evidence, values and context in the formulation of public health policies. The authors of one such framework describe it like this: "The goal is therefore to foster a dialogue among stakeholders that will promote decisions that are more nuanced, more transparent and, ultimately, more likely to have an impact on improving health. Nonetheless, decision-making remains an inherently iterative and often somewhat disorganized process, especially as we move towards population-based and global-level decisions" (10).

We hope that this document provides you with some tools that will help you make decisions in alcohol prevention that are grounded in the best available evidence, while making explicit the values and context that guide your decision.

1. Introduction

1.1. ABOUT RARHA

The Joint Action on Reducing Alcohol Related Harm (RARHA) was co-funded by the EU under the second EU Health Programme together with the contribution from MS. RARHA was a three-year action aiming at supporting MS to carry out work on common priorities in line with the EU Alcohol Strategy, and strengthen MS capacity to address and reduce alcohol related harm.

The Joint Action RARHA was coordinated by the Ministry of Health in Portugal (General Directorate for Intervention on Addictive Behaviours and Dependencies – SICAD). 31 Associated Partners and 28 Collaborating Partners took part in the Joint Action. In the group of associated partners, there were 27 EU MS together with Iceland, Norway and Switzerland. The group of collaborating partners included, among others, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), World Health Organization (WHO), Pompidou Group and the Organisation for Economic Co-operation and Development (OECD). SICAD ensured the coordination of all partners involved, as well as the coordination of the Joint Action WPs.

The work in RARHA was divided into three horizontal and three vertical working areas, which contributed to a better understanding of European and national realities through the harmonization of concepts and data collection, while facilitating the monitoring of this phenomenon. The horizontal themes of WPs were: coordination, dissemination and evaluation. The vertical WPs addressed issues such as: a) generating more comparable data across EU MS on consumption patterns and on alcohol related harm (WP4); b) understanding the scientific basis for different guidelines for low risk drinking across Europe, to provide guidance to policy makers (WP5); and c) developing a tool kit to disseminate good practices on early intervention (for more information see CHAPTER 4), public awareness campaigns (for more information see CHAPTER 5) and school-based programmes (for more information see CHAPTER 6) (WP6).

1.2. WORK PACKAGE 6 DESCRIPTION

The aim of the WP6 was to contribute to the implementation of the EU strategy to support MS in reducing alcohol related harm, by focusing on concrete examples of good practice approaches that are implemented in MS. They present an important evidence base for MS' policy decisions and actions in the fields of alcohol prevention, treatment and harm reduction.

This WP built on the information gathered by the WHO report Alcohol in the European Union, which indicates that information activities related to alcohol consumption are widespread. Good practice approaches exist but are not collectively evaluated and available for use by other MS, while in some settings, they seem to be missing. WP6 work was also built on the results of related projects funded under the EU Health Programme and under the EU Research Framework Programme. There are several good practice compilations – publications and databases – many of which have been produced with EU-funding. The challenge within the WP6 was to make them more accessible and more useful for the intended beneficiaries, in this case for relevant ministries, policy makers, public health professionals, NGOs or other stakeholders and professionals responsible for designing and implementing alcohol policy interventions.

WP6 communication strategies were further developed in order to optimize the dissemination of alcohol related information to the general public and specific sub-groups. An important goal was to strengthen capacities of EU MS in building up information-based public education campaigns in combination with personal and online communication on the subject of drinking behaviour and self-help guidance.

The main tasks within WP6 were: a) Providing good practice examples; b) Developing good practice criteria; c) Compiling examples into a tool kit; and d) Disseminating the tool kit.

This European-wide assessment of alcohol prevention interventions was a unique attempt to improve the quality of alcohol prevention interventions in the MS. It was a first step towards a continuing exchange of field experience in order to promote evidence-based implementation of alcohol related interventions, and for professionals to profit from existing theoretical and practical knowledge and experience.

2. Methodology

2.1. SELECTION PROCEDURE FOR THE GROUPS OF INTERVENTIONS

The MS representatives in the CNAPA were asked to select groups of interventions for the exchange of good practices to reduce alcohol related harm in the framework of information dissemination. Selected were the following three groups of interventions:

1. **Early interventions** (Early identification and brief intervention for hazardous and harmful drinking);
2. **Public awareness interventions** (including new media, social networks and online tools for behaviour change);
3. **School-based interventions** (information and education).

The selection of these three areas was based on the results of the needs assessment, decided by voting and confirmed by the RARHA Advisory Group. You can find the theoretical background for the three groups of interventions and the descriptions of the accepted good practice interventions later on in the tool kit (see CHAPTERS 4, 5, and 6).

2.2. GOOD PRACTICE DEFINITION

A review of good practice definitions in prevention was carried out, aimed at the preparation of a most suitable and exact definition of good practice (11—20). Based on the research, three versions of the definition were prepared, which were then presented to the partners for the discussion. Finally, we came to a final version of the good practice definition: "Good practice refers to a preventive intervention (action/activity/working method/project/programme/service) that was found to be effective in accomplishing the set objectives and thus in reducing alcohol related harm. The intervention in question has been evaluated either through a systematic review of available evidence AND/OR expert opinion AND/OR at least one outcome evaluation. Furthermore, it has been implemented in a real world setting so that the practicality of the intervention and possibly the cost-effectiveness has also been examined."

2.3. QUESTIONNAIRE FOR COLLECTING GOOD PRACTICES

The questionnaire for collecting good practices was prepared based on similar other projects' questionnaires on collecting good practices examples on alcohol prevention (21—31). In November 2014, after the WP6 partners revised and supplemented the questionnaire, it was re-sent to WP6 partners for piloting. The questionnaire consisted of six sections (for full version see ANNEX 2):

1. Evidence base (quick scan – defined in ANNEX 2)
2. Basic facts
3. Development (including preparation, planning and core processes)
4. Implementation
5. Evaluation
6. Additional information

An email letter requesting information on interventions was sent out in December 2014 to previously identified professionals together with the attached questionnaire in PDF form. The collection phase ended in April 2015. For few countries, we didn't manage to collect any data, mainly because Contact Persons reported that their existing interventions did not meet the eligibility criteria defined in the questionnaire.

2.4. ASSESSMENT CRITERIA

In order to assess the collected interventions, we have developed the assessment criteria based on an existing Dutch system for evaluating health-based interventions (for more information see ANNEX 3).

TABLE 1: ASSESSMENT CRITERIA IN DETAIL

1.	**The intervention is well described**
PROBLEM	Risk or theme is comprehensively and clearly described (e.g. description of nature, severity and possible consequences of the problem).
OBJECTIVES	Clearly described and if relevant differentiated in the main objectives and sub-objectives.
TARGET GROUP	Clearly described on the basis of relevant characteristics.
APPROACH	The design of the intervention is described (frequency, intensity, duration, timing of activities, recruitment method and location where it will be implemented).
2.	**The intervention is implemented in the real world/feasible/transferable**
PARTICIPANTS' SATISFACTION	The intervention is accepted by the target group.
PREREQUISITES FOR IMPLEMENTATION	• The necessary costs of and/or hours needed for the intervention are specified and transparent. • The specific skills and vocational training of the professionals who will implement the intervention are described as well as which people are needed to support the intervention and described how this support can be created. • There is an implementation plan or action plan. • A manual is available with a concrete description of activities (if relevant). • The methods and instruments used are didactically sound and comprehensibly described.
3.	**The intervention has a theoretical base**
THEORETICAL BASE	• The intervention is built on a well-founded programme theory or is based on generally accepted and evidence-based theories (e.g. meta-analyses, literature reviews, studies on implicit knowledge). • The effective elements (or techniques or principles) in the approach are stated and justified, in the framework of a change model or an intervention theory, or based on results of previously conducted research.
4.	**The intervention has been evaluated**
EVALUATION	• Method of the evaluation is described. • The outcomes found are the most relevant given the objective, programme theory and the target group for the intervention. • Possible negative effects have been identified and stated. • Information on attrition (dropout rate) is available.

There are four levels of evidence-based depending on the design of the studies that were looking into the effects of the intervention. A good practice must accomplish all listed criteria in the specific section to be recognized as theoretically sound at the basic level, or at the level of first indications of effectiveness or at the level of good indications of effectiveness, etc.

TABLE 2: LEVELS OF EVIDENCE

BASIC LEVEL: THEORETICALLY SOUND	• Theoretically sound and with positive results (observational or qualitative studies)
FIRST INDICATIONS OF EFFECTIVENESS	• The above basic level criteria and • Pre-post study without control group
GOOD INDICATIONS OF EFFECTIVENESS	• All of the above criteria for the first indications of effectiveness • A reliable and valid measurement of the intervention's effect was conducted with: – An experimental or quasi experimental design or – A repeated N = 1 study (at least 6 cases) with a baseline or a time series design with a single or multiple baseline or alternating treatments or a study into the correlation between the extent to which an intervention has been used and the extent to which the intended outcomes were achieved or – The effects of the study are compared with other research into the effects of the usual situation or another form of care for a similar target group
STRONG INDICATIONS OF EFFECTIVENESS	• All of the above criteria for the good indications of effectiveness • There is a follow-up of at least 6 months

2.5. ASSESSMENT PROCEDURE

All interventions were assessed from April to August 2015. All received interventions were assessed based on the criteria established by the WP6 good practice tool kit assessment team. When an intervention met the criteria described in Table 1, it was subsequently categorized to the levels of evidence described in Table 2.

During the assessment process, it became apparent that there were a lot of intervention descriptions that did not contain enough information to properly assess the intervention. However, there was not enough time and there were not enough resources available to request for more information and do a second assessment round for every intervention that had information missing. Therefore, it was decided that if more than five of the criteria points were unclear, the intervention was immediately rejected. If less than five of the criteria points were unclear, a request for more information was sent, and the intervention was reassessed after receiving this information.

3. Results

3.1. SURVEY RESULTS

All results are presented in ANNEX 4 of this tool kit. Below, we present selected features of collected intervention information.

19 countries responded to our request. Total number of interventions received is 48, 43 of them are interventions with evidence base (quick scan). Table 3 shows the number and percentage of collected interventions with evidence base by groups of interventions. 21 interventions are in Early intervention group, 9 are in Public awareness intervention group and 13 interventions are in School-based intervention group.

TABLE 3: NUMBERS AND PERCENTAGES OF SELECTED EVIDENCE-BASED INTERVENTIONS BY GROUPS OF INTERVENTIONS

Country	Early interventions	Public awareness interventions	School-based interventions
Total 43 (100 %)	**21 (49 %)**	**9 (21 %)**	**13 (30 %)**

The data in the Table 4 represents the funding of the interventions with evidence base. Multi choice was possible for this question, for example, the intervention can be funded by national/regional/local government and by non-governmental organization. 56 % of interventions were funded by national/regional/local government.

TABLE 4: FUNDERS OF SELECTED EVIDENCE-BASED GOOD PRACTICE EXAMPLES BY GROUPS OF INTERVENTIONS

Evidence-based interventions (n=43)	Early interventions	Public awareness interventions	School-based interventions	All interventions
A National/regional/local government	16	9	10	35 (56 %)
B Educational, public health and/or research institution	3	2	3	8 (12 %)
C Non-governmental organization	5	2	0	7 (11 %)

Evidence-based interventions (n=43)	Early interventions	Public awareness interventions	School-based interventions	All interventions
D Private sector company/ organization	1	2	0	3 (5 %)
E Alcohol/ Catering industry	0	1	0	1 (2 %)
F Other resources	3	3	3	9 (14 %)

Table 5 demonstrates the data about stakeholders, involved in the development of evidence-based interventions. Multi choice answer was possible. Intermediate target was the most common (21 %).

TABLE 5: STAKEHOLDERS, INVOLVED IN THE DEVELOPMENT OF SELECTED GOOD PRACTICES BY GROUPS OF INTERVENTIONS

Evidence-based interventions (n=43)	Early interventions	Public awareness interventions	School-based interventions	All interventions
A Target groups	10	6	5	21 (13 %)
B Intermediate target groups	15	6	12	33 (21 %)
C Economic operators	0	5	0	5 (3 %)
D Government	15	8	6	29 (18 %)
E Funders	5	4	1	10 (6 %)
F Researchers	13	7	8	28 (18 %)
G Civil society representatives (NGOs)	5	5	5	15 (10 %)
H Other	7	5	5	17 (11 %)

Target groups of evidence-based interventions are listed in Table 6. Multi choice was also possible. The interventions targeted predominately adolescents (22 interventions), parents (17 interventions), young adults (15 interventions), adults and general population (14 interventions both).

TABLE 6: TARGET GROUPS

Evidence-based interventions (n=43)	Early interventions	Public awareness interventions	School-based interventions	All interventions
A General population	7	6	1	14 (9.5 %)
B Children (before adolescence)	3	3	2	8 (5.5 %)
C Adolescents	7	4	11	22 (15 %)
D Young adults	11	4	0	15 (10 %)
E Adults	7	5	1	13 (9 %)
F Elderly population	4	1	0	5 (3.5 %)
G Parents	9	3	5	17 (12 %)
H Pregnant women	4	1	0	5 (3 %)
I Women	6	2	0	8 (5.5 %)
J Men	6	2	0	8 (5.5 %)
K Families	5	2	1	8 (5.5 %)
L Drivers	2	3	0	5 (3 %)
M Party goers	2	2	0	4 (3 %)
N Vulnerable social groups	8	2	1	11 (7 %)
O Other	1	3	0	4 (3 %)

The collected interventions were mostly implemented on national level (40 %), followed by implementations on regional level (29 %) and on local level (25 %).

Most interventions (77 %) are embedded in a broader national/regional/local policy or action plan.

69 % of interventions are integrated in the system (intervention was not performed only once but it is repeated or integrated in the prevention system) while 13 % are periodic and 18 % were performed only once.

Most interventions (63 %) are based on scientific evidence, 32 % on past experience and 5 % on other.

The evaluation of the intervention was mostly made by internal party (45 %), 17 % by external party and 38 % by both. Collected interventions were evaluated mainly as process evaluation (48 %) and impacts/effects/outcome evaluation (45 %). 21 interventions were evaluated using both methods of evaluation.

3.2. AGGREGATED ASSESSMENT RESULTS

All received interventions were assessed based on the criteria established by the WP6 good practice tool kit assessment team (for more information, see CHAPTER 2.4).

The results of the interventions' assessment are described in Table 7. In total, 43 descriptions of evidence-based interventions were received, of which 26 are accepted into the tool kit (57 %). Of the early interventions, eleven were accepted in the tool kit (52 %) because all intervention criteria were met. Seven public awareness interventions were accepted (78 %). Finally, of the school-based interventions, eight interventions were accepted into the tool kit (62 %).

TABLE 7: RESULTS PER INTERVENTION TYPE

	Early interventions	Public awareness interventions	School-based interventions	Total
Rejected interventions	10	3	5	18
Accepted interventions	11	7	8	26
Total no. of interventions received	21	9	13	43
% Accepted	52 %	78 %	62 %	59 %

Interventions, which were not accepted, did not meet the following common requirements:

1. **The intervention is well-described:** A problem that would often arise during assessment was that the goal of the intervention wasn't clearly described. Furthermore, the description of the intervention was often not complete or clear. For example, an intervention would be described in general terms, but no specifics would be given on frequency, intensity or duration.

2. **The intervention is implemented in the real world/feasible/transferable:** Specifics on financial costs or time that needed to be invested were often missing or unclear, also, there wasn't a manual or a concrete description of activities for the intervention available.
3. **The intervention has a theoretical base:** It was often the case that there weren't any effective elements (or techniques or principles) in the approach stated or specified, in the framework of a change model or an intervention theory, or based on results of previously conducted research.
4. **The intervention has been evaluated:** The outcomes found weren't always the most relevant given the objective that was stated in the intervention description. This often occurred simultaneously with an unclear description of the intervention goal. In these cases, it was impossible to assess the effectiveness of the intervention properly.

All the accepted interventions were divided onto four different levels of evidence during assessment described in Table 2. Table 8 shows how many of the accepted interventions were accepted into different levels of evidence.

TABLE 8: LEVELS OF EVIDENCE

	Early interventions	Public awareness interventions	School-based interventions	Total
Basic level	4	4	0	8
First indications for effectiveness	1	2	2	5
Good indications for effectiveness	1	1	3	5
Strong indications for effectiveness	5	0	3	8
Total	**11**	**7**	**8**	**26**

The distribution of the submitted interventions by country is visible in Table 9. Some of the interventions were accepted immediately, because the associated contact person sent in sufficient information and all of the intervention criteria were met. Other interventions were accepted into the tool kit after reassessment, when the associated contact person sent in additional information, after which all intervention criteria were met. Of the rejected interventions, some were rejected because they simply did not meet the

intervention-criteria. Furthermore, a number of rejected interventions lacked information, so a request was made to the associated contact person for additional information. This information, however, was never received from the contact person. These interventions have been rejected because it remains unclear whether they are a good fit for the tool kit.

TABLE 9: THE DISTRIBUTION OF SUBMITTED INTERVENTIONS BY COUNTRY

Country	Submitted interventions	Submitted interventions that met the basic criteria	Accepted interventions	Of which reassessed	Rejected interventions	Request for more information was made, none received
Austria	3	3	1	1	2	1
Bulgaria	1	1	-	-	1	-
Croatia	2	2	2	2	-	-
Cyprus	1	0	0	0	0	0
Finland	2	2	2	2	-	-
Germany	2	2	1	-	1	1
Greece	2	2	1	1	1	-
Ireland	2	2	1	1	1	-
Italy	2	2	2	1	-	-
Liechtenstein	1	0	0	0	0	0
Lithuania	2	2	1	-	1	-
Luxembourg	1	1	1	1	-	-
Netherlands	2	2	2	-	-	-
Norway	3	3	2	1	1	-
Poland	2	2	2	2	-	-
Portugal	8	5	2	1	3	-
Slovenia	3	3	2	1	1	-
Spain	2	2	1	1	1	1
Sweden	7	7	3	-	4	3
Total	**48**	**43**	**26**	**15**	**17**	**6**

Most accepted interventions in the same categories were somewhat similar, in the sense that school-based interventions often included programmes 'targeting' both students as well as their parents, to prevent or reduce alcohol use among adolescents. Regarding early interventions, many programmes focused on providing training for healthcare professionals to recognize alcohol-related problems within their field.

It was a different story concerning the public awareness campaigns. There were interventions aimed at visitors of football stadiums ("do not drink **too** much"), but also campaigns aimed at drivers of boats and employees ("do not drink at all"). It was difficult to assess public awareness campaigns with the criteria that were set up there, because in some cases these were not entirely applicable (for example, during the evaluation there wasn't always information available on participants' dropout because intervention-related activities were sometimes directly evaluated by spontaneously recruited participants/visitors of certain events). Therefore, in addition to meeting the criteria, a more general impression of the public awareness campaign was taken into account if doubts arose whether to include the intervention in the tool kit.

4.

Early Interventions

4.1. DEFINITION

Early interventions are therapeutic strategies that usually consist of or combine two elements: early identification of hazardous or harmful substance use and brief interventions or treatment of those involved (32).

1. **Early identification** is an approach to detecting an actual or potential alcohol problem through clinical judgement or by screening using standardized questionnaires (33). The screening tools are usually self-completion questionnaires, comprising between one and ten questions to fill in. Early identification should lead either to further assessment, to a brief intervention or to specialized treatment if necessary. For instance, the AUDIT (Alcohol Use Disorders Identification Test), developed by WHO, assesses the frequency and intensity of alcohol consumption and identifies individuals with alcohol consumption problems as (34):
   - hazardous drinking is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others;
   - harmful use refers to alcohol consumption, which results in consequences for physical and mental health;
   - alcohol dependence is a cluster of behavioural, cognitive and physiological phenomena that may develop after repeated alcohol use.
2. **Brief interventions** are short advisory or educational sessions and psychological counselling often provided in health care settings (35) but also in emergency departments, trauma care, acute medical care, obstetric services, sexual health clinics, pharmacies, and criminal justice services. A brief intervention can consist of feedback and structured advice (based on the FRAMES – see below – or motivational interviewing principles), accompanied by hand-outs. A simple brief intervention takes around 5 minutes and consists of the following components:
   - **Feedback:** on the patient's degree of risk for alcohol problems;
   - **Responsibility:** change is the patient's responsibility;
   - **Advice:** provision of clear advice when requested;
   - **Menu:** what are the options for change?;
   - **Empathy:** an approach that is warm, reflective and understanding; and
   - **Self-efficacy:** increasing optimism about behaviour change (36).

Brief interventions can be divided into:

- **simple brief interventions** – structured advice taking no more than a few minutes, and
- **extended brief interventions** – structured therapies taking app. 20–30 minutes and often involving one or more sessions.

4.2. IMPLEMENTATION

Recently, some researchers have analysed the development of brief interventions on alcohol, including the assessment of its four key elements: efficacy, effectiveness, implementation and demonstration (37). They concluded that both efficacy and effectiveness of brief alcohol interventions have been comprehensively demonstrated, and that intervention effects seem to be replicable and stable over time and across different study contexts. However, more efforts should be focused on promoting sustained implementation of screening and brief alcohol intervention approaches. In addition, it is important to reach those who might benefit from such interventions and receive support. The implementation of early identification and brief interventions (EIBI) in primary care centres should firstly improve professionals' performance in screening and brief intervention activities. The ODHIN study examined the effectiveness and efficiency of three implementation interventions (training and support, financial reimbursement and internet-based) on the primary health care providers' delivery of screening and advice to heavy drinkers. Its results showed that the provision of a combination of training and support and financial reimbursement led to the highest rate of patients screened in the five participating countries (38). These results were reported as similar to those, which demonstrated the effectiveness of training and support in promoting screening and intervention for hazardous and harmful alcohol consumption (39, 40). Authors also suggest that both, training and support and financial reimbursement, should be accompanied by a strong government support, especially in those countries where the costs of preventive strategies are lower than the estimated health effects of alcohol consumption.

Implementing early interventions to reduce harmful alcohol consumption should be done by means of:

- availability of clinical guidelines for early identification and brief advice programmes,
- provision of training programmes for primary care providers on early identification and brief advice interventions,
- systematization and monitoring quantity and quality of early identification and brief advice programmes, and
- offering financial support for delivering early identification and brief advice programmes (41).

Barriers (42):

- Health and social workers are too busy to deal with the problems people present them with;
- Health and social workers are not trained in counselling for reducing alcohol consumption;
- Health and social workers believe that alcohol counselling involves family and wider social effects, and is therefore difficult;
- General practitioners are not organised in a way to do preventive interventions;
- Health and social workers do not believe that patients would take their advice and change their behaviour;
- Health and social workers do not have suitable materials available;
- Government health policies in general do not support health and social workers who want to implement prevention activities.

4.3. EFFECTIVENESS AND COST-EFFECTIVENESS

There is increasing evidence of effectiveness of brief interventions in primary health care service, emergency departments, trauma care, acute medical care, obstetric services, sexual health clinics, pharmacies and criminal justice services.

- **Primary health care services:** Brief advice in primary health care has been shown to reduce the quantity, frequency and intensity of drinking, and alcohol-related morbidity and mortality. In the UK, implementation of brief interventions in primary care settings has led to a reduction from hazardous or harmful to low-risk levels among both men and women (43). Later reviews have also concluded that brief interventions are effective in reducing consumption among men and women at six and 12 months following the intervention (44).
- **Emergency care:** There is a weaker evidence base for the impact of brief advice undertaken in emergency care settings. In the USA, researchers recommended including screening and brief interventions for alcohol-related problems in these contexts (45) and a British study followed a group of patients and found that those who received an intervention were drinking at significantly lower levels than those in the control group (46). Another international study estimated that 10—18 % of injured patients attending emergency departments are alcohol-related cases (47).
- **Workplace settings:** Although the evidence of the impact of occupational health based brief advice programmes is very limited and guidance

for practice is not widely available, occupational health services can consider offering them. The European Workplace and Alcohol (EWA) project was aimed at increasing knowledge about how interventions in workplace settings can have a positive impact on alcohol-related awareness, attitudes, policies and behaviour in several countries in Europe (48). Results showed that alcohol has a very negative impact on work and preventive alcohol interventions are needed to raise awareness towards alcohol consumption and help implementing alcohol policies. In addition, the implementation of company-based interventions resulted in high levels of awareness, improvement of attitudes, reduction of hazardous drinking and problems at workplace due to workers' alcohol consumption. EIBI strategies at work-places should include: an identification of the target population using an appropriate screening instrument, providing brief advice, specialist referrals, adaptation of the individual's workplace, information to the employee and assuring privacy and confidentiality (49).

- **Social services and other settings:** There is no robust evidence to justify a comprehensive roll-out of brief advice programmes in social service and other settings. Action is now focussed on gathering useful evidence for the acceptability and feasibility of EIBI. Implementation of programmes should be adapted to the specific service setting in each country.
- **Criminal justice settings:** Includes the police, courts, prisons and probation services. Growing evidence show that identification and brief advice in these settings is effective and reduces reoffending rates. Detainees with a positive AUDIT score were more frequent A&E attendees and had worse overall health than negative AUDIT scorers. They were more likely to be violent offenders than other offenders and had more arrests, more days in court and more use of social services.
- **Computerized or electronic EIBI:** Some evidence suggests that online programmes for alcohol problems can help users of groups less likely to access traditional alcohol-related services, such as women, young people and at-risk drinkers (50). Other studies show that internet-based behavioural interventions can be helpful in delivering brief advice among hazardous drinkers (51). However, the efficacy and feasibility of these interventions haven't been analysed properly and results should be taken with caution due to the potential limitations of health-care settings to implement these programmes, the professionals' limitations of time and training and the strategies to involve patients according to their characteristics.
- **Cost-effectiveness:** Brief interventions have the potential to save future costs and bring individual benefits in terms of reducing the risk

of premature death and alcohol-related morbidity. Studies published in 2002 in the UK suggested that brief interventions would yield savings of around £ 2,000 per life year (52). Another study confirmed that Simple brief interventions (SBI) are highly cost-effective with estimated scores of ICERs (Cost-Effectiveness Ratios) of € 550/Quality Adjusted Life Year (QALY) gained for a programme of SBI at the next general physician's registration and € 590/QALY for SBI at the next general physician's consultation (53).

All this evidence is reflected in the accepted interventions, which can be found in CHAPTER 4.4.

4.4. ACCEPTED INTERVENTIONS

TABLE 10: SUMMARY OF ACCEPTED EARLY INTERVENTIONS ACCORDING TO LEVEL OF EFFECTIVENESS

Indication of effectiveness	Name[1]	Country
Basic	MOVE – Motivational Brief Intervention for Young People at Risk	Croatia
	IPIB – Identificazione Precoce Intervento Breve	Italy
	Online Course on Brief Alcohol Intervention (Ota puheeksi alkoholi; Puheeksi-oton perusteet – verkkokurssi)	Finland
	Towards a Framework for Implementing Evidence-Based Alcohol Interventions	Ireland
First	School-Based Intervention for Drug Using Students	Poland
Good	The National Risk Drinking Project	Sweden
Strong	Web-ICAIP – Web-Based Individual Coping and Alcohol-Intervention Programme	Sweden
	Nine Months Zero (Negen Maanden Niet)	Netherlands
	The Swedish National Alcohol Helpline (Alkohollinjen)	Sweden
	"Drink Less" Programme	Catalonia/Spain
	Trampoline (Trampolin)	Germany

1 Click on the name of the intervention to jump to the description.

4.4.1. Basic level

TABLE 11: MOVE – BRIEF MOTIVATIONAL INTERVENTION FOR YOUNG PEOPLE AT RISK

	BASIC FACTS						
NAME	**MOVE – Brief Motivational Intervention for Young People at Risk**						
ABSTRACT	The Office for Combating Narcotic Drug Abuse in cooperation with other institutions (Croatian Public Health Institute, Ministry of Social Policy and Youth and Ministry of Health) organised a course on "MOVE – Brief Motivational Intervention for Young People at Risk" (3-day workshops) with the purpose to improve communication skills of experts who work as counsellors to young people at risk and to teach them some new counselling techniques. Workshops are carried out by two licensed trainers who work together and a guest trainer – a police officer. The three-day workshop is divided in 12 modules based on experiences from different therapeutic concepts and theories that seek to diversify short counselling conversations. Every module consists of a theoretical and a practical part. The Office for Combating Narcotic Drug Abuse has provided this kind of training since 2008.						
FUNDING	National/regional/local government						
LEVEL	National		Regional		Local		
AIMS & OBJECTIVES	The main aim is to provide an intervention which improves counselling skills with the aim to promote and support young people's willingness to change problematic drug use or risk behaviour through counselling based on motivational interviewing. The aim of MOVE is to help reduce risk patterns of consumption among young people as a strategy of selective prevention. The goal is also to improve and encourage cross-sector cooperation, which is achieved by the multidisciplinary group of participants.						
	DEVELOPMENT						
STAKEHOLDER INVOLVEMENT	Target group(s)		Intermediate target group		Government		Civil society (NGOs)
LOGIC MODEL	Scientific evidence: "MOVE" education is based on Motivational interview (Miller, W.R. and Rollnick, S., 1991), Transtheoretical model of change (Prochaska and Di Clemente), The salutogenic model – A. Antonovsky, brief motivational interventions (handling ambivalence; empathy; detecting and integrating discrepancies; entering into dialogue; handling resistance; setting objectives; making agreements)						
ELEMENTS OF PLANNING	Literature review and/ or formative research	Needs assessment	Financial plan	Human resource management plan	Time schedule	Partners' agreement	Evaluation plan
	IMPLEMENTATION						
TIMEFRAME	Continuous	It is carried out continuously from 2015 to 2017 in the "Croatian Action plan on drugs" We carry out 2-4 courses per year since 2013.					

TARGET GROUP(S)	Adolescents	Young adults	Adults	Vulnerable population(s): persons struggling with substance abuse
COMMUNICATION CHANNELS	Direct communication	Course on counselling based on "MOVE" Manual for trainers (original Publisher: ginko Landeskoordinierungsstelle für Suchtvorbeugung, Federal State of Nordrhein-Westfalen, Germany, Mulheim a.d. Ruhr 2002)		
CORE ACTIVITIES	Training sessions (three-day workshops) and providing a Manual for participants			
SUPPORTIVE ACTIVITIES	Supervision			
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process	Impact	Outcome	
RESULTS	Since the beginning of the implementation of the "MOVE" training (2008), process evaluation is conducted continuously. At the end of every workshop, participants complete a questionnaire about their satisfaction with the training, assessing trainers' work, the group and the process. The questionnaire includes questions on participants' satisfaction with the theoretical part, the practical part, the organisation, the possibilities of using parts of the training in their everyday work, and the participants can also add observations and suggestions for improvement. In 2013, we developed an additional evaluation questionnaire aimed at testing the effectiveness of the transmission of content of education and testing the effect of the acquired knowledge on dynamics and frequency of arriving in treatment/counselling. This questionnaire consists of: a) a part, which relates to the way the content of the training is delivered, and b) a part, which refers to the number of clients in treatment, counsellors and the frequency of visiting clients in treatment. The questionnaire is distributed at the beginning and at the end of the three-day training. **Results:** In generally, the participants are a) Completely satisfied with the training, (Zagreb, 29-31.10.2014 (44 %); Valbandon, 19-21.11.2015. (31 %)) b) Partly satisfied with the training, (Zagreb, 29-31.10.2014 (56 %); Valbandon, 19-21.11.2015. (69 %)) In both courses no one was: c) partly unsatisfied, or d) completely unsatisfied. The majority will recommend this training to their colleague. The results about how training is delivered are differing from one workshop to another, depending on trainers and participants. However, in two different courses, which were conducted in 2014, the majority of participants show better knowledge of the content of "MOVE" training in the end in comparison to the beginning of the education. As most interesting content, they mention "resistance", "ambivalence" and "detection of discrepancies". Furthermore, it is very difficult to determine how the participation of counsellors in "MOVE" training influences the number of clients who start and stayi in treatment, because their clients usually choose counselling on demand and during a predefined period. Their use of the new knowledge in their everyday work should be further and repeatedly tested. Considering that counsellors who are participants in "MOVE" training cannot influence clients to start and stay in the counselling process with their work methods, we will have to redesign the evaluation questionnaire and leave out part B of the questionnaire mentioned above.			

REPORT	WHO: "Improving the lives of children and young people: case studies from Europe Volume 3"
FOLLOW-UP	For all 12 licensed trainers, The Office for Combating Narcotic Drug Abuse organised a supervision course in 2010. Supervision trainers are coming from Germany – ginko Stiftung für Prävention, Kaiserstraße 90, 45468 Mülheim an der Ruhr.
	ADDITIONAL INFORMATION
WEBSITE	drogeiovisnosti.gov.hr www.ginko-stiftung.de/move/default.aspx
CONTACT DETAILS	Contact person: **Josipa-Lovorka Andreić**, Head of the Department for Programs and Strategies Organization: **Government of the Republic of Croatia**, The Office for Combating Narcotic Drug Abuse Address: Preobraženska 4/II, Zagreb Country: Croatia Telephone number: +385 14 8781 23 E-mail address: josipa.lovorka.andreic@uredzadroge.hr

TABLE 12: IPIB – IDENTIFICAZIONE PRECOCE INTERVENTO BREVE

	BASIC FACTS		
NAME	**IPIB – Identificazione Precoce Intervento Breve: the formal institutional standard of training for primary health care professionals in Italy allowing participants to be trained themselves and to train other professionals on early identification and brief intervention on alcohol**		
ABSTRACT	The National Committee on Alcohol, set by the frame law on alcohol 125/2001, indicated the training programmes on the national EIBI (Early Intervention and Brief Intervention; in Italian: IPIB -Identificazione Precoce Intervento Breve) based on PHEPA II project, as the formal institutional standard of training for Primary Health Care (PHC) professionals (the target group), and the National Observatory on Alcohol, National Center for Epidemiology, Surveillance and Health Promotion, of the Istituto Superiore di Sanità (NOA-CNESPS, ISS) as the national provider of the training activities in tight connection with the SIA (Italian Society of Alcohology) and the Regions. Thus, starting from 2006 the NOA-CNESPS played a pivotal role in carrying out a formal activity in preparing a country strategy aimed at the implementation and dissemination of a common standard of training and at the coherent application of the IPIB now explicitly included in all national public health documents and carried out under the frame of different national – international programmes. The ISS-IPIB training courses follow the PHEPA standard: six training sessions for each course (Session 1: Introduction and basic concepts; Session 2: Early Identification; Session 3-4: Brief Intervention; Session 5: Alcohol dependence; Session 6: Implementation of the EIBI alcohol programme). Duration: 1 or 2 days, according to the settings. As recruitment method, the web page of the ISS publishes the call for the selection of candidates for the training programmes IPIB as well as the programme of the course that allowed to 24 participants (www.iss.it).		
FUNDING	National/regional/local government		
LEVEL	National	Regional	Local
AIMS & OBJECTIVES	The training course has been opened to General Physicians and, generally speaking, to all the physicians involved in the PHC and also to the experts from other services and specialities such as to the Ser.T.S. (Services for the treatment of dependences), family advice bureau, professionals involved in the workplace prevention setting, psychiatrists and psychologists, with the objective of enhancing professional skills, knowledge, attitudes and motivation of health workers engaged in PHC and face the challenge consists of subjects with hazardous and harmful alcohol consumption (HHAC).		

	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Government	Funders	Researchers
LOGIC MODEL	**Scientific:** Many reviews and scientific documents on the evidence of effectiveness and cost-effectiveness of EIBI for HHAC in PHC setting (from 2004 with the WHO Collaborative Project on Identification and Management of Alcohol-related Problems in Primary Health Care, Phase IV). At national level, regarding the screening instruments, the AUDIT has been previously validated in 1997 (Piccinelli M. et al, 1997. BMJ, 314:420-424) as well as a national study to evaluate the feasibility of adapting a shorter version of the WHO AUDIT (AUDIT-C) in a PHC setting has been published in www.iss.it/binary/alco/cont/Boll %20farm %20 alcol %2006 %2029 %201-6.1182506126.pdf (Struzzo P. et al, 2006). **Past experience:** the IPIB-ISS working team started its activities in April 2006 publishing the national strategy, organising conferences to announce, promote and disseminate the IPIB training programme. IPIB training is not yet compulsory for the professionals of the National Health System, but an example of implementation at the Regional level has been the specific training experience of the Tuscany Region, a programme for all the Regions on IPIB in the workplaces funded by the Centre for Controls of Diseases (CCM) of the Italian Ministry of Health (MoH). The NOA-CNESPS, ISS, implemented 11 residential courses.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Time schedule	Communication plan	Evaluation plan
	IMPLEMENTATION			
TIMEFRAME	Periodic			
TARGET GROUP(S)	General practitioners and other Primary Health Care professionals			
COMMUNICATION CHANNELS	Social media	Website	E-mail	Meetings/ conferences with experts/ colleagues	Direct communication	Guidelines
CORE ACTIVITIES	Training courses, presentation and distribution of a wide range of materials (campaigns, tool kits, translation and adaptation of the PHEPA training manual and clinical guidelines for alcohol prevention, adaptation of the training courses for different target groups (i.e. children, adolescents, pregnant women, families and health professionals).			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	IPIB activities are submitted to formal evaluation to MoH and reported to the Parliament in supporting alcohol prevention and the frame law on alcohol 125/2001.

RESULTS	Generally, the main result of this initiative is the inclusion of the EIBI training programme among the activities of the National Alcohol and Health Plan 2007-2010 (Piano Nazionale Alcol e Salute – PNAS) and of the National Prevention Plan of the Ministry of Health, and of the Regional Prevention Plans. At the end of each course, participants fulfilled the original PHEPA evaluation for the main topics of the course. One description of conclusions (available for each course) in term of knowledge and satisfaction has been presented at the INEBRIA annual meeting in Rome in 2013 (www.inebria.net/Du14/pdf/2013_09_19_20.pdf)
REPORT	Not public
FOLLOW-UP	The activities are reported in the Annual Report of the MoH to the Parliament in relation to the implementation of the law 125/2001.
	ADDITIONAL INFORMATION
WEBSITE	www.epicentro.iss.it/alcol/
CONTACT DETAILS	Contact person: **Claudia Gandin, Emanuele Scafato** Organization: **Istituto Superiore di Sanità** Address: Via Giano della Bella, Roma Country: Italy Telephone number: +39 06 4990 4192 – 4028 E-mail address: claudia.gandin@iss.it; emanuele.scafato@iss.it

TABLE 13: ONLINE COURSE ON BRIEF ALCOHOL INTERVENTION (OTA PUHEEKSI ALKOHOLI; PUHEEKSIOTON PERUSTEET – VERKKOKURSSI)

	BASIC FACTS			
NAME	**Online Course on Brief Alcohol Intervention / Ota puheeksi alkoholi; Puheeksioton perusteet – verkkokurssi**			
ABSTRACT	A-Clinic Foundation's online course on brief alcohol intervention aims to increase the capacity of primary health care professionals to detect harmful alcohol use. The course is aimed at primary health care practitioners and students, especially nurses and doctors. It is carried out in the cooperation with the target municipalities and public organizations. The objective is to ensure that the whole work community has uniform approach to brief alcohol intervention. After that, the organization can be sure that every worker can commit to agreed operating model and their work can be evaluated by themselves. A-Clinic Foundation runs their own evaluation and is willing to give support to organizations if necessary. The responsibility is shared with A-Clinic Foundation as producer and public organizations as contacting public in large scale. Initially, the online course was part of A-Clinic Foundation's project that started in 2011. The content of the course was produced by a multi-disciplinary professional team, and the course was launched in August 2013. In January 2015, there were more than 1300 registered students. The implementation is continuous and there is a constant demand of cost-efficient ways to decrease health and social problems.			
FUNDING	Finland's Slot Machine Association (RAY), which is supervised by Ministry of Social Affairs and Health in Finland			
LEVEL	National			
AIMS & OBJECTIVES	The main aim is to provide knowledge of the techniques and practices in brief intervention for professionals and students who encounter problem drinkers in their work.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Intermediate target group	Funders	Researchers	Civil society (NGOs)	Kotka and Pyhtää municipalities´ health care management.
LOGIC MODEL	**Past experience:** There is strong evidence in primary health care and specialized medical care that observing harmful alcohol use and targeting it at an early stage is very helpful. The benefit lasts for several years and it can be repeated. The efficiency of the brief intervention method is widely recognized.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Detailed plan of action	Financial plan	
	Human resource management plan	Time schedule	Partners' agreement	
	Communication plan	Evaluation plan	Process plan	

	IMPLEMENTATION					
TIMEFRAME	Continuous					
TARGET GROUP(S)	General population					
COMMUNICATION CHANNELS	Brochures/ leaflets/items	Telephone/ mobile	Website	E-mail	Meetings/ conferences with experts/ colleagues	Direct communication
CORE ACTIVITIES	The course was launched in August 2013. In January 2015, there were more than 1300 participants. The demand is continuous. Originally, the target group was primary health care practitioners and students, but due to the interest, the course is now offered to special health care and social work professionals as well. The course benefits all professionals that encounter harmful alcohol use in their work.					
SUPPORTIVE ACTIVITIES	Consultancy	Training	Helpdesk	Reports to partner during the process		

	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	The need for the training was monitored by an initial survey for the students (voluntary online survey).
RESULTS	So far, according to the initial survey, 85 % of respondents had encountered situations in their work in which they would have benefited from knowledge on the treatment of alcohol abuse. 38 % encountered these situations often. Respondents felt they needed more practical information and tools in order to implement brief alcohol intervention.			
FOLLOW-UP	The follow-up survey was undertaken between 19th April and 18th May 2016. A total of 326 answers were received to an online questionnaire (with an answer rate of 26 %). Altogether, the survey reached 1277 respondents. The majority (88 % of all respondents) rated the course as excellent or good. 86 % of respondents felt that they received new information of brief alcohol intervention through the course. 64 % of respondents were able to utilize new information in their work. Those, who responded differently, expressed that they do not work with customers anymore or that they have not encountered situations where to use brief intervention. Additionally, one natural reason for the situation is that some of the respondents were students. 83 % of respondents were motivated to use brief alcohol intervention at their work. After the completion of the course, half of the respondents did not know if there were common objectives about brief intervention in their organization. 30 % stated that common objectives had not been set. Many of those, who answered that no common objectives had been set, stated that they did not know the reason for the lack of goals nor did they see a need for setting goals. 29 % of respondents felt that they need more training on brief intervention, among others, on motivation of change, encountering (challenging) customers or alcohol use of elderly or young. 95 % of respondents felt that the realization of the web-based course was good. 86 % stated that the course was easy to use. Some encountered technical problems and stated their wish for more explicit instructions. ↓			

FOLLOW-UP	↓ Some answers to the question about improvement ideas or free feedback: • there could be a way to rehearse content of the course (like reminding messages, printable leaflet of main points); • course could be more applicable to diverse customer situations in addition to patient-nurse or patient-doctor situations; • it would be instructive to hear other people's experiences who attend the course (like the possibility of chat); • video clips could have contained also failed/challenging intervention situations; • a need for clearer instructions for logging in the course and printing out certificate; • video clips were good; • course was a clear and versatile entity; • course was important.
	ADDITIONAL INFORMATION
WEBSITE	www.otapuheeksi.fi
CONTACT DETAILS	Contact person: **Pirkko Hakkarainen**, Digital Services Manager Organization: **A-Clinic Foundation** Address: Maistraatinportti 2, 00240 Helsinki Country: Finland Telephone number: +358 50 5780 806 E-mail address: pirkko.hakkarainen@a-klinikka.fi

TABLE 14: TOWARDS A FRAMEWORK FOR IMPLEMENTING EVIDENCE-BASED ALCOHOL INTERVENTIONS

	BASIC FACTS			
NAME	**Towards a Framework for Implementing Evidence-Based Alcohol Interventions**			
ABSTRACT	The initial focus of the project was to test feasibility of screening and brief intervention (SBI) within emergency departments. In February 2008, a mapping exercise was undertaken with all acute hospitals nationally. The results of this exercise showed the level of response to alcohol related attendances and helped to identify acute hospitals where significant interventions were already in place. A national meeting with persons interested in alcohol in the acute hospital setting took place in June 2008. The mapping document and national meeting identified seven hospitals where the feasibility test could be carried out. Multi-disciplinary meetings were held with staff in seven hospitals and four of the seven hospitals were able to test feasibility of SBI in the emergency department. Staff were briefed on the project in four hospitals and agreed that over the period from December 2009 to February 2010, they would administer the screening tool and deliver appropriate interventions. Staff was asked to screen everyone attending the emergency department, it was acknowledged at the outset that there are certain circumstances where this is not feasible for staff.			
FUNDING	Health service executive			
LEVEL	National			
AIMS & OBJECTIVES	The study tested the feasibility of screening and brief intervention (SBI) within four emergency departments.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Intermediate target group (Teachers, management of the school, medical and social workers, etc.)	Funders	Staff in acute hospital setting	
LOGIC MODEL	**Scientific:** World Health Organisation. (2009) Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol related harm. Geneva: WHO. World Health Organisation. (2001) The Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care The literature provides clear and consistent support for the role of nurses and other health care professionals in delivering brief interventions to people with hazardous and harmful alcohol use (Allen, 1998; D'onofrio et al, 2002; Herring & Thom, 1999; Anderson et al, 2001 and Goodall et al, 2008). These brief psychological interventions aim to investigate a potential problem and motivate individuals to do something about their substance abuse, either by natural, client directed means (self-change) or by seeking additional substance misuse treatment (Health Research Board, 2006).			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Time schedule
	Partners' agreement	Communication plan	Evaluation plan	

	IMPLEMENTATION			
TIMEFRAME	Non-recurring			
TARGET GROUP(S)	General population			
COMMUNICATION CHANNELS	Radio	Newspapers/magazines	Brochures/leaflets/items	Website
	E-mail	Meetings/conference with experts/colleagues	Direct communication	
CORE ACTIVITIES	A Guiding Framework for the Education and Training in Screening and Brief Intervention for Problem Alcohol Use for Nurses and Midwives was developed. A National Screening and Brief Intervention Training Programme was developed. The results of the feasibility test were published in the Irish Medical Journal in 2014. A dedicated website section was developed for screening and brief intervention on the Health Service Executive website. An online alcohol self-assessment tool has been developed. Screening and Brief intervention has been recommended at National Policy level.			
SUPPORTIVE ACTIVITIES	Training			
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process			
RESULTS	**Policy:** • There should be a policy for addressing hazardous and harmful alcohol use in all acute hospitals. • One of the existing frontline staff should be dedicated as an alcohol liaison nurse for each hospital. The alcohol liaison nurse will provide support to nursing and medical staff to enable them to deliver screening and brief interventions and will act as a resource to improve hospital management of problem and dependent drinkers. • The M-SASQ single item screening question should be included in standard patient documentation. • There should be a written detoxification protocol and appropriate services for acute hospitals. • Screening and brief intervention should be extended beyond the emergency department to the wider hospital. **Service Provision:** • There should be a clear referral pathway to drug and alcohol services and primary care teams for patients requiring a referral from the emergency department after screening. • Consideration should be given to the inclusion of general drugs screening (instrument based) within acute hospitals. **ICT:** • Improved electronic data collection to capture patients who have received a brief intervention and a referral to specialist services. • The M-SASQ single item screening question should be included in electronic patient records. • An evidence-based self-assessment tool should be provided within hospital waiting rooms and on the HSE and www.drugs.ie website. ↓			

RESULTS	↓ **Training:** • Multi-disciplinary training should be provided in Screening and Brief Intervention (SBI) at all stages of career development, beginning in student training. • An e-learning programme should be developed for the SAOR model of training. **National:** • A public education campaign should be devised for alcohol related harms and new standard drinks information. This exercise demonstrated that there is much benefit in systematic screening for alcohol in Emergency Departments as our drinking patterns are such that much morbidity can be prevented. Ideally, the screening should become part of the normal clinical assessment.
REPORT	http://www.lenus.ie/hse/handle/10147/313130 HSE: "Towards a Framework for Implementing Evidence-based Alcohol Interventions"
FOLLOW-UP	The results of the feasibility study were submitted to the steering group examining the inclusion of alcohol with the National Drugs Strategy. Upon publication of the Steering group report on a National Substance Misuse Strategy they recommended the following: Alcohol liaison nurses should be assigned to all general hospitals for the purpose of coordinating care planning and/or screening and brief interventions for patients with alcohol-related disorders/illnesses. http://health.gov.ie/wp-content/uploads/2014/03/Steering_Group_Report_NSMS.pdf "A Guiding Framework for the Education and Training in Screening and Brief Intervention for Problem Alcohol Use" was developed: The Guiding Framework provides a standardised approach to the education and training of nurses, midwives and health and social care professionals who can then undertake screening and brief intervention in both acute and community care settings. The education and training programme uses the SAOR© (Support, Ask, Assess, Offer Assistance, and Refer) model for screening and brief intervention for problem alcohol use. Since 2012, approximately 1,400 staff have been trained in the SAOR© model. A SAOR© Train the Trainer Programme has been developed and is currently being rolled out to support further delivery of training. A number of screening and brief intervention resources have been developed for the Irish setting including an online alcohol self-assessment tool to identify hazardous and harmful alcohol use.
	ADDITIONAL INFORMATION
WEBSITE	www.hse.ie/eng/services/Publications/topics/alcohol/alcoholscreening.html
CONTACT DETAILS	Contact person: **Ruth Armstrong**, Project Manager-Alcohol Organization: **Health Service Executive** Address: Oak House, Millennium Park, Naas, Co.Kildare Country: Ireland Telephone number: +353 86 3801 155 E-mail address: ruth.armstrong@hse.ie

4.4.2. First indication of effectiveness

TABLE 15: SCHOOL-BASED INTERVENTION FOR DRUG USING STUDENTS

	BASIC FACTS					
NAME	**School-Based Intervention for Drug Using Students**					
ABSTRACT	The preventive intervention is a suggested course of action that school representatives can take in order to help a student and his or her parents to deal with a situation of crisis and overcome a licit or an illicit drug problem. It is a 12-hour training course which aims at preparing participants to conduct intervention talks with pupils and their parents and agree on a contract.					
FUNDING	National/regional/local government					
LEVEL	National					
AIMS & OBJECTIVES	The general objective of this programme is to limit psychoactive substance use among pupils and improve their school performance. To develop a coherent intervention addressed to pupils using psychoactive substances in school. To implement the intervention and to support positive changes in a student's behaviour related to alcohol, tobacco or drug use.					
STAKEHOLDER INVOLVEMENT	Intermediate target group	Government	Funders	Researchers		
LOGIC MODEL	Scientific model: crisis intervention, alcohol brief intervention in PHCU, motivational interview					
ELEMENTS OF PLANNING	Literature review and/ or formative research	Needs assessment	Detailed plan of action	Human resource management plan	Time schedule	Evaluation plan
	IMPLEMENTATION					
TIMEFRAME	Continuous					
TARGET GROUP(S)	Children		Adolescents		Parents	
COMMUNICATION CHANNELS	Brochures/leaflets/items		Meetings, conferences with experts/colleagues		Scientific publications	
CORE ACTIVITIES	Meetings with schools' staff, training sessions, supervisions					
SUPPORTIVE ACTIVITIES	Consultancy			Team meetings		

	EVALUATION
RESPONSIBILITY	Internal
TYPE	Process Impact Outcome
RESULTS	In the opinion of respondents, 44 % of interventions ended successfully. This means that persistent change in student behaviour was achieved or there was no evidence of further breaking of school rules by the student. Based on the gathered information, it can be concluded that this school-based intervention method can be useful for school staff and that for most part, it fits their potential skills. Results indicate that in half of participating schools at least some of the proposed system modifications were implemented and in majority of schools teachers used key elements of the intervention method while solving problems related to students' conduct or drug use. In proceeding stages, good communication and openness in parent-school contacts were crucial for the programme effectiveness. These were also a source of positive reinforcement for the people involved.
REPORT	EMCDDA: "School-based intervention for drug using students" Borucka A., Pisarska A, Okulicz-Kozaryn K. [Evaluation of a school-based intervention method for drug using students]. [Article in Polish], Med Wieku Rozwoj. 2003 Jan-Mar;7(1 Pt 2):157-72. Okulicz-Kozaryn K, Borucka A, Pisarska A. [Introduction of a school-based intervention method targeted for drug using students. Barriers related to the co-operation between parents and teachers].[Article in Polish] Med Wieku Rozwoj. 2003 Jan-Mar; 7(1 Pt 2):173-92.
FOLLOW-UP	No
	ADDITIONAL INFORMATION
WEBSITE	
CONTACT DETAILS	Contact person: **Agnieszka Pisarska**, DMSc Organization: **Prevention Unit, Institute of Neurology and Psychiatry** Address: 9 Sobieskiego Str. 02-957 Warsaw Country: Poland Telephone number: +48 22 4582 630 E-mail address: agapisar@ipin.edu.pl

4.4.3. Good indication of effectiveness

TABLE 16: THE NATIONAL RISK DRINKING PROJECT

	BASIC FACTS			
NAME	**The National Risk Drinking Project**			
ABSTRACT	The Risk Drinking Project was a Government assignment to the Swedish National Institute of Public Health (now Public Health Agency of Sweden) from 2004 to 2010 with the objective of giving questions about drinking habits an obvious place in everyday healthcare. The project was initially targeted at those who work in primary care, child healthcare, maternity care and the occupational health services. Work was later expanded to also include universities and hospitals.			
FUNDING	National/regional/local government			
LEVEL	National		Regional	
AIMS & OBJECTIVES	**Objectives:** Healthcare personnel bring up alcohol issues frequently in routine care. Healthcare personnel have strong self-efficacy, good knowledge and positive attitudes with regard to alcohol issues.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Government	Researchers
	Medical Professional Organisations, Hospitals, Local Public Health workers			
LOGIC MODEL	**Scientific model:** The Risk Drinking Project began with a baseline questionnaire. The target group comprised all general practitioners, registrars and district nurses empowered to issue prescriptions active in Sweden in primary care, nurses in child healthcare, midwives in maternity care, occupational health physicians and nurses in the occupational health services. **Past experience:** The work of the Risk Drinking Project began with an analysis of obstacles and opportunities to spread and introduce secondary alcohol prevention in Swedish healthcare. First, previous implementation efforts in Swedish and non-Swedish primary care were studied and good examples of methods such as The Risk Drinking Workshop and Motivational Interviewing was included in the programme. Evidence-based Implementation Strategies such as peer to peer training, "bottom up" approach, building on already existing structures etc. was also included.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Evaluation plan

	IMPLEMENTATION				
TIMEFRAME	Continuous				
TARGET GROUP(S)	General population	Adults	Parents	Pregnant women	Families
COMMUNICATION CHANNELS	Television	Newspapers/ magazines	Brochures/leaflets/ items	Telephone/mobile	
	Website	E-mail	Meetings, conferences with experts/ colleagues	Guidelines	
CORE ACTIVITIES	The activities consisted of training, information and conferences for healthcare personnel.				
SUPPORTIVE ACTIVITIES	Consultancy	Training	Team meetings		
	EVALUATION				
RESPONSIBILITY	External and internal				
TYPE	Process	Impact	Outcome		
RESULTS	The evaluation shows that significant improvements occurred in most variables studied (outcome measurements). Within primary care, the personnel have become more active in discussing alcohol with patients, have obtained more knowledge about counselling patients regarding alcohol and have gained greater confidence in their own ability (improved self-efficacy) to help patients reduce their hazardous alcohol consumption. Activity in the form of discussions concerning alcohol has increased more than for other life habits. The evaluation also indicates a connection between the degree of alcohol prevention activity and how much training the personnel received in the handling of hazardous alcohol consumption. The personnel with more training were generally more active.				
REPORT	FOLKHALSOMYNDIGHETEN: "Alcohol issues in daily healthcare"				
FOLLOW-UP	Yes A follow up was done after three years from the base-line.				
	ADDITIONAL INFORMATION				
WEBSITE	www.folkhalsomyndigheten.se				
CONTACT DETAILS	Contact person: **Åsa Wetterqvist**, Special adviser Organization: **Public Health Agency of Sweden** Address: 171 82 Solna Country: Sweden Telephone number: +46 10 2052 000 E-mail address: asa.wetterqvist@folkhalsomyndigheten.se				

4.4.4. Strong indication of effectiveness

TABLE 17: WEB-ICAIP – WEB-BASED INDIVIDUAL COPING AND ALCOHOL-INTERVENTION PROGRAMME

	BASIC FACTS				
NAME	**Web-ICAIP – Web-Based Individual Coping and Alcohol-Intervention Programme for Children of Parents with Alcohol Problems (Alkohol och coping)**				
ABSTRACT	This study consists of a randomized controlled trial (RCT) with two parallel conditions where one group has access to the web-ICAIP intervention and the other consists of a waiting list control group representing treatment as usual (TAU). About 200 persons aged 15-19 participates in the study. Web-ICAIP is presented with an image of a playing board, containing a set of filmed lectures, practices and feedback. Some of the elements are mandatory, some are optional. The lectures are on substance abuse in the family and describe a number of coping strategies. The interactive elements are designed to engage the targets and make them describe their feelings and everyday life.				
FUNDING	National/regional/local government	Non-governmental organisation			
LEVEL	National				
AIMS & OBJECTIVES	The purpose of the programme Web-ICAIP is to strengthen adolescents' coping behaviour, improve their mental health, and postponing the onset or decreasing risky alcohol consumption.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Intermediate target group	Researchers			
LOGIC MODEL	**Scientific:** This study consists of a RCT with two parallel conditions where one group has access to the web-ICAIP intervention and the other consists of a waiting list control group representing treatment as usual (TAU). Participants were recruited via Facebook-ads and via the web site Drugsmart (www.drugsmart.com) which, in addition to more general information about alcohol and other drugs, contains information, facts, and activities targeted to children of substance abusing parents.				
ELEMENTS OF PLANNING	Literature review and/ or formative research	Needs assessment	Detailed plan of action	Financial plan	Evaluation plan
	IMPLEMENTATION				

TIMEFRAME	Non-recurring			
TARGET GROUP(S)	Adolescents		Young adults	
COMMUNICATION CHANNELS	Social media	Website	Meetings / conferences with experts/colleagues	Scientific publications
CORE ACTIVITIES	Web-ICAIP will be implemented at the website www.drugsmart.com, operated by The Swedish Council for Information on Alcohol and Other Drugs (CAN) when the final results of the evaluation will be published.			
SUPPORTIVE ACTIVITIES	Team meetings			
	EVALUATION			
RESPONSIBILITY	External			
TYPE	Impact	Outcome		
RESULTS	About 200 persons aged 15-19 participated in the study. Preliminary results at follow-up after 2 and 6 months show that a large proportion of the participants use non-functioning coping strategies and suffer from psychological disorders and have a risky alcohol consumptions themselves. Most of the participants have symptoms of depression and four out of ten have a risky alcohol consumption. The preliminary results show that participants in the intervention group decrease their alcohol consumption to a higher extent compared to the participants in the control group. Final results will be published in 2015.			
REPORT	www.biomedcentral.com/1471-2458/12/35			
FOLLOW-UP	Yes	Results of the final follow-up will be published in 2015.		
	ADDITIONAL INFORMATION			
WEBSITE	http://stad.org/sv/forskning/barn-i-missbruksmilj-bim (only in Swedish)			
CONTACT DETAILS	Contact person: **Anna Raninen**, Head of Department Organization: **Swedish Council for Information on Alcohol and Other Drugs** Address: PO Box 70412, SE-10725 Stockholm Country: Sweden Telephone number: +47 72 3714 321 E-mail address: anna.raninen@can.se			

TABLE 18: NINE MONTHS ZERO (NEGEN MAANDEN NIET)

	BASIC FACTS				
NAME	**Nine Months Zero (Negen Maanden Niet)**				
ABSTRACT	The intervention is an online computer tailored intervention aimed to reduce alcohol use during pregnancy. This intervention is for pregnant women using alcohol. Participants fill in a baseline questionnaire and two follow-up questionnaires 6 weeks and 3 months after baseline. After each questionnaire, they receive tailored advice. Participants are recruited through gynaecologists and midwives or directed through pregnancy and alcohol related websites.				
FUNDING	Education/public health/research institution				
LEVEL	National				
AIMS & OBJECTIVES	The main aim is that pregnant women who drink alcohol, stop drinking. **Main objectives are:** • to increase knowledge of harmful effects of alcohol use during pregnancy, • better understanding that advantages of not drinking are more important than the disadvantages, • better skills in dealing with absence of social support to abstain from alcohol during pregnancy, • to help making plans to achieve alcohol abstinence during pregnancy.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Funders	Researchers	Health insurance
LOGIC MODEL	The intervention is based on the I-Change Model (De Vries, et al., 2003). This model has been applied within several previous health promotion studies.				
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action		
	Financial plan	Human resource management plan	Time schedule		
	Partners' agreement	Communication plan	Evaluation plan		
	IMPLEMENTATION				
TIMEFRAME	Non-recurring				
TARGET GROUP(S)	Pregnant women				
COMMUNICATION CHANNELS	Newspapers/magazines	Brochures/leaflets/items	Social media		
	Website	E-mail	Meetings/conferences with experts/colleagues		
	Direct communication	Guidelines	Scientific publications		

CORE ACTIVITIES	Presentations for gynaecologists and midwives to promote the intervention.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process	Outcome	Outcome	
RESULTS	Nine Months Zero proved to be effective. 78 % of the participating pregnant women stopped drinking after fulfilling the intervention, compared to 45 % of the women who were only consulted by the regular health care professionals. The intervention is recommended as an attractive intervention for pregnant women using alcohol.			
REPORT	www.jmir.org/2014/12/e274			
FOLLOW-UP	No			
	ADDITIONAL INFORMATION			
WEBSITE	www.alcoholenzwangerschap.nl/negenmaandenniet.html			
CONTACT DETAILS	Contact person: **Wim van Dalen** Organization: **Dutch Institute for Alcohol Policy STAP** Address: PO Box 9769, 3506 GT Utrecht Country: Netherlands Telephone number: +31 30 6565 041 E-mail address: wvandalen@stap.nl			

TABLE 19: THE SWEDISH NATIONAL ALCOHOL HELPLINE (ALKOHOLLINJEN)

	BASIC FACTS		
NAME	**The Swedish National Alcohol Helpline (Alkohollinjen)**		
ABSTRACT	Since 2007, The Swedish National Alcohol Helpline (Alkohollinjen) provides an easily available and low-threshold service to hazardous and harmful alcohol users in the community. The callers usually have relatively severe alcohol problems at first contact. Most of them have previously been in contact with various health care services. Though almost half of them have sought some kind of help to change their alcohol habits, only one in five turned to health care providers. The social conditions of the callers are usually relatively orderly with an occupation, a family and access to social support. Practically all users report being very content with the reception at first contact with the Alcohol Helpline. The Helpline provides a viable community service for harmful and hazardous alcohol users. A first study showed that the proportion of participants having possible alcohol dependence was reduced from 64 per cent at the first contact to 19 per cent at the 12-month follow-up. Further studies are warranted in order to strengthen our preliminary conclusion of possible effectiveness of the counselling provided at the Helpline. As a next step, a randomized controlled trial including an alternative counselling model with a self-help material was initiated in May 2015.		
FUNDING	National/regional government		
LEVEL	National	Regional	
AIMS & OBJECTIVES	To provide an easily available, low threshold service to hazardous and harmful alcohol users in the community.		
	DEVELOPMENT		
STAKEHOLDER INVOLVEMENT	Researchers	Government	Funders
LOGIC MODEL	**Scientific:** The counselling at the Alcohol Helpline is primarily based on Motivational Interviewing (MI), combined with elements of Cognitive Behaviour Therapy. Many studies carried out in health care settings have shown that brief interventions are both effective and cost-effective, especially for patients with hazardous or harmful alcohol use. Participants in these studies are typically non-treatment-seeking primary care patients identified by opportunistic screening. There is evidence that Motivational Interviewing (MI) has been proved effective in reducing alcohol consumption. Telephone-based interventions have shown to be effective in the treatment of mental health problems and for smoking cessation and are available at a low cost.		
ELEMENTS OF PLANNING	Needs assessment	Financial plan	Human resource management plan
	IMPLEMENTATION		
TIMEFRAME	Continuous		

TARGET GROUP(S)	General population					
COMMUNICATION CHANNELS	Website	Newspapers/ magazines	Brochures/ leaflets/items	Meetings/ conferences with experts/ colleagues	Guidelines	Scientific publications
CORE ACTIVITIES	The Alcohol Helpline operates on two or three lines simultaneously, during 33 hours a week. All contacts with the callers are registered in a computerized client record subject to rules of confidentiality commonly used within the Swedish health care system. The Alcohol Use Disorders Identification Test (AUDIT) is used for the assessment of the client's alcohol use and alcohol problems. Clients needing additional support are referred to other service providers.					
SUPPORTIVE ACTIVITIES	Training		Supervision		Team meetings	
	EVALUATION					
RESPONSIBILITY	External and internal					
TYPE	Impact			Outcome		
RESULTS	At 12-month follow-up, respondents had significantly reduced their AUDIT score to half of the baseline values, and one third of the participants were abstinent or consumed alcohol at a low-risk level. Participating in more than one counselling session as compared to one session was associated with a tendency to shift to a to a lower AUDIT zone at follow-up among women.					
REPORT	www.substanceabusepolicy.com/content/9/1/22					
FOLLOW-UP	Yes	In first study a 12-month follow-up, in ongoing RCT 6 and 12 months follow-ups.				
	ADDITIONAL INFORMATION					
WEBSITE	alkohollinjen.se					
CONTACT DETAILS	Contact person: **Kerstin Damström Thakker**, Head of the Swedish National Alcohol Helpline Organization: **Centre for Epidemiology and Community Medicine, Alcohol and Tobacco Prevention Unit** Address: PO Box 1497, SE-171 29 Solna, Sweden Country: Sweden Telephone number: +47 72 3714 321 E-mail address: anna.raninen@can.se					

TABLE 20: "DRINK LESS" PROGRAMME

	BASIC FACTS			
NAME	**"Drink Less" Programme**			
ABSTRACT	The "Drink less" programme is being implemented since 2002 by The Programme on Substance of the Public Health Agency of Catalonia in collaboration with other expert organisations. Its aim is to reduce risky drinking and alcohol-related problems affecting the population attending the primary health centres (PHC). 367 PHC are involved. In order to get an early intervention and brief intervention for risky consumption, the programme provides the PHC professionals with training and suitable support instruments for consultations.			
FUNDING	National/regional			
LEVEL	Regional			
AIMS & OBJECTIVES	The main aim is to reduce risky drinking and alcohol-related problems affecting the population attending the PHC. The main objectives are to increase screening and brief intervention rates by increasing awareness among the health professionals on the importance of hazardous and harmful alcohol consumption. In addition to that, the project aims at raising awareness on the risks of hazardous and harmful drinking among population attending PHC.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Government	Researchers
	Societat Catalana de Medicina Familiar i Comunitària (CAMFiC)		Associació d'Infermeria Familiar i Comunitària (AIFICC)	
LOGIC MODEL	**Scientific:** Drink Less programme was born in 1995 in the frame of the collaborative international WHO project on "Alcohol and Primary Care". It follows the training and support model elaborated in the context of Phase III of the WHO Collaborative Project.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Communication plan
	Evaluation plan			

	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	General population	Young adults	Adults	Elderly population
	Pregnant women	Women	Men	
COMMUNICATION CHANNELS	Newspapers/ magazines	Brochures/leaflets/ items	Website	E-mail
	Meetings/conferences with experts/ colleagues	Direct communication	Guidelines	Scientific publications
	Platform	Annual Conference		
CORE ACTIVITIES	Training and continuous education, promotion of alcohol-related research actions, support and communication activities, continuous elaboration of supporting materials.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings Helpdesk
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process	Impact	Outcome	
RESULTS	Number of referents of the Drink Less programme was 724, number of PHC centres with referents was 357, alcohol screening at the PHC was 50 %, hazardous and harmful drinking at the PHC was 2 %.			
REPORT	www.inebria.net/Du14/pdf/2011_11_21_segura.pdf			
FOLLOW-UP	Yes	Annual evaluation with an ongoing improvement of the indicators collection process. The DAFO technique was used for an exhaustive analysis.		
	ADDITIONAL INFORMATION			
WEBSITE	beveumenys.cat drogues.gencat.cat			
CONTACT DETAILS	Contact person: **Joan Colom** Organization: **Program on Substance Abuse. Public Health Agency of Catalonia. Department of Health.** Address: Roc Boronat, 81,95 Barcelona Country: Catalonia/Spain Telephone number: +34 93 5513 610 E-mail address: beveumenys.salut@gencat.cat			

TABLE 21: TRAMPOLINE (TRAMPOLIN)

	BASIC FACTS			
NAME	**Trampoline/Trampolin**			
ABSTRACT	TRAMPOLINE group programme for children aged 8-12 years with at least one substance-abusing or -dependent caregiver was tested among 218 children from substance-affected families in a multicentre randomised controlled trial in 27 outpatient counselling facilities across Germany. The intervention is geared to the issues and needs of children of substance-abusers (COS), it especially explores the role of psychoeducation on children well-being, including addiction-related content and activities.			
FUNDING	National/regional/local government	Non-governmental organisation		
LEVEL	National			
AIMS & OBJECTIVES	The overall goal of TRAMPOLINE is to prevent substance use disorders (SUD) in children from substance affected families. The specific objectives were to teach participants effective strategies for coping with stress, to reduce the psychological stress for participants resulting from parental substance abuse or dependency by extending children's knowledge about alcohol and drugs, their effects on people and the consequences of substance-related disorders for affected persons and their families and to improve feelings of self-worth and self-efficacy and to help develop a positive concept of self.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Researchers	Civil society (NGOs)	
LOGIC MODEL	The theoretical underpinnings of the programme were derived from existing literature.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	
	Financial plan	Human resource management plan	Time schedule	
	Partners' agreement	Communication plan	Evaluation plan	
	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	Children	Parents	Vulnerable population(s): isolated children	
COMMUNICATION CHANNELS	Brochures/leaflets/items	Website	Meetings/conferences with experts/colleagues	
CORE ACTIVITIES	In developing the TRAMPOLINE group programme, a three-step approach was chosen: reviewing the international literature, inviting experts in the field (counsellors, social workers), conducting and closely monitoring a pilot trial of the programme. The resulting detailed manual includes nine weekly 90-minute models for the children as well as two optional parent sessions.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings

	EVALUATION		
RESPONSIBILITY	External and internal		
TYPE	Process	Impact	Outcome
RESULTS	Both interventions showed significant effects over time. The effects were grouped in pre-post effect, pre-follow-up effects and effects during follow up. All effects except for one exception (constructive-palliative emotion regulation) developed in the desired direction (substance-related avoidant coping, mental distress, cognitive capabilities, self-worth etc.). Significant group differences were found in the areas of knowledge, mental distress, and social isolation. Intervention group participants showed significantly increased knowledge, significantly reduced mental distress and significant less social isolation compared to control group participants. No group differences were found regarding self-efficacy and self-worth.		
REPORT	**Outcome and process:** Broening, S., Wiedow, A., Wartberg, L., Ruths, S., Haevelmann, A., Kindermann, S., Moesgen, D., Schaunig-Busch, I., Klein, M. & Thomasius, R. (2012). Targeting children of substance-using parents with the community-based group intervention TRAMPOLINE: a randomised controlled trial--design, evaluation, recruitment issues. BMC Public Health, 12-223. **Process:** Haevelmann, A., Broening, S., Klein, M., Moesgen, D., Wartberg, L., & Thomasius, R (2013). Empirical Quality Assurance in the Evaluation of "Trampoline" – A Group Intervention for Children of Substance-using Parents. Suchttherapie, 14(03), 128-134. ()		
FOLLOW-UP	Yes	6-month follow-up to detect sleeper effects and test the stability of effects uncovered in the post-measurement	

	ADDITIONAL INFORMATION
WEBSITE	www.projekt-trampolin.de
CONTACT DETAILS	Contact person: **Rainer Thomasius, Prof Dr** Organization: **Universitätsklinikum Hamburg-Eppendorf, Zentrum für Suchtfrage des Kindes- und Jugendaltes** Address: Martinistraße 52, 20246 Hamburg Country: Germany Telephone number: +49 40 7410 59307 E-mail address: thomasius@uke.de

5.

Public Awareness Interventions

5.1. DEFINITION

Public communication campaigns[1] can be defined as purposive attempts to inform or influence behaviours in large audiences within a specified time period using an organized set of communication activities and featuring an array of mediated messages in multiple channels generally to produce non-commercial benefits to individuals and society (54; 55).

"Public awareness campaigns" and "public communication campaigns" are umbrella terms. Most campaigns aim at **individual behaviour change**. **Media advocacy campaigns** seek to achieve policy change by exerting influence on **public will** and engagement.

Social marketing is an established and effective approach (56) in health promotion and prevention (57). It is a set of evidence and experience-based concepts and principles drawn from the field of marketing that provide a systematic approach to influence behaviours that benefit individuals and communities for the greater social good.

Social marketing is defined as an approach that seeks to integrate marketing concepts into other approaches to influence behaviours that benefit individuals and communities for social good (58). This approach draws on data about beliefs, attitudes and behaviours, behavioural theory, and experiential evidence, about what works and doesn't work in changing behaviours, to develop public health interventions. Social marketing also incorporates input from end-users, stakeholders, partners and an analysis of external competitive forces that either encourage desired and restrict undesired behaviours.

The European Centre for Disease Prevention and Control describes social marketing as (58) "a set of evidence and experience-based concepts and principles drawn from the field of marketing that provide a systematic approach to influence behaviours that benefit individuals and communities for the greater social good. Like commercial marketing, it is a fusion of science, practical 'know how' and reflective practice focused on continuously improving the effectiveness and efficiency of programmes."

According to Andreasen's definition (59), to be labelled social marketing, a campaign must:

- apply commercial marketing technology,
- have the influencing of voluntary behaviour as its bottom line, and

1 The terms "public awareness interventions" and "public communication campaigns" are used interchangeably here. The term "public communication campaigns" is the term used in the definition cited.

- primarily seek to benefit individuals/families or the broader society and not the marketing organization itself.

TABLE 22: CRITERIA FOR SOCIAL MARKETING (60)

Criterion	Criterion Description
1. Behaviour change	Behaviour change is the benchmark used to design and evaluate interventions.
2. Audience research	Projects consistently use audience research to (a) understand target audiences at the outset of interventions, (b) routinely pre-test intervention elements before they are implemented, and (c) monitor interventions as they are rolled out.
3. Segmentation	There is careful segmentation of target audiences to ensure maximum efficiency and effectiveness in the use of scarce resources.
4. Exchange	The central element of any influence strategy is creating attractive and motivational exchanges with target audiences.
5. Marketing Mix	The strategy attempts to use all four P's of the traditional marketing mix. That is, it creates attractive benefit packages (products) while minimizing the costs (price) wherever possible, making the exchange convenient and easy (place) and communicating powerful messages through media relevant to – and preferred by – target audiences (promotion).
6. Competition	Careful attention is paid to the competition faced by the desired behaviour.

In a review of 31 public health campaigns in German-speaking countries (57), only one met all six criteria and eight fulfilled at least four – despite 52 % of the campaigners reporting using social marketing techniques.

5.2. IMPLEMENTATION

Important factors for campaign success (61; 62)

1. Launching a strategic planning process

- The campaign should have a clear objective that is part of an overall strategy.
- The campaign should be based on established theories of persuasion, not on whim or "common sense".

2. Selecting a strategic objective

The overall strategy should focus on one of the following areas:

1. individual behaviour change,
2. changes in interpersonal and social processes,

3. support for institutional or community-based interventions,
4. promotion of public action for environmental change.

3. Selecting the target audience

Within the selected focus area, campaign messages should address a well-defined target audience. Usually, one size does not fit everyone.

4. Developing a staged approach

The target audience should be assumed to show resistance to the message. Therefore, a persuasive message must accomplish three functions:

1. Raise a question in the receiver's mind about the advisability of an action or belief, with strong communications that are difficult to counter;
2. Provide an answer to the question;
3. Target or tailor the persuasive message to unique susceptibilities of the group or individual to enhance message effects.

5. Defining the key promise

- The last step in the persuasion process should consist of the target audience taking a specific action.
- People are more likely to attend to and retain campaign messages that meet their needs or support their values. Therefore, it is crucial to define the single most important benefit the target audience will receive by taking the specified action: the "key promise".
- Supporting statements should explain why the promised benefit is in the target audience's interest, anticipate potential counterarguments and invalidate them.
- Media overload or distraction captures attention and lowers the target audience's ability to counter-argue.

6. Avoiding fear appeals

- Although counter-intuitive, 60 years of research have shown that emotionally-charged portrayals of negative consequences associated with behaviours that are discouraged (scare tactics) are rarely effective and sometimes harmful, making the problem behaviour more resistant to change.
- One reason that fear appeals are still widely used is that focus groups tend to rate them as effective, despite positive reinforcement approaches having been shown to be generally superior.
- Fear appeals usually fail because the threats prove unrealistic or are easily disconfirmed by experience.

- If fear appeals are rejected later, this usually results in an even worse outcome than if the appeal had never been given.
- If the threat is not consistent with the target audience's experience, it will fail or backfire, and also raise resistance to future prevention campaigns.
- Usually, subtle message appeals are more effective than extreme threats or extremely directive language, which often have adverse effects.

7. Selecting the right message source

- The credibility and trustworthiness of the source determine the persuasiveness of the message.
- Sources who have nothing to gain by the target audience's agreement are more credible and trustworthy.
- Prominently featuring the logo of the funding organisation may sometimes undermine the target audience's receptivity to the message.

8. Selecting a mix of media channels

Media channels should be selected according to the target audience's media preferences, the objectives of the campaign and cost.

9. Maximising media exposure

- Repetition helps drawing attention to the message, facilitates learning and increases liking, unless it is excessive.
- Airing spots in high frequency bursts ("flights") is more effective than broadcasting them over a long period.

10. Conducting formative research

- Entering into a dialogue with the audience throughout campaign development is a prerequisite for an effective campaign.
- At a minimum, tests with focus groups should be conducted at an early stage.

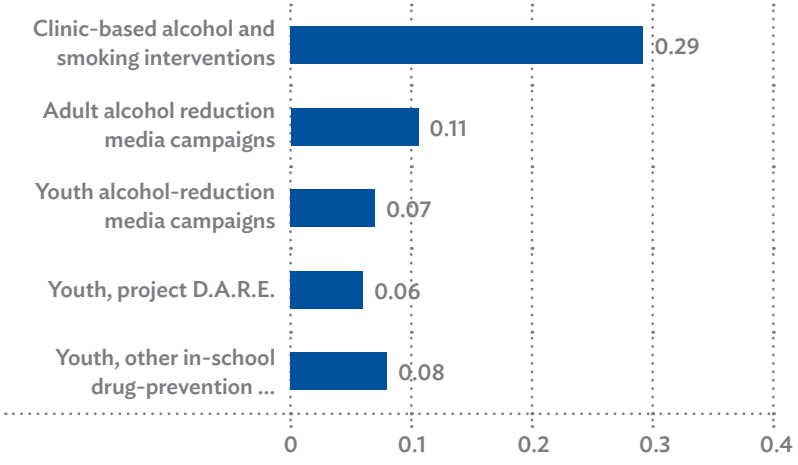
11. Conducting process and outcome evaluations

Whenever possible, both process and outcome evaluations should be incorporated at an early planning stage.

5.3. EFFECTIVENESS AND COST-EFFECTIVENESS

Targeted and well-executed campaigns can have small-to-moderate effects on knowledge, beliefs, attitudes and behaviour (63).

FIGURE 1: COMPARATIVE EFFECTIVENESS (ADAPTED FROM 64)



Meta-analytic studies in the United States have found campaigns without a coercive element (e.g. legal) to yield average effects on target behaviours in the magnitude of 5 percentage points (r = 0.05) (65). Larger effect sizes were found for alcohol reduction than for smoking cessation (64).

Regarding alcohol prevention via mass media, the strongest and most robust evidence of effectiveness is available for campaigns reducing alcohol-impaired driving. A systematic review (66) found a median decrease in alcohol-related traffic accidents of 13 percent. Estimations of the societal benefits outweighed the campaign costs by far.

All this evidence is reflected in the accepted interventions, which can be found in CHAPTER 5.4.

5.4. ACCEPTED INTERVENTIONS

TABLE 23: SUMMARY OF ACCEPTED PUBLIC AWARENESS/EDUCATION INTERVENTIONS ACCORDING TO THE LEVEL OF EFFECTIVENESS

Indication of effectiveness	Name[2]	Country
Basic	Don't Drink and Drive a Boat (Klar for sjøen, in Norwegian)	Norway
	Message in the Bottle (Sporočilo v steklenici)	Slovenia
	APD – Alcohol Prevention Day	Italy
	VOLLFAN statt voll fett	Austria
First	Raising Awareness Among Employers at Workplace	Croatia
	No Alcohol Under 16 Years – We Stick on It! (Keen Alkohol ënner 16 Joer. Mir halen eis drun!)	Luxemburg
Good	The Local Alcohol, Tobacco and Gambling Policy Model (PAKKA – Paikallinen alkoholi-, tupakka- ja rahapelipolitiikka -malli)	Finland
Strong	/	

2 Click on the name of the intervention to get to the description.

5.4.1. Basic level

TABLE 24: DON'T DRINK AND DRIVE A BOAT (KLAR FOR SJØEN, IN NORWEGIAN)

	BASIC FACTS				
NAME	**Don't Drink and Drive a Boat (Klar for sjøen, in Norwegian)**				
ABSTRACT	The intervention called "Don't Drink and Drive a Boat" aims to reduce alcohol related accidents and deaths in connection with the use of pleasure crafts. They seek to increase the boaters' knowledge on safe boating and the risks of combining alcohol and boating. They do so by a combination of direct communication, mass media, information material and social media, repeatedly throughout the boating season, in all parts of Norway.				
FUNDING	National/regional/local government				
LEVEL	National	Regional	Local		
AIMS & OBJECTIVES	To reduce the alcohol related accidents and deaths caused by boaters.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Target group(s)	Government	Civil society (NGOs)	The national trade organization (for pleasure crafts)	
LOGIC MODEL	**Scientific evidence** – it has been evaluated (by the International Research Institute of Stavanger) as helpful to maintain a collective awareness of risks, dangers and abstinence/moderation. **Past experience** – ten years of continuously evaluating and improving the intervention, in close cooperation with the partners.				
ELEMENTS OF PLANNING	Literature review and/or formative research	Detailed plan of action	Financial plan	Time schedule	
	Communication plan	Evaluation plan			
	IMPLEMENTATION				
TIMEFRAME	Periodic				
TARGET GROUP(S)	Boaters, in specific men (from their teens and older).				
COMMUNICATION CHANNELS	Television	Radio	Newspapers/ magazines	Billboards	Brochures/leaflets/ items
	Social media	Website	E-mail	Meetings/conferences with experts/ colleagues	Direct communication (one on one or in the group)

CORE ACTIVITIES	One on one communication, press releases, informative news on partners' web sites and social media, information material handed out at sea-/boat-related events, advertising.
SUPPORTIVE ACTIVITIES	Consultancy
	EVALUATION
RESPONSIBILITY	External and internal
TYPE	Process Impact Outcome
RESULTS	82 % of the population (15 years and older) noticed the basic message. The intervention succeeded in raising the public awareness on risks.
REPORT	/
FOLLOW-UP	No
	ADDITIONAL INFORMATION
WEBSITE	www.avogtil.no/sone/pa-sjoen/ (only in Norwegian) https://youtu.be/9qHdPhkSSNQ (film about the intervention in English)
CONTACT DETAILS	Contact person: **Kari Randen**, CEO Organization: **AV-OG-TIL** Address: Torggata 1, 0181 Oslo Country: Norway Telephone number: +47 23 2145 31 E-mail address: kari@avogtil.no

TABLE 25: MESSAGE IN THE BOTTLE (SPOROČILO V STEKLENICI)

	BASIC FACTS			
NAME	**Message in the Bottle (Sporočilo v steklenici)**			
ABSTRACT	The Department of Family Medicine at the Faculty of Medicine, University of Ljubljana, started the long-term project called "Message in the Bottle" in 2003. Our target was the population as a whole including medical professionals. Many different products were prepared for "above-the-line", "below-the-line" and "through the line" approaches: postcards, brochures, manuals, posters for different kinds of exhibitions and "commercial campaigns", billboards, radio and TV spots, city-light public displays, website banners and in 2008 website www.nalijem.si, which includes 28-item anonymous questionnaire for self-assessment of alcohol drinking.			
FUNDING	National/regional/local government		Private sector company/organisation	
LEVEL	National			
AIMS & OBJECTIVES	Its main aims are to reframe the understanding of alcohol issues, to change the social climate on alcohol and to reduce alcohol-related harm.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Researchers	Department of Family Medicine at the Faculty of Medicine, University of Ljubljana		
LOGIC MODEL	Alcohol drinking is an ongoing problem in Slovenia and, being stimulated by an international WHO Phase IV international collaborative project, we prepared the "Message in the Bottle" project. The idea and the performance of the website with its questionnaire has been influenced and supported by some colleagues from other countries at the international INEBRIA conference.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Communication plan	Evaluation plan
	IMPLEMENTATION			
TIMEFRAME	Continuous	Non-recurring: more than 2 years		
TARGET GROUP(S)	General population			
COMMUNICATION CHANNELS	Television	Radio	Newspapers/ magazines	Billboards
	Brochures/leaflets/ items	Website	Meetings/conferences with experts/ colleagues	Guidelines

CORE ACTIVITIES	Events, published brochures, posters, radio and TV spots, journal information, media interviews, banners on several websites, own website.
SUPPORTIVE ACTIVITIES	Team meetings
	EVALUATION
RESPONSIBILITY	Internal
TYPE	Impact Outcome
RESULTS	The internet intervention – structured feedback has statistically significantly reduced participants alcohol drinking.
REPORT	The drinking habits of users of an alcohol drinking screening website in Slovenia. Slovenian Journal of Public Health 2015; (in press).
FOLLOW-UP	Yes The respondents will be invited to fill out our website questionnaire again after one and two years.
	ADDITIONAL INFORMATION
WEBSITE	www.nalijem.si
CONTACT DETAILS	Contact person: **Prof. Marko Kolšek, MD, PhD** Organization: **Department of Family Medicine at the Faculty of Medicine, University of Ljubljana** Address: Poljanski nasip 58, SVN – 1000 Ljubljana Country: Slovenia Telephone number: +386 14 3869 15 E-mail address: marko.kolsek@mf.uni-lj.si

TABLE 26: APD – ALCOHOL PREVENTION DAY

	BASIC FACTS		
NAME	**APD – Alcohol Prevention Day and national campaigns for the implementation of the frame law on alcohol 125/2001**		
ABSTRACT	Since 2001, the National Observatory on Alcohol of the National Centre for Epidemiology, Surveillance and Health Promotion of the Istituto Superiore di Sanità (NOA CNESPS, ISS) has been committed to the exploitation of the campaigns of the Italian Ministry of Health (MoH), including the APD, promoted by mean of the 125/2001 frame law on alcohol. The APD is a part of the yearly initiative that promotes the month of April as a month of alcoholism prevention. It is a unique National opportunity to share practical and effective actions and good practices by several regional, municipal and local realities based on the experience and commitment of voluntary associations and self-and mutual-help, including Alcoholics Anonymous, Alateen and Al-Anon, and many non-conventional or formal associations ensuring valuable support to those in strong need of help or in the difficult process of rehabilitation and social reintegration. Each year, more than 250 key stakeholders participate in the event. European and international key speakers are usually invited from the European Commission, the WHO Regional Office for Europe and/or Head Quarter, scientists and researchers. Languages used are Italian and English with translation. The APD is the occasion to present and renew the offer of a wide range of materials useful for the alcohol prevention in children, adolescents, pregnant women, families, policy makers and health professionals disseminated by ISS all over Italy. All public domain materials are made available at the CNESPS, ISS web page (EPICENTRO www.epicentro.iss.it/alcol). Since 2001, APD represents a benchmark for Regional and Municipal authorities. The format and contents are replicated at the local level multiplying the attention to the central and burning issues on actions and initiatives, on which all the main stakeholders are committed in order to contribute to better deal with the reduction of alcohol related harms and risks across the different target populations. Most relevant is the integration of health and social activities solicited by the APD approach, and the availability of a standardized format of information provided by NOA CNESPS widely spreading the core of prevention information through the web channel. • ISS, EPICENTRO Webpage: http://www.epicentro.iss.it/alcol/apd13.asp • Materials: http://www.epicentro.iss.it/alcol/materiali.asp • Italia. Legge 30 marzo 2001, n. 125. Legge quadro in materia di alcol e di problemi alcol-correlati. Gazzetta Ufficiale n. 90, del 18 aprile 2001 (frame law on alcohol). • MoH, Report of the MoH to the Parliament, available at: http://www.salute.gov.it • ISS, Annual epidemiological monitoring report, available at: http://www.epicentro.iss.it The APD is funded and supported by the MoH by means of the 125/2001 Frame Law on alcohol.		
FUNDING	National/regional/local government		
LEVEL	National	Regional	Local

AIMS & OBJECTIVES	The APD is the central moment for an in depth debate that goes beyond the limit of the conference and reverberates throughout the year, deserving attention on several and main final users' roles (i.e. the institutions, researchers, health and prevention professionals, policy makers, media, civil society) and on concrete actions to be implemented by the main stakeholders involved to contribute to tackling a problem that has been demonstrated to generate each year in Italy 50 billion euros of social and health costs. The event is carried out yearly under the objectives provided by the national frame law on alcohol 125/2001; all over Europe, the Italian law represents a unique example of implementation of the Paris 1994 European Charter on Alcohol principles and a concrete endorsement of the recalls of the European Parliament Resolution for a Community strategy on alcohol, the European Alcohol Action Plans and the WHO specific international guidelines.

DEVELOPMENT

STAKEHOLDER INVOLVEMENT	Government	Funders	Researchers	Civil society (NGOs)	Media, civil society
LOGIC MODEL	**Scientific:** The event usually focuses on developments in alcohol prevention and policy, alcohol treatment and treatment systems and it is organized in the collaboration with the Italian Society of Alcohology (SIA), the AICAT (Associazione dei Club Territoriali Alcologici, alcoholics in treatment clubs) and it is supported by the Ministry of Health (MoH). The APD is the occasion for the presentation and distribution of a wide range of materials adopted by the MoH as the formal National Campaign tool kit for alcohol prevention in the different population's specific target groups (i.e. children, adolescents, pregnant women, families and health professionals). The event draws both alcohol professionals and policy makers, and is part of an Alcohol Prevention Month (APM), usually in April. **Past experience:** Since 2001, the NOA at CNESPS – ISS has organized and sponsored 13 editions of the APD. The last event was held in April 2015 in the collaboration with the Italian Ministry of Health (MoH), the Italian Society of Alcohology (SIA), the Italian Association of Territorial Alcoholics Clubs (AICAT) and EUROCARE Italia.				
ELEMENTS OF PLANNING	Literature review and/ or formative research	Needs assessment	Time schedule	Communication plan	Evaluation plan

IMPLEMENTATION

TIMEFRAME	Continuous (Continuous as implementations in alcohol prevention and policy at national, regional and municipal levels)	Periodic (on annual basis, for the implementation of monitoring and reporting activity on the implementation of the frame law on alcohol)

TARGET GROUP(S)	General population	Children	Adolescents	Young adults
	Adults	Old adults	Parents	Pregnant women
	Women	Men	Families	Drivers
	Party goers	Vulnerable population(s): people struggling with substance abuse, isolated elderly people, workers		

COMMUNICATION CHANNELS	Television	Radio	Newspapers/ magazines	Brochures/leaflets/items
	Social media	Website	E-mail	Meetings/conferences with experts/ colleagues
	Direct communication	Guidelines	The APD attracts media attention that by mean TV broadcasting of ad hoc programmes, journals and magazine articles and radio interviews make the event successful in driving initiatives all over Italy.	
CORE ACTIVITIES	The APD is the occasion for the presentation and distribution of a wide range of materials adopted by the MoH as the formal National Campaign tool kit for alcohol prevention in the different target groups (i.e. children, adolescents, pregnant women, families and health professionals).			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings Helpdesk
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	
RESULTS	For 14 years, starting from 2001, the APD is part of the yearly initiative that promotes the month of April as a month of alcoholism prevention. It is a unique national opportunity to share practical and effective actions and good practices by several regional, municipal and local realities based on the experience and commitment of voluntary associations and self- and mutual-help, including Alcoholics Anonymous, Alateen and Al-Anon, and many non-conventional or formal associations ensuring valuable support to those in strong need of help or in the difficult process of rehabilitation and social reintegration. Every year, formal monitoring data on alcohol are presented at the APD processed and analysed by NOA CNESPS from the national databases of the Multipurpose Survey on Households – Aspects of daily life of the National Institute of Statistics (ISTAT) and other relevant EU sources. The most relevant evidences of the year monitoring of alcohol consumption are included in the yearly report of the MoH to the Parliament published in the MoH website.			
REPORT	Not public			
FOLLOW-UP	The activities are reported in the Annual Report of the MoH to the Parliament in relationship to the implementation of the law 125/2001.			
	ADDITIONAL INFORMATION			
WEBSITE	http://www.epicentro.iss.it/alcol/apd.asp			
CONTACT DETAILS	Contact person: **Claudia Gandin, Emanuele Scafato** Organization: **Istituto Superiore di Sanità** Address: Via Giano della Bella, Roma Country: Italy Telephone number: +39 06 4990 4192/4028 E-mail address: claudia.gandin@iss.it; emanuele.scafato@iss.it			

TABLE 27: VOLLFAN STATT VOLL FETT

	BASIC FACTS
NAME	**VOLLFAN statt voll fett, Alcohol Prevention Campaign in both premier league Vienna Soccer Clubs "Rapid Wien" and "FK Austria"**
ABSTRACT	>VOLLFAN statt vollfett< is an alcohol prevention campaign in Vienna' located premier league soccer stadiums of the clubs Rapid Wien and FK Austria and First Vienna FC 1894 . It takes place during the games of both soccer clubs. The campaign started in April 2011 and is currently still running. The external evaluation is finished. The target group of the campaign are juveniles and young adult visitors of soccer games aged between 16 and 30 years and also multipliers like representatives from soccer clubs and fan clubs, on site gastronomy, security personal and event employees. Theoretical Framework: The Fanproject is based on the "peer to peer" approach. The trained peers are recruited from their own soccer fan scene. >VOLLFAN statt vollfett< doesn't postulate abstinence as an ultimate aim. The main aim is to reduce risks of drinking alcohol. The project mainly draws on the risk-competence approach as a proved effect model within the addiction prevention. Risk-competence aims to a sensitive risk-taking with all health related risk situations. Therefore, the development of decision making and coping skills are important to act individual and social compatible.
FUNDING	National/regional/local government
LEVEL	Local
AIMS & OBJECTIVES	• Development of a responsible and risk conscious approach in handling with alcohol among the soccer clubs, their multipliers and the teenage and young adult soccer fans; • Increasing the consumption of non-alcoholic drinks in and around the soccer stadiums; • Promotion of awareness of the own alcohol-consumption and drinking patterns among the adolescent and young adult soccer fans; • The juveniles and young adult stadium visitors act self-responsibly regarding their alcohol-consumption.
	DEVELOPMENT
STAKEHOLDER INVOLVEMENT	Target group(s) Intermediate target group Economic operator Government Funders Researchers
LOGIC MODEL	**Scientific:** The project mainly draws on the risk competence approach as a proved effect model within the addiction prevention. Risk competence aims to a sensitive risk taking with all health related risk situations. Therefore the development of decision making and coping skills are important to act individual and social compatible. The public health Professor, Peter Franzkowiak, describes following sub objectives: being informed about drug effects and the risks of addiction, to abstain certain substances, consequently avoiding consumption in specific situations or development phase, a critical questioning on the use of legal and illicit substances, the development and trial of safety rules for consumption and the development of a enjoyment oriented harm reduced consumption. The fan project, as part of the campaign, is based on the "peer to peer" approach, which is derived from the social learning and the lifespan psychology theories. **Past experience:** Participation of the soccer clubs and the fans were helpful for the development of the project. The alcohol quiz and in joy activities are helpful to get in contact with the target group. The opinions and experiences of the peers are important for the further development of the project, so they are involved in the monitoring of the project.

ELEMENTS OF PLANNING	Literature review and/or formative research	Detailed plan of action	Financial plan	Human resource management plan	
	Time schedule	Partners' agreement	Communication plan	Evaluation plan	
	IMPLEMENTATION				
TIMEFRAME	Continuous				
TARGET GROUP(S)	Adolescents	Young adults	Adults		
COMMUNICATION CHANNELS	Television	Radio	Newspapers/ magazines	Billboards	Brochures/ leaflets/items
	Website	Social media	E-mail	Meetings/ conferences with experts/ colleagues	Direct communication
	Guidelines	Schroers, A./Männersdorfer, M. (2012). PartyFit! – Zeitgemäße Alkoholsuchtprävention bei Events. In: Schmidt-Semisch, Henning: Stöver, H. (Hrsg.): Saufen mit Sinn? Harm Reduction beim Alkoholkonsum. Fachhochschulverlag. Frankfurt. S. 233-247.			
CORE ACTIVITIES	Communication measures for building awareness (e.g. soccer club magazines, Facebook, advertisements in public transportation). On site activities by peer teams and outdoor education trainers. Trainings for the peers and also for members of the soccer clubs.				
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings	
	EVALUATION				
RESPONSIBILITY	External				
TYPE	Process				
RESULTS	Positive results: Soccer related approach, Juvenile visual language, participation of the peers, on-site activities. Recommended by the evaluation: to get in contact with the target group, peers need an ongoing training and supervision by peer-coordinators, on-site activities should be adapted to stay interesting for the target group, the setting is very demanding for alcohol prevention projects.				
REPORT	http://www.fgoe.org/projektfoerderung/gefoerderte-projekte/FgoeProject_195				
FOLLOW-UP	No				

	ADDITIONAL INFORMATION
WEBSITE	http://www.facebook.com/rapidvollfans, http://www.facebook.com/austriavollfans, http://www.youtube.com/watch?v=SCYO-DNiw7E&feature=relmfu, http://www.youtube.com/watch?v=1fBX5jUhzP4 http://sdw.wien/ueber-uns/suchtpraevention/arbeitsbereiche/ projekte-zur-betriebliche-suchtpraevention/
CONTACT DETAILS	Contact person: **Artur Schroers, Dr.,** Head of Science and Research SDW Organization: **Institut für Suchtprävention, Sucht- und Drogenhilfe Wien/SDW** Address: Modecenterstrasse 14/C/2nd floor, 1030 Wien Country: Austria Telephone number: +431 40 0087 321 E-mail address: artur.schroers@sd-wien.at

5.4.2. First indication of effectiveness

TABLE 28: RAISING AWARENESS AMONG EMPLOYERS AT WORKPLACE

	BASIC FACTS			
NAME	**Raising Awareness Among Employers at Workplace**			
ABSTRACT	Interdisciplinary team developed materials for raising awareness at workplace (education and seminar materials, training for the intervention providers, questionnaires for raising awareness, intervention evaluation and alcohol policy assessment). Intervention was conducted in six companies, 746 employees were included. The time-frame of intervention was three months (August-November 2012). Public and private, small to international and various sectors' companies were included. The intervention was part of the "European workplace and alcohol" (EWA) project.			
FUNDING	National/regional/local government	European commission – The Second Programme of Community Action in the Field of Health 2008-2013		
LEVEL	National			
AIMS & OBJECTIVES	The main aim was to produce, to pilot and to evaluate alcohol interventions at workplace. The main objectives were to improve workplace productivity, to reduce workplace accidents, to raise awareness amongst employees about health and alcohol correlation and to support employees to change their alcohol-related behaviour.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Intermediate target group	Economic operator	Government	Researchers
LOGIC MODEL	The rationale is described in the document Guidelines for pilot interventions and work plan that can be found at http://www.eurocare.org/eu_projects/ewa/deliverables/by_work_package/guidelines_and_analysis			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	
	Financial plan	Human resource management plan	Time schedule	
	Partners' agreement	Communication plan	Evaluation plan	
	IMPLEMENTATION			
TIMEFRAME	Non-recurring			
TARGET GROUP(S)	Adults	Drivers	Employees and employers	

COMMUNICATION CHANNELS	Brochures/leaflets/ items	Telephone/mobile	Website	E-mail
	Meetings/confer- ence with experts/ colleagues	Direct communication	Guidelines	
CORE ACTIVITIES	Background case studies of good practice, background study of legal framework, development of intervention materials (training for intervention providers, materials for intervention providers, materials for intervention receivers), organizing regional, national and international events/presentations of the results, publishing and distributing tool kits and recommendations.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Impact			
RESULTS	The results suggested that awareness rose significantly in 5/6 companies, alcohol consumption consequences decreased in 5/6 companies and alcohol policies tackled/ improved in 6/6 companies.			
REPORT	http://www.eurocare.org/eu_projects/ewa/deliverables/by_work_package/evaluation (evaluation strategy, coverage, quality and satisfaction reports)			
FOLLOW-UP	No			
	ADDITIONAL INFORMATION			
WEBSITE	http://zzjz-zz.hr/novestranice/zzindex_sing.php?tekst_id=126&menu_id=133			
CONTACT DETAILS	Contact person: **Prof. Branko Kolarić, MD, PhD** Organization: **Andrija Stampar Teaching Institute of Public Health** Address: Mirogojska 16, 10000 Zagreb Country: Croatia Telephone number: +385 14 6963 45 E-mail address: branko.kolaric@stampar.hr			

TABLE 29: NO ALCOHOL UNDER 16 YEARS – WE STICK ON IT! (KEEN ALKOHOL ËNNER 16 JOER. MIR HALEN EIS DRUN!)

	BASIC FACTS			
NAME	**No Alcohol Under 16 Years – We Stick on It! (Keen Alkohol ënner 16 Joer. Mir halen eis drun!)**			
ABSTRACT	Since May 2007, Ministry of Health, CePT (National Prevention Center for Addictions) and "Alcohol" multidisciplinary working group promote adults' social responsibility towards children and adolescents in points of sale (incl. petrol stations) and catering industry (community approach).			
FUNDING	National/regional/local government	Education/public health/ research institution	Non-governmental organisation	
LEVEL	National	Regional	Local	
AIMS & OBJECTIVES	Ensure comprehension and respect of the current legislation. Promote adults' social responsibility towards children and adolescents. Protect children and adolescents from the harmful effects of an early initiation of alcohol consumption.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Government	Civil society (NGOs)
LOGIC MODEL	**Scientific:** Theory of Social Learning (Bandura)			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Communication plan
	Evaluation plan			
	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	General population	Adults	Parents	
COMMUNICATION CHANNELS	Television	Radio	Newspapers/ magazines	Billboards	Brochures/ leaflets/items
	Telephone/ mobile	Website	E-mail	Meetings/ conferences with experts/ colleagues	Direct communication
	Guidelines	Scientific publications	Network communication with: • national representation of municipalities (Syndicat des Villes et Communes Luxembourgeoises), • national and local police.		

CORE ACTIVITIES	• Press conference; • Distribution of campaign material (posters, stickers, booklets, flyers for points of sale/ supermarkets and hospitality sector, guidelines and checklists for the organization of parties and other public events); • Information letter/e-mail to parents with children aged from 12 to 16 years by their municipality; • Realization of alcohol-free events in the municipality; • Support of a good implementation of the legislation by the local police (campaign publicity before the event, age control at the entry); • Training sessions for school employers and teachers, social workers in youth centres; • Implementation of alternative activities for adolescents aged between 12 and 15 years by local youth clubs; • Decision that the "Late Night Bus" (which assures the transport to specific parties) doesn't carry adolescents aged < 16 years.
SUPPORTIVE ACTIVITIES	Training Team meetings Helpdesk
	EVALUATION
RESPONSIBILITY	External
TYPE	Impact Outcome
RESULTS	The results of the scientific evaluation, realized by the University of Luxembourg were published in 2012 in a publication called *Local network creation as strategic concept in the prevention Evaluation of an awareness campaign for reduction of harmful alcohol consumption in adolescence.*
REPORT	SORES Research project (University of Luxembourg): "Social responsibility as a strategic conception of prevention work", 2009-2012.
FOLLOW-UP	No
	ADDITIONAL INFORMATION
WEBSITE	www.cept.lu
CONTACT DETAILS	Contact person: **Dr Simone Steil, Silke Gansen** Organization: **Division de la Médecine Préventive** Address: Allée Marconi – Villa LouvignyL-2120 Luxembourg Country: Luxembourg Telephone number: +352 247 855 60 E-mail address: simone.steil@ms.etat.lu, silke.christmann@ms.etat.lu

5.4.3. Good indication of effectiveness

TABLE 30: THE LOCAL ALCOHOL, TOBACCO AND GAMBLING POLICY MODEL (PAKKA – PAIKALLINEN ALKOHOLI-, TUPAKKA- JA RAHAPELIPOLITIIKKA -MALLI)

	BASIC FACTS					
NAME	**The Local Alcohol, Tobacco and Gambling Policy Model (PAKKA – Paikallinen alkoholi-, tupakka- ja rahapelipolitiikka -malli)**					
ABSTRACT	The Local Alcohol, Tobacco and Gambling Policy Pakka is a model for community action, tailored to the Finnish context and aimed at preventing harm from substance use, smoking and gambling through local cooperation. The focus is on the availability of alcohol, tobacco and slot machines. Activities to reduce availability are focussed on situations where under-18s have access to alcohol, tobacco or slot machines and where alcoholic beverages are being sold or served to intoxicated people or minors. The Pakka model brings together key actors in the community – public authorities, economic operators, young people, parents, and the media – to pool their expertise to reduce harm in the community. The development of Pakka model started as a project focussed on local alcohol policy in 2004 in pilot communities with support from local actors, the national Alcohol Action Plan and substance use prevention experts.					
FUNDING	National/regional/local government	The evaluation study received support from the government alcohol retail monopoly Alko Inc. Support has also been received from national funds for the development of health and social services (Programme Kaste).				
LEVEL	National	Regional	Local			
AIMS & OBJECTIVES	To reduce underage (<18 years) access to alcohol, tobacco and slot machines as well as to reduce serving of alcoholic beverages to intoxicated people and to enhance enforcement of legislation related to these.					
	DEVELOPMENT					
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Economic operator	Government	Researchers	Local and regional media
LOGIC MODEL	Scientific model: Warpenius K & al. Peliin ei puututa: Alkoholin, tupakan ja rahapeliautomaattien ikärajavalvontaa testanneet ostokokeet vähittäisliikkeissä. [Enforcing age limits on purchases of alcohol and tobacco and the use of slot machines: test purchases in retail outlets.] Yhteiskuntapolitiikka 77 (4): 375-385, 2012. **Past experience:** Holmila M & al. Paikallinen alkoholipolitiikka: Pakka-hankkeen loppuraportti. [Local Alcohol Policy: Final report of the PAKKA Project]. National Institute for Health and Welfare, Report 5/2009.					
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan	Human resource management plan	
	Time schedule	Partners' agreement	Communication plan	Evaluation plan		

	IMPLEMENTATION					
TIMEFRAME	Continuous					
TARGET GROUP(S)	General population	Children	Adolescents	Young adults		
COMMUNICATION CHANNELS	Radio	Newspapers/ magazines	Brochures/leaflets/ items	Website		
	E-mail	Meetings, conferences with experts/ colleagues	Direct communication	Scientific publications		
	The Innokylä web platform for exchange and networking					
CORE ACTIVITIES	Wide range of activities at the local level, for example, local work groups to address supply, mystery shopping, trainings to retailers and restaurant personnel, awareness campaigns, school activities, etc. At national level: network of Pakka developers (coordinators), handbooks and other materials and a dedicated web site.					
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings	Helpdesk	Dedicated web site and handbook
	EVALUATION					
RESPONSIBILITY	External					
TYPE	Process		Impact		Outcome	
RESULTS	The Pakka Project substantially enhanced the enforcement of the Alcohol Act: reduction of harms, fostering responsible serving and sale of alcohol, development of economic operators' own control measures. The structure and professional approach to substance use prevention were enhanced.					
REPORT	http://urn.fi/URN:NBN:fi-fe201205085235					
FOLLOW-UP	Yes	Dissemination of the PAKKA model for community action is a priority in substance use prevention at national level. The aim is that the model is being implemented in half of the municipalities in Finland by 2020.				
	ADDITIONAL INFORMATION					
WEBSITE	http://www.thl.fi/fi/web/alkoholi-tupakka-ja-riippuvuudet/ehkaiseva-paihdetyo/ehkaisevan-paihdetyon-menetelmat/verkko-pakka-ehkaisevaan-paihdetyohon www.innokyla.fi/web/verkosto711139					
CONTACT DETAILS	Contact person: **Jaana Markkula, Development Manager** Organization: **National Institute of Health and Welfare (THL)** Address: Mannerheimintie 168b, 00271 Helsinki Finland/ P.O. Box 30, FI-00271 Helsinki Country: Finland Telephone number: +358 29 5248 802 E-mail address: jaana.markkula@thl.fi					

6. School-Based Interventions

6.1. DEFINITION

The basic element of all **school-based interventions** is that the school-setting functions as a tool to reach young people in order to promote healthy behaviour. School-based prevention programmes may vary on the content, the approach, the duration etc., but they are defined based on the setting of implementation (school) and target-group (school community: students, teachers, parents).

Most often programmes target the first classes of the high-school period (aged 12—15 years). Very often the topics alcohol, tobacco and drugs are combined in these programmes. Besides that, the goals of these programmes are very diverse: from preventing alcohol use, increasing knowledge about alcohol/drugs/tobacco, delaying the onset of first use, affect social norms, attitudes and expectations connected to use of substances, training of refusal skills to focusing on "life-skills-training". Many programmes include teacher trainings and others are combined with family-based interventions.

6.2. IMPLEMENTATION

A school-based alcohol prevention programme should be proportionate and part of the holistic approach envisaged in the concept of the health-promoting school. It should also be based on educational practices that have proven effective, e.g. by targeting a relevant period in young people's development, talking to young people from the target group during the development phase, testing the intervention with both teachers and members of the target group, ensuring the programme is interactive and based on skill development, setting behaviour change goals that are relevant for all participants, returning to conduct booster sessions in subsequent years, incorporating information that is of immediate practical use for young people, conducting appropriate teacher training for delivering the material interactively, making any programme that proves to be effective widely available and marketing it to increase exposure.

School and community interventions may be usefully combined, in part because community efforts can help restrict young people's access to alcohol. Communities with better enforcement of minimum purchase ages have lower rates of alcohol use and of heavy episodic drinking (38).

Finally, it can be stated that every student of a certain age has the right to be well informed about the risks of alcohol, although the impact of this is unsecure. It is a challenge for parents as well as for teachers to make young people aware of this easily available substance.

6.3. EFFECTIVENESS AND COST-EFFECTIVENESS

1. Involving the broader environment is more effective

Babor et al. (69) point out that many school-based alcohol prevention programmes are effective in increasing knowledge and sometimes alcohol-related attitudes, but fewer programmes are capable in changing actual drinking behaviour (70). Other authors claim that there is sufficient evidence from controlled trials that carefully designed preventive interventions can improve adolescent health by changing behaviours of young people (71).

To enhance the likelihood of effectiveness, the broader environment (policy, pricing, modifying the drinking context, regulating the physical availability of alcohol, drunk-driving prevention, restrictions on marketing and early intervention services) should also be involved.

2. Cost-effectiveness: not much evidence

There is a paucity of evidence on cost effectiveness regarding school-based alcohol prevention programmes (72; 73). US data suggest high cost-effectiveness of school based prevention programmes such as Good Behaviour Game, Life Skills Program (74).

3. Positive results

- A large systematic Cochrane review, in which 53 studies were included, identified studies that showed no effects on alcohol use, as well as studies that demonstrated significant effects (68).
- Alcohol prevention programmes facilitated by computers or internet showed some significant effects on average alcohol consumption and binge drinking (75).
- A systematic review of Australian programmes demonstrated significant reductions in alcohol use (and other substances) for five of the seven intervention programmes. Effects were mostly small (76). Most of the programmes were based on social learning principles or cognitive behaviour therapy. Two programmes also focused on changing the school environment (whole-school approach).

- There is some evidence that supports the idea that early stage universal intervention (that is before alcohol consumption behaviours have become established), thus delaying the onset of alcohol use, may have the potential to be more effective than universal interventions targeting older youth (72; 73). For older age groups (grade 8 and further), to restricting availability of alcohol and indicated brief interventions are more effective instruments (70).

4. Effective ingredients: no clear pattern

- There was no clear pattern recognizable that could distinguish studies with no effect from studies with significant effects (68). The evidence suggests that more generic psychosocial and developmental prevention programmes can be effective, such as Life Skills Training Program (general life skills), the Unplugged programme (social skills and norms), and the Good Behaviour Game (development of behaviour norms and peer affiliation).
- There is little evidence that interventions with multiple components are more effective than interventions with single components (67).
- A comprehensive systematic review of reviews (77) identified five elements for effective school health education (among others: alcohol education): 1) use of theory, 2) addressing social influences, especially social norms, 3) addressing cognitive skills and socio-emotional behavioural skills, 4) training of facilitators, 5) multiple components (a finding which is contrary to 67).

All this evidence is reflected in the accepted interventions, which can be found in CHAPTER 6.4.

6.4. ACCEPTED INTERVENTIONS

TABLE 31: SUMMARY OF ACCEPTED SCHOOL-BASED INTERVENTIONS ACCORDING TO THE LEVEL OF EFFECTIVENESS

Indication of effectiveness	Name[1]	Country
Basic	/	
First	Me and the Others Programme (Programa Eu e os Outros)	Portugal
	I'm also Involved in Prevention (Ειμαι Και Εγω Στην Προληψη)	Greece
Good	Unplugged (Gyvai)	Lithuania
	Unplugged (Izštekani)	Slovenia
	Stop to Think: Prevention Programme of Use/Abuse of Alcohol in School Aged Adolescents	Portugal
Strong	Slick Tracy Home Team Programme and Amazing Alternatives programme (PDD – Program Domowych Detektywów + FM – Fantastyczne Możliwości)	Poland
	PAS – Preventing Heavy Alcohol Use in Adolescents	Netherlands
	Love & Limits (Kjærlighet og Grenser)[2]	Norway

1 Click on the name of the intervention to get to the description.

2 The intervention Strengthening Families Programme (Kjærlighet & Grenser) reaches the families through schools, but is implemented outside the school. Schools are used as a channel.

6.4.1. First indication of effectiveness

TABLE 32: ME AND THE OTHERS PROGRAMME (PROGRAMA EU E OS OUTROS)

	BASIC FACTS				
NAME	**Me and the Others Programme (Programa Eu e os Outros)**				
ABSTRACT	Universal Prevention Programme was created in 2007 by the Portuguese Institute of Drug and Drug Addiction (IDT), General Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD). It consists of seven 90-minute sessions on a weekly basis. It uses narratives as a methodology to address issues related with substances abuse and adolescence development process, with groups of young people aged between 12 and 18 years. The programme is ran by professionals from different institutions that work with adolescents after a training programme conducted by the national/regional coordination of the Programme (SICAD from the Portuguese Health Ministry). The programme can be run in consecutive years using different narratives. There are 9 narratives available, each one approaches a different kind of addictive behaviour (alcohol, tobacco, cannabis, pathological gambling, etc.) to be explored through the 7 sessions according to the identified needs of the target population.				
FUNDING	National/regional/local government				
LEVEL	National	Regional	Local	It is in the process of being adopted to Azores autonomous region as well as Cape Verde reality.	
AIMS & OBJECTIVES	This Programme is aimed at promoting a better knowledge and use of resources (like helplines, websites, linked with drugs and alcohol misuse, adolescent's counselling network, etc.) and to promote youngsters' healthy lifestyles, and their social and personal development.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Government	Researchers	Civil society (NGOs) also schools, social services child protection homes ...
	Teachers, psychologists, nurses, social educators, parents. As partners, the SICAD works with other stakeholders such as the Health General Directorate, Education General Directorate, the National Commission for Gender Equality, the Portuguese Institute of Sport and Youth, Police Department for the Intervention in Schools (Safe School), the National Institute for Rehabilitation, among others. In the research area, the SICAD works, or has worked in the past, with several faculties that were involved in small studies such as the Faculty of Psychology of the Lisbon University, the Lusíada University of Oporto; the Identities and Diversities Research Centre of the Leiria Polytechnic Institute; the Education and Communication School of the University of Algarve and the Évora's Nursing School, among others.				

LOGIC MODEL	**Scientific:** Theory of Planed Behaviour (TPB), Information-Motivation-Behaviour skills Model (IMB). **Past experience:** This programme is based on previous experience using the same approach to explore themes related to drug abuse among children (Master thesis: "E agora Ruca'" – Avaliação dos Critérios de Tomada de Decisão de Participantes num Programa de Âmbito Preventivo em Meio Escolar, Marreiros, N., 2007).			
ELEMENTS OF PLANNING	Literature review and/or formative research		Needs assessment	Detailed plan of action
	Human resource management plan	Time schedule	Partners' agreement	Evaluation plan
	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	Adolescents	Adolescents with academic failure, adolescents in care, indicated prevention in at-risk groups/individuals		
COMMUNICATION CHANNELS	Website	Meetings/conferences with experts/colleagues	Direct communications	
	Guidelines	Scientific publications	Helpline support and referral	
CORE ACTIVITIES	Production of the 9 narratives, support manual, guidelines for the implementation of the programme, training programme, annual reports, scientific articles, dissemination of the results in expert meetings.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process	Impact	Outcome	
RESULTS	The programme has been evaluated using the Life Effectiveness Questionnaire, which differentiates 8 factors (time management, social competence, achievement and motivation, intellectual flexibility, task leadership, emotion control, active/initiative attitude and self-confidence). The results obtained until 2012 showed significant changes (95 % confidence) with positive developments during the pre-test and post-test in all scales (except in the achievement motivation). In 2014, using a different questionnaire, there were significant differences between pre and post test in the areas of knowledge, attitudes and behaviours related to alcohol consumption. This results will be present in a paper to be delivered in 2016.			
REPORT	Each year a Programme report is produced in Portuguese. Some of the data is translated into English to join the national report for the EMCCDA.			
FOLLOW-UP	The evaluation process has undergone improvements in recent years and it is expected of future implementation of follow up (already in the year 2015)			

	ADDITIONAL INFORMATION
WEBSITE	www.tu-alinhas.pt www.sicad.pt
CONTACT DETAILS	Contact person: **Patricia Pissarra, MSc or Melo, Raul, Dr.** Organization: **SICAD** Address: Av. República n.º 61, 3º Country: Portugal Telephone number: +351 21 1119 000 E-mail address: raul.melo@sicad.min-saude.pt or eu.outros@sicad.min-saude.pt

TABLE 33: I'M ALSO INVOLVED IN PREVENTION (ΕΙΜΑΙ ΚΑΙ ΕΓΩ ΣΤΗΝ ΠΡΟΛΗΨΗ)

	BASIC FACTS				
NAME	**I'm also Involved in Prevention (Ειμαι Και Εγω Στην Προληψη)**				
ABSTRACT	This programme has been organized by the multidisciplinary team of 'Pronoi' Addiction Prevention Center, Athens (GREECE) in order to cover on a sustainable basis the needs of students of Secondary Education for the information regarding alcohol, substance use and addictions in general (alcohol, smoking, drugs, etc.). Methodology used is Brief Psychoeducational Intervention (universal prevention). Content of the intervention is the definition of addiction, differences between use & abuse, stages of addiction, consequences of abuse and addiction, definition of prevention, understanding how media influences work, deconstructing advertising messages, development of personal responsibility for one's health, getting involved in promoting prevention principles at school, creation of an advertisement promoting alcohol prevention messages, etc. Techniques that are used are discussion, work in small groups, power point presentation, video, music, drawing, role playing, brainstorming, questionnaires, etc. The intervention is implemented in a group format of 20-25 students per session (a single session is 3.5 hours long) and in a circle formation to facilitate the interactive and experiential approach of the intervention. The programme is approved and supported by the Ministry of Education – Health Education Office so schools apply to the centre in order to participate in the programme each year.				
FUNDING	National/regional/local government				
LEVEL	Local				
AIMS & OBJECTIVES	The general aim of the intervention is to educate and inform adolescents regarding alcohol and substance use (definition, causal factors, consequences, etc.) providing emphasis also on the role of media and peer influences on the use and addiction of alcohol and other substances.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Intermediate target group		Ministry of Education OKANA		
LOGIC MODEL	**Scientific:** This intervention draws on elements of the rational model/factual approach through the provision of information about the health risks and the social influence resistance model, which focuses on the social context in which substance is used. Our intervention is clearly based on Bandura's social cognitive theory with emphasis on the social environment of the adolescent. Therefore, it focuses on building skills to recognize negative influences aiming to change knowledge about and attitudes toward substance abuse with the ultimate goal of influencing behaviour. **Past experience:** There was a growing need from schools & communities to address these issues and types of interventions in the past that usually had the form of an informative lecture by a guest speaker in front of an audience of 300 students were not effective and this has been proved by a number of studies in the field of prevention research. From our experience with brief psychoeducational interventions, we saw that we could start a very productive discussion with adolescents and provide them with food for thought.				
ELEMENTS OF PLANNING	Literature review and/ or formative research	Needs assessment	Detailed plan of action	Time schedule	Evaluation plan

	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	Adolescents			
COMMUNICATION CHANNELS	Brochures/ leaflets/items	Website	Meetings/conferences with experts/colleagues	Direct communication
CORE ACTIVITIES	The programme has been running since 2004 and each year it has 15-20 groups of students participating (approximately 4,500 students). Event: Teen festival of advertisements regarding prevention of alcohol and other addictions (it takes place every 3 years).			
SUPPORTIVE ACTIVITIES	Team meetings	Collaboration with the Counselling Psychology Department of the Manchester Metropolitan University		
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	
RESULTS	The outcome evaluation examined adolescents' changes in attitudes and knowledge about alcohol, tobacco and illicit drugs, after their participation in a preventive substance abuse short term intervention. Pre and post intervention measurements explored this change in a sample of 125 Greek students (60 males, 65 females; mean age=14.7) from three different schools. Results showed that adolescents' anti-substance attitudes changed after the intervention primarily towards alcohol and secondly towards cigarettes, whereas there was not significant change in their attitudes towards drugs; young women presented stronger anti-substance attitudes than young men. Before the intervention, adolescents' anti-drugs attitudes were stronger than their attitudes towards alcohol and smoking for both genders; after the intervention, adolescents' anti-drugs attitudes were found to be stronger than their anti-alcohol and anti-smoking attitudes, for both genders. It is concluded that such interventions, even though short-term, have an impact on adolescents' attitudes towards substances, as well as on their knowledge about them; a fact which reinforces the need for research-based interventions.			
REPORT	Loizou D. Preventive substance abuse among greek adolescents: evaluation of a community based psycho-educational programme. Unpublished Dissertation Thesis. Manchester Metropolitan University in collaboration with 'Pronoi' Substance Use Prevention Centre of Municipality of Kifissia, 2009, Athens, Greece.			
FOLLOW-UP	No			
	ADDITIONAL INFORMATION			
WEBSITE	www.pronoi.org.gr			
CONTACT DETAILS	Contact person: **Ms Vasiliki Alexaki**, Social Worker, Prevention Worker Organization: **Center for the Prevention of Addiction & Psychosocial Health Promotion "PRONOI" Municipality of Kifissia and Organization Against Drugs OKANA** Address: Parou 2 & Ch.Lada, Kifissia 14563, Athens Country: Greece Telephone number: +302 10 8082 673 E-mail address: vasoalexaki@pronoi.org.gr			

6.4.2. Good indication of effectiveness

TABLE 34: UNPLUGGED (GYVAI)

	BASIC FACTS	
NAME	**Unplugged (Gyvai)**	
ABSTRACT	Unplugged is a school-based prevention programme based on the comprehensive social influence approach, targeted to adolescents aged 12-14 years and aimed to reduce the initiation, the use and abuse of alcohol, tobacco and illicit drugs. It was conducted in seven European countries, known as the EU-Dap project. The programme has been evaluated in a large European collaborative randomised controlled trial (EU-Dap). The programme consists of 12 lessons and 3 seminars for parents. The content of the programme includes information about alcohol, tobacco, marijuana and other drugs, and combines life skills and normative beliefs.	
FUNDING	UNPLUGGED programme was created in EU-Dap project, which was funded by the European Commission.	The IKEA Social Initiative funded the translation, adaptation and dissemination of UNPLUGGED programme in Lithuania.
LEVEL	National	
AIMS & OBJECTIVES	The unplugged programme aims to provide healthy, drug free adolescence. The main objectives are to increase health related awareness and knowledge of social influences, to improve knowledge, attitudes and skills concerning health behaviours and drug use, to reduce the use of tobacco, alcohol and cannabis and to reduce the likelihood of future drug abuse.	
	DEVELOPMENT	
STAKEHOLDER INVOLVEMENT	Intermediate target group	Researchers Prevention practitioners
LOGIC MODEL	**Scientific:** UNPLUGGED programme is based on Comprehensive Social Influence model where behaviours are introduced and trained to strengthen attitudes and skills that aid in resisting pressures towards drug use. The interactive methods used in those programmes are focused on enhancing competence to integrate relations and a strong social web in the approach to drugs and drug use.	
ELEMENTS OF PLANNING	Literature review and/or formative research Financial plan Time schedule	Detailed plan of action Partners' agreement Evaluation plan
	IMPLEMENTATION	
TIMEFRAME	Continuous	
TARGET GROUP(S)	Adolescents	Parents

COMMUNICATION CHANNELS	Social media	Website	E-mail	Meetings/conferences with experts/ colleagues
	Direct com-munications	Guidelines	Scientific publications	
CORE ACTIVITIES	Translation and publication of materials, 2 days training session for teachers, social pedagogues and psychologist, consultations and evaluation meetings.			
SUPPORTIVE ACTIVITIES	Consultancy		Training	Team meetings
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process		Impact	Outcome
RESULTS	The EU-Dap UNPLUGGED programme has a preventive effect on early onset of drug use and on the transition of experimental to frequent use. The effect has more influence on boys than on girls. The effectiveness of Unplugged intervention after 2nd questionnaire (3 months post intervention) showed 30 % reduction of daily smoking, 28 % reduction of recent drunkenness and 23 % reduction of experimenting cannabis.			
REPORT	www.eudap.net/pdf/finalreport2.pdf			
FOLLOW-UP	Yes	After the adaptation and piloting Unplugged in Lithuania, the follow-up evaluation was organized.		
	ADDITIONAL INFORMATION			
WEBSITE	www.eudap.net			
CONTACT DETAILS	Contact person: **Bernadeta Lazauninkaite** Organization: **Mentor Lithuania** Address: Gedimino av. 12, Vilnius Country: Lithuania Telephone number: +370 61 1278 72 E-mail address: bernadeta@mentorlietuva.org			

TABLE 35: UNPLUGGED (IZŠTEKANI)

	BASIC FACTS			
NAME	**Unplugged (Izštekani)**			
ABSTRACT	Unplugged is a school-based prevention programme based on the comprehensive social influence approach, targeted to adolescents aged 12-14 years and aimed to reduce the initiation, the use and abuse of alcohol, tobacco and illicit drugs. The programme consists of 12 lessons and lasts for three months. The content of the programme includes information about alcohol, tobacco, marijuana and other drugs, and combines life skills and normative beliefs. The programme is implemented by previously trained teachers, who are provided with all the necessary tools (handbook, workbook for students and teaching cards). Parents are also included in the programme. The participation of parents was really low (around 20 %), which led us to integrate this programme into prevention programme for parents called Effekt. EFFEKT (formerly the Örebro Prevention Program) seeks to reduce teenage alcohol use by changing the attitudes of their parents. Parents are encouraged to communicate zero-tolerance policies about alcohol use to their children. Information is disseminated to parents at school meetings at the beginning of each semester and through regular letters sent home throughout the middle-school year. Utrip institute started with the pilot implementation of this programme in school year 2014/15. (www.blueprintsprograms.com/factSheet.php?pid=e973a64ce098778bb7327fe57d8a607be981cbd3) The programme has been evaluated in a large European collaborative randomised controlled trial (EU-Dap), conducted in seven European countries between 2004 and 2007. It has also been evaluated in Slovenia as a part of pilot implementation of the programme in school year 2010/2011. 48 Slovenian primary schools (26 in the intervention group and 22 in the control group) participated in the pilot phase. The effectiveness evaluation showed that the programme is effective at 3 months follow-up in preventing cigarette use, drunkenness episodes and use of cannabis among students aged 12-14 year. The effect on drunkenness and cannabis is maintained at a 1 year follow-up. UTRIP is the national centre of the Unplugged programme for Slovenia. At the moment, more than 30 schools across Slovenia still implement the curricula regularly or occasionally.			
FUNDING	National/regional/local government		Swiss Government (Swiss Contribution)	
LEVEL	National			
AIMS & OBJECTIVES	The Unplugged programme aims to reduce the prevalence of alcohol abusers, tobacco smokers and substance users among youth, curbing or delaying initiation and stopping transition from experimental use to addiction.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Intermediate target group	Government	Researchers	Civil society (NGOs)

LOGIC MODEL	**Scientific:** Unplugged is based on Social learning theory, Life skills theory, Health belief model, theory of Reasoned Action-Attitude and Social norms theory. **Past experience:** The programme has been evaluated between 2004 and 2007 in the EU-Dap study, a large European collaborative randomised controlled trial, conducted between September 2004 and May 2007 in seven European countries: Austria, Belgium, Germany, Greece, Italy, Spain and Sweden, and involving 143 schools, 345 classes and 7,079 students.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Communication plan
	Evaluation plan			
	IMPLEMENTATION			
TIMEFRAME	Periodic			
TARGET GROUP(S)	Adolescents		Parents	
COMMUNICATION CHANNELS	Brochures/leaflets/ items	Social media	Social media	Website
	Meetings/conferences with experts/ colleagues	Guidelines	Direct communications	Scientific publications
CORE ACTIVITIES	The programme is implemented by previously trained teachers, who are provided with all the necessary tools (handbook, workbook for students and teaching cards). Trainings are organised by the UTRIP Institute at least twice a year. In June 2012, the UTRIP Institute issued a document entitled "Guidelines and Recommendations for School-based Prevention", which presents in detail some of the key assumptions of effective school-based prevention and basic principles that schools can use in practice or to develop and implement high-quality prevention programmes. Guidelines and recommendations are available in English and Slovenian on the EMCDDA website as an example of good practice in the field of standards and guidelines: www.emcdda.europa.eu/themes/best-practice/standards/prevention.			
SUPPORTIVE ACTIVITIES	Training		Promotional leaflet	
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	

RESULTS	Evaluation results show that the programme was very successful in the intervention group of schools in comparison with the control group. The comparison was made based on the initial situation and the evaluation carried out four months after the implementation of the programme in the intervention group. Results show that smoking, occasional drinking, frequent drinking and intoxication as well as marijuana use and the use of other illicit drugs decreased significantly among students who participated in the implementation (intervention group), while it had not changed much among students in the control group. If we compare these data to the initial situation, also as regards the predictions of children about their future use of alcohol, tobacco and other drugs, we find that the Unplugged programme has significantly reduced the actual use in the intervention group.
REPORT	NIJZ: "Nacionalno poročilo 2014 o stanju na področju prepovedanih drog v RS"
FOLLOW-UP	There is a follow-up evaluation planned in the next two years.
	ADDITIONAL INFORMATION
WEBSITE	www.izstekani.net www.eudap.net
CONTACT DETAILS	Contact person: **Mrs Sanela Talić** Organization: **Institute for Research and Development "Utrip"** Address: Vošnjakova ulica 1, 1000 Ljubljana Country: Slovenia Telephone number: +386 31 6574 12 E-mail: address: sanela@institut-utrip.si

TABLE 36: STOP TO THINK: PREVENTION PROGRAMME OF USE/ ABUSE OF ALCOHOL IN SCHOOL AGED ADOLESCENTS

	BASIC FACTS			
NAME	**Stop to Think: Prevention Programme of Use/Abuse of Alcohol in School Aged Adolescents**			
ABSTRACT	The "Stop to think" prevention programme was developed in the classroom with interactive methodologies with an objective to prevent alcohol use/abuse among school-aged adolescents. Quasi-experimental study was used as a method, with pre- and post-test. 178 participants were involved, 70 of them were in experimental group and 108 were in the control group. The Alcohol Knowledge Questionnaire, Alcohol Expectancy Questionnaire and Social Skills Rating System were used. The experimental group showed a positive evolution of knowledge and expectations about alcohol, perception of peer alcohol use and reported consumption. The programme proved to be effective in stabilizing alcohol consumption, increasing knowledge, stabilizing the positive expectations, and in the perception of peer alcohol use.			
FUNDING	Education/public health/research institution			
LEVEL	Local – School covered for a Health Center of Coimbra City			
AIMS & OBJECTIVES	To increase knowledge about alcohol and its consequences, to increase the perception of risk in relation to the inopportune consumption of alcohol, to delay the start of alcohol consumption and to decrease the tendency for consumption. Main objectives are also to correct perception of alcohol consumption, to construct secure and positive expectations on alcohol decrease, to develop social skills that increase the responsible decision-making in risky situations and to delay the onset of alcohol experimentation.			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Researchers	
LOGIC MODEL	**Scientific:** The "Stop to Think" intervention programme was built based on the results of a systematic literature review, assessed based on the results of the study of contextualized evaluation of the alcohol consumption phenomenon among students of the 3rd cycle, and integrating also the suggestions of the experts consulted. **Past experience:** the model can be analysed by consulting the published scientific articles.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Communication plan
	Evaluation plan			

	IMPLEMENTATION		
TIMEFRAME	Non-recurring		
TARGET GROUP(S)	Adolescents		
COMMUNICATION CHANNELS	Meetings/conferences with experts/colleagues	Guidelines	Scientific publications
CORE ACTIVITIES	The programme consists of 11 sessions (12 classes/90 minutes) that were developed by the Mental Health Nurse and 5 complementary activities (14 classes/90 minutes), performed by the teacher, during a school year with extra sessions over the next two years.		
SUPPORTIVE ACTIVITIES	Consultancy	Team meetings	
	EVALUATION		
RESPONSIBILITY	Internal		
TYPE	Process	Impact	Outcome
RESULTS	The programme proved to be effective in stabilizing alcohol consumption, increasing knowledge, stabilizing the positive expectations and in the perception of peer alcohol use. Further research should be developed and follow-up should continue to consolidate these findings.		
REPORT	www.scielo.br/pdf/ean/v17n3/en_1414-8145-ean-17-03-0466.pdf		
FOLLOW-UP	No		
	ADDITIONAL INFORMATION		
WEBSITE			
CONTACT DETAILS	Contact person: **Teresa Barroso, PhD** Organization: **School Nursing Coimbra** Address: Av. Bissaya Barreto, Coimbra Country: Portugal Telephone number: +351 96 7214 649 E-mail address: tbarroso@esenfc.pt		

6.4.3. Strong indication of effectiveness

TABLE 37: SLICK TRACY HOME TEAM PROGRAMME AND AMAZING ALTERNATIVES PROGRAMME (PDD – PROGRAM DOMOWYCH DETEKTYWÓW + FM – FANTASTYCZNE MOŻLIWOŚCI)

	BASIC FACTS			
NAME	**The Polish version of the US Slick Tracy Home Team Programme and Amazing Alternatives Programme (both belong to the Northland Project) (PDD – Program Domowych Detektywów + FM – Fantastyczne Możliwości)**			
ABSTRACT	PDD and FM are universal alcohol prevention programmes to be implemented in the consecutive school years. PDD targets students aged 10-12 years (in Poland they attend 4th or 5th grade of primary school) and FM targets students aged 11-13 years (5th or 6th grade). Both curricula consist of teacher- and peer-led sessions (in PDD – 5 sessions, based on comic booklets; and in FM – 6, based on audio-taped stories of 4 adolescents) combined with parent-child activities to be undertaken at home. Elected peer leaders, trained by their teachers, introduce the topic of each session to their classmates, facilitate small-group discussions, problem solving activities, games and role playing. The activities in the students' booklets are designed to facilitate parent-child communication about alcohol and other substance use and to establish effective family rules to deal with under-age drinking. At the end of the programme, a family evening is organized where pupils present posters to their parents and participate in other fun activities. The entire programme PDD + FM requires two consecutive school years and about 12-15 weeks to complete in each school year.			
FUNDING	National/regional/local government (most often is funded by local governments)			
LEVEL	National			
AIMS & OBJECTIVES	The programme aims to reduce under-age alcohol consumption. Specific objectives are to reduce intention to drink; to strengthen selected protective factors related to alcohol use: social pressure resisting skills, perception of peer norms against drinking and to decrease pro-alcohol attitudes; to facilitate parent-child communication about alcohol and other risky behaviours and to improve student's knowledge (on alcohol advertising and modelling, peer pressure and the consequences of underage alcohol consumption).			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Government	Funders
	Researchers	Primary school teachers	Primary schools principals	

LOGIC MODEL	**Scientific:** Modelling and strengthening desired child behavior by significant peer and parental involvement are the main prevention strategies utilized in the programme. These strategies are drawn from grounded psychosocial theories: theory of reasoned action (Ajzen & Fishbein, 1980), social learning theory (Bandura, 1986) and problem-behaviour theory (Jessor, 1987, 1998)			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Human resource management plan
	Time schedule	Partners' agreement	Evaluation plan	
	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	Pre-adolescents and their parents			
COMMUNICATION CHANNELS	Newspapers/ magazines	Brochures/leaflets/ items	Website	E-mail
	Meetings/confer-ences with experts/ colleagues	Direct communications	Guidelines	Scientific publications
CORE ACTIVITIES	Careful cultural adaptation of the original US programmes, elaboration of Polish materials, pilot implementation, process evaluation, training sessions, supervisions and published material.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Training	Team meetings
	EVALUATION			
RESPONSIBILITY	Internal			
TYPE	Process		Outcome	
RESULTS	**Process evaluation.** PDD. The evaluation found that the programme had been fully implemented in all intervention schools. According to self-report data from both students and parents, over 90 % of the students participated in the booklet activities, most frequently with their mothers. Similar rates were identified from the teachers' classroom records. Girls, pupils in two-parent families and 'good' students were significantly more likely to complete more booklets. The rate of participation in the family evening was also high, with 74 % of students attending, 56 % with at least one parent. Teachers were given two alternative methods of selecting peer leaders in the classroom: election from a whole group of students; or election from small, pre-selected groups. Although most of the selections were based on student popularity, group interviews with teachers established that the peer-leader election procedure differed from class to class. Being a peer leader was perceived by students as an honour. In the teachers' opinions, the trained peer leaders were very motivated and fully engaged in the programme activities. Although they experienced some difficulties with discipline during small group activities, they generally performed their tasks well or very well.↓			

RESULTS	↓ FM. Cross-cultural adaptation of the programme consisted of three stages: a) preparation of the preliminary version of educational materials; b) pilot evaluation of the preliminary version of the programme (4 classrooms); and c) pilot study of the programme implementation in eight different communities in Poland (21 classrooms). Qualitative methods were used including focus-group interviews with students, peer leaders and programme delivers, observations of classroom sessions and open-ended questions for students and parents. The results showed that programme required substantial changes to be used in Polish schools. Classroom sessions were reduced from eight to six, and alcohol-related contents were also reduced. The scenarios of the classroom sessions were revised and new content was added to address issues important for teenagers (e.g. relationships with peers, shyness management). The process evaluation of FM held in Morag (a small town and surrounding villages) as a part of routine implementation found that programme was fully implemented in all eight participating classes (n=139) with high quality of programme delivery. It was evidenced by high rates of family evening participation (over 75 % of students and parents), high rates of parental participation (94 % of parents completed at least half of booklets activities), and high rates of students satisfaction (90 % of students were satisfied). **Outcome evaluation** Results of 27 month follow-up outcome evaluation of PDD + FM: beneficial effects of the two-year programme have been identified for the whole group of the intermediating variables (MANOVA, F= 3.64; p<0.001). In particular, significant favourable changes were identified in participants' pro-alcohol attitudes (F=4.12, p<0.043), knowledge about consequences of drinking (F=18.82, p<0.001) and assertiveness beliefs (F=9.89, p<0.002). Other analyses indicated that participation in the two-year programme was associated with less drunkenness and alcohol drinking with peers.
REPORT	EMCDDA: "Examples of evaluated practices: EDDRA" Article in Psychiatria Polska Bobrowski K. J., Pisarska A., Ostaszewski K., Borucka A. (2014). Skuteczność programu profilaktyki alkoholowej dla dzieci na progu dojrzewania (Effectiveness of alcohol prevention programme for pre-adolescents), Psychiatria Polska, 48 (3): 527-539.
FOLLOW-UP	Yes 27 months after the baseline

ADDITIONAL INFORMATION

WEBSITE AND PUBLICATIONS	prom.ipin.edu.pl Bobrowski K. (2004) Ocena odroczonych efektów Programu Domowych Detektywów mierzonych po czterech miesiacach od zakonczenia programu (The Slick Tracy Home Detectives Program outcome evaluation – a four-month follow-up), Alkoholizm i Narkomania 18(1-2), 61-76. Okulicz-Kozaryn K. Bobrowski K., Borucka A., Ostaszewski K., Pisarska A. (2000): Poprawność realizacji Programu Domowych Detektywów a jego skuteczność (Adequacy of the "Program Domowych Detektywów" implementation and its effectiveness). Alkoholizm i Narkomania t. 13(2); 235-254. Ostaszewski, K., Bobrowski, K., Borucka, A., Okulicz-Kozaryn, K., Pisarska, A., Perry, C., Williams, C. (1998) 'Program Domowych Detektywów. Adaptacja amerykanskiego programu profilaktyki alkoholowej dla mlodziezy we wczesnym okresie dojrzewania' ('A Polish adaptation of the US alcohol primary prevention programme for young adolescents'), Alkoholizm i Narkomania, 3, 339–60. ↓

WEBSITE AND PUBLICATIONS	↓ Ostaszewski K., Bobrowski K., Borucka A., Okulicz-Kozaryn K., Pisarska A. (2000): Ocena skuteczności programu wczesnej profilaktyki alkoholowej "Program Domowych Detektywów" (Outcome evaluation of the alcohol primary prevention programme "Program Domowych Detektywow"). Alkoholizm i Narkomania 13, 1; 83-103. Ostaszewski K., Bobrowski K, Borucka A., Okulicz-Kozaryn K., Pisarska, A. (2000): Chapter 7. Evaluating innovative drug-prevention programmes: Lessons learned. [in:] Evaluation – a key tool for improving drug prevention. EMCDDA Scientific Monograph Series No 5, European Commission, EMCDDA, 75-85. Pisarska, A., Ostaszewski, K., Borucka, A., Bobrowski, K., Okulicz-Kozaryn, K. (2005) Adaptacja amerykańskiego programu profilaktyki alkoholowej Fantastyczne Możliwości – znaczenie ewaluacji procesu i badań jakościowych (Cross-cultural adaptation of the Amazing Alternatives – American alcohol prevention programme: the importance of the process evaluation and qualitative methods), Alkoholizm i Narkomania (Alcohol and Drug Abuse), 18, 3, 43-62. Bobrowski, K., Kocoń, K., Pisarska, A. (2005) Efekty dwuletniego programu profilaktyki alkoholowej. (The results of the two-year alcohol prevention programme) Alkoholizm i Narkomania (Alcohol and Drug Abuse), 18, 3, 25-41 Bobrowski, K. (2006). Zajęcie dla hobbystów – badanie odroczonych efektów programów profilaktycznych. (Hobby activities – analysing the postponed effects of preventive programmes) W: Diagnostyka, profilaktyka i socjoterapia w teorii i praktyce pedagogicznej. Deptuła, M. (red.) Wydawnictwo Uniwersytetu im. K. Wielkiego. Bydgoszcz, 221-236.
CONTACT DETAILS	Contact person: **Krzysztof Ostaszewski, PhD** Organization: **Institute of Psychiatry and Neurology** Address: Sobieskiego 9, 02-957 Warsaw Country: Poland Telephone number: +48 22 4582 630 E-mail address: ostasz@ipin.edu.pl

TABLE 38: PAS – PREVENTING HEAVY ALCOHOL USE IN ADOLESCENTS

	BASIC FACTS			
NAME	**PAS – Preventing Heavy Alcohol Use in Adolescents**			
ABSTRACT	PAS aims to delay the onset of alcohol use and to reduce heavy drinking by young people. The intervention consists of two parts: 1) an intervention for parents and 2) an intervention for junior high school students. The parents increase their restrictive and prohibitory attitudes toward underage drinking and are motivated to apply rules for their teen children, whereas the students develop more self-control and a healthy attitude towards alcohol. The intervention is targeted at students between 12 and 16 years. In total, PAS has a 3-year running time. The parent intervention was modelled after the Swedish Örebro Prevention Programme. In the Netherlands, the national coordinating body of PAS is located at the Trimbos Institute (Netherlands Institute of Mental Health and Addiction) within the broader Healthy School and Drugs programme. Prevention professionals of local municipal health and addiction agencies implement PAS at the schools. They provide the presentation at the parents' evening, train the teachers (1-day training for working with the e-learning programme), and take care of, in close cooperation with the school staff, the overall implementation of alcohol prevention activities at a school.			
FUNDING	National/regional/local government			
LEVEL	National		Local	
AIMS & OBJECTIVES	The main aim is to the delay onset of alcohol use and to reduce heavy drinking by young people. Sub goals are to motivate parents to apply restrictive rules regarding alcohol for their teen children and to develop more self-control and a healthy attitude towards alcohol (for students).			
	DEVELOPMENT			
STAKEHOLDER INVOLVEMENT	Target group(s)	Intermediate target group	Researchers	Material developers, creatives
LOGIC MODEL	**Scientific:** Scientific knowledge on alcohol specific socialization, parental norms and parental alcohol use (parent intervention); • The results of the Örebro Prevention Programme (parent intervention); • Theory of planned behaviour and social cognitive theory (student intervention). **Past experience:** Schools need prevention programmes that are focused on their needs and are not too difficult to implement. Very comprehensive programmes can be effective, however, they may be too intensive and costly for a school. PAS is a short and feasible intervention that can be implemented in an easy way without wasting too much resources.			
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan
	Human resource management plan	Time schedule	Partners' agreement	Communication plan
	Evaluation plan			

	IMPLEMENTATION			
TIMEFRAME	Continuous			
TARGET GROUP(S)	Adolescents	Parents		
COMMUNICATION CHANNELS	Brochures/leaflets/items	Website	E-mail	
	Meetings/conferences with experts/ colleagues	Guidelines	Scientific publications	
CORE ACTIVITIES	Parents and students are involved. Students' activities are four individual e-lessons for first-year classes and booster lesson after 1 year. Core activities are also training-the-trainer for prevention professionals of 1 day, provided by Trimbos Institute (this training is aimed at the execution of the whole Healthy School and Drug Programme) and training of teachers by the prevention professionals of 1.5 hour.			
SUPPORTIVE ACTIVITIES	Consultancy	Supervision	Team meetings	Team meetings	Helpdesk
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	
RESULTS	The combined PAS intervention (and not the separate parent and student interventions) showed substantial and significant effects on heavy weekly drinking, weekly drinking and frequency of drinking. Effects were maintained at follow-ups at 22 months (on weekly drinking and frequency of drinking), at 34 months (on heavy weekly and weekly drinking) and at 50 months when the legal drinking age of 16 was reached (on heavy weekly drinking and amount of alcohol use). Now the legal age in the Netherlands is 18. The PAS intervention was effective according to the theoretical assumptions that underlie the intervention (rules and attitudes by parents mediated the effect, as well as self-reported perceived rules and self-efficacy as was reported by the adolescents). The combined PAS intervention is more effective among adolescents with low self-control and lenient parents. The combined intervention was particularly effective in delaying the onset of heavy weekly drinking in a higher-risk subsample of adolescents (i.e. those attending lower levels of education and reporting higher levels of externalizing behaviour). The combined PAS intervention is also effective in curbing adolescents' drinking behaviour in those who already were drinking at baseline.			
REPORT	All articles are published in international peer-reviewed journals			
FOLLOW-UP	Yes	At 22, 35 and 50 months		
	ADDITIONAL INFORMATION			
WEBSITE	www.dgsg.nl/scholen/dgsg-vo/leerling-en-ouders---alcohol-en-roken			
CONTACT DETAILS	Contact person: **Jeroen Lammers, MSc** Organization: **Trimbos Institute** Address: P.o box 725, 3500 AS Utrecht Country: Netherlands Telephone number: +31 30 2971 100 E-mail address: jlammers@trimbos.nl			

TABLE 39: LOVE & LIMITS (KJÆRLIGHET OG GRENSER)

	BASIC FACTS				
NAME	**Love & Limits (Kjærlighet og Grenser)**				
ABSTRACT	The Norwegian version of Strengthening Families Programme for Parents and Youth. The programme is dedicated to all families with children aged 10–14 years. Methods used are reflection, discussion and practical training, individually and in groups. Themes are based on resilience theory. Meetings last 2 hours per week for 8 weeks. Some of the meetings are conducted during school hours. All families with children in the same class participate together. Municipalities are invited to send their public health nurses, social workers or teachers to a free educational course of 2 days to prepare them for instructing the meetings in their local school. More than 60 municipalities in Norway are using the intervention (of 428). The intervention was first developed in the USA by Karol Kumpfer at the University of Utah and Virginia Molgaard at Iowa State University. SFP is the title of the group of programmes based on the K. Kumpfer's concept (it includes several programmes for various age groups). SFP 10-14 is one of these programmes and it is known under this specific abbreviation.				
FUNDING	National/regional/local government				
LEVEL	Local				
AIMS & OBJECTIVES	To prevent problematic use of alcohol, narcotics and tobacco among young people.				
	DEVELOPMENT				
STAKEHOLDER INVOLVEMENT	Intermediate target group	Government	Researchers		
LOGIC MODEL	**Scientific:** Resilience theory. Risk and protective factors. Theory on communication and psychological development. **Past experience:** Practical experience has shown that this intervention is eligible, and easy to implement. The target group and the instructors both enjoy this intervention and believe in its efficacy.				
ELEMENTS OF PLANNING	Literature review and/or formative research	Needs assessment	Detailed plan of action	Financial plan	
	Human resource management plan	Time schedule	Partners' agreement	Communication plan	
	IMPLEMENTATION				
TIMEFRAME	Continuous				
TARGET GROUP(S)	General population	Children	Adolescents	Parents	Families
COMMUNICATION CHANNELS	Brochures/leaflets/items	Social media	Website	E-mail	Scientific publications

CORE ACTIVITIES	SPECIFY			
SUPPORTIVE ACTIVITIES	Consultancy	Training	Team meetings	Helpdesk
	EVALUATION			
RESPONSIBILITY	External and internal			
TYPE	Process	Impact	Outcome	
RESULTS	The intervention prevents problematic use of alcohol in young people.			
REPORT	Cochrane-review: Foxcroft D.R., Tsertsvadze A., (2011) Universal family-based prevention programmes for alcohol misuse in young people (Review). The Cochrane collaboration. Wiley.			
FOLLOW-UP	The Cochrane – review from 2011 is a follow-up from 2003.			
	ADDITIONAL INFORMATION			
WEBSITE	http://borgestadklinikken.no/kompetansesenter/rusforebygging-i-skolen/familieprogrammet-kjerlighet-og-grenser			
CONTACT DETAILS	Contact person: **Wiig, Eli Marie**, PhD-candidate Organization: **KoRus Sør, Borgestadklinikken** Address: PO box 1, Sentrum, 3701 Skien Country: Norway Telephone number: +47 99 1656 68 E-mail address: eli.marie.wiig@borgestadklinikken.no			

7.

The Ethics of Alcohol Prevention

This tool kit is about facilitating the transfer of interventions by providing information on their effectiveness and their evidence base. Why a chapter on ethics then? Ethics is moral philosophy. It is concerned with questions of right and wrong. Rather than providing definitive answers, ethics assesses and evaluates different courses of action (78). The idea of the chapter on ethics in the ANNEX 5 is to familiarise practitioners and policymakers in the field of alcohol prevention with ethical dimensions of their work and to make these aspects explicit.

Alcohol prevention involves a wide range of organisations – governmental and non-governmental. All practitioners and policymakers in alcohol prevention make decisions that have ethical implications, knowingly or not (78). Yet, the role of government in public health is unique. Unlike stakeholders in civil society, the responsibility of government to care for the public's health and welfare is grounded in its policy powers (79). Certain interventions, like regulation, taxation and the optimal allocation of public funds to prevention activities, are the prerogative of the executive branch of government (79). Due to these far-reaching responsibilities and powers, the mandate of public health is an inherently moral one (80), particularly when involving governmental action.

Undoubtedly, it is ethically mandated to consider the best available evidence regarding the effectiveness and cost-effectiveness of an intervention, as scientific evidence constitutes a firm ground for decision-making and the drafting of alcohol policies. Effectiveness and cost-effectiveness, however, are not ethical categories. A solid evidence base is, in and by itself, insufficient as a justification for governmental action. An intervention may be both, effective and cost-effective, but unjustified from an ethical point of view.

Alcohol prevention has a long tradition of making recourse to scientific evidence as a justification for action. Historically, prohibition was tightly interwoven with eugenics, a discipline that was considered at the forefront of academic research at the time. Scientific evidence was, however, equally central to the arguments of the opponents of prohibition.

The Drys' argument rested on what they perceived as evidence of inherited acquired characteristics in modified form, brought on by alcohol. A poster about the effect of alcohol on "racial cells" by "noted Dutch scientist and psychiatrist, Doctor K. Herman Bouman, University of Amsterdam, Holland", which was sold in the United States for classroom use by the National Education Association concluded: "These creative cells in alcoholic parents — if not completely destroyed — are degenerated and the child suffers the fatal consequences even before birth. The children of drinking parents show a strong tendency toward weakened mentality — there are more idiots and

inferior individuals among them. It is even probable that the germ plasm itself — that vital spark which continues on thru countless centuries — is so affected by alcohol that the children for generations to come suffer from the sins of the fathers. It is the race that counts and alcohol is an enemy of its advance." (81)[1].

The Wets' refutation of these claims rested on three different lines of argument. Some did not accept the evidence for a damaging hereditary effect of alcohol as conclusive proof. Others invoked evolution theory, arguing that alcohol tended to "eliminate the unfit". A third group based their criticism of prohibition on a combination of "alcoholic selection" and "hereditary alcoholic damage" (81): "*We can't look at this from an ethical or humanitarian standpoint; we've got to consider it on a scientific basis*. If you go to breed horses or dogs or cattle or pigs or any of those things, you must, and do, go at it scientifically. If you don't do that soon ... we shall eventually go even below the level of mediocrity; and that is not what you want to do to the human race." ("Latest Scientific Investigation in America of the Action of Alcohol on the Brain, the Nervous System and Heredity: By Prof. Charles R. Stockard, Cornell University.", in: 81).

The topic of ethics may not always have received such deliberate and explicit disregard. Yet, ethical considerations remained conspicuously absent when translating research findings into policy action. Such neglect of the ethical implications in alcohol prevention later led to measures such as the mass sterilisation of alcoholics and other "degenerates" – both voluntary and involuntary – first in the United States, later in Nazi Germany and a number of other European nations such, some of which continued with this practice until the 1970s (83).

These historical examples illustrate what can happen if alcohol prevention policy is based *solely* on the best available evidence. Today, such coercive measures are unlikely to receive majority support and appear irreconcilable with the Charter of Fundamental Rights of the European Union and similar legal frameworks for the protection of Human Rights[2]. Nevertheless, ethical dilemmas are pertinent to alcohol prevention today. Even the

1 The concept of "blastophtoria" (germ lesion) brought on by alcohol as a "racial poison" gained great popularity in scientific circles at the time. Emil Kraepelin (1856-1926), a proponent of prohibition and arguably the founder of modern scientific psychiatry, worried that "the number of idiots, epileptics, psychopaths, criminals, prostitutes, and tramps who descend from alcoholic and syphilitic parents, and who transfer their inferiority to their offspring, is incalculable. Of course, the damage will be balanced in part by their lower viability; however, our highly developed social welfare has the sad side-effect that it operates against the natural self-cleansing of our people. We may barely hope that the degeneration-potential will be strong enough in the long term to eliminate the overflowing sources of germ lesion." ( ).

2 Note, however, the recent emergence of "voluntary" sterilisation of addicts with a monetary incentive ("Should drug addicts be paid to be sterilized?" The Guardian, 12.06.2010).

best evidence base is no replacement for ethics, as scientific knowledge is never absolute and only valid until proven wrong. Also, in societies that are increasingly secular and/or pluralistic, the need to establish common values becomes all the more acute (84).

The historical examples may serve to highlight the importance of ethics in alcohol prevention as a *delimiter* of evidence-based justifications for interventions. Conversely, making reference to ethics may sometimes be required to *extend* preventive measures beyond what would be justified by relying solely on a positivist empirical paradigm, as in case of the "precautionary principle" which holds that under certain circumstances the dictum "better safe than sorry" supersedes falsifiable scientific evidence.

A comprehensive discussion of ethical questions in alcohol prevention would be beyond the scope of the ethics chapter (for more information see ANNEX 5). If, however, the chapter elucidates some of the underlying ethical dimensions or removes them from complete obscurity, it will have achieved its purpose.

8. Recommendations for Good Practice Approaches

To reduce alcohol related harm, a wide range of prevention interventions has been developed, but on the other hand, risky alcohol consumption remains a big health problem. Furthermore, prevention science is very complex and requires the involvement of a multidisciplinary team. Recommendations derived from effective interventions may help prevention practitioners to select, modify or develop more effective programmes. You can find examples of general principles and standards for prevention intervention development in ANNEX 6 (e.g. EMCDDA project stages and components). Below, you can find the main principles for the development and dissemination of preventive interventions.

8.1. USE TESTED AND EFFECTIVE FRAMEWORKS

There is a whole range of theories and models for health prevention interventions. Irrespective of that only few appear to have withstood the test of time and continue to be frequently utilized in present-day research (85). The challenge for health promotion planners, which framework to choose to achieve the set goals, remains. Planning models are much broader than theories, moreover they are inclusive of theories (86). They instruct the prevention practitioners about which theory/ies should be used, and when and how they should be applied. Another factor to consider in intervention development is innovation in terms of a new method, idea or product (87). The evidence base in many areas of public health intervention is relatively weak; therefore, a discovery of innovative approaches is crucial. The most commonly used theories, models and frameworks in public health intervention planning are:

1. Psychological theories 'per se'

In their review, Linke et al. (85) highlighted following psychological theories: at the individual level, the health belief model, the theory of reasoned action and the theory of planned behaviour; at the interpersonal level, the social cognitive theory and the transtheoretical model; and at the ecological level, the socio-ecological model. Experiences show that individual-focused theories are more suitable for one-time or short-term problems, whereas interventions for longer term problems are often more appropriately designed using interpersonal (and presumably ecological) frameworks.

2. Precede-Proceed Model (PPM)
The PPM is an ecological approach – in this framework, health behaviour is regarded as being influenced by both individual and environmental factors to health promotion (88). One guiding principle of the model is to direct initial attention to outcomes, rather than inputs. It guides planners through a process that starts with desired outcomes and then works backwards to achieving those objectives.

3. The Planned Approach to Community Health (PATCH)
One of the key strategies of the PATCH model is to build linkages within the community and between the community and the state health department, universities and other organizations (89). The goal of PATCH is to increase the active participation of communities, to analyse community data, set priorities, plan interventions, implement and evaluate comprehensive, community-based health promotion programmes targeted toward priority health problems.

4. Multilevel Approach to Community Health (MATCH)
MATCH is a practical and comprehensive model, which places the health educator at the centre of planning and can be implemented without an extensive local needs assessment (89). It gives more attention to implementation.

5. Intervention Mapping (IM)
IM provides guidelines and tools for the selection of theoretical foundations that may improve our understanding of health behaviours and health behaviour change, and is characterized by three perspectives: an ecological approach, participation of all stakeholders and the use of theories and evidence. IM is not a theoretical framework by itself, and it has not yet been compared with other health promotion planning frameworks (90).

6. Social Marketing (for more information see CHAPTER 5)

8.2. RESEARCH AND PLAN INTERVENTIONS CAREFULLY

When we look precisely at all different planning models and research results of previous prevention interventions, we can draw a lot of parallels. They all, more or less, have the same main messages. What should not be missing in the process of development and implementation of good practice approaches?

1. Needs Assessment

Prior to developing a new alcohol prevention intervention, it is essential to obtain the social, epidemiological, behavioural and environmental diagnosis (88). In other words – a situation analysis has to be done: identify the health problem, its behavioural risk factors and their associated individual and environmental determinants for the at-risk target population (91).

Further, you should get to know your target audience very well: research of consumers' experiences, values and needs (92). Public health advocates tend to think narrowly in terms of promised health benefits, but those benefits may not be primary motivators for the target audience (62). Therefore, in the process of consumer analysis, programme planers should search for a broader range of benefits that might be appealing to the target audience.

In case of implementing an already developed intervention, a situation analysis is also needed. It is important to adjust the prevention intervention to the existing environment. Consequently, the intervention will not be carried out exactly as the original, but the main mechanism will remain the same.

2. Goal/Objective definition

A well done analysis already incorporates general goals/objectives. A good strategy to set clear goals/objectives is to use the SMART method. The characteristics of smart goals/objectives are (93): 1) **S**pecific (target a specific area for improvement); 2) **M**easureable (quantify or at least suggest an indicator of progress); 3) **A**ssignable (specify who will do it); 4) **R**ealistic (state what results can realistically be achieved, given available resources); and 5) **T**ime-related (specify when the result(s) can be achieved).

3. Programme and implementation plan

We now have the situation analysis, a defined target population and goals/objectives, which is a good foundation for the preparation of a programme plan. The next step is to use theory-based methods and practical strategies for changing behaviours and translating them into a unique programme plan to achieve each objective (86; 91). Theory driven programmes have a theoretical justification, are based on accurate information, and are supported by empirical research (94).

In their study, Nation and his colleagues (94) defined 9 principles of effective interventions: "There were five principles associated with programme characteristics: Programmes a) were comprehensive; b) included varied teaching methods; c) provided sufficient dosage; d) were theory driven; and e) provided opportunities for positive relationships. Two principles were specifically related to matching programmes to the target group:

Programmes a) were appropriately timed; and b) were socio-culturally relevant. Finally, there were two principles related to programme implementation and evaluation: Programmes a) included outcome evaluation; and b) involved well-trained staff".

A practical solution might be the adaptation of a selected intervention, which proved to be effective in another country (or culture or population). Nevertheless, we have to be aware that an evidence-based effective programme is not a guarantee for a successful implementation. If the programme providers are inappropriately selected and do not have the necessary skills, the results can be disappointing. As mentioned in the previous paragraph, the staff has to be well-trained. Formalized training gives the programme-providers the opportunity to practice, and have their questions answered. Furthermore, the sensitiveness, competences, received support, and supervision enhance the implementation of programmes (94).

8.3. PLAN THE EVALUATION PARALLEL TO PROGRAMME DEVELOPMENT

A common way of thinking is that evaluation is something that follows after the end of a process. Consequently, prevention planners, too, often fail to think about evaluation until after their programmes are up and running (95). Instead, programme development and evaluation planning is actually an interactive process. The evaluation team should choose the appropriate type of evaluation, define evaluation indicators in line with goals and objectives, clarify what data will be collected, and how it will be done (1). Therefore, team members must have the necessary expertise.

There are several types of evaluation, each type has a different purpose and thus is appropriate at different stages in the development of the programme. Prior to programme initiation, the **formative evaluation** should be conducted (96). The goal is to determine whether an element of a programme is feasible, appropriate and meaningful for the target population. Other types of evaluation are the process, impact and outcome evaluation. **Process evaluation** is designed to monitor programmes ensuring fidelity to programme blueprints and to provide corrective feedback where changes are needed – it assesses the way a programme is delivered, rather than the effectiveness (internal evaluation is considered more suitable). **Outcome evaluation** is defined (1) as the systematic collection and analysis of outcome data by assessing the progress in the outcome objectives that the programme is to achieve (external evaluation is considered more suitable).

"Randomised controlled trial" is a study type of outcome evaluation involving random allocation of individuals or natural groups to control and intervention groups. A control group/comparison group is a group of people who serve as a reference point to interpret changes in the intervention group during the outcome evaluation (1). The individuals in the control group are essentially similar to the intervention participants but do not receive the intervention, or they may receive an alternative intervention, or take part in a prevention-unrelated activity. In both groups; the data is collected using the same procedures. If changes occur only in the intervention group, it is more likely that they have been caused by the intervention. If changes occur in both groups, they may be unrelated to the intervention and caused by a different, unknown factor. **Impact evaluation** is designed to assess programme effectiveness in achieving its ultimate goals – whether behavioural and environmental objectives have been met (provides evidence for use in policy and funding decisions).

Human resources are one of the most common barriers that can prevent thorough evaluations, beside lack of financial resources, lack of technical support, and practical feasibility (1). An **external evaluation** (where the evaluation is carried out by an external organization – e.g. university, consultancy) vs**. internal evaluation** (the individual or team conducting the evaluation works within the organization) can be a solution in the case of lack of human resources, but it is more expensive. Moreover, external evaluation has a higher degree of **independence** (i.e. independent evaluation – findings are available from independent investigators, not from the programme developers).

8.4. DO COMPREHENSIBLE DISSEMINATION

As dissemination occurs in the end of the project cycle, it is possible that all resources have been used up. It is therefore important to include the costs for dissemination in the financial plan. Dissemination of findings creates new and sometimes generalizable knowledge that can be highly beneficial to public health professionals and to the community. Therefore, once the evaluated data are collected and analysed (1; 96): a) it has to be decided, whether the programme should be sustained; b) a formal report including background information on the evaluation should follow.
A programme should be continued if there is a strong evidence-based argument to support its continuation (1). In the end, it is the responsibility of commissioners and funders to recognise and sustain effective or promising

programmes. A dedicated strategy to secure funding can provide a better financial sustainability. Furthermore, intervention developers should cooperate with stakeholders and decision-makers from the outset. If the evidence suggests that a programme should not be continued, then the findings should be inspected closely to determine why outcomes were not achieved (1). The lessons learnt from the initial implementation may indicate how the programme could be improved, and provide support to trial a modified version of the intervention.

Once the intervention has been completed, information about the programme should be communicated to relevant stakeholders (e.g. participants, the scientific and/or prevention community). Careful planning ensures that the correct target audiences are supplied with relevant information in an adequate format. It is important to make the content of the dissemination comprehensible for the user.

8.5. AVOID THE MOST COMMON MISTAKES

COMMON MISTAKES IN THE DEVELOPMENT OF PUBLIC HEALTH INTERVENTIONS (62; 78; 93; 95—105)

1. DEVELOPMENT WITHOUT APPROPRIATE COMPETENCIES AND EXPERTISE

Developers of prevention interventions should have competencies and expertise on prevention principles, theories and practice, and should be trained and/or specialised professionals who have the support of public institutions (education, health and social services) or work for accredited or recognised institutions or NGOs.

2. INTERVENTIONS WITHOUT A FRAMEWORK

Interventions have a bigger impact in case they include effective elements (or techniques or principles), a framework of a change model or an intervention theory, or they are based on results of previously conducted research. The challenge for health promotion planners, which framework to choose to achieve the set goals, remains.

3. UNDEFINED TARGET GROUP AND THE SPECIALIZED GROUPS WITHIN

After an accurate definition of the target group, a consideration of individual, cultural, and socio-demographic differences and their moderating effects on treatment outcomes should follow.

4. UNDEFINED GOALS/OBJECTIVES

A good strategy to set clear goals/objectives is to use the SMART method. A goal/objective definition also has to be done, when programme planners choose to replicate programmes, because different situations lead to different goals/objectives.

5. INADEQUATE OR MISSING EVALUATION

Unclear description of goals/objectives simultaneously leads to unclear or irrelevant evaluation. Evaluation should be planned parallel to prevention programme development, as programme development and evaluation is actually an interactive process. There are several types of evaluation, each type has a different purpose, and is thus appropriate at different stages in the development of the programme.

6. FORGETTING ETHICAL ISSUES

When the goal/s is/are to change behaviours, even health-promoting ones, it must attend to ethical issues involving the use of human subject. Well-meaning programmes can also have harmful effects.

7. SCARE TACTICS AND ZERO TOLERANCE APPROACHES

Campaigns focusing on negative consequences and zero tolerance approaches are/were typically used in school programmes. Psychological and educational research has found the connection between zero tolerance approaches and negative outcomes. Alternative non-punitive approaches emphasize social, behavioural and cognitive skill-building; character education; targeted behavioural support; preventive measures that can improve school climate.

8. INEFFECTIVE USAGE OF NEW COMMUNICATION TECHNIQUES

Using new communication technologies has never been so important for health promoters, therefore "the worst position an organisation can take in relation to social media is to have no position at all". Social media is agile, cheap and potentially far-reaching. But it is important to use it right. Using social media as a one-way communication tool is a strategy for failure. If what you're writing sounds like brochure copy, you need to have another look at it. It has to be clear why you are using social media, make sure you have the right resources and skills, post regularly, provide reason for people to visit and share your page, invest in paid advertising and plan a strategy to continue engagement with the audience after the initial campaign.

9. DISSEMINATION MISTAKES

Interventions should be possible to implement in the real world, they should be feasible and transferable. Therefore, the intervention has to be clearly described. Specifically, financial costs or time needed to be invested have to be clear. It makes no sense to spend resources on publications or evaluations that are not user-friendly (often because of highly technical language), and are therefore unlikely to result in actual innovation adoption.

Four broadly defined domains were examined in this chapter: 1) theories and models, 2) designing, planning and implementing an intervention; 3) delivery evaluation; and 4) dissemination. The most important is to be aware of the connection between all elements.

A good idea is just the beginning of a complex and socially responsible process. The complexity of prevention science requires the involvement of a multidisciplinary team, therefore carefully selected team members are necessary to meet the challenges of intervention development 96). To face the challenge of complexity it is important that practitioners are:

- aware of and informed about policy frames and programmes in this field;
- involved, engaged and integrated in a multidisciplinary team work;
- involved in their communities – real and virtual (linked to scientific societies and networks);
- updated (promotion of self-expertise by means of training and self-education);
- sensitive and with high moral standards;
- creative and innovative.

A well prepared intervention is not enough to achieve the set goals. To enhance the likelihood of effectiveness, the broader environment (policy, pricing, modifying the drinking context, regulating the physical availability of alcohol, drink-driving prevention, restrictions on marketing and early intervention services) should be involved from the beginning of the process.

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List of Acronyms Used

AUDIT – Alcohol Use Disorders Identification Test

CNAPA – Committee on National Alcohol Policy and Action

EIBI – Early and Brief Interventions

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

EU – European Union

ICER – Cost-Effectiveness Ratios

MS – Member States

OECD – Organisation for Economic Co-operation and Development

QALY – Quality Adjusted Life Year

RARHA – Reducing Alcohol Related Harm

RCTS – Randomised-Controlled Trials

SBI – Simple Brief Interventions

SICAD – General Directorate for Intervention on Addictive Behaviours and Dependencies

WHO – World Health Organization

WP – Work Package

Subject Index

Annexes

ANNEX 1: WP6 PARTNERS

TABLE 40: THE LIST (IN ALPHABETICAL ORDER) OF JOINT ACTION RARHA PARTNERS WHO CONTRIBUTED TO WP 6 IN 2014-2016

Partner Organization	Country	Participants
National Center of Public Health and Analyses (NCPHA)	BG	Plamen Dimitrov Mirela Strandzheva
Cyprus Anti-Drugs Council (CAC)	CY	Leda Christodoulou Lampros Samartzis
Federal Centre for Health Education (BZgA)	DE	Axel Budde Michaela Goecke Ursula Münstermann
Danish Health Authority (SST)	DK	Kit Broholm
National Institute of Public Health (SIF)	DK	Janne Schurmann Tolstrup
National Institute for Health Development (TAI)	EE	Helen Noormets Triinu Täht
REITOX Focal Point of the EMCDDA, University Mental Health Research Institute (UMHRI)	EL	Ioulia Bafi Anna Kokkevi
Ministry of Health, Social Services and Equality (MSSSI)	ES	Tomás Hernández Sonia Moncada
Program on Substance Abuse, Public Health Agency of Catalonia, Department of Health, Government of Catalonia (ASPCAT, GENCAT)	ES	Joan Colom Lidia Segura Jorge Palacio-Vieira
National Institute for Prevention and Health Education (INPES)	F	Pierre Arwidson Chloe Cogordan Jennifer Davies Jean Baptiste Richard Claude Riviere
National Institute for Health and Welfare (THL)	FI	Marjatta Montonen
Directorate of Health (EL)	IS	Rafn M. Jónsson
Natioanl Institute of Health (ISS)	IT	Lucia Galluzzo Claudia Gandin Silvia Ghirini Sonia Martire Emanuele Scafato
Drug, tobacco and alcohol control departament (NTAKD)	LT	Inga Bankauskienė Grazina Belian

Partner Organization	Country	Participants
Dutch Institute for Alcohol Policy (STAP)	NL	Avalon de Bruijn Wim van Dalen Kirsten Vegt
National Institute for Public Health and the Environment (RIVM)	NL	Djoeke van Dale
The Netherlands Institute of Health and Addiction	NL	Linda Bolier
The Norwegian Directorate of Health (HDIR)	NO	Jens Guslund Maj Berger Saether
The State Agncy for Prevention of Alcohol-Related Problems (PARPA)	PL	Krzysztof Brzózka Katarzyna Okulicz Kozaryn
General-Directorate for Intervention on Addictive Behaviours and Dependencies (SICAD), Ministry of Health	PT	Paula Frango Raúl Melo
National Institute of Public Health (INSP)	RO	Florentina Furtunescu
National Institute of Public Health (NIJZ)	SI	Aleš Lamut Janja Mišič Sandra Radoš Krnel Teja Rozman
European Alcohol Policy Alliance (EUROCARE)	(BE)	Nils Garnes Aleksandra Kaczmarek Mariann Skar
EuroHealthNet	(BE)	Ingrid Stegeman
The Organisation for Economic Co-operation and Development (OECD)	(F)	Michele Cecchini

ANNEX 2: QUESTIONNAIRE FOR COLLECTING GOOD PRACTICES

Joint Action on Reducing Alcohol Related Harm (JA RARHA) is an initiative under the EU Health Programme to take forward the work in line with the EU Strategy on Alcohol Related Harm by strengthening the common knowledge base (www.rarha.eu). The work is carried out through a cooperation of expert organisations working in the field of public health from 31 European countries. The activities under the JA RARHA will be carried out from January 2014 till December 2016. **RARHA's Work Package 6 produces a Tool Kit on the interventions that have demonstrated their effectiveness, transferability, relevance and costs-effectiveness,** to facilitate exchange between MS' (Member States) public health bodies. For that purpose, we have developed the questionnaire to collect the examples of good practices, which consists of six sections:

- Evidence base (quick scan)
- Basic facts
- Development (including preparation, planning and core processes)
- Implementation
- Evaluation
- Additional information

In the communication with MS representatives, as well as WP6 partners, we decided to collect **the examples of good practices appertain to one of the three groups of interventions:**

- **Early interventions (Early identification and brief intervention for hazardous and harmful drinking)**
- **Public awareness/education interventions (including new media, social networks and online tools for behaviour change)**
- **School-based interventions (information and education)**

Building on your expertise, we are kindly asking you to complete the questionnaire with the requested information. Feel free to send more than one example per country/organization. Should you require further information please contact:

Sandra Radoš Krnel,
National expert at National Institute of Public Health, Slovenia
sandra.rados-krnel@nijz.si

Please return the questionnaire by 15th of January 2015 to
sandra.rados-krnel@nijz.si

Interpretation of the terms

- **Intervention:** The term intervention refers to a defined set of structured activities carried out in (direct or indirect) contact with target population in order to produce a certain outcome. Interventions can be implemented in different settings, have various aims and objectives and vary in their methodology and duration.
- **Good practice**[1]**:** Good practice refers to an intervention that was found to be effective in accomplishing the set objectives and thus in reducing alcohol related harm. The intervention in question has been evaluated either through a systematic review of available evidence and/or expert opinion and/or at least one outcome evaluation.[2] Furthermore, it has been implemented in a real world setting so

1 This definition was collectively formed and agreed upon by WP6 partners in JA RARHA.

2 The EDDRA database defines outcome evaluation as measurement of how far the specific objectives have been achieved. Cf. EMCDDA European drug prevention quality standards (p. 207): "The basic level outcome evaluation aims to understand if the intervention produced change in participants in line with the defined goals and objectives without causing any harms." http://prevention-standards.eu/wp-content/uploads/2013/06/EMCDDA-EDPQS-Manual.pdf

that the practicality of the intervention and possibly the cost-effectiveness has also been examined.

- **Early intervention:** An early intervention aims to identify and intervene before the onset of medical and social problems and requires proactive case finding of individuals at risk. Early interventions involve various educational and health promotion programmes and techniques, including community development and capacity building to identify and assist people at risk.[3]
- **Early identification:** Early identification is an approach to detect a real or potential alcohol problem through clinical judgement or screening using standardized questionnaires.[3]
- **Brief interventions:** Brief interventions are short advisory or educational sessions, counselling and motivational interviewing provided in primary health care settings[2]. Brief alcohol interventions are typically delivered by primary care practitioners or health workers to hazardous and harmful drinkers identified by screening in the context of routine primary care and to help harmful drinkers to change their behaviours.[4] The brief interventions can be carried out also in other health and social care settings including emergency departments, trauma care, acute medical care, obstetric services, sexual health clinics, pharmacies and criminal justice services.
- **Public awareness/education interventions:** Public health communication campaigns are part of social marketing and can be defined as purposive attempts to inform or influence behaviours in large audiences within a specified time period, using an organised set of communication activities and featuring an array of mediated messages in multiple channels, generally to produce non-commercial benefits to individuals and society.[5,6]

School-based interventions: School-based alcohol education programmes have been the method of choice in attempts to prevent alcohol-related problems among youngsters. School-based alcohol use prevention programmes can increase knowledge, change attitudes toward alcohol and, in some cases, reduce the level of alcohol drinking. There are knowledge-based programmes providing students with mainly knowledge on alcohol, media influences and peer influences, as opposed to more comprehensive programmes that include alcohol-related information combined with training of refusal skills, self-management skills and social-skills. Some programmes are combined with family-based interventions.[7]

Evidence base (quick scan)

Before starting to fill in the questionnaire, please read carefully the **first 2 questions representing the basic criteria for inclusion of examples of good practices in the Tool Kit.**

- Are all of the following elements described in such detail that the methodology is comprehendible and transferable, allowing for some estimate of effectiveness?*
- Objectives
- Target group
- Approach
- Prerequisites for implementation
- Participants' satisfaction

3 Assembly of European Regions (AER), European Commission (2010). Early Identification and Brief Intervention in Primary Healthcare, Fact sheet. Available at: http://www.aer.eu/fileadmin/user_upload/MainIssues/Health/2010/Alcohol_Factsheets/Factsheet_14_-_Early_Identification_and_Brief_Intervention_in_Primary_Healthcare_-_.pdf (acceded Oct 2014)

4 Babor T, Higgins-Biddle J. Brie f intervention For Hazardous and Harmful Drinking A Manual for Use in Primary Care (2001). World Health Organization, Department of Mental Health and Substance Dependence.

5 Rice, R. E., & Atkin, C. K. (2013). Public communication campaigns (4th ed.). Thousand Oaks, Calif.: Sage.

6 Rogers, E. M., & Storey, J. D. (1987). In Berger C. R., Chaffee S. H. (Eds.), Handbook of communication science. Beverly Hills: Sage publication

7 Babor T.F, Caetano R. Evidence-based alcohol policy in the Americas: strengths, weaknesses, and future challenges. Rev Panam Salud Publica. 2005; 18(4/5):327–37.

**Evidence base: e.g. descriptive study, observational research, document analysis, interviews and participants' satisfaction survey.*

☐ Yes ☐ No

- Does the intervention build on a well-founded programme theory or is it based on generally accepted and evidence-based theories?*

**Evidence base: e.g. meta-analyses, literature reviews, studies on implicit knowledge.*

☐ Yes ☐ No

**ONLY IF YOU ANSWERED BOTH OF THESE QUESTION YES,
PROCEED WITH THE COMPLETION OF THIS QUESTIONNAIRE.**

We are particularly interested in interventions with a strong evidence base; therefore, if you did not answer YES to these two questions, your proposed intervention would not fit this requirement meaning that your best practice is NOT ELIGIBLE for the purpose of JA RARHA.

Basic Facts

- Name of the intervention in English and/or in original language:

  _____

- Short description of the intervention (abstract): WHO, WHAT, WHERE, WHEN, HOW (Please give a short description of the aim of the intervention, the target group and the design/method – sequence of activities, frequency, intensity, duration, recruitment method):

  _____

  _____

  _____

  _____

  _____

- To which type of interventions does your example of good practice belong to (choose only one)?
  - Early interventions (Early identification and brief intervention for hazardous and harmful drinking)
  - Public awareness/education interventions (including new media, social networks and online tools for behaviour change)
  - School-based interventions (information and education)

- Who funds/funded your example of good practice (it is possible to mark more than one answer)?
- National/regional/local government
- Educational, public health and/or research institution
- Non-governmental organization
- Private sector company/organization
- Alcohol/Catering industry
- Other resources (please specify)

_____

- What is/was the level of implementation of your example of good practice (it is possible to mark more than one answer)?
  - National
  - Regional
  - Local (municipality level)
  - Other (please specify)

_____

- What are the main aims and the main objectives of your example of good practice?

_____

_____

- Please give a description of the problem the good practice example wants to tackle (nature, size, spread and possible consequences of the problem):

_____

_____

- Is your example of good practice embedded in a broader national/regional/local policy or action plan?
  - Yes (please describe)

_____

_____

  - No

- The basic message and/or slogan is (if applicable):

_____

_____

Development (including preparation, planning and core processes)

- Which of these stakeholders were involved in the development of your example of good practice (it is possible to mark more than one group of stakeholders):
  - Target groups
  - Intermediate target groups (teachers, management of the school, medical and social workers, etc.)
  - Economic operators (alcohol and connected industry)
  - Government (national, regional, local)
  - Funders
  - Researchers
  - Representatives of civil society (NGOs)
  - Other (please add)

  _____

- Please describe the logic model (the rationale or logical framework) of your example of good practice (it is possible to mark more than one answer)?
  - Scientific evidence – models or theory (please describe)

    _____

    _____

  - Past experience – could be based on qualitative/quantitative research or based on practical experience from previous interventions (please describe)

    _____

    _____

  - Other (please describe)

    _____

    _____

- Elements of planning (please mark all activities that were done in the preparation phase):
  - Literature review and/or formative research
  - Needs assessment (e.g. assessing the target population through epidemiological and other data, needs identified in the provision of prevention and early intervention)
  - Detailed plan of action
  - Financial plan
  - Human resource management plan (considering specific knowledge and skills, training if needed)
  - Time schedule
  - Partners agreement
  - Communication plan
  - Evaluation plan
  - Other (please add)

  _____

Implementation

- Implementation of your example of good practice is/was:
  - Continuous (integrated in the system)
  - Periodic, please specify:

_____

- Single – How long did it last?
  - Less than one year
  - One year
  - From one to two years
  - More than two years

- Target groups (it is possible to mark more than one target group):
  - General population
  - Children (before adolescence)
  - Adolescents
  - Young adults
  - Adults
  - Elderly population
  - Parents
  - Pregnant women
  - Women
  - Men
  - Families
  - Drivers
  - Party goers
  - Vulnerable social groups[8]

    - Ethnic minorities
    - Migrants
    - Disabled people
    - Homeless
    - Persons struggling with substance abuse
    - Isolated elderly people
    - Isolated children
    - Other: _____

8 Groups that experience a higher risk of poverty and social exclusion than the general population. Ethnic minorities, migrants, disabled people, the homeless, those struggling with substance abuse, isolated elderly people and children all often face difficulties that can lead to further social exclusion, such as low levels of education and unemployment or underemployment. Source: Social protection and Social inclusion Glossary. DG Employment, Social Affairs and Inclusion (http://ec.europa.eu/employment_social/spsi/vulnerable_groups_en.htm).

- Other (please add):

- Which communication channels were used (it is possible to mark more than one dissemination channel)?
  - Television
  - Radio
  - Newspapers and magazines
  - Billboards
  - Brochures/leaflets/items
  - Telephone/mobile
  - Social media (Twitter, Facebook, Linked-in, Instagram, Snapchat, WhatsApp)
  - Website
  - E-mail
  - Meetings/conferences with experts/colleagues
  - Direct communication (one on one or in the group)
  - Guidelines
  - Scientific publications
  - Other (please add)

- Who implements/implemented the intervention (an individual or a team or an organization or a network of organisations; describe professional background of the team, etc.)?

- What core activities are/have been implemented (i.e. the activities that have been implemented in order to achieve the objectives of the intervention, such as for example training sessions, events, material published)?

- What supportive activities are/have been carried out?
  - Consultancy
  - Supervision
  - Training
  - Team meetings
  - Helpdesk
  - None
  - Other (please describe)

Evaluation

- Who did the evaluation?
  - An external party
  - An internal party (representatives of the intervention, own organisation)
  - Both – internal and external parties

- What has been measured/evaluated?
  - Process evaluation (respondents, method, participants' satisfaction) (please describe)

    _____

  - Evaluation of the impacts/effects/outcome (please describe the design)

    _____

  - Other (please add and describe)

    _____

- What are the main results/conclusions/recommendations of the evaluation (please describe)?

  _____

- Is the evaluation report available, preferably in English or at least an English summary? (if yes, please provide link/reference/document)

  _____

- Was there a follow-up (describe how) or is any follow-up evaluation planned in the future?

  _____

- What were, in your opinion, the pre-conditions for success? Were there any facilitating factors?

  _____

- Were any obstacles encountered (if yes, please describe how these obstacles have been overcome and how they affected the results)?

  _____

- Were there any harmful or negative effects revealed by the assessment of the intervention?

  _____

- What are the main lessons to be learned?

  _____

- How could, in your opinion, this intervention be improved?

Additional information

- Web page related to the intervention:

- References (with possible links) to the most important articles or reports on the intervention:

- Other relevant documents (implementation manuals, training manuals, posters, videos or other tools available for use or adaptation, etc.):*

** Please attach these documents to the e-mail when returning the questionnaire.*

Final comments or suggestions:

Contact details

- Contact details of person completing the form:
  - Name and surname, titles
  - Organization
  - Address
  - Country
  - Telephone number (+ country code)
  - E-mail address

- Contact details of person who may be contacted for further information (if different from person completing the form):
  - Name and surname, titles _____
  - Organization _____
  - Address _____
  - Country _____
  - Telephone number (+ country code) _____
  - E-mail address _____

ANNEX 3: DUTCH RECOGNITION SYSTEM FOR INTERVENTIONS

Identifying and promoting good practices of health promotion interventions

The RIVM (National Institute for Public Health and the Environment) Centre for Healthy Living (CGL) supports the delivery of efficient and effective local health promotion in the Netherlands. It promotes the use of the most appropriate lifestyle interventions (health promotion and primary and secondary prevention) by clearly presenting available interventions, planning instruments, communication materials and links to relevant Dutch knowledge and support organizations on the portal Loketgezondleven.nl. This portal also presents information on the quality, effectiveness and feasibility of health promotion interventions.

Database with lifestyle interventions

Organizations working in the field of health promotion interventions can request for the inclusion of their intervention in the database with health promotion (lifestyle) interventions. In 2014, the database contained 1,900 interventions. The Centre for Healthy Living promotes gathering interventions, for instance by holding workshops. The uptake of interventions is stimulated by the Dutch Research Foundation (ZonMw) and the Ministry of Health, Welfare and Sports. Every organization with a grant for research or implementation of a lifestyle intervention needs to enter their intervention in the database of Loketgezondleven.nl.

Procedure for selecting best practices

To identify and select best practices, the Centre for Healthy Living developed an assessment system for interventions, i.e. the Dutch Recognition System. The aim of the recognition system is to gain a better view into the quality and effectiveness of health promotion interventions and to increase the quality of professional practice in health promotion. Organizations are supported to submit an intervention using a standard submission form. Inclusion criteria for submitting are the availability of:

- a manual of the intervention,
- a process evaluation,
- the material for the next two years,
- a contact person for questions about the implementation of the intervention.

The registration desk of the Centre for Healthy Living checks the criteria for inclusion, the completeness and quality of the submitted forms, and it provides and gives initial feedback to improve the submission if necessary. They also check the relevance of the intervention. Then there are two types of assessment possible (see Figure 1, next page):

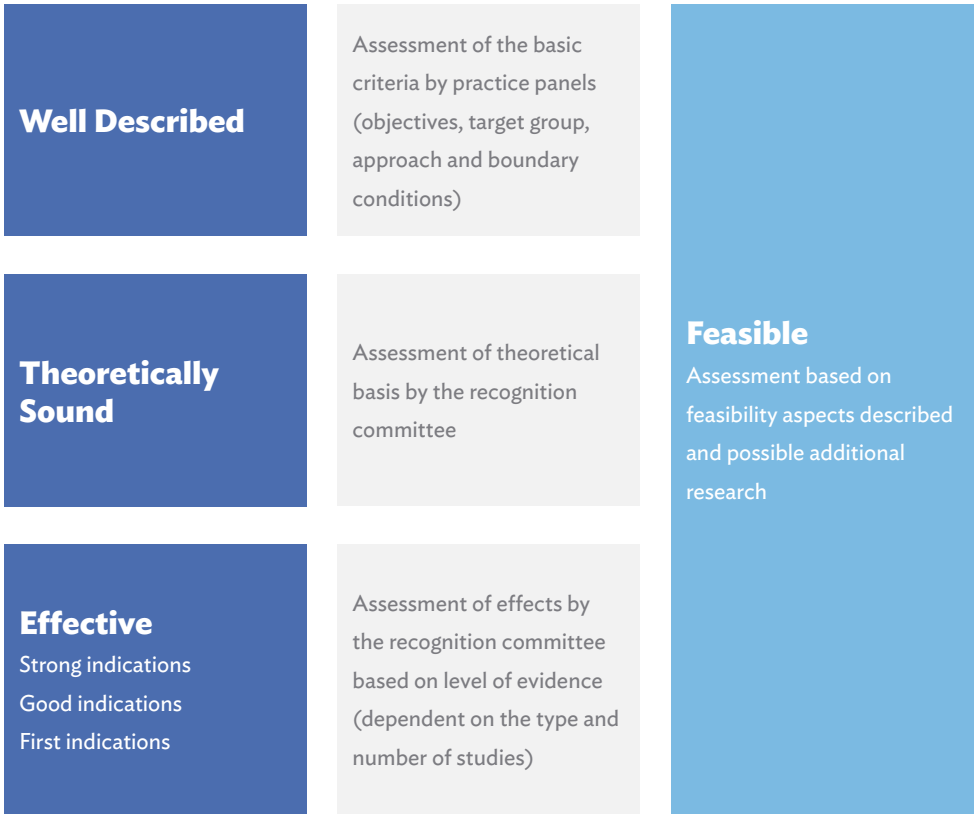
An assessment of the objective description, target group, approach and boundary conditions by professional practitioners or other experts from the sector concerned. This happens in the form of a peer review by practice panels. Based on this, interventions can receive the assessment **'Well Described'**.

An assessment of the theoretical basis and/or effectiveness of the intervention by an independent expert committee. Interventions that are assessed as good by the Recognition Committee receive a recognition **'Theoretically Sound'** or **'Effective'** There are several subcommittees for different types of interventions; for example youth health care and health promotion for adults and elderly.

For both types of assessment, an evaluation for feasibility is also possible; i.e. strong and weak features with respect to the feasibility of the interventions. Interventions that are assessed to be feasible are easy to adapt to another context.

Detailed description of the criteria of the different assessment levels is presented in the annex.

FIGURE 2: LEVELS OF ASSESSMENT ACCORDING TO THE DUTCH RECOGNITION SYSTEM



Below the elaborated criteria are presented for:

- Well Described
- Theoretically Sound
- Feasibility (this is not presented as separate level but is an important part for all levels)
- Effectiveness

TABLE 41: CRITERIA FOR "WELL DESCRIBED"

1. Description	Background	• Nature, size, spread and possible consequences of the problem or theme are clearly described.
	Target group	• The target group for the intervention is clearly described based on relevant characteristics; possible inclusion and exclusion criteria are stated. • If the target group is involved in the development of the intervention, then it is described how this happens.
	Objectives	• The objectives have been formulated as tangibly as possible and if relevant are distinguished in main objective and sub-objectives.
	Approach	• Design: the sequence, frequency, intensity, duration, timing of activities, recruitment method and location of the intervention are described. • Content: the method of the intervention is described as completely as possible in concrete activities. • A description is given of the parties involved in the implementation and how these parties collaborate. • The materials needed and their availability are clearly described.
2. Consistency	Accountability: impetus (first step) for substantiation	• The relationship between background, objectives, target groups and approach are clearly described.
3. Implementation	Costs	• The necessary costs of and/or hours needed for the intervention are stated.
	Expertise	• The specific skills and vocational training of the professionals who will implement the intervention are described.
	Support needed from people	• Which people are needed to support the intervention is stated and how this support can be created is described.
	Manual	• The manual contains a description of the objectives, target group and materials, as well as the content of the various activities.
	Support for realising the intervention	• If support is offered for the implementation and realization of the intervention, then this is described.
	Quality control	It is described how the quality of the realized intervention must be monitored.

TABLE 42: CRITERIA FOR "THEORETICALLY SOUND"

1. Description	• The same as Well Described
2. Criteria for the Theoretical underpinning/ intervention logic	• The problem, risk or theme is completely and clearly described with data about; for example, the nature, severity, size, spread, perception of those involved, costs and other possible consequences. • An analysis has been made of how the problem has arisen whereas the possible causal, risk, maintenance, mitigating or protective factors are described. • The factors that will be tackled with the intervention are stated and linked to the objectives and sub-objectives of the intervention (justifying objectives). • The effective elements (or techniques or principles) in the approach are stated and justified in the framework of a change model or an intervention theory or based on the results of research carried out previously. • Target groups, objectives and working method fit together: a justification is given of how the chosen approach will be able to effectively achieve the objectives for this target group. • Where relevant, sources are stated with respect to the theoretical underpinning.
3. Criteria for implementation conditions/feasibility	• The intervention is transferable: – there is a manual or protocol for transfer; – there is support for the introduction of the intervention (training the trainer, supervision, helpdesk, etc.); – there is a system for implementation or an implementation plan. • Data about maintenance, quality care and safeguarding are specified (licences, monitoring system, registrations, return days) will be realised. • The boundary conditions essential for the implementation are specified. These are the boundary conditions at the level of: – the intervention (use of personnel, use of time, costs (specified)); – the implementing professionals (training, experience, competencies); – the organisation (internal and external support, possibilities for internal and external collaboration). • It is likely that the objective can be realised within the boundary conditions and stated costs. • If the intervention has not been developed in the Netherlands, the original context is briefly described and the modifications made to adapt the intervention to the Dutch situation are explained. • If relevant to the problem or the area of implementation, the intervention offers space for flexibility: the manual contains information about the effective principles or elements that must be adhered to. • A pre-test or process evaluation has been carried out and – the study design is described, – data are available about, for example, the scope, success and failure factors and the assessment of implementers, – the results are positive and/or – the intervention has been modified (insofar as necessary) on the basis of these results. • If applicable: research reveals the relevant context factors that influence the effect and implementation of the intervention.

TABLE 43: CRITERIA FOR "EFFECTIVENESS"

General criteria for all the levels of effectiveness	• The outcomes are most relevant for the objective and the target group for the intervention. • The changes related to the objective and the target group of the intervention: – The studies reveal that the intended target group has been effectively achieved. – The instruments used provide a reliable and valid operationalization to measure the realisation of the objectives of the intervention. – Satisfactory statistical techniques have been used (if applicable). • The size of the effect is indicated in terms of Cohen's D or the data to calculate Cohen's D is specified. • The size of the effects is reasonably convincing and matches the objective and the target group of the intervention. • Possible negative effects have been stated. • The research has been documented so that replication of the study is possible. • The intervention has been implemented as intended. It has been demonstrated that the elements of the intervention have actually been applied. • In the committee's opinion there are enough studies from which it is apparent that during the implementation of the intervention changes occurred in accordance with the intervention's objective.
Strong indications for effectiveness	• The design of the empirical research provides for at least a strong causal level of evidence (Table 2). The research has a quasi-experimental/experimental or, if that is not possible, another design (for example, repeated case studies, a study into the correlation between the extent to which the intervention is applied and the extent to which the intended outcomes have occurred, or a cohort study) of high quality. The studies have been carried out in everyday practice and have a follow-up period of at least six months. • The number of studies can vary considerably, depending on the quality and nature of the study. Rules of thumb for the minimum are: – There are at least two Dutch studies into the intervention in question with a strong or very strong level of evidence or one Dutch study into the intervention in question in combination with at least one national or international study into this or a comparable intervention with a strong or very strong level of evidence. The Recognition Committee will ultimately assess the comparability. – In case of repeated case studies there are at least ten cases carried out by different treating practitioners under different conditions.
Good indications for effectiveness	• The design of the empirical research provides for at least a moderate causal level of evidence. The research has a quasi-experimental/experimental or another design (for example, repeated case studies, a study into the correlation between the extent to which the intervention is applied and the extent to which the intended outcomes have occurred, or a cohort study). The studies have not necessarily been carried out in everyday practice or have not yet been followed-up. • The number of studies can vary considerably, depending on the quality and nature of the study. Rules of thumb for the minimum are: – There are at least two Dutch studies into the intervention in question with a moderate to fairly strong level of evidence or one Dutch study into the intervention in question in combination with at least one national or international study into this or a comparable intervention with at least a moderate level of evidence. The Recognition Committee will ultimately assess the comparability. – For Dutch research into the intervention in question with a strong to very strong level of evidence one study is sufficient for the recognition at this level of effectiveness. – For repeated case studies at least six cases must have been carried out by different treating practitioners under different conditions.

First indications for effectiveness	• The design of the empirical research provides for at least a weak causal level of evidence. There is a baseline measurement (prior to/at the start of the intervention) and a follow-up measurement (at the end of the intervention), without a control condition. • There are at least two Dutch studies into the intervention in question with a weak level of evidence or one Dutch study into the intervention in question in combination with at least one national or international study into this or a comparable intervention with at least a weak level of evidence.

Promotion of the best practice in the Loketgezondleven.nl database

All health promotion interventions requesting for publication or assessment are presented in the Loketgezondleven.nl intervention database, including the level of assessment. When searching for health promotion interventions on a specific theme, the interventions with the best available evidence will be presented at the top of the list. In the database, interventions or best practices can be searched on the level of assessment or by using key words on the topic, target group, setting or by using free text words. Table 1 shows the amount of assessed interventions and their assessment level, dated at June 2014. At this moment, there are approximately 244 interventions, which are assessed by the committee or practice panel. These are the interventions, which are recommended for use.

TABLE 44: TOTAL OF ASSESSED INTERVENTIONS IN THE DUTCH PORTAL LOKETGEZONDLEVEN.NL, JUNE 2014

Strong indications of effectiveness	**5**
Good indications of effectiveness	22
First indications of effectiveness*	1
Theoretical Sound	136
Well Described	80

** The assessment of this level started this year*

List of recommended interventions for diabetes and other chronic diseases. Overview

The database contains lists of recommended interventions for several topics, for example diabetes mellitus type 2, chronic diseases, the elderly, community interventions, overweight, alcohol, depression, primary school interventions, etc. The recommended interventions are provided from the 244 interventions with an assessment level. These lists of recommended interventions are part of online manuals for healthy municipalities that support local professionals and local policy makers in their local work in the field of health promotion.

TABLE 45: CRITERIA FOR CAUSAL LEVEL OF EVIDENCE OF EMPIRICAL RESEARCH

Causal level of evidence Design	Study characteristics
Very strong	The same criteria apply here as in the level below with the difference that: • There is an experimental study design (i.e. there is a random allocation of study subjects to research groups) or there is another design that demonstrates the causal relationship between intervention and effect.
Strong	The same criteria apply here as in the level below with the addition that: • There is a follow-up (rule of thumb: 6 months) or there is another design that provides sufficient oversight of the stability of the results.
Fairly strong	The same criteria apply here as in the level below with the difference that: • The study was carried out in everyday practice/is representative for everyday practice.
Reasonable	The same criteria apply here as in the level below with the difference that: • It is a study with an experimental or quasi-experimental design and a control group (care as usual) or a repeated N=1 study with a baseline or a time series design with a single or multiple baseline or alternating treatments or a study into the correlation between the extent to which an intervention has been used and the extent to which the intended outcomes have occurred. • The design is of high quality. • The study has not been carried out in everyday practice/is not representative for everyday practice or the representativeness for everyday practice is not known.
Moderate	The same criteria apply here as in the level below with the addition that: • The results are comparable with other research into the effects of the usual situation, practice or care (care as usual) or another form of care for a similar target group.
Weak	The requirements that apply to this level are: • The research is documented so that replication of the study is possible. • The measured effect is related to the objective and the target group of the intervention. • The measurement has been carried out with reliable and valid instruments. • A baseline measurement (prior to/or at the start of the intervention) and a follow-up measurement (at the end of the intervention) have taken place. • The results have been analysed using a satisfactory statistical technique, have been tested for significance, and an accepted outcome measurement (such as Cohen's D or an Odds Ratio) has been or can be calculated.
Very weak	The study does not satisfy the minimum requirements for an empirical study with a causal level of evidence.

ANNEX 4: SURVEY DATA

***Legend:**

E = Early interventions

P = Public awareness interventions

S = School-based interventions

A = All interventions together

TABLE 46: OVERVIEW OF VARIABLES (QUESTIONS) INCLUDED IN THE ANALYSIS

QUESTION
6. Who funds/funded your example of good practice?
7. What is/was the level of implementation of your example of good practice?
10. Is your example of good practice embedded in a broader national/regional/ local policy or action plan?
12. Which of these stakeholders were involved in the development of your example of good practice?
13. Please describe the logic model (the rationale or logical framework) of your example of good practice.
14. Elements of planning.
15. Implementation of your example of good practice is/was
16. Target groups.
17. Which communication channels were used?
20. What supportive activities are/have been carried out?
21. Who performed the evaluation?
22. What was measured/evaluated?

TABLE 47: COLLECTED EVIDENCE-BASED INTERVENTIONS AND INTERVENTION AREAS

Countries responded	Submitted evidence-based interventions	E	P	S
Austria	3	●	●●	
Bulgaria	1	●		
Croatia	2	●	●	
Finland	2	●	●	
Germany	2	●●		
Greece	2			●●
Ireland	2	●●		
Italy	2	●	●	
Lithuania	2	●		●
Luxembourg	1		●	
Netherlands	2	●		●
Norway	3	●	●	●
Poland	2	●		●
Portugal	5	●●		●●●
Slovenia	3		●●	●
Spain	2	●		●
Sweden	7	●●●●●		●●
Total = 32 countries	**43**	**21**	**9**	**13**

TABLE 48: LEVEL OF IMPLEMENTATION

Evidence-based interventions (n=43)	Multi choice	E	P	S	A	
VARIABLE 7. What is/was the level of implementation of your example of good practice?	A. National B. Regional C. Local (municipality level) D. Other	N	N	N	N	%
		E	P	S	A	
A National		12	7	7	26	40 %
B Regional		9	5	5	19	29 %
C Local (municipality level)		5	6	5	16	25 %
D Other		2	0	2	4	6 %
Total		**28**	**18**	**19**	**65**	**100 %**

TABLE 49: INCLUSION INTO A BROADER NATIONAL/REGIONAL/LOCAL POLICY OR ACTION PLAN

Evidence-based interventions (n=43)		E	P	S	A	
VARIABLE 10. Is your example of good practice embedded in a broader national/ regional/local policy or action plan?	a. Yes b. No	N	N	N	N	%
		E	P	S	A	
A yes		16	9	8	33	77 %
B no		5	0	5	10	23 %
Total		**21**	**9**	**13**	**43**	**100 %**

TABLE 50: RATIONALE OR LOGICAL FRAMEWORK OF GOOD PRACTICE

Evidence-based interventions (n=43)	Multi choice	E	P	S	A	
VARIABLE 13. Please describe the logic model (the rationale or logical framework) of your example of good practice.	A. Scientific evidence B. Past experience C. Other	N	N	N	N %	
		E	P	S	A	
A Scientific evidence		20	8	13	41	63 %
B Past experience		9	5	7	21	32 %
C Other		2	1	0	3	5 %
Total		**31**	**14**	**20**	**65**	**100 %**

TABLE 51: ELEMENTS OF PLANNING

Evidence-based interventions (n=43)				
Q 14. Elements of planning				
	E	P	S	A
A Literature review and/or formative research	18	9	11	38 (13 %)
B Needs assessment	18	7	10	35 (12 %)
C Detailed plan of action	15	8	12	35 (12 %)
D Financial plan	13	8	8	29 (10 %)
E Human resource management plan	13	7	10	30 (10 %)
F Time schedule	16	9	11	36 (12 %)
G Partners agreement	13	6	10	29 (9 %)
H Communication plan	8	9	6	23 (8 %)
I Evaluation plan	17	9	11	37 (12 %)
J Other	3	0	3	6 (2 %)
Total	**116**	**63**	**81**	**260 (100 %)**

TABLE 52: ELEMENTS OF PLANNING

Country	a. Literature review and/or formative research	b. Needs assessment	c. Detailed plan of action	d. Financial plan	e. Human resource management plan	f. Time schedule	g. Partners agreement	h. Communication plan	i. Evaluation plan	j. Other
1 Austria 1	●		●	●	●	●	●	●	●	
2 Austria 2	●	●	●	●	●	●	●	●	●	
3 Austria 3	●		●	●		●	●		●	
4 Bulgaria	●	●			●	●			●	
5 Croatia 1	●	●		●	●	●	●		●	
6 Croatia 2	●	●	●	●	●	●	●	●	●	
7 Finland 1	●		●	●	●	●	●	●	●	●
8 Finland 2	●	●	●	●	●	●	●	●	●	
9 Germany 1	●	●	●	●	●	●	●	●	●	
10 Germany 2	●	●	●	●	●	●	●		●	
11 Greece 1	●	●	●			●			●	
12 Greece 2	●	●	●	●	●	●	●	●	●	●
13 Ireland 1		●	●							
14 Ireland 2	●	●	●			●	●	●	●	
15 Italy 1	●	●				●		●	●	
16 Italy 2	●	●				●		●	●	
17 Lithuania 1	●		●	●		●	●		●	
18 Lithuania 2	●	●			●					
19 Luxembourg	●	●	●	●	●	●	●	●	●	
20 Netherlands 1	●	●	●	●	●	●	●	●	●	
21 Netherlands 2	●	●	●	●	●	●	●	●	●	

Country	a. Literature review and/or formative research	b. Needs assessment	c. Detailed plan of action	d. Financial plan	e. Human resource management plan	f. Time schedule	g. Partners agreement	h. Communication plan	i. Evaluation plan	j. Other
22 Norway 1	●		●	●		●		●	●	
23 Norway 2			●	●		●	●			
24 Norway 3	●	●	●	●	●	●	●	●		
25 Poland 1	●	●	●		●	●			●	
26 Poland 2	●	●	●		●	●	●		●	
27 Portugal 1	●	●	●		●	●	●		●	
28 Portugal 2	●	●	●		●				●	
29 Portugal 3	●	●			●					
30 Portugal 4	●	●	●	●	●	●	●	●	●	
31 Portugal 8	●	●	●		●	●	●	●	●	
32 Slovenia 1	●	●	●	●	●	●		●	●	
33 Slovenia 2	●	●	●	●	●	●	●	●	●	
34 Slovenia 3	●	●	●	●	●	●	●	●	●	
35 Spain 1	●	●	●	●	●	●	●	●	●	
36 Spain 2	●	●	●	●	●	●	●	●	●	
37 Sweden 1	●	●	●	●	●	●	●	●	●	●
38 Sweden 2	●	●		●					●	●
39 Sweden 3	●	●	●	●					●	
40 Sweden 4			●	●	●	●	●		●	
41 Sweden 5										●
42 Sweden 6	●	●	●	●	●	●	●		●	
43 Sweden 7		●	●	●		●	●		●	

TABLE 53: IMPLEMENTATION TIME FRAME

Evidence-based interventions (n=43)	Choice[1]	E	P	S	A	
VARIABLE 15. Implementation of your example of good practice is/was	A. Continuous (integrated in the system) B. Periodic C. Single	N	N	N	N	%
		E	P	S	A	
A Continuous (integrated in the system)		12	5	10	27	69 %
B Periodic		3	1	1	5	13 %
C Single		4	1	2	7	18 %
Total		**19**	**7**	**13**	**39**	**100 %**

1 There was only one possible answer.

TABLE 54: COMMUNICATION CHANNELS

Evidence-based interventions (n=43)

Q 17. Which communication channels were used?

	E	P	S	A	
A	Television	2	7	1	10	4 %
B	Radio	2	8	0	10	4 %
C	Newspapers and magazines	5	8	3	16	6 %
D	Billboards	0	5	0	5	2 %
E	Brochures/leaflets/items	13	9	8	30	11 %
F	Telephone/mobile	5	2	1	8	3 %
G	Social media	6	5	3	14	5 %
H	Website	12	9	10	31	12 %
I	E-mail	9	8	6	23	9 %
J	Meetings/conferences with experts/colleagues	15	9	12	36	14 %
K	Direct communication	13	8	7	28	10 %
L	Guidelines	7	6	9	22	8 %
M	Scientific publications	10	4	7	21	8 %
N	Other	4	5	1	10	4 %
Total		**103**	**93**	**68**	**264**	**100 %**

TABLE 55: WHICH COMMUNICATION CHANNELS WERE USED?

	Country	a. Television	b. Radio b. Radio	c. Newspapers and magazines	d. Billboards	e. Brochures/leaflets/ items	f. Telephone/mobile	g. Social media	h. Website	I. E-mail	j. Meetings/conferences with experts/colleagues	k. Direct communication	l. Guidelines	m. Scientific publications	n. Other
1	Austria 1	●	●	●	●	●		●	●	●	●	●	●		●
2	Austria 2	●	●	●	●	●		●	●	●	●	●	●	●	●
3	Austria 3						●					●			●
4	Bulgaria					●	●				●	●	●	●	
5	Croatia 1											●			●
6	Croatia 2					●	●		●	●	●	●	●		
7	Finland 1					●	●		●	●	●	●			●
8	Finland 2		●	●		●			●	●	●	●		●	●
9	Germany 1					●			●		●			●	
10	Germany 2					●						●		●	
11	Greece 1					●			●		●	●			
12	Greece 2	●		●		●	●			●	●	●	●		
13	Ireland 1					●					●	●			
14	Ireland 2		●	●		●			●	●		●			
15	Italy 1	●	●	●		●		●	●	●	●	●	●		●
16	Italy 2							●	●	●	●	●	●		
17	Lithuania 1							●	●	●	●	●	●	●	
18	Lithuania 2										●		●		
19	Luxembourg	●	●	●	●	●	●		●	●	●	●	●	●	●
20	Netherlands 1					●			●	●	●		●	●	
21	Netherlands 2			●		●		●	●	●	●	●	●	●	

Country	a. Television	b. Radio b. Radio	c. Newspapers and magazines	d. Billboards	e. Brochures/leaflets/ items	f. Telephone/mobile	g. Social media	h. Website	I. E-mail	j. Meetings/conferences with experts/colleagues	k. Direct communication	l. Guidelines	m. Scientific publications	n. Other
22 Norway 1	●	●	●	●	●		●	●	●	●	●			
23 Norway 2					●		●	●	●					
24 Norway 3					●		●	●	●				●	
25 Poland 1					●					●			●	
26 Poland 2			●		●			●	●	●	●	●	●	
27 Portugal 1								●		●	●	●	●	●
28 Portugal 2										●	●			
29 Portugal 3							●		●					
30 Portugal 4										●		●	●	
31 Portugal 8						●			●	●	●			
32 Slovenia 1	●	●	●	●	●			●		●		●		
33 Slovenia 2	●	●	●		●		●	●	●	●	●		●	●
34 Slovenia 3					●		●	●	●	●	●	●	●	
35 Spain 1			●					●		●				
36 Spain 2			●		●			●	●	●	●	●	●	
37 Sweden 1	●	●	●		●		●	●		●	●	●	●	●
38 Sweden 2								●		●			●	
39 Sweden 3							●	●		●			●	
40 Sweden 4					●			●		●		●		
41 Sweden 5					●			●		●		●		
42 Sweden 6	●		●		●	●		●	●	●		●	●	
43 Sweden 7					●			●		●	●			

TABLE 56: SUPPORTIVE ACTIVITIES

Evidence-based interventions (n=43)

Q 20. What supportive activities are/have been carried out?

	E	P	S	A	
A Consultancy	12	7	9	28	22 %
B Supervision	8	4	7	19	15 %
C Training	14	7	11	32	25 %
D Team meetings	13	8	11	32	25 %
E Helpdesk	2	3	3	8	6 %
F None	1	0	0	1	1 %
G Other	4	1	3	8	6 %
Total	**54**	**30**	**44**	**128**	**100 %**

TABLE 57: SUPPORTIVE ACTIVITIES

Country	a. Consultancy	b. Supervision	c. Training	d. Team meetings	e. Helpdesk	f. None	g. Other
1 Austria 1	●	●	●	●			
2 Austria 2	●		●	●			
3 Austria 3	●						
4 Bulgaria		●		●			
5 Croatia 1		●				●	●
6 Croatia 2	●	●	●	●			
7 Finland 1	●		●		●		●
8 Finland 2	●	●	●	●	●		●
9 Germany 1	●	●	●	●			
10 Germany 2	●		●				●
11 Greece 1				●			●
12 Greece 2		●	●	●	●		
13 Ireland 1	●		●	●			
14 Ireland 2			●				
15 Italy 1	●	●	●	●	●		
16 Italy 2	●	●	●	●			
17 Lithuania 1	●		●	●			
18 Lithuania 2			●				
19 Luxembourg			●	●	●		
20 Netherlands 1	●	●	●	●	●		
21 Netherlands 2	●	●	●	●			
22 Norway 1	●						

Country	a. Consultancy	b. Supervision	c. Training	d. Team meetings	e. Helpdesk	f. None	g. Other
23 Norway 2	●	●	●	●			
24 Norway 3	●		●	●	●		
25 Poland 1	●			●			
26 Poland 2	●	●	●	●			
27 Portugal 1	●	●	●	●			
28 Portugal 2		●	●				
29 Portugal 3			●	●			
30 Portugal 4	●			●			
31 Portugal 8				●			
32 Slovenia 1				●			
33 Slovenia 2	●		●	●			
34 Slovenia 3			●				
35 Spain 1	●	●	●	●			●
36 Spain 2	●	●	●	●	●		
37 Sweden 1	●	●	●	●			
38 Sweden 2							●
39 Sweden 3				●			
40 Sweden 4	●		●	●			
41 Sweden 5	●	●	●	●			
42 Sweden 6	●		●	●			
43 Sweden 7			●				

TABLE 58: WHO PERFORMED THE EVALUATION?

Evidence-based interventions (n=43)	Multi choice	E	P	S	A	
VARIABLE 21. Who performed the evaluation?	A. An external party B. An internal party C. Both – internal and external party	N	N	N	N %	
		E	P	S	A	
A An external party		3	3	1	7	17 %
B An internal party		9	3	7	19	45 %
C Both – internal and external party		8	3	5	16	38 %
Total		**20**	**9**	**13**	**42**	**100 %**

TABLE 59: WHAT HAS BEEN MEASURED/EVALUATED?

Evidence-based interventions (n=43)	Multi choice	E	P	S	A	
VARIABLE 22. What was measured/evaluated?	A. Process evaluation B. Evaluation of the impacts/effects/outcome C. Other	N	N	N	N %	
A Process evaluation		16	6	12	34	48 %
B Evaluation of the impacts/effects/ outcome		15	6	11	32	45 %
C Other		3	2	0	5	7 %
Total		**34**	**14**	**23**	**71**	**100 %**

ANNEX 5: THE ETHICS OF ALCOHOL PREVENTION

1. Why ethics?

Alcohol prevention falls in the domain of public health. Whilst bioethics has evolved into a well-established "partner discipline" of clinical medicine, providing frameworks for ethical problems in the clinic and for patient-physician interactions, ethical problems in the realm of public health field have received relatively less attention (Maeckelberghe and Schröder-Bäck, 2007; Greco and Petrini, 2004).

In North America, despite some "modest" progress, a lack of systematic instruction in ethics, both in public health and in epidemiology, has been lamented, (Lee, 2013). In this light, it may offer some consolation that public health ethics appears to have changed its status from "one of the best-kept secrets on the American intellectual scene" (Weed, 2004) to "a nascent field" (Lee, 2012). These self-professed shortcomings notwithstanding, the Anglo-American discourse suffers from less developmental delay than in Europe (Wehkamp, 2008) and has provided a number of pertinent frameworks (for an overview: Lee, 2012, including the Nuffield Council on Bioethics "Stewardship" model, the most prominent example from Europe).

The rationale for advancing public health ethics in Europe is twofold. First, public health differs from clinical practice in its scope. The discipline deals with populations, communities and factors outside the immediate health domain and it puts a greater focus on prevention. Therefore, bioethical frameworks cannot simply be adopted by public health (Lee, 2012). Second, the communities that make up populations are diverse and their beliefs and practices heterogeneous. This creates a need for public health ethics to take social, political and cultural contexts into consideration as well as different value systems and philosophies (Upshur, 2002).

Reasoning with a multitude of world views appears imperative in Europe where alcohol is deeply embedded in different "drinking cultures" and distinctive consumption practices prevail, and frameworks developed in a different cultural context may not be easily imported.

Alcohol prevention is not ethical per se. Adhering to the principle of beneficence and building on a solid evidence base are both necessary conditions for an intervention to be considered ethical, but they are not sufficient. Making the right decision in public health has two components: a scientific and an ethical one (Wehkamp, 2008).

Many decisions regarding the design and the provision of interventions in alcohol prevention have ethical ramifications. The purpose of this chapter is to briefly outline some of the relevant ethical dimensions. A good portion of this chapter draws largely on the contents and structure of Faden and Shebaya (2015). Rather than providing guidance for decision-making, it aims to stimulate readers to reflect on their position along a number of value spectra in alcohol prevention, since "ethics is essentially a reflective task that requires participants to be explicit about what they believe, what they value and on what grounds" (Upshur, 2002).

2. Distinctive Challenges of Public Health Ethics (cf. Faden and Shebaya, 2015)

Public health ethics are the moral foundation of public health and its justification. Health can be conceived of as a component of welfare. In this view, public health is seen as a duty to maximise welfare. At the core of this perspective lies a conflict between collective benefit and individual liberty. Public health can also be understood as social justice. From this perspective, the provision of a sufficient level of health takes primacy and the just allocation of finite resources is the core dilemma.

1. Faden and Shebaya (2015) describe four characteristics of the public health domain that distinguish public health ethics from the ethics of clinical practice or the ethics of biomedical science:
2. The question: "Is health a public or collective good?"
3. A particular focus on prevention
4. A common involvement of government action
5. An intrinsic outcome-orientation

First, public health is concerned with populations and communities, not individuals. Therefore, it is difficult to delineate the benefits to one individual from those to another. The benefits and burdens, however, often affect subpopulations differently, which raises a number of ethical questions regarding public health:

- Who is public health good for?
- Whose health is it concerned with?
- What sacrifices are acceptable?
- Is there a difference between public health and population health?
- Why is public health worth it?

Second, paradigmatically, prevention is the territory of public health. Inherent to this focus are a number of unique moral challenges. Sometimes, greater importance is placed on the alleviation of existing harm than on long-term prevention strategies. This includes the allocation of funding and public support. This priority given to curative measures may in part be due to preventive interventions producing costs in the present but benefits in the future. In addition, these benefits are usually confined to some individuals. Often, the identities of public health beneficiaries cannot be predicted and their numbers can only be estimated by means of probabilistic methods. These factors aggravate the (perceived) intangibility of public health benefits and give rise to ethical questions that are distinctive of the public health domain.

- How should we think about statistical and unidentified lives and persons?
- Should health gains in the future be treated as worth less than health gains in the present?
- In some cases, the beneficiaries are members of future generations, complicating the moral picture even further.

Third, public health often entails government action, many public health measures being coercive or backed by the force of law. Particularly with regard to environmental prevention, public health is focused on regulation and public policy, less on individual actions and services. Any state action must address tensions between justice, security and the scope of legal restrictions and regulations. Finding a trade-off between personal freedom and collective action may provide a cause for concern about paternalism. This moral dilemma is not peculiar to the public health arena. However, in an area as deeply personal as individual health choices, the justificatory need for the exercise of public authority and the imposition of public sanctions is particularly strong.

Fourth, public health involves an intrinsic outcome-orientation. It has a strong consequentialist orientation: public health is about avoiding bad health outcomes and advancing good ones. For those who regard this outcome orientation as the moral justification and foundation of public health, constraints by deontological concerns are required – as within any consequentialist framework – such as rights and justice-related concerns or the fair distribution of burdens. For those who view social justice as the moral foundation of public health, the moral implications of public health's consequentialist orientation are addressed within the frame provided by considerations of justice.

In a global world, the boundaries of what constitutes "the public" are not readily demarcated. A single country is not always the most plausible unit and a national focus may sometimes be difficult to morally justify. When diseases cross borders or when justice and equity are unevenly distributed across borders, questions regarding an obligation for international cooperation may arise. Conversely, national boundaries are nevertheless relevant to public health for a number of reasons. Policies and regulations are usually set by countries and individuals and they vary accordingly. Although countries report health indicators to supranational institutions at EU level or to the WHO, international law enforcement

mechanisms are weak and the moral implications of these practical limitations remain unclear. Structurally, the determinants of ill health are similar to environmental issues as they are not restricted by national boundaries.

3. Justifications for alcohol prevention

A. Overall benefit

A popular argument holds that alcohol policy decisions made on the basis of overall statistics and demographic trends are ultimately better for all of us, even if particular interventions may not benefit some of us. Thus, the task of public health ethics is not to justify each particular intervention directly. Rather, alcohol prevention in general can be justified in the same way as a market economy, driving on one side of the road or other broad and useful conventions that involve some coercive action but also enable individuals to access greater benefits (within certain pre-established parameters). When properly regulated and managed, the existence of these conventions is by and large better than their absence for everyone. In this line of argument, particular interventions derive their justification from the higher-order principle of "overall benefit" or they build upon this top level justification. This argument has a lot of appeal, particularly as a way of justifying measures of environmental alcohol prevention.

Ultimately however, a focus on the overall benefit is insufficient on its own as a justification for alcohol prevention, as it does not provide a basis for setting the parameters of preventive alcohol policy action. Only abstinence would provide an absolute limit to harm. However, inherent to the legal status of alcohol, its popularity and the lack of public support for its prohibition, it will remain a matter of debate up to which level drinkers must tolerate governmental restrictions and at what point the state's duty to protect the rights of the non-drinker supersedes the drinker's rights of freedom.

B. Collective action and efficiency

A similar argument rests on the premise that health is a public good, which can only be attained by a concerted action of all, requiring rules for coordinated action and near-universal participation. This justification conceptualises alcohol prevention as a coordination or collective efficiency problem that, in order to be solved, requires near-universal compliance. To reap the benefits of this "health for all" approach, everyone needs to participate and show solidarity.[1]

Protective measures that affect the population at large are commonplace, both within the context of public health and beyond, e.g. in consumer protection. Outside the realm of alcohol policy, they often constitute the only feasible or acceptably efficient way to reach the entire population, sometimes leaving little room for non-cooperation.[2]

Arguments, in which collective efficiency takes centre stage, claim that our world is too complex to continuously make independent and conscious consumption choices. The number of consumer decisions to be made and the depth of understanding required to assess their health effects can be overbearing. This situation provides the justification for ceding control of consumption risks from the consumer to state actors who are equipped with expertise in health, analogous to the role law enforcement agents play regarding public security.

Like the "overall benefit" argument, structuring alcohol prevention as a coordination or collective efficiency task does not provide exact parameters regarding the scope of prevention. Determining the particular circumstances that mandate preventive alcohol policy measures and selecting the most

1 Citing Bruun, Sulkunen (1997) holds that "the truly modem universalistic principle of prevention came with the theory of total consumption" because this approach to alcohol control focusses on per capita consumption rather than on individuals, specific risk groups or certain drinking practices. Involving policy measures aimed at reducing the availability of alcohol, including price policy, opening hours, restrictions on the number of sales outlets and on advertising. Underlying this strategy, according to Sulkunen (1997) and emblematic of "welfare state thinking" in this period, is the principle that "moderate drinkers should sacrifice some of their pleasure and comfort to show solidarity with those more at risk". The author claims that later justifications of such policy measures with appeals to the "public good" were fully cognizant of the potential violations to individual freedom.

2 Prominent examples are water fluoridation or following treatment protocol in TB infection.

appropriate instruments for alcohol prevention are tasks that retain a decidedly ethical dimension.

In universal alcohol prevention, this problem is particularly acute. It is compounded whenever members of at-risk populations tend to differ substantially in terms of their intra-personal parameters such as health literacy, self-efficacy or risk-seeking behaviour. Since, by definition, universal alcohol prevention addresses the entirety of a population, it is unlikely to fully account for a diversity of needs and competencies. At worst, a mismatch between the specific demands of a vulnerable subpopulation and an intervention that targets the general public may result in an uneven distribution of benefits and burdens and thus run counter to the pursuit of health as a public good.

Some claims in support of collective efficiency arguments are made regarding the general cognitive limitations and bounded rationality of human decision making. From this standpoint, the disproportionate political power of corporate interests and the practices employed for the manipulation and exploitation of consumers' cognitive vulnerabilities affect health interests in the population at large and are not restricted to vulnerable subpopulations. Such claims have great appeal with regard to children and adolescents. Representing a subsample of the general population with a prima facie presumption of vulnerability, young people are typically the main target group of universal alcohol prevention.

C. The harm principle

The harm principle is "perhaps the foundational principle for public health ethics in a democratic society" (Upshur, 2003), and probably the least controversial justification for public health interventions. Its central tenet was set out in John Stuart Mill's essay "On Liberty": "The only purpose, for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant" (Mill, 1959).

The harm principle is the moral basis for the control of infectious diseases by means of quarantine, isolation and compulsory treatment. The principle holds that state authority should only apply such coercive measures as a last resort, once less restrictive means have failed. This dictum has been codified in the Siracusa Principles[3], which stipulate that restrictions on human rights must meet standards of legality, evidence-based necessity, proportionality, and gradualism. Less restrictive means like education, facilitation and discussion should thus precede coercion by interdiction, regulation and incarceration. (Upshur, 2003).

An example of the significance of the harm principle in liberal democracies is the public's persuasion of the harmful effects of "second hand smoke" for the justification of smoking bans in public places (Faden and Shebaya, 2015). Due to their broad persuasiveness, appeals made about harm to others have also been made in less obvious contexts (e.g. "passive drinking" for the justification of alcohol prevention).

The harm principle has been interpreted to include credible threat of significant economic harm to others as well as physical harm (e.g. alcohol policy: appeal to the financial burden on the health care system and indirect costs such as absenteeism or presenteeism). The harm principle, however, does not state whether physical harms to others outweigh economic harms or, more generally, how harm is to be understood.

Irrespective of how restrictive or expansive the interpretation of the harm principle may be in this regard, it is insufficient as a justification for all alcohol policy causes.

Recently, it is increasingly being challenged that individuals are capable of determining what is in their own interests (Conly, 2014; Sunstein, 2013), thus justifying governmental non-coercive action in the guise of providing "nudges" for decision-making.

D. Paternalism

Arguably the most controversial concept in public health ethics, from a paternalist perspective, protecting or promoting a person's welfare justifies interference with their liberty of action.

3 The Siracusa Principles provide guidance on the conditions for restriction of human rights under the International Covenant on Civil and Political Rights (ICCPR). They are a non-binding document, developed by non-governmental organisations and adopted by the United Nations Economic and Social Council in 1984 (UN Commission on Human Rights, 1984).

Unmediated classic paternalistic positions are rarely used exclusively or primarily for the justification of public health policy, although interventions often may have paternalistic effects. "Milder" forms of paternalism, such as "soft" or "weak" paternalism and "libertarian paternalism" are far more common, however. The former two terms are generally being used synonymously. They imply some degree of interference to individual choices with regard to voluntariness or autonomy. Under conditions that significantly compromise a person's autonomy or voluntariness, such as cognitive disability or immaturity and, in very limited cases, ignorance or false beliefs, soft or weak paternalism holds that the preference voiced or held is not entitled to robust respect. Sometimes, this includes adaptive preferences: i.e. when individuals modify their preferences in order to adapt to difficult, unjust or undesirable circumstances, as they have been subject to interference.

Simply put, the distinguishing element between soft and strong paternalism is that a decision or preference must be fundamentally compromised, not simply mistaken or ignorant to justify interference with individual choice. This distinction is important because it reflects a difference in approach or attitude. In strong paternalism, the interference is based on the content of a preference indicating that something appears not to be in the preference holder's interest, whereas in soft paternalism interference is not justified, unless the relevant compromising conditions obtain (e.g. the limiting ability of adolescents to act on preferences for alcohol).

Recently, "nudges" have gained popularity with public health policy and liberal governments (USA, UK, Germany, Singapore). Labelled "interventions in choice architecture", nudges are the focus of libertarian paternalism. This subcategory of paternalism defends interventions by planners (such as public health authorities) in the environmental architecture, in which people decide and act to make it easier to behave in ways that are in their best interests (including their health). Libertarian paternalism sees such interventions justified if two conditions are met. The manipulation must be to a person's benefit, in their own eyes, not against their will. The interventions must be designed in a way that still lets people exercise their freedom in ways that run counter to welfare, thus "liberty-preserving".

Nudge theory and libertarian paternalism are grounded in cognitive psychology, in the concepts of bounded rationality and the weakness of will.

E. Integration of public health ethics into a systematic framework

Recently, public health ethicists have proposed frameworks for the inclusion of public health ethics (Andermann, Pang, Newton, Davis, & Panisset, 2016; Lee, Wright, & Semaan, 2013; Marckmann, Schmidt, Sofaer, & Strech, 2015; Petrini, 2010; ten Have, de Beaufort, Mackenbach, & van der Heide, 2010). Marckmann et al. (2015) hold that any such framework must meet two fundamental requirements:

1. It must be based on an explicit ethical justification (an underlying ethical theory or at least an explicit ethical approach).
2. It must include a methodological approach, relating general normative considerations (e.g. ethical norms, values and principles) and the available empirical evidence to concrete interventions, programmes or policies.

Acknowledging that there exsists an "intractable disagreement about which ethical theory is correct", Marckmann et al. (2015) propose a coherentist model of justification, which may overcome the diversity of normative orientations in pluraistic societies. Instead of building on a single moral principle as its foundation like classical ethical theories, coherentism builds a moral framework based on "considered judgments" from everyday life that are specified, tested and revised. The goal is to reach a "reflective equilibrium" of considerations about single cases. These prima facie assumptions constitute prima facie general moral norms[4] that need to be followed, unless a conflict evolves with ethical norms of a higher order. According to Marckmann et al. (2015), a

4 An example of such "considered judgements" are the principles of beneficence, non-maleficence, respect for autonomy and justice in biomedicine.

coherentist model has the advantages of finding consensus on the level of prima facie mid-level binding principles and of making controversies more transparent because they can be analysed as conflicts of principles with different weights.

Marckmann et al. (2015) have developed the following substantive normative criteria, conditions for a fair process and methodological process for putting public health ethics practice.

TABLE 60: SUBSTANTIVE NORMATIVE CRITERIA FOR ETHICAL ANALYSIS IN PUBLIC HEALTH (MARCKMANN ET AL., 2015)

	Normative criteria
1	Expected health benefits for the target population:
	Range of expected effects (endpoints);
	Magnitude and likelihood of each effect;
	Strength of evidence of each effect;
	Public health (practical) relevance of effects;
	Incremental benefit compared to alternative interventions.
2	Potential harms and burdens:
	Range of potential negative effects (endpoints);
	Magnitude and likelihood of each negative effect;
	Strength of evidence of each negative effect;
	Public health (practical) relevance of negative effects;
	Burdens and harms compared to alternative interventions.
3	Impact on autonomy:
	Health-related empowerment (e.g. improved health literacy);
	Respect for individual autonomous choice (e.g. possibility of informed consent, least restrictive means);
	Protection of privacy and confidentiality (e.g. data protection).
4	Impact on equity:
	Access to the public health intervention;
	Distribution of the intervention's benefits, burdens and risks;
	Impact on health disparities;
	Need for compensation?

5	Expected efficiency:	
	Incremental cost-benefit/cost-effectiveness ratio;	
	Strength of evidence for expected efficiency.	

TABLE 61: CONDITIONS FOR A FAIR DECISION PROCESS (MARCKMANN ET AL., 2015)

Conditions for a fair decision process		
1	Transparency	Decision process including database and underlying normative assumptions should be transparent and public.
2	Consistency	Application of the same principles, criteria and rules across different public health interventions → equal treatment of different populations.
3	Justification	Decisions should be based on relevant reasons, i.e. based on the normative criteria for public health ethics (see Table 61).
4	Participation	Populations affected by the public health intervention should be able to participate in the decision about the implementation.
5	Managing conflicts of interest	Decisions about public health interventions should be organised so as to minimise any existing and manage any remaining conflicts of interests of decision makers.
6	Openness for revision	Implementations of public health interventions should be open for revision (e.g. if data basis changes or certain aspects have been neglected).
7	Regulation	Voluntary or legal regulation should guarantee that these conditions for a fair decision process are met.

TABLE 62: METHODOLOGICAL APPROACH FOR PUTTING PUBLIC HEALTH ETHICS INTO PRACTICE (MARCKMANN ET AL., 2015)

Step	Task
1 Description	Describe the goals, methods, target population, etc. of the public health programme.
2 Specification	Specify or supplement (if necessary) the five normative criteria for the public health programme.
3 Evaluation	Evaluate the public health intervention based on each of the 5 normative criteria (see Table 62).
4 Synthesis	Balance and integrate the 5 single evaluations of step 3 to arrive at an overall evaluation of the public health intervention.
5 Recommendation	Develop recommendations for the design, implementation or modification of the public health intervention.
6 Monitoring	Monitor and re-evaluate the ethical implications in regular time intervals.

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ANNEX 6: EXAMPLES OF PRINCIPLES AND STANDARDS IN PREVENTION DEVELOPMENT

TABLE 63: DESCRIPTION OF PRINCIPLES

Description of principles
1. DEVELOPMENTAL FOCUS This includes variations in manifestations of risk, promotive and protective factors over the life course; the accomplishment of developmental tasks and the timing and course of disorders. Further, the developmental context and timing of interventions must be considered. Together, these sub-assumptions point to the necessity for considering timing, context, and content of interventions, such as preventive screening, and assessment of an identified population to target the intervention (universal, selected, and indicated).
2. TRANSACTIONAL ECOLOGICAL The individual, family, school, community and larger socio-political and physical environments are interdependent and best understood and influenced by approaches that account for transactional processes across multiple levels. These range from interactions between genetic and other biological processes and dynamics of social relationships, within the context of environmental factors. Within this overall framework, prevention science draws from a wide range of theories that explain the dynamics of human development and behaviour.
3. HUMAN MOTIVATION AND CHANGE PROCESSES The design of effective interventions, which seek change in individuals and environments must address the role of human motivation, intentions and self-efficacy as well as an understanding of mechanisms of risk, promotion and protection.
4. A CYCLE OF RESEARCH ACTIVITIES Prevention science involves progressive steps, which include (1) conducting research to understand predictors of problem and positive developmental outcomes and understanding the epidemiology and natural history of the problem; (2) developing interventions to motivate changes in individuals and environments, based on theories of human behaviour and our understanding or mechanisms for behaviour change; (3) testing the efficacy of these preventive interventions; and (4) testing the effectiveness of efficacious interventions in contexts under realistic delivery conditions. Dissemination of research findings is the responsibility of prevention researchers. These steps are critical for accruing knowledge and assuring the quality of delivery of comprehensive prevention. The components of the Intervention Model and Evaluation Model are depicted above.
5. A TEAM APPROACH Transdisciplinary teams with an array of expertise are required to address the complexity of the issues addressed by prevention science. This expertise includes understanding the etiology of a range of problem behaviours; intervention development and practice expertise; knowledge of research design, sampling and data collection and analysis; as well as understanding programme and policy implementation and analysis.
6. ETHICAL PRACTICES • Beneficence and non-malfeasance: Prevention researchers seek to benefit vulnerable populations and to avoid causing harm. • Fidelity and responsibility: Prevention researchers establish relationships of trust with the targeted population, the population setting and the larger social context. • Integrity: Prevention researchers promote accuracy, honesty, and truthfulness in the science, teaching and the practice of prevention science. • Justice: Prevention researchers recognize that fairness and justice entitle all persons to benefit from the contributions of prevention science. In addition, prevention researchers assure that all persons are treated equitably and are provided quality services in the conduct of their research. • Respect for people's rights and dignity: Prevention researchers respect the dignity and worth of all people, and the rights of individuals to privacy, confidentiality and self-determination.

7. DEVELOPMENTAL EPIDEMIOLOGY OF THE TARGET POPULATION

Acknowledgement of heterogeneity: For many problems and conditions that are the focus of prevention science, considerable heterogeneity in etiology and outcomes within and across populations is likely. Heterogeneity is inherent in the epidemiology of these problems and conditions and is therefore critical to understanding risk variations in processes and mechanisms that are reflected in intervention design.

8. CONTINUOUS FEEDBACK BETWEEN THEORETICAL AND EMPIRICAL INVESTIGATIONS

Theory seeks to explain the mechanisms that account for a behavioural outcome discovered through empirical epidemiological investigations or evaluations of prevention interventions. Theory also drives the development of preventive interventions, which are implemented and assessed for efficacy and effectiveness. The investigation of intervention effects, in particular a focus on whether hypothesized mediators carry the intervention effect, in turn leads to refinement of theory, etiological processes and the intervention. Practitioners identify the needs of their population and context and develop a logic model for addressing those needs. Evidence-based interventions can then be selected to address specific needs based on the conceptualization of the problem. To achieve the shared vision for improving the nation's health, both groups of professionals need to collaborate and utilize their collective skills and particular expertise. Research must be informed by practice just as practice must be informed by research. Clearly, moving practice into policy requires a partnership between researchers and practitioners.

9. IMPROVING PUBLIC HEALTH

To achieve the vision of prevention science to improve the nation's health, scientists and community prevention practitioners need to collaborate and utilize their collective skills and particular expertise. Science, practice and policy must be mutually informed by research in controlled and natural settings.

10. SOCIAL JUSTICE

Social justice is related to the Human Rights Movement and the Health as a Right Movement. Social justice is the ethical and moral imperative to understand why certain population subgroups have a disproportionate burden of disease, disability and death, and to design and implement prevention programmes and systems and policy changes to address the root causes of inequities.

11. STRATEGIES FOR ENSURING SUSTAINABILITY OF PREVENTION INTERVENTIONS

- Building community and organizational capacity in management, advocacy, fundraising and training.
- Utilizing simple, user-friendly materials and tools.
- Involving community members in every step of the intervention research cycle.
- Developing, implementing and institutionalizing cost-recovery mechanisms.
- Developing, implementing and institutionalizing quality assurance and self-assessment tools.
- Building on pre-existing structures.
- Developing intervention leaders and "champions".
- Encouraging cross-community learning.

Society for Prevention Research. Standards of Knowledge for the Science of Prevention. June 2011. Retrieved from: http://www.preventionresearch.org.

TABLE 64: PROJECT STAGES AND COMPONENTS WITHIN THE EUROPEAN DRUG PREVENTION QUALITY STANDARDS

Cross-cutting considerations
A. Sustainabilitity and funding
B. Communication and stakeholder involvement
C. Staff development
D. Ethical drug prevention
1. Needs assessment
1.1 Knowing drug-related policy and legislation
1.2 Assessing drug use and community needs
1.3 Describing the need – Justifying the intervention
1.4 Understanding the target population
2. **Resource assessment**
2.1 Assessing target population and community resources
2.2 Assessing internal capacities
3. **Programme formulation**
3.1 Defining the target population
3.2 Using a theoretical model
3.3 Defining aims, goals, and objectives
3.4 Defining the setting
3.5 Referring to evidence of effectiveness
3.6 Determining the timeline
4 **Intervention design**
4.1 Desining for quality and effectiveness
4.2 If selecting and existing intervention
4.3 Tailoring the intervention to the target population
4.4 If planning final evaluations

Cross-cutting considerations
5. Management and mobilisation of resources
5.1 Planning the programme – Illustrating the project plan
5.2 Planning financial requirements
5.3 Setting up the team
5.4 Recruiting and retaining participants
5.5 Preparing programme materials
5.6 Providing a project description
6. **Delivery and monitoring**
6.1 If conducting a pilot intervention
6.2 Implementing the intervention
6.3 monitoring the implementation
6.4 Adjusting the implementation
7. **Final evaluations**
7.1 If conducting an outcome evaluation
7.2 If conducting a process evaluation
8. **Dissemination and improvement**
8.1 Determining weather the programme should be sustained
8.2 Disseminating information about the programme
8.3 If producing a final report

EMCDDA Manuals. European drug prevention quality standards. A manual for prevention professionals. Luxembourg: Publications Office of the European Union, 2011.

TABLE 65: DEFINITIONS OF THE PRINCIPLES OF EFFECTIVE PROGRAMMES

Comprehensive	Multicomponent interventions that address critical domains (e.g., family, peers, community) that influence the development and perpetuation of behaviors to be prevented
Varied teaching methods	Programes involve diverse teaching methodc that focus on increasing awareness and understanding of the problem behaviors and acquiring or enhancing skills
Sufficient dosage	Programes provide enough intervention to produce the desired effects and provide follow-up as necessary to maintain effects
Theory driven	Programes have a theoretical justification, are based on accurate information, and are supported by empirical research
Positive relationships	Programes provide exposure to adults and peers in a way that promotes strong relationship and supports positive outcomes
Appopriately timed	Programes are iniated early enough to have an impact on the development of the problem behavoir and are sensitive to the developmental needs of participants
Socioculturally relevant	Programes are tailored to the community and cultural norms of the participants and make efforts to include the target group in programe planning and implementation
Outcome evaluation	Programes have clear goals and objectives and make an effort to systematically document their results relative to the goals
Well-trained staff	Programe staff support the programe and are provided with training regarding the implementation of the intervention

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