SURVEY ON SCHOOL-BASED PREVENTION PROGRAMMES IN THE EU

Analysis of a pilot questionnaire survey on school-based prevention programmes carried out by the EMCDDA in 2001

Gregor Burkhart[1] & Mónica López López

[1] Gregor.Burkhart@emcdda.org

Contents

1. BACKGROUND

This report analyses and discusses the information gathered from 50 school-based prevention programmes from EU member states, which answered to a standardised questionnaire in fall 2001. The European Monitoring Centre on Drugs and Drug Addiction began by that time to pilot more quantitative information collection on the state of drug prevention in the European Union in order to develop a core set of variables, which are relevant to "visualise" and monitor prevention in Europe by quality (models and contents of programmes) and by coverage indicators (e.g. n° of schools or teachers which implement them), also with a view to assess the feasibility to map prevention efforts within the EU in a long term perspective. This survey focuses explicitly on programmes not already inserted into EDDRA (http://www.reitox.emcdda.org:8008/eddra/) and aimed at facilitating the answering of questions by proposing already pre-formulated selection options for objectives, models and some other category variables, which in the EDDRA questionnaire are open free text fields and often perceived as difficult to fill in. However, the items and the selection options in the questionnaire were result of a previous analysis of school-based prevention programmes already inserted into EDDRA. The creation of this questionnaire answers to the need of developing a common monitoring instrument, which makes it possible to collect and analyse prevention interventions carried out in the EU. Contrary to the EDDRA questionnaire, which is a quite demanding tool to describe good practice examples in detail, this survey questionnaire concentrates on some selected key parameters to describe easy and quickly school-based prevention responses on a broader level and without exclusion criteria.

The questionnaire of only one page (attached in Annex 3: School Programmes Questionnaire on page 35, also translated into Spanish, Italian, French and Greek) was sent to 368 addressees, programme leaders, National Focal Points and other known actors in the prevention field, in an electronic (Word form, locked) version. It was sent back by 50 respondents. The information has been compiled in an Excel database. The standardized form of the questionnaire is composed of 31 questions, from which this analysis pays special attention to the following key variables:

- Objectives.
- Models.
- Evaluation indicators.
- Actors involved.
- Concreteness level of implementation guidelines.
- Number of teachers trained and hours of training
- Material used.

Before we open the discussion of the results, it is necessary to clarify some methodological aspects: We have analysed 50 programmes from 9 EU Member States (no response from 6 countries!), but the results of each country can not be interpreted as the paradigmatic intervention model nor as the prevention coverage of the country. The number of programmes from each member state is not big and not homogenous enough to affirm that a determined intervention model prevails over others.

Moreover, there are important national differences in the number of programmes that responded to the questionnaire (from Spain or Italy with a sum of 14 programmes each, to Sweden with one programme, see Figure 1-1).

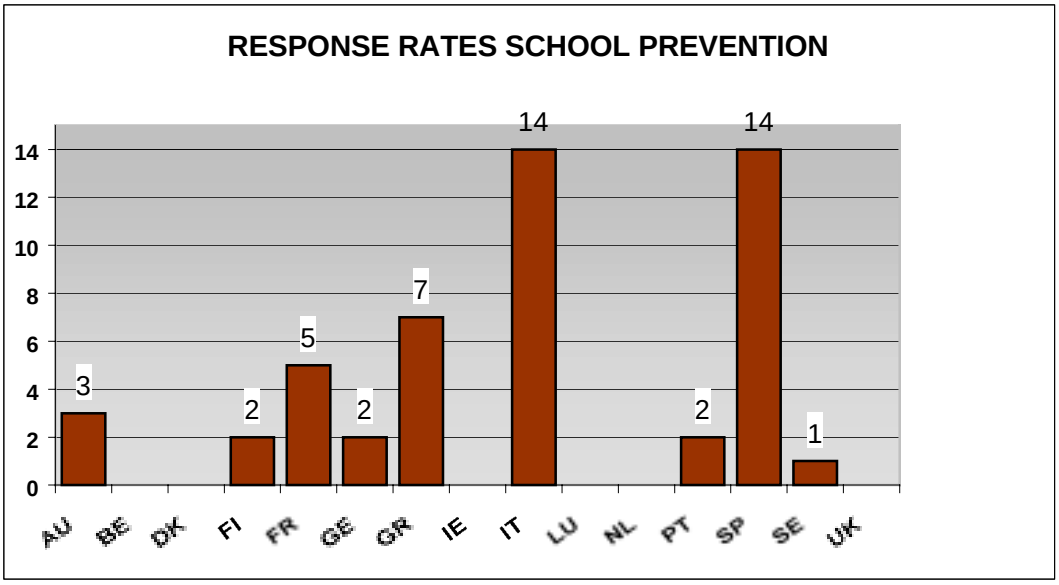


Figure 1-1

Due to this fact, there are member states, which are much more represented than others, and several hypotheses might explain this. The argument “federal system” as an explanation for low response rates does not explain the extremely high responses from Spain (which has a federal system comparable to Germany), and the argument, “technical problems, no e-mail” does not explain the very low responses from Germany and Netherlands (where many programmes have e-mail and are well-equipped). These response rates could reflect the aversive perception of questionnaires (Austria) and of structured feedback itself (NL) in some countries and highlight the need for better coordination of questionnaire exercises with national authorities and International organisations (UNDCP and Mentor Foundation were sending similar questionnaires at the same time as the EMCDDA questionnaires were sent out). The existence of functioning networks with regular training exercises and the use of similar questionnaires by funding authorities, like in Spain, were however considered a facilitating factor. Spain has had a network for several years now. People know it very well and react easily and with routine to questionnaires.

Therefore, the objective of this project is not to compare the prevention coverage in the different EU member states. We are not going to speak about country trends. These questionnaires inform however on the degree of knowledge that professionals have about their interventions, if their performances are consistent with their theoretical models and the objectives that they affirm to have. At the same time, this tool offers the possibility to check if evidence-based elements of successful school drug-prevention programmes are known and used by the professionals. In the retrieved programmes we have found some examples where the strategies considered most effective are totally unknown. From the nine theoretical models offered in the questionnaire, e.g. a French programme declares not to know any of them.

On the other hand, in the course of the analysis we have realised that some questionnaire items can be improved. This is important, as this questionnaire was the basis for EMCDDA Standard Tables, which are used by National Focal Points since 2002 to gather annual information on ongoing programmes in a common comparable format. The questions related to the duration and the intensity of the programmes seem to be confusing. Some programmes had answered about the age of the programme instead about the duration of the specific intervention, which is the relevant information for us. In order to solve this misunderstanding, we have simplified this part for the Standard Tables by explaining and reducing the questions, from four to the following two:

- Duration of the intervention (number of months).
- Intensity (number of sessions).

To make the comparison between programmes easy, in the Standard Tables we only ask for the programme duration in months.

Due to the problem of comparability of these quantitative variables we have abstained from using this information for the present analysis.

Concerning the questionnaire, we have to mention some suggestions made by the respondents. The most common suggestions refer to the lack of space to describe the programme and to explain the indicators and results. There are also some requests for clearer and more explicit questions.

2. DISCUSSION OF RESULTS: PROGRAMME CONTENTS

Objectives in school programmes

To promote healthy lifestyles (Health Promotion) is the most common objective among school-based prevention programmes (24 programmes), following by Develop Personal and Social Skills (13 programmes) and Information and Awareness (10 programmes). The three secondary objectives most chosen were: Develop Personal and Social Skills (21 programmes), Health Promotion (9 programmes) and Information and Awareness (8 programmes).

The trend in most of the programmes seems to be the combination of several objectives, mainly Health Promotion and the Development of Personal and Social Skills.

Health promotion is most often mentioned, probably because it is a more all-embracing, less demanding and fluffier concept.

It is encouraging to discover that life skills based approaches, nowadays considered to be most effective, is one of the most often chosen objective.

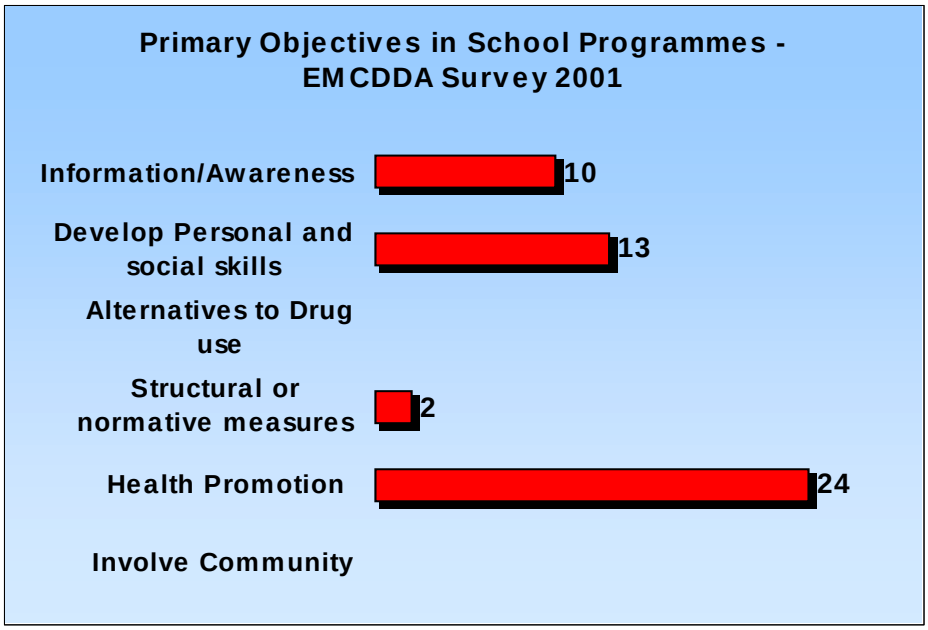


Figure 2-1

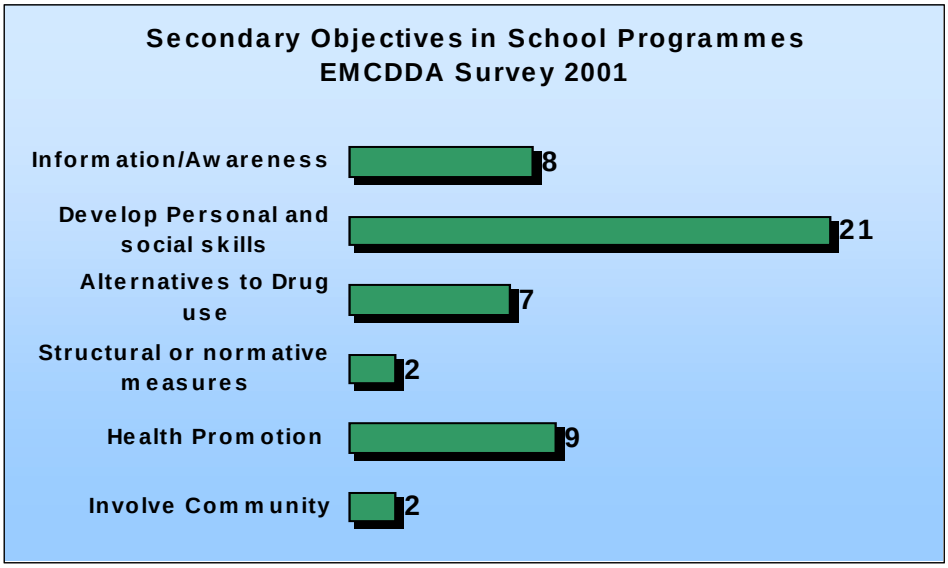


Figure 2-2

Models in school programmes

The most used model in school prevention also seems to be the Health Promotion Model (19 programmes); followed by the Life Skills Model (9 programmes) and Peer Approaches (8 programmes). The high number of interventions, which are based on the Health Promotion Model, might be due to the fact that Health Promotion is a very general model, which includes many different aspects and approaches and can therefore be attributed to many programmes without contradictions (this is basically the same explanation as under objectives). Probably more people know something about this model, whereas the specific and better-defined models (Social Development, Social Influence, Problem/Risk Behaviour, Reasoned Action-Attitude) are less known. It might be argued that also *life skills* and *peer approaches* are "umbrella terms" which cover several concepts, but other findings in this analysis show (see following chapters) that there is more specific knowledge related to them.

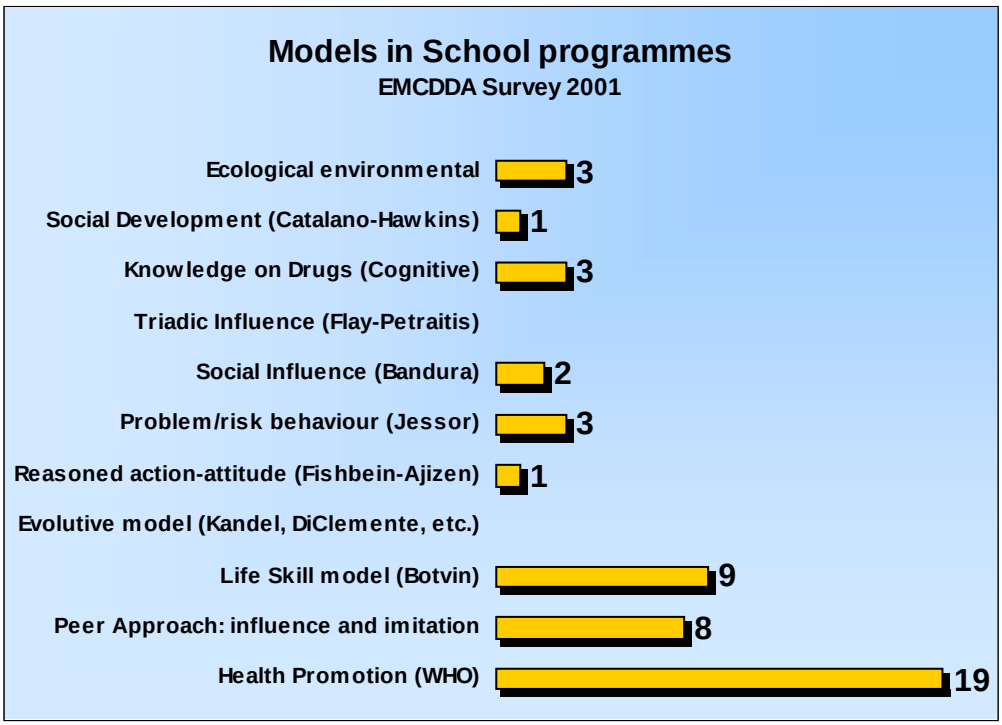


Figure 2-3

Family involvement in school programmes

To involve families as much as possible in school-based prevention programmes is considered an unconditional factor for success (see EMCDDA policy briefing No 5). Therefore family involvement has been included as a variable in the questionnaire. Still the question remains open how intensively these families are really involved.

It appears (Figure 2-4) that families are more involved in reasoned action-attitude, social development and social influence models, and considerably less so in the other models. It is in so far logical as these models give main importance to

important others from which a child learns norms and attitudes that will influence drugs use behaviours (especially Social Development). Family involvement is lowest in peer approaches (and in the related problem behaviour model) and knowledge-based models, which is essentially to be expected. An interesting finding is however, that the ecologic-environmental model is combined with quite a low family involvement, contrary to what we'd associate with a systemic model. Also from a "holistic" model like *health promotion* a more intensive family involvement would have been expected.

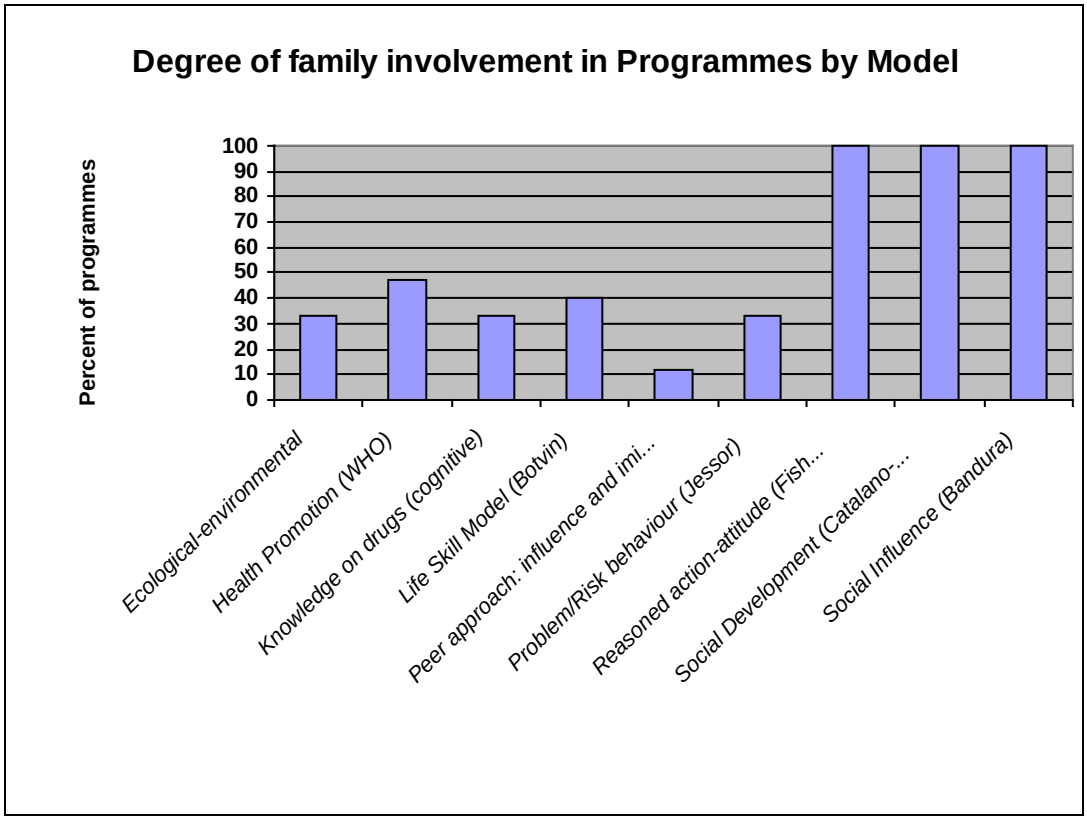


Figure 2-4

Figure 2-4 above shows family involvement as percentage of programmes using a certain model. It has to be read with caution however, especially because the 100% ranks of the specific models are based on very low numbers of programmes based on these models, as Figure 2-5 below shows: the column height shows the absolute number of programmes and their family involvement by model: the specific models have a high family participation but some of them are represented by a too low absolute number of programmes (right side of the chart).

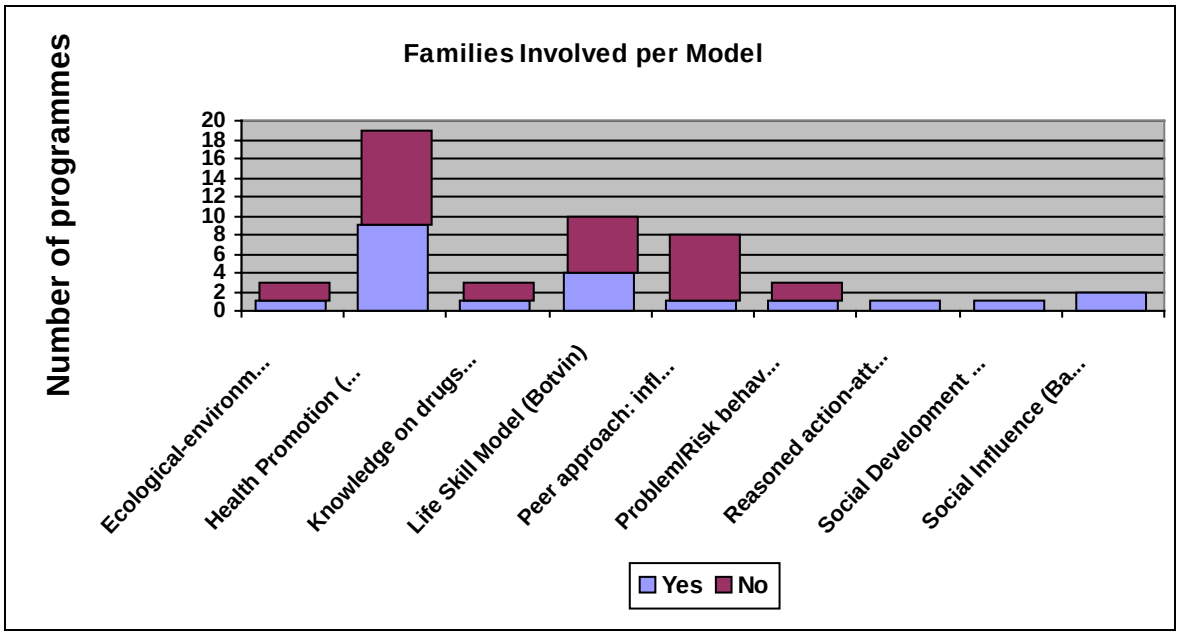


Figure 2-5

Despite its limited statistical value, the variable "family involvement" allows to understand and interpret better the contents of the programmes analysed and the plausibility of their theoretical foundations: certain prevention theories obligatorily foresee family involvement, which should be accomplished in the programme design.

School programme delivery

Another important factor in school prevention is its delivery. Figure 2-6 shows that all interventions in kindergartens are carried out by educators ("T yes-no P") but with a high involvement of prevention professionals too ("T and P"). In the school programmes there are more prevention professionals involved, even without teachers ("no T – P yes" – yellow). Concluding, the involvement of professionals increases with the age of intervention groups (the school level). It shows that higher levels of specific training are invested when the intervention is focussed on older youth.

In the figure some programmes (N=3) are neither delivered by teachers nor by professionals. They have been carried out by students in two cases and by a psychologist in the third case, which was not considered a professional by that programme (a peer approach).

The surprising fact seems to be that teachers and professionals deliver programmes in a joint performance; and that this is observed to a large extent in secondary school interventions. An explanation might be, however, that prevention professionals give counselling and supervising support to teachers for prevention programmes, which explains these high figures of "joint delivery".

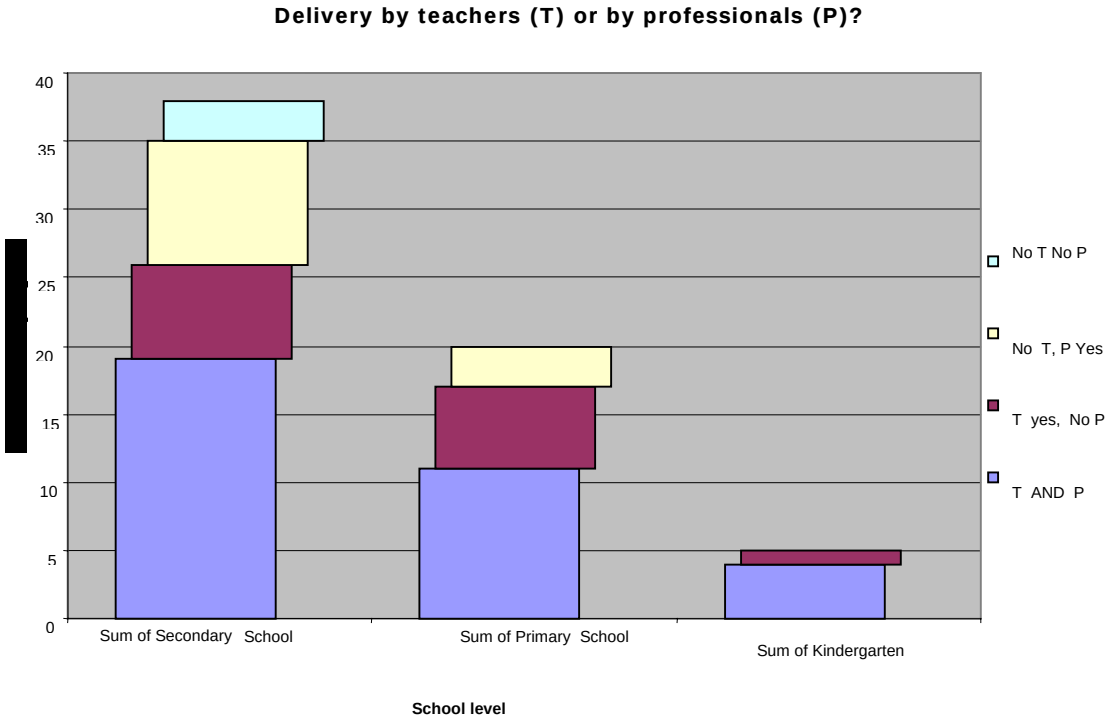


Figure 2-6

Teacher training in school programmes

Successful interventions are carried out by well-trained teachers or prevention professionals (see EMCDDA policy briefing 5). This requires that they must receive regular and qualified training in the specific areas and techniques of the respective programmes. The data available through the questionnaires give at least indicative information about the amount of teacher training in programmes according to their theoretical model (Figure 2-7). The hypothesis is that there is a relationship between the amount of teacher training and the level of theory complexity in the programmes. When looking at the accumulated number of teachers trained, in fact programmes based on Problem/Risk Behaviour-oriented programmes seems to provide a bigger number of teachers trained (1418 teachers), followed by Life Skill Model (1058 teachers).

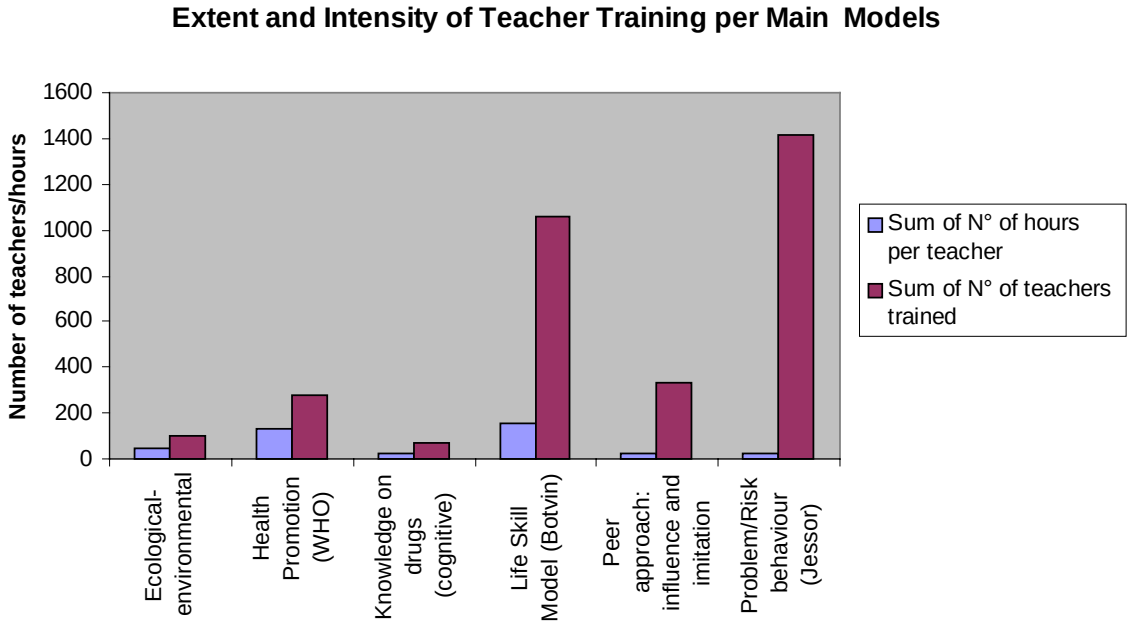


Figure 2-7

The numbers of teachers trained and the hours of training in the programmes analysed differ very much across the models and doesn't give good information on the intensity of delivery by itself alone. The most relevant variable to assess the teacher training level in programmes is, however, "number of training hours per teacher". Unfortunately only 25 of the programmes analysed (50% of total) provided information on this variable, which made it difficult to break down such a low total number into theoretical models. Therefore, the blue columns in Figure 2-7 indicating the accumulated training hours per teacher are not a reliable value.

With a view to the incompleteness of concrete data on teacher training, an indirect measure of training provision is nevertheless the relative number of programmes that *were able to provide* this kind of information Figure 2-8, under the hypothesis that if programmes don't even register or account for this simple programme element, the training of teachers isn't probably very structured nor organised.

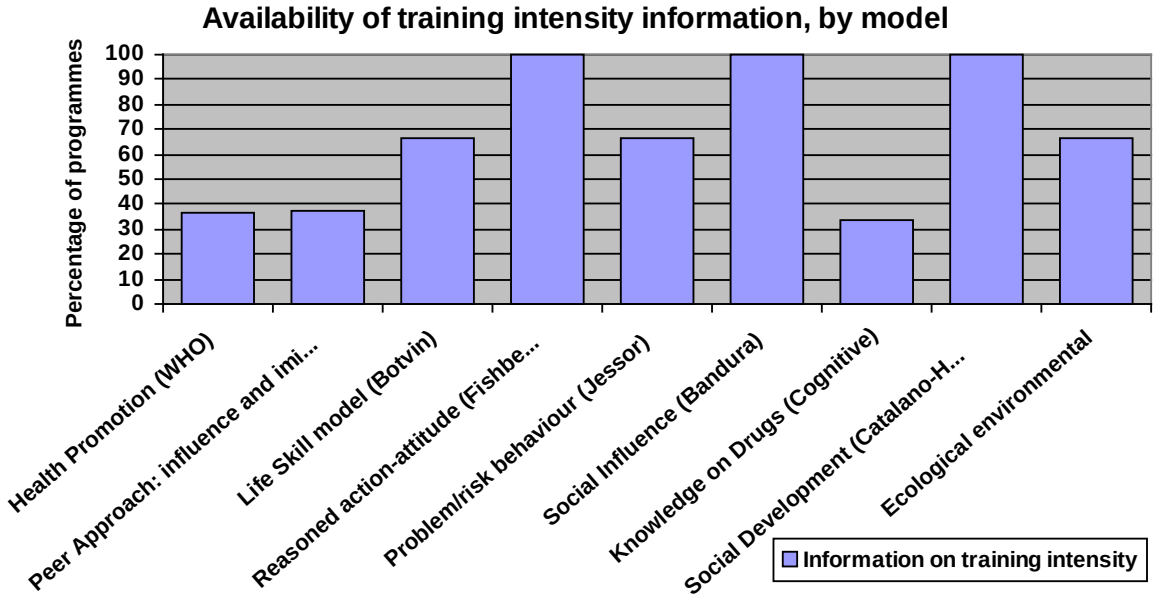


Figure 2-8

Figure 2-8 shows that in fact the more constructed programme approaches include also a higher percentage of programmes that could provide information on teacher training in hours. The higher provision of training corresponds with the most complex models, i.e. the ones with a bigger “theoretical load”.

Material used in school programmes

A programme that uses original material (i.e. manuals for teacher, workbooks for pupils, discussion material: videos, etc) has, to a high degree, the structure and contents of the original programme, which this material belongs to. This material has been investigated and evaluated and more probably contributes to programme effectiveness as it is typically derived from successful programmes. On the other side, it might have the disadvantage of being implemented in a different cultural or social context of the original programme. To overcome these problems, some programmes use *adapted material*; it follows the guidelines of the original programme but adapts it to specific needs of the environment of implementation. The third option is to use *self-developed material*, which is a more spontaneous and probably less structured approach, created for a specific intervention.

The hypothesis here is that a programme, which uses original or adapted material, supposedly well conceptualised with a well-constructed outline, would be associated with a higher degree of teacher training, according to the needs of complex and thoroughly constructed programmes. The material used in the school programmes of this analysis (Figure 2-9) is in most cases self developed or adapted.

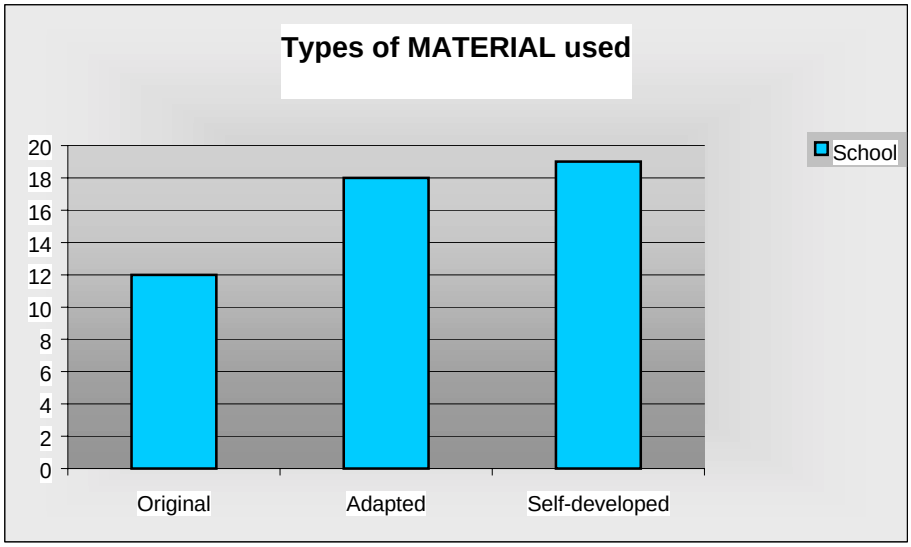


Figure 2-9

Figure 2-10 shows that the hypothesis is confirmed: the number of teachers trained and the hours of training are higher when the material used has been adapted or is original. On the other hand, self-developed material, which is the most prevalent option by the programmes, is associated with fewer teachers trained and less hours of training per teacher.

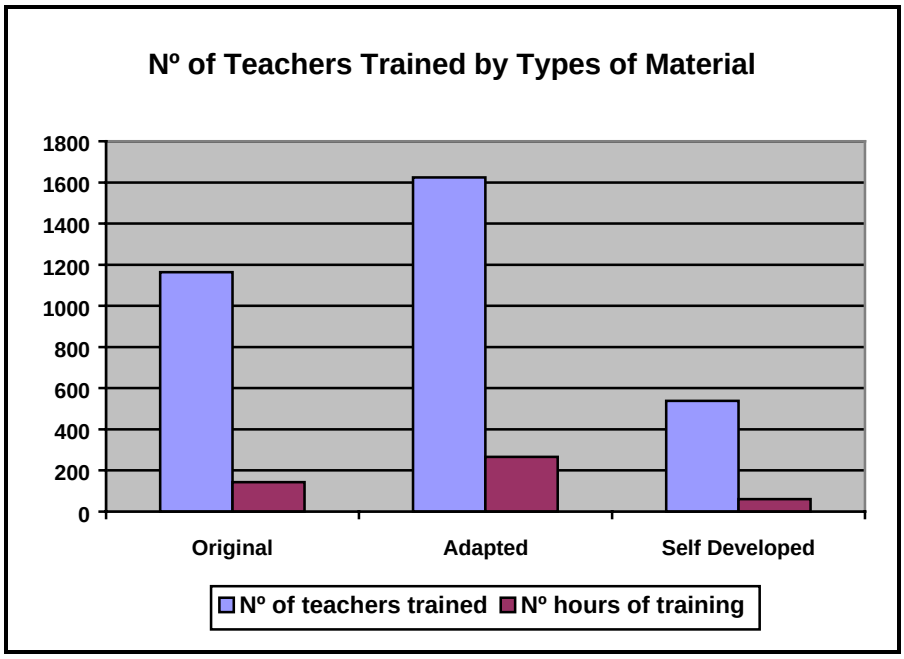


Figure 2-10

Concreteness level of the material

The material used in prevention programmes differs considerably in its degree of detail: from general guidelines to on how to broadly deal with certain topics to manuals that describe in detail the topic to be dealt with and the contents of

discussions and discourses for every session. Programme delivery tends to be more accurate if the programme manual is specific and detailed, also because the teachers' acceptance of a programme is better in this case[i]. The majority of the programmes answered (Figure 2-11) that they have structured manuals (36 programmes). From the 14 interventions that say that they have just general guidelines, 6 belong to the Health Promotion Model. This fact confirms the assumption of Health Promotion programmes being more general and less structured.

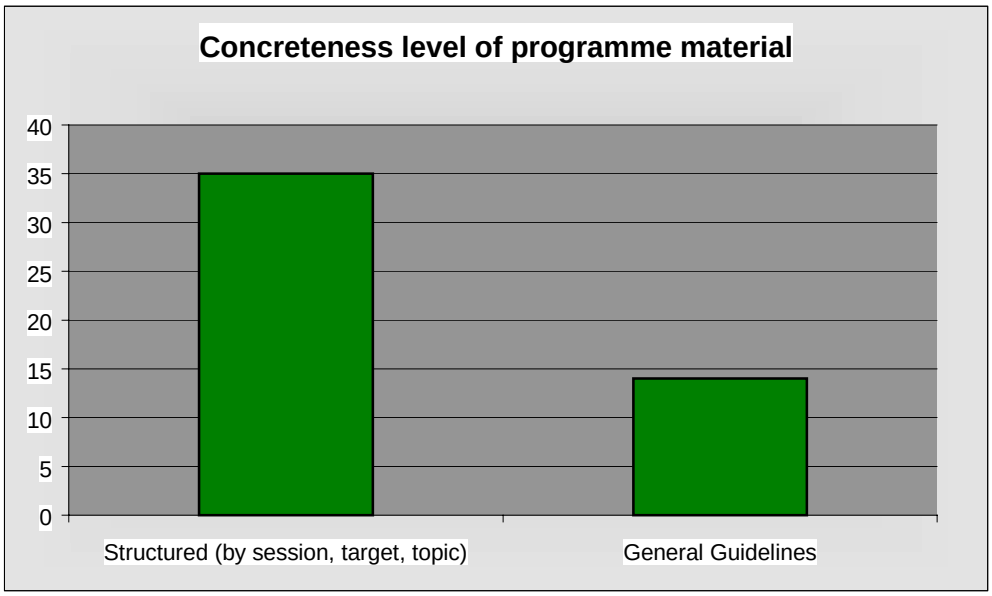


Figure 2-11

Figure 2-12 additionally shows the relation between the concreteness level of material and material types. More structured programmes (by session, target, topic) use more adapted or original material. On the other hand, programmes based on general guidelines tend to use self-developed material. This confirms the hypothesis that programmes based on well-researched and evaluated theories (i.e. which use the respective materials) have also higher level of concreteness and structure, which facilitates teachers' work and adherence to the programme curriculum.

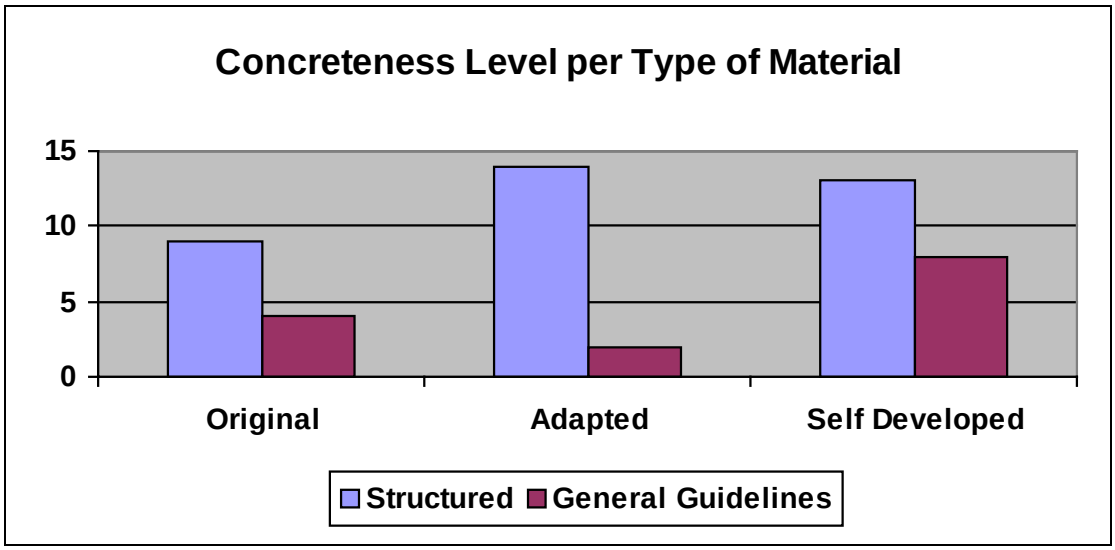


Figure 2-12

3. DISCUSSION OF RESULTS: EVALUATION

Among the programmes, which are analysed here, the most frequently (Figure 3-1) mentioned type of evaluation is the most advanced one: *outcome evaluation with any kind of control* (21 programmes), followed by *process evaluation only* (19 programmes). This suggests a very high level of programme design in this sample. Only few programmes say they have no evaluation at all.

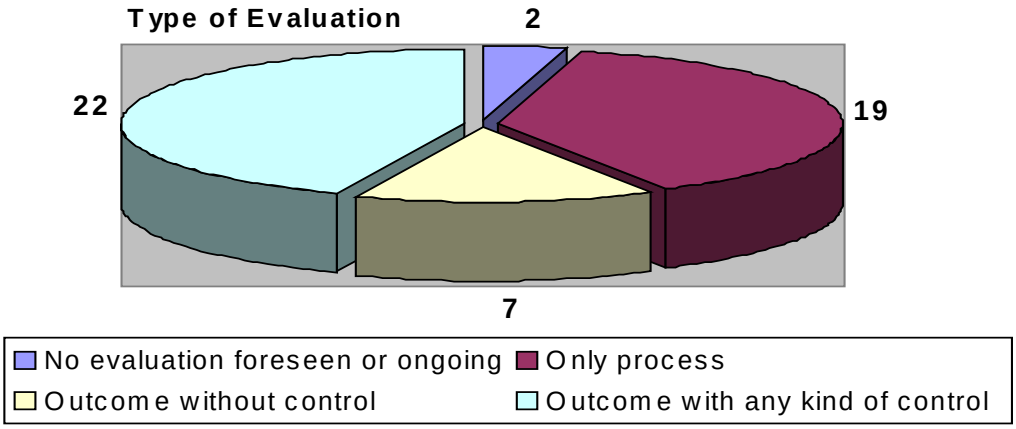


Figure 3-1

There are however several reasons to believe that this allegedly high level of evaluation isn't reflecting reality. It is well known that most school-based prevention programmes in member states are not evaluated. The most probable reason for this high response rate is that only programmes, which are interested in evaluation or have done some evaluation, answered the questionnaire. Beside this, the following considerations and analyses also suggest that evaluation quality is not very advanced.

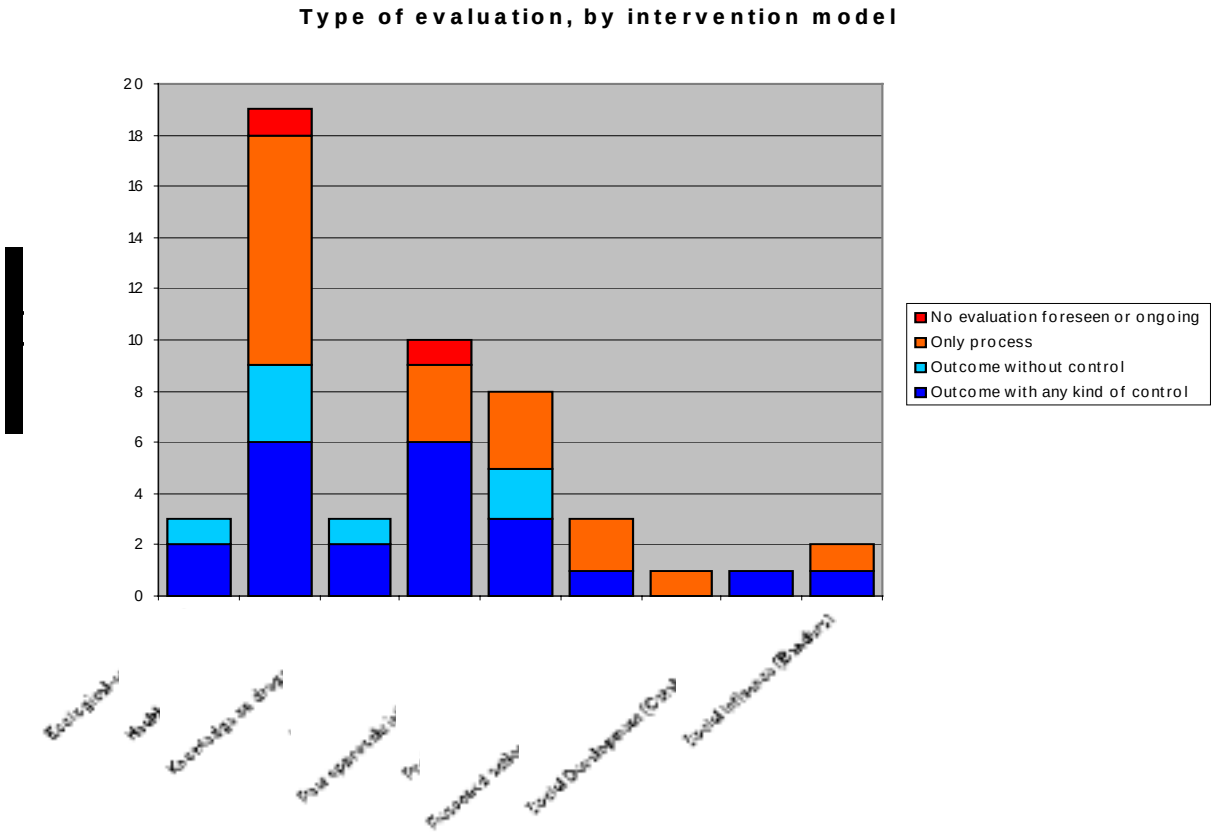


Figure 3-2

It is interesting to notice also that the most used model, Health Promotion, is mostly evaluated through process evaluation only. On the other hand, programmes based on Life Skill Model (Botvin) tend to have an outcome evaluation with control more often. This can be due to the problem, which we were referring to previously: the generality of the Health Promotion Model. Nevertheless the high level of structure and specificity of the Botvin Model makes it easier to be evaluated.

Indicators

Indicators can be considered a measure of the internal coherence of a programme as they are supposed to be chosen in order to produce the most relevant information about the achievement of a programme's philosophy and aims and about its real level of evaluation (i.e. contrary to what programme makers declare to be the evaluation level). The indicator variables are expected to reflect the objectives and the main theoretical model of the intervention. But in most of the cases analysed here, reality stays far behind this ideal. 14 out of the 50 programmes don't have defined evaluation indicators at all. This contrasts considerably with the high evaluation level stated by the programmes themselves (see above in Figure 3-1).

The evaluation indicators mostly chosen by our programmes were "*number of participants involved*" and "*acquisition of knowledge*". The number and content of evaluation indicators are presented in the following table (Double counts are possible as several indicators could be mentioned by a same programme):

Table 1

Short of variable	INDICATOR	Nº of programmes
P.V.	Number of participants involved in the project (pupils, parents, teachers).	14
M.V.	Acquisition of knowledge (about drugs, risk reduction, protective factors…).*	6
P.V.	Improved group climate.	4
M.V.	Improved communication in the family, in the classroom.	4
M.V.	Attitudes towards drugs, towards the intervention. *	4
O.V.	Prevalence rates of drug use.	4
P.V.	Degree of satisfaction and the acceptance with the project.	3
O.V.	Intention to use drugs in the future. *	3
P.V.	Level of cooperation with students, parents.	3
M.V.	Problem behaviours (antisocial behaviour). *	3
P.V.	Involvement of participants. *	2
M.V.	Perception of risk situations. *	2
M.V.	Self-Efficacy. *	2
M.V.	Self-Esteem	1
M.V.	Self-concept.	1
M.V.	Improved life skills.	1
M.V.	Decision-making. *	1
O.V.	Intention of developing alternatives of drug uses.	1
Frequency of outcome **or** mediating variables used in programmes		33
Frequency of process variables used in programmes		26

M.V. = Mediating Variable / P.V. = Process Variable / O.V. = Outcome Variable.

** Evaluation instruments for these indicators can be found in the EMCDDA evaluation instruments bank at:* http://www.emcdda.org/responses/methods_tools/eib.shtml

The majority of indicators used are process indicators and among them most measure programme acceptance. This suggests that most programmes have

chosen evaluation indicators, which are most easy to measure, sometimes not related to objectives or models chosen. On the other side there is a considerable number of intermediate variables mentioned, which can be found in literature and in the EMCDDA evaluation instruments bank and which are helpful to complement outcome evaluations. Under this perspective, a relatively advanced level of programme design can be found in some of the programmes analysed here.

In a more detailed comparison of objectives, model and indicators chosen, however some interesting discrepancies were found. For instance one programme that chose “Information/Awareness” and “Health Promotion” as first and second objectives respectively and claimed to be based on a “peer approach” model, used “A) Number of pupils attended. B) Risk perception questionnaire. C) Surveys on the image of the substances in the young peoples´ mentality” as indicators and is allegedly outcome evaluated (with control), but without results, *(See in Annex 1 examples of clear structure and of discrepancy).* In Table 2, for all programmes of this analysis, the linkage and degree of logical coherence of programme elements can be seen and checked by the reader him/herself. Most programmes have in fact interesting combinations of objectives, models and indicators.

Many indicators chosen by the programmes are not really indicators (“A couple of Thesis”), and we have also seen that professionals tend to confuse process and outcome variables (for instance, a programme which claims to make outcome evaluation uses “the number of pupils attended” as evaluation indicator, which is a process variable (not outcome variable!). These findings demonstrate the need to intensify training for prevention professionals in evaluation basics.

Results of evaluation

From the 50 programmes that responded, only 26 provided evaluation results. 16 programmes (i.e. ca. 30%) don’t provide evaluation results at all, whereas evaluation is in process in the remaining 8. This contrasts strongly with the information in Figure 3-1 where only 2 programmes admitted not to have done any evaluation at all.

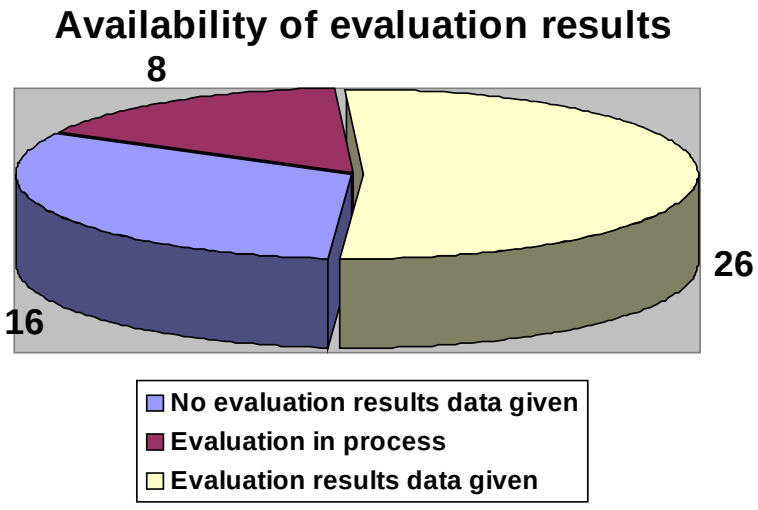


Figure 3-3

Also these, not very encouraging results, can be analysed according to the intervention models used. It is interesting, that a certain pattern could be identified when looking at the programmes that provide or foresee evaluation results (Figure 3-4) and at those that don't (Figure 3-5). Basically, programmes using more specific models are able to provide evaluation results. Again, Life Skills based programmes accomplish better with their declared level of evaluation, than for instance Health Promotion programmes do: most of them provide some results and very few don't provide any (Figure 3-5).

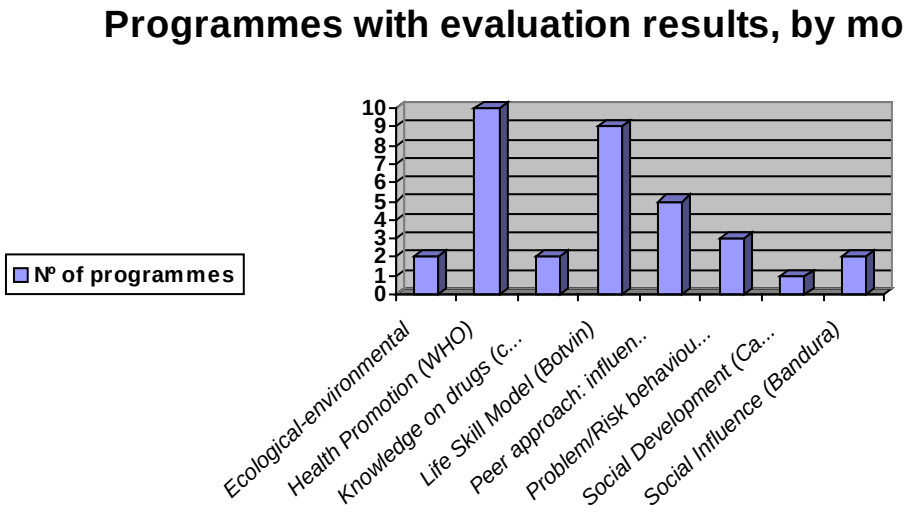


Figure 3-4

A selective look at programmes not providing any evaluation results is equally informative: half of all Health Promotion based programmes are not providing any results despite of all but one allegedly have some kind of evaluation carried out (see Figure 3-2). Concerning approaches like ecological, peer-based, etc., the relationship of results/non-results is more balanced.

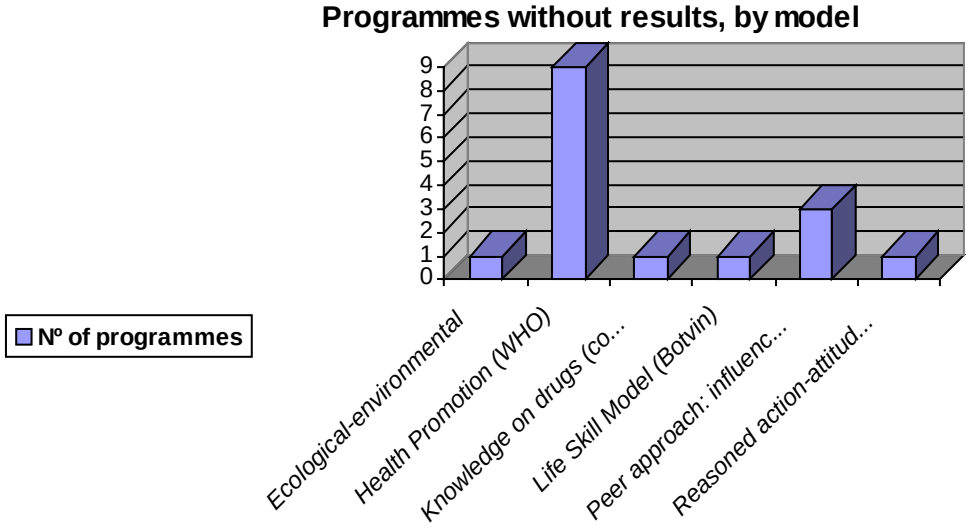


Figure 3-5

Using a qualitative content analysis (see Table 2, p. 29), the majority of the results given are not very specified and focus mostly on the acceptance and satisfaction of programme participants. Even some of the programmes which allegedly have an outcome evaluation, provide under "results" information which is only process related or simply about perceptions, like the following examples:

- "*Of a total of 42 questionnaires, the majority replied that they were satisfied with the subject's development and health education programmes*."
- "*Good acceptation of the programme by the participants*"
- "*Teachers considered the programme as an effective intervention*"
- *"Perceived efficiency of the programme in health promotion habits by teachers"*

Some of the more developed programmes present results of a good evaluation, independently of it being positive or not. For instance: "*We notice a lower percentage of teenagers which start tobacco and alcohol use*". It would obviously be desirable to have more detailed and quantitative data, which support the results described. It might however be the restriction of space in the questionnaire that did not allow the programmes to give a comprehensive amount of information: the questionnaire was developed as a screening instrument and therefore intentionally kept short (one page) and with field limitation.

4. CONCLUSIONS

This questionnaire survey was a pilot project aiming to find indicators that describe and compare prevention policies in the EU member states. Even if the limited number or responses to the questionnaire does not permit to draw comparisons across EU member states, the information gathered permitted us to combine and

to compare several internal programme variables and to draw some conclusions about the programmes. This analysis also allowed for comparing reality of prevention programmes responding to this questionnaire against an ideal situation of good practice.

Relevant aspects of prevention programmes are for example the theory-base, the training level, and the evaluation quality. These variables could quite well be compared even under limited statistical conditions. Before planning an intervention, professionals should carefully examine these variables in other programmes that have been carried out previously, and make use of this experience base.

Ideally, according to the lessons learnt from prevention research, interventions should be carried out by well-trained teachers or prevention professionals, have a clear structure (needs, objectives and means must fit together), be theory-driven, based on intervention models with positive evidence, and report back (according to sensible evaluation indicators). This requires that prevention professionals as well as teachers receive regular and qualified training in these areas and techniques[ii]. These are all variables of programme structure and design and are often neglected, because policy-makers are too often only interested in quick effectiveness information. This is however difficult to provide without assuring good quality of the former elements: evidence shows that one of the most important reasons that prevention programmes fail, is insufficient implementation (theories not put into place)[iii]. Focus in prevention policies should be on the adequacy of its implementation, on its delivery and contents, under the hypothesis that prevention quality can be improved by creating standards for programmes, professionals and services and by tight coordination and control, as for any other intervention with effect on human health.

The theoretical foundation of a programme is important, not only for academic reasons, but also because there is a clear relationship between the theoretical models (or components of these models) of programmes and the positive effects of these programmes. For instance, interventions, which focus only on knowledge or only on intra-personal skills or on affective education, and those omitting social and peer influence, usually do not yield any results[iv]

On the basis of these considerations, an analysis of objectives, models, actors and evaluation methods yields sufficient information on the quality and theoretical orientation of programmes, even if the statistical power and the description of evaluation results it not strong enough.

General findings

The findings of this analysis show a consistent pattern of relationships between models used and other variables: in a synoptic view over all aspects, it can in fact be seen that programmes in this sample, which are based on specific and well defined theories …

- show a higher level of evaluation,

- more likely provide evaluation results,
- use more concrete and more developed materials and
- invest more efforts in training of prevention agents.

All analysis patterns point in the direction that life skills approaches and more specific models are more convincing in aspects of coherence and of implementation of lessons from literature. This consistency was not necessarily to be expected in the analysis of this first European exercise, where response rates were very low and unequal between countries and where a common understanding of programme descriptions was not to be taken as granted. This is important as a first evaluation of the questionnaires used as a standard information tool among member states ("standard tables"). If member states are able to provide information on formal school-based prevention programmes in this format (i.e. a core set of key variables on programmes), useful conclusions and recommendations for prevention planning can be made. This analysis also shows that quantitative information gathering of qualitative categories in prevention programmes is possible and has a usefulness that goes far beyond simple mapping of services: it allows to combine and compare several variables that describe programme functioning and design. This is especially important because most school-based prevention programmes in the EU are not adequately evaluated, which makes it difficult to learn directly from a large number of European experiences and to meta-analyse evaluation results. For the future development of drug prevention in schools in Europe, this exercise might be an incentive for a higher quality standard, including evaluation.

Specific findings

- **Intervention Objectives and Models:** Health promotion is the most frequent primary objective and by large the most frequently mentioned intervention model. There seems to be strong tendency to prefer more general aims and theoretical frameworks or – polemically formulated – a certain difficulty to describe the programme philosophy in specific terms.
- **Family involvement** is high in health promotion and life-skills programmes. It is difficult to verify the real intensity of parents' involvement. Ecological programmes involve parents less than expected.
- **Programme delivery** through professionals increases with the age of the target group and involves both them and teachers to a surprisingly high extent together.
- **Teacher training** has highest importance in life-skills programmes. These programmes and the ones based on specific models also provide more information on training. Health promotion and information-based programmes have the lowest ratings on these variables.
- **Material used:** The concreteness of the material and its fidelity to already evaluated programmes are closely related to the degree of teacher training.

Materials which are adapted from well-constructed, evaluated and concrete programmes (i.e. defining contents for every session) can more easily be used by teachers and facilitate programme implementation. Self-developed material is however more frequently used. Evidence of prevention programmes results has shown to be transferable to other countries and cultures[v]: it is therefore feasible to use material from other programmes, even if they derive from other cultures.

- **Degree of evaluation:** The programmes themselves indicate the degree of evaluation higher than it is in reality. Life skills programmes and more specific models provide a relatively higher level (outcome) of evaluation than e.g. health promotion programmes and other less complex models. More specific models seem to facilitate evaluation or to give greater emphasis to it.

- **Evaluation indicators:** The evaluation indicators chosen by the programmes reflect to a considerable extent the objectives and the theoretical model underlying to the intervention, but ca. a third of the programmes doesn't have any indicators defined. There are some discrepancies between objectives, model and indicators to be found: indicators often seem to be chosen just for easy measuring, no matter if they really mirror objectives or model of the respective programme. The majority of indicators used are process indicators. Professionals tend to confuse process and outcome variables. Some indicators chosen by the programmes are not real indicators.

- **Availability of evaluation results:** The programmes themselves indicate the extent of evaluation results as higher than it is in reality: there are less evaluation results available than evaluations allegedly carried out or ongoing. In consistence with other findings, the results of evaluations are more likely to be provided from Life-skills and specific programmes than from health promotion based programmes.

5. Recommendations

Training of professionals - be they teachers or prevention professionals - is a key factor: If professionals know what they are really doing when carrying out prevention programmes, they have fewer difficulties in reporting to information systems and with basic evaluations, as the response rates from Spain indicate.

If more specific and concrete theory knowledge is passed on to professionals instead of umbrella concepts like health promotion, it can be expected that the degree of intensity, concreteness, clarity and evaluation of programmes increase.

Coherence between programme objectives, theory base, resources and evaluation must get major attention and priority. This is the only way of guaranteeing that programme delivery and contents keep close to the theories and models they are based on. If programmes are not thoroughly evaluated (the norm in Europe), this

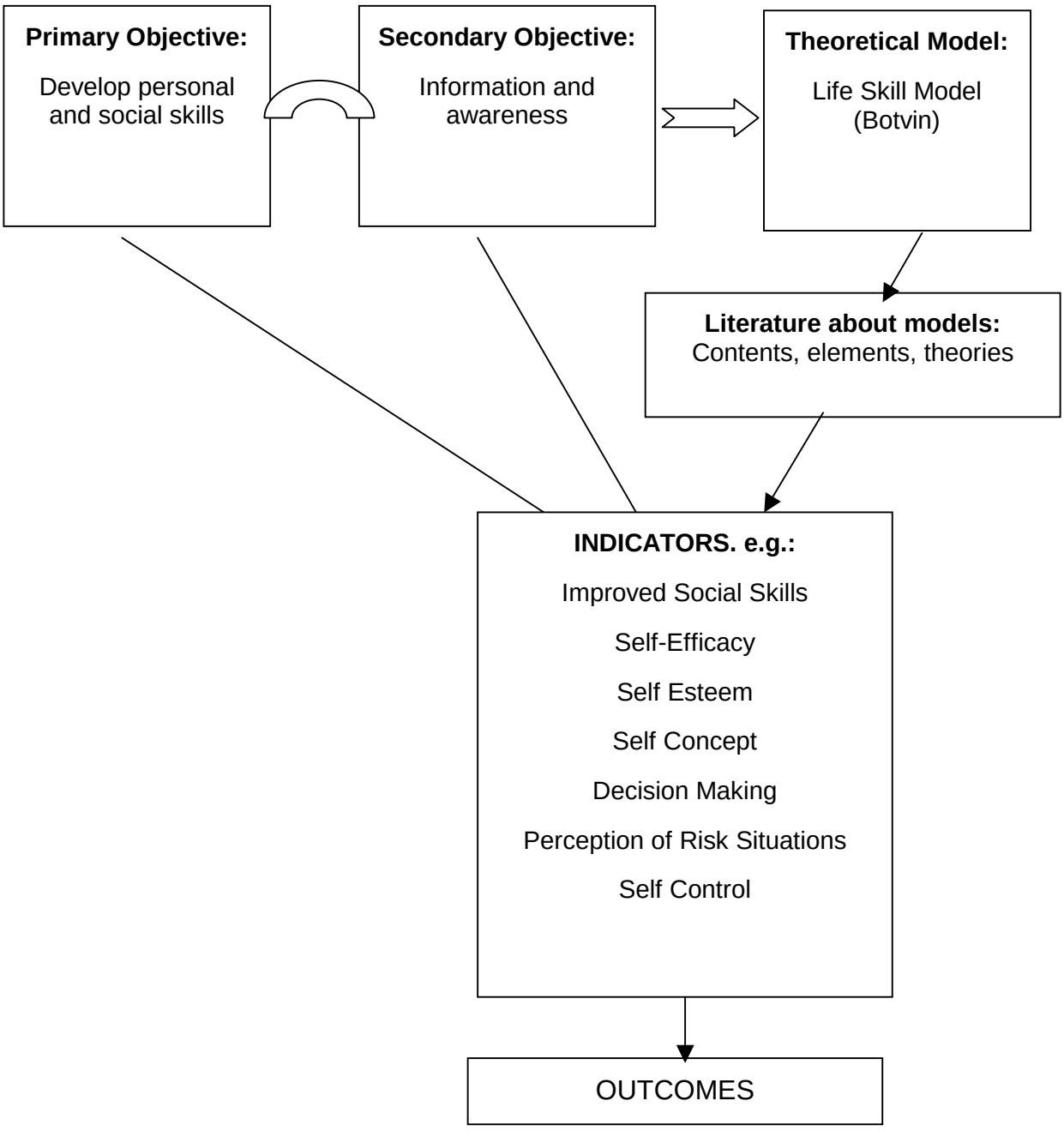
coherence rule assures at least that they are comparable to successful programmes that have already proved their effectiveness.

Adapted or original materials can be well applied in other contexts. There is no evidence that programmes (and the materials used) improve if they are reinvented and developed anew for every cultural context.

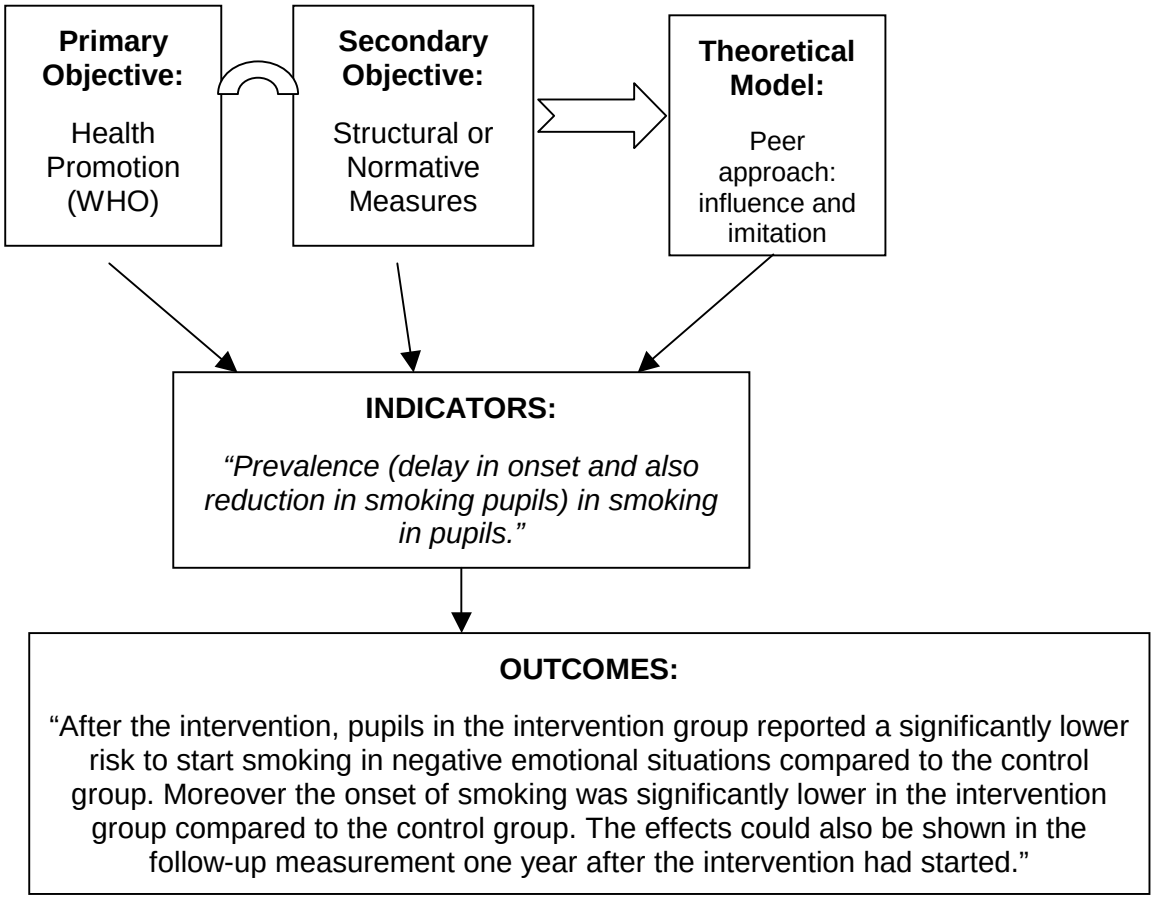
Standardised questionnaires are useful to draw a picture of contents and delivery of school-based prevention programmes, and can also provide useful qualitative information. They raise the awareness of professionals about the need to structure and describe programmes according to key variables and quality criteria.

ANNEX 1: COHERENCE OF PROGRAMME STRUCTURE

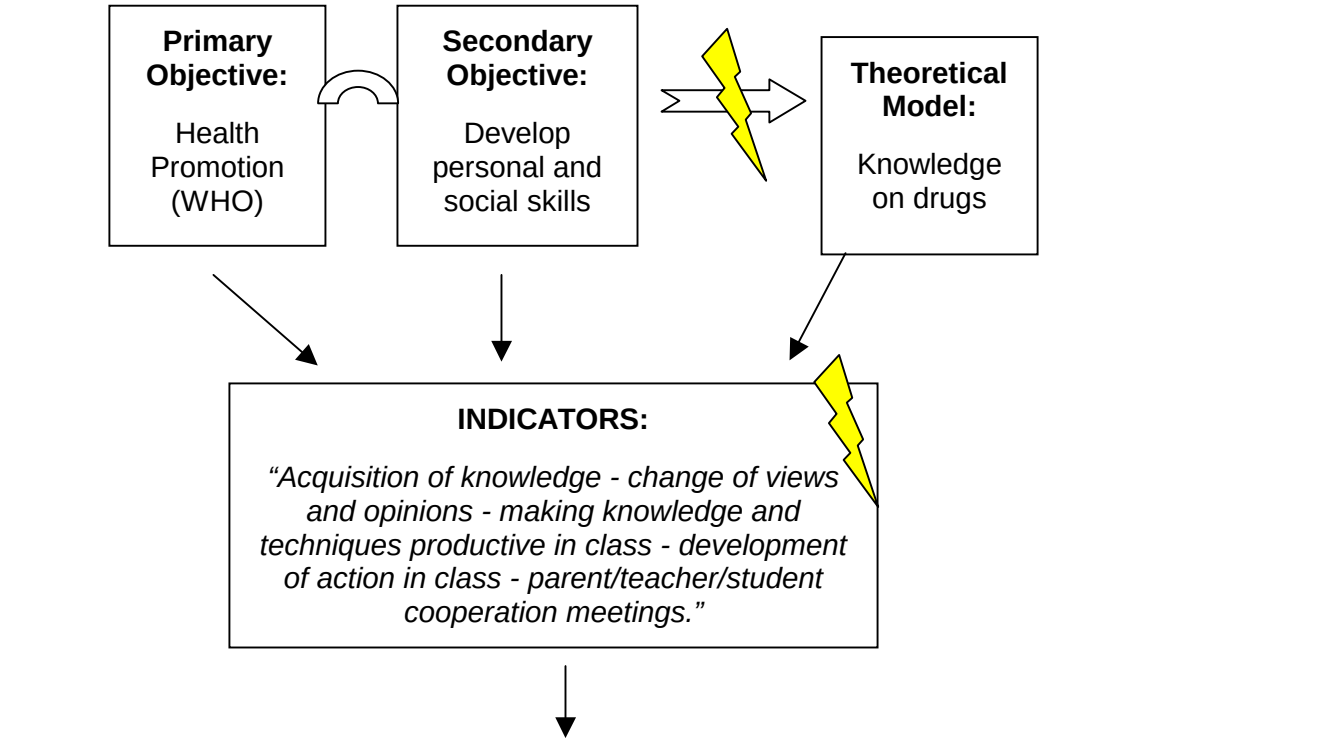
Ideal Example



Example from this analysis



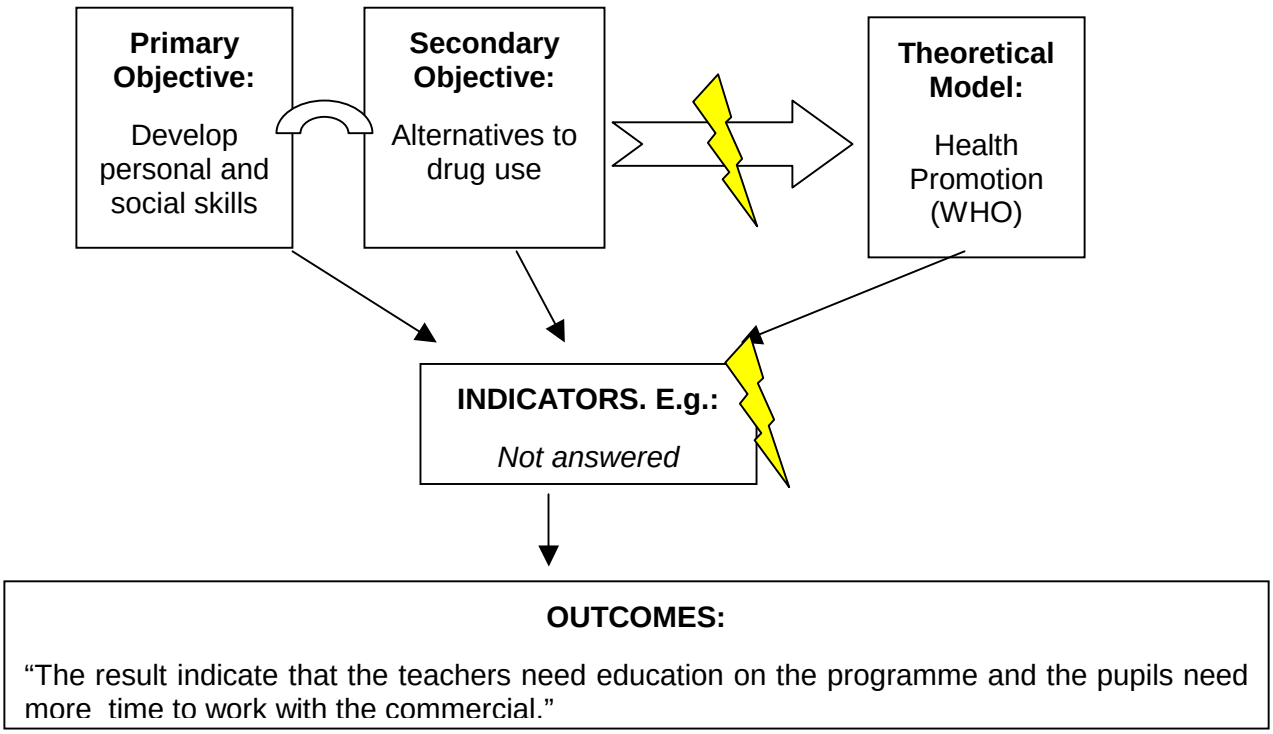
Example 1 of discrepancy from the analysis



OUTCOMES:

"Of a total of 42 questionnaires, the majority replied that they were satisfied with the subject's development and health education programmes and said that their views had changed.10 teachers have implemented health education interventions in 6 high schools, 6 have undertaken health education programmes in 4 high schools. Also, a mixed parent/teacher group was formed, holding 4 meetings."

Example 2 of discrepancy from the analysis



ANNEX 2: PROGRAMME ELEMENTS

Table 2

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
1	Develop personal and social skills	+	Health Promotion	=>	Life Skill Model (Botvin)	A couple of Thesis	4	Teachers: The atmosphere at school has recovered. Students: We learn to know better each other at Nuisku.
2	Develop personal and social skills	+	Alternatives to Drug Use	=>	Health Promotion (WHO)		4	The results indicate that the teachers need education on the programme and the pupils need more time to work with the commercial.
3	Health Promotion	+	Develop personal and social skills	=>	Knowledge on drugs (cognitive)	Acquisition of knowledge - change of views and opinions - making knowledge and techniques productive in class - development of action in class - parent/teacher/student cooperation meetings.	4	Of a total of 42 questionnaires, the majority replied that they were satisfied with the subject's development and health education programmes and said that their views had changed.10 teachers have implemented health education interventions in 6 high schools, 6 have undertaken health education programmes in 4 high schools. Also, a mixed parent/teacher group was formed, holding 4 meetings (Triandria)
4	Develop personal and social skills	+	Health Promotion	=>	Life Skill Model (Botvin)	Acquisition of knowledge in matters relating to prevention and health promotion - development of health education classroom programmes - meetings of a mixed parent-teacher group.	4	Of the total of 14 questionnaires completed by the teachers participating in the programme, all gave a positive reply to the question What knowledge did you acquire?". Knowledge acquired: pedagogical psychological information and prevention. Skills mentioned: techniques for the treatment of behavioural problems new behaviours"
5	Health Promotion	+	Develop personal and social skills	=>	Life Skill Model (Botvin)	Requests for cooperation with the prevention centre - requests for cooperation in developing health education programmes - reduction of negative communication in class - degree of improvement of positive communication knowledge of the factors that protect against use.	4	A large number of participants requested the continuation of the action or further cooperation with the prevention centre. in addition many people acknowledged the role of school and family in prevention and preventive factors (e.g. communication).
6	Health Promotion	+	Develop personal and social skills	=>	Life Skill Model (Botvin)	Degree of involvement in health training programmes - requests for cooperation with the promotion centre - knowledge of the organisation of health education programmes in schools - knowledge of drug use prevention factors.	4	A large number of participants requested the continuation of the action or further cooperation with the prevention centre. in addition many people acknowledged the role of school and family in prevention and preventive factors (e.g. communication)

[2] **Note:** Blank cells means that not data has been given by the programme.

[3] **Level of evaluation: 1 =** No evaluation foreseen or ongoing, **2 =** Process only, **3 =** Outcome without control, **4 =** Outcome without any kind of control.

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
7	Information/ Awareness	+	Involve Community	=>	Knowledge on drugs (cognitive)	Due to the nature and long duration of the project no outcome study planned. Some student process evaluation published. A large survey among professionals undertaken. Indicators: continuing popularity to locally organised training, continuing demand for the material; large media support.	3	Over 150 awareness training sessions for over 15 000 professionals. Several books and video programs produced. Information for general public in mass media. Children are the most primary ones needing help in alcohol/drug families. It's not commonly known, how harms caused by use of substances may effect children's emotional life, choices in life and ones own later use of alcohol and drugs.
8	Health Promotion	+	Structural or Normative Measures	=>	Peer approach: influence and imitation	Lower prevalence (delay in onset and also reduction in smoking pupils) in smoking in pupils	4	After the intervention, pupils in the intervention group reported a significantly lower risk to start smoking in negative emotional situations compared to the control group. Moreover the onset of smoking was significantly lower in the intervention group compared to the control group. The effects could also be shown in the follow-up measurement one year after the intervention had started.
9	Develop personal and social skills	+	Develop personal and social skills	=>	Life skill model (Botvin)	a. Immediate participation of target group in the project; b. Number of teachers stating they received support in their role; c. Active learning methods utilization frequency; d. Student attitude towards active learning methods and the project in general; e. Teachers' attitude towards the project.	2	Teachers assess that: a. their understanding for students has been enhanced; b. children respond positively to group work; c. further processing is required for the adaptation of material to Greek standards; d. lack of logistical infrastructure and the short implementation time (1 hour per week) made it difficult for them.
10	Information/ Awareness	+	Information/Awareness	=>	Health Promotion (WHO)	Quantitative: Number of indiv. approached-responded-attended-completed the training. Qualitative: Coordinator feeling from the process - participant degree of satisfaction - Participation experience- Supplementary material attractiveness. Impact index: via questionnaires.	3	We consider that there was a direct result, from the educators' side, in relation to the primary objectives set out. Attendance was regular & precise, and participation in the process was active. The seminar responded sufficiently to their initial expectations. They requested more interventions & time for them, as well as extension of cooperation with the Centre for Prevention.
11	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	1. Individual programme attendance (consistency; constant attendance in group meetings & supervising) 2. Info. number/type. 3. Providing personal experiences to groups. 4. Number of educators approached by students. 5. Program continuation per year.	2	Individual (educator, parent; student) attendance on the program gradually increasing; along with consistency of program attendance; with a strong need of educators for supplementary meetings at the Centre. Each time information adaptation and increase is attempted depending on the feedback provided by the teams to the Centre through the evaluation sheets.
12	Develop personal and social skills	+	Health Promotion	=>	Life Skill Model (Botvin)	Prevention, Health Promotion, self-esteem, social skills, decisions	2	The evaluation result has been very positive. 100 % of teachers requested the continuation of the action.
13	Health Promotion	+	Develop personal and social skills	=>	Ecological-environmental	Evaluation of the self-concept by a Quasi-experimental design	3	Good acceptation of the programme by the participants. Any significant variation at self-concept results.
14	Develop personal and social skills	+	Alternatives to Drug Use	=>	Social Influence (Bandura)		2	Teachers consider Ordago as a effective programme in training pupils at decision taking process in drugs offer situations.
15	Health Promotion	+	Develop personal and social skills	=>	Life Skill Model (Botvin)		2	Perceived efficiency by the teachers in health promotion habits.

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
16	Develop personal and social skills	+	Information/Awareness	=>	Problem/Risk behaviour (Jessor)	Use of tobacco, alcohol and other substances; the implication in antisocial performances, the knowledge on drugs, attitude towards drugs.	4	Lower percentage of teenagers who start tobacco and alcohol uses. Positive effects of the programme founded at people who consumed tobacco and alcohol before the initial evaluation. Effects of the intervention founded too at antisocial and problematic behaviours.
17	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	Number of teachers and parents attended. Parents' degree of satisfaction with the diptych. Training courses. Work group organisation.	2	Project achievements: teachers have realized that we are making prevention, we have penetrated in our knowledge, parents assistance to the training course, continuity of the parents school, the enthusiasm of the speakers, the introduction of the chess. The negative part: Ignorance in the most of the families, institutional bureaucracy.
18	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	Evaluation of the project design (objectives, target group, activities). Evaluation of the outcomes.	4	In process.
19	Health Promotion	+	Develop personal and social skills	=>	Social Influence (Bandura)	Knowledge, attitudes, intentions of behaviour and behaviour	4	Results are provisional due to the evaluation is made each 4 years.
20	Develop personal and social skills	+	Health Promotion	=>	Health Promotion (WHO)	In process	4	
21	Information/ Awareness	+	Health Promotion	=>	Health Promotion (WHO)	Number of classes, which promise stop smoking, number of classes, which really complete that promise. Incidents at classroom. Number of classes participating on the contest of preventive messages. Teachers' evaluation.	4	79 teachers, 93 classrooms and 2192 pupils started the compromise; 84 classrooms and 1970 pupils completed; 96% of tutors answered the evaluation questionnaire. 100% presented the record of effects. The guide usefulness was evaluated with a punctuation media of 3.85 among 5, the support material with 4.13 among 5. From the 8 tutorial activities, the most implemented were the visual and the technological ones.
22	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)		4	
23	Develop personal and social skills	+	Health Promotion	=>	Peer approach: influence and imitation	Number of pupils attended. Number of parents attended to the sessions. Parents' degree of satisfaction with the material.	2	Parents evaluation: the films were considered very adapted/adapted in the 100%. A 66% use the didactic material. The 100% speak with their sons about the proposed topic. A 95% would share the session with young people. For a 29% the schedule is very adapted.
24	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	Participants' degree of satisfaction.	4	Evaluation made by EDEX KOLEKTIBOA, the creators of the programme, among the Autonomous Community of Pais Vasco.

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
25	Develop personal and social skills	+	Information/Awareness	=>	Peer approach: influence and imitation	Number of schools, pupils and teachers attended. Perception of risk situations. Communication between pupils and between pupils and teachers. Alternatives to drug use.	3	Nº of schools reached: 31, Nº of pupils: 5858, Nº of teachers: 516, Nº of teacher training sessions: 188, Nº sessions with pupils: 307. A 67% of young people perceive alcohol use risks.
26	Develop personal and social skills	+	Structural or Normative Measures	=>	Ecological-environmental	Behaviour, intention, beliefs, perception of social procedure, Self-Efficacy.	4	In process
27	Health Promotion	+	Develop personal and social skills	=>	Social Development (Catalano-Hawkins)	Locus of control + structured evaluation questionnaires	4	At the end of the first year, the pupils show a better internalisation of the locus of control than the non-participant pupils. Teachers requested the continuation of the programme.
28	Health Promotion	+	Information/Awareness	=>	Health Promotion (WHO)	Implication of the group resource in the duration, integration and redundancy (school programs, environment), relational improvement intra and extra school, evolution of the representations and the acquisitions; tobacco consume, absenteeism, aggressive and drunkenness behaviour.	2	Positive effects of the formation: cohesion between adults, co-operation with the environment, interest supported in the follow-up concerted health and social pupils.
29	Information/ Awareness	+	Health Promotion	=>	Health Promotion (WHO)		1	In process
30	Develop personal and social skills	+	Information/Awareness	=>	Problem/Risk behaviour (Jessor)	Capacity of elaboration and distancing	2	Development of the capacity of elaboration and the capacity for distancing, decrease of the tensions inter and intra-personal; decrease of the aggressiveness; search diagnosis of children or teenagers in danger
31	Develop personal and social skills	+	Information/Awareness	=>	Life Skill Model (Botvin)	Oral expression of pupils, individual behaviour modifications, class group attitude, relations with the others (adults or peers), analyses situations and intervention capacity, reactions in front of events, which can exceed you.	1	In process
32	Develop personal and social skills	+	Involve Community	=>	Peer approach: influence and imitation	Impact on the life quality and the climate; improvement of the communication among the different members of the educational community; adults among them; pupils and adults; and pupils among them.	4	The impact of the existence of the device of the pupils actors of prevention appears on two levels: a personal impact for the young person; a collective impact at educational Community level. (cf Evaluation report of this action by Robert Ballion on www.eduscol.education.fr)
33	Information/ Awareness	+	Develop personal and social skills	=>	Reasoned action-attitude (Fishbein-Aijzen)	Number of participants in the parents meetings, follow-up project, evaluation sheets for every workshop.	2	
34	Structural or Normative Measures	+	Develop personal and social skills	=>	Life Skill Model (Botvin)	Participating Länder, number school classes, quality of training, continuity, learning climate, integration of outsiders, communication behaviour, well being, attitude towards drugs and addictive behaviours	4	

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
35	Structural or Normative Measures	+	Develop personal and social skills	=>	Problem/Risk behaviour (Jessor)	Guidelines implemented in school? Yes/No Practical competence of teachers dealing with pupils at risk improved? Targeted interventions carried out?	2	Only sporadic implementation experiences until now functioning co-operation with teachers was pre-condition to implement binding procedures. In these cases there was high satisfaction and relief among teachers. Targeted interventions clarified the situation quickly. When implemented without training: interesting and correct approach but hardly implementable.
36	Develop personal and social skills	+	Structural or Normative Measures	=>	Life Skill Model (Botvin)	Yearly control of measures by structured questionnaires: target group (project training counselling information sessions, etc) Number of people reached.	4	The professionals carried out 2.600 pedagogical measures in 2000. 50% in or with schools. ± 2/3 of interventions aim at multiplicators, which were trained, counselled and supported. In total 37.000 people reached in 2.000.
37	Information/ Awareness	+	Health Promotion	=>	Peer approach: influence and imitation	A) Number of pupils attended. B) Risk perception questionnaire. C) Surveys on the image of the substances in the young people mentality.	4	
38	Information/ Awareness	+	Alternatives to drug use	=>	Health Promotion (WHO)	Process evaluation: Number of pupils attended; collaboration degree with teachers. Result evaluation (where possible): Measure of the increment of knowledge	3	Not available yet.
39	Information/ Awareness	+	Alternatives to drug use	=>	Peer approach: influence and imitation	Process evaluation: Number of pupils attended; collaboration degree with teachers. Result evaluation (where possible):	3	Not available yet.
40	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)		2	Not available yet.
41	Health Promotion	+	Develop personal and social skills	=>	Peer approach: influence and imitation		2	
42	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	Evaluation questionnaire.	2	
43	Health Promotion	+	Information/Awareness	=>	Knowledge on drugs (cognitive)		4	
44	Health Promotion	+	Alternatives to Drug Use	=>	Health Promotion (WHO)		2	
45	Health Promotion	+	Information/Awareness	=>	Health Promotion (WHO)		2	
46	Health Promotion	+	Alternatives to Drug Use	=>	Peer approach: influence and imitation		2	

Nº programme	Primary objective	+	*Secondary objective*	=>	Main intervention model	Indicators[2]	Evaluation[3]	Results
47	Information/ Awareness	+	Alternatives to Drug Use	=>	Ecological-environmental		4	
48	Health Promotion	+	Health Promotion	=>	Health Promotion (WHO)	Number of participants. Evaluation questionnaire.	2	
49	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)	Evaluation questionnaire.	3	
50	Health Promotion	+	Develop personal and social skills	=>	Health Promotion (WHO)		2	

Main problems identified:

- Many indicators chosen by the programmes are not real indicators. E.g.: Programme nº 30
- Often programmes tend to confuse process and outcome variables. E.g.: Programme nº 37
- If you are using process variables you cannot say that you are making outcome evaluation. E.g.: Programme nº 1
- Many programmes affirm to make outcome evaluation but they do not even give results of its intervention. E.g.: Programme nº 47
- Many programmes seem to choose the most easily to measure evaluation indicators, independently of their objectives or model.

Evidence of training needs for prevention professionals.

ANNEX 3: SCHOOL PROGRAMMES QUESTIONNAIRE

Official **Name** and **localisation** of the programme ***OVERWRITE THIS TEXT, MAX. 75 CHARACTERS + NAME OF TOWN/MUNICIPALITY*** **Descriptive Name**: ***PLEASE OVERWRITE THIS TEXT WITH A DESCRIPTIVE PROGRAMME DEFINITION, 150 CHARACTERS MAX.***
Organisation: ***Please overwrite with the name of your organisation, 100 characters max.*** Contact person (Phone, e-mail): Please overwrite this text, 250 characters maximum, remember to put the INTERNATIONAL phone number

Below, please select (s) from a yellow drop-down list, fill in (f), or select one or more tick-boxes (t)

1. Setting: Kindergarten [t] ☐
   Primary School [t] ☐
   Secondary School [t] ☐ (including professional school) Families involved? [t] ☐
2. Agents implementing the programme:

   Teachers /educators [t] ☐ Professionals [t] ☐ Others [f]:

3. Description [f]: ***Please overwrite this text with a short description of your programme: the initial situation, how it is carried out, special characteristics and other brief information necessary to understand its principle, max. 500 characters***

4.a. Primary objective [s]: Information/Awareness

4.b. *Secondary objective* [s]: Information/Awareness

5. Main intervention model [s]: Health Promotion (WHO)

6. **Duration** [f]: years, [f] months + **Intensity**: n° of sessions [f]: per [s] Month

7. Material [s]: Original , its concreteness level [s]: Structured (by session, target, topic)

8. Evaluation [s]: Outcome with any kind of control

9. Indicators [f]: ***IF POSSIBLE, please overwrite this text with a set of indicators you might have used to assess the achievement of the objectives stated in point 4. A list of variables is sufficient, if any. 300 Characters maximum***

10. Results [f]: ***Please overwrite this text with any results of the evaluation, follow-ups or with other conclusions on the programme, if available. Maximum length 400 characters***

11. Coverage, if available: either Number of schools covered [f]:

    and/or: Number of pupils reached [f]:

    and/or: Number of teachers trained [f]: N° of hours per teacher:

    and/or: Number of families reached [f]:

12. Place for your suggestions, criticism, comments on the questionnaire or on the programme, 300 characters

[i] Pérez Oñate, I. (1995) **Osasunkume, La aventura de la vida – Evaluación**. Bilbao: EDEX Kolektiboa

[ii] Paglia, A., Room, R. (1999) Preventing Substance Use problems among youth: a literature review and recommendations. **The Journal of Primary Prevention**, Vol. 20, No. 1, pp. 3-50.

[iii] Resnicow & Botvin (1993). School-based substance use prevention programs: Why do effects decay? **Preventive Medicine**, 22, 484-490

[iv] Hansen, W.B. (1992), School-based substance abuse prevention: A review of the state of the art in curriculum, 1980-1990. **Health Education Research** 7(3): 403-30.

[v] Sindballe, A-M. (2000). **Unge og rusmidler – evidensbaseret forebyggelse i skolen**. MPH-Thesis. Institute of Public Health. Copenhagen University.