Engagement of youth organisations in prevention interventions in the field of alcohol policy

(Updated version)

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Summary

Background: Youth organisations are often providers or participants in various prevention interventions in the field of alcohol policy, especially in schools and communities at universal level. Their involvement in prevention seems to be very important and valuable due to increasing risky and harmful drinking paterns among young people. Unfortunately, youth organisations are mostly involved in prevention interventions which are not classified as effective evidence-based prevention practices[1], but there is a great potential to upgrade their knowledge and skills in purpose to improve effectiveness of their existing and future interventions.

Objective: The main objective of this report is to map alcohol-related prevention interventions in youth organisations. The report aims to map youth organisations in Europe regarding their involvement in evidence-based alcohol practices and level of youth participation in those practices. This report also aims to review existing scientific evidence on effective approaches and good or best practices[2] which are already used or could be used by youth organisations in the future.

Methods: Online survey was conducted among youth organisations to map existing alcohol-related prevention interventions in this sector. Sixty seven organisations have participated in the survey from 25 European and 2 non-European countries. In addition, systematic literature and relevant good or best practice databases review was conducted, along with a combined quality appraisal and evidence weighting assessment to identify evidence-based effective approaches with active engagement of youth organisations. After all relevance and quality screening was completed, the review identified 32 relevant resources reporting on evidence-based approaches which could be utilized in the future engagement of youth organisations in prevention interventions in the field of alcohol policy. The results were analysed thematically and with reference to pre-specified aims and objectives of the review. The review focuses attention mostly on those practices which are already present in youth organisations, such as peer-led education, (media) advocacy, age or over-serving control, mystery shopping, school-

[1] **Evidence-based practices** are interventions that show consistent evidence of being related to preferred outcomes based on best available evidence. Evidence-based practices are defined as the integration of the best available research with expertise in the context of target group characteristics, culture, and preferences (adapted on the basis of EMCDDA online glossary) (http://www.emcdda.europa.eu/publications/glossary).

[2] **Good practice** refers to a well-described and feasible intervention that was found to be effective in accomplishing the set objectives, is theory based and has been evaluated positively by means of observational or qualitative studies. **Best practice** refers to a well-described and feasible intervention that was found to be effective in reducing alcohol-related harm and has been evaluated by means of quantitative studies.

based and community-based prevention, because it is more effective and meaningful to improve existing practices then starting from the scratch.

Conclusions: Youth organizations are often involved in preventive activities in the field of alcohol policy.The survey shows that several youth organisations are already involved in practicing effective prevention interventions in the field of alcohol policy which is a good starting point for the future developments in this field. There is a great and untapped potential in youth organizations to improve quality work in prevention (especially when it comes to multi-component approaches and/or coolaboration with other relevant stakeholders, such as authorities, health and social services, police etc.). The review of scientific literature and databases of good or best practices indicates that there are several evidence-based approaches in the field of prevention that are very appropriate for the implementation by youth organisations (e.g. advocacy and mystery shopping) and those interventions should be widely promoted and disseminated in the youth sector in the future.

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1. Introduction

Youth organisations[3] are often involved as providers or participants in various prevention interventions[4] in relation to alcohol policy and reduction of alcohol-related harm. This fact is very important, because alcohol consumption is especially problematic amongst youth and this

[3] **Youth organisations** include youth associations and/or youth networks, youth clubs, youth councils, student unions or other organisations of/for young people at international, national, regional and local level.

[4] **Prevention intervention** describes an activity that will be carried out in order to prevent substance use behaviour. Prevention interventions can be realised in different settings and with different methods and contents. The duration can vary between one-off activities and long-term projects running for several months or more (EMCDDA Glossary).

phenomenon causes increasing concern worldwide to policy makers, health and social services, law enforcement professionals, teachers, parents, youth workers etc. (WHO, 2014a). In many countries heavy episodic or binge drinking is prevalent amongst young people and presents an increased risk for accidents, violence, criminal activity, poorer health and social outcomes (Foxcroft & Tsertsvadze, 2011). Young people are responsible for a high proportion of alcohol-related burden (e.g. mortality, fights, unprotected sex etc.) (Anderson & Baumberg, 2006). Amongst young people, early initiation of alcohol use has been shown to be linked to later binge drinking, heavy drinking and alcohol-related problems (AMA, 2004). Therefore, it is very important that young people are also concerned about the situation and try to be active in the field of prevention in purpose to change this worring reality amongst their peers.

In recent study (by Gatti and colleagues, 2015) more similarities than differences with respect to alcohol drinking habits among young people across Europe were found. Northern- and Eastern-European adolescents show an alcohol affinity higher than adolescents from Western and Southern Europe. Frequent drinking is more common in Northern and Central European countries, while Northern and Eastern European Countries are leading with respect to drunkenness of lifetime users. Regarding heavy drinking, some remarkable differences for single countries (e.g. Finland, Portugal and Czech Republic) were indicated (Gatti et al., 2015).

Another recent study (by Soellner and colleagues, 2014) revealed that clear differences were observed between the various countries regarding youth drinking. Overall, 60.4% of the adolescents have been drinking beer, wine and breezers at least once in their lifetime and 34.2% have been drinking spirits. The last month prevalence rates are nearly half, respectively 28.1% and 13.5%. The prevalence rates for heavy episodic drinking are 28.1% for beer, wine and breezers and 13.5 % for spirits. These results are congruent with previous cross-national studies, such as the ESPAD study (Soellner et al., 2014).

When comparing the different countries, the following conclusions can be made according to above-mentioned study. The highest lifetime prevalence rates of alcohol use for beer, wine, and breezers were found among Eastern European countries, led by Estonia (85.7%), followed by Hungary (84.7%), Czech Republic (84.2%), and Lithuania (81.7%). The lowest prevalence rates for lifetime use was found in Iceland (21.6%), and Bosnia and Herzegovina (30.9%).The country ranking for last month prevalence of beer, wine & breezers differs only minimally with Hungary leading (45.9%), followed by Estonia (44.6%), and Denmark (39.8%). The rates for use during the last four weeks were lowest for Bosnia & Herzegovina (7.5%), followed by Iceland (9.3%). The country rankings were quite similar for spirits (Soellner et al., 2014).

The same study indicated high prevalence rates in heavy episodic drinking of beer, wine and breezers in mainly Northern, Western and Anglo-Saxon countries. The highest prevalence rates are observed in Ireland (26.1%), Finland (25.5%), Denmark (22.2%), the Netherlands (19.2%), and Germany (16.7%). Low prevalence rates are observed in Armenia (2.9%), France (3.9%), Iceland (4.4%), Bosnia and Herzegovina (4.9%) and in other countries that border the Mediterranean sea. The binge drinking prevalence rates for spirits are quite similar. The only exception now is that some countries that border the Baltic Sea (Estonia, 19.9%; Lithuania, 11.4%; and Poland, 11.9%) now complement Ireland (16.7%) and Denmark (15.2%) as the top ranking countries with the highest prevalence rates of heavy episodic drinking. The lowest rates of heavy episodic drinking (spirits) were found in Armenia (1.5%), Bosnia & Herzegovina (1.6%), and Iceland (1.6%). Gaining sound knowledge about youth drinking patterns across European countries could be helpful for assessing the relevance of effective alcohol policies and prevention approaches as well (Soellner et al., 2014).

Youth organisations are involved particularly in prevention activities in schools and communities at universal level (addressing entire population within a particular setting without any prior screening for risk factors). Most of those activities consist of informing (generally warning) young people (peers) about the effects or dangers of alcohol consumption. In school and community settings, prevention activities by youth organisatons typically take the form of alcohol awareness education, social and peer resistance skills, normative feedback, development of behavioural norms and positive peer affiliations (EMCDDA, 2014; Foxcroft et al., 2003). In many countries youth organisations are also involved in different environmental prevention strategies, such as public health advocacy activities (e.g. advocating for legislation changes regarding availability and affordability of alcohol to young people, advocating for alcohol advertisement or marketing bans, conducting mystery shopping actions, disclosuring immoral operations of industry etc.) (Burkhart, 2011; EMCDDA, 2014).

According to the survey conducted as a part of the project and past experience of most project partners (especially Alcohol Policy Youth Network), there is a great and untapped potential for inclusion of youth organisations in different effective prevention interventions as they could have strong and direct impact on effectiveness of alcohol policy in particular country (e.g. raising the price of alcohol, raising the minimum legal drinking age, increasing retailers liability on the consumption of alcohol, decreasing exposure to alcohol advertising etc.) (Shults et al., 2009). Furthermore, participation of youth organisation in such activities is even more valuable and effective if those interventions are based on multicomponent approaches which include a

combination of efforts by different stakeholders – usualy at local level (Shults et al., 2009). It means that youth is not only a target group (which often is the case), but equaly relevant and active stakeholder in community mobilisation partnerships like others (e.g. authorities, schools, health and social services, police officers, families, media etc.) (UNODC, 2013). Also media campaigns which are often used by youth organisations in the field of alcohol policy and are usually defined as ineffective prevention interventions in the literature could potentially be effective if they are combined with other effective prevention components (e.g. connection with other evidence-based prevention programmes in school, families, community and workplace) (UNODC, 2013).

This report aims to map alcohol-related prevention interventions in youth organisations. It aims to map youth organisations in Europe regarding their involvement or engagement in evidence-based and other alcohol-related practices and level of youth participation in those practices. This report also aims to review existing scientific evidence on effective interventions and approaches or good or best practices which are already used or could be used by interested youth organisations in the future. For the first time, the survey identifies a rather large group of sixty four youth organisations from Europe which are already involved in at least some prevention activities in the field of alcohol policy. The present list of youth organisations (see Annex 4) could be amended in the future according to the involvement of new organisations in this field.

4. Methodology

Firstly, in purpose to map alcohol-related prevention intervention in youth organisations, the project partners of the "Let it hAPYN!" project conducted a survey among youth organisations in the period from January and March 2014. We sent an email invitation to participate in the survey to more than 2.500 email addresses of youth organisations and youth workers across Europe. The emailing list was developed by the Alcohol Policy Youth Network (APYN) in previous years for the purposes of effective communication with youth organisations. As it was already mentioned in a previous section of this report, gaining sound knowledge about youth drinking patterns across European countries and (in addition) the present engagement of youth organisation in different prevention interventions and their knowledge and skills in the field of alcohol policy could significantly help in directing further developments in this field.

The survey was conducted on the basis of snowballing technique (sending an email and asking for further distribution and promotion among youth organisation at national level) as this method was the only feasible at that moment to get as many youth organisations in Europe as

possible to participate in the survey. Most of first phase recipients of survey invitation have been identified as a leading or very relevant youth organisations or organisations for young people in particular countries which are already involved in prevention activities (not only in the field of alcohol, but also with regards to other substances, such as tobacco or illicit drugs). Only organisations with at least some experience with prevention were included in the data collection and analysis. After sending them first invitation (in January 2014), additional two reminders were send to them by email in the period between January and March 2014 to increase the response rate among youth organisations. Some key countries are missing in the survey (e.g. Spain, Greece, Poland, Hungary, Luxembourg, Latvia etc.) although exceptional efforts were made by project partners to get youth organisations from all European countries involved in the survey.

The questionnaire (see Annex 1) contained questions on (a) organisational details (e.g. type of organisation, number of members, formal links with national coalitions in the field of alcohol policy, formal links with alcohol industry etc.), (b) involvement in prevention interventions (e.g. types of prevention interventions implemented by youth organisations and evaluation practice), (c) knowledge and skills in prevention (e.g. importance of particular knowledge and skills, current state-of-art regarding knowledge and skills) and (d) advocacy (e.g. types of advocacy actions, types of media actions etc.).

In addition, a comprehensive search strategy was employed to identify the relevant literature. The following electronic databases were searched: Google Scholar, MEDLINE/PubMed, EBSCO, Cochrane, ERIC, PsycINFO, ScienceDirect, Science Citation Index, SpringerLink and several others. »Grey literature« and the journals not indexed in the above databases were searched comprehensively through specialist prevention-related websites. Several best practice web databases were searched as well: the EMCDDA Best practice portal, the SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) and the Blueprints for Healthy Youth Development database. The main search terms included: prevention interventions, youth organisations (all types), alcohol policy, peer-led education/training, peer interventions, age control, over-serving, mystery shopping, (media) advocacy, school-based prevention and community-based prevention. More than 500 search results were found (such as scientific articles, systematic and literature reviews, good or best practice descriptions, publications, guidelines and recommendations etc.) and they were additionally assessed for the inclusion in the futher evaluation and analysis.

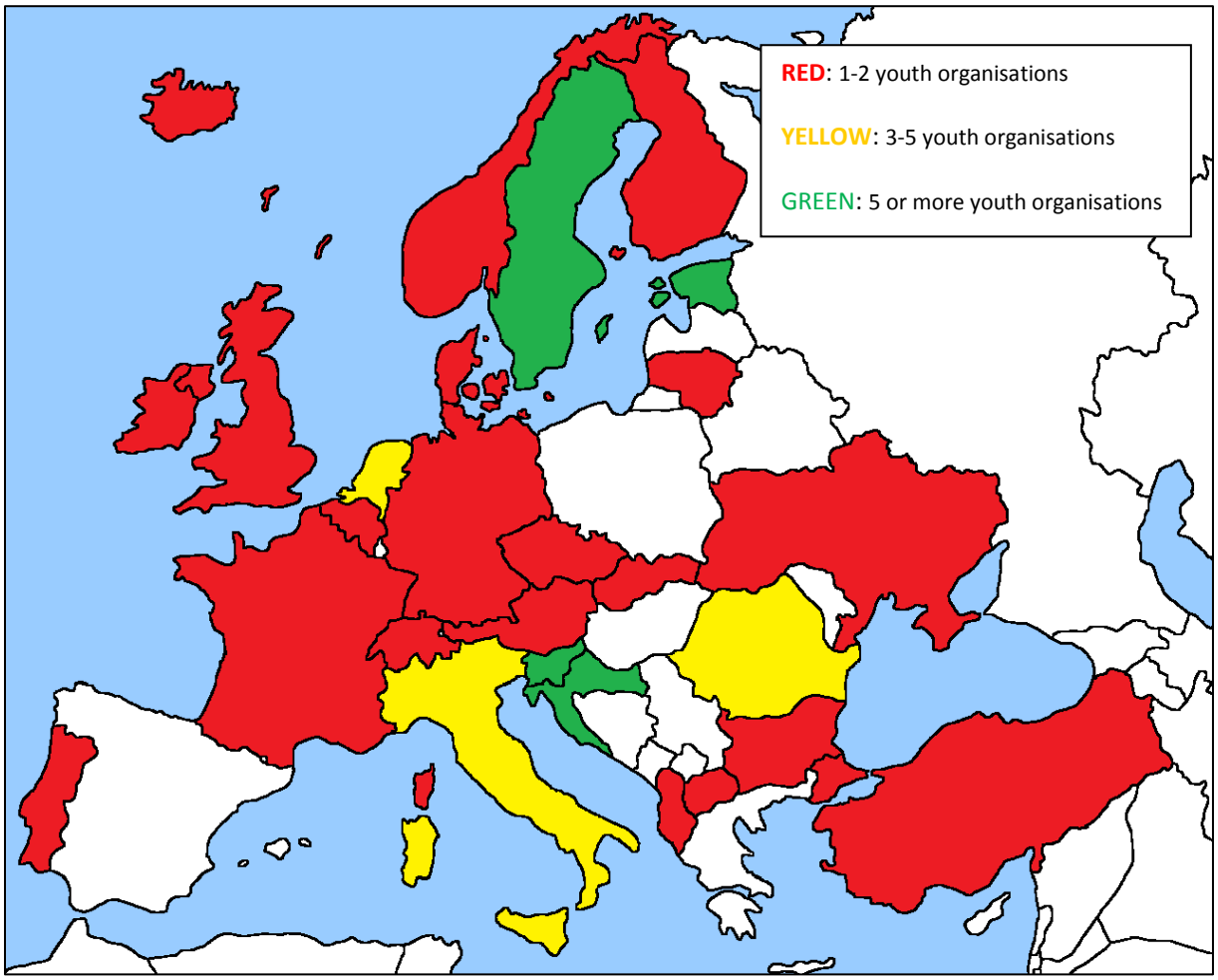
Only English literature was included and there was no year limit. Literature for possible inclusion was identified according to the search strategy described, and abstracts and summaries obtained. The authors evaluated independently each abstract or summary against inclusion criteria, which included direct engagement of young people or youth organisation in the prevention intervention implementation, feasibility of implementation by youth organisations and at least some evidence of possible effectiveness in practice. We have focused our assessment in those studies and research which clearly shows what work and what does not work in prevention in the field of alcohol policy. A significant number of abstracts and summaries (more than 280) were excluded because they were not within the aims and scope of the review and project aims. Most of excluded results focus on prevention interventions and approaches which try to engage young people as participants and not as facilitators or implementers of activities. Despite the limitations placed on the review by the chosen criteria and focus, the literature is still vast (more than 220 articles and other publications). According to the relevance only 36 articles, publications or other resources were selected for further analysis and used in this review.

3. Youth organisations in Europe and their involvement in prevention

General information on sample

Sixty seven organisations have participated in the survey at the beginning of 2014 (see full report in Annex 2). They originated from 25 European and 2 non-European countries. The most represented countries are Slovenia, Croatia, Sweden and Estonia. The most common types of youth organisations participated in the survey were youth (umbrella) organisations at national level (20) and regional/local level (13), followed by youth councils at national level (8). Some other types of youth organisations include youth associations, youth clubs, international youth or student organisations, youth charities, youth wing of political parties etc.

Figure 1 – Map of participating European countries and number of youth organisatons by country



Almost half of the surveyed organisations (48.4%) have more than 100 members, 16.1% of them have between 51 and 100 members, 17.7% of them have between 21 and 50 members and the rest (17.7%) have up to 20 members. If we look at the distribution of the organisations by the number of active members (e.g. actively involved in activities and interventions as providers, facilitators, trainers etc.), we notice that the largest amount (32.3%) have up to 20 active members, 30.6% of them have more than 100 active members, 14.5% of them have between 51 and 100 active members and the rest (22.6%) have between 21 and 50 active members.

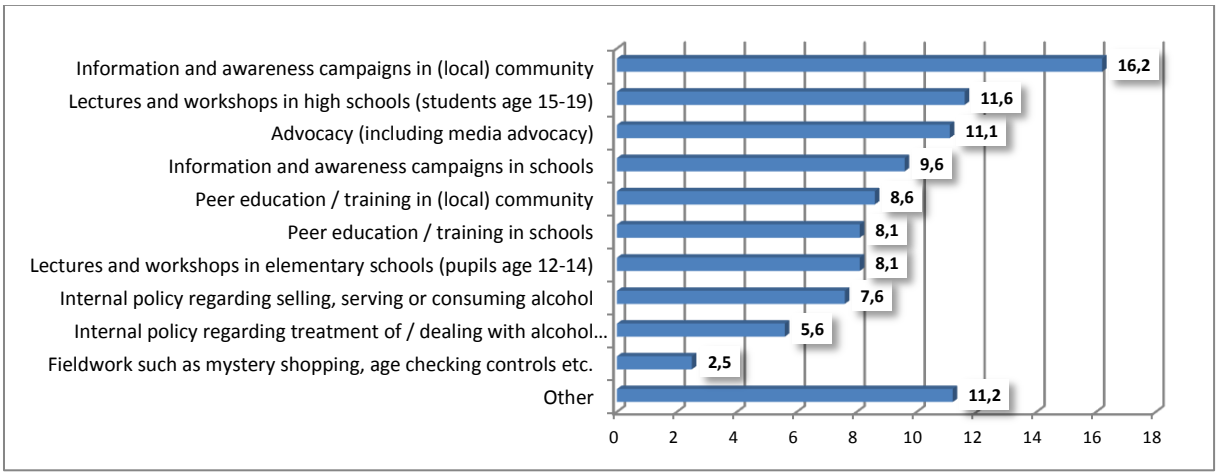
Only 22% of surveyed organisations have some formal links with national coalitions in the field of alcohol policy, such as national forums on alcohol and health, alcohol or drug policy commissions, interministerial working groups and similar. Only 27% of surveyed organisations have some formal links with European or international coalitions in the field of alcohol policy, such as Alcohol Policy Youth Network, European Alcohol and Health Forum, Global Alcohol Policy Alliance, Eurocare, Active, IOGT International, Nordic Alcohol and Drug Policy Network

etc. Only one organisation from Austria has also a formal link with business company or business related organisation in the field of alcohol. More than half of the surveyed organisations are specialised in particular profession, such as medicine, public health, psychology, social work, youth mobility, mental health, education, deaf/hearing impaired youth, addictions etc.

Involvement in prevention interventions in the field of alcohol

Of the surveyed organisations 30.2% of them are involved in prevention interventions in the field of alcohol as leading organisations, another 11.1% of them are leaders and also partners in such interventions. 27% of them take part in interventions only as partners. The largest group (31.7%) represents the organisations with no involvement in such activities. The most popular types of prevention interventions conducted by organisations in our sample are activities such as information and awareness campaigns (25.8%), lectures and workshops (19.7%) and peer education or training (16.7%). One other popular prevention intervention is advocacy (including media advocacy) which are conducted by 11.1% of surveyed organisations. There not so many organisations which have internal policies regarding selling alcohol, dealing with alcohol problems or treatment of and dealing with alcohol problems. The least popular among listed prevention interventions is fieldwork, such as mystery shopping, age checking controls etc. (see Figure 2). Respondents have also listed prevention interventions, such as low-threshold centre for children and youth, national coordination activities, working with law enforcement etc.

Figure 2: What type of prevention interventions your organisation implements? (in %)



Evaluation of prevention interventions in youth organisations

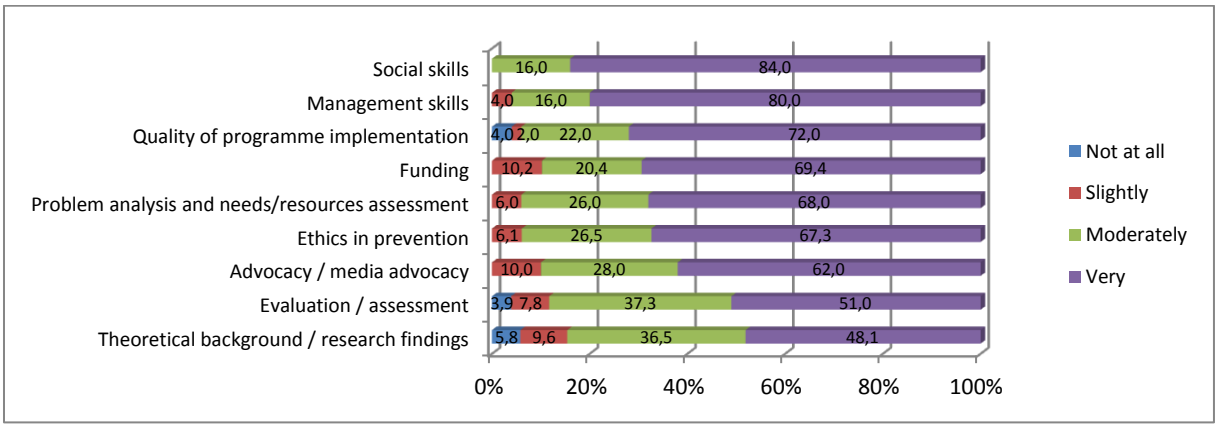
The majority (74%) of organisations conduct at least some evaluation of their past prevention activities. But still 26% of them have no evaluation. Only 16% of organizations perform both process and outcome/impact evaluation. Process evaluation is conducted by 38% and outcome/impact evaluation by 20% of surveyed organisations.

From the results we can see that number of active members have no clear influence on the evaluation of intervention prevention programmes. While it would be logical to assume that the organisations with more active members would have more easily and so more likely conducted evaluation of their programmes. That seems not to be the case. Organisations with links to national, European or international coalitions have higher likelihood to evaluate their programmes. Organisations specialised in certain field have also higher likelihood to evaluate their programmes.

Knowledge and skills related to quality of prevention interventions in youth organisations

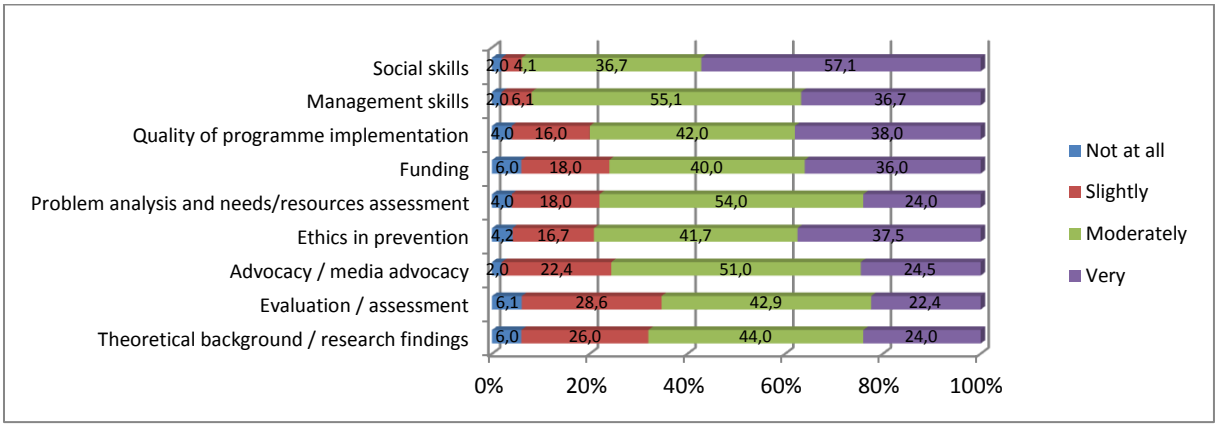
Social skills are the most important skills that youth worker needs in opinion of the organisations. The vast majority (84%) believe that social skills are very important, the rest have said that they are moderately important. Among most important skills are also management skills, quality of programme implementation and funding. All in all we can see that organizations believe that all mentioned skills and knowledge are important. The least important is the knowledge of theoretical background and research findings, followed by evaluation/assessment skills (see Figure 3).

Figure 3: Importance of particular knowledge/skills for youth workers in your institution? (in %)



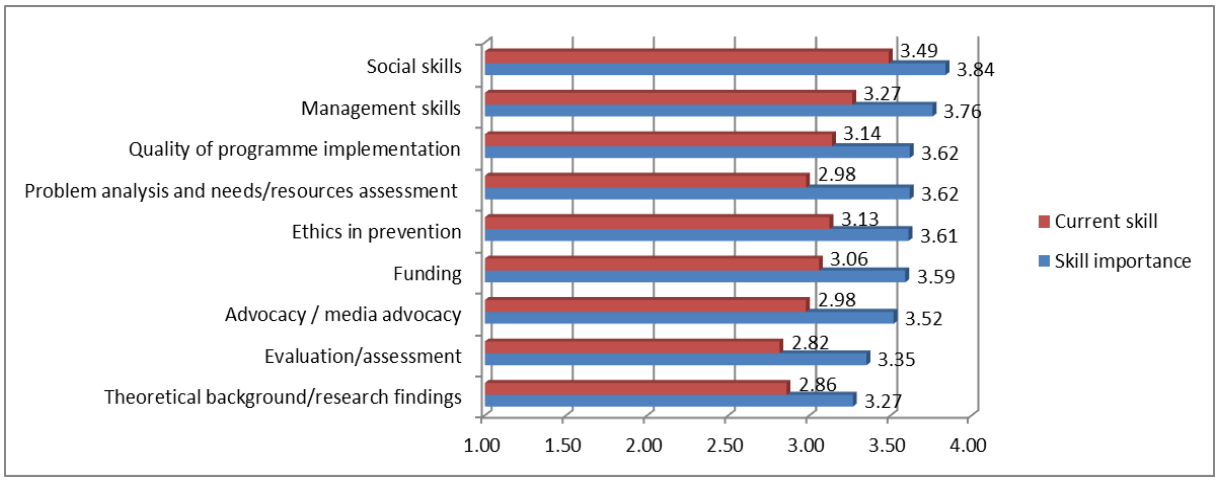
If we look at what youth organisations think about how adequately their people are currently prepared for work in prevention regarding particular knowledge/skills, we can notice that social skills are the most developed in surveyed organisations. Knowledge or skills regarding quality of programme implementation, ethics in prevention, management skills and funding are also relatively well developed. Other skills and knowledge are less developed in youth organisations (see Figure 4). If we compare both figures (Figure 3 and Figure 4) we can notice that there is a huge potential for improvements regarding all mentioned knowledge and skills including most developed social skills which would lead to more quality prevention work in youth organisations.

Figure 4: How adequately the people in youth organisations are currently prepared for work within prevention regarding particular knowledge/skills? (in %)



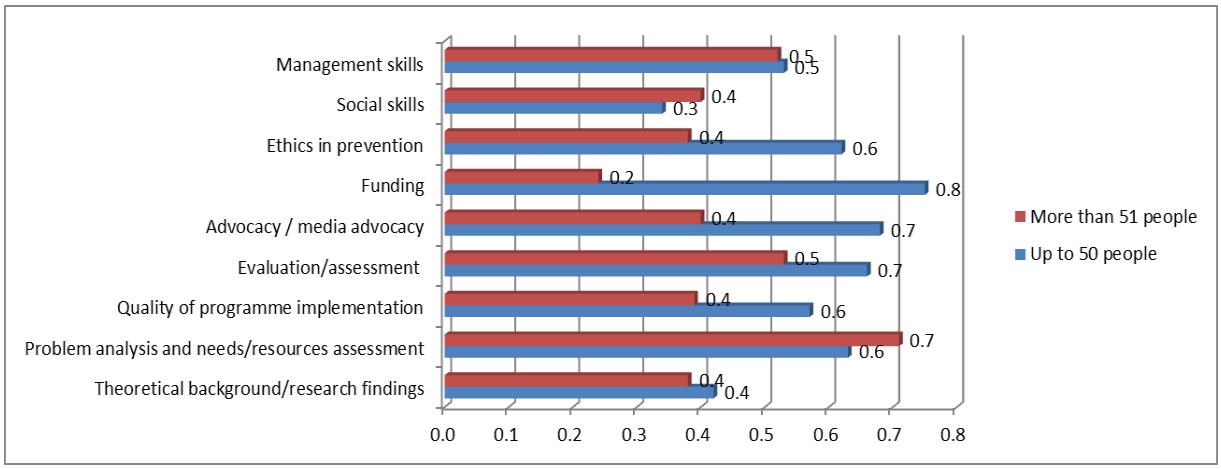
We have scored previous answers on a scale from 1 to 4 and calculated the means. We can see that in every category current skills more or less in equal measure lag that same skills prescribed importance by the surveyed organisations (see Figure 5). The gap is the largest in the category of problem analysis and need/resources assessment and smallest in the category of social skills.

Figure 5: Comparison between current skills and the importance of those skills in youth organisations



The results also show that organisations with less active members have in general larger skills/knowledge deficit in comparison to organisations with more active members. The result was expected since more members logically mean more vast and diverse skills/knowledge pool to draw from. The difference shows itself most in categories such as funding, ethics in prevention and quality of programme implementation in that order by magnitude respectively (see Figure 6).

Figure 6: Comparison between current skills and the importance by the number of active members



Advocacy actions in youth organisations

The majority of organisations (68%) preform some form of advocacy actions. If we look at how organisations influence alcohol-related governmental actions, we see that more than a quarter (28%) of their advocacy actions target policy-making process, 25% target policy changes and

17% focus on decision-making process. Another 14% of advocacy actions are focused on influencing policy implementation. The least frequent (12%) are advocacy actions that focus on influencing strategies and international policy process. The most popular form of media advocacy is posting on the websites (28%), followed by posts in new media (26%). Another 18% of media advocacy actions consist of press releases. Less often used are interviews/talk shows (14%), letters to editors (10%) and press conferences (5%). Other forms of media advocacy mentioned were position papers and consultations.

3. What is an evidence for most popular prevention interventions in youth organisations (review)?

Although World Health Organisation (WHO) promotes so-called "best buys" in alcohol policy which include only policy measures, such as raising taxes on alcohol, restricting access to retailed alcohol and enforcing bans on alcohol advertising (WHO, 2014b), there are several prevention interventions not directly related to policies which could be classified as effective and evidence-based approaches as well and could be easily utilized by youth organisations in Europe. The purpose of the review of all relevant scientific resources and databases was to identify those interventions which are already present and some of them also rather popular among youth organisations according to the survey and assess their potential effectiveness and feasibility in practice in the European context. The review also gives solid background scientific information of presented approaches which could help in promotion and dissemination purposes. The project will (at the later stages) test some of those approaches as pilots in different settings and countries and recommend selected approaches for further implementation in youth sector in the field of alcohol policy.

Peer-led education / peer-led training

Peer-led education (or peer-led training) is very common and popular form of prevention interventions in youth organisations according to our survey and literature. Peer-led education approaches involve the recruitment and training of peer educators to deliver interventions in a variety of settings including schools, youth organisations, youth clubs etc. Peer-led education is often delivered in conjunction with teacher-led school-based prevention interventions (Cuijpers, 2002; Cairns et al., 2011).

Advantages of peer educators in such interventions include particulary (a) communication in a youth-friendly style, (b) sharing challenges, interests and experiences of the youth, (c) better understanding of youth situation than teachers or other (mostly external) prevention workers, (d) better level of trust and comfort with their peers for more open discussions of sensitive topics such as health, and (e) better access to hidden populations (Jaworski et al., 2013; Medley et al., 2009). Peer-led education has value for the peer educators themselves as well, especially by increasing their skills in communication and organisation, knowledge about health and teaching experience. It improves their job opportunities, eligibility for higher education and personal healthy lifestyle. Peer-led education also has limitations, especially lack of training and

experience in comparison with professional prevention educators (Jaworski et al., 2013; Medley et al., 2009).

Evidence on the effectiveness of peer-led health education is rare, especially there is no evidence regarding relationship between such an approach and improved behavioural outcomes in youth (Jaworski et al., 2013; Medley et al., 2009; Martin et al., 2013; Cairns et al., 2011; Simoni et al., 2011). There is some evidence that peer-to-peer delivery is more effective when combined with peer driven planning and other techniques aimed at deeper engagement with target audiences (including design, development and implementation) (Cairns et al., 2011; Anderson & Baumberg, 2006). There is also some evidence that the interactive nature of peer-to-peer delivery is a key benefit (rather than the peer delivery per se), but this requires expert facilitation and guidance, as well as rigorous evaluation to ensure that impacts are as intended and positive (Cairns et al., 2011; Black et al., 1998).

Age control / over-serving

Availability is an important predictor of early and excessive alcohol consumption by adolescents. Many countries have implemented age limits to prevent underage purchases of alcohol (Gosselt et al., 2012). The age limit varies across countries (18 years in most of European countries, 16 in Denmark and the Netherlands, 21 in the United States etc.). Minimum legal drinking age per se may reduce the extent of alcohol-related harm among youth, but even if there is an age limit there is still a considerable proportion of minors who can get alcohol very easily and drink heavily (Rossow et al., 2008; Gosselt et al., 2007). For example, research in the Netherlands shows that 90 % of the 15-year-old adolescents have had experience with drinking alcoholic beverages, and that 52 % drink alcohol on a weekly basis. Almost 20 % of the male and 10 % of the female 15-year-old adolescents drink more than 10 glasses of alcohol on an average weekend day, and 63 % of the 15-year-olds report to have been drunk at least once in their lives (Warpenius et al., 2010).

It is known from the evidence that multi-component community-based interventions (such as Responsible Beverage Service (RBS) in Nordic countries) can have a significant impact on over-serving of alcohol when training of servers (especially if mandatory) and house policies are combined with effective law enforcement (e.g. licencing control or control on consistency in law implementation) and active inclusion of health and social sectors. Such community mobilization approaches are also promising if they target high-risk drinking contexts and community level policy processes and if they include (media) advocacy actions (Warpenius et al., 2010, UNODC, 2013). Evidence also shows that age limits, set out in regulations (which often differ between

countries and even between products) are effective only when compliance with these rules is sufficient. Legal age restrictions without enforcement and facilitation clearly do not suffice to protect adolescents from early exposure to alcohol (Gosselt et al., 2007; Gosselt et al., 2012). Another problem might be that many salespeople are young and part-time workers (e.g. students) with a high turnover and they may therefore be less willing and committed to implement age checking (Rossow et al., 2008).

In some countries (e.g. Netherlands) mystery shopping is rather often used as an effective way of measuring alcohol age compliance. Due to legal or ethical reasons mystery shoppers are sometimes pseudo-underage buyers (younger-looking mystery shoppers who have reached the legal age to buy alcohol), but the results are found to be much better if researchers or authorities work with real underage mystery shoppers. Mystery shopping is often combined with adolescents' self-reports and self-reports of store managers or vendors (Gosselt et al., 2007; Gosselt, 2011).

Advocacy / media advocacy

Advocacy is often very effective way of influencing policy- and decision-making processes with the aim of developing, establishing or changing policies and practices and of establishing and sustaining programmes and services. Advocacy can include many activities that a person or organisation undertakes including media campaigns, public speaking, commissioning and publishing research or polls etc. Advocacy has the potential to shape or change policy in a way that can impact the health of thousands, if not millions, of people. History shows that public health advocacy works (e.g. changes in policies or regulations in the field of tobacco and traffic accidents). Some of the most well-known public health advocacy examples include youth involvement in tobacco and (recently) alcohol prevention and control (Thackeray et al., 2010; Casswell & Thamarangsi, 2009). Strategic media advocacy seems to be one of very effective environmental-focused intervention strategies in purpose to increase public awareness of the problems associated with underage drinking and to increase public awareness of, and support for, the interventions (Flewelling et al., 2013).

Most of the time public health educators are confronted by challenging arguments from alcohol industry. For example, industry insists that most people drink responsibly and that the companies should not be blamed if some people abuse their products. Public health educators often struggle to respond to such arguments (Dorfman et al., 2005). In those cases, there is a

plenty of strong evidence against industry produced by different institutions such as WHO, European Commission and several relevant international scientific groups which can be used by public health educators.

Young people are part of the community and can become part of the solution to alcohol-related problems as well. Providing opportunities for youth to successfully participate in social change, giving them a voice, and be involved in civic affairs may develop a generation of youth who carry these skills into adulthood. Armed with advocacy skills and empowered by previous successful experience, these youth may become adults who are involved in larger policy-based decisions that will address the social determinants of health. Furthermore, being involved in advocacy is likely to influence their health-related attitudes, beliefs, options, and behaviors (Winkleby et al., 2004). In addition, people are more likely to be involved in a cause when they are recruited by close friends and other activists. Being part of a network of family and friends who are already involved in the cause is also a predictor of personal involvement (Passy & Giugni, 2001; Thackeray & Hunter, 2010).

Interactive and structured school-based prevention programmes

According to many studies, interactive and structured (typically 10-15 sessions once a week) school-based programmes can prevent substance use. Such programmes develop personal and social skills (coping, decision making and resistance skills) and discuss social influences (social norms, expectations, normative beliefs) related to drug use. They can also prevent other problem behaviours such as dropping out of school and truancy. Most evidence is on universal programmes, but there is evidence that universal skills based education can be preventive also among high risk groups. These programmes are typically delivered by trained facilitators, mostly teachers, but also trained peers. However, also programmes delivered through computers or the internet can reduce substance abuse (UNODC, 2013).

Prevention programmes or interventions in general using non-interactive methods, such as lecturing, as a primary delivery strategy and information-giving alone approach (particularly scare tactics or fear arousal) has no or even negative prevention outcomes. Many prevention practitioners (including youth organisations) often use unstructured dialogue sessions as a delivery strategy as well (e.g. discussing negative effects of alcohol, tobacco or illicit drugs), which is also linked to no or negative outcomes. Several other characteristics are also typical for ineffective prevention strategies, such as focusing only on the building of self-esteem and emotional education, addressing only ethical or moral decision making or values, using ex-drug

users or alcoholics as testimonials and using police officers to deliver the programme (UNODC, 2013; Tobler & Stratton, 1997; Botvin & Botvin, 1992).

Other interventions

Internal policies or rules within youth organisations (similar to school policies) may reduce substance use among their leaders, staff, members or volunteers and discourage negative behaviours. Such policies usually mandate that substances should not be used on youth organisation premises and during activities. They (especially if developed with the involvement of leaders, staff, members or volunteers) also create transparent and non-punitive mechanisms to address incidents of use transforming it into an educational and health promoting opportunity. Furthermore, internal policies and practices may enhance youth participation, positive bonding and commitment to youth organisation. They also may include substance use cessation support, referral to treatment or other care and brief interventions (e.g. to moderate effect size in reducing drinking quantities) as selective prevention approach. They are typically implemented jointly with other prevention interventions, such as skills based education (UNODC, 2013).

Some other prevention approaches have been shown to have minimal impact on changing substance-using behaviour or even being counter-productive, but remain popular and are considered effective. Furthermore, there are very few implementers who really use effective content delivery (e.g. how programmes are delivered, by whom, to whom, where etc.) (Ennett, 2003). The most popular ineffective prevention strategies include one-off programmes (e.g. one or two- hour lectures and workshops to large audiences), didactic or one-way lectures, providing factual information on the harm caused by drugs, extolling non-use, and seeking commitment for non-use, resistance skills programmes preparing students to face peer-pressure and to "just say no" to drugs. (UNODC, 2013; Gorman, 2003; Hawthorne et al., 1995; Clayton, 1996).

Discussion

Youth organisations have to take into account available scientific evidence and quality standards that give very clear instructions about what works and what does not in prevention. Authorities and youth organisations themselves have to invest in quality prevention and disinvest from activities for which there is no or very little evidence of effectiveness, and develop training or

education to overcome the lack of knowledge and skills. There is no need to change such non- or counter-effective prevention practices overnight, but the leaders and the trainers are responsible to incorporate quality standards and effective components into prevention interventions step-by-step. There is evidence that many youth organisations in Europe already use effective practices, such as mystery shopping and advocacy. It means that those practices should be promoted and disseminated in other youth organisations as well. There is also evidence that several youth organisations are involved in multi-component approaches at local level and/or coolaborate with other relevant stakeholders, such as national, regional or local authorities, health and social services and police which very likely leads to better results of their activities in policies and practice. With improved knowledge and skills regarding quality evidence-based prevention and minimum quality standards in general, youth organisations could become even more influential and respected stakeholders in the community at all levels.

Limitations

There are some limitations in this review, especially regarding the survey among youth organisations. There are some key country missing in the survey, such as Spain, Greece, Poland, Hungary, Luxembourg and Latvia. But still, there was a significant number of youth organisations (67) involved in the online survey and their list represents the first such list of youth organisations in Europe with regards to involvement in alcohol-related prevention interventions. Furthermore, there are rather large number of scientific articles, studies, reviews and other publications which were not included in our review and are strongly related to some of the addressed topics in this report. On the basis of presented search strategy we are confident that the most relevant references were selected, especially systematic and literature reviews and guidelines and recommendations which already consist the most important findings and conclusions from extensive list of sourses and references, including scientific literature and key publications by UNODC, EMCDDA, WHO, UNAIDS etc.

Conclusions

Youth organizations are often involved in preventive activities in the field of alcohol policy, mainly in schools and local communities. Alcohol consumption among young people is one of those topics for which the interest of the professionals and the public in the world is increasing, so it is very important that young people are worried about this and are actively involved by themselves within youth organisations.

The **key findings from the survey** among youth organisations which could be used in the future improvements and developments in the field of alcohol policy in youth sector are as follows:

- Less than one fifth of surveyed organisations have some formal **links with national coalitions** and a little bit more than one quarter of surveyed organisations have some formal links with **European or international coalitions** in the field of alcohol policy which should be improved in the forthcoming years with a help of quality promotion and dissemination plan.

- More than two thirds of the surveyed organisations are involved in **prevention interventions in the field of alcohol** which is rather good proportion and shows interest of youth organisation to work in this field. There are still many of surveyed organisations (about one third) which are not involved in such activities.

- The most popular **types of prevention interventions** in youth organisations are activities such as information and awareness campaigns, lectures and workshops, peer education or training and advocacy. There are not many organisations which are involved in some recommended evidence-based and effective prevention interventions, such as internal policies mystery shopping and other age checking controls.

- About three quarters of surveyed youth organisations conducted at least some **evaluation** of their past prevention activities (mostly process and very little outcome evaluation) and about one quarter of them have no evaluation.

- The survey also shows that there is a huge potential for improvements regarding all mentioned **knowledge and skills** (which are necessary for quality prevention work) including most developed social skills. The improvements (e.g. trainings) in this area would lead to more quality prevention work in youth organisations.

Several **evidence-based practices** were assessed in the review and are recommended for implementation in youth organisations:

- **Peer-led education / peer-led training**: We have found nine relevant references regarding this topic which give us rather clear picture about scientific evidence and effectiveness of such approach (Cuijpers, 2002; Cairns et al., 2011; Jaworski et al., 2013; Medley et al., 2009; Martin et al., 2013; Cairns et al., 2011; Simoni et al., 2011; Anderson

& Baumberg, 2006; Black et al., 1998). Those interventions are very popular among youth organisations according to our survey, but there is very rare scientific evidence of effectiveness of such interventions. There is no evidence regarding the relationship between this approach and improving behaviour among young people. There is some evidence when this approach is combined with the methods through which young people are professionally guided and involved in the planning, design, development and implementation of interventions. Interactivity itself increases effectiveness as well.

- **Age control / over-serving**: We have found six key references regarding this topic which give us substantial scientific evidence and support the effectiveness of such approach (Gosselt et al., 2007; Gosselt, 2011; Gosselt et al., 2012; Rossow et al., 2008; Warpenius et al., 2010; UNODC, 2013). Multi-component interventions aimed at community have a significantly greater impact, especially in combination with the training of staff in nightlife venues, effective supervision by the competent institutions, active involvement of health and social services, and (media) advocacy. Interventions such as mystery shopping seem to be very effective according to the scientific evidence, particularly in cooperation with the supervisory or law enforcement institutions.

- **Advocacy / media advocacy**: We have found seven key references regarding advocacy which clearly support the effectiveness of such approach in youth organisations (Thackeray et al., 2010; Casswell & Thamarangsi, 2009; Flewelling et al., 2013; Dorfman et al., 2005; Passy & Giugni, 2001; Thackeray & Hunter, 2010; Winkleby et al., 2004). Advocacy is very often effective approach by youth organisations in influencing public health-related policy-making and decision-making processes (e.g. tobacco and alcohol policy). Positive effects on young people's own behaviour, norms and attitudes are also achieved simply by their active involvement in advocacy activities.

- **Interactive and structured school-based prevention programmes**: We have found three most relevant references which give us very clear answers regarding school-based prevention programmes (UNODC, 2013; Tobler & Stratton, 1997; Botvin & Botvin, 1992). Especially the publication on prevention standards published in 2013 by United Nations Office for Drugs and Crime (UNODC) gathers all the most relevant resources in this field, thus it is the best and most valuable reference itself for this review. Interventions which include interactivity, structured lessons (10-15) once a week (plus a »booster«), qualified or trained facilitators, skills training, emphasizing short-term effects of substance use and normative education seem to be effective as well.

- **Other interventions**: There are several other evidence-based and effective prevention practices according to the international prevention standards by UNODC (UNODC, 2013). In relation to youth organisations, the internal alcohol-related policies seem to be effective (e.g. ban on alcohol consumption and intake at the events of the organisation).

- **Ineffective practices which should be avoided by youth organisations**: There is rather strong evidence what does not work in prevention which includes one-off lectures or workshops, scare tactics or fear arousal, unstructured interventions, one-way debates, interventions based only on delivering information on the harmful consequences of substance use, self-esteem only approaches, moralizing, using ex-drug users or alcoholics' testimonials and police officers as facilitators etc. Several other ineffective approaches should be avoided by youth organisations as well, especially those based on »say no to alcohol or other drugs« approaches. The best reference which was used in our review regarding ineffective prevention practices was above-mentioned publication on prevention standards by UNODC (UNODC, 2013). Additionally, four more relevant references were used in our review (Ennett, 2003; Gorman, 2003; Hawthorne et al., 1995; Clayton, 1996).

In summary, there is a great potential in youth organizations for quality work in prevention. It is highly recommended that youth organisations are involved in multi-component approaches at local level and/or coolaborate with other relevant stakeholders, such as national, regional or local authorities, health and social services and police. Youth organisations have to take into account available scientific evidence and minimum quality standards that give very clear instructions about what works and what does not in prevention.

Authorities at all levels and youth organisations themselves have to invest in quality prevention and disinvest from activities for which there is no or very little evidence of effectiveness, and develop training and education programmes to overcome the lack of knowledge and skills in youth organisations with regard to quality implementation and evaluation of prevention interventions. This process is impossible to carry out overnight, but we need to lay the foundations on which the situation in this area will change for the better in the forthcoming years.

On the basis of national pilot implementations of good or best practices at later stages of the project, a practical manual on how to implement quality prevention interventions in the field of

alcohol policy will be developed by project consortium and disseminated at the final dissemination event (conference).

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Annex 1 - Mapping Alcohol-Related Prevention Interventions in Youth Organisations (questionnaire)

Mapping Alcohol-Related Prevention Interventions in Youth Organisations

Let it hAPYN! Project has been funded by the European Commission's Health Programme (2008-2013) to empower youth sector with a better overview of evidence-based alcohol interventions or programmes. Among other objectives the project aims to develop an inventory of evidence-based alcohol intervention programmes and other practices focusing on young people. The project also aims to map youth organisations in Europe regarding their involvement in evidence-based alcohol practices by type of organisation (youth organisations, youth clubs, youth councils, student unions or other organisations of/for young people) and level of young people's participation in those practices.

The project is leaded by the Alcohol Policy Youth Network (APYN). APYN is a network of youth organisations that work towards the prevention and reduction of alcohol-related harm. APYN develops and supports effective alcohol policy to assure healthy lifestyles and environments for young people. We do this through building capacity of youth organizations on: (a) research on young people and alcohol; (b) advocacy of alcohol policy and (c) maintenance or change of attitudes and behaviours that would improve young people's welbeing. Other partners in the project are: Institute Utrip (Slovenia), STAP (Netherlands) and Eurocare (Belgium).

By prevention interventions, we mean all interventions, policies and activities in purpose to decrease risky and harmful drinking of alcohol among youth, to postpone initiation to alcohol use, contribute to the health, safety and well-being of each individual, promote healthy behaviour, personal and social confidence and competence, and reflect evidence-based approaches that have shown to be effective.

Your institution has been identified as a leading or very relevant youth organisation in your country. Please can you complete this questionnaire telling us about your work in the alcohol-related field. The information you provide will be used in a register of prevention activities by youth organisations across Europe to be displayed on the APYN website (www.apyn.org), and linked to from www.letithapyn.eu. Your organization will receive advice from project partners regarding future prevention intervention planning and will be invited to participate on trainings and conference.

The questionnaire is in English. If you can, please provide your answers in English. If you need any help with understanding the requirements and/or the questionnaire, then please contact us (info@institut-utrip.si). We advise that one person within organisation who is responsible for prevention interventions fulfil the questionnaire. The deadline for fulfilled questionnaire is **Tuesday, 24th of December 2013**.

Please circulate this questionnaire to your collaborators and colleagues in the youth sector in your country, especially those working in the field of alcohol policy and prevention.

SECTION 1: Organisation details

General information:

1. Organisation:
2. Department (if applicable):
3. Address:
4. Country:
5. Email:
6. Website:
7. Telephone number:
8. Contact person:

What sort of youth organisation is your organisation?

1. Youth (umbrella) organisation at international level
2. Youth (umbrella) organisation at national level
3. Youth (umbrella) organisation at regional/local level
4. Youth council at international level
5. Youth council at national level
6. Youth council at regional/local level
7. Student union at international level
8. Student union at national level
9. Student union at regional/local level
10. Youth club
11. Other (please, specify): _____

What is the overall number of members in your organisation?

1. Up to 20 people
2. 21 to 50 people
3. 51 to 100 people
4. More than 101 people

What is the number of active members in your organisation?

1. Up to 20 people
2. 21 to 50 people
3. 51 to 100 people
4. More than 101 people

Does your organisation have any formal links with national coalition in the field of alcohol policy, such as interministerial council, governmental commission / committee or similar?

1. Yes
2. No

If yes, name this coalition (in English): _____

Does your organisation have any formal links with European or other international coalitions in the field of alcohol policy, such as Eurocare, Alcohol Policy Network, Alcohol Policy Youth Network etc.

1. Yes
2. No

If yes, which (please, specify): _____

Does you organisation have any formal links with business company or business-related organisation (e.g. alcohol industry or non-profit organisation established by alcohol industry or similar)?

1. Yes
2. No

If yes, which (please, specify): _____

Is your organisation specialized in particular profession, such as medicine, psychology, social work, youth mobility, mental health etc.?

If yes, which (please, specify): _____

SECTION 2: Prevention interventions in youth organisations

Is your youth organisation involved in any prevention intervention in the field of alcohol?

1. Yes, as leaders
2. Yes, as partners
3. No

What type of prevention interventions your organisation implements? *(select all that apply)*

1. Lectures and workshops in elementary schools (pupils age 12-14)
2. Lectures and workshops in high schools (students age 15-19)
3. Information and awareness campaigns in schools
4. Information and awareness campaigns in (local) community
5. Peer education / training in schools
6. Peer education / training in (local) community
7. Advocacy (including media advocacy)
8. Fieldwork such as mystery shopping, age checking controls etc.
9. Responsible beverage service training of staff in retail industry (e.g. bars, clubs)
10. We have an internal policy regarding selling, serving or consuming alcohol
11. We have an internal policy regarding the treatment of / dealing with alcohol problems
12. Others (write): _____

Please, describe shortly your prevention interventions or policy in the field of alcohol (not more than 5 lines for each prevention intervention or policy). Please, attach specific materials if you use them as a part of your intervention or policy (including house rules or internal policy).

Does your organisation evaluate prevention interventions?

1. Yes, process evaluation (e.g. satisfaction with intervention, realisation of all activities etc.)
2. Yes, outcome/impact evaluation (e.g. changes in attitudes and behaviour, pre-post tests)
3. No

SECTION 3: Knowledge and skills in prevention

How important do you find knowledge/skills in these areas (below) for youth workers in your institution?

	NOT AT ALL	SLIGHTLY	MODERATELY	VERY
Theoretical background/research findings (e.g. epidemiology, behavioral science, psychology etc.)				
Problem analysis and needs/resources assessment (e.g. knowing the problem, needs and resources)				
Quality of programme implementation (e.g. quality of program delivery, training for delivery)				
Evaluation/assessment (e.g. research and methodology skills)				
Advocacy / media advocacy (e.g. influence on policy development and youth sector funding)				
Funding (e.g. knowing opportunities for funding)				
Ethics in prevention (e.g. gender or culture issues)				
Social skills (e.g. communication, team work, collaboration and networking)				
Management skills (e.g. building and maintaining team, motivating people)				

How adequately do you feel that the people in your organisation are currently prepared for work within prevention regarding this areas?

	NOT AT ALL	SLIGHTLY	MODERATELY	VERY
Theoretical background/research findings (e.g. epidemiology, behavioral science, psychology etc.)				
Problem analysis and needs/resources assessment (e.g. knowing the problem, needs and resources)				
Quality of programme implementation (e.g. quality of program delivery, training for delivery)				
Evaluation/assessment (e.g. research and methodology skills)				
Advocacy / media advocacy (e.g. influence on policy development and youth sector funding)				
Funding (e.g. knowing opportunities for funding)				
Ethics in prevention (e.g. gender or culture issues)				

Social skills (e.g. communication, team work, collaboration and networking)				
Management skills (e.g. building and maintaining team, motivating people)				

SECTION 4: Advocacy

What kind of advocacy actions does your organisation implement?

1. Influencing alcohol-related policy-making process (e.g. at the ministries, municipalities)
2. Influencing alcohol-related decision-making process (e.g. in the parliament, political parties)
3. Influencing alcohol-related policy changes (all levels: policy-making and decision-making)
4. Influencing alcohol-related policy implementation (e.g. consistency in implementation)
5. Influencing alcohol-related strategies and alcohol-related international policy processes
6. Others (please, specify): _____

What kind of media actions do you do in alcohol-related advocacy purposes (e.g. media advocacy actions)?

1. Press releases
2. Press conferences
3. Interviews / talk shows
4. Letters to editors
5. Posts on the website
6. Posts in new media (e.g. Facebook, Twitter etc.)
7. Others (list): _____

Please, describe how you perform advocacy actions (what exactly you do, what kind of topics etc.)

Thanks for collaboration!

Let it hAPYN! project team

Annex 2 – The survey report

Methodology

In purpose to map alcohol-related prevention intervention in youth organisations, the project partners of the "Let it hAPYN!" project conducted a survey among youth organisations in the period from January and March 2014. We sent an email invitation to participate in the survey to more than 2.500 email addresses of youth organisations and youth workers across Europe. The emailing list was developed by the Alcohol Policy Youth Network (APYN) in previous years for the purposes of effective communication with youth organisations. As it was already mentioned in a previous section of this report, gaining sound knowledge about youth drinking patterns across European countries and (in addition) the present engagement of youth organisation in different prevention interventions and their knowledge and skills in the field of alcohol policy could significantly help in directing further developments in this field.

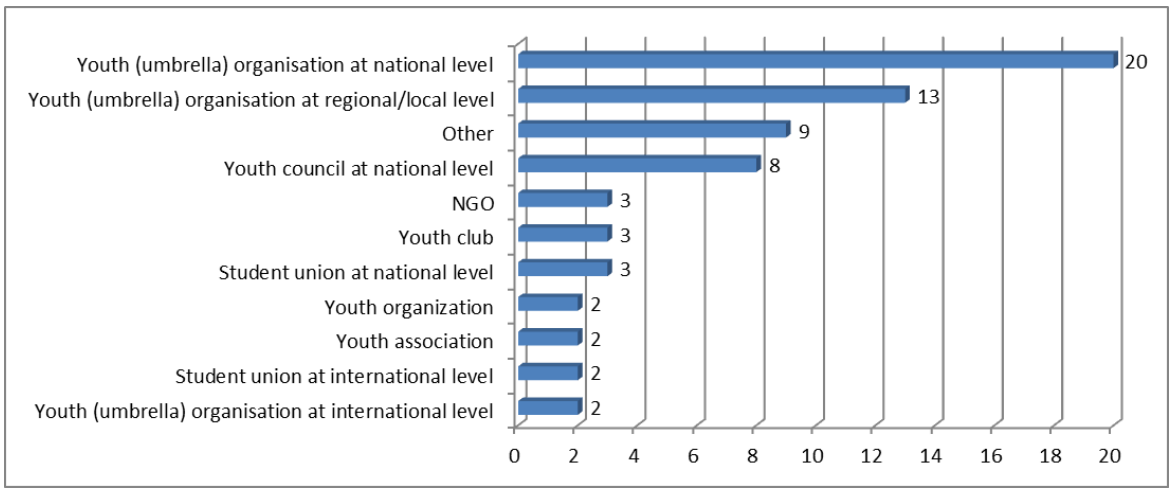
The survey was conducted on the basis of snowballing technique (sending an email and asking for further distribution and promotion among youth organisation at national level) as this method was the only feasible at that moment to get as many youth organisations in Europe as possible to participate in the survey. Most of first phase recipients of survey invitation have been identified as a leading or very relevant youth organisations or organisations for young people in particular countries which are already involved in prevention activities (not only in the field of alcohol, but also with regards to other substances, such as tobacco or illicit drugs). Only organisations with at least some experience with prevention were included in the data collection and analysis. After sending them first invitation (in January 2014), additional two reminders were send to them by email in the period between January and March 2014 to increase the response rate among youth organisations. Some key countries are missing in the survey (e.g. Spain, Greece, Poland, Hungary, Luxembourg, Latvia etc.) although exceptional efforts were made by project partners to get youth organisations from all European countries involved in the survey.

The questionnaire (see Annex 1) contained questions on (a) organisational details (e.g. type of organisation, number of members, formal links with national coalitions in the field of alcohol policy, formal links with alcohol industry etc.), (b) involvement in prevention interventions (e.g. types of prevention interventions implemented by youth organisations and evaluation practice), (c) knowledge and skills in prevention (e.g. importance of particular knowledge and skills, current state-of-art regarding knowledge and skills) and (d) advocacy (e.g. types of advocacy actions, types of media actions etc.).

General information about the sample

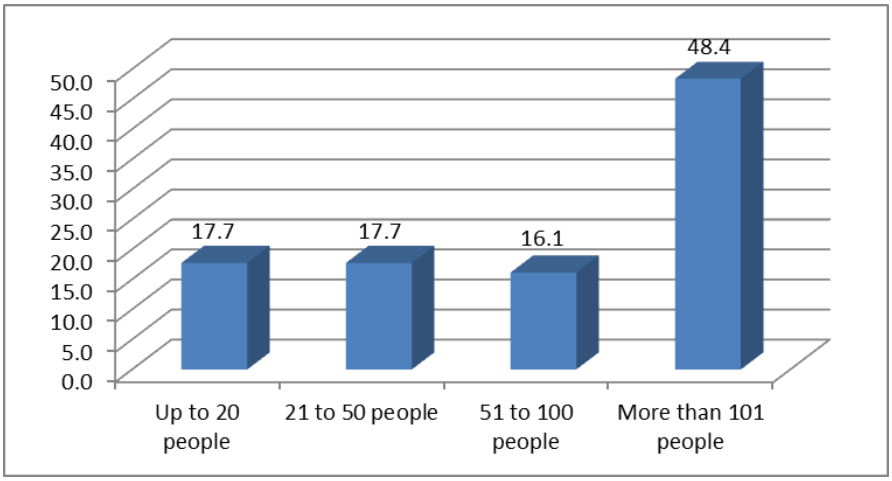
Sixty seven organisations have participated in our survey. They originated from 27 mainly European countries (2 non European). The most represented countries were: Slovenia, Croatia, Sweden and Estonia.

Figure 1: What sort of youth organisation is your organisation? (frequency)



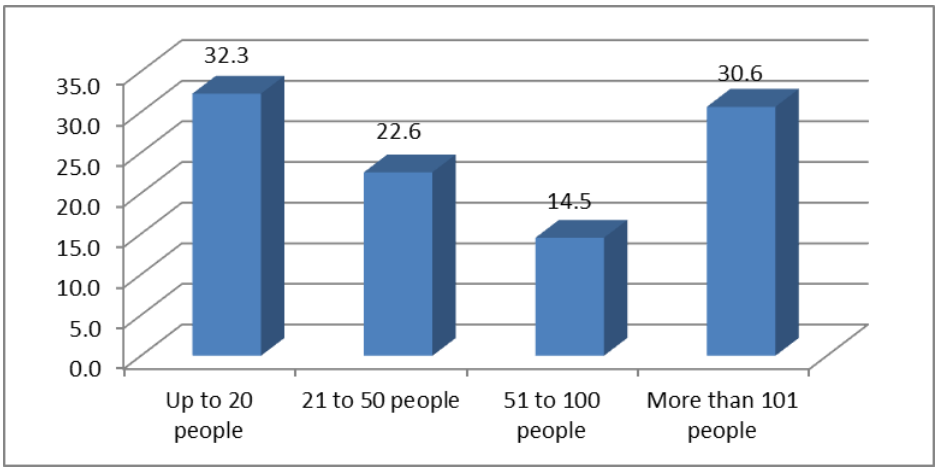
The most common types of youth organisations in our survey were youth (umbrella) organisation at national level (20) and regional/local level (13), folowed by youth council at national level (8). All other types were represented by three or less units of analysis. The Other group contained some specific types of youth organisations, associations, clubs, umbrella organisations. Also it contained a charity, youth wing of political party, a state organisation for supporting youth, family club and other less well defined organisations.

Figure 2: What is the overall number of members in your organisation? (in %)



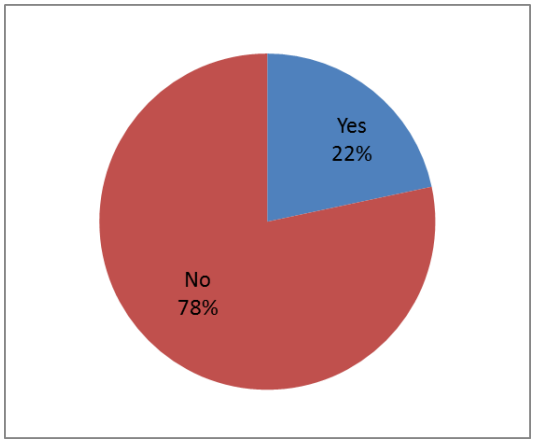
Almost half of the surveyed organizations (48.4%) have more than 101 members. The other half of the organizations is equally divided in 3 groups. 16.1% of the organizations have between 51 to 100 members, 17.7% have 21-50 members and the rest (17.7%) have up to 20 members.

Figure 3: What is the number of active members in your organisation? (in %)



If we look at the distribution of the organizations by the number of active members, we notice that the largest amount (32.3%) have up to 20 active members. Following them from the other side of the scale are organizations with more than 101 active members (30.6%). The smallest group (14.5%) consists of organisation with the number of members between 51 and 100. The rest (22.6%) have 21 to 50 active members.

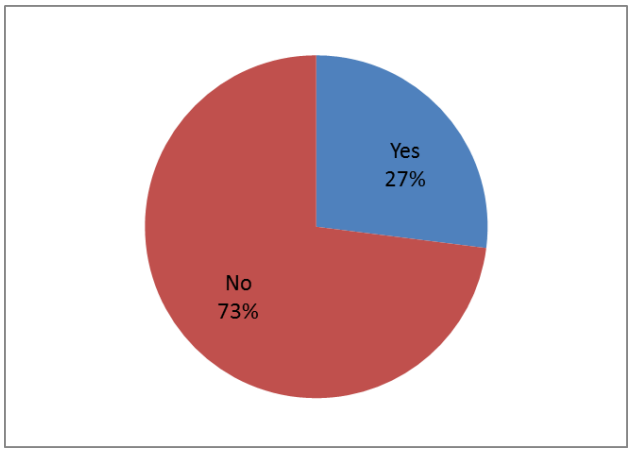
Figure 4: Does your organisation have any formal links with national coalition in the field of alcohol policy, such as interministerial council, governmental commission / committee or similar?



Only 22% of organisations have some formal links with a national coalition in the field of alcohol policy. Other 78% have no such links.

Some examples of such links: ACTIVE, Alcohol Action Ireland, National Forum on Alcohol and Health, Healthy Estonia Foundation, Drug Commission and other.

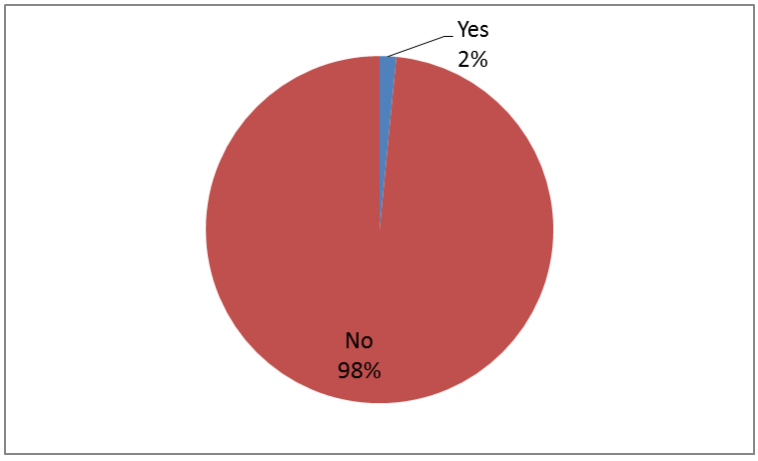
Figure 5: Does your organisation have any formal links with European or other international coalitions in the field of alcohol policy, such as Eurocare, Alcohol Policy Network, Alcohol Policy Youth Network etc. (in %)



The majority of organizations (73%) have no formal links with European or international coalitions in the field of alcohol policy.

Some examples of such links: Alcohol Policy Youth Network, European Health and Alcohol Forum, Global Alcohol Policy Alliance, European Alcohol and Health Forum, Eurocare, Active, IOGT International, Nordic Alcohol and Drug Policy Network and others

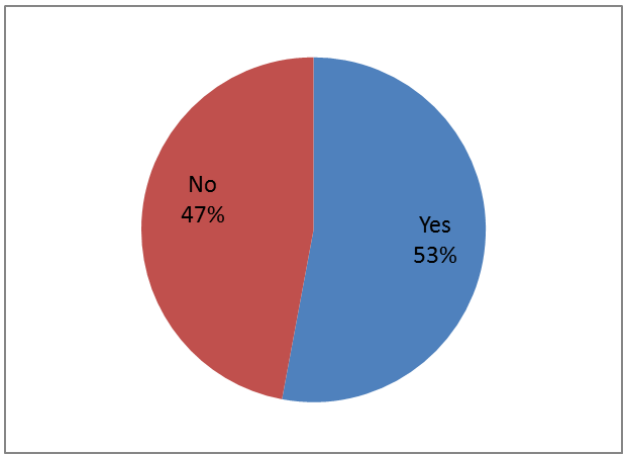
Figure 6: Does you organisation have any formal links with business company or business-related organisation (e.g. alcohol industry or non-profit organisation established by alcohol industry or similar)? (in %)



Only one (2%) organisation in our sample has a formal link with business company or business

related organisation. That particular business related organisation is Austrian "No alcohol!".

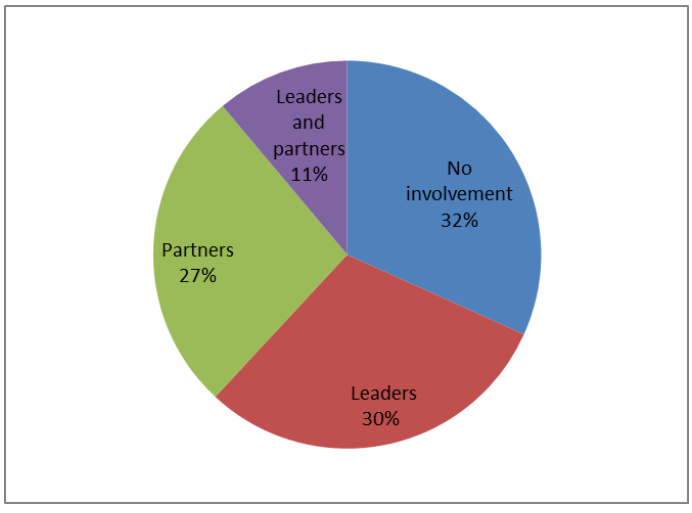
Figure 7: Is your organisation specialized in particular profession, such as medicine, psychology, social work, youth mobility, mental health etc.? (in %)



More than half of the surveyed organisations are specialised in particular profession, such as medicine, psychology, social work, youth mobility, mental health etc.

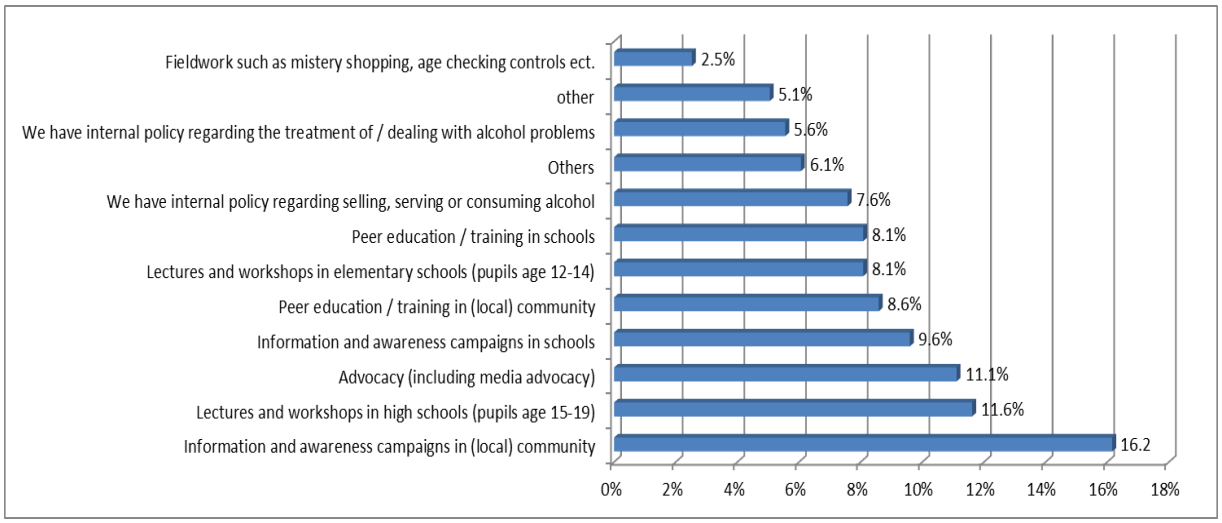
Some examples of such specialisation: Medicine and public health, social work, psychology, youth mobility, education, deaf/hearing impaired youth, addictions and others.

Figure 8: Is your organisation involved in any prevention intervention in the field of alcohol? (in %)



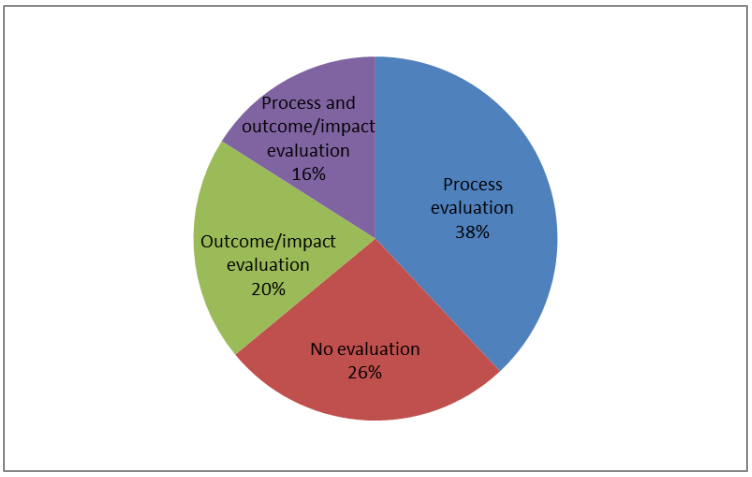
Of the surveyed organizations 30.2 in % of them are leaders of the prevention interventions in the field of alcohol, another 11.1% of organisations are leaders and also partners in such projects. 27% of organisations take part in prevention interventions as partners. The largest group (31.7%) are the organizations with no involvement in such activities.

Figure 9: What type of prevention interventions your organisation implements? (in %)



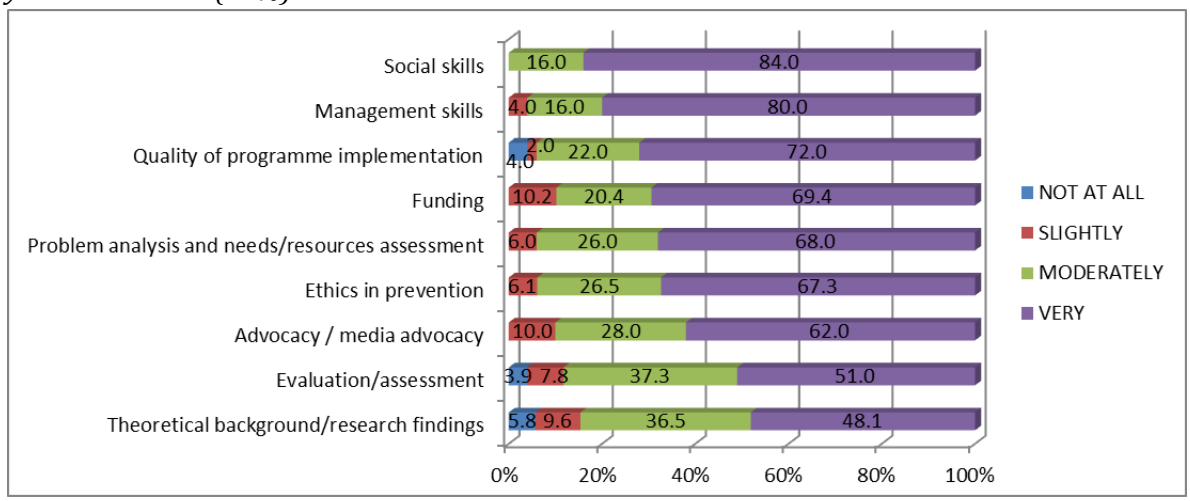
The most popular types of prevention interventions conducted by organizations in our sample are activities such as Information and awareness campaigns, lectures and workshops and also peer education. These are activities that mainly hope to educate the youth about alcohol. One other popular prevention intervention is advocacy (including media advocacy) which compromises 11.1% of all activity. Also present are internal policies regarding selling alcohol, dealing with alcohol problems etc. The least popular among listed prevention interventions is Fieldwork such as mystery shopping, age checking controls. Respondents have also listed prevention interventions such as: Low-threshold centre for children and youth, National coordination and awareness promotion meetings among the youth organizations, working with penal institutions and a variety of answers similar to those present by the questionnaire but different in certain aspects.

Figure 10: Does your organisation evaluate prevention interventions? (in %)



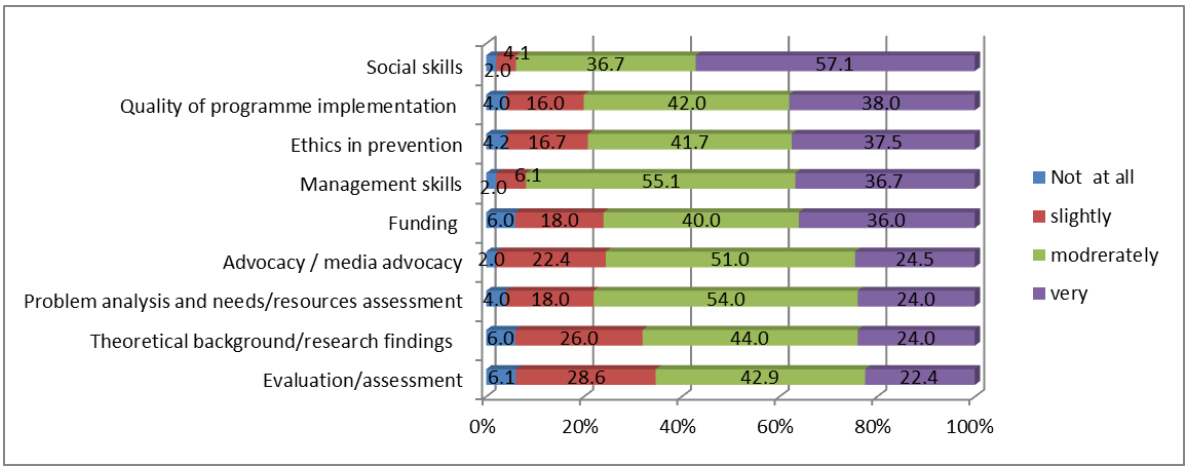
Something to note is the discovery that the majority (74%) of organisations conduct some kind of evaluation of their past projects. But still 26% of them have no evaluations! 16% of organizations preform both process evaluations and outcome/impact evaluations. Only process evaluations or outcome/impact evaluations are conducted respectively by 38% and 20% of organisations.

Figure 11: How important do you find knowledge/skills in these areas (below) for youth workers in your institution? (in %)



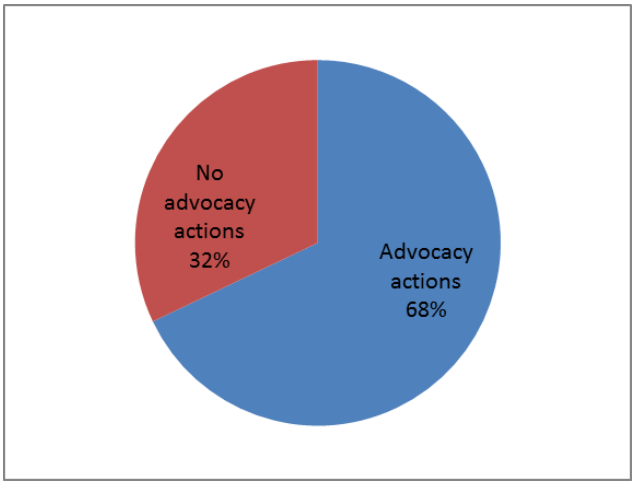
The most important skill that youth worker needs in opinion of the organisations is Social skills. The vast majority (84%) believe that social skills are very important, the rest have said that they are moderately important. Also among most important skills are: Management skills, Quality of programme implementation and funding. All in all we can see that organizations believe that all mentioned skills and knowledge are important. The least important is the knowledge of theoretical background and research findings, followed by evaluation/assessment skills.

Figure 12: How adequately do you feel that the people in your organization are currently prepared for work within prevention regarding these areas? (in %)



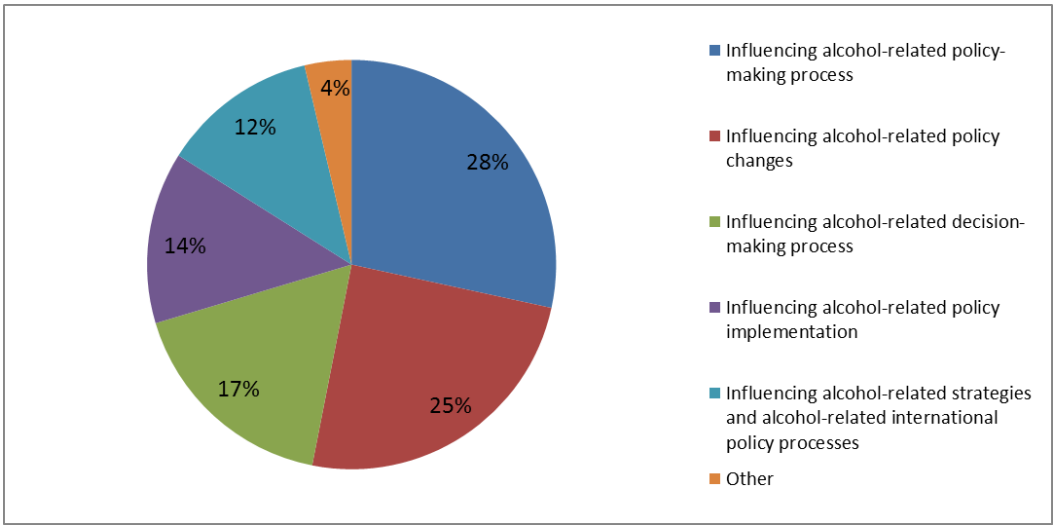
If we look at how adequately organizations feel that their people are currently prepared for work within prevention regarding these areas, we can see three groups. The first group consists of only Social skills. These are the skills that are most developed in surveyed organisations. In the middle group are: Quality of program implementation, ethics in prevention, management skills and funding. In the third group are skills and knowledge that is least adequately present among organisations members. Said skills are: Advocacy/media advocacy, Problem analysis and needs/resources assessment, theoretical background/research finding and evaluation/assessment. For all listed skills the majority of organisations fell that their members are adequately prepared.

Figure 13: Implementation of advocacy actions (in %)



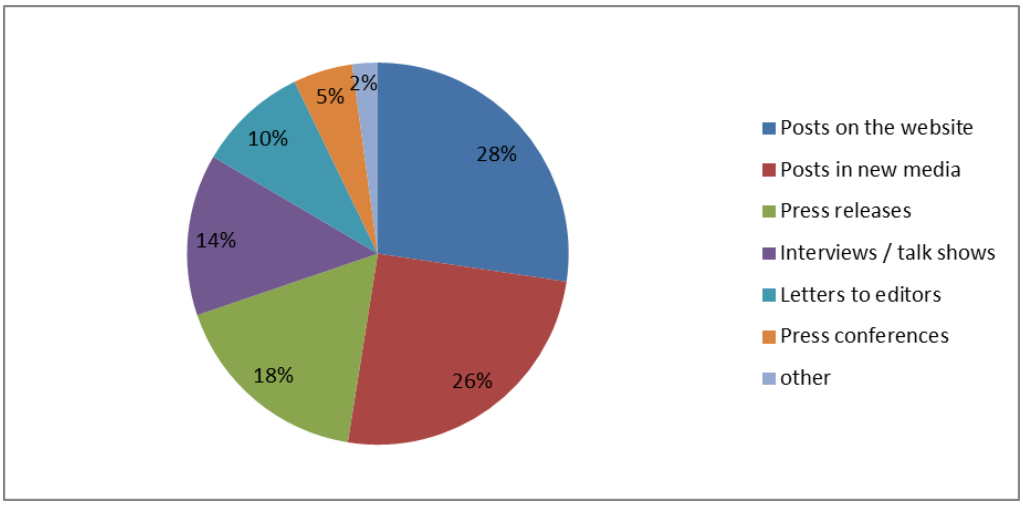
The majority of organizations (68%) preform some form of advocacy actions.

Figure 14: What kind of advocacy actions does your organisation implement? (in %)



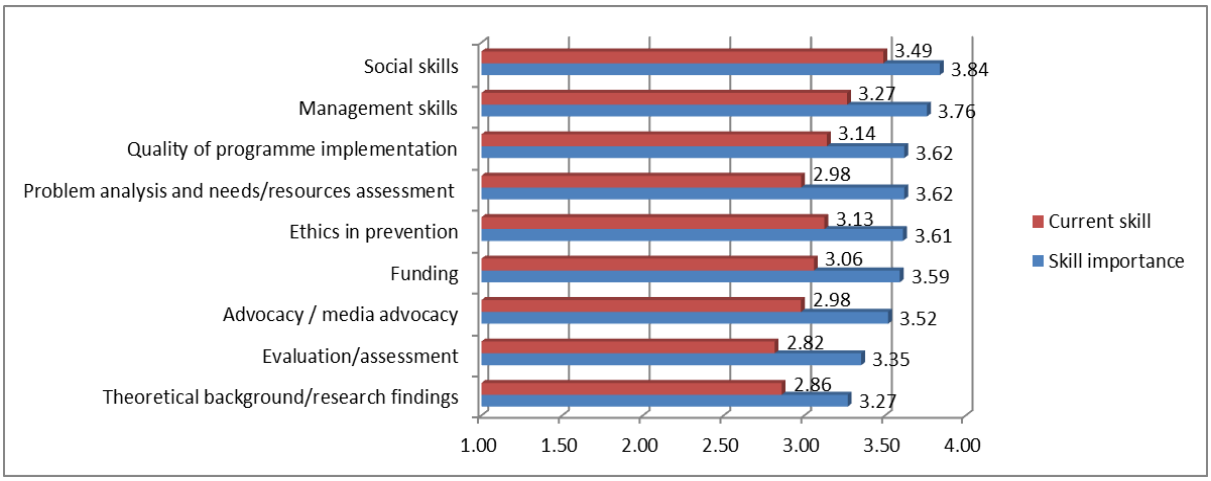
If we look at how organizations influence alcohol related governmental actions, we see that almost a quarter in % (28%) of their advocacy actions target policy-making process. 25% target policy changes and 17% focuses on decision-making process. Another 14% of advocacy actions are involved in influencing policy implementation. The least frequent (12%) are advocacy actions that focus on influencing strategies and international policy process.

Figure 15: What kind of media actions do you do in alcohol-related advocacy purposes (e.g. media advocacy actions)? (in %)



The most popular (28%) form of media advocacy is posts on the websites, followed by posts in new media (26%). Another 18% of media advocacy actions consist of press releases. Less often used are: Interviews/talk shows (14%), letters to editors (10%) and press conferences (5%). Other forms of media advocacy mentioned were position papers and consultations.

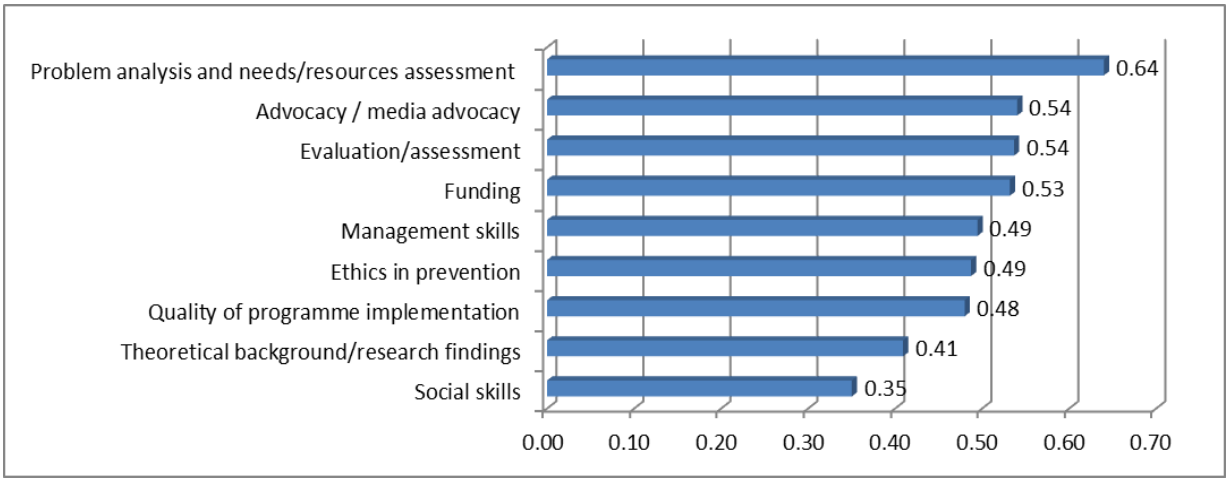
Figure 16: Comparison between current skills of organisations members and the importance of those skills.



We have scored previous answers on a scale from 1 to 4 and calculated the means.

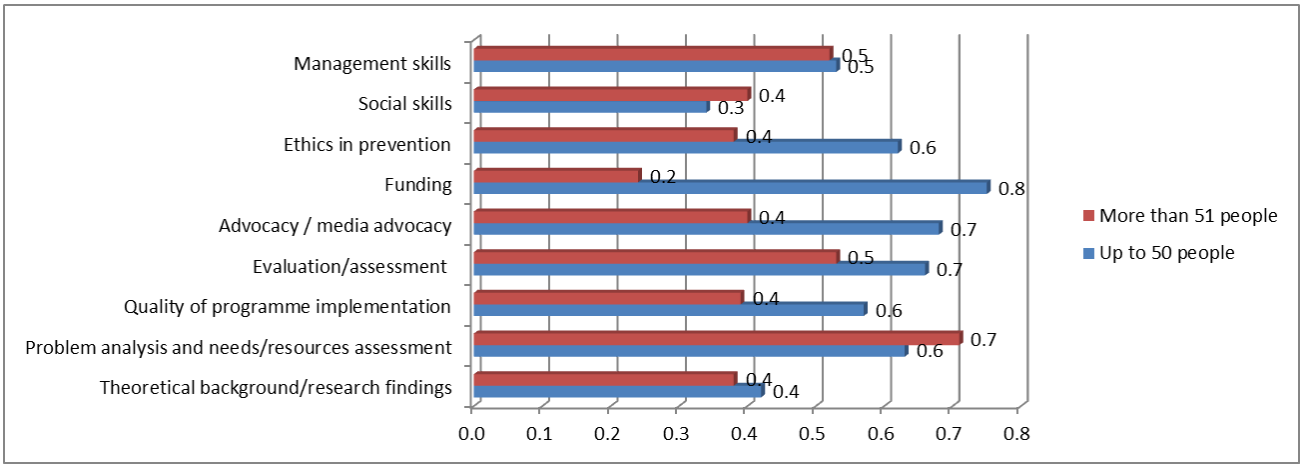
We can see that in every category current skill more or less in equal measure lags that same skills prescribed importance by the surveyed organizations.

Figure 17: Difference between current skills of organisations members and the importance of those skills.



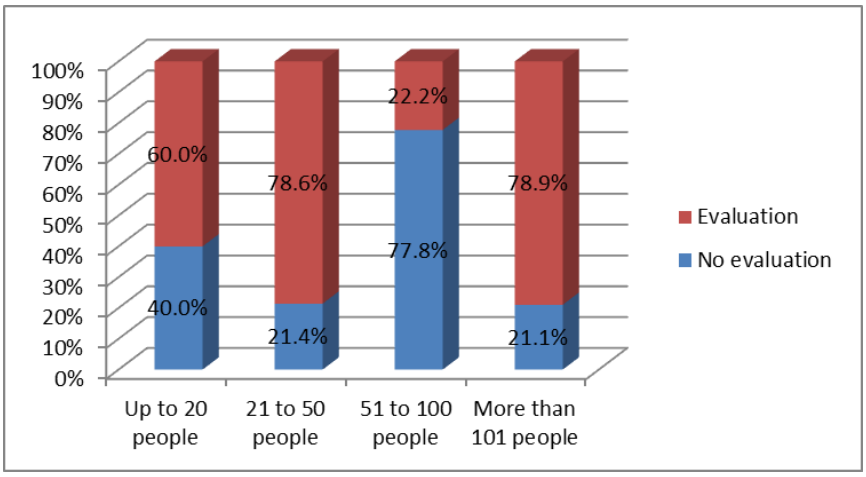
The gap is the largest in the category of problem analysis and need/resources assessment and smallest in the category of social skills.

Figure 18: Comparison of the current skill and its importance by the amount of active members in organisation.



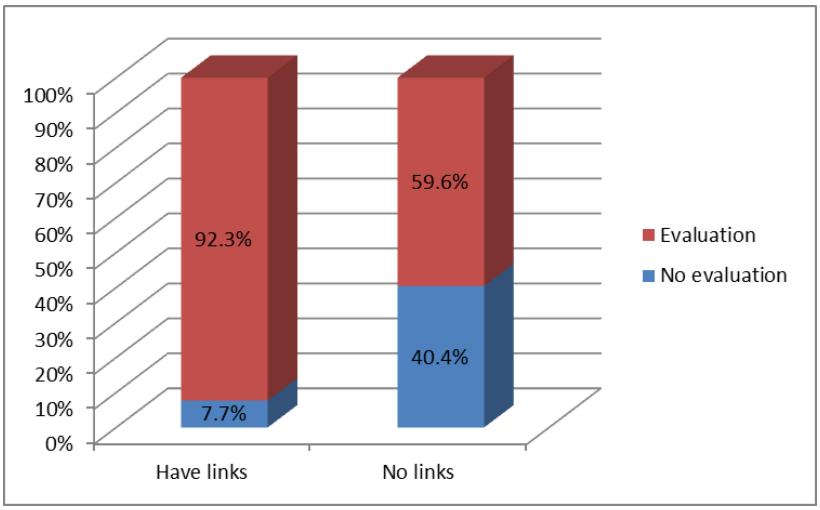
The chart shows us that organizations with less active members have in general larger skill/knowledge deficit in comparison with organizations with more active members. The result was expected since more members logically mean more vast and diverse skill/knowledge pool to draw from. The difference shows itself most in categories: Funding, ethics in prevention and quality of programme implementation in that order by magnitude respectively.

Figure 19: Evaluation of intervention prevention programmes by amount of active members (in %)



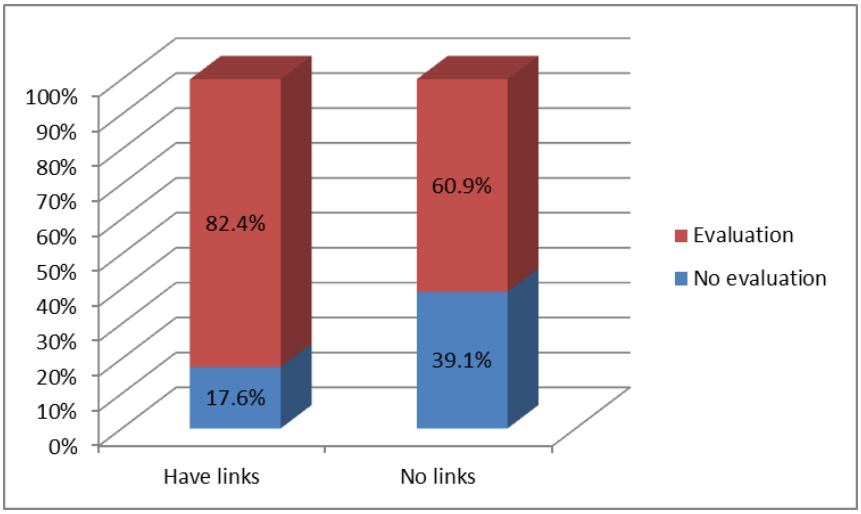
From the chart we can see that amount of active members have no clear influence on the evaluation of intervention prevention programmes. While it would be logical to assume that the organization with more active members would have more easily and so more likely conducted evaluations of its programs, that seems not to be the case.

Figure 20: Evaluation of intervention prevention programmes by having formal links with national coalitions (in %)



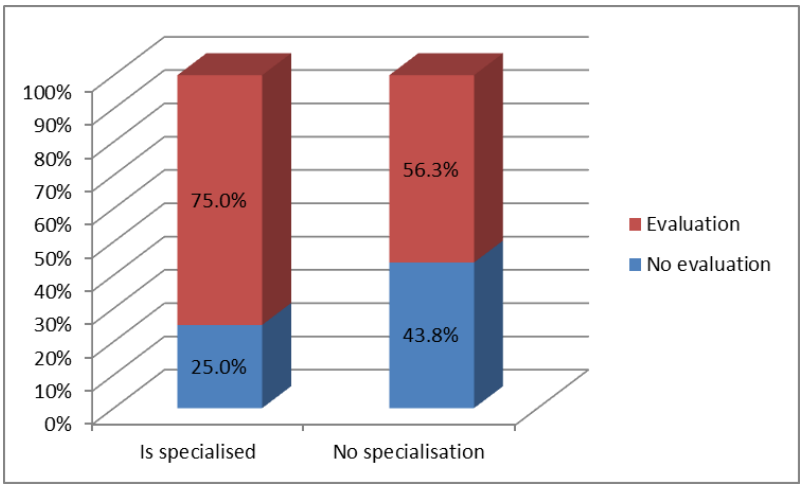
Organisations with links to national coalitions have higher likelihood to evaluate their programs.

Figure 21: Evaluation of intervention prevention programmes by having formal links with European or international coalitions (in %)



Organisations with links to European or international coalitions have also higher likelihood to evaluate their programs.

Figure 22: Evaluation of intervention prevention programmes by being specialised in certain field (in %)



Organisations specialised in certain field have higher likelihood to evaluate their programs.

Annex 3 – Index of content of the manual and draft visual structure of key tables

The content of manual will include sections as follows:

1. **Introduction**

   Short description of the manual, rationale and methodology
2. **Participants**

   Description of participants at the national consultations (pilots)
3. **Assessment**

   Description of the evaluation questionnaire for national consultations (pilots) and findings
4. **Conclusions**

   Description of key conclusions related to evidence-based practices review and pilots
5. **Acknowledgments**

   Short description of key contributors to the manual, including participants on pilots

6. **Draft structure of the table for each piloted evidence-based prevention intervention**

<table>
<tr><th colspan="2">Evidence-based practice</th><th colspan="2">Findings</th><th>Related practice</th></tr>
<tr><td rowspan="4">1.</td><td>E.g. Mystery shopping

Description: (from the review)</td><td colspan="2">Description of findings from an evaluation of national consultations
(evaluation questionnaire)</td><td>E.g. example from the Netherlands (study)</td></tr>
<tr><td>Evidence</td><td colspan="2">Ranking of feasibility</td><td>Comments</td></tr>
<tr><td rowspan="3">Stars from * to ***
(according to collected evidence from scientific literature and other resources)</td><td>Most / faily</td><td>%</td><td rowspan="3"></td></tr>
<tr><td>Neutral</td><td>%</td></tr>
<tr><td>Not / hardly</td><td>%</td></tr>
</table>

Annex 4 – List of respondents in the survey among youth organisations

Institution / organisation	City / town	Country	E-mail	Website	Contact person
A Woman in Power	Tirane	Albania	violathoma@live.com	awomaninpower.com	
bOJA/Bundesweites Netzwerk Offene Jugendarbeit - Centre of competence for Open Youth Work in Austria	Vienna	Austria	daniela.kern@boja.at	www.boja.at	Daniela Kern-Stoiber
Austrian National Youth Council	Vienna	Austria	office@jugendvertretung.at	www.jugendvertretung.at	Maria Lettner
European Medical Students' Association	Brussels	Belgium	vpe@emsa-europe.eu	www.emsa-europe.org	Ibukun Adepoju
Association of Medical Students - Plovdiv	Plovdiv	Bulgaria	asm-plovdiv@gmail.com	asm-plovdiv.blogspot.com/	Borislav Drenski
Center for Missing and Exploited Children	Osijek	Croatia	tomislav@cnzd.org	www.cnzd.org/site2/	Tomislav Ramljak
Youth centre Zaprešić	Zaprešić	Croatia	kristina@czmz.hr	www.czmz.hr	Kristina Kulaš
CINAZ	Zadar	Croatia	udrugacinaz@gmail.com	www.udrugacinaz.hr	Morana Rogić
Association for prevention of socio pathological behaviour of youth "Prevention"	Nova Gradiška	Croatia	udruga.prevencija@gmail.com	www.prevencija.hr	Aleksandra Grubać
CEDAR Centre for Education, Counseling and Personal Development	Zagreb	Croatia	ured@centarcedar.hr	www.centarcedar.hr	Ksenija Rissi
Udruga "TI SI OK"	Zagreb	Croatia	tisiok@gmail.com	www.tisiok.hr	sonja jarebica
Savjetovalište "Mali Plac"	Zagreb	Croatia	savjetovalistemaliplac@gmail.com	www.maliplac.com	Jadranka Laub
Youth association Alfa Albona	Labin	Croatia	alfa.albona@gmail.com	www.alfa-albona.hr	Alen Halilović
Autonomous centre - ACT	Čakovec	Croatia	info@actnow.hr	www.actnow.hr	Igor Roginek
Centre of Technical Culture Rijeka	Rijeka	Croatia	zprce@ctk-rijeka.hr	www.ctk-rijeka.hr	Zagorka Prce
Magdaléna, o.p.s.	Mníšek pod Brdy	Czech Republic	info@magdalena-ops.cz	www.magdalena-ops.cz	Nevsimal Petr
Pedagocical and psychological conselling of Brno	Brno	Czech republic	sladkova@pppbrno.cz	www.poradenskecentrum.cz	Lenka Skácelová
International Medical Cooperation Comittee	København	Denmark	imcc@imcc.dk	www.imcc.dk	
Estonian Scout Association	Tallinn	Estonia	info@skaut.ee	www.skaut.ee	
Urban Style	Tallinn	Estonia	info@jjstreet.ee	www.jjstreet.ee	Peeter Taim
Estonian Medical Students Association	Tartu	Estonia	eays. president@gmail.com	www.eays.ee	Marta Velgan

MTÜ MUG.ee	Tallinn	Estonia	mugweeb@hotmail.com	mug.ee	Inna Sammel
NGO AUH		Estonia	info@auh-auh.ee	www.auh.ee	Keijo Lindeberg
Kännikapina/Boozerebellion	Helsinki	Finland	paamaja@kannikapina.fi	www.kannikapina.fi	Anki Sirola
International Federation of Medical Students' Associations	Ferney-Voltaire	France	lph@ifmsa.org	ifmsa.org	Petar Velikov / Altagracia Mares
Bvmd	Berlin	Germany	NPO@bvmd.de	bvmd.de	Philippa Seika
Núll Prósent		Iceland	nullprosent@nullprosent.is		
NYCI	Dublin	Ireland	research@nyci.ie	www.youth.ie	
WACAT	Genova	Italy	ennio@palmesino.it	www.alcoholnet.net	Ennio Palmesino
Associazione Italiana Cooperazione Europa Mondo - AICEM	Rome	Italy	info@aicem.it	www.icem.it	Dario Coppi
Cesavo		Italy	davide@cesavo.it	www.cesavo.it	Davide Pesce
National tobacco and alcohol control coalition (NTAKK)	Vilnius	Lithuania	news@koalicija.org	www.koalicija.org	Vaida Liutkute
Lithuanian medical students association (LiMSA)	Kaunas	Lithuania	npo@limsa.lt	www.limsa.lt	Lukas Galkus
Multikultura		Macedonia	info@multikultura.org	www.multikultura.org.mk	Arlinda Mazllami
Center for Intercultural Dialogue	Kumanovo	Macedonia	contact@cid.mk	www.cid.mk	Manevski Stefan
FORUT/Juvente/IOGT		Norway	ognoyknut@gmail.com	juvente.no	Knut Ognøy
Portuguese National Youth Council	Lisboa	Portugal	geral@cnj.pt	www.cnj.pt	Sara Silvestre
rede ex aequo	Lisboa	Portugal	geral@rea.pt	rea.pt	Gustavo Briz
The Association for Development through Education, Information and Support - D.E.I.S.		Romania	contact@deis.ro	www.deis.ro	Diana Sabo
Youth Can Do It		Romania	contact@youthcandoit.eu	www.youthcandoit.eu	Grosar Vlad-Alexandru
Dunare.EDU		Romania	dunare.edu@gmail.com	www.dunaredu.org	
Nezávislá organizácia mladých - NOM Slovakia	Šaľa	Slovakia	patrik@nom.sk	www.nom.sk	Patrik Šulík
No Excuse Slovenia	Ljubljana	Slovenia	dasa.kokole@noexcuse.si	www.noexcuse.si	Daša Kokole
Youth Centre Domžale	Domžale	Slovenia	info@czm-domzale.si	www.czm-domzale.si	Tinkara

					Koleša
Youth center Krško	Krško	Slovenia	katarina@mc-krsko.si	www.mc-krsko.si	Katarina Ceglar
Youth network MaMa	Ljubljana	Slovenia	info@mreza-mama.si	www.mreza-mama.si	Maja Drobne
MoTA - Museum of Transitory Art	Ljubljana	Slovenia	mota.museum@gmail.com	www.motamuseum.com	Martin Bricelj
Mladinski center Prlekije-Pokrajinski center NVO	Ljutomer	Slovenia	mcp@siol.net	www.klopotec.net; www.mc-prlekije.si	Nina Stegmüller
Active - Sobriety, Friendship and Peace		Sweden	policy@activeeurope.org	www.activeeurope.org	Vasilka Lalevska
Sveriges Ekonomföreningars Riksorganisation (S.E.R.O.)	Stockholm	Sweden	ordf@sero.nu	sero.nu	Alice Stenström
Ung Vänster (Young Left of Sweden)	Stockholm	Sweden	info@ungvanster.se	www.ungvanter.se	Truls Presson
Centerpartiets Ungdomsförbund	Stockholm	Sweden	Karin.falldin@centerpartiet.se	Www.cuf.se	Karin Fälldin
Rädda Barnens Ungdomsförbund		Sweden	rbuf@rbuf.se	www.rbuf.se	Sara Thiringer
Swedish Deaf Youth Assocation		Sweden	kansli@sduf.se	www.sduf.se	Florian Tirnovan
Swedish Finnish Youth Organisation	Stockholm	Sweden	info@rsn.nu	www.rsn.nu	Veera Jokirinne
Saminuorra		Sweden	info@saminuorra.org	www.saminuorra.org	Sara Ajnnak
KiM - Kinder im Mittelpunkt	Basel	Switzerland	info@kinder-im-mittelpunkt.ch	www.kinder-im-mittelpunkt.ch	Stina Klee
PerspectieF. Christen Unie-jongeren	Amersfoort	The Netherlands	politiek@perspectief.nu	www.perspectief.nu	Erik-Jan Hakvoort
S.S.R.-N.U.		The Netherlands	vicarius@ssr-nu.nl	ssrnu.nl	Vicarius der Afdeling
Jonge Socialisten in de PvdA	Amsterdam	The Netherlands	info@js.nl	www.js.nl	E.L. Smid
Civil Life Association	Bursa	Turkey	info@siyamder.org	www.siyamder.org	Enes Efendioglu
The Green Crescent	Istanbul	Turkey	info@yesilay.org.tr	www.yesilay.org.tr/	İsmail Memis
Lugansk Regional Center for Youth Initiatives Support	Lugansk	Ukraine	molod-info@ukr.net	sms.lugansk.ua	Oleksii Murashkevych
White Ribbon Association	Solihull, West Midlands	United Kingdom	vickki@white-ribbon.org.uk	www.white-ribbon.org.uk	Victoria Taylor-Smith / Mary Ayres