To Empower the Community in response to Alcohol Threats (ECAT)

Manual for alcohol prevention in local communities

Johan Rosiers (ed.)

David Möbius (ed.)

Mieke Autrique (ed.)

Colofon

Editors
Johan Rosiers, Vereniging voor Alcohol – en andere Drugproblemen vzw, Brussels
David Möbius, Vereniging voor Alcohol – en andere Drugproblemen vzw, Brussels
Mieke Autrique, Vereniging voor Alcohol – en andere Drugproblemen vzw, Brussels

Acknowledgments
The editors wish to thank dr. Alfred Uhl and Irene Schmutterer (Ludwig-Boltzmann-Institut), Roos Deventer (CGG Middelpunt), Steve Bauwens, Koen De Ruytter and Lien Baeteman (City of Oostende), Martina Thrän, Stefanie Hecht, Rüdiger Dunst and Yvonne Ernst (Diakonisches Werk Baden), dr. Emanuele Scafato (Istituto Superiore di Sanità), Tiziana Codenotti (Eurocare Italia), dr. Marjetka Kersmanc (Zavod za zdravstveno varstvo Kranj), Don Shenker (Alcohol Concern), Libby Ranzetta (Ranzetta Consulting) and Chinelo Nwajiobi (Municipal Borough of Enfield) for their constructive cooperation in the ECAT project. Our special thanks goes out to dr. Alfred Uhl for reviewing the chapters and to Libby Ranzetta for conducting a last linguistic check on the revised texts.

Layout manual
www.epo.be

VAD
VERENIGING VOOR ALCOHOL- EN ANDERE DRUGPROBLEMEN vzw

in an associated partnership with

ZAVOD ZA ZDRAVSTVENO VARSTVO KRANJ

Alcohol Concern
Making Sense of Alcohol

LBI Sucht
ANTON-PROKSCH-INSTITUT

Diakonie

ISTITUTO SUPERIORE DI SANITÀ

To Empower the Community in response to Alcohol Threats (ECAT)

Manual for alcohol prevention in local communities

Johan Rosiers (ed.)

David Möbius (ed.)

Mieke Autrique (ed.)

This project has received funding from the European Community

Table of contents

Foreword

As an umbrella organisation with more than 60 members and as partner organisation of the Flemish Government, VAD coordinates the alcohol and drug policy in the Flemish Region of Belgium. One of the corner stones of our approach is to enhance community-based alcohol policies. Four years ago, we wanted to share our expertise in this matter with international partners and wanted to learn from other experiences. We used the opportunity of the "EC Programme of community action in the field of public health (2003-2008)" to achieve this goal. In 2005 we submitted a proposal for funding a European project, named "to Empower the Community in response to Alcohol Threats" (ECAT). Our proposal was accepted for co-funding by the European Commission and from 1 December 2006 on, the ECAT project took off for a period of 2 years.

In order to start the ECAT project under the best constellation we set high standards for establishing partnerships. Two main criteria for the selection of associated partners were:

1. the partners should have relevant expertise in alcohol policy, research and community-based prevention,
2. the ECAT network should represent the European Community as much as possible (geographical and cultural coverage).

I can affirm that we succeeded in accomplishing the first criterion. All partners added an essential surplus in the project. Concerning the second criterion, we had to lower our initial aim when a supranational Scandinavian partner had to abandon the project a few weeks before the official start.

In the first year of the ECAT project we focussed on the development of the concept and methods of evidence-based alcohol prevention strategies in the local community, supported by a local communication campaign. We developed a comprehensive yet too theoretical draft of the manual. One of the partners described it adequately: "this is the bible, now we need a more practical tool." Based on the feedback of the partners, our ECAT collaborators revised the manual into a practical instrument, taking cultural differences into account. In the second year the associated partners put the ECAT method into practice. In eight local communities in Austria,

Belgium, Germany, Italy, Slovenia and the UK local ECAT projects were implemented. The experiences in these pilot projects allowed us to refine the ECAT methodology, so it will be more easily applicable throughout Europe.

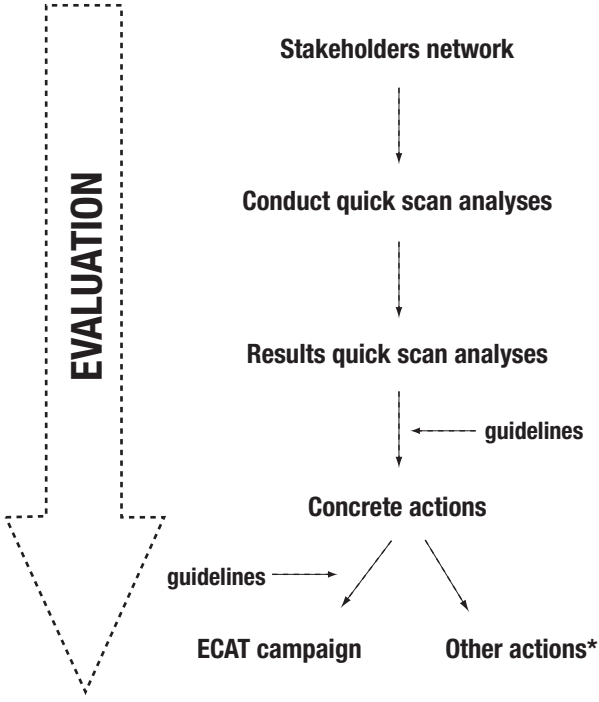
Despite the limited opportunities to explore the benefits of the ECAT methodology, due to the narrow timescale of the European project, the experiences in the local projects have proven that ECAT hosts great potentials. This innovative community-based alcohol prevention approach, relying on an active participation of local stakeholders, the conduct of a local quick scan analysis, the embedding of strategies in guidelines and the process-related integration of evaluation, led to promising results. I hope that this manual transmits my positive feelings about this to the readers.

My last words are dedicated to the partners who contributed a lot in achieving the ECAT objectives. First of all I would like to thank our associated partners and the local field staff: dr. Alfred Uhl and Irene Schmutterer (Ludwig-Boltzmann-Institut) in Austria; Roos Deventer (CGG Middelpunt), Steve Bauwens, Koen De Ruytter and Lien Baeteman (City of Oostende) in Belgium; Martina Thrän, Stefanie Hecht, Rüdiger Dunst and Yvonne Ernst (Diakonisches Werk Baden) in Germany; dr. Emanuele Scafato (Istituto Superiore di Sanità) and Tiziana Codenotti (Eurocare Italia) in Italy; dr. Marjetka Kersmanc (Zavod za zdravstveno varstvo Kranj) in Slovenia; Don Shenker (Alcohol Concern), Libby Ranzetta (Ranzetta Consulting) and Chinelo Nwajiobi (Municipal Borough of Enfield) in the UK. This project has been realised successfully thanks to the dedicated efforts of VAD staff members Johan Rosiers as project coordinator and David Möbius as project collaborator. Mieke Autrique and Els Vandenberghe of VAD have supported the project with their expertise in the field of evaluation and campaigns. I also want to express my gratitude to the European Commission for co-funding the ECAT project.

I hope this book makes good reading.

Marijs Geirnaert
Director VAD

Part 1
Methodological concept of ECAT



* the results of the Quick scan analyses may result in other actions, byond the scope of ECAT

Chapter 1 General introduction to ECAT

David Möbius
ECAT project collaborator, Vereniging voor
Alcohol- en Andere Drugproblemen – VAD, Brussels (B)
Johan Rosiers
ECAT project coordinator, Vereniging voor
Alcohol- en Andere Drugproblemen – VAD, Brussels (B)

1. ECAT: alcohol prevention in a community setting

The project 'to Empower the Community in response to Alcohol Threats' (ECAT) started from the principles and findings of a number of recent community-based prevention trials that have sought to reduce problems related to drinking by using a range of interventions and strategies[1]. In these community programmes, a combined set of activities was organised in a specific region or town, aimed at adolescents, as well as parents and other people and organisations. An important characteristic of such community interventions is that people living in the community play an important role in deciding which interventions are developed and for whom. In ECAT, a community was defined as a geographical area, with a limited number of people (30,000 – 60,000), that is a district, a village, or a town, where relationships (social, cultural, and economic) among people and forms of active participation exist to some extent.

By gathering evidence-based practices and good practices of alcohol prevention on a local community level, ECAT aimed at identifying the success factors of this form of alcohol prevention and at translating them into practical guidelines. Furthermore, ECAT started from the fact that – because communication campaigns on alcohol prevention generally are organised on a higher geographical level (national or regional) and aimed at the general population – there is lack of experience and good practices in evaluated communication campaigns targeting alcohol in a community setting. In a broader context, ECAT is established as a catalyst to

1 An overview and description of some of these community prevention trials and possible interventions can be found in the ECAT publication 'Scientific evidence for the ECAT methodology'.

encourage local collaborative and intersectoral cooperation to achieve a reduction in alcohol related harm. Finally, the experiences in the ECAT project can add important complementary value to alcohol prevention campaigning, since they incorporate a focus on specific target groups and specific alcohol topics that are highly relevant in a local community setting.

In their *Framework for alcohol policy in the WHO European Region*, the World Health Organisation acknowledges that local community involvement is crucial in preventing or reducing alcohol related harm. "It is important to empower individuals to make significant lifestyle changes, but all choices are made and created in a cultural and situational context, and behaviour around alcohol is no different. [...] In order to empower local communities to take effective action, local needs, interests, resources and abilities, as well as the level of evidence, must all be addressed" (WHO, 2006: 10-11). ECAT takes these recommendations seriously by elaborating guidelines for the development and the implementation of alcohol prevention campaigns in eight participating communities. In order for an approach to be tailor made for a given community, it is essential to have a good outlook on the prevalent situation and the influencing factors of (problematic) alcohol use in that community. An essential part of the ECAT methodology therefore consists of conducting a quick scan analysis in each participating community.

Evidence suggests that for a community strategy to be successful, a combination of evidence-based interventions and an awareness-raising communication campaign on the alcohol theme within the community is necessary. This communication campaign is an essential means for preparing the ground for specific interventions. Once the community members are sensitised and informed on a problem, other, rather small-cased approaches (interpersonal, face-to-face communication) and a supportive environment are necessary to obtain and maintain behaviour change. ECAT aims at helping to realise an integral approach on a local level, using communication means in combination with both targeted and population strategies, ultimately leading to the creation of a supportive community environment to tackle alcohol problems, including the development of a local alcohol strategy. This means that community

action is not itself a strategy, but rather is a mode of working that uses one or more prevention strategies. After all, alcohol problems are the outcomes of processes driven and sustained by the community at large. These processes have the potential to affect all members of the community, but – because of individual and environmental factors – produce adverse effects in certain groups more than in others. Consequently, it is important that we look at the use of alcohol from the environment of the drinker and the elements that play a role in that (physical, social and economic environment). ECAT comes up to this by recommending specific interventions for a specific community problem, combined with recommending general evidence based prevention interventions (supported by the community at large). In short, we can say that ECAT aims at closing the gap between prevention and policy by proposing intervention methods making structural changes.

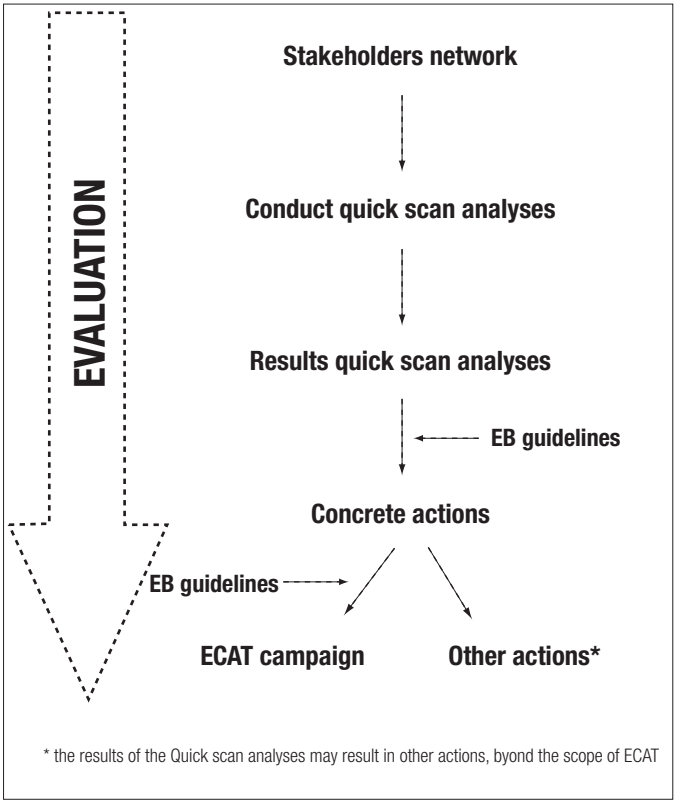
2. The ECAT guidelines

This manual is composed of five major elements:

1. Setting up a local network of stakeholders
2. Conducting a quick scan analysis
3. Community-based interventions
4. Evaluation
5. Experiences and good practices from the ECAT pilot communities

The aim of this manual is to provide a framework for the development of a community alcohol strategy within a local network of stakeholders and based on the results of a community analysis (quick scan) in each participating community. The ECAT approach thus combines the implementation of specific interventions, starting from a specific problem in the community, with giving recommendations on the implementation of general interventions supported by the community at large. In order to have a clear overview of the different steps taken in this project, a strategic concept for the development of the ECAT campaign has been elaborated (figure 1).

Figure 1: ECAT scheme



(1) The first step taken was the setting-up of a local, cross-sectoral network of stakeholders, including the appointment of a local coordinator. This partnership approach is seen to be a key element to bring about community level change. Evidence indicates that alcohol prevention initiatives addressing the entire community and using approaches going beyond educational programmes or communication messages to attempt changes in local social, economic, or physical environment related to risky drinking benefit a lot by setting up an intersectoral network of stakeholders. ECAT embodies this principle in the following main objective: "*Local stakeholders know the prior needs for (re)orienting the local alcohol policy and are capable to translate these needs into concrete actions, such as a local alcohol prevention campaign aimed at the prior target group(s).*"

(2) In order to implement relevant actions in the field of community alcohol prevention, it is essential to have a good outlook on the prevalent situation and on the influencing factors of (problematic) alcohol use as well as on the community-based strengths to counter the problems. The ECAT quick scan is developed to combine two success factors in the embedding of community-based action and policy: availability of "evidence" and assessment of the degree of local support. To define prior target groups and topics, the quick scan method developed for this project is highly recommended. It should be noted that the results of the quick scan analysis may result in other activities, beyond the scope of the ECAT communication campaign. Once the community is sensitised and informed on alcohol related issues, these results should be used to determine further actions to be taken.

(3) Communities do not form a single unity, but are formed by several elements by which the totality of community life is a combination of various transient and partial communities. Some of them are more enduring (like family ties), others consist of seemingly superficial and passing social ties (like friendships in the local pub) (Holmila, 1997). Therefore, the intention is to reduce the collective risk through appropriate interventions affecting community processes. Rather than basing prevention strategies on single assumptions about deterministic behaviour, the community approach should employ interventions that alter the social, cultural, economic and physical environment in such a way as to promote shifts away from the conditions that favour the occurrence of alcohol-involved problems. In this manual, a short overview of potential interventions to be implemented in a community is given. More information on these interventions can be found in the ECAT publication 'Scientific evidence for the ECAT methodology'.

(4) In the chapter on evaluation, evaluation issues are discussed and important aspects in the evaluation of community projects are highlighted. Lessons learnt from the ECAT project are integrated. In general, community alcohol prevention demands a flexible and broad approach to evaluation, drawn from modern applied social science evaluation methodologies. It demands early evaluation input, qualitative as well as

quantitative methods, process studies in addition to outcome studies, realism about the possibilities for using control or reference groups, and close involvement by researchers in planning the programmes they are evaluating. This means evaluation runs as a continuous thread through the different phases of community projects.

(5) As indicated before, the ECAT methodology was tested in eight pilot communities, situated in different parts of the European Union: Ostend in Belgium, Kranj in Slovenia, Enfield in the United Kingdom, Achern, Leimen and St.-Leon-Rot in Germany, Padova in Italy and Gmunden in Austria. The experiences these communities had in working with the ECAT methodology is described in part 2 of this manual. This part also highlights some good practices in community alcohol prevention.

3. First things first: setting up a local stakeholders network

Problems associated with the use of alcohol are manifested in many different spheres of community life. This makes community alcohol prevention an activity transgressing the numerous responsibilities of the municipality and thus has multiple stakeholders. For that reason, one primary objective of community action towards these problems is to identify those sectors of community life that are currently working with problem drinkers or experiencing social or economic costs due to alcohol problems, and to assemble them in a network: the ECAT stakeholders' network. In our context stakeholders are actors who have a personal interest in the issue of (problematic) alcohol use and are confronted directly with consequences of decisions on that issue. This includes professionals working in relevant sectors (health professionals, bar owners, police force,...) as well as local policy makers (politicians or public servants) as well as representatives of local residents (e.g. representatives of community associations or socio-cultural organisations). Of course, this enumeration is not limited. Depending on the local situation, relevant stakeholders can be identified via "social mapping" and/or via using snow ball-techniques by asking the first contacted stakeholders to indicate other important local stakeholders. The specific local situation

also makes that some stakeholders are more easily to engage in your network than others.

Every country, every region, every community has its specific composition of stakeholders. For instance, for the Flemish region of Belgium, VAD recommends to invite representatives of the following sectors to take part 1n the local stakeholders' network:

- providers of health services (doctors and other professional categories),
- alcohol and drug prevention actors,
- workplaces,
- police and judiciary services,
- community centre work and local resident associations,
- leisure services and sports clubs,
- social service departments,
- education services,
- youth services and youth clubs,
- catering and hospitality trade (consumption industry, restaurants, pubs, clubs, night shops, ...).

To make decisions on behalf of the organisation they are representing, it is important to work with good representatives of the organisation or group. This means that, when contacting these members, it is important to clearly explain what is being expected of each member. It is also important that every member is an equal partner and has its own share in the meetings. In order to facilitate the whole networking process, it is recommended to appoint a **local coordinator** to guide this process. It is essential that someone takes the lead and acts as the motor of the network. This role is vital for community prevention projects by providing the direction and drive required to stay on track. Keeping in mind that one of the objectives of ECAT is setting priorities for the (re)orienting of the local alcohol policy, an option to consider is to mandate a representative of the municipality for the coordination of the ECAT project. Of course, before starting the coordination, this local coordinator has to learn the ropes of the ECAT concept and process. After becoming familiar to the ECAT concept, he/she will start the coordination with the launching of the stakeholders' network and the preparations to outline and implement the evaluation process.
The coordinator has to be someone with sufficient experiences and skills, necessary for the success of the project. He/she needs to be familiar with the local customs, norms and values. The coordinator also has to pay a lot

of attention to group dynamics and therefore always needs to favour interactions among the ECAT-stakeholders. Another important quality the local coordinator needs to have is the ability of being sensitive to interruptions and dealing with it in a creative way: by naming it in a non accusatory way, by talking about it afterwards, by making clear agreements, ...

Setting up a local stakeholders' network is only a first yet important step towards a community alcohol prevention project. Some guidelines on the participation of the stakeholders' network in the quick scan analysis are given in the next chapter. But the participation does not stop there. In the ECAT project the stakeholders' network is the main pillar in the whole process: after the conduct of the quick scan analysis the quick scan results have to be translated into a prevention campaign and other actions, following the recommendations of chapter 3. Besides, the stakeholders' network has an important role in evaluating the project, as described in chapter 4.

Chapter 2 Quick scan analysis of the local alcohol situation. A short cut to a panoramic view

Johan Rosiers
ECAT project coordinator, Vereniging voor
Alcohol- en Andere Drugproblemen – VAD, Brussels (B)

1. Introduction to quick scan

Quick scan: what and why?

To implement relevant actions in the field of alcohol prevention, it is essential to have a good overview of the present situation and the factors influencing (problematic) alcohol use. At this moment, there is still a lack of quick scan methods for assessing needs related to alcohol in local communities. Some promising local initiatives for quick scan analysis of alcohol related problems have been deployed, but a solid, generally applicable conceptual tool to develop such a quick scan is still missing. The ECAT project has been developed to narrow this gap by developing, implementing and evaluating a quick scan method for local community analysis.

Quick scan is a term that is quite commonly used in the Dutch-speaking region. It is quite similar to the notion of rapid assessment. Quick scan is typically undertaken in situations where results are expected within such a limited time scale that conventional research approaches (extensive surveys, in-depth qualitative studies, …) are ruled out. Quick scan is based on the analysis of existing data and on the results of short term research. One important consideration is that the term "quick" may be deceptive. The conduct of this quick scan analysis still demands substantial investments of time, personnel and funding. During an estimated period of four months, these conditions should be accomplished.

The quick scan analysis should be seen as the starting point for interventions. The results of the quick scan give useful information to develop interventions. It triggers the profiling of local situations and problems related to alcohol, the identification of intervention targets and the bundling of actors and resources. Quick scans contribute information that can be used to develop or improve community-based policies, programmes and

other initiatives to reduce harms associated with particular issues such as substance use (Ogborne, 2006).

Objectives of quick scan in the ECAT project

The conduct of a quick scan analysis in the local communities was one of the pillars of the ECAT project. Together with the production of guidelines for the development and the implementation of alcohol prevention campaigns, a quick scan method for local analysis has been developed. The main aim of the quick scan is to identify prior target groups and topics and to develop a strategic concept to translate the results of the community analysis into a local alcohol prevention strategy and, as an element of it, into a local alcohol prevention campaign. This is embodied in the following main objective:

> *Local stakeholders know the prior needs for (re)orienting the local alcohol policy and are capable of translating these needs into concrete actions, such as a local alcohol prevention campaign aimed at the prior target group(s).*

This main objective is to be achieved by the following intermediary objectives:

- local stakeholders find their way to existing data sources for local analysis,
- local stakeholders gain better knowledge of the options and advantages for complementary data collection,
- based on considerations with the local stakeholders, leading project members are able to set priorities for the (re)development of local alcohol policies.

It is obvious that local stakeholders play an important role in the ECAT quick scan since they have good insights into alcohol matters in the local community. We use the term stakeholders, following the notion given by Boots and Midford (2007). To Boots and Midford, key informants are seen as more passive observers or informants who can give more objective information on a subject, whereas the term stakeholder includes a whole continuum of roles, going from a more passive observer/informant notion to a more involving and interactive role that includes a more subjective participation. Key informants may be stakeholders but they may be just observers who are not influenced personally by any decision. In ECAT we define stakeholders as persons who have a personal interest in the issue of

(problematic) alcohol use and are confronted directly with consequences of decisions on that issue.

Elements of quick scan analysis

The ECAT quick scan method is based on three main elements:

- the collection and processing of existing archival data on the alcohol situation,
- the complementary qualitative data collection within the local stakeholders' network,
- the translation of the quick scan results into a local alcohol prevention strategy which, amongst other possible actions, consists of a communication campaign in the local community.

In the context of the ECAT project, an alcohol prevention campaign should be seen as a goal-orientated action within the larger plan, as part of a broader alcohol policy approach. The campaign should be embedded in a local alcohol strategy and it should be endorsed by all participants, including local policy makers. The conclusions of the quick scan process and the resulting actions need endorsement from local policy makers, but without a strong influence from their side.

2. Quick scan in the ECAT project: methodological framework

We design the ECAT quick scan method in three steps:

- we start from a set of quick scan principles,
- we describe the methodological process of the ECAT quick scan,
- we supply a methodological framework to collect relevant data and indicators.

2.1. Principles in analysing data

We define four general principles for analysing data.

Community-based orientation

The translation of the results of a quick scan analysis into a local strategy emphasises policy initiatives on a higher level. The results of a local analy-

sis provide useful information to develop local health promotion implementations and interventions complementary to national health promotion actions.
The relevance and impact of the quick scan is higher when local stakeholders are allowed to participate in reflecting on the results and their implications. Both professionals as well as members from the population and/or specific target groups should be part of the process. A solid intersectoral participation is beneficial for the realisation of the intended actions because the contextual support for these actions will be higher.

"Quick" as key term in intervention-orientated analysis
Local communities mostly lack the time, money and expertise needed to conduct an intensive scientific analysis. To offer these communities a valuable and realistic alternative, ECAT aimed to develop a quick scan analysis method to be conducted in a time scale of about four months. "Quick" most certainly implies well-considered planning to avoid a lack of time in the further stages of the assessment procedure. Overkill in gathering information is to be avoided. It is better to spend more time on the iterative cycle of analysing the results.

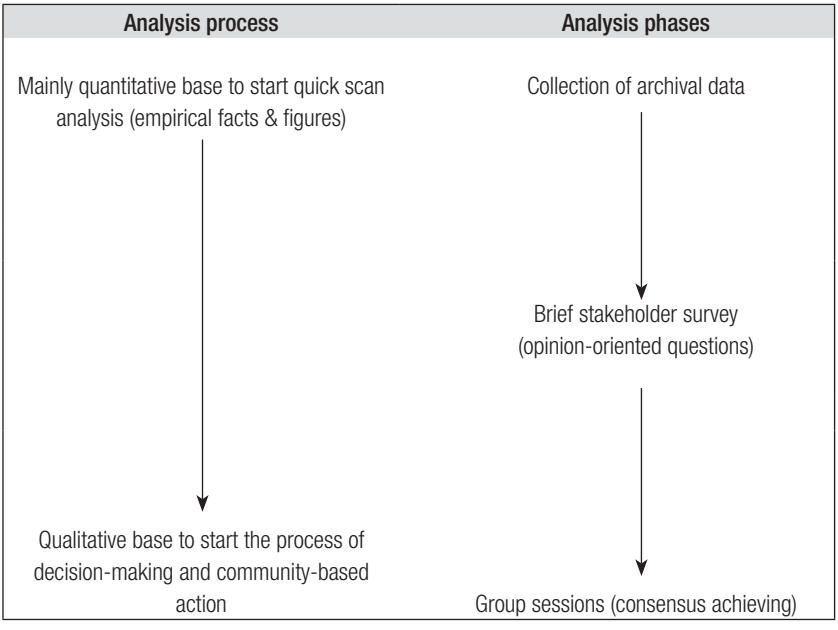
Iterative cycle of analysis
The principles of rapid assessment techniques and community-based working are integrated in the iterative process of quick scan analysis. Existing data and results from additional data gathering are to be discussed and rediscussed with local stakeholders in order to refine the data and to translate the finding into relevant and realistic strategies.

Triangulation of data
Methodological triangulation means combining equivalent data based on different assessment methods. It is used to reduce the weaknesses of one method by using additional equivalent methods. The most common form of triangulation consists of a targeted combination of quantitative methods and qualitative methods. But there are also other forms of triangulation, like comparing the findings of two or more researchers using the same method or comparing different collected data (e.g. interviews with observations).

2.2. Methodological process of the ECAT quick scan

The ECAT quick scan method is to be seen as a predominantly qualitative-based analysis process, starting from quantitative data and completed and adjusted by qualitative data. It can be seen as the qualitative completion of a rough quantitative image. Or, put into conceptual terms, it is a process of translating empirical facts and figures into community-based action.
Specifically, we start from existing or archival data (mostly quantitative) and start a process within the stakeholders network of adding qualitative data (experiences, reflections and opinions) which should merge to result in consensus. The first step of the quick scan procedure should provide solid quantitative data. These data are primarily aimed at the extent of (problematic) alcohol use but need more refinement, in terms of verification (are the first results recognisable for the local stakeholders?) and illustration (useful background information to illustrate the context of the phenomenon). This may be achieved by the qualitative research methods, as described in the next paragraph.

Figure 1: Process and phases of analysis



In this process from mainly quantitative facts and figures to qualitative results for implementing community-based actions, the data from the first two phases of analysis serve as a base for discussion with stakeholders. The decision-making product of the quick scan analysis takes place in the community-based group sessions.
But the evidence-based approach still plays an important role in community-based actions. In making choices and starting actions, the stakeholders not only should take the quick scan results into account but also the evidence-based findings described in chapter 3.

2.3. Methodological framework to collect the data

The challenge of the quick scan is to find the most relevant information while spending the least time and energy. For that purpose, the quick scan analysis of ECAT is built upon three phases of data collection and analysis. The purpose for each of these three phases is to collect as much relevant information as possible linked to the following four main dimensions:

1. alcohol consumption and drinking patterns,
2. alcohol related harm,
3. social and contextual backgrounds of alcohol consumption,
4. potential strengths to counter alcohol related problems in the local community.

⇒ Phase 1: Collecting archival data
Analysis of archival data implies gathering already existing data about alcohol use, such as hospital discharge figures, consultation data in primary care or in alcohol counselling services or police records. The use of archival data has some clear benefits as well as some weaknesses. The most notable benefits are that repeated assessments of the data are possible (if the data are reliable and accurate) and the potential for triangulation, leading to a better validity (De Ruyver et al., 2006). The most prominent weaknesses are risk of underreporting, difficulties to compare data due to variations of recording and entry of data and reluctance to hand out or to share data (Nygaard et al., 2007).
The first challenge when collecting archival data is to get a complete as possible overview of what relevant data are available and to obtain these data. To do so, it is necessary to inform the stakeholders of the ongoing

search for archival data. The local stakeholders often have access to several sources that can be useful for analysis or they can inform you about other relevant sources.

The data may come from different sources, for instance:

- existing publications (research reports, annual reports, …)
- existing monitoring systems (alcohol and drug monitors, police statistics, …)
- existing data from client registration systems (alcohol and drug services, primary health care services, general practitioners, counseling services, …).

Data from different geographical levels (national, regional and local level) may be used. Obviously, the lower this level is, the more accurate these data are. But data concerning the most relevant indicators rarely exist on a local level. Regional and national data may be used to fill this gap, but only with caution: a strict generalisation of these data onto the local setting is not appropriate. Data from higher levels may only serve as an indicative point of reference that needs endorsement from local stakeholders.

Once the archival data are collected and weighed according to their relevance and accuracy, they can be documented and summarised. The findings based on the archival data analysis have to be compared with data from the stakeholders survey and have to be discussed in the group sessions with local stakeholders.

⇒ Phase 2: Brief stakeholders' questionnaire

As indicated in figure 1 additional information has to be gathered via a brief questionnaire addressed to the stakeholders. This questionnaire consists of four opinion-oriented questions. The questions of the questionnaire are based on instruments used in community surveys on alcohol issues, conducted among key informants and community members (Midford et al., 2005; Schineanu et al., 2007). The brief stakeholders' questionnaire can be found in annex 1.

Having selected the stakeholders, each of them should receive this brief questionnaire. Since our quick scan method does imply a limited time schedule, the stakeholders should return their completed questionnaire within five working days. A reminder on the last day, for instance by phoning the non-respondents, could raise the number of received questionnaire.

Once the deadline has passed, the ECAT project coordinator should process the collected data. Since the number of respondents is rather limited and the options to process the data statistically are very basic, it may be done via the good old-fashioned way of tally marks. Once the data are processed, the results have to be reported in the preliminary report.

⇒ Phase 3: Guidelines for group sessions

The brief stakeholders' questionnaire is an intermediate step towards the qualitative completion and adjustment of the data. But in order to gain more insight into the situation and problems of alcohol use and the opportunities to tackle these problems, additional qualitative steps are needed. ECAT promoted the combination of two qualitative methods: focus groups and the nominal group technique "brainwriting". Both methods are described below.

As you will read in the following chapters, most local ECAT projects chose variants of, or alternatives to these two methods. The most occuring influential factors for this were:

- a too limited time span to follow the whole quick scan procedure,
- a limited willingness of the stakeholders to follow the procedure,
- a lack of familiarity with the methodology,
- a lack of need to conduct the brainwriting sessions because there was already enough discussion in previous steps of the quick scan analysis,
- specific unforeseen circumstances, such as political blockage or bureaucratic delay.

In some cases the methodology tended more towards expert panels or peer review groups. But these experiences were also interesting contributions to a feasible quick scan method. In part 2 you can read more about the quick scan experiences in the different ECAT communities.

Focus groups

The focus group method is an interview and not a problem-solving session or a decision-making group session. The strengths of focus groups reside in the topics being narrowly focused, usually seeking reactions to something rather than exploring complex issues in depth and details (Patton, 2002).

The steps of a focus group process are described in annex 2. All together the process generally takes about 6 to 9 weeks.

It is common to organise several focus group sessions on a single topic. A single focus group session lasts about two hours and focuses on a specific set of issues, in our case on the four main dimensions of (problematic) alcohol use, as indicated above. These sessions give a better insight in the participants experiences, attitudes, beliefs and desires. In methodological literature the ideal number of participants is mostly 8 to 10. Focus groups should be composed of people who have a good insight in the topics to be discussed. In our case, the stakeholders ought to be the pool of participants. Others may be included if they are perceived to be valuable in adding and/or checking information.

Every focus group is hosted by a moderator, who is responsible for the development of the process by launching new issues or questions and encouraging interaction. The moderator tries not to interfere in this interaction, except if there is a risk that the interaction could stop prematurely. He or she controls the process in a subsidiary way. While the participants talk, the moderator listens actively, without taking notes. A previously developed script provides the moderator with questions to ask and topics to cover. A script has several benefits:

- the process of writing a script helps you to put the questions in context for the participants,
- a script ensures that each focus group is conducted in a similar way, making the results more reliable,
- a script helps the moderator stay on track and on time,
- a script is helpful when the moderator is external to the process, for instance a hired moderator (Simon, 1999).

The moderator may change the order of questions and topics to keep the discussion flowing smoothly. The moderator has to be a good judge of time to decide when to encourage more discussion on a topic and when to move on. The combination of moderating and interviewing is complex enough to consider the involvement of an observer. The moderator can focus on facilitating the group session while the observer takes detailed notes and deals with unforeseen needs that arise (Krueger, 1994). The observer takes notes of the interaction, covering important statements as well as the body language of participants.

It is the responsibility of the moderator to summarize the results. Typically this summary is combined with transcripts or recordings of the sessions.

Brainwriting

As already indicated, other methods than brainwriting can be used. But it is advisable to use this method, since it is part of the original concept. And it adds an important complementary value to the focus group sessions. Simon (1999) describes the last step of the focus group process as "translating results into action." She gives the following suggestions for this process:

- schedule a meeting to review the summaries and discuss their implications,
- put the focus group information in context. Refer to your purpose statement and analyse the answers or insights of the focus groups. Compare, contrast, and combine the focus group information with information gathered from other sources such as surveys, interviews, or secondary research sources,
- highlight the main themes, issues, problems, or questions that arose in the focus groups. Discuss and record how you plan to address them,
- if there is a lot of information, prioritise it. Then decide what actions need to be taken with regard to the priority items. For example, share the information with local policy makers, build some items into staff work plans, and incorporate specific suggestions into the budget.

Most of Simon's suggestions fit perfectly in the use of brainwriting. Brainwriting, a nominal group technique also known as 'world café', is an alternative method to brainstorming, in the sense that it tries to encourage a more uniform participation within a group via individual idea generation. Like brainstorming, brainwriting is designed to generate a lot of ideas in a short amount of time. The major difference to brainstorming is that the participants give their input in a written way.

Brainwriting is particularly effective because it overrules the classic problem of brainstorming: individuals cannot dominate the choice of ideas, everyone can generate ideas and more timid individuals will be less hesitant to express their ideas (Hughes, n.d.).

A convenient variant for the ECAT quick scan is the 6-3-5-method, i.e.

- groups of 6 participants are formed,
- participants reflect on 3 ideas per round,
- each round takes 5 minutes.

Six participants per group is seen as the ideal number to enhance the generation of ideas without being unmanageable. To limit the time investment, it is advisable to take a limited number of representatives, a kind of mandated "spokespersons", from each focus group session in the brain-

writing session. Try to get a good representation of every participating group within the stakeholders' network.
A coach, in our project the ECAT coordinator, is responsible for the preparatory work, has to be present at the brainwriting sessions (explaining the method, collecting the forms) and is responsible for analysis and reporting.
The procedure of the 6-3-5 brainwriting method is as follows:

1. Each participant receives a prewritten brainwriting form (see annex 3). The problem to be addressed is written at the top of the form. Since we use this method for the translation of the quick scan findings into actions, the problems should refer to the quick scan results about (problematic) alcohol use. For instance: "during the weekends, young visitors to the night life district often become intoxicated after excessive drinking."
2. In the first round, participants have 5 minutes to write 3 ideas in the brainwriting form. If the problem is known in advance, for instance if a list of summarised problems was previously disseminated in the group of participants, the participants have enough time to think about ideas. They may already have developed ideas before entering the brainwriting session. This benefits the process of the session.
3. At the end of each round (after 5 minutes), the form is passed to the person on the right. As each person gets a form from the person on the left, they read all the ideas on the sheet and then add up to three new ones. Ideas from other participants should foster new ideas. The new ideas can be new, or can be variations of or additions to ideas already on the sheet. There is no talking or discussion during these rounds.
4. The process is completed when each participant gets his/her own form back, now filled up with many ideas. The coach collects all forms.
5. The last step is to sort the ideas, using clustering and prioritisation techniques. In annex 3 a practical example of to do this is presented.

3. Application of the quick scan in the ECAT project: step-by-step guide

To conclude this chapter on the ECAT quick scan we fit the information into a practical plan consisting of 10 steps, with basic actions described for every step. To execute these steps properly, it is important to consider the corre-

sponding background information and to implement the available tools that are described in this chapter, in the following chapter and in annexes 2 and 3. It is advisable to follow the chronology of the steps. Occasionally there might be a temporary overlap, for instance if you still receive useful secondary data when the stakeholders questionnaire has already started. In some circumstances beyond one's control, due to a specific local hiatus or unexpected circumstances, some steps may be adapted, replaced by valuable alternatives or even skipped if the process and/or planning is jeopardised otherwise. But the basic rule is to follow the process step by step. If this procedure and the time schedule is followed, the process of quick scanning should be finished within four months.

STEPS	ACTIONS
Step 1 (week 1 – week 4)	**Selection of a network of local stakeholders** (both professionals and members of the population) • select a group of local stakeholder (e.g. existing consulting group on alcohol or local alcohol prevention coordinator) • contact the members of this stakeholder network: – explain the purpose of the ECAT project, of the quick scan as part of it and of the important role the stakeholders have in it – request their participation in the stakeholders network – ask them if they know other stakeholders on the subject of (problematic) alcohol use ⇒ "snowballing" • if some crucial professions or sectors are not (sufficiently) represented in the stakeholders group so far, try to contact other persons via snowballing or social mapping • make a planning scheme and send it to the stakeholders
Step 2 (week 1 – week 4)	**Collecting of archival data** on the alcohol phenomenon and alcohol policy • collect as much data as possible on alcohol consumption and drinking patterns, alcohol related harm, social and contextual backgrounds and potential strengths to counter alcohol related problems in the local community (preferably local or regional data), • ask each stakeholder and others for useful data and information: research reports, annual reports, client databases, etc., • process the data and information and summarize the most relevant results in a preliminary report.
Step 3 (week 4 – week 6)	**Survey stakeholders** • translate the questionnaire (see annex 1) into your language and adapt it to your local situation, for example filling in the name of the municipality/city or adjusting issues to make it relevant to local respondents, • disseminate the questionnaire to the stakeholders' network, • indicate a strict deadline (maximum 1 week after receiving the questionnaire,)

	• contact non-responding stakeholders by telephone two days before the deadline, • process the data via basic descriptive statistics (frequency tables) and clustering of open questions, • summarize the results and add this summary as a chapter to the preliminary report.
Step 4 (week 6 – week 10)	**Focus group sessions** • select the participants in these focus groups from the pool of stakeholders and make sure that the population is represented. Group the selected participants in groups of 8 to 10 . Do not organise more than 4 focus groups or it will become too time-consuming for quick scan purposes, • follow the guideline for conducting focus groups (see § 2.3 and annex 2), • process the data, summarize the results and add this summary as a chapter to the preliminary report.
Step 5 (week 11)	**Dissemination of the preliminary report**, based on the outcome of steps 2 to 4. At the end of the report, the main results should be translated in summarising "statements" (not too much, about 5 main results would be ideal). The report is disseminated to the stakeholders
Step 6 (week 12)	**Brainwriting session**, based on the summarising statements of the preliminary report. • use the summarising statements of step 5 as problem description on the brainwriting form, • select a "representative" sample of stakeholders by asking each focus group to mandate a limited number of participants as "spokespersons" and conduct one or two 6-3-5 brainwriting sessions with members of the stakeholders network (see annex 3), • after the 6-3-5 session is finished, give the group(s) a well-deserved pause of at least 30 minutes, • (if you held two brainwriting session(s), unite the groups and) start clustering using the affinity diagram technique (see annex 3).
Step 7 (week 13)	**Second preliminary report**, consisting of the summary report of the finished affinity diagram and a list of headers and super headers. Send this report to the stakeholders and ask them to rank the headers and super headers within the next two days.
Step 8 (week 14)	**Third preliminary report**, presenting the ranking list of headers and super headers (ranked by average score).
Step 9 (week 15)	**Concluding quick scan meeting with stakeholders**, with following agenda items: • consensus on prioritisation of problems and actions, • selection of the prevention campaign topic, • process evaluation, • product evaluation (quick scan method), • closing informal meeting to thank every participant and to talk things over (with a bite to eat and a drink).
Step 10 (week 16)	**Writing the final quick scan analysis report**, consisting of the results of all data processing and the results of steps 8 and 9 as conclusion. Send a copy of this report to every participant in the quick scan process and to all other relevant professionals, policy makers and distribution channels for the population (e.g. community centres, socio-cultural organisations). This should be the base for further action planning.

References

Boots, K. & Midford, R. (2007). Involving stakeholders in the evaluation of community alcohol projects: finding a balance between subjective insight and objective facts. S*ubstance Use & Misuse*, 42 *(12)*, 1955-1969.

De Ruyver, B., Ponsaers, P., Lemaître, A. & Maquet, C. (2006). *MILD – Monitor Integraal Lokaal Drugbeleid.Eindrapport / Moniteur de Politique Integrée (Locale) en matière de Drogue. Rapport Final*. Brussel: Federaal Wetenschapsbeleid.

Hughes, C. (n.d.). *Brainwriting*. Retrieved 4th September 2008 from http://cqi.ucok.edu/brainpres.pdf (University of Central Oklahoma).

Midford, R. , Young, D., Playford, D., Kite, E., Chikritzhs, T. & Pascal, R. (2005). *An evaluation of liquor licensing restrictions in the western Australian community of Port Hedland*. Perth: NDRI.

Nygaard et al., (2007). Archival data: colelction and use in community alcohol projects. *Substance Use & Misuse*, *42(12)*, 1945-1953.

Ogborne, A. (2006). *Rapid assessments of substance abuse problems: Guidelines and resources with an emphasis on the use and abuse of methamphetamine in Canada*. Ottawa: Canadian Centre on Substance Abuse.

Patton, M.Q. (2002). *Qualitative research & evaluation methods (3rd edition)*. Thousand Oaks: Sage Publications.

Schineanu, A., Welander, F. & Midford, R. (2007). *Report on the Klagoorlie-Boulder community baseline survey, comprising readiness for change interviews with key informants and a survey of community members*. Retrieved 5th September 2008 from http://www.ndri.curtin.edu.au/pdfs/kaap/baseline_study_report_2007.pdf (Kalgoorlie Alcohol Action Project).

Simon, J.S. (1999). *Fieldstone Alliance Nonprofit Guide to Conducting Successful Focus Groups*. St. Paul: Fieldstone Alliance.

Annex 1: Brief questionnaire for local stakeholders

1. What do you consider to be main alcohol problem(s) in [COMMUNITY]? (Indicate maximum 3 problems)

- □ Alcohol related violence and other crime (assaults, sexual abuse, ...)
- □ Public anti-social behaviour (public drunkenness, vandalism, ...)
- □ Drink driving
- □ Underage drinking
- □ Family dysfunction (broken family relations, domestic violence, ...)
- □ Intoxicated people at work
- □ Excessive drinking in sporting clubs
- □ Alcohol consumption seen as normative (youngsters mimicking adults, ...)
- □ Alcohol abuse (high consumption, binge drinking, ...)
- □ Alcohol related injuries
- □ Easy access to alcohol (irresponsible selling or service, provision by third party, ...)
- □ Health, emotional and psychological problems due to alcohol consumption
- □ Social consequences (financial problems, unemployment, ...)
- □ Other (describe briefly):
- □ Other (describe briefly):

2. What is your opinion on the following local alcohol related issues?

	Agree	Not sure	Disagree
There are too many drinking establishments in [COMMUNITY]	□	□	□
Alcohol is a bigger problem in [COMMUNITY] than elsewhere	□	□	□
The community of [COMMUNITY] is involved in preventing alcohol problems	□	□	□
How much a person drinks is a private matter	□	□	□
People in [COMMUNITY] are drinking less now than 12 months ago	□	□	□
Alcohol plays a central role in the social life of [COMMUNITY]	□	□	□

Alcohol is less of a problem now than 12 months ago	☐	☐	☐
It's safe to walk home from the pub in the evening	☐	☐	☐
Information on alcohol and alcohol related harm is readily available in [COMMUNITY]	☐	☐	☐
There is a lot being done locally about alcohol problems	☐	☐	☐
Young people should be taught about alcohol	☐	☐	☐

3. In your opinion, what should be done locally to reduce alcohol problems in [COMMUNITY]?

4. Is there anything else you want to mention about alcohol problems in [COMMUNITY]?

Thank you very much for your participation.

Annex 2: Guideline for conducting focus groups

The following guideline is based on Judith S. Simons publication "Fieldstone Alliance Nonprofit Guide to Conducting Successful Focus Groups". She describes the processing of focus groups in ten steps. Some of these steps are already incorporated in the first stages of the ECAT project. The text boxes indicate a specific linking of the steps to the ECAT project.

Step 1- Define the purpose

A clear, specific purpose statement is essential in order to develop the right questions and elicit the best information. After writing the initial purpose statement, the next question is "why do we want to know that?" Usually the answer to that will lead to a clearer and more refined purpose statement. The clearer the purpose statement, the easier it will be to design the rest of the process.

Step 2- Establish a timeline

A focus group cannot be developed overnight. The whole process generally takes 6 to 9 weeks. Due to the overlap with the first data collection steps, the focus group process in ECAT can be limited to 4 to 5 weeks. Below is a list of standard components and a typical timeline.

1. Following preparatory steps (from 4 to 2 weeks prior)
   - select a moderator and observer,
   - develop a script based on the selected questions,
   - preparatory arrangements: reservation of session site, invitations (sending and follow-up), make room arrangements (seating, equipment, refreshments, etc.).
2. Final preparatory steps (last 2 days prior to focus group session),
   - place a reminder call to the participants,
   - gather session materials.
3. Conduct the focus group session(s)
4. Acknowledgement and data processing (following week)
   - send a thank-you letter to the participants,
   - transcribe notes from the session,
   - summarize the session and mail summary to the participants, with possibility to add annotations.
5. Reporting
   - analyse the sessions and write a report when all information is gathered

Step 3- Identify and invite participants

This step includes the determination of the number of participants, the selection of participants based on a list of key attributes, the collection of names and contact information, and the sending of invitations.

ECAT: use previously compiled list of selected stakeholders.

Step 4- Generate the questions

Because the focus group will last up to two hours, you will only have time for four or five main questions.

ECAT: the four main items of data collection, as mentioned in the introductory paragraph of 2.3. may be used as main questions:

- what are typical features of alcohol consumption and drinking patterns in the local community?
- what is the situation on alcohol related harm in the local community?
- what social and contextual backgrounds have an influence on the alcohol consumption in the local community?
- what are the potential strengths to counter alcohol related problems in the local community?

Each main question has to be subdivided into introductory or warm-up questions and more serious questions that get at the heart of your research. To be effective, focus group questions should be open-ended ("How...?, "Why ...?", ...) and move from the general to the specific.

Once you have a list of questions, look at your purpose statement again. Which questions seem really important? Now look at your list of possible participants. Which questions would they be able to answer? Eliminate irrelevant questions. Then, arrange the questions in a sequence that will be comfortable for the participants, moving from the general to the specific, easy to challenging, and positive to negative.

Before using the questions in an actual focus group session, test them out. Do the responses you get give you the information you need? Go through the questions yourself and try answering them as if you were in the focus group or put some staff members together for a practice focus group and try the questions out. If they work, use them. If not, revise them.

Step 5- Generate a script

Generating the questions is a prelude to developing a more detailed script for your focus group.

Plan on a one- to two-hour time frame. Be cautious not to exceed two hours. After two hours the attention span of participants and moderator starts to fade; the questions and subsequent discussion lose their relevance. To keep the full attention of the participants, make sure sections are no more than 20 minutes long. There are three parts to a focus group script:

1. the opening: the time for the moderator to welcome the group, introduce the purpose and context of the focus group, explain what a focus group is and how it will flow;
2. the question section is where you ask the questions that you designed and tested in step 4;
3. the closing section, including thanking the participants, giving them an opportunity for further input, telling them how the data will be used, and explaining when the process will be completed.

Step 6- Select a moderator

A focus group moderator should be able to deal tactfully with outspoken group members, keep the discussion on track, and make sure every participant is heard. You can also use a two-person team, where one person moderates the discussion and another records it. Be wary of anything about the moderator(s) that might make participants uncomfortable, for example a person knowing to much personal details of the participants. Also consider qualities that might make participants more comfortable. For example an external moderator may be viewed as more objective and may elicit more honest responses from participants.

Step 7- Choose the location

Above all, you need a closed setting in which about ten participants feel comfortable expressing their opinions. It should be cosy and informal enough to encourage conversation. Also important is the accessibility, considering safety, transportation, parking, etc.

Step 8- Conduct the focus group

The materials you need for the focus group session are the focus group script, the list of participants, name tags, notepads and pencils, flip chart or

easel paper, markers, registration equipment, a watch or clock and refreshments.

The moderator should be in the room before the participants, set out the refreshments, and arrange the room so all participants can view one another (e.g. round table or U-shaped seating). As participants arrive, the moderator should set the tone for a comfortable, enjoyable discussion by welcoming them just as would any gracious host.

Once the focus group session starts, the script has to be followed. This demands all the skills of the moderator. In a way he or she has to handle it as a combination of running a meeting and managing group dynamics. Attention to the following items will help ensure success:

1. set the tone; participants should have fun and feel good about the session,
2. make sure every participant is heard,
3. get full answers,
4. monitor time closely,
5. keep the discussion on track,
6. head off exchanges of opinion about individual items.

Step 9- Interpret and report results

There are three steps to creating a report on your focus group:

1. summarize each meeting

   Check the tape quality to be sure that it is useable. If there is some failure, it is easier to reconstruct the discussion immediately after the session. Transcribe notes that were taken soon after the session and write a summary of the focus group. The quick turnaround time on the transcription helps to avoid memory lapses. It is easiest for the moderator to remember what was meant by a particular acronym or shorthand immediately after the session than it is later.
2. analyse the summaries

   Start by reading all the focus group summaries in one sitting. Look for trends (comments that seem to appear repeatedly in the data) and surprises (unexpected comments that are worth noting). Keep in mind that context and tone are just as important as the reiteration of particular words.
3. write the report

The final report can take many different shapes, but it should include all information about the background and purpose of the focus group, details of the sessions, results, and conclusions.

Step 10- Translate Results Into Action

The essentials for this step correspond largely to the (possible) next step in the ECAT project, i.e. a brainwriting session. Besides, it is essential to give follow up to the participants. Mail them the summary from their session, send them a thank-you letter, and include them in correspondence about how the information was used.

Annex 3: Tools and techniques for 6-3-5 brainwriting

Brainwriting form

For each stated alcohol related finding, a separate form should be drawn as shown in the example below. Bear in mind that enough space is needed to write the ideas, so using forms in DIN A3 or larger is advisable. Each participant notes up to three solution oriented ideas for the problem. After five minutes, the form will be passed to the participant to the right. The process continues until each participant has had the opportunity to write ideas for each problem.

Group: Date:		**Problem:** during the weekends, young visitors of the night life district often get intoxicated after excessive drinking	
Participant	Idea 1	Idea 2	Idea 3
1			
2			
3			
4			
5			
6			

Analysis of the brainwriting session: clustering and prioritisation of the ideas

After having completed the brainwriting session, the results have to be analysed. But the data of the session are too "raw" to draw the results immediately. Therefore, the data first have to be clustered together with the participants. To do so, we use a participative technique. After the clustering, it is necessary to reach a consensus within the group of stakeholders on prioritisation, so the discussion can begin about which clusters to merge or eliminate. An appropriate tool is the affinity diagram (also called K-J method), since it groups and interconnects.
To do so in a structured way, the ECAT coordinator should coach this process as facilitator. While facilitating the activity, he/she must pay constant

attention. Otherwise, he/she may lose touch with what is happening, and it may be difficult to regain an understanding of the data structure. Affinity diagramming can be quite tiring. Do not allow the activity to continue past the point of tiredness or boredom. Avoid having more than two consecutive affinity diagramming sessions during a workshop.

The method of the clustering and prioritisation by using an affinity diagram is based on seven steps and procedes as follows.

1. Immediately after the brainwriting session, all ideas are copied onto sticky notes (larger type). Display the notes by spreading them randomly on a large work surface (flip charts, blackboard, wall,...). All the notes have to be visible to everyone. Make sure that there is enough light to read the notes. The participants gather around the notes and participate in the next steps.
2. It is very important that nobody talks during this step. The participants sort the ideas into related groups by looking for two ideas that seem to be related and placing them together in a separate column. Other ideas that are related to these can be added to that group. Then the participants look for other ideas that are related to each other and establish new groups. If a note seems to belong in two groups, make a second note. This process is repeated until the team has placed all of the ideas in groups. It is possible that some "loners" that do not seem to fit a group remain at the end.
3. Create header cards for the groups. Participants have to talk again in this step. They can discuss the shape of the chart, any surprising patterns, and especially reasons for moving controversial notes. A few more changes may be made.

   When ideas are grouped, select a header for each group. A header is an idea that captures the essential link between the ideas contained in a group of cards. This header is written on a sticky note and must consist of a phrase or sentence that clearly conveys the meaning. Place it at the top of the group. It is better to write or highlight this note in a different colour.
4. Combine groups into "super groups" if appropriate, by discovering a relationship among two or more groups and arranging them in columns under a super header. The same rules apply for super headers as for regular header cards.

5. Draw the finished affinity diagram. Write a problem statement at the top of the diagram. Place header and super header notes above the groups of ideas. Review and clarify the ideas and groupings. Make a summary report of the finished affinity diagram.
6. Attribute levels of priority. Send the list of the headers and super headers and a blank ranking form to all the stakeholders. Each stakeholder should rank the super headers and headers by priority of action: what is to be acted upon first? Give the stakeholders two days to complete the ranking form and collect all forms. Then make a general ranking list by sorting the super headers and headers by the average score.
7. Arrange a meeting with the stakeholders and present them the general ranking list of priorities. Make them clear that some discussion is still possible, but without questioning the result of the general prioritisation list. It is most important that a consensus on the priorities is reached. If this is achieved, the results of the quick scan are ready to be translated into actions.

Chapter 3 Community-based alcohol prevention: what works?

David Möbius
ECAT project collaborator, Vereniging voor
Alcohol- en andere Drugproblemen – VAD, Brussels (B)

1. Introduction

Based on the findings of the ECAT literature review on community-based prevention towards alcohol related problems, the ECAT-project uses both targeted and population based strategies. Indeed, evidence and good practices in community alcohol prevention indicates that introducing a mix of measures is most effective: some regulatory, addressing the population at large and others aimed at individuals at -risk, high-risk behaviours, or high-risk settings. They include educating individuals about drinking, while at the same time actively increasing their safety. Ultimately, what works is a range of evidence based measures designed to achieve short-term as much as long-term results. These measures are:

a) The introduction of evidence based alcohol prevention interventions
b) Regulations and enforcement
c) A communication campaign (to prepare the ground for prevention, regulations and enforcement)

(a) Within a community approach, the selection of appropriate strategies requires the identification of those alcohol related problems that are of greatest concern to the community. Dependent on the results of the quick scan conducted in the community, it is ultimately a judgement by the members of the stakeholders' network as to which problems require which action and their commitment to get involved. However, to arrive at their choice of the most appropriate strategies for their community, it is necessary for them to take into account the specific circumstances and evidences concerning community alcohol prevention. One should bear in mind that communities are often not as orderly and neat as conceptual models, and frequently respond in counter-intuitive and unpredict-

able ways to the carefully designed data reports and recommendations of prevention professionals (Ryan & Reynolds, 1990). Nevertheless, it is most important that local alcohol prevention is broadly based and emphasizes elements that are of proven efficacy[1]

(b) Apart from implementing these evidence based alcohol prevention interventions, there is strong evidence that introducing alcohol related regulations and the enforcement of these regulations is most effective in reducing alcohol related problems (Babor et al., 2003). However, the options for a community to regulate alcohol related issues strongly depend on the legislative framework of the country of which the community is part.

(c) By providing as many community members as possible with accurate information on the health, social, and economic consequences of alcohol use, they are equipped with the tools necessary to participate in a meaningful way in the development of strategies and future activities to reduce the risks associated with alcohol consumption. Communication campaigns thus play a very particular role in creating and reinforcing awareness of the problems created by alcohol use and preparing the ground for specific interventions (Voedsel- en Warenautoriteit, 2007). Therefore, an essential aspect of ECAT is the implementation of a communication campaign in the community.

2. The introduction of evidence based alcohol prevention interventions

In this section, an overview of interventions found to be effective in dealing with alcohol related problems is given. It should be noted however that these interventions are only recommendations. During the discussions foreseen in the quick scan analysis, the members of the stakeholders' network should discuss these recommendations and eventually decide whether to introduce them into their local alcohol strategy or not. Based on the findings of the ECAT literature review, it is recommended

1 The suggested interventions are derived from the overview of evidence based interventions presented in the literature review. Specific information on these interventions can be found there as well.

that the following interventions are introduced to the stakeholders' network:

- Brief interventions in primary care and accident and emergency departments
- Work based programmes
- Responsible Beverage Service (RBS)

In the next section of these guidelines, these interventions will be dealt with separately in order to make clear which aspects should be kept in mind when designing the community action plan. Most likely, it will not be feasible to implement all of these interventions in a given community. Depending on the local (political) situation, national regulations, culture and so on, each community needs to implement what is appropriate for the community in question. For example, due to local priorities, it will not be possible in some communities to mobilise fully the police to take part 1n the project. It is also important to keep in mind that various stakeholders are subject to different pressures. Consequently, political agendas and financial interests and responsibilities at different levels can either be facilitators or obstacles in this kind of work. For example, the livelihood of restaurant and shop owners is partly dependent upon selling alcohol within a competitive marketplace. Obviously, this will pose problems when they are, for example, asked to take measures that reduce their alcohol sales without compensation by increased sales of non-alcoholic products. Thus, if there is no clear advantage to them by making environmental improvements outside their premises, or by investing in training their staff in responsible serving practice, it is foreseeable that they will be reluctant to accept the costs (Mistral et al., 2006). Furthermore, the good practices and specific training courses described in this part of the guidelines are not necessarily the only options to be implemented in your community. It is a possibility to use these materials but it is also possible to use other materials with proven value and/or to develop specific ones for your community. Examples of such materials can also be found in this section. However, when using existing materials like these, they have to be marked with the ECAT-logo which can be found at the ECAT-website (more information on this can be found in the section on the communication campaign).

2.1 Brief interventions in primary care and, accident and emergency departments

Brief interventions head the list of evidence-based methods, favouring their effectiveness in reducing alcohol consumption to low-risk levels among hazardous and harmful drinkers. A systematic review of the evidence for the efficacy of brief behavioural counselling interventions in primary care settings conducted by Whithlock et al. (2004) found that there is review-level evidence to show that brief interventions (especially multi-contact interventions) can reduce net weekly drinking by 13% to 34%, resulting in 2.9 to 8.7 fewer mean drinks per week and a significant effect on recommended or safe alcohol use. Furthermore there is review-level evidence to suggest that heavy drinkers receiving brief interventions are twice as likely to moderate their drinking six to 12 months after an intervention when compared with drinkers receiving no intervention (Mulhivill, et al., 2005).

For providers of health services it is therefore recommended that:

- Representatives of hospital based staff and general practitioners are engaged to become active members of the local stakeholders' network,
- Hospital based staff and community-based general practitioners receive training to enable them to implement the key indicators and record alcohol related presentations. Furthermore, it is recommended that they receive training in recognising and responding to alcohol problems (competence improvement),
- All hospital based and community-based physical and mental health staff are aware of 'safe limits',
- Support materials are made available to workers who have been trained to recognise and respond to alcohol problems,
- Information about alcohol consumption is integrated into existing health assessment/screening procedures,
- General practitioners have a range of brief intervention support materials to help them to intervene effectively,
- Hospital and community-based mental health service units provide alcohol education sessions,
- Accident and emergency departments display information about alcohol and accidents.

A highly recommended instrument for the training of primary health care workers in recognising and responding effectively to hazardous drinking is a training manual developed by the EC-funded *PHEPA project (Primary Health care European Project on Alcohol)* aimed at integrating health promotion interventions for hazardous and harmful alcohol consumption in primary health care professionals' daily clinical work. This manual, by Anderson et al. (2005), offers the trainer five different sections to prepare them for different levels of training (including work documents, overheads and handouts). Furthermore, the manual includes some recommendations for primary health care workers to optimise results:

- Questions about alcohol use could be incorporated into a general history of lifestyle questions or into a general health questionnaire (questions about exercise, nutrition, smoking and medications).
- Patients at high risk of illicit drug use could be asked about alcohol and other drug use.
- The physician should adopt a non-confrontational, non-judgemental and empathetic approach when interviewing the patient and when discussing screening results.
- When recording screening results, the physician should indicate that a positive screen is not necessarily a diagnosis.
- The extent and limits of confidentially must be clearly explained to the patient if a positive score is detected. The charts of patients who screen positive should be flagged, but the reminders should remain neutral.

Given the evidence that the impact of brief interventions for hazardous and harmful alcohol consumption diminishes after four years, screening could be repeated every four years, unless there was a clinical reason to undertake it sooner.

The manual can be downloaded at: http://www.gencat.net/salut/phepa/units/phepa/pdf/tripa_training_ok.pdf

2.2 Work based programmes

Since the majority of adults are employed and thus are spending a significant proportion of their time at work, the workplace provides several opportunities for implementing prevention strategies. Evaluation studies have indicated that workplace programmes succeeded in returning substantial proportions of employees with alcohol problems to effective performance (McAllister 1993; Blum and Roman 1995). The European Parliament (2007) therefore recognises that tackling the problem of hazardous and harmful alcohol consumption at work is an effective approach, especially considering that the working environment is a place where information can be distributed widely.

For workplaces (managers, personnel departments, occupational health departments, employee organisations, etc), it is recommended that:

- Representatives of workplaces are engaged to become active members of the local stakeholders' network,
- They develop and implement comprehensive alcohol policies,
- They have information available to employees about safe drinking limits,
- Alcohol issues are included in any healthy workplace initiative,
- Opportunities for access to counselling are made available to employees experiencing problems with their drinking,
- Occupational health workers receive training to recognise and respond to alcohol related problems experienced by employees,
- Stress management training is available via the workplace.

In general, issues around alcohol in the workplace, employers' bars, lunchtime drinking and so on require comprehensive consultation before any rules or recommendations are drawn up. Be prepared for all kind of objections, lack of cooperation and lack of understanding. Therefore, ensure that other agencies or groups, like worker representatives, support and are willing to back this issue (Mathrani, 1995).

The American psychosocial *Team Awareness programme* provides skills training in peer referral, team building, and stress management. Informational training used a didactic review of policy, employee assistance, and drug testing. The training manuals from the Team Awareness programme can be downloaded at:

- http://www.ibr.tcu.edu/_private/confirmmanuals.asp#TeamAwareness (Team Awareness, Drugs in the Workplace: 8-Hour Training for Workplace Substance Abuse Prevention)
- http://www.ibr.tcu.edu/_private/confirmmanuals.asp#TeamAwarenessSB (Team Awareness, Small Business: 4-Hour Training Package for Workplace Substance Abuse Prevention)

2.3 Responsible Beverage Service (RBS)

In the recent decade, attempts to reduce alcohol related harm have targeted the settings in which drinking takes place. These training programmes provide education and training to servers of alcoholic beverages with the goal of altering their serving practices to prevent patron intoxication and alcohol-impaired driving. When implemented as part of a more comprehensive community-based approach, responsible server programmes have been found to be effective, particularly for night-time

crashes amongst young people (Wagenaar et al., 2000). There is also review-level evidence to suggest that intensive, high quality, face-to-face server training, when accompanied by strong and active management support, is effective in reducing intoxication levels in customers (Mulvihill et al., 2005).

For the catering and hospitality trade sector, it is therefore recommended that:

- Representatives of all sub sectors within the catering and hospitality trade (restaurant and shop holders, alcohol suppliers etc.) are engaged to become active members of the local stakeholders network,
- Owners of establishments selling alcoholic beverages receive training on the licensing law and alcohol education,
- All server staff receive the same training (about standard drink sizes, proper ID checking, recognising inebriation, not over-serving intoxicated individuals, and dealing (in non-confrontational ways) with patrons who have consumed too much alcohol,
- All door staff should receive training (to recognise potential conflicts before they occur and to dealwwith problems constructively rather than aggressively),
- Establishments serving alcoholic beverages display information about units and safe limits at the point of sale,
- Alternatives to alcohol are prominently displayed in places where alcohol is sold and served.

It is important that the owners of establishments selling alcoholic beverages are motivated to come up to the recommendations described above (RBS, safer bar environments etc). However, often the desire to reduce problems is in conflict with the profit motive: cutting down on the client's drinking has the potential to cut profits. Promotional materials (beer mats on the tables or posters in bathrooms, for example) can be used to impart advice about safety, or about testing for drugs that may have been added to drinks (Stimson et al., 2007).

A **Good Practice** to involve bars and their owners in a community project is the "Best Bar None" scheme, originated by the Greater Manchester Police City Centre Safe Initiative as part of the *UK Community Alcohol Prevention Programme* (UKCAPP). This initiative has shown to be an effective way of getting local publicans and licensees to recognise the importance of customer safety and safe drinking. Awards and the right to display the Best Bar None logo (a "safe pub" logo to attract clientèle) are given to pubs, bars, and clubs that are deemed to have adequately considered door policy, crime prevention and emergency procedures, and policies related to drinking and drugs (Mistral et al., 2006). The final evaluation of UKCAPP can be downloaded from http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0039.pdf

A very useful guidance is *The responsible serving of alcoholic beverages: a complete staff training course for bars, restaurants, and caterers* by Beth Dugan (2006). This handbook was designed to help bar owners and managers make necessary changes, and train their employees in order to mitigate legal risks when serving alcohol. The book includes sections on policy changes as well as a bar training programme. Managers can use the companion CD, and print out those parts most applicable to their operation.

Good Practice*:* A good example of a community project in which server training formed the main component was the STAD-project (*'Stockholm Prevents Alcohol and Drug Problems'*) held in Stockholm (Sweden). Key elements in the responsible beverage service (RBS) training programme were medical and behavioral effects of alcohol, the Swedish Alcohol Law, crimes related to licensed premises, knowledge of other drugs and conflict management. One component in the RBS training consisted of the practice of skills used to refuse alcohol service to an intoxicated patron. The main target groups for the training were servers, doormen and owners of licensed premises. The results showed that licensed premises with RBS-trained staff refused alcohol service more often than licensed premises without RBS-trained staff. However, this was only possible through a combination of RBS-training, community mobilisation and an increased enforcement of extant alcohol laws (Wallin et al., 2005). More information on the STAD-project, including materials, can be found on www.stad.org

2.4 Other preventative interventions

As stated above, it is important that local alcohol prevention is broadly based and emphasises elements that are of proven efficacy. However, it must be stated that a lack of proven effectiveness does not always imply that a measure should not be implemented. For example, the fact that no studies have shown sustained effects of education does not prove that such effects do not exist. It is possible that these activities have long-term effects which are very hard to separate from other influences and documents in scientific studies. Consequently, it would be inappropriate

to stop alcohol education in schools and not to take it up as part of a local alcohol prevention strategy. In the short overview below, a couple of interventions that are not found to be effective on an evidence base but nevertheless might be recommended to implement in the community - depending on the local needs exposed by the quick scan analysis - are summed up.

School based education

Despite many years of research, the effects of most school-based programmes are rather small and programme failures are common. Although reviews indicate that prevention programmes have large effects on the knowledge and attitudes of scholars, this does not necessarily results in a change in drinking-behaviour. (Anderson & Baumberg, 2006; Trimbos Instituut, 2006). A recent review of the effectiveness and cost-effectiveness of interventions delivered in primary and secondary schools to prevent and/or reduce alcohol use by young people under the age of 18 years found that there is a lack of clear, long-term evidence for the effectiveness of school-based interventions (Jones et al., 2007). Furthermore, one should bear in mind that working with schools may not be particularly easy, depending on the organisation of the school system and the perceived role of the school in the community. Good communication needs to be established with the education authority and the individual school. If the work fits into a project already running in the school, and it is clear that the project will not add substantially to teachers' already heavy workloads and full curricula, there may be more chance of success (Mathrani, 1995). Educators also need to be aware that their message is not the only message being disseminated, and that they can never be sure what people will actually hear, and what they will miss (Witte, 1994). Despite these objections it is recommended for educational services that:

- They are represented in the local stakeholders' network,
- They ensure that the following areas are covered by the school curriculum: awareness of units and limits, alcohol and unsafe sex, alcohol and gender issues, alcohol and relationships, drinking and driving,
- Teachers and other school staff receive adequate support and training to ensure they can implement an alcohol programme (competence improvement) in their schools.

A good example of a well-designed study is the ***School Health and Alcohol Harm Reduction Project*** (SHAHRP study) from Australia, which aimed to reduce alcohol related harm in secondary school students (McBride et al., 2004). The SHAHRP teacher manual and/or student workbooks are free of charge and can be downloaded at http://www.ndri.curtin.edu.au/shahrp/download.html.

Parents

Parents can influence their children's drinking by setting rules in the home and by monitoring these rules. Parents are also important community members and can influence community norms on drinking and on action to prevent drinking (Rehnman et al., 2005; Van der Vorst, 2007). Therefore parents' evenings for example can be very useful to inform them about the effects of alcohol on young children and to present them with the issue. On these parent evenings, easy accessible presentations can be held in which the parents' questions should be made explicit. The presentations can deal with topics such as setting rules, recent developments, physical, psychological and social consequences, reasons for alcohol use, practical tips, what to do or not to do as a parent, and so on (Koning, 2006).

Good Practice: *Alcohol Awareness Training for Parenting Professionals*
This UK training course for parenting professionals uses a variety of experiential and direct teaching methods, as well as case studies, role-play, and card sort exercises to create an active learning environment. The course is intended to be largely self-contained in order that no extra study or information gathering is necessary.
This training course can be downloaded at: http://www.alcoholandfamilies.org.uk/taining_materials/12.6.pdf

Leisure services and sports clubs

For leisure services and sports clubs, it is recommended that:

- Representatives of all kinds of leisure services and sports clubs are engaged to become active members of the local stakeholders network,
- Information about alcohol and accidents is targeted in appropriate locations, such as swimming pools,
- Safer drinking is encouraged by ensuring there are a wide range of alternatives to alcohol, prominently displayed in sports centres' bars.

Social service departments

For social service departments, it is recommended that:

- They are represented in the local stakeholders' network,
- They agree on a set of standardised key indicators to identify a range of alcohol related problems, e.g. physical and emotional ill health, accidents, family/relationship problems,
- They receive specialist alcohol training, e.g. alcohol and child protection, alcohol and the elderly, alcohol and mental health,
- They make a range of support materials available to enable them to intervene effectively,
- They make alcohol awareness training available to support staff such as home helps.

Out-of-school youth services

For youth services, it is recommended that:

- They are engaged to become active members of the local stakeholders' network,
- They address alcohol issues (awareness of units and limits, alcohol and unsafe sex, alcohol and gender issues, alcohol and relationships, drinking and driving) in informal youth settings,
- They make sure that youth workers are adequately supported and trained to ensure they can effectively implement alcohol programmes (competence improvement).

3. Regulations and enforcement

There is growing evidence for the impact of setting rules to regulate the availability of alcoholic beverages for specific target groups, such as limiting the hours and days of sale and raising the minimum drinking age. However, the effectiveness of these measures relies heavily on adequate enforcement. For instance, passing a minimum drinking age law will have little effect if it is not backed up with a credible threat to remove the licenses of outlets that persist in selling alcohol to minors (Anderson & Baumberg, 2006). Furthermore, national legislation often stands in the way of dealing with specific problems at the local level (e.g. in Belgium, communities can only deal with night shops selling alcohol to youngsters if the police have made several reports of public nuisance). Despite these sometimes limited opportunities for communities, which differ from country to country, it is

recommended to fully investigate and make use of the very specific legislative and enforcement authority concerning alcohol present in the community at stake. There are often possibilities for setting rules at the local level concerning setting age limits, licences, alcohol and traffic, marketing (e.g. no alcohol marketing on materials owned by the local authority) and self-regulation (e.g. prohibition or restrictions on organising happy hours). Also the stakeholders in the local network can help the local authority with organising better enforcement of national and local regulations: the catering and hospitality trade for example can make concrete commitments on improving the enforcement of age limits, on prohibiting the over-serving of intoxicated persons and on applying sensible closing times. Thus, community-based measures need to be accompanied by enforcement for them to be effective on a longer term. Therefore, it is recommended that:

- Representatives of the police are engaged to become active members of the local stakeholders' network,
- The police receive training in recognising and responding to alcohol problems (competence improvement),
- The police encourage owners of establishments selling alcoholic beverages to display information about drinking and driving (e.g. posters, beer mats etc),
- The police play a role in schools especially on the issue of drinking and driving,
- The police operate high profile breath testing campaigns,
- Police stations display information on where to go for help,
- The police pro-actively hand out information on alcohol services when alcohol is a factor in an arrest/incident,
- Active enforcement of alcohol related regulations (frequent checks) takes place,
- Uniformed police presence is highly visible around late-night public transport and in known 'hotspots' (high profile targeted policing).

Good Practice: A good example of this kind of intervention is the *Complying with the Minimum Drinking Age project (CMDA),* held in the US Midwest. This project was designed to test the effects of two interventions designed to reduce alcohol sales to minors:

- training for management of retail alcohol establishments,
- enforcement check of alcohol establishments.

Results of this trial show that enforcement checks on alcohol outlets reduce the likelihood of illegal alcohol sales to underage youth, with a deterrent effect in both on-premise and off-premise establishments. However, this deterrent effect was only observed in those establishments that had actually been checked by law enforcement and thus did not affect other establishments in the community. Therefore, law enforcement agencies should be encouraged to conduct frequent checks. More information on the outcomes of this community trial can be found in Wagenaar et al. (2005). The manual with instructions on how to conduct or implement compliance checks can be downloaded at http://www.epi.umn.edu/alcohol/manual/manual.pdf

4. The ECAT communication campaign: preparing the ground for a local alcohol strategy

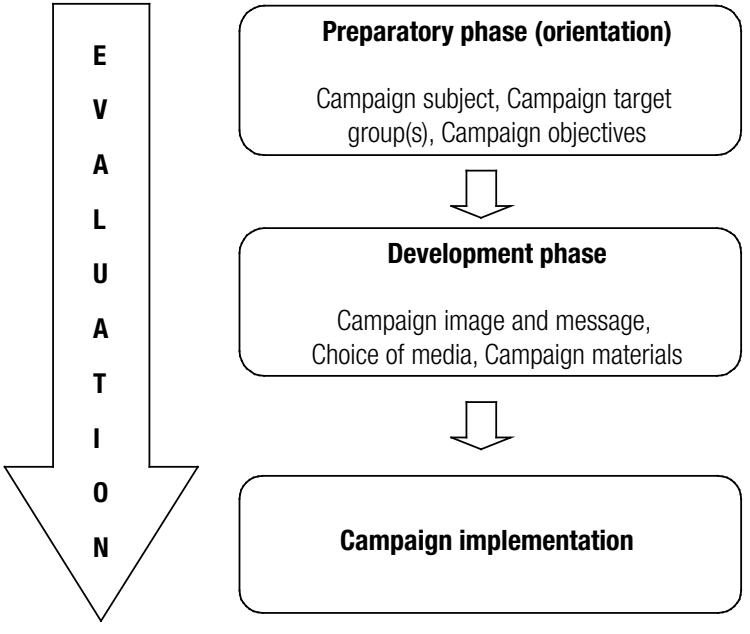
In order to create support for the rationale behind the interventions and the objectives of the local alcohol prevention strategy, the implementation of a communication campaign is an important step to be taken. A communication campaign can be broadly defined as any deliberate endeavour to influence all or particular sections of the public by using a range of media. In the case of alcohol related communication campaigns these sections might include groups 'at risk', particular or professional interest groups and opinion formers and, of course, the media itself. Alcohol related communication campaigns should be used to raise awareness and increase knowledge of related problems, as well as to complement and support drug and/or alcohol interventions at governmental and/or community level. By placing the issue of easy access to alcohol and the lack of effective coping with alcohol related problems on both the political and community level agendas, media advocacy will also be able to sustain momentum in both national and local arenas (Huckle et al., 2005; Home Office, 2001). The European Parliament also recommends its Member States to promote communication campaigns designed to raise awareness about the risks of hazardous and harmful alcohol consumption. "First of all, accurate information should be provided through an awareness-raising campaign at all levels – family, school and media. [...] Action should be taken through education and information because hazardous and harmful alcohol consump-

tion is essentially, like so many other behavioural problems, a question of attitude. To improve society, we need to change general attitudes" (European Parliament, 2007: 13-14). All this indicates that implementing an alcohol communication campaign in the community should not be seen as the icing on the alcohol strategy cake, but as a substantial part of the cake itself. Indeed, creating a public basis for a local alcohol strategy is a precondition for the community to comply with the strategy and therefore forms a key aspect in any ECAT based community oriented project.

4.1 The development of the ECAT communication campaign

In general, the construction of a communication campaign consists of four major phases (figure 1): (1) Preparatory phase, (2) development phase, (3) campaign implementation, and (4) evaluation. When filling in these four phases, it is of course very important to take into account the findings of the quick scan analysis. After all, they are the basis for determining the content of the communication campaign.

Figure 1: Schematic overview of the different phases in the ECAT communication campaign



4.1.1. Preparatory Phase - Orientation (intrinsic and practical)

Communication campaign subject

For most people, drinking alcohol is not harmful. However, misuse or irresponsible consumption potentially causes harm to individuals, especially through a large number of health problems. Given the fact that alcohol use often is a social activity, many consequences of problematic alcohol use can be characterised as being social. Thus, alcohol is widely spread and therefore used in a variety of settings: traffic, workplace, family, leisure time, sports. Each of these settings is characterised by different patterns of use and different consequences related to problematic alcohol intake. To address these and other community problems, as detected by the quick scan analysis, in a communication campaign, it is highly recommended that the campaign uses only one campaign logo expressing the campaign subject. Otherwise, it is very difficult for the community members to have a clear and unambiguous image of the aim of the communication campaign.

For the ECAT communication campaign it was decided to choose one campaign logo and strapline to be used as a signature and canvas for local application in all participating communities: an image of a pink elephant[2] combined with the slogan ***'Alcohol. Take a sober look'***. For the participating communities to easily receive this logo and strapline, a website has been made available on which the ECAT participants could download them and other useful materials (in the different languages).
The graphic design concept for the local communication campaigns can be found in annex 1.

Communication campaign target group(s)

A single message or campaign cannot pretend to do everything for everyone. Therefore, a target audience or group is essential for the intervention. Target group here refers to the population to be affected by the communication campaign and corresponding interventions. This can be:

- the general population of drinkers,
- high risk drinkers or groups considered to be particularly vulnerable to the adverse effects of alcohol (e.g. adolescents),

2 A pink elephant is associated with drinking too much alcohol ('Seeing pink elephants' is a euphemism for drunken hallucination caused by delirium tremens).

- persons already manifesting harmful drinking and alcohol dependence (Babor et al., 2003).

Based on the results of the quick scan analysis, the target group for the local ECAT communication campaign should be determined. Defining this target audience is one of the most important aspects of campaign development. Rather than defining an audience purely in demographic terms (age, gender and ethnic grouping), defining the audience in terms of their psychographics (attitudes, values and beliefs) is considered to be a much more effective way (Tones, 1996; ALAC, 1999). To be more effective, it is suggested that messages are also pitched at those who have a direct interpersonal influence in shaping the lives of those around them, such as parents or general practitioners (intermediary target groups). Indeed, efforts towards the reduction of alcohol related harm must be meaningful to the intended audiences (Stimson et al., 2007).

Example from the Austrian ECAT project (Gmunden)

Based on the results of the quick scan analysis, the following target groups were determined:

- *Final target group*: young people between 13-22 years of age.
- *Intermediary target groups*: bar/club owners, parents, officials of associations, police, city officials and politicians

Communication campaign objectives

Evidence suggests that change by means of a communication campaign is likely to be gradual at best and will only influence a small proportion of the population. In order to be able to evaluate the local communication campaign despite the lack of influencing power, objectives need to be SMART: ***S****pecific*, ***M****easurable*, ***A****cceptable*, ***R****ealistic* and ***T****ime-specific*. The ECAT communication campaign counts three types of objectives:

- to raise awareness (of the problems associated with alcohol misuse);
- to provide information (about alcohol and its effects, about alcohol services);
- to change attitudes (e.g. to foster negative feelings about alcohol misuse or positive feelings about moderate use).

Based on the results of the quick scan analysis in the community and taking the SMART principles objective-types into account, final and intermediate objectives for the communication campaign need to be formulated.

Example from the Slovenian ECAT project (Kranj):
Final objective: to reduce hazardous drinking patterns among young people, especially binge drinking.
Intermediate objectives:

- to encourage young people to have fun without alcohol,
- to inform the general public about the use of alcohol among children and young people,
- to influence young people's attitudes around alcohol,
- to increase young people's understanding of the negative consequences of drinking.

4.1.2. Development phase

Thinking up and developing the communication campaign image and message

Once the orientation phase has been completed, the strategy for the communication campaign needs to be formulated. In general terms, this communication campaign strategy describes:

- How to reach the different target groups,
- Different aspects to be emphasised,
- The necessary means of communication.

Hiring a media company to provide the necessary creative input to get your message across can be a good idea. However, to lower the costs for local campaigning, it may be more feasible to involve youngsters, students or other creative community members. This approach is in line with existing evidence indicating that messages should be appropriate to the target group using a vocabulary which is relevant and familiar to the intended audience (Home Office, 2001). In other words, because individual behaviours are based on constructs that are developed in a social context, it is important that the communication campaign uses language that accurately reflects the interpretive schemes developed by the target group (Lederman & Stewart, 2005). Furthermore, it is suggested that repetition of a single message during a communication campaign is held to have greater impact than the presentation of a variety of messages (ALAC, 1999; Tones, 1996).

Good practice from the Slovenian ECAT project (Kranj)

The budget for the local ECAT communication campaign was rather small. Therefore, they did not engage the services of a media company for preparing and implementing the campaign. The campaigning costs were lowered by getting the target group (i.e. young people) to create the slogan themselves. The posters, booklets and website accompanying the campaign were designed by graphic arts students.

Choice of media

There are different forms of communications available to use. Following the evidence on communication options presented in the ECAT-literature review, the following communication media are recommended:

- Posters, flyers and leaflets,
- Newspapers and magazines (editorials): press release/article,
- Press conference and press map,
- Radio stations/ local and regional television,
- Lectures and public events.

Posters, flyers and leaflets

A poster mostly contains a message aimed at a wide public audience. However, to give more extensive information, a poster is not the best medium: a leaflet or flyer can be the solution. The dissemination of posters and leaflets is a task for the different stakeholders. A personal approach towards the target group by handing over the posters and leaflets to them is considered to be the most successful way to do this.

Newspapers and magazines (editorials): Press release/article

To give the ECAT project more attention in the community, it is recommended to generate newsworthy stories by means of a press release or press article in a community paper. One option is writing an article about the project (giving a concise overview of its different aspects) and publicising it in a local information paper. Another option is letting the theme return repeatedly in a fixed section in which one aspect of the project and its objectives can be described each time. Finally, it is also possible to present the theme in different sections of a newspaper or magazine: health section, youth news, prevention etc. A press release on the other hand is short, powerful and clear and gives one central message. The principles on which a good press release are built on can be found in the ECAT literature review.

Press conference and press map

Besides a paper version of your story, you can also choose to invite journalists to come over personally to hear your story about the project. Therefore it is useful to announce the initiative in advance. It is also important to offer the journalists a comprehensive press map in which the project is made clear. However, it is not good to just read this aloud during the press conference (journalists mostly experience this as a waste of time). This makes the creation of a purposeful invitation and press map highly important. Recommendations on the content of the press map and the organisation and timing of a press conference can be found in the ECAT literature review.

Radio stations/ local and regional television

There are a variety of ways to announce your initiative by means of the local television or radio. You can for example ask for an interview. Here it is recommended to keep your message as short as possible, otherwise the attention of most listeners will be lost (mostly after approximately 3 minutes). If you want the local radio or television to attend a press conference, it is recommended to give at least three weeks' notice.

Lectures and public events

Public events can highlight the problems ECAT aims to act upon. Events such as public hearings can help your partnership to achieve several goals: these events simultaneously motivate participants, inform the community at large, and promote the issue of alcohol problems by offering the media a story with real local news value. Therefore, being creative in your selection and promotion of special events is crucial. Use the event to attract additional groups to your partnership as participants or sponsors. Be sure to involve all members of your local stakeholders' network, as their support is necessary to ensure widespread interest in the event (Join Together, 1998).

Example from the Slovenian ECAT project (Kranj)

Communication initiatives taken:

- Workshop for bar owners and staff
- Press conference
- Activities during the 'festival of young people' in Kranj
- ECAT - stalls for young people
- Public event : Workshop about alcohol for general public
- Posters in Kranj
- Workshops about alcohol at schools
- Press releases in local and regional newspapers
- Website (www.zvv-kr.si)

Development of campaign materials

It is recommended to hire a media company to get your message across. They will also have a good view on how and where to print the materials. But then again, this demands a large financial input. Therefore, less expensive alternatives are at hand: for example, it is possible to use existing materials, developed in the ECAT project. However, they have to be marked with the ECAT-logo and stripline: stickers with this logo are developed and provided to the ECAT-partners in order to mark the materials as ECAT products.

Good practices in the development of campaign materials in the ECAT communities can be found in part 2 of this manual.

4.1.3. Communication campaign implementation

The dissemination of the campaign materials and the organisation of other chosen communication initiatives (such as press conferences and public events) will be a task for the stakeholders. After all, they are part of the community structures and therefore are the most appropriate partner to implement the communication campaign within their network. A practical description of the implementation of the communication campaigns in the participating ECAT communities can be found in part 2 of this manual.

4.1.4. Evaluation

The evaluation of the ECAT-communication campaign is described in chapter 4 in part 1 of this manual.

References

Alcohol Advisory Council of New Zealand (ALAC) (1999). *Best practice guidelines worldwide for information services concerned with safe drinking.* Wellington: ALAC Occasional Publication No 9.

Anderson, P. & Baumberg, B. (2006). *Alcohol in Europe: a public health perspective. A report for the European Commission*. London: Institute of Alcohol Studies.

Anderson, P., Gual, A. & Colom, J. (2005). *Alcohol and Primary Health Care: Clinical Guidelines on Identification and Brief Interventions.* Barcelona: Department of Health of the Government of Catalonia.

Babor, T.F., Caetano, R., Casswell S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J.W., Gruenewald, P.J., Hill, L., Holder, H.D., Homel, R., Österberg, E., Rehm, J., Room, R. & Rossow, I. (2003). *Alcohol: No Ordinary Commodity. Research and Public Policy*. Oxford: Oxford Medical Publication, Oxford University Press.

Blum, T.C., & Roman, P.M. (1995). *Cost-Effectiveness and Preventive Implications of Employee Assistance Programmes*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Dugan, B. (2006). *The Responsible Serving of Alcoholic Beverages: a complete staff training course for bars, restaurants, and caterers.* Ocala: Atlantic Publishing Group.

European Parliament (2007). *Report on an European Union Strategy to support Member States in reducing alcohol related harm (2007/2005(INI))*. Committee on the Environment, Public Health and Food Safety.

Home Office (2001). *Let's Get Real: Communicating with the public about drugs.* London: Home Office.

Huckle, T., Conway, K., Casswell, S. & Pledger, M. (2005). Evaluation of a regional community action intervention in New Zealand to improve age checks for young people purchasing alcohol. *Health Promotion International*, 20(2), 147-155.

Join Together (1998). *Save lives! Recommendations to Reduce Underage Access to Alcohol & Action Steps for Your Community*. Boston: Join Together.

Jones, L., James, M., Jefferson, T., Lushey, C., Morleo, M., Stokes, E., Sumnall, H., Witty, K. & Bellis, M. (2007). *Alcohol and Schools: Review of effectiveness and cost-effectiveness. Main report (PHIAC 14.3a).* http://www.nice.org.uk/nicemedia/pdf/AlcoholSchoolsConsReview.pdf (accessed June 2008).

Koning, I. (2006). *Project 'de gezonde toekomst', Volendam. Een alcoholproject voor en door ouders van jonge tieners.* Presentation given at the International study conference about local and national alcohol policy, Maastricht, 31 may 2006.

Lederman, L.C. & Stewart, L.P. (2005). *Changing the Culture of College Drinking. A Socially Situated Health Communication Campaign.* Cresskill: Hampton Press.

Mathrani, S. (1995). *Guidelines for city action on alcohol.* Copenhagen: WHO Regional Office for Europe.

McAllister, P.O. (1993). An evaluation of counseling for employer-referred problem drinkers. *Health Bulletin*, 51, 285–294.

McBride, N., Farringdon, F. Midford, R., Meuleners, L. & Phillips, M. (2004). Harm minimization in school drug education: final results of the School Health and Alcohol Harm Reduction Project (SHAHRP). *Addiction*, 99, 278-291.

Mistral, W., Velleman, R., Templeton, L. & Mastache, C. (2006). Local action to prevent alcohol problems: Is the UK Community Alcohol Prevention Programme the best solution? *International Journal of Drug Policy*, 17, 278-284.

Mulvihill, C., Taylor, L., Waller, S., Naidoo, B. & Thom, B. (2005). *Prevention and reduction of alcohol misuse. Evidence briefing 2nd edition.* London: NHS.

Rehnman, C., Larsson, J. & Andreasson, S. (2005). The beer campaign in Stockholm – Attempting to restrict the availability of alcohol to young people. *Alcohol*, 37, 65-71.

Ryan, B.E. & Reynolds, R.I. (1990). An applied systems approach to reduction of alcohol problems in San Diego, California. *Contemporary Drug Problems*, 17(3), 325-343.

Stimson, G., Grant, M., Choquet, M. & Garrison, P. (2007). *Drinking in Context: Patterns, Interventions, and Partnerships.* New York: Routledge.

Tones, K. (1996). Models of Mass Media: hypodermic, aerosol or agent provocateur? *Drugs: education, prevention and policy*, 3(1), 29-37.

Trimbos instituut (2006). Alcoholgebruik en jongeren onder de 16 jaar: schadelijke effecten en effectiviteit van alcoholinterventies. Utrecht: Trimbos Instituut.

Van Der Vorst, H., Engels, R.C.M.E., Meeus, W., Dekovic, M. & Van Leeuwe, J. (2007). The role of alcohol-specific socialization in adolescents' drinking behaviour. Addiction, 100, 1464-1476.

Voedsel- en warenautoriteit (2007). Handleiding integraal alcoholbeleid: een integrale benadering. Den Haag: Ministerie van VWS.

Wagenaar, A.C., Murray, D.M., Gehan, J.P, Wolfson, M., Forster, J.L., Toomey, T.L., Perry, C.L. & Jones-Webb, R. (2000). Communities Mobilizing for Change on Alcohol: Outcomes from a Randomized Community Trial. Journal of Studies on Alcohol, 61, 85-94.

Wagenaar, A.C., Toomey, T.L. & Erickson, D.J. (2005). Preventing youth access to alcohol: outcomes from a multi-community time series trial. Addiction, 100, 335-345.

Wallin, E., Gripenberg, J. & Andréasson, S. (2005). Overserving at Licensed Premises in Stockholm: Effects of a Community Action Project. Journal of Studies on Alcohol, 66, 806-814.

Whitlock, E.P., Polen, M.R., Green, C.A., Orleans, T. & Klein, J. (2004). Behavioral Counselling Interventions in Primary Care To Reduce Risky/Harmful Alcohol Use by Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine, 140(7), 557-580.

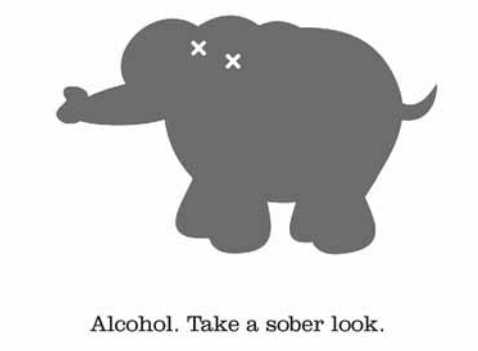
Witte, K. (1994). The manipulative nature of health communication research: Ethical issues and guidelines. American Behavioral Scientist, 38, 285-293.

Annex 1: Graphic design concept for the ECAT communication campaign

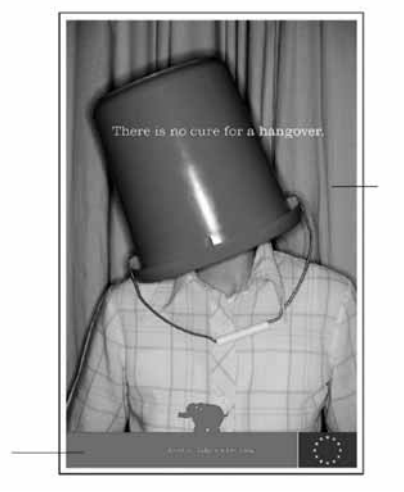
Difficulty:
The concept and image need to have the ability to support the ECAT communication objectives:

- in different countries,
- in different settings,
- translating different local topics,
- towards different target groups.

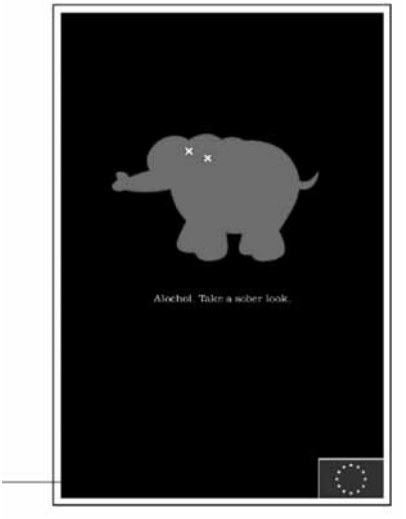
Solution:
1 (one) campaign logo & strapline used as signature and canvas for local applications



Applications
Example_poster with image

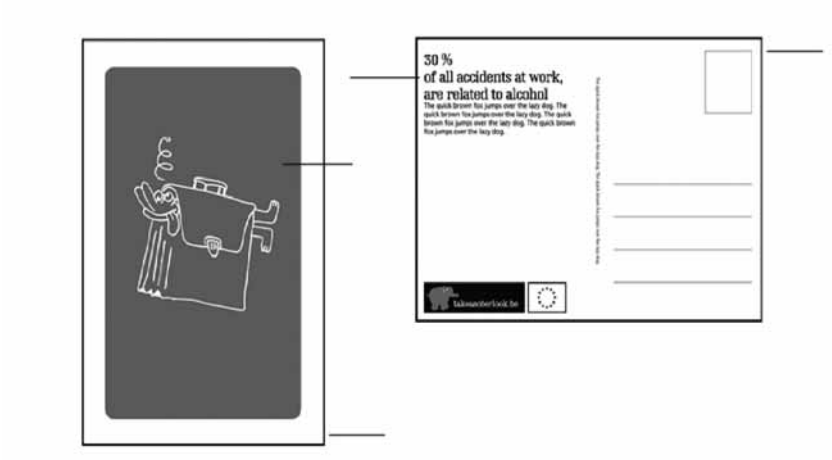


Example_poster 'stand-alone'



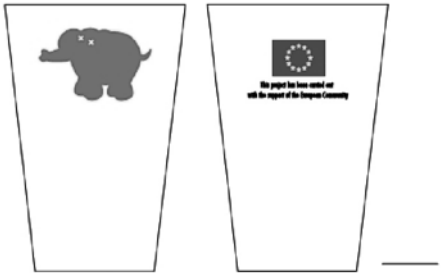
Example_poster with text

Example_postcard



Example_other

- goblet with baseline/url & EU logo
- t-shirt with baseline/url (in Dutch) & EU logo
- sticker



Materials provided to ECAT participants

- .eps file of logo & strapline (B&W, RGB, CMYK)
- .eps file of stand-alone poster
- .eps file fo stand-alone postcard
- .eps file of stand-alone sticker
- digital samples of applications
- design manual with guidelines ('how to use')

Chapter 4 Evaluation of community projects: science meets society

Mieke Autrique
ECAT project collaborator, Vereniging voor
Alcohol- en andere Drugproblemen - VAD, Brussels (B).

1. Introduction

The use and abuse of alcohol is a complex phenomenon that results from the interplay between the substance, the individual, and environmental factors (VAD, 2006). The resources, policies, practices and collaborations required in preventing and evaluating alcohol problems are as multifaceted and complex as the problems themselves (Kaftarian & Hansen, 1994). This is also the case for alcohol related community projects. Community-based prevention is an area where science meets society head on (Andréasson et al., 2007). The objectives and interventions of community projects, and therefore also relevant research and evaluation questions and methods, are influenced by their context and the stakeholders that are involved. This means the process of community projects is dynamic rather than systematic and chronological and *the* standard evaluation method for community projects does not exist (Alting et al., 2003). In the following, these issues are discussed and important aspects in the evaluation of community projects are highlighted. Lessons learnt from the ECAT project are included. It is important here to keep in mind the specific nature of ECAT, with its focus on communication campaigns. Communication campaigns are only one element of community projects, although an essential element. They are needed to raise awareness of the problems created by alcohol use and to prepare the ground for specific interventions (Voedsel- en Warenautoriteit, 2007). However, for most ECAT communities it was not feasible to develop and implement these specific interventions within the time range of the ECAT project.

2. Planning and participation

In community projects, the evaluation strategy should be built in right from the beginning, so the projects can be improved while they are still running. An evaluation plan is important in setting up the evaluation (see annex 1). In this, the objectives and available resources of the project need to be taken into account (Keenan et al., 2000). In setting up the evaluation, advice and assistance from people experienced in evaluation is essential. It is also important to ensure ongoing participation of and feedback from stakeholders. Stakeholders may disagree on the effects and results that should be reached concerning the implementation and effectiveness of community interventions, the nature and level of evidence that should be attained and the research and evaluation methods that should be used. The involvement of different stakeholders necessitates a consensus on basic assumptions, evaluation methods and the outcomes and results they intend to reach (Alting et al., 2003).

3. Need for a tailor-made approach

In the evaluation of the development, implementation and effectiveness of community interventions, it is not easy to reconcile the community approach with the demand for control of research and evaluation. Classic research designs like the randomized controlled trial (RCT) are important standards but appear not to match with the dynamic and partly uncontrollable nature of the community approach (Alting et al., 2003). An evaluation framework that takes into account the reality of alcohol problem prevention in the community is needed (Duignan et al., 1993).
In going through the research literature for a suitable framework for evaluation, it appears to be best to move away from the model provided by the outcome evaluation aspects of biomedical clinical trials. Community alcohol prevention demands a flexible and broad approach to evaluation drawn from modern applied social science evaluation methodologies. It demands early evaluation input, qualitative as well as quantitative methods, process in addition to outcome studies, for a realistic approach to using control or reference groups, and close involvement by researchers in planning the programmes they are evaluating (Duignan et al., 1993).

Current community projects are characterised by varying degrees of scientific rigour involving diverse evaluation methodologies (Kaftarian & Hansen, 1994). There is no research method that meets the requirements of all community projects, nor is it possible to provide one generally applicable instrument. For the ECAT project this certainly was the case, since community projects were developed in 8 different communities, in 6 different countries. Research and evaluation need to be set up with the specific context in mind and need to be tailor-made, taking into account the circumstances and interventions of the specific project.

4. Different kinds of evaluation

In evaluating community projects, a distinction can be made between process evaluation and outcome evaluation, and formative evaluation and summative evaluation. The terms process and outcome evaluation indicate the *type* of data that need to be collected (EMCDDA, 2007). The terms formative and summative evaluation are derived from *when* the data are processed (EMCDDA, 2007) and thus refer to the developmental state of the programme being evaluated (Scriven, 1967).

Formative evaluation takes places in the formative phase, while a programme is still being developed (Uhl, 2000). Formative evaluation results can be used to refine and improve the programme on an ongoing basis from an early stage. Sometimes this kind of evaluation is conceived as being part of the process evaluation or just as a part of the developmental stage. *Summative evaluation* takes place in the summative phase, after a programme has been finalised (Uhl, 2000).

Process evaluation describes what occurred in programme planning, implementation, and running. It can take place on a small or large scale depending on the resources available and the need to communicate to others the details of what occurred during the programme. It provides a detailed description of what occurred during a programme. It also assists in interpreting outcome evaluation results by providing possible explanations of observed outcomes. *Outcome evaluation* attempts to measure whether the programme objectives have been achieved (Duignan et al., 1993). The focus in community projects is mainly on formative and process evaluation, since outcome evaluation is not always feasible.

5. A continuous thread

The process of community communication campaigns and other specific interventions can be seen as consisting of three major phases: (1) preparatory phase (including problem analysis) (2) development phase and (3) implementation. The evaluation runs as a continuous thread through the different phases of community projects.
Firstly, the guidelines for conducting the quick scan analysis and the translation of this analysis into concrete actions - with a focus on communication campaigns - (preparatory phase and transition to development phase), are a means for formative evaluation. Relevant information that results from carrying out the different steps of the guidelines is continuously collected. Feedback for planning and decision making is provided to stakeholders.
This way, this framework ensures that the project meets a demand, is well designed, and is well implemented (Duignan et al., 1993). Secondly, it is also important to evaluate which obstacles were encountered in carrying out these steps, or in other words to do a process evaluation of the preparatory and (transition to) the development phase of the intervention. There is limited value in using a quasi-experimental evaluation designed to evaluate community mobilisation projects which emphasise a community development approach and mainly consist of nonlinear processes (Boots & Midford, 2007; Buscema, 1998; Treno & Holder, 1997). The implementation and effectiveness of community interventions can be evaluated by means of a process evaluation and outcome evaluation. In the following, tools to carry out these evaluations, developed for the ECAT project, are presented. The first tool considers the quick scan analysis and the second community interventions.

Quick Scan

For a process evaluation of the preparatory phase and the transition to the development phase, we have to take a look at the quick scan analysis. The quick scan triggers, by providing guidelines, the profiling of local problems and the identification of intervention objectives by stakeholders. This means it becomes possible to evaluate community processes within a systematic framework. For ECAT purposes, a process evaluation questionnaire was developed that starts from the phased outline of the iterative process of the ECAT quick scan analysis. This instrument can be found in annex 2. It considers which obstacles were met in carrying out the different

steps of the quick scan and which results were obtained. More specifically, it verifies if it was possible to define prior target groups and prior topics, to develop a composite picture of the problem and to translate the results of the analysis into a local communication campaign. This way, the preparatory phase and the transition to the development phase are evaluated.

Community interventions

Based on the quick scan results, concrete community-based interventions are to be set up and carried out. Different aspects of these community interventions can be evaluated. A form was developed for evaluating the development phase and the implementation phase of the ECAT communication campaigns and specific interventions. In this form, stakeholders can indicate what they consider important project aims and can give an understanding of community-level processes. This form and the manual for this form can be found in annexes 3a and 3b. First of all, a description of the target group(s), the objectives and the different campaign elements can be set out. Secondly, the implementation of the interventions can be evaluated by describing what went well / what went wrong concerning timing and budget, describing barriers and facilitating factors that were encountered during the implementation and measuring reach, visibility and acceptance. By evaluating the development and implementation phase, an indication can be given of the impact of the communication campaign. The evaluation method can differ in each community, depending on the nature of the interventions, the feasibility and the importance stakeholders attach to the evaluation.

In outcome evaluation, one should focus on intermediate objectives, which contribute to the final effects. Within the possibilities and limited time range of most community projects, it is difficult or even impossible to demonstrate outcomes on behaviour and final health-related outcomes (Alting et al., 2003). In the ECAT community projects, with their focus on communication campaigns, such outcomes are not even to be expected. This consideration must be seen in the light of the fact that mass media interventions as such are generally held to be ineffective in changing behaviour, and that if they do have an impact, it is by raising awareness in the early stages of efforts to bring about healthier lifestyles (ALAC, 1999). Change is likely to be gradual at best and will only influence a small proportion of the population.

For ECAT, a proposal was made to measure reach, visibility and impact, based on a careful comparison between different options for research design and previous research. This instrument can be found in annex 4. It did not appear to be feasible in any of the community projects however to conduct a thorough outcome evaluation. In most projects, given the timetable, mobilising stakeholders and organising the communication campaign was the main concern. Our experiences have shown that a great deal of effective evaluation work can still be carried out in such projects in the formative and process evaluation areas (Duignan et al., 1993). A mix of quantitative and qualitative methods and instruments for the evaluation of the community approach is recommended, with a focus on formative and process evaluation. In the following we will explore, by means of a four-stage model, how to concede to the limited feasibility of outcome evaluation in community projects, what kind of research is feasible and what can be attained.

6. What is feasible?

The four-stage model Veerman & Van Yperen (2007) developed in youth care practice for the classification and development of effective interventions, could help in determining what kind of research is appropriate and feasible in community projects and what kind of evidence is attached to it.
In the first stage of this developmental model, a specification of the core elements of an intervention is required. This stage may involve needs assessment, descriptive research and implementation studies. The evidence resulting from this research is called 'descriptive evidence'. This means an intervention is potentially effective.
In the second stage, the explication of an underlying intervention theory (e.g., what works with whom and why) is required. This stage may involve both literature reviews and techniques to elicit the knowledge of experts. The evidence that is gathered in this stage is called 'theoretical evidence'. This means the effectiveness of an intervention is plausible.
In the third stage, preliminary evidence that the intervention works in practice is required. This stage may involve client satisfaction studies, goal attainment studies, pre-post test studies, quality control studies, benchmark studies, correlation studies, and quasi-experimental studies. The evidence resulting from these studies is called 'indicative evidence'.

In the fourth stage, clear evidence that the observed effects are caused by the intervention is required. This stage may involve RCTs and well-designed repeated case studies. It shows which elements of an intervention are or are not effective. This is called 'causal evidence'.

When community interventions are based on a thorough needs assessment and problem analysis, and underlying intervention theory and literature reviews, as happened in the ECAT project, we can say there is a level of theoretical evidence for their effectiveness. If community projects are carried out over a longer period of time, it should also be feasible to attain indicative evidence for interventions. This model is particularly relevant since most of the time an outcome evaluation is not feasible in community projects. It emphasises the importance again of a thorough process evaluation and of using the existing literature and expert opinions, as included in the ECAT guidelines. Community interventions should be developed in a systematic way, should at least be theory driven and should emphasise elements that are of proven efficacy.

This is acknowledged in the community, at least in the official rhetoric. In reality however, evidence is only one factor among many to be considered (Andréasson et al., 2007). One should bear in mind that communities cannot perfectly fit into neat conceptual models: they frequently respond in counter-intuitive and unanticipated ways to the carefully designed guidelines and recommendations of prevention professionals (Ryan & Reynolds, 1990). This is why often community interventions are in their execution modified to a large extent by local political and practical constraints (Andréasson et al., 2007; Duignan et al., 1993).
Still, it is very important that the knowledge and experiences acquired in the design, implementation and evaluation of community projects are accurately described and shared (Alting et al., 2003). This way, good practices can be used as an inspiration, starting point or example by other community projects and the development of theory becomes possible. For ECAT, each community project reported on the different phases they went through, including the evaluation. Their experiences can be found in the following chapter.

References

Alting, D.E.M., Bouwens, J.G.M., Keijsers, J.F.E.M. (2003). *Het evalueren van community interventies. Resultaten en conclusies van een reviewstudie naar onderzoeksmethoden en meetinstrumenten*. Woerden: NIGZ

Andréasson, S., Sjöström, E. & Bränstörm, R. (2007). A six-community prevention trial to reduce alcohol and drug use-related problems in Sweden: planning and early findings. *Substance Use & Misuse*, *42*, 2017-2027.

Boots, K & Midford, R. (2007). Involving stakeholders in the evaluation of community alcohol projects: finding a balance between subjective insight and objective facts. *Substance Use and Misuse*, *42*, 1955-1969.

Buscema, M. (Ed.) (1998). Artificial neural networks and complex social systems. III. Applications. *Substance Use & Misuse*, *33*, 553-916.

De Graaff, D. & Poort, E. (2004). *Evaluatie van de zomercampagne 2003 'drank: de kater komt later'.* Haarlem: ResCon.

Duignan, P., Casswell, S. & Stewart, L. (1993). *Evaluating community projects: conceptual and methodological issues illustrated from the community action project and the liquor licensing project in New Zealand.* In: Greenfield, T.K. & Zimmerman, R. (eds.) Experiences with community action projects: new research in the prevention of alcohol and other drug problems. CSAP Prevention Monograph – 14.

EMCDDA (1998). *Evaluating drug prevention in the European Union.* Lisbon: EMCDDA.

EMCDDA (2000). *Evaluation: a key tool for improving drug prevention.* Lisbon: EMCDDA.

EMCDDA (2007) *PERK Prevention and Evaluation Resources Kit* http://www.emcdda.europa.eu/html.cfm/index9932EN.html

Foekema (1997). *Evaluatie campagne 'drank maakt meer kapot'* . Woerden: NIGZ

Jason, L.A., Pokorny, S.B., Kohner, K. & Bennetto, L. (1994). An evaluation of the short-term impact of a media-based substance abuse prevention programme. *Journal of Community & Applied Psychology*, *4*, 63-69.

Kaftarian, S.J. & Hansen, W.B. (1994). Improving methodologies for the evaluation of community-based substance abuse prevention programmes. *Journal of Community Psychology, CSAP special issue*, 3-5.

Keenan, M., Lang, E., Brooke, T., Lynch, J. & Welsh, M. (2000). *Community partnerships kit. Supporting local community action on illicit drug issues.* Canberra: Commonwealth Department of Health and Aged Care.

Kröger, C., Winter, H. & Shaw, R. (1998). *Richtlijnen voor de evaluatie van drugpreventie. Handleiding voor planners en beoordelaars van preventieve acties.* EMCDDA: www.emcdda.europa.eu

Nanin, J.E., Parsons, J.T., Bimbi, D.S., Grov, C. & Brown, J.T. (2006). Community reactions to campaigns addressing crystal metamphetamine use among gay and bisexual men in New York City. *Journal of Drug Education, 36(4)*, 297-315.

NIGZ (1999). *Evaluatie alcohol-zomercampagne 1998 'Het is hier fantastisch!'* Woerden: NIGZ.

NIGZ (2003). *Campagne 'jongeren en alcoholgebruik': eindrapportage.* Woerden: NIGZ.

Reed, K., Cheadle, A. & Thompson, B. (2000). Evaluating prevention programmes with the Results Mapping evaluation tool: a case study of a youth substance abuse prevention programme. *Health Education Research*, *15*, 73-84.

Ryan, B.E. & Reynolds, R.I. (1990). An applied systems approach to reduction of alcohol problems in San Diego, California. *Contemporary Drug Problems*, *17(3)*, 325-343.

Scottish executive alcohol misuse (2004). *Post-campaign evaluation*. http://www.scotland.gov.uk/publications/2005/09/0285549/55532

Scriven, M. (1967) The methodology of evaluation. In: Tyler, R.W., Gagne, R.M., Scriven, M. (eds.) Perspectives of curriculum evaluation. Chicago: Rand-McNally.

Treno, A.J. & Holder, H.D. (1997). Community mobilization, organizing, and media advocacy. A discussion of methodological issues. *Evaluation Review*, *21(2)*, 166-190.

Uhl, A. (2000) *The limits of evaluation*. In: Neaman, R., Nilson, M. & Solberg, U. (eds.) Evaluation: A key tool for improving drug prevention. EMCDDA Scientific Monograph Series, 5. Lisbon: EMCDDA.

VAD (2006). *Visietekst evidence-based preventie.* http://www.vad.be

VAD (2008). *Evidence-based werken in de alcohol- en drugssector.* (in press)

Van der Laan, N. & Frerichs, R. (2003). *Evaluatie campagne 'Ben jij sterker dan drank?'* Woerden: NIGZ.

Veerman, J.W. & van Yperen, T.A. (2007). Degrees of freedom and degrees of certainty. A developmental model for the establishment of evidence-based youth care. Evaluation and Programme Planning, 30(2), 212-221.

Voedsel- en Warenautoriteit (2007). *Handleiding integraal alcoholbeleid: een integrale benadering.* Den Haag: Ministerie van VWS.

Windsor, R.A., Baranowski, T., Clark, N. & Cutter, G. (1984) *Evaluation of health promotion and education programmes.* Palo Alto: Mayfield publishing Company.

Annex 1: evaluation plan for community interventions (based on Keenan et al., 2000)

LOOK: What are the objectives of your intervention? Which objectives do you want to evaluate? Who has an interest in the evaluation? Why is the evaluation being conducted?

THINK: What are the key questions that should be asked? What information do you need to answer the key questions? How will you collect this information? Who will carry out the evaluation? What resources are available to undertake the evaluation? How is the information going to be used?

ACT: list any resources that are needed to collect the information (e.g. special forms, time, administration resources, ...). Work with your group to collect and sort the information you need.

REFLECT: does the evaluation give an accurate reflection of what has happened in the project? Are there any further relevant questions that need to be answered? How will you act on this information? Who will you share the information with, and how?

What do you want to know? (evaluation key questions)	How and from whom will you collect this information? (method)	Who will carry out this evaluation?	What is your timing?	What are the available resources?

Annex 2: process evaluation questionnaire Quick Scan

This questionnaire can be used to evaluate the process of the preparatory phase and part of the development phase. It is based on the phased outline of the iterative process of the Quick Scan, consisting of 10 steps (see chapter 2). When filling in this questionnaire, you should take this outline as your starting point.

10 steps

In the fist part of this questionnaire, a description can be provided of obstacles encountered during the quick scan.
- "carried out": tick the box if you have carried out this step
- "obstacles": if you have encountered obstacles while carrying out this step, describe them (lack of information, skills, resources, time etc)

STEP	ACTIONS	CARRIED OUT	OBSTACLES
Step 1	Select a network of local stakeholders	☐	
Step 2	Collect existing secondary data	☐	
Step 3	Survey stakeholders	☐	
Step 4	Focus Group sessions	☐	
Step 5	First preliminary report	☐	
Step 6	Brainstorming session	☐	
Step 7	Second preliminary report	☐	

-

Results

In this part of the questionnaire you can indicate which results were obtained by means of the Quick Scan or why you were not able to obtain these results.

- Have you been able to define prior target groups?
  - ☐ yes, easily
  - ☐ yes, but not so easily, because _____
  - ☐ no, because _____

– Have you been able to define prior topics?
  ☐ yes, easily
  ☐ yes, but not so easily, because _____
  ☐ no, because _____

- Have you been able to develop a composite picture of the problem?
  ☐ yes, easily
  ☐ yes, but not so easily, because _____
  ☐ no, because _____

– Have you been able to translate the results of the analysis into a local campaign?
  ☐ yes, easily
  ☐ yes, but not so easily, because _____
  ☐ no, because _____

Annex 3a: process evaluation of community interventions

Stakeholders and partners

Stakeholder	What is their task?	How do you involve them?

1. Target group(s)

Final target group(s): **Intermediate target group(s):**

2. Objectives

Final objectives: **Intermediate objectives:**

3. Campaign

Intermediate target group	Final target Group
Information Education Sensitization Motivation Facilitation/ support	Information Education Sensitization Motivation Facilitation/ support
Explain:	**Explain:**

Concept of intervention and different elements:

4. Implementation

Planning

Context analysis

	Barriers	Facilitating factors
Situation / environment		
Actors		
Intervention		

5. Results

Reach and visibility: **Acceptance and appreciation:**

Annex 3b: process evaluation of community interventions: manual

This feedback form can be used as the basis for the process evaluation of community interventions. It consists of five parts. The first three parts, a description of the target group(s), the objectives, and the different elements of the intervention, are mainly a summary of the intervention as a whole. The fourth part considers the implementation of the intervention and the fifth part the results of the implementation.

Apart from evaluation, this feedback form could be useful to plan your intervention and the implementation of this intervention.

Each part explains what information is needed and examples are provided based on a fictitious campaign for people going to clubs, festivals and parties.

Stakeholders and partners

Here you fill in which (external) partners you involve in the development of the intervention, what their task is and how you involve them.

Stakeholder	What is their task?	How do you involve them?

1. Target group(s)

The intermediate target groups and the final target group(s) of your intervention, determined on the basis of the quick scan, are described here. Intermediate target groups can be prevention workers as well as workers in different sectors, such as teachers, club owners, general practitioners, youth workers, etc.... The final target group is the group whose behaviour, attitudes, knowledge, ... the prevention is aimed at, such as students, adolescents, 55+, ...

Example:

- *Final target group: Clubbers and people going to parties and festivals between 15 and 25 years old,*
- *Intermediate target groups: Prevention workers, club owners, people organizing parties and festivals.*

Final target group(s): **Intermediate target group(s):**

2. Objectives

The objectives of your intervention, determined on the basis of the quick scan are described here, for each target group separately. You can make a distinction between final objectives and intermediate objectives. Final objectives are based on the behaviour and the environmental conditions you want to change. Intermediate objectives are based on determinants of the behaviour and the environmental conditions you want to change, for example knowledge, attitude, ... You try to specify and refine the intermediate goals as the development of the intervention proceeds. The 'SMART' acronym can be a help: objectives have to be Specific, Measurable, Acceptable and achievable, Realistic and within a Time-frame.

Example:
Final objectives:

- *Clubbers and people going to festivals & parties, reduce the risks associated with their alcohol and drug use,*
- *Clubbers and people going to festivals & parties, help and support each other when one of them has problems because of his/ her alcohol / drug use,*

- *Club owners and people organizing festivals & parties, take measures to prevent problems with alcohol and drugs for clubbers and people going to festivals & parties.*

Intermediate objectives:

d) Clubbers and people going to festivals & parties, know the risks of alcohol and drug use,

e) Clubbers and people going to festivals & parties, recognize signals when someone gets into trouble because of his/ her alcohol / drug use,

f) Club owners and people organizing festivals & parties know the risks associated with alcohol / drug use.

Final objectives: Intermediate objectives:

3. Intervention

On the basis of the quick scan, your target group and your objectives, you decide by what kind of intervention you could reach these objectives.
You indicate which method is behind your intervention, for your intermediate target group(s) as well as your final target group(s): inform (give information), educate (teach knowledge and skills), sensitize, motivate and/ or facilitate/ support. You explain why you choose to do this for this target group and these objectives.

Intermediate target group	Final target Group
Information	Information
Education	Education
Sensitization	Sensitization
Motivation	Motivation
Facilitation/ support	Facilitation/ support
Explain:	**Explain:**

You explain your **intervention concep**t and describe the **different aspects and elements** of your intervention. You explain why you chose this intervention for this target group(s) and objectives.
Example: website, gadgets, training for club owners, flyers, ... (+ description of these elements)

Concept of intervention and different elements:

4. Implementation plan

Planning
You indicate what went well concerning timing and budget of your implementation, what went wrong and why.

Context analysis
You describe the situation and the environment at which the intervention is aimed, you make an inventory of the key players for the implementation, you describe characteristics of these key players and describe aspects of the intervention that are relevant for the implementation. For each of these domains, you keep track of the barriers and facilitating factors you encounter and describe how you tried to deal with them.

	Barriers	**Facilitating factors**
Situation / environment	You analyse the situation and the environment in which the intervention is implemented. More specifically, the policy aspect and contextual / societal trends and traditions.	
Example	• *No flyers can be distributed at a festival due to the environmental rules at this festival* • *Prevention at festivals is rejected because of the recommended zero tolerance policy*	• *Festivals are a spectacle where there is room for other activities that offer education/ entertainment*
Actors	You give an overview of the actors relevant to the implementation. That is, the target group(s) of the intervention, as well as other channels that can be used for the implementation. For each actor(group) you have a look at networks / mutual relations, knowledge and skills to implement the intervention, attitude, readiness to implement the intervention, arena, timing (does this intervention come at the right time?)	
Example	*The feasibility of the campaign depends on efforts of prevention workers and the degree to which organizers and club owners favour prevention of alcohol and other drugs at their events*	*There is a partnership and collaboration with music media aimed at youngsters, which raises the credibility of the preventive message*

Intervention	You give an overview of the characteristics of the intervention that might be / were a barrier or a facilitating factor for the implementation and that might affect / did affect the effectiveness of the intervention. You check the feasibility of the intervention. You check if advantages and disadvantages are balanced, if costs and profits are balanced, if the intervention is consistent with existing concepts, norms, values, behaviours and needs, if the time necessary for the implementation is acceptable, how the target group(s) value the intervention, if the results of the intervention can be made visible	
Example	*Clubbers think the campaign messages are pedantic*	*Clubbers like the gadgets of the campaign*

5. Results

You describe the results of the implementation:

- **reach and visibility:** you describe everything that is relevant to get an idea of the reach and visibility of your intervention, for example:
  - How many flyers / posters / ... did you disseminate?
  - Where did you disseminate these?
  - Is your intervention applied / used? By whom?
  - ...
- **acceptance and appreciation:**
  - what do you know about the appreciation of the intervention by the target group(s)?
  - how did you evaluate this?

Annex 4: Reach, visibility and impact of campaigns in community projects

This is a questionnaire that can be used to measure reach, visibility and impact on awareness of communication campaigns in community projects. The questions will have to be adapted, depending on the campaign and the target group. The way the survey is held (by phone, on the internet, face-to-face, …) has to be taken into account, too.

1.	Respondent data *(for example age, gender, … depending on the target group)*	
2.	Have you seen any posters or leaflets on the subject of alcohol during the last 3 months?	☐ yes ☐ no → **5**
3.	Can you describe these?	
4.	Where have you seen these?	
5.	During the period of ..., a campaign was conducted on alcohol use for … *(target group)* with posters and leaflets. This campaign has a specific name. Do you know this name?	☐ yes, namely **if correct → 7** ☐ no
6.	The name of the campaign is '…'. Have you already seen or heard this name somewhere?	☐ yes ☐ maybe ☐ no
7.	On the posters and leaflets a certain slogan was used. Can you tell me which slogan?	☐ yes, namely **if correct → 9** ☐ no
8.	The slogan of this campaign was '…'. Have you already seen or heard this slogan somewhere?	☐ yes ☐ maybe ☐ no
9.	Here you can see a poster of the campaign on alcohol use for … *(target group)*, that could be seen on … *(place)*. Have you seen this poster in the past few months? (leaflet)	☐ yes, regularly ☐ yes, once / now and then ☐ no, never → **end of the questionnaire**
10.	Where exactly have you seen this poster?	☐ school ☐ railway station ☐… ☐ I don't know
11.	To which extent do you think this poster is appropriate to make … (target group) aware of the disadvantages of excessive alcohol use?	☐ very appropriate ☐ appropriate ☐ not so appropriate ☐ not appropriate at all ☐ I don't know

12.	To which extent have you become convinced, after seeing the posters, that by drinking too much alcohol, you can experience disadvantages, such as… ?	☐ very convinced ☐ somewhat convinced ☐ not so convinced ☐ not convinced at all ☐ I don't know
13.	Do you think excessive alcohol use can lead to … for you?	☐ yes, I think so ☐ yes, but it won't happen to me ☐ no, I don't think so ☐ I don't know
14.	To which extent did the posters make you consider / think about the disadvantages of alcohol?	☐ very much ☐ somewhat ☐ not so much ☐ not at all ☐ I don't know
15.	Have you been talking with others about your own alcohol use as a result of the posters?	☐ yes, regularly ☐ yes, sometimes ☐ no, never → **end of the questionnaire** ☐ I don't know (anymore)
16.	With whom have you been talking about your own alcohol use?	☐ friends ☐ parents ☐ brother / sister ☐ colleagues ☐ classmates ☐ other, namely: ☐ I don't know (anymore)

Part 2

Experiences from the ECAT pilot projects

Chapter 1 Gmunden (Austria): drunken youths in the centre of a tourism idyll

Authors:
Irene Schmutterer, Rudolf Gruber,
Alfred Uhl, Christoph Lagemann

Gmunden, with its idyllic location right on the shores of Traunsee Lake is a popular Austrian tourist attraction and a favoured place for weddings. It already became an officially recognized Spa Resort in 1862 and is nowadays mainly known for the Gmundner Ceramics & Manufacturing and the romantic Austrian TV series "Schlosshotel Orth". Directly in the city centre of Gmunden there is a café – by day an attraction for tourists, in the evening during the weekends a hot spot for young people to go out. Alcohol associated noise and troubles increase, but café and bar owners are not willing to cooperate and decision makers do not want to annoy them.

1. Local setting

The Austrian community Gmunden is situated in Upper Austria, in the region Salzkammergut. Gmunden covers 63,49 km² and has about 15,548 inhabitants. Our community has fewer inhabitants than suggested. This is because communities of more than 30,000 inhabitants are very rare in Austria. Only 12 of the 2357 Austrian communities have a population range above 30,000.

We chose Gmunden as a partner in the ECAT project, because the community was very interested in doing addiction prevention and agreed to participating in the ECAT project. We think that starting a community oriented programme makes sense only in communities where a problem has already been identified by key persons. Only then is there sufficient local motivation.

Because more and more people of Gmunden noticed alcohol associated noise and troubles in front of certain cafés and bars in the centre of Gmunden during the weekends, the idea of doing something about it in the form of alcohol prevention arose. For analysing the current situation and to get

further practical support from professionals, in November 2006 August Mayer, school principal and town official for school, kindergarten, family and social matters in Gmunden contacted the Institute for Addiction Prevention (ISP) in Linz, with which we work together closely. Gmunden had a specific target group in mind, namely young people between 13 and 18 years of age. To find adequate measures of prevention they were interested in Gmunden's young people's consumption patterns and habits: where, how, under which circumstances, from which age are they consuming and what their attitudes towards alcohol and other drugs are.
In autumn 2007 analysis of the current situation started by consulting relevant stakeholders via a short questionnaire and a focus group interview (quick scan). From this time on a stakeholder network was established and grew. There has been a local coordinator for the project since January 2008.

2. Stakeholders' network

The composition of the stakeholders' network was started by August Mayer, the initiator of the project. With technical support from the ISP in Linz he involved interested persons from relevant institutions. Finally he managed to gain someone from the Youth Welfare Service, headmasters and teachers of two different schools, police officers, street workers (social worker), Youth Centre staff , Alcohol Counselling staff, Ambulance Service staff and City officials and politicians to build a network. The local coordinator of the project is a lawyer working at the youth welfare office.
Unfortunately it was not possible to get someone from the catering and hospitality trade industry, who deals with young people, into the network. The stakeholders agreed that it would be very important to get the owner of the café, where young people of Gmunden meet and drink alcohol at the weekends and where most alcohol associated troubles happen (both inside and outside the café), into the network. But till now he hasn't wanted to join the network and is uninterested in any other form of cooperation.
One idea to solve this problem was to confront the owner of the café with the fact, that the majority of the police reports related to injuries and violence are related to his café and the area outside, particularly at weekends. At the moment the stakeholders hope that the planned panel discussion with local politicians will force the owner of the café to act.

3. Quick scan analysis

With our special situation in Austria/Gmunden we were not able to follow the quick scan strictly step by step, but used it as a helpful grid. Prevention can be rigidly programme oriented or flexibly expert-interaction oriented. The later is more appropriate for the Austrian prevention culture. This enables the participants to adapt and optimise and also save money (e.g. in campaigns). Projects are also cheaper and more effective if stakeholders develop structures themselves and acquire ownership for the projects. This requires that the project initiators remain more in the background and help primarily on demand.

After establishing a network of local stakeholders (step 1) our partners from the ISP tried to collect secondary existing data with the help of the stakeholders (step 2). But there was only little secondary data available. Existing data are often difficult to access, often difficult to interpret and therefore a sensible option is to get additional data from the stakeholders involved. For example a police officer was able to provide specific data on where the cases of violence had occured in Gmunden in the last year. Step 3 (survey among stakeholders) and step 4 (focus group session) of the quick scan were carried out shortly after this. Relevant stakeholders were invited to take part 1n a focus group session and to answer a short questionnaire constructed by ISP focusing on specific problem areas. The preliminary report (step 5) was not sent to the stakeholders but presented in a PowerPoint Presentation and distributed in this meeting directly. The report focused on secondary data collection and interpretation, focus group session protocols and stakeholder questionnaire results. The ISP also provided information and instructions about community oriented prevention programmes. Steps 6 to 9 did not happen exactly in line with the ECAT concept. After the "first preliminary report meeting" there were three more meetings with stakeholders: one meeting to give instructions and find a local coordinator, a second meeting to define objectives, to find criteria for evaluation and to build working groups and a third meeting to present the outcomes of the working groups. Between the second and third meeting the working groups (4 different ones) met to collect ideas (similar to the ECAT brain writing session). After each stakeholder meeting all stakeholders received a protocol of the meeting (similar to step 7). The outcomes of all working group sessions were presented

at the third stakeholder meeting. We didn't organise a ranking, because at the meetings a clear hierarchy of general headings and specific objectives was elaborated without organising any ranking, which made steps 8 and 9 impossible. The final quick scan report (step 10) was distributed by the stakeholders to other relevant professionals, to reach the population. A press conference was held to disseminate information about the outcomes and the planned project and campaign.

4. Main results of the quick scan

At the beginning the community had a specific target group in mind, namely young people between 13 and 18 years old. During the quick scan the final target group was extended to a group of 13- to 22-year-olds. Intermediate target groups were defined as bar/club owners, parents, officials of associations, school, police, city officials and politicians. The main results of the quick scan were, that there is a geographic focus of alcohol related violence, in front of Rathauscafé Brandl situated in the town hall (see pictures). Consumption of alcohol is associated with violence, physical harm and damage to property (vandalism). The majority of café and bar owners in Gmunden accepts responsibility for alcohol problems - checking age limits and state of drunkenness, but a small group of about four – those that are frequently attended by young people – doesn't want to accept it (Rathauscafé Brandl, Café Citrus, Linde, Blauer Affe). At the same time it must be considered that many young people drink alcohol before they go out to drink in cafés or bars. Unlike their parents, most young people are familiar with youth protection laws, but don't care about them. Many young people are confronted with peer pressure, pressure to perform, bad prospects regarding their working future etc.

5. Campaign – realisations and plans

The four working groups, which developed during quick scan process met repeatedly to develop ideas on how to translate the results into actions. There are monthly meetings were all stakeholders come together to report and discuss ideas and implementations of the different working groups.

Working group 1 concentrates on catering and hospitality trade, local politics and police services. They are trying to find solutions for the problem of physical harm due to alcohol related violence at weekend nights in front of cafés and bars, mainly attended by young people. They had the idea of an earlier closing time (2 am instead of 4 am). For many years the closing time was 2 am and then extended to 4 am some years ago. Later closing times encourage that patrons to come later and drink more at home before going out – thus drinking more altogether. They do not consume more in the bars therefore the bars do not earn more – but police statistics show an increase in violence and physical harm since the opening hours were extended. Bar owners can be forced to close earlier, if there are problems with noise or violence. But those responsible, who could set an earlier closing time don't want to annoy bar owners. Now the stakeholders hope that the prevention project will put so much pressure on bar owners and politicians that a solution will be found. Another idea was to install better street lights in problem areas – a measure which is already implemented. A third idea was to improve the shuttle bus system to get patrons home immediately and safely, without having to wait for taxis. Politicians, whose support is needed for the implementation of this measure, are willing to think about it, but they said that it will be at least one year before anything happens. A forth idea was to invite persons from the catering and hospitality trade for a discussion, to find a solution that is acceptable for all. This happened on the 28th of October 2008.

Working group 2 works on actions concerning family and school. Ideas are age-specific education and information about alcohol effects and problems for young people between 10 and 15 years old in all schools of Gmunden, to continue and expand afternoon programmes at schools, like looking after the pupils, doing homework together and offering leisure activities and to increase knowledge about youth protection laws (mainly in parents, since young people know them quite well already). In autumn 2008 workshops have been done in schools. Trainers from the field of prevention went to schools to speak with young people about their drinking habits. For younger school children (Elementary School) it is planed to organise a theatre for children (about alcohol associated problems in families), after which the children should have the opportunity to speak about the play with their teachers, who should be trained for this before.

Working group 3 plans actions in the field of out-of-school youth services and associations involving youths. Ideas from this group have been non-

alcoholic cocktail bars at events involving youth – either leased from the ISP in Linz or organised by young people locally, meetings for functionaries of associations in Gmunden, concerning responsible serving supported by prevention experts from ISP. At the beginning of August 2008 a special summer event for young people of Gmunden has been organised with local bands, providing preventive information, free water and non-alcoholic bars. The summer event has already taken place.
Working group 4 pays attention to public relations. There were two articles in the local media to inform the public about this project, the relevant situation, when it started, and its goals. At the beginning of July an information desk was organised at the local health day. In autumn a panel discussion with local politicians and a series of alcohol related articles in the local media are planned. Furthermore the stakeholders were so impressed by the beer mats from the Belgian prevention project, that they plan to print beer mats and distribute them in local bars.

6. Evaluation

Because the prevention project in Gmunden has only just started and a lot of activities are planned to begin in autumn, it would not have made sense to evaluate reach and visibility of the campaign thus far. So we made a kind of preliminary evaluation by asking the stakeholders how satisfied they are with their project, if they have the feeling that the community will benefit from the project - if they think, that the project will have effects on the defined topic - were problems arose and if they have advice for similar future projects. We surveyed the stakeholders via an anonymous questionnaire, where they were asked to choose between given answers and make comments to them.
The stakeholders are largely very satisfied with their project. They are little sceptical regarding their defined topic (young people and alcohol related problems at weekends in front of bars in the city centre). They are not sure - if it will be possible to find a consensus with the bar owners. At the same time they are sure - that a campaign without structural changes will not be enough. They like the atmosphere of the network meetings, that everything can be discussed in an open way and that the participants are willing to do something. They are glad, that the project is already known and that

they receive positive feedback, but they also told us, that it is sad, that the implementation of some ideas is problematic or impossible. They think that it is important to have stakeholders from different fields, to have precise goals, to inform politicians competently and to have someone - who is familiar with prevention work and guides them professionally through the project. In addiction they think they could try to talk to young people during the night in front of bars and also to the bar owners.

Chapter 2 The ECAT project in Oostende (Belgium)

Authors:
Lien Baeteman, Steve Bauwens, Roos Deventer

1. Locations

Oostende is a city in the province of West Flanders that stands roughly in the centre of the Belgian coast. It is the biggest town on the coast and an important tourist and economic centre. The city also has a port and airport. On 1 January 2008 Oostende had a population of 69,146. In the summer the number of inhabitants quadruples to just less than 300,000. This large number can be explained by the many tourists who come to the seaside on holiday.

Demographically Oostende is rather an aging city, with an average of one in four inhabitants over 65. It has quite a high percentage of underprivileged people and fairly high unemployment, with a high percentage of long-term job seekers. A quarter of Oostende's unemployed are young (18-25).

The local authority on Oostende is investing in drug support, including the Medico-Social Centre (MSOC) and the streetwork programme. There is an active drug policy as part of the safety and prevention plan. The overall aim of this policy is to make the drug problem manageable. An integrated and holistic approach is used in which the policy areas of health, welfare, public order and safety are linked to one another.

Oostende has the basis it needs for this in its policy and in the sectors concerned. There is an extensive network of partners who advise on drug policy. Sectors such as education, justice, healthcare, welfare, preventive work, etc. are represented in a consultative structure.

For a long time Oostende has been paying heed to the subject of alcohol. Several awareness-raising campaigns on the effects of excessive drinking and being under the influence have been organised, aimed at the education sector and nightlife. A screening list for spotting and discussing alcohol problems has been drawn up for doctors. Schools and youth clubs are addressing the problem as part of the development of their drug policy. The Safe Night Out ("Veilig Uitgaan") project by the police in Oostende is working on a series of

structural measures and campaigns to tackle trouble resulting from excessive drinking in a nightlife district. Campaigns are being developed whose target groups are parents who drink and young children.

2. Stages in the development of the campaign in Oostende

The project plan consisted of the following stages: 1. selection of a network of key figures, 2. quick-scan analysis, 3. ECAT campaign (among others) and 4. evaluation.

2.1. Network of stakeholders

The already existing drug policy steering group operated as the network of stakeholders in Oostende. Since this group gave high priority to the subject of alcohol over the previous few years, its awareness no longer needed raising. The important sectors in the field are represented within its structure. A project plan and schedule were arranged jointly with the steering group. The steering group is composed of representatives of the following sectors and organisations: local policy (including the councillors responsible for alcohol and drug policy), hospitals, schools advisory services, welfare centres, mental health centre, streetwork, a drug counselling centre, magistrates, senior police officers and officials working on local alcohol and drug policy.

2.2. Quick scan

The steering group elected to administer the quick scan via the network of stakeholders. The representatives on the steering committee were asked to write to the stakeholders in their organisations by email. In addition representatives of the catering and hospitality trade were asked for information orally.
Oostende used the comprehensive ECAT questionnaire. The stakeholders were asked about the nature and extent of the alcohol problem in Oostende. The results were contextualised using the results of alcohol related scientific research and statistical data and discussed with the drugs policy

steering committee and four focus groups (medical, education, nightlife and welfare sectors).

The most important conclusions were:

1. Some 50 stakeholders from the various sectors experience the consequences of problem drinking. They are confronted with them practically every day;
2. To a great extent people are concerned about drinking at ever-younger ages. Attention is also turning to excessive drinking by young people, young adults and people going out on the town;
3. Every sector also has to deal with specific risk groups and problem drinkers: the unemployed and people who rely on benefit, drug-taking parents with children, drink driving, domestic violence, binge drinking etc.

We distinguish three groups of users

1. Under 16-'s:
   starting age is about 13 to 14
   the amount that young people drink is highly dependent on age
2. 16-25 year olds
   mainly people out on the town
   this age group drinks most
3. Risk groups and problem drinkers
   this group covers all ages

There are two approaches to define problem use:
- frequency and quantity: more than 14 glasses per week for women, and more than 21 glasses per week for men, 2 alcohol-free days
- problem use of alcohol: use of alcohol that is characterised by clear risks, both situational (e.g. the risk of road accidents) and to health (e.g. diseases of the liver). Problem drinkers are people who use alcohol in a way that is a problem.

2.3. From analysis to alcohol policy

Various approaches were distilled from the analysis. A policy can be aimed at health, welfare and safety. The network of stakeholders has committed

itself for the next few years to working with the city on the following objectives:

- combating the use of alcohol under age 16,
- stimulating responsible use, compliance with the law and avoidance of nuisance and crime,
- identifying harmful alcohol use early and avoiding social and personal problems.

Target groups:

- under 16-'s,
- 16 to 25 year olds,
- risk groups (children of parents with an alcohol or drug problem, the underprivileged, children who drink at an early age) and problem drinkers (drinkers who fall above a certain threshold value).

For the under-16 target group we are aiming at:

- increased familiarity with the normality of not drinking under age 16,
- parents who are aware of the risks of drinking at an early age.

Strategies

- alcohol prevention at school, information about stimulants, the risks of using alcohol, social skills - like learning to say 'no', peer pressure and looking after yourself,
- nutritional initiatives, advising parents and making them aware of their role,
- increasing compliance with the law on supplying alcohol to young people under 16.

For the 16-25 target group we are aiming at:

- increasing awareness of the risks that alcohol use entails (in nightlife) in terms of health, safety and welfare,
- better compliance with the law on serving intoxicated customers,
- promoting measures to avoid alcohol related nuisance and crime.

Strategies

- counselling for 16-25 year olds to make them aware of the risks they run by using/abusing alcohol,

- educating the social environment to recognise problems and react correctly,
- further promotion of tackling the problem of alcohol in the various drugs policies,
- information about recommended daily intake.

For the risk groups and problem drinkers target group (drinkers who fall above a certain threshold value) we are aiming at:

- avoiding serious health problems,
- avoiding damage to the environment,
- encouraging responsible behaviour.

Strategies

- timely intervention strategies,
- searching out people with alcohol problems and motivating them to seek or obtain help (screening lists).

When building an integrated policy, it is important that all the partners put out a common core message for each target group. Oostende's main focus group chose the following core messages:

< 16 years old

- No alcohol under 16,
- If you drink, do it responsibly (binge drinking),
- Bear in mind the risks of excessive use of alcohol (health and safety).

16 to 18 years old

- Treat alcohol responsibly (binge drinking),
- No spirits under 18,
- Bear in mind the risks of excessive use of alcohol (health and safety).

18 to 25 years old

- Treat alcohol responsibly (binge drinking),
- Bear in mind the risks of excessive use of alcohol (health and safety).

3. The Oostende ECAT campaign: PROOSTende.be

The 16 to 25 year olds were chosen as the first target group for a campaign. The partners considered that, in the first place, young people had to have their awareness raised. All the partners see the consequences of alcohol related problems from nightlife.
This is a campaign, not a complete policy plan. It is obvious that other measures can/will be included in the drugs policy of future years. In the near future, a second ECAT campaign will be launched for Oostende's secondary schools.

Target group of the first campaign: 16 to 25 year olds
Core messages:

1. Treat alcohol responsibly (attention to binge drinking).
2. No spirits under 18.
3. Be aware of the risks (to both health and safety)

The eye catchers of the campaign are two animation characters: DJ Maxxxxx and D-Man. DJMaxxxxx is a kind of superhero for a healthy and positive nightlife in the town. He gives revellers tips on going out that should ensure a healthier, safer and more pleasant atmosphere. D-Man is the drug policy's central figure. He will be popping up everywhere in all the new drug campaigns.

PROOSTende.be

On the website www.proostende.be we provide accurate information about alcohol, e.g. we inform young people how to assess their BAC when they are drinking. Informing them in that way is part of our efforts to educate people to use alcohol in a responsible way.
The Oostende rock-singer Arno gave the city council permission to use the track "Hit The Night" from his CD "Jus De Box" (2007 EMI) for the Oostende ECAT campaign. The visitors can listen to the track at www.proostende.be and take part 1n the competition to remix the track.
At www.proostende.be we have a "Did you know?" page where we give answers to a whole range of alcohol related FAQ's for young people. These questions are split into four groups: road safety, health, addiction and age. If this is not helpful, or the young person is having problems with alcohol,

we refer him or her to the DrugLijn (the anonymous help-line of VAD – the Association for Alcohol and other Drug problems) and to the Oostende youth advisory centre (CAW/JZ Middenkust). Their staff specialise in counselling young people.
There are also three online tests on the website. In the breathalyser test you input a number of personal details such as gender, weight and the number of alcoholic drinks you drank within a certain time to get an indication of whether or not you are over the legal limit of 0.5 mg, and, if applicable, how long it will take before the BAC drops below the limit for driving a car. A health test provides health advice based on your answers to 5 questions about your drinking habits. Finally, a knowledge test gives you the opportunity to test your knowledge of addiction.

5000 CDs of "Hit The Night" by Arno

We disseminated 5000 free CDs of "Hit The Night" via Oostende's late-night bars and secondary schools. The CD also contained the PROOSTende.be promotional video. A local resident who works in the audiovisual sector wrote the screenplay for this video as well as producing the video. He also plays the leading role in the film. This film can also be downloaded on the website www.PROOSTende.be. It was promoted via various internet forums.

90,000 beer mats

In May 2008 a total of 90,000 beer mats were disseminated in close to 50 late-night bars. These beer mats showed the prevention message "Anyone who's planning on doing some serious drinking had better look out for the pink elephant." This refers to the pink elephant of the ECAT logo but also to the proverbial pink elephant that appears in hallucinations caused by excessive alcohol use. Through the highly visible beer mat we intended that the target group would reflect on the topic of using alcohol in responsible way and on the risks of binge drinking, which is more and more common among young people.

4. Evaluation

The website www.PROOSTende.be became a big success. In the period from 9 May to 18 August 2008, more than 9,000 people visited this site

and 18 People participated in the remix competition on the track 'Hit The Night' by Arno. In August 2008 all the contributions were put online and visitors to the website were invited to vote. The winner of the contest got 2,098 preference votes.

During a summer youth event on the beach and in the nightlife district, 81 young people from Oostende were asked to assess the visibility of the local ECAT campaign and to give their appreciation of it. 60.5% of the respondents had noticed the beer mats in the local late-night bars. 49% were aware of the remix competition with the campaign CD. 49 % of the respondents knew the website www.PROOSTende.be. Based on these results, we evaluate the ECAT campaign as being successful in terms of reach and visibility.

Chapter 3 ECAT project in Germany: Achern, Leimen and St.-Leon-rot

Authors:
Martina Thrän, Stefanie Hecht, Rüdiger Dunst, Helm Jetter

Diakonisches Werk Baden (DWB) was asked to come on board as project partner in autumn 2006. The idea of jointly approaching targeted alcohol-prevention work came at the right time for us, since the politically-instigated regionalisation of services working in prevention and counselling and treatment of substance abuse and addiction forced us to develop regional addiction support networks.
Since 2004, DWB has been working on regional addiction support networks in urban and rural districts. These networks provide improved care and should avoid, or reduce duplication of facilities.
It was thus a good opportunity for us to speed up the development of existing regional networks in the field of preventive work. The ECAT project method is treatment-oriented and can readily be deployed in our community-oriented socio-political setting in Baden-Württemberg.
Even so, there were difficulties in implementation, resulting in procedural changes, which we shall describe below.

1. Locations

We chose three implementation sites in order to be in a position to try out the application of the ECAT method into differing regional settings. The locations selected followed the recommendations of the project description, with a population size between 15,000 and 100,000 inhabitants, and the existence of a local network working on alcohol issues.

- **Achern:** This community has approx. 26,000 inhabitants; it is located in South-West Germany in the state of Baden-Württemberg. It is surrounded by a well-known wine-producing area. Daily alcohol use – particularly wine – is a normal phenomenon among the people in this wine-producing district. Drinking is acceptable at any time of

the day. The DWB branch provides addiction prevention activities in Achern. The demand for this service is very high.

- **Leimen**: This community of approx. 25,000 inhabitants is a southern suburb of the city of Heidelberg. In view of the high proportion of immigrants from the former Commonwealth of Independent States (ex-USSR), there are some clear social problems related to legal and illegal drug abuse.
- **St. Leon-Rot**: The community has approx. 12,000 inhabitants; it is a fast-expanding area with no particular social problems, but with high consultation rates for alcohol dependency in the local alcohol counselling centres. The community was created 30 years ago by merging two villages. Since then the historical overlap of parallel social institutions continued.

2. Start of the project

The managers at the addiction counselling centres involved approached the mayor or head of social-services department in the selected communities in order to present the project and to get their support.
Simultaneously, we secured support from Baden-Württemberg's ministry of social affairs, through inviting the mayors of the selected communities to get involved in the EU pilot project. This way we were able to get all 3 communities involved from the start of the project.
At Achern, Leimen and St. Leon-Rot, a list of potential stakeholders was compiled in consultation with local addiction officers and the mayors were invited to attend a first stakeholder meeting.

We invited members of the following target groups

- Politics: mayors, heads of local social services and town-clerk's offices, group chairs, community addiction officers and youth administrators,
- Schools: school principals and addiction-officer teaching staff at primary and high schools,
- Secondary schools, special schools, business schools and grammar schools,
- Judiciary: public prosecutors, probation officers, district courts, police,

- Public welfare: addiction counselling centres of DWB and Baden-Württemberg regional association, Caritas counselling centres, psychological counselling centres, youth clubs, social services, child-protection associations, youth officers and self-help facilities for addiction,
- Community employment officers,
- Healthcare sector: hospitals, specialist doctors, pædiatricians, psychiatric outpatient departments, addiction clinics, health-insurance companies, psychotherapists,
- Church institutions: protestant and catholic priesthoods,
- Catering and hospitality trade (DEHOGA),
- Local industry,
- Associations: sports clubs, voluntary fire brigade, town bands, protection organisations, German Red Cross, technical relief work.

At the individual locations, between 70 and 120 potential stakeholders were contacted via letters or by phone. They were briefed in writing and orally on the ECAT project and invited to collaborate.
At the Achern site, the questionnaire was handed out at a stakeholders' meeting to the aforementioned target groups. At the other locations, it was issued at the first stakeholders' meeting. The response-rate was lower at Achern, presumably for that reason.
The assessment of the questionnaires yielded different results in the various locations – as was to be expected. The follow-up of the project was organised separately at each site.

3. Stakeholders' meetings

Around 20-30 people regularly attended the stakeholders' meetings in Achern, approx. 70 at St. Leon-Rot and approx. 20 at Leimen.
In the course of the project the different steps to be taken were explained again. The results of the quick scan were evaluated by the project leader and presented to stakeholders; these results formed the basis for further work in the project groups.
With regard to substance, at the first stage the debated issues relating to the participants' expectations were wide-ranging. However, using the results of the quick scan it was possible to get a consensus on the principal target groups and on setting common goals.

3.1 St. Leon-Rot

The survey figures relating to high consumption and binge-drinking confirmed the common assumption. The fact that a distinction was made between risky consumption, high consumption, binge-drinking and dependency came as a relief to the participants from focus groups. This way, participants were better able to identify the existence of high levels of binge-drinking among young people in the communities.
The results were thoroughly debated with regard to the extent of alcohol use in the various social settings, the age of the target groups concerned, and the consequences.
The highest need for treatment was defined to be in young people aged between 10 and 16 years old. It was decided to concentrate on this target group and, building on the smoothly-running regional school-based prevention work by Drogen e.V. Heidelberg, we agreed on a training programme for youth leaders at clubs and young persons' associations.

Measures

Special training courses were planned for people holding positions in clubs (managers and youth leaders) (see annex 1). A preliminary event took place on 11 September 2008, at which further training measures were devised in groups of 10 – 12 people. Approximately 10 training sessions will take place altogether. In this way we shall pursue the goal of drawing attention to the issue of alcohol consumption among young people and informing about the available help facilities.
The planning of additional stages in the project and further measures will take place in close consultation with the local council, mayor and local government, but at the earliest, training courses can be planned in November of 2008.

3.2 Achern

At the second stakeholders' meeting the project proceeding in Achern was based on the meta-plan technique (see annex 2). The following goals were decided: More publicity work should be pursued in the communities in order to increase the state of knowledge, and to create more publicity for the project.

Subsidiary working groups were set up in order to pursue these goals, through planning 'Publicity work' and 'Addiction-prevention measures'.

Measures from the focus group "Publicity work"

- *Newspaper series* in the local press on the topics: youth-protection legislation; summary of local, regional and trans-regional help facilities, publicising interviews with people concerned with the issues (i.e. judges, police, works and staff councils),
- *Flyer* for counsellors from other specialised social organisations with a survey of the help facilities available in Achern in the field of addiction,
- *Website* for the town of Achern,
- The current website for the town of Achern is to be redesigned, and should be expanded in this context, with information on the topics relating to the use of addictive substances, dependency and facilities for getting help.

Measures from the focus group "Addiction prevention measures"

- *Questionnaire initiative "Spotlight on Achern"*
  Producing a questionnaire on the topic "individual use / coping individually with alcohol". This should stimulate a debate on individual behaviour relating to alcohol consumption.
  Target group: residents of Achern aged 10 years and older.
  The stakeholders conducted the surveys in their particular social fields (market places, supermarkets, parks, outside and inside discos). Young people at the V.I.P. youth club at Achern were involved in compiling the questionnaire.
  The results of the survey are to be used as the basis for further prevention measures.

Measures at school

- *"Role-reversal" project work with school pupils (see annex 3)*
  Target group: Young people at grade 7
  Goals:
  – Character-building
  – Age-related information on psychoactive substances and coping with addictive sub- stances

- Encouraging ability to deal with conflict and cope with frustration
- Attitude-orienting
- Independence and ability to form relationships
- Motivation to lead an active and productive life

- *Theatre group*
  To round off the first part of the ECAT project, a performance by the theatre troupe "Total normal" is planned in Achern.
  Subject-matter: common addictions and a completely normal life. Everyday life situations are addressed in order to illustrate possible causes in the addiction process.

3.3 Leimen

The results were aIso discussed in depth at two stakeholders' meetings in Leimen, and the following targets were set for further project work:

- *Information* on the issues alcohol consumption, abuse and dependency.
  In a series of training-courses based on a peer group approach and conceptualized for those caring for young people, all associations and youth organisations should be addressed, just as at St. Leon-Rot (see annex 1).
- *Intensified work at publicising* and reporting the ECAT campaign through newspaper articles in the local press.
- *School projects* should be elaborated and implemented at local schools of all types. Start of the measures: November 2008

4. Problems over implementation

The start was delayed at all three locations owing to initial questions of responsibility on the part of the local authorities and the fact, that we could not secure participation by our community contact persons without the support of the regional ministry of social affairs.
In all three settings the project leaders chose a method deviating from the proposed form of moderation and used the meta-plan technique (see annex 2), commonly used in Germany. We were unable to apply the method of brain-writing provided for in the conceptual framework,

owing to the limited amount of time our individual participants could invest.

5. Results of the project and proposals for its continuation

At all three locations the structured concept of networking as described in the project guidelines was perceived favourably. The very diverse selection of stakeholders turned out to be valuable and benefited the work on the project. The commitment of the focus groups was very high and will certainly remain that way in the future, as the group members found this form of collaboration to be highly constructive and efficient. Creativity is very high in the focus groups, since the stakeholders come from a wide range of professions, hence a great diversity of ways of going about things is possible. Although the project was restricted in duration, those involved are open to its continuation. It would undoubtedly be advisable to arrange the follow-up again within a limited timescale, as it ensures tighter time-management for the groups.

Initial feedback recorded from the advice and counselling points indicate that the subject of alcohol use is widely discussed among people in the community. An important first step towards achieving the aim of the project has thus been taken.

Measures in Leimen an St. Leon Rot will only be implemented in November 2008, but there have already been some implementations in Achern:

- 1288 questionnaires about Achern's the citizens' alcohol consumption have been compiled,
- the newspaper series has been started, several articles have been published in the local newspaper of Achern,
- the theatre play as a closing event of the local ECAT project in Achern is scheduled for mid-November.

Next steps in all three settings include the future financing, as all three communities and their stakeholders wish to continue the work of the focus groups.

The work on the EU project was certainly an additional complication for the institutions taking part. This has paid off, however, since the additional publicity value for the institutions is very great and collaboration in the

communities has clearly improved. We found the collaboration with the EU partners to be extremely stimulating and informative. It is possible to work very profitably at this level, without competition and very constructively.

Annex 1: Seminar for youth workers: substance-related awareness

Seminar contents: Alcohol and medications – tobacco – illegal drugs
In the various sections, guidance is given on low-risk use, hazardous use, abusive use and dependency. It includes early recognition and facilities for help.
Use of addictive substances, whether occasional or regular, in moderation or to excess, appears to many young people as a sure-fire method of coping temporarily with fundamental problems like inarticulacy, blackouts, isolation, lack of sense of purpose, poverty or futility. In the long run, however, many problems simply become more acute, bringing health, family or other social consequences in their wake that cannot be ignored.
Viewed from an epidemiological perspective, boys and men are particularly severely affected by problems resulting from alcohol and drug dependency. At the same time, their ability, resources and prospects of getting a grip on their problems are underdeveloped.
Group size: 10 – 15 people.
Composition according to age-group to ensure education commensurate with age.
Duration: 2 x 2 hours.
Guidance: Two co-workers from the Drogen e.V. action association (with abstaining dependents if appropriate)
Costs are covered by the ECAT project.

Annex 2: Metaplan Method

Metaplan is a technique that involves all participants of a meeting in its process. Every step of the discussion is visualized with cards, all cards are clustered by the participants and the moderators.
Moderation is always necessary when it comes down to classifying information in groups, associating, brainstorming or visualising plans and decisions. It is sensible to link moderation to the written form of discussion (Metaplan).
Advantages of visualization are:

- everyone has a clear picture of the meeting procedure,
- avoidance of repeating contnents,
- possibility of anonymous statements (if desirable),
- secondary, yet important thoughts are put on record,
- most people prefer a visual approach over one that is only verbal.

Short descripton of the Metaplan method
Ressources

- a transportable pinboard,
- pens in different colours,
- cards in diefferent shapes and colours,
- pins.

self adhesive dots
Procedure of a Metaplan session is geared to the several stages of a problem solving process:

- an adequate phase of getting to know each other should be included, especially if not all participants have met before,
- the creation of problem awareness is maintained by reducing a question to its fundamental keyword, writing it on a card and placing it on the pin board,
- cards of different colours and shapes are distributed to the participants,
- all participants write down their ideas on cards (working in groups is possible, too),
- after collecting all the cards, start reading each one aloud and pin them on the board, discussing each card's position in relation to the other ones – is it something that belongs to an already mentioned

keyword (place it below that keyword), or is it something completely new (place it next to the keyword, starting a new cluster)?

- after having pinned all the cards on the board, let the group discuss the positions of the cards one last time,
- create headers for each cluster, write them down on new cards, and pin them on the board – these categories will now be the basis for further discussion,
- optionally, it is possible to have a voting for each header – each participant can add self adhesice dots to the header that he considers the most important issue,
- at the end further steps are discussed.

The tasks of a moderator

The moderator fulfills the role of a helper, the puts the group in the position, to follow their own central theme. He is not the group's leader, but an expert for all possible kinds of communication. He stays neutral, within the aim of enabling selfdependent action and reaction by the participants.
Usually the Metaplan method is applied in further education.
The method is particularly useful to bring about decisions in a transparent way. At the same time it is a democratic method, as all participants write down their opinions, and therefore, even minority opinions are present at the pinboard. Furthermore, results that have been fixed on the pinboard can be are well archivable, and can also be used for exhibitions etc. Because of its possibilities that are geared at the participants the moderation method, particularly in combination with pinboards is a essential method of the constructivist pedagogics.

Annex 3 : Summary draft on role-reversal in preventing addiction

Starting-point

- Children are not always treated as being the really creative, active agent when devising and implementing preventive measures.

Aims

- Central aspects are: character-building of young people, informing them on psycho-active substances appropriate for their age; addiction and its prevention, and promoting a positive school ethos.
- Pupils should be enabled to relate to opposing positions in conversations with other pupils.
- Children should be given support in encouraging their ability to deal with conflict, frustration; their attitudes, autonomy and ability to form relationships.
- Pupils should be motivated to structure an active, creative lifestyle and learn how to manage and cope with difficult life episodes.
- The task of professional prevention of addiction involves making professionally-based information available, and dealing with ill-informed opinions and lack of information from adults and children.
- Exaggerated, excessively angst-ridden portrayals are an issue just as much as biased ideologies that focus only on positive aspects of particular substances.

Method of proceeding

- Children are always formed into small groups of 3 – 6 pupils.
- They settle on a topic relating to a specific addiction and discuss the particular method of illustrating it autonomously (Theatre/Sketch/ PPP/ presentation/Film, etc.)
- Each pupil prepares a topic relating to the subject "Addiction" within the class community. They have 8 x 45 minutes to brief themselves in school, to discuss and debate, get support through carers.
- Remaining preparations for the relevant parents' evening take place independently at home.
- Pupils will present their work to parents at a parents' evening.
- After the presentations, a thoroughgoing debate will be held among both parents and pupils.

- Thanks to the commitment displayed by the children, they obtain not only information, but also achieve the increased self-confidence needed to say "No!" to addictive substances.
- The pupils attain this self-assurance by working through and dealing with topics relating to "addiction" issues autonomously and responsibly, and giving presentations to their parents.
- The fact that children take on a change of role, brief and inform their parents, motivates pupils in a special way.
- Co-operation and communication, openness and trust between parents and children should be improved by this project. In this way it should provide the basic preconditions for the prevention of addiction.

Further planning

- The project should be extended:
- It is intended to implement this procedure over several years (3 academic years) and thereby ensure there will be an ongoing debate.
- In this way, children of varying ages should come to talk about and discuss the subject of "addiction"

Chapter 4 ECAT Project in Italy: principles and local implementation

Authors:
Emanuele Scafato, Tiziana Codenotti, Rosario Russo, Claudia Gandin, Lucia Galluzzo, Silvia Ghirini

The ECAT activities in Italy followed a process mainly driven by a government crisis that influenced the creation of the stakeholders' panel due to the lack of institutional individuals to be in charge of the roles required by the ECAT activities. Nonetheless, the very first step to facilitate a local project according to the ECAT recommendation started at national level with a panel of national experts who were invited to express their views during the Alcohol Prevention Day held in Rome in April 2008. The informal panel involved representatives from different professional fields such as epidemiology, prevention, communication, alcohol specialists, scientific societies, ministries, health bodies, advocacy, self-help groups and municipalities. The analysis of the available epidemiological trends, provided by the Istituto Superiore di Sanità (ISS), presented on the occasion of the APD and incorporated in the Annual Report of the Ministry of Heath to the Parliament and in the Annual Report of the Heath Status of the Nation submitted to the panel was the basis on which the final choice was oriented. As a part of this process the Italian Society of Alcohology (SIA) was involved in giving an advice according to the scientific evidence related to the priorities proposed as the main subject of the communication campaign. The final selected target (underage people, minors) took specifically into account the local and regional data where the ECAT activities were intended to take place, namely Padua, and particularly one selected district. At the local level, as a result of the quick scan activities performed later in July together with local stakeholders, the issues of drink driving, alcohol and parents and alcohol and pregnancy were included with the original selected target (underage people, minors).

1. Local setting

The selection of the local community was made, in accordance with the Italian ECAT coordinator, Prof. Emanuele Scafato, to identify the area where the alcohol prevention campaign could be implemented. In accordance with the ECAT proposal for selection criteria a middle-scaled community was identified within the city of Padua (a so-called city district). This is an area with about 28,000 inhabitants with specific territorial characteristics and local peculiarities. Moreover, this district has some sort of antecedents regarding alcohol related activities and, above all, a well-structured cross-sectoral consultation platform. This network called "Gruppo di rete territoriale La Bricola" was established in 2004, originally to support families with minors and adolescents. The main problems were particularly related to young people's problematic and anti-social behaviours in general. Very soon it was realised that alcohol related issues were to be more widely addressed as they played an important role in these behaviours. Therefore it was agreed to include actions and initiatives which included information, training and sensitisation activities focussing on alcohol related problems.

2. Stakeholders' network

As already mentioned, the selection of the local community for the ECAT local implementation was strongly influenced by the existence of a well-structured, longstanding cross-sectoral consultation platform. Therefore no particular selection criteria were adopted and the ECAT project was presented and discussed within the context of the network's regular meetings. The possibility of implementing the ECAT project in this area was facilitated by the head of the Alcohol Unit at the Local Health Unit of Padua, who has been actively participating in the platform work from the beginning. He played an important role in supporting the project implementation and in explaining the added value of including the network activities in the context of a European project, in order to increase community empowerment for the management of alcohol related problems.
The stakeholders' network includes public and private professionals and non-professionals (active citizens) from different fields: health, social welfare, education, local authorities and policymakers, local police, eco-

nomic operators (mainly retailers through their representatives), alcohol and non-alcohol associations and formal and informal youth groups. The public institutions were represented by the City Government through the Social Affairs Departments, by the Padua Local Health Service through the Alcohol Unit and by representatives of schools located in this area. Moreover, a wide range of voluntary and non-governmental organisations actively participated. These included parents' informal groups, local parishes, families involved in the Clubs of Alcoholics in Treatment (AICAT) and youth groups.

3. Quick scan analysis

Quick scan analysis or rapid assessment allowed us to have quite a good picture of the prevalent situation and the influencing factors related to alcohol use. A brief quick scan questionnaire to stakeholders was translated and used. Analysis of existing data represented an essential factor in easily identifying priorities and target groups.

4. Results

The general ECAT Slogan "Alcol meglio la sobrietà" (adaptation of "Alcohol: take a sober look") was judged appropriate to increase awareness and to solicit healthy behaviours in individuals as well as across society. Information used in the posters and booklets specifically produced for the ECAT activities from a WHO Charter on Alcohol principally devoted to children and adolescents and a specific article of the law on alcohol issued in 2001 were considered as added values to empower young people to change or at least to re-evaluate their alcohol use and increase the level of youth protection by emphasising the negative consequences of alcohol. The topics and the target groups agreed upon for the development of actions and for the campaign reflect the epidemiological data on the general population on one hand and the population's needs and expectations on the other. Moreover, they were also reinforced by putting them in the framework of the *European Strategy to support Member States in reducing the problems related to harmful and hazardous alcohol consumption* adopted in 2006.

Indeed, the priority areas identified in the European Strategy include the protection of children, adolescents and the unborn, thus including the issue of alcohol and pregnancy, and the reduction of alcohol related road accidents. These are exactly the topics and target groups on which the activities of the ECAT campaign are based. Permission given by the ISS to print and use the *ad hoc* materials has been an added value in facing some financial constraint linked to the lack of funding for the implementation of the ECAT campaign at the local level. The ECAT strapline and logo were integrated into the already available booklets developed by the ISS, the WHO CC for Research on Alcohol, the Ministry of Health and the SIA: a booklet on drink-driving (designated driver "Il Pilota" : *Never drink and drive*), a booklet with the "Alcohol and young people: Ten golden rules for parents"; the leaflet "Tips for teens" and the booklet for girls "Alcohol, are you sure". Furthermore some original materials were developed: 1) ECAT leaflet 2) ECAT poster and 3) a wide poster to be used as a billboard in the public places where ECAT initiatives were planned. All the materials will be put on the website of the ISS, together with a report of the project in order to disseminate the standards and the procedure of the decision-making process related to the overall activities. This will also give more opportunities for ECAT to be integrated into future prevention activities nationwide and support the culture of empowering the community with a much more appropriate way to deal with alcohol related problems.

5. Campaign

The translation of the assessment into actions was shared among the stakeholders' network and unanimously designed to answer to the community's needs. The decision was to use already planned local community activities like festivals or celebrations and to devote a specific space to the initiatives related to alcohol use. These activities were well attended and therefore represented a guarantee for reaching a great number of young and adult people. Community-based strategies were used in order to create a supportive environment by using targeted and population strategies, with the final aim of building a communication campaign for the prevention of alcohol related harms. Distribution of information materials targeted both the general population and young people and parents (examples at-

tached). Blood Alcohol Concentration (BAC) tests on a voluntary basis were performed by professionals, in order to make people more aware of their possible impaired abilities to drive, BAC precursors analysis and brief advice were offered when requested, using the information materials as guidelines.

6. Evaluation

Evaluation is integrated in the process, but one difficulty encountered is how to evaluate the whole campaign in a quite short time. The campaign started early in September and will end early in October when all the results will be subject to a complete evaluation according to the ECAT procedure. By now it can be said that a general satisfaction and a very high participation of people in the ECAT activities has been experienced by the personnel involved. There is also a willingness to proceed with further initiatives in public places, schools and events devoted to young people. The ECAT experience is considered to be a new instrument in tailoring prevention activities to reducing alcohol related risk in the community. Furthermore a much more appropriate level of attention was paid by the stakeholders involved who felt ECAT to be a valid opportunity to reorient the identification of priorities and integrate the decision-making process according to a standard procedure that will help in regularly re-evaluating and analysing the needs of the community.

Chapter 5 Development and progress of ECAT project in Slovenia

Authors:
Marjetka Hovnik Kersmanc, Katra Lesjak

With a registered use of 8.8 l. of pure alcohol per inhabitant (2005) Slovenia ranks among the top of European countries. Despite there being no tradition of producing alcoholic beverages, the Gorenjska region also deals with a problem of alcohol, which is an important public health issue. Alcohol contributes to illnesses and mortality, especially to premature mortality and consequences of alcohol abuse can be felt - on a social and economic level. The Institute of Public Health Kranj (IPH Kranj) joined the ECAT Project aiming to reduce the use and diminish the consequences of alcohol abuse in local environments of Slovenia. IPH Kranj is a public health institute representing the cornerstone of preventive activities in the Gorenjska region.

1. Local setting

The activities of IPH Kranj mainly cover the Gorenjska region. This was also the reason why we chose a local environment in the area of the Gorenjska region for the implementation of the ECAT Project in Slovenia. Kranj was the only city to meet the selection criteria of 30,000 to 60,000 inhabitants. Furthermore, there is a general interest in Kranj to prevent alcohol abuse and the local environment is clearly defined in geographical terms. Kranj is the 4th largest city in Slovenia. It has approximately 53,000 inhabitants and occupies an area of 151 km^2. Kranj is the economic, trade and cultural centre of the Gorenjska region. The city does not have its own alcohol policy but they are dealing with the issue and different sectors are trying to find a solution.

2. Stakeholders' network

In September 2007 we started building a local stakeholders' network in order to act in the field of alcohol prevention. Different sectors within the city

of Kranj were invited to join the network in order to contribute to reducing the problems associated with alcohol use: health sector, social institutions, education institutions and nurseries, police, judicial institutions, working organizations, non-governmental groups, youth (students clubs), alcohol industry, local authorities and politicians. At the network's first meeting the participants were acquainted with the ECAT Project and their potential role in it. They were also invited to participate in further activities. The common conclusion of the participants was that there is interest in the field of preventing and diminishing harmful use of alcohol in the Municipality of Kranj. Local partners in the Project were: Institute of Public Health Kranj (holder and coordinator of the Project), Centre for Addictions and Local Association Group Kranj, Social Work Centre Kranj, halls of residence for students of secondary and higher education in Kranj, Secondary School of Economics Kranj, Pharmacies of the Gorenjska region, Students' Club, Recovered Alcoholic's Club, Nurseries of Kranj, the Municipality of Kranj, local association of the Red Cross Kranj, the Police Station of Kranj, the Health Centre of Kranj. The enumerated partners were also more or less active in the continuation of the Project. Due to their workload, general practitioners did not participate in the Project, the only exception being a handful of general practitioners who completed the questionnaire.

3. Quick scan analysis of the community

A quick scan analysis with regard to alcohol use, and especially alcohol abuse was conducted, with the aim of identifying the key problem and target group for the prevention campaign and also for choosing actions aimed at reducing the damage associated with alcohol. The following was used:

- archival data collection (routinely collected data by health services, police and social institutions, referring to inhabitants of the Municipality of Kranj and data collected during research on the use of alcohol among young people (ESPAD) in the Gorenjska region and research of behaviour patterns among the adult population in the Gorenjska region);
- stakeholders' survey (in October 2007, 38 questionnaires were sent to general practitioners, the police, the Social Work Centre, the Municipality of Kranj, pharmacies, education institutions and nurseries – the response rate was 26%);

- focus groups (at the end of January 2008, a focus group was conducted among young people and another one among stakeholders in February 2008).

The collected data were analysed and presented in a preliminary report which was communicated to all members of the local network. The second and third preliminary report and final report were drawn up on the basis of discussions and meetings of the stakeholders' network (March 2008).

4. Results

The main results of the quick scan analysis showed:

- **in the field of alcohol use and drinking patterns** – that in the Gorenjska region (and in Kranj) drinking of alcoholic beverages is present among both teenagers and adults (low percentage of abstainers); that young people drink considerable amounts of alcohol and that the average age at first contact with alcohol is decreasing; that the proportion of young people who drink alcohol is increasing as well as the frequency of drinking and the amount of alcohol they drink; that at least 17% of young people already had problems associated with alcohol; that at least 10% of adults in the Gorenjska region are excessive drinkers; that more than 40% of the young people aged between 15 and 16 years were intoxicated during the last year prior to the survey as were also half of the adult men and one third of adult women and that general practitioners reported 20% of their patients having drinking problems.
- **in the field of damage associated with alcohol** – that among inhabitants of Kranj there are 350 annual first visits to general practitioners, about 108 hospital treatments and about 11 deaths (3% of all deaths) resulting from the reasons which can be directly linked to alcohol and also about 54 cases of temporary absences from work accounting for approx. 2521 days per year. According to the Police data there are 31% of violations against law and order associated with alcohol; in 2007 one tenth of drivers were driving under the influence of alcohol and 39 cases of alcohol addiction are being treated each year at the Social Work Centre of Kranj.
- **with regard to social and substantive background –** that according to adults alcohol is very easily accessible; that young people esti-

mate it as easily accessible and that they know exactly in which pubs they will be served alcohol despite the legal ban of serving alcoholic beverages to minors or intoxicated people; that when it comes to binge drinking the most exposed group at risk are young people. The prevailing opinion is also that there are too many places in Kranj, where alcoholic beverages are being sold or served, that young people should be better informed about alcohol and the damage it can cause, that the participation of the community in solving the alcohol issue is insufficient and that not enough has been done in this direction;

- **approaches towards solving issues associated with alcohol** – that the existing legislation is not sufficiently respected and implemented; that tolerance to alcohol needs to be decreased and that we need to inform and educate young people as well as the wider public and encourage cross-cutting cooperation.

Based on the record of the situation, drinking (especially excessive drinking) and binge drinking among young people was identified as the key problem in the Municipality of Kranj. Consequently, young people were chosen as a primary target group for the campaign and the providers of alcoholic beverages and general public were chosen as indirect target groups.

5. Campaign

The results of the quick scan analysis were put into action at the second meeting of the stakeholders' network. Based on the key problem which was identified (drinking, especially excessive drinking and binge drinking among young people) each participant wrote two ideas that aimed at solving the problem. The ideas collected in this way were then written on the board. After that, we sorted the ideas into different groups, discussed them, and chose the best approach for the identified problem: informing and having fun without alcohol abuse. The conclusions of the meeting were communicated to all members of the local stakeholders' network. They were also invited to discuss and to submit additional proposals with regard to the content of the campaign and associated activities.

The development of the campaign took place in four main phases:

- *preparatory phase* (subject matter of the campaign, target groups, objectives of the campaign);

- *development phase* (campaign's message, materials, support activities, visual image);
- *implementation of the campaign*;
- *assessment of the campaign*.

Besides the local stakeholders also young people (the target group) participated in the organizing and implementing the campaign. They formulated the tag-line and the visual image of the campaign themselves, and also organised stands about alcohol for young people.

The aim of the campaign was to encourage young people to make informed decisions on the use of alcohol based on the right information to motivate and encourage them to avoid risky behaviour associated with alcohol and to motivate them to spend some active spare time without alcohol (and other drugs).

Target group:

- The direct target group of the communication campaign were young people (with special attention on third and fourth grade students of secondary education, i.e. the age group between 17 and 20 years). Third grade students were chosen because they go on a traditional trip at the end of the year, where drinking alcohol and binge drinking are often present. Fourth grade students were chosen since in most cases they are adults and have legal access to alcohol according to the applicable legislation but they often participate in excessive drinking of alcoholic beverages and binge drinking,
- The indirect target group were the providers of alcoholic beverages and the general public.

Final goals of the campaign:

to decrease alcohol consumption among adolescents; decrease risky use of alcohol, especially binge drinking among young people.

Intermediate goals:

- To raise awareness among young people about the dangers and consequences of drinking, especially excessive drinking and binge drinking,
- To encourage young people to have fun without alcohol,
- To influence the views, decisions and behaviour of young people who use alcohol beverages not to do it regularly and to drink in such a way as to reduce the risk for themselves and others,

- To inform the personnel serving and selling alcoholic drinks about the problem of binge drinking among young people and their role in lessening the problem,
- To inform general public about the alcohol issue among young people.

6. Realisations and plans

The campaign »Alcohol. Take a sober look.« with slogan "Being sober doesn't mean being boring". ("Be sober = be cool") officially began in the Municipality of Kranj on 6th May 2008 with a press conference.
Certain activities (workshops for students organising stands about alcohol among young people – educating educators) had already begun in April. A workshop for the providers of alcoholic beverages in the area of Kranj was also planned for April but was cancelled due to a lack of interest. The education objective was to show to this target group that alcohol was a public health related issue and to inform and to sensitise them about their role in decreasing alcohol related issues among young people.
The campaign reached its peak between 9th and 17th May during the Youth Week in Kranj. During this time a lot of young people gathered in Kranj to participate in different activities. Campaign and related activities took place all May and June:

- Activities during Youth Week
  1. ECAT stands "*Be sober = be cool.*" at a central square in Kranj (in cooperation with the Students Club of Kranj three educated students wearing T-shirts with ECAT logo and the campaign's tag-line informed young people about alcohol and raised the awareness among them about the dangers of excessive drinking and binge drinking; they also informed minors that every use of alcohol under the age of 18 is considered to be abuse; young people then had the opportunity to verify their knowledge about alcohol in a quiz and could win a prize if their answers were correct);
  2. ECAT workshop "*Be sober = be cool.*" for the general public (its aim was to raise public awareness and to encourage making reasonable and healthy decisions associated with alcohol – if participating in the workshop one could learn about alcohol, its effect on human beings and on society as a whole, about the dangers of excessive use

of alcohol and binge drinking and how to deal with alcohol without putting individuals and society at risk; the concept of the campaign was also presented as well as its message and promotional material).

- Workshops about alcohol in secondary schools in the Municipality of Kranj (in May and June 2008, third grade students and seniors could take part 1n workshops at those secondary schools in the Municipality of Kranj which expressed interest in this activity – students could learn about alcohol and its effects and a special emphasis was put on raising awareness about excessive drinking; discussions on how to reduce risks and damage associated with alcohol also took place and each student was given an informative booklet »Message in a glass«);
- All secondary schools received an informative booklet »Message in a glass« (including instructions for further distribution) for each fourth grade student or senior, respectively;
- Informing the wider public through bills (city bills, bills at schools, residence halls for students of secondary and higher education, health centre, pharmacies, nurseries, police, city hall and other public places), media, web page (content: What is alcohol? What happens with alcohol in our bodies? Effects of alcohol. Alcohol has different effects on individuals. Dangers of binge drinking. How much alcohol can an individual consume? How to reduce the risk to the lowest possible level? How to help an individual who is intoxicated? Where to seek help? Useful links).

Materials used during campaign included: bills, informative booklets »Message in a glass«, T-shirts, writing pads, labels, Frisbees.

7. Evaluation

The evaluation of the campaign was done through process evaluation. However, the visibility and partially the impact of the campaign were also evaluated.

7.1 Process evaluation

Process evaluation was done on the basis of a uniform ECAT form. It contained a description of local partners (their role and participation in the

campaign), target groups, objectives of the campaign, approaches towards target groups and concept and elements of the campaign. Context analysis showed the following barriers and facilitating factors.

	Barriers	Facilitating factors
Situation / environment	Public bill-posting in Kranj is allowed on places specifically determined for this purpose and for which the concession was granted to advertising agencies – this is associated with financial costs. Bill-posting in institutions is allowed if the institution gives its consent. Providers of alcoholic beverages show no interest for the prevention in the field of alcohol.	Main activities of the campaign took place during time when a lot of young people gathered in Kranj for the Youth Week. We approached young people in school where we were able to cover the generation of third and fourth grade students or seniors, respectively.
Actors	Insufficient participation of most local partners (with the exception of health services, police, school, young people and the Municipality of Kranj) in preparing and implementing the campaign. Due to low project budget the workload on the personnel at the Institute of Public Health Kranj was very heavy as they had to prepare, implement and evaluate the campaign and also implement workshops at schools. The implementation of workshops at schools depended on the interest a school showed for the activity and on the time each school devoted to the implementation of the workshop.	Cooperation with young people (Students Club, school) and different local institutions contributed to increased credibility and publicity of the campaign. The press conference which took place at City Hall and at which the Mayor and the representative of Ministry of Health participated, drew attention of different media. Since young people created the tag-line and the visual image of the materials, these were better accepted among young people. Stands were organised by young people (educated students) what contributed to increased credibility of the preventive message.

Intervention	Some institutions did not post the bills. The workshop for the providers of alcoholic beverages was cancelled as there were no requests for participation. Workshops at schools: in some classes students were not particularly interested in the topic; some schools did not decide to host workshops due to lack of time. Distributing materials to fourth grade students or seniors, respectively: some schools did not respect the recommendations regarding the distribution of booklets to students. Stands: the last stand took place during the parade of senior students and thus recorded less visits. Workshop for general public: • Since alcohol is socially acceptable, the prevention in this field is not an interesting topic for the general public; this was probably the reason for the workshop's low participation rate. • Other activities took place simultaneously.	Promotional material and tag-line appeal to young people. Workshops at schools were welcomed among most young people. Young people show motivation in participating in the quiz where they won a prize for a correct answer.

In the framework of the campaign, city bills were posted for two months at six places in Kranj, 548 bills (68x48cm) were distributed as well as over 4000 informative booklets »Message in a glass«; a press conference took place (9 media were present and a press release was sent to 69 e-mail addresses); three one-day stands about alcohol for young people were organised (at least 350 young people participated in the quiz) as well as one workshop about alcohol for the general public; ten workshops about alcohol at three secondary schools for third grade students took place (covering 22 classes or 660 students) and a web page was created.

7.2 Reach and visibility of the campaign

Reach and visibility of the campaign were assessed on the basis of the translated and adapted ECAT evaluation questionnaire. It was sent to three secondary schools. First, second and third grade students completed the questionnaires. 204 completed questionnaires were returned. To the question if they have seen, heard or read anything about an alcohol prevention campaign in Kranj during last two months, 35% of students answered 'yes'. Most of the students noticed the campaign through bills posted at school or in the city and they also found out about it through media coverage. 31% of students were acquainted with the name of the campaign »Alcohol. Take a sober look.«. 55% of students knew the slogan of the campaign "Being sober doesn't mean being boring". (»Be sober = be cool.«) and 73% of students noticed it. The most known material among students were the bills (76% of students), 27% of students knew about informative booklet, while between 2 and 6 % of students knew about other materials. 19% of students did not remember any of the material used during the campaign. Mentioned materials were most often spotted at school (55% of students), followed by the street (39% of students) and stands (17% of students). Other places were rarely mentioned. The bill that was printed at the end of the questionnaire was recognized by 77% of students (50% of students saw it several times and 27% of students saw it once). Most of the times, they saw this bill at school (50% of students) and in the street (34% of students).

7.3 Acceptance and appreciation of the campaign

The acceptance of the campaign within the target group, i.e. among young people, was partially verified on the basis of the evaluation questionnaire distributed among participants at the end of workshops at a secondary school. 89 third grade students took place in the survey (23 boys and 63 girls; three students did not specify their gender) answering five questions. The content of the workshop got the average assessment of 3.56 (out of 5); moderator conducting the workshop earned the assessment of 3.87 and the informative booklet »Message in a glass« got the average assessment of 3.60. To the question 'Do you think you will benefit from the information that you got here today?' 11.2% of students answered very much; 23.6%

much; 44.9% little; 13.5% not at all and 6.7% of students chose the answer I don't know. 16.1% of students are convinced that the information they got will influence their attitude towards alcoholism or alcohol use, respectively. The results of the campaign were also discussed at the final meeting of the stakeholders' network. A general opinion was, that the campaign was positively accepted in the local environment and that it reached the target group. Schools are especially interested in organizing future workshops for high school students in order to reduce damage associated with alcohol - and in including younger age groups in the future as well.
Stakeholders are also interested in continuing the activities.

Chapter 6 Encouraging sensible drinking in Enfield (UK)

Authors:
Libby Ranzetta, Chinelo Nwajiobi, Don Shenker

The ECAT project in Enfield has two components: an information campaign to raise awareness of alcohol units and recommended sensible limits; and a workplace alcohol awareness training programme. The workplace project uses peer trainers – professionals who do not have a formal training role – to deliver the alcohol awareness session to their colleagues.

1. About Enfield

Enfield is a borough in the northern-most part of Greater London, 12 miles from central London. The population is quite diverse – state school pupils have recorded themselves under 87 different ethnic groups. The single largest minority grouping recorded in the 2001 Census was Other White at 13% - this is composed largely of Greek, Turkish and Cypriots.

With a total population of 280,000, the original intention was to apply the ECAT project to a part of the borough. However, once the stakeholder group was established and the nature of the project decided upon, it was agreed that the work should cover the whole borough.

2. Stakeholders' network

The stakeholders network comprised senior officers from a wide range of organisations that have an interest in alcohol prevention. The support of two key people – the Head of Licensing and Head of Community Safety – meant the stakeholders were willing to join. The network met quarterly through the duration of the ECAT project, with meetings facilitated by the local coordinator and chaired by the Head of Licensing.

The organisations represented in the network are as follows:

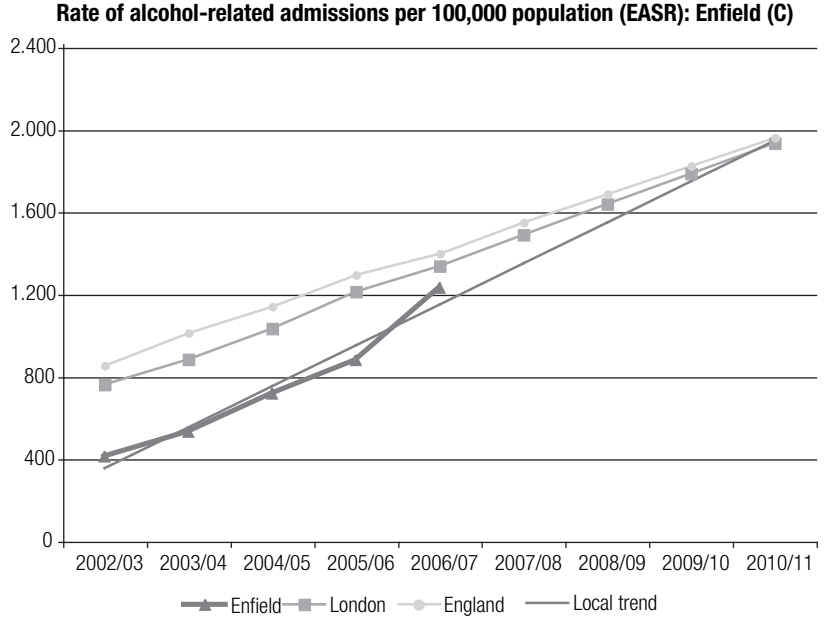
- Environmental Health and Regulation – council department responsible for trading standards,
- Metropolitan Police – local police,
- Community Safety Unit – multi-agency team responsible for reducing crime,
- Licensing – council department responsible for alcohol licensing,
- Drug and Alcohol Action Team – council department responsible for commissioning alcohol treatment,
- Probation Service,
- Fire Brigade,
- Youth Offending Team – multi-agency team dealing with youth crimePrimary Care Trust – local National Health Service trust,
- London Ambulance Service,
- Business – a local licensee,
- Community Empowerment Network – representing the voluntary sector,
- Domestic Violence Forum – multi-agency forum,
- Safeguarding Children Board – multi-agency board responsible for protection children from harm,
- Enfield Observatory – centre for data, research and statistics about Enfield,
- Chase Farm Hospital – acute hospital in the north of the borough,
- North Middlesex Hospital – acute hospital in the south of the borough,
- Enfield Business and Retailers Association – catering and hospitality trade association.

3. Quick scan analysis

The analysis was conducted using existing local data from the police, ambulance service and health trust. There was no local data available on levels of alcohol consumption, so regional data for Greater London was used to extrapolate estimates for Enfield.

In London, 21% of adults drink at hazardous or harmful levels and 5% are alcohol dependent. For Enfield this means about 39,000 are drinking at hazardous or harmful levels and about 9,400 are alcohol dependent. Figure 1 shows that admissions to hospital for alcohol related conditions have tripled in the four years since 2002/02

Figure 1: alcohol related hospital admissions per 100,000 population (EASR), Enfield



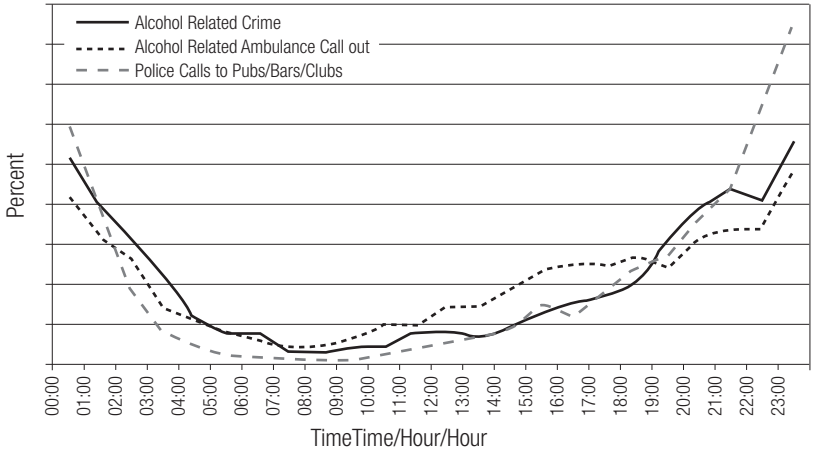
Analysis of crime data for alcohol related offences shows that of 1,857 recorded between April 2004 and the end of March 2007, 731 (39%) were domestic violence (Table 1). For non-domestic violence offences, half (563) involved violence against the person, and nearly a fifth (199, 17.7%) were criminal damage (vandalism).

Table 1: breakdown of alcohol related crime, April 04 to end March 07

Offence	Domestic	%	Non-domestic	%
Criminal damage	44	6	199	17.7
Domestic incident	272	37.2	0	0
Shoplifting	0	0	113	10.0
Violence against the person	398	54.4	563	50.0
Other offence	17	2.3	251	22.3
Total	**731**	**100**	**1126**	**100**

Figure 2 shows that police and ambulance data both indicate a clear pattern for alcohol related offences, of a sharp rise between 19:00 and midnight, decreasing gradually into the early hours.

Figure 2: timeline for alcohol related offences, April 04 to end March 07

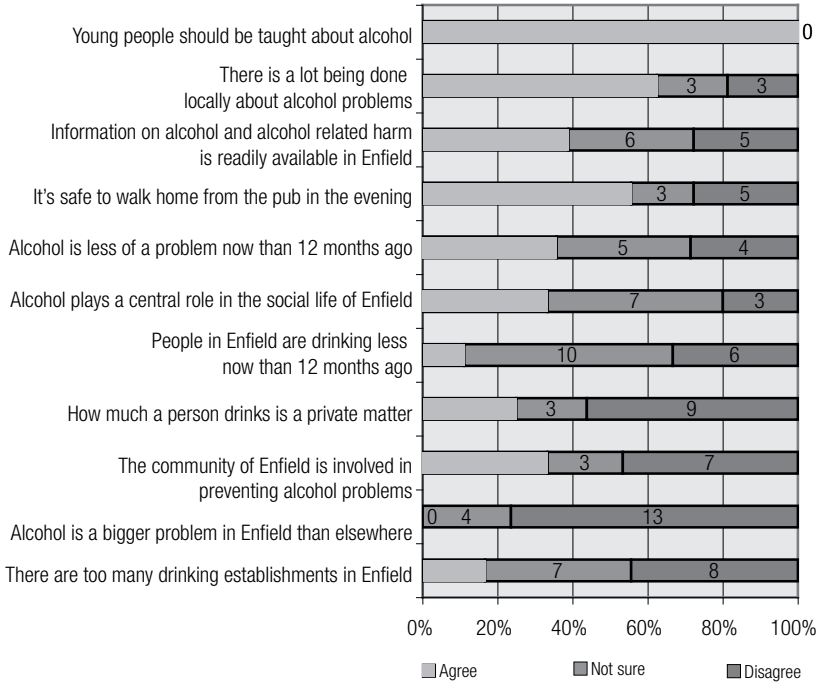


The stakeholders completed a brief questionnaire indicating their opinions about alcohol problems in Enfield. The main problems in Enfield were felt to be public anti-social behaviour and underage drinking.

What do you consider to be main alcohol problem(s) in Enfield?

All stakeholders agreed that young people should be taught about alcohol, but most disagreed that alcohol is a bigger problem in Enfield than elsewhere.

What is your opinion on the following local alcohol related issues?



The stakeholders gave a range of response to the question "in your opinion, what should be done locally to reduce alcohol problems in Enfield?" These included better alcohol education in schools and information for adults, better enforcement of licensing laws to stop underage sales, early intervention in alcohol problems and better treatment, provision of alternative activities for young people.

Two focus groups were held with members of the stakeholders network to discuss the quantitative data, review the evidence for best practice, and decide upon the community-based project. The groups considered the following possible areas of work:

- Brief interventions in primary care, accident and emergency departments,
- Work based programmes,
- School based education,
- Server training,
- Enforcement.

All but work based programmes and server training were already underway in Enfield to some extent. The focus groups decided that server training would be difficult because of high turnover of staff in pubs and clubs. Also, enforcement activity in the borough had reduced alcohol related crime and disorder associated with pubs to a manageable level. The groups therefore decided to develop a workplace project.

After formal presentation of the quick scan findings, a meeting of the stakeholder network agreed to proceed with a workplace project and an information campaign to raise awareness of recommended sensible drinking levels.

4. The campaign

Local and national surveys show that people are largely ignorant of the government's advice on sensible drinking, and have poor understand of the concept of 'units' – a standardised way of describing the amount of alcohol in a drink. The ECAT project took place at a time when the Department of Health had launched a £3M 'Know Your Limits' campaign aimed at raising awareness of units and recommended limits. The Enfield campaign was designed to reinforce the straightforward information message, but in a local context.

Picture 14 in the middle section shows the alcohol information page that was included in the 2008 Community Safety booklet – a free publication that is delivered to every household in the borough. It contains information on local public services and sources of help and advice. In addition, 2,000 postcards were produced for use in conjunction with 'unit calculators' at health promotion events. The postcards carry the AUDIT C questions (how often did you have a drink containing alcohol in the past year; how many drinks did you have on a typical day when you were drinking in the past year; how often did you have six or more drinks on one occasion in the past year), plus information on what the answers mean and what the recommended daily limits are. Unit calculators, supplied by the Drinkaware Trust, are cardboard discs that can be manipulated to show how many units of alcohol are contained in different types and sizes of drinks.

5. Workplace project

It was decided to raise awareness of alcohol in the workplace through a peer training programme, whereby professionals from different organisations deliver alcohol awareness sessions to their peers. Over three days, 15 people were trained to deliver the sessions. The group comprised: four police officers; three fire officers; a nurse; a health promoter; a housing officer; four service users (recovering alcoholics); and a community safety officer. The professionals then delivered alcohol awareness sessions to colleagues and, in some cases, members of the public in a programme that will continue until April 2009.

Only three of the group had previous training experience. The theory behind using 'lay' trainers – people who do not have formal training expertise – is that they bring authenticity and originality to the planning and delivery of awareness sessions, and they can tailor the sessions precisely to the needs of their colleagues because they have first-hand experience of how alcohol impacts on their work.
As part of this project, some information about alcohol in the workplace was distributed to all businesses in Enfield via the Enfield Business and Retailers' Association newsletter. Support in developing workplace alcohol policies and running awareness sessions was also offered.

6. Evaluation of the campaign

There will be a formal evaluation of the Community Safety booklet – the main element of the campaign – in the autumn of 2008. Unfortunately, distribution of the booklet happened later than anticipated due to delays from other organisations that contributed information to it. It has not been possible therefore to evaluate its effect in time for inclusion in this report.

1,000 postcards have been distributed at health promotion events, shows, talks and via the peer trainers. A consultant from one of the local hospital Emergency Departments requested a supply for the hospital reception area, so that patients can do the questionnaire whilst waiting for treatment.

Surveys have been carried out where possible at shows where the postcard has been given out. The survey asks:

- Before using the postcard did you know about units of alcohol (yes/no)
- Did you know what the recommended limits were (yes/no)
- How likely are you to reduce the amount you drink as result of using the postcard (very likely/quite likely/neither likely nor unlikely/unlikely/very unlikely)

47 people completed the survey. 77% said they knew about units; 41% said they knew what the recommended limits are. In response to the question about reducing drinking, 9% said they were quite likely to do so, 39% said unlikely and 52% said very unlikely. Anecdotally, a large number of people took cards and calculators away 'for my husband' or friends. The AUDIT C questionnaire seems to be a simple but effective way of engaging people in thinking about their drinking levels – especially those people who are currently exceeding the recommended limits.

In terms of the process of developing the campaign, it was necessary to condense some of the ECAT steps because the stakeholders were reluctant to meet too frequently. In effect the brainwriting session did not take place, so the project development happened within the focus groups. This meant that the focus groups had less time to consider the evidence for best practice, and it was not possible to reach consensus on the campaign materials and artwork to be used. The resulting campaign simply uses the ECAT and EU logos as a result.

The workplace project will be evaluated in March 2009, with an interim evaluation at the end of September 2008. The interim evalution will include feedback from the peer trainers at a 'refresher' session for them, analysis of the evaluation forms completed by participants attending the alcohol awareness sessions, and semi-structred interview with a sample of participants.

ECAT logo and slogan

Members of the ECAT network

Austrian ECAT project in Gmunden

Beer mats distributed in local bars in Gmunden

Rathauscafe Brandl by night

Belgian ECAT project in Oostende

Promille-test on the website www.proostende.be

DJ Maxxxxx and D-Man ready to distribute prevention materials in secondary schools

German ECAT project in Achern

Achern stakeholders meeting

Working Group ‘preventive measures to addiction’

Italian ECAT project in Padova

Dr. Scafato standing next to the ECAT poster for the national alcohol prevention day

ECAT information leaflet for general population: the more you know, the less you are at risk

Slovenian ECAT project in Kranj

Peer education to students at the Quadrille dance parade (May 2008)

Campaign materials

United Kingdom ECAT project in Enfield

Foto of stakeholders' meeting

Information dissemination in local media

ECAT conference 24/10/2008

VAD director: Marijs Geirnaert opening the ECAT conference (Flemish Parliament)

Audience at the ECAT conference

Part 3

Summary

Summary of the ECAT project

Johan Rosiers
ECAT project coordinator, Vereniging voor
Alcohol- en Andere Drugproblemen – VAD, Brussels (B)

At the end of 2006 a community-based alcohol prevention project started in 6 European countries: Austria, Belgium, Germany, Italy, Slovenia and the UK. The project was named ECAT, an acronym for "to Empower the Community in response to Alcohol Threats". The aim of ECAT was to develop a methodology for raising the effectiveness of local alcohol prevention. Essential to the ECAT project is that members from the community have a participative role in the decision of strategies and interventions.

1. Motives behind the ECAT project

The premise of the project was to give a response to the need for good practices in evaluated alcohol prevention in a local community setting, by combining self-developed methods for local analysis and evaluation with gathered evidence-based practices and good practices of alcohol prevention on a local community level. The ECAT project emphasises that methodological contributions for developing tailor-made strategies and actions should be endorsed by a local communication campaign on alcohol prevention. Scientific literature proved that the combination of evidence-based interventions and an awareness-raising communication campaign for alcohol prevention within the community enhances the chances for success. The communication campaign is a supportive element for specific interventions. Sensitising and informing the community members on a problem smoothens the way for other interventions.

To enhance the power of local prevention campaigns and other prevention actions, it is important to get a good look on the local alcohol situation first. Alcohol problems are often the result of processes within the community, so it is important to look at the consumption of alcohol and at cultural, social and economic elements that play a role in it.

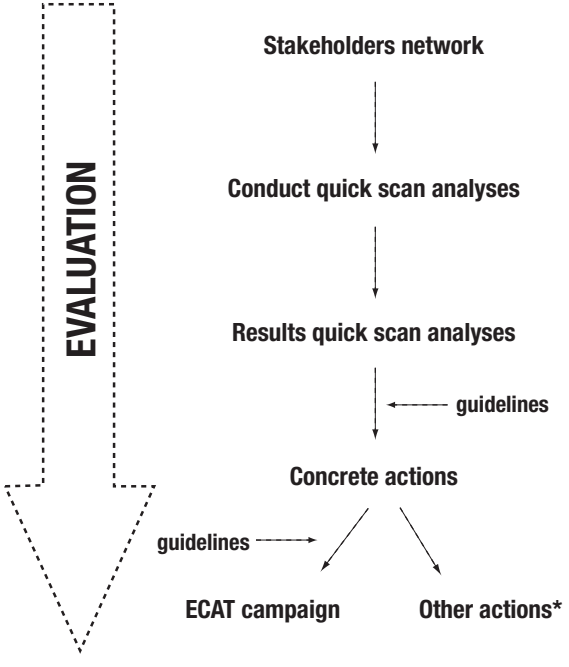
It is obvious that the evaluation of local prevention actions is essential for measuring the success of the inclusive approach.

Part 1 of the manual consists of the four main elements that are mentioned above:
1. Setting up a local network of stakeholders.
2. Conducting a quick scan analysis.
3. Adding evidence to community-based interventions.
4. Planning and implementing evaluation in a feasible way.
In addition, the ECAT methodology got an important surplus by sharing experiences and good practices from the pilot projects in the six participating countries. These are documented in part 2 of the manual.

2. The pillars of the ECAT methodology explained step-by-step

As already mentioned, the ECAT methodology consists of four main elements. These elements are part of the phased model that is illustrated in figure 1.

Figure 1: ECAT scheme



* the results of the Quick scan analyses may result in other actions, byond the scope of ECAT

Put in chronological order, the setup of a stakeholders' network is the first step before coming to the quick scan analysis. The translation of the results of the quick scan analysis into actions has to be endorsed by the (evidence-based) guidelines, at the point of choosing actions. Evaluation runs through the process as a continuous thread.
To get the process of these four main elements properly done, some supporting steps have to be taken as well. That is why we come to six concrete steps. These are described below, in a more general way. To accomplish these steps accurately, it is advisable to follow the instructions and tools that are integrated in part 1 of the manual.

2.1. Assigning a local coordinator

In order to facilitate the whole networking process, it is recommended to appoint a local coordinator to guide the ECAT project. His or her role is to provide the direction and drive to stay on track. Since one of the objectives of ECAT is setting priorities for the (re)orienting of the local alcohol policy, an option to consider is to mandate a representative of the municipality for the coordination of the ECAT project. After becoming familiar to the ECAT concept and methods, he or she will start the coordination with the launching of the stakeholders' network and the preparations to outline and implement the evaluation process.

2.2. Planning and implementing evaluation throughout the process

The process of community projects is too dynamic to use ready-made standard evaluation methods, even more because in ECAT, community projects were developed in 8 different local communities, in 6 different countries. Instead, community-based alcohol prevention needs a flexible and comprehensive approach to evaluation. As in most community projects, the focus of the ECAT evaluation is put on formative and process evaluation, since outcome evaluation was not feasible in the limited allocated period of nine months (the local projects only started in the second year of the ECAT project).
Community interventions should be developed in a systematic way, they should at least be theory-driven and should emphasise elements that are

of proven efficacy. Because of the lack of available resources (time, staff, expertise, ...) to conduct an outcome evaluations, process evaluation and the integration of existing literature and expert opinions are most valuable alternatives. These two elements are included in ECAT. A reliable level of theoretical evidence for effectiveness is provided, since the community interventions of ECAT are based on a systematic needs assessment and problem analysis (i.c. quick scan analysis) and on solid theoretical and good practice assumptions based on literature reviews.

Because of the typical time bound restrictions in community prevention projects, the evaluation strategy should be built in right from the beginning, so the projects can be improved while still running. A model for evaluation planning is integrated in the ECAT evaluation. In this planning the stakeholders have a continuous important role, starting with the necessity to obtain a consensus on basic assumptions, evaluation methods and outcomes and results they intend to reach.

Evaluation runs as a continuous thread through the different phases of community projects. The ECAT concept to develop community interventions with a focus on communication campaigns is perfectly shaped for formative evaluation. Relevant information is continuously collected in the different steps of the project. Feedback on the project planning and on the decision-making is provided by stakeholders. It is also important to do a process evaluation by describing which obstacles are encountered in the different steps of the project.

The ECAT pilot projects showed that describing and sharing knowledge and experiences in designing, implementing and evaluating community projects is very valuable. Good practices are useful as an inspiration source or example for other community projects and contribute to theory-building on this matter. In ECAT, each community project reported on the different phases they went through, including evaluation.

2.3. Setting up a local stakeholders' network

Setting up a local stakeholders' network is a first yet important step towards a community alcohol prevention project. Alcohol related problems are manifest in different spheres of community life. So developing community alcohol prevention becomes the responsibility of multiple stakeholders. A prior objective of community action to counter these problems is to

identify community stakeholders that are working in the alcohol domain or that are experiencing consequences of (problematic) alcohol use, and to assemble them in the ECAT stakeholders' network. This includes professionals working in relevant sectors (health professionals, bar owners, police, ...) as well as local policy makers (politicians or public servants) as well as representatives of local residents (e.g. representatives of community associations or socio-cultural organisations).
To make decisions on behalf of the organisation, sector or group they are representing, it is important to assemble good representatives of the organisation, sector or group. When contacting these members, it is very important that the objectives and expectations are very clearly explained to them. It is also important that each member of the stakeholders' network is an equal partner and has its own share in the meetings and consultation rounds.
Guidelines on the participation of the stakeholders' network in the quick scan analysis are given in chapter 1 of the manual. But their role remains important throughout the whole process: in the quick scan analysis, in the translation of quick scan results into prevention interventions, in evaluating the project.

2.4. Conducting a local quick scan

The quick scan analysis is the first tangible step towards prevention interventions. The results of the quick scan provide a look on the local situation and problems related to alcohol, the intervention targets (topics and target groups) and the available actors and resources. This is essential to develop prevention strategies interventions with the highest relevance for the local community.
The ECAT quick scan is not based on a top-down approach, where generalised findings on alcohol from a higher level provide the basis for local actions. Instead, the ECAT quick scan uses the local stakeholders as data source and reviewer of data. In that way, all collected data (even from higher geographical levels) are weighed and (re)assessed. This approach enhances the relevance and perceptability for the local community members. The impact of working with the quick scan results is also higher because local stakeholders are allowed to participate in reflecting on the results and their implications.

Two essential methodological strengths of the ECAT quick scan are:

- the iterative cycle of analysis: gathered data are discussed and re-discussed with local stakeholders in order to refine the data and to translate the findings into relevant and realistic strategies,
- mixed methods/data triangulation: in the first step of the quick scan, the collection of mainly quantitative data provides a first broad view on the alcohol situation. In the following qualitative steps of the iterative cycle, this result will be amplified, refined and adjusted by the local stakeholders.

The ECAT quick scan integrates three phases of data collection:

1. collection of archival data on alcohol related topics, like existing publications (research reports, annual reports, …), existing monitoring systems (alcohol and drug monitors, police statistics, …) and existing data from client registration systems (alcohol and drug services, primary health care services, general practitioners, ...);
2. brief stakeholders' questionnaire, based on four opinion-oriented questions about the local alcohol situation. The stakeholders give their opinion on the main alcohol problems, on a predefined list of potential alcohol problems, on what should be done to reduce alcohol problems and they are offered the opportunity to add their personal views, ideas and concerns on the subject;
3. complementary qualitative data collection and translation of the quick scan results into prevention strategies and interventions, based on group consulting methods within the local stakeholders' network (i.c. focus groups and brainwriting).

Tools and methodological frameworks for conducting the quick scan properly are described in chapter 2 of the manual.

2.5. Integrating the intervention guidelines in ECAT

The findings of the ECAT literature review on community-based prevention indicate that combining the following measures is most effective:

- the inclusion of evidence-based alcohol prevention interventions, depending on the results of the quick scan analysis conducted in the community and on the assessment of the local stakeholders. Their decision on which problems require which intervention should be based on evidences in community alcohol prevention,

- regulations and enforcement: there is strong evidence that alcohol related regulations and the enforcement of these regulations are most effective to reduce alcohol related problems, but the options for a community to regulate alcohol related issues strongly depend on the legislative framework,
- a supportive communication campaign for other interventions: communication campaigns have a complementary role of creating and reinforcing awareness of alcohol related problems, smoothening the way for other preventive actions.

Chapter 3 of the manual includes a list of good practices in community-based alcohol prevention, based on these three evidences. The following evidence-based interventions are highlighted in the manual:

- brief interventions in primary care, accident and emergency departments, including recommendations for information and sensitising of the (para)medical staff and for training to enhance skills and expertise to recognise and handle alcohol problems,
- work-based programmes, including recommendations for alcohol policy in the workplace, initiatives to inform and sensitise the personnel and training initiatives to recognise and manage alcohol related problems,
- responsible beverage serving, including recommendations for training initiatives towards owners and personnel of catering and hospitality trade and sensitisation initiatives to lower the alcohol use in their trade,
- other prevention interventions: school-based interventions, parent-oriented approaches, prevention initiatives in leisure services and sport clubs, social service departments and out-of-school youth services.

Concerning regulations and enforcement, there is a growing consensus on the effectiveness of setting rules to regulate the availability of alcoholic beverages for specific target groups, such as limiting the hours and days of sale and raising the minimum drinking age. But this effectiveness depends on adequate enforcement and on a corresponding national legislation. ECAT recommends to investigate and use legislative and enforcement authority and to set rules in the community, like setting age limits for selling and serving alcoholic drinks, BAC controls in traffic, marketing restrictions (e.g. no alcohol marketing on materials owned by the local authority) and self-regulation (e.g. prohibition or restrictions on organising happy hours).

Community-based measures need to be accompanied by enforcement to be effective on a longer term. Recommendations in this domain highlight the important role of the police, especially in controlling for infractions. Other local stakeholders have also an important role, more specifically the catering and hospitality trade in self-regulating the selling and serving of alcohol to young people and already intoxicated people.
The third effective measure is communication campaigning as endorsement of a broader prevention strategy. ECAT follows the recommendations on preventive communication campaigns concerning alcohol that the European Parliament published in 2007. Creating a public basis for a local alcohol strategy by running a local alcohol prevention campaign is one of the key factor for success in the ECAT concept. We define a communication campaign as any deliberate effort to influence all or particular sections of the public via different media. Alcohol related communication campaigns are aimed at raising awareness and increasing knowledge of alcohol related problems, as well as to endorse governmental interventions on different levels. In general, the construction of a communication campaign generally consists of four major phases:

- the preparatory phase, including the selection of the subject, target group and objectives of the communication campaign (extracted from the quick scan results and the guidelines),
- the development phase, in which the campaign image and message are developed (in our project: the pink elephant), media are selected (posters, flyers, press, ...) and campaign materials are developed,
- the campaign implementation,
- the campaign evaluation.

2.6. Putting ECAT into action

Part 2 of the manual illustrates the first experiences in the implementation of the ECAT concept and methodology in eight local communities in six countries.
At the beginning of the ECAT project, we set the ideal population size to 30,000-60,000 inhabitants. But in the course of the project we realised this criterion was too restricting. In the smaller countries Austria, Belgium and Slovenia too few communities qualified for this criterion. In bigger cities it was unrealistic to fragment districts to comply to the desired number of

people. So we decided to loosen this criterion. The population size of the eight participating communities varied from 12,000 (St.-Leon-Rot in Germany) to 280,000 (Northern London borough Enfield in the UK). The selected local communities were mostly municipalities or cities, but in two cases city districts formed the scenery of ECAT: in Enfield (UK) and in a city district of Padova (Italy). There was also a great variety in the characteristics of the communities. Two communities were touristic centres (Gmunden in Austria and Oostende in Belgium). Two communities were marked by the regional production of alcoholic beverages (Achern in Germany and Kranj in Slovenia). Two communities had specific multi-ethnical population features (Enfield in the UK and Leimen in Germany).

All local ECAT projects managed to compose a strong multisectoral stakeholders' network. The following sectors were represented in most communities, education, social welfare, police, judicial services, youth organizations, alcohol and drug counseling and treatment services, primary health care (e.g. hospitals, emergency departments, ambulance services,…) and city authorities (civil servants and politicians). In most communities, representatives of catering and hospitality trade (retailers, bar owners, …) were also invited but their willingness to participate was generally low.

Most communities started applying the quick scan methodology as recommended in the ECAT manual. The collection of archival data and the use of the short stakeholders' questionnaire were conducted as foreseen. Most communities conducted the focus group sessions in the proposed way, but the brainwriting sessions were only partly implemented. This was mostly due to a lack of time, resulting from unforeseeable institutional circumstances during the process (political changes after elections, bureaucratic procedures to ensure the support of authorities, …) or to reluctance from the stakeholders to participate in all steps of the quick scan analysis. Nevertheless, we recommend to conduct all steps of the quick scan because this gives good results, as the Slovenian quick scan analysis proves. Most important lesson to learn from the ECAT pilots is to foresee enough time for conducting the quick scan (at least 6 months) and to inform the stakeholders on the commitments that are expected from them during that period.

The results of the quick scan analysis and the intervention guidelines gave enough grounding to make endorsed choices for local action. All local projects choose young people as prior target group, mostly aimed

at prevention concerning excessive drinking and binge drinking. School-based prevention and information and sensitising via information campaigns, workshops, info desks at popular places or events were commonly implemented. Among the other chosen topics in the ECAT pilots were harm reduction, drink driving, alcohol and pregnancy, work-based programmes and public nuisance. Most communities put emphasis on parent-oriented prevention and on public announcement (e.g. articles in regional media).
The short timescale for the local projects did not permit to do an extensive evaluation. Evaluation was mostly limited to a reach and visibility evaluation and an appraisal of the participating stakeholders. For both aspects, all communities showed good evaluation results. Only the Slovenian partner managed to conduct a proper process evaluation, as recommended in the ECAT methodology. This process evaluation resulted in very useful results for continuing and extending the ECAT project.
Every local project is described in the chapters of part 2.

3. The crosslink between ECAT and the alcohol policys of EU and WHO

Besides the important fact that the ECAT project was facilitated by the EC co-funding in the Community Action Programme for Public Health 2003-2008, the ECAT results have shown good local implementations of the EU strategy in reducing alcohol related harm. In the 2006 published official communication from the European Commission "An EU strategy to support Member States in reducing alcohol related harm"[11] the following five priority themes are highlighted:

- Protect young people, children and the unborn child,
- Reduce injuries and death from alcohol related road accidents,
- Prevent alcohol related harm among adults and reduce the negative impact on the workplace,
- Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns,
- Develop and maintain a common evidence base at EU level.

1 http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0625en01.pdf

The choices made for interventions in the local ECAT campaigns, based on the local quick scan analysis and substantiated by evidence-based guidelines, correspond largely with these five EU priority themes.
The EC document mentions that national strategies could be more effective if they are supported by local and community-based activities, which is the core issue of ECAT. The community-based approach of ECAT, built on the structural participation of multi-sector stakeholders is congruent with recommendations in the mentioned EC document, as well as the integration of a communication campaign as endorsing element for further alcohol prevention interventions.
The ECAT concept is also congruent with recommendations to counter alcohol related problems of the World Health Organisation (WHO). The 2007 published "WHO Expert Committee on problems related to alcohol consumption - 2nd report"[2] points out advantages of implementing an alcohol policy at the local level. The inclusion of a communication campaign is mentioned as a key element.

4. The future of ECAT

In the buildup of the ECAT project we appraised it more appropriate to spend enough time on the development and continuous improvement of the concept and methodology. The downside of this decision was that the available time for testing the ECAT concept and methodology in local pilot projects was rather limited (more or less 9 months). Nevertheless, the positive and promising results of these pilot projects showed the great potentials of ECAT. This was confirmed by the appraisals of the people involved on different levels: the ECAT collaborators of main partner VAD, the ECAT associated partners in six countries and the stakeholders and politicians in the eight participating local communities.
The project will continue in most communities where ECAT was implemented, as it should be in the spirit of community-based work. The results of quick scan analysis, guidelines, evaluation and the campaign are the fundaments for a larger construction design, namely a local alcohol strategy or policy. Moreover, the ECAT applications will be extended to other communities in some of the participating countries.

2 http://www.who.int/substance_abuse/expert_committee_alcohol_trs944.pdf

We hope that this manual will contribute to the disclosure and extension of the ECAT method throughout Europe. Without any doubt the future of ECAT will be marked by methodological evolutions coming from different practical applications of ECAT. This upgrading would be no less than our biggest whish. ECAT has proven its value as basic concept, now it is up to you to use its potentials and to increase its value by implementing it in the specific social, cultural, political and economic context of your community.

The ECAT project was managed by the ECAT Expert Working Group: Johan Rosiers, David Möbius, Mieke Autrique and Els Vandenberghe (main partner VAD, Belgium); dr. Alfred Uhl and Irene Schmutterer (Ludwig Boltzmann-Institut) in Austria; Roos Deventer (CGG Middelpunt), Steve Bauwens, Koen De Ruytter and Lien Baeteman (City of Oostende) in Belgium; Martina Thrän, Stefanie Hecht, Rüdiger Dunst and Yvonne Ernst (Diakonisches Werk Baden) in Germany, dr. Emanuele Scafato (Istituto Superiore di Sanità) and Tiziana Codenotti (Eurocare Italia) in Italy; Don Shenker (Alcohol Concern), Libby Ranzetta (Ranzetta Consulting) and Chinelo Nwajiobi (Municipal Borough of Enfield) in the UK.