Good Practice in School Based Alcohol Education Programmes

Betsy Thom

Corresponding author at

Drug and Alcohol Research Centre
Middlesex University
The Burroughs
Hendon
London NW4 4BT

b.thom@mdx.ac.uk

00(44) 1292283081

forthcoming in *Patient Education and Counselling*

Abstract

Objective: To identify elements of good practice in designing and delivering alcohol education programmes in schools.
Methods: Literature reviews and published programme evaluations were used to identify key elements of good practice.
Results: Principles of good practive are identified and discussed. Five main issues are highlighted: choosing a universal or targetted approach, the need for theoretical frameworks, adopting a stand-alone or multi-component approach; issues of delivery and programme fidelity, and balancing programme fidelity and cultural relevance.
Conclusions: Programme objectives, programme fidelity and cultural context are important factors in designing programmes and will influence outcomes and evaluation of success.
Practice: Programme development and implementation can draw on results from evaluated programmes to design alcohol education programmes suited to specific contexts, the availability of resources and the perceived needs of the target groupand the problem to be addressed.
Implications: In developing alcohol education programmes, there is a need to draw on the evidence and experience accrued from previous efforts.

Highlights

Key elements of good practice in developing and implementing alcohol education programmes are discussed. Evidence and insights from evaluated programmes on what 'works' are presented and illustrative examples provided. Five main aspects of good practice are highlighted: choosing a universal or targetted approach, the need for theoretical frameworks, adopting a stand-alone or multi-component approach; issues of delivery and programme fidelity, and balancing programme fidelity and cultural relevance.

1. Introduction

Alcohol education is a contested arena. The conclusion emerging from past reviews and emphasised by many health advocates, is that alcohol education is ineffective as a means of preventing or changing young people's alcohol consumption (WHO, 2009; Babor et al., 2010). However, later reviews and assessments of alcohol education in schools have challenged the claim that these programmes are ineffective (e.g. Foxcroft and Tservadze, 2011; Teesson et al., 2012; Midford et al., 2012).

This paper aims to:

- consider divergent opinions regarding the role of education and, in particular, how 'success' is defined in assessing alcohol education programmes,
- raise questions regarding what constitutes 'good practice' in alcohol education, and
- identify core principles of 'good practice' to inform the development and implementation of school-based alcohol education.

The intention is to provide a basis for further examination of ways to develop and deliver effective alcohol education. Key questions such as 'what can be expected of alcohol education', 'what is *effective* alcohol education', 'how is it measured', and 'what do we mean by good practice', are considered before presenting insights from the published literature on these issues. The paper concludes with suggestions for principles of 'good practice' in developing and implementing alcohol education programmes in schools.

The paper is based on a literature search to identify main systematic and thematic reviews of alcohol education programmes published in English since 2000. These reviews were used to identify programmes deemed to have been successful. In addition, the paper draws on examination of a large number of studies reviewed for the development of the IARF Alcohol Education Guide (http://www.alcoholedguide.org/intro). As part of the IARF project, the review team drew up selection criteria for inclusion on the website of programmes which provided examples of 'good practice' – or which illustrated some aspects of good practice. To be included programmes had to have: a longitudinal or repeated cross-sectional design that included experimental, quasi-experimental or structured single-group designs with pre- and post- test assessments; outcome evaluation to test changes in knowledge/ attitudes/ beliefs/ intentions/ behaviours; measurable impact showing change in the desired direction (distinguishing statistically significant from non-statistically significant change); good documentation.

2. What is expected of school based alcohol education?

'Education' about alcohol can occur in many ways – through observation of parents and peers from an early age, through exposure to media representation, through public awareness campaigns, and in schools – learning about alcohol is

no different than learning about anything else (Velleman, 2009a). This paper concentrates on learning acquired through formal educational activities and programmes delivered to young people in schools. As one of the four main pillars if socialisation (along with the family, the media and the wider community) there is a clear rationale for delivering alcohol education in schools both to prevent the onset of harmful drinking patterns and to identify and respond to harmful drinking when it occurs. Among other reasons, research findings suggest that drinking at an early age is likely to be linked to a range of other difficulties and have a detrimental effect on school performance (Velleman, 2009).

However, expectations about alcohol education in schools are often based on the assumption that it is the role of alcohol education to influence (and change) behaviour in a particular, desired direction. This assumption lies at the heart of disagreements, mentioned earlier, about the effectiveness of alcohol education and emphasises the socialisation function of education. But education is not solely concerned with socialisation. In discussing the role of education, Biesta (2009) reminds us of its different functions – qualification, socialisation, individuation (or subjectification, ie the ways in which education contributes to human freedom) and notes that the weight accorded to the three functions is important. He argues that, although the three functions overlap, increasingly socialisation has become the dominant function with the emphasis on 'the kind of person that should be 'produced' through education' (p9). This relegates to second place questions about what pupils should know and should be able to do (qualification). Further, the socialisation emphasis stresses 'moulding' of individuals according to templates (formulas) at the expense of providing opportunity to question, challenge or pose alternatives and enhance individuation. This broader framework of educational theory and philosophy is important in considering more specific forms of education. In the case of alcohol education, it could be argued that the socialisation function is uppermost and that this influences programme aims and outcomes and how outcomes are measured.

2.1 Measuring 'success' in school based alcohol education programmes

Alcohol education for school aged young people has largely been concerned with targeting behaviour, aiming either to prevent alcohol use altogether, or to delay the onset of use, or to preventing harmful use (defined in a variety of ways). Outcomes of intervention vary between programmes but behaviour change is generally measured as: no use, delayed onset of use, or significant reductions in use (frequency of drinking, binge drinking, amount consumed). Impact (effectiveness) is measured soon after the intervention ends and at variable periods thereafter. (Foxcroft and Tservadze, 2011).

Programme outcomes other than behavioural – such as knowledge and skills acquisition – are seen as secondary and achievement of such goals as less successful outcomes of educational effort than the achievement of the intended drinking (or non-drinking) behaviour (e.g. see Jones et al. 2007). Foxcroft *et al* (2008:10) illustrate this point, 'Ineffective interventions were regarded as those that had no statistically significant influence on subsequent self-reported

drinking behaviour'. Similarly, in a systematic review of the effectiveness of school based education, Cairns *et al.* (2011:executive summary) supported the findings from other research and reviews that 'neither knowledge and attitude change, nor acceptability of an intervention is predictive of positive behaviour change' – again emphasising behaviour change in the desired direction as the effectiveness outcome.

Recent research has suggested the need for analyses that can disentangle the complexities of alcohol education approaches and distinguish between the range of outcomes which might be expected from alcohol education activities. As Midford *et al*. (2012:103) comment,

> …school drug education has generally not been that successful at reducing alcohol or other drug use ……. (which)… raises the question as to whether the effectiveness of school drug education should be measured by abstinence or reduced use, or whether harm reduction is a more realistic and useful measure of success.

At the same time, even where a goal of harm reduction is accepted, only successful socialisation is seen as an effective result, ignoring any gains made in the spheres of qualification and individuation. Clearly, the socialisation function - influencing, changing or modifying behaviour - lies at the heart of alcohol education programmes. However, the approaches and methods needed to achieve the desired behavioural outcome often depend on paying attention to the qualification and individuation functions of education, for instance, by ensuring that children have adequate and appropriate knowledge and skills to resist or make informed choices about drinking.

3. What is 'good practice'?

Before continuing, we need to consider what is meant by the term 'good practice'. If we equate 'good practice' with 'best practice', the definition developed by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is applicable to intervention in alcohol consumption as well as in drug use. The definition states that,

Best practice is the best application of available evidence to current activities in the drugs field.

- underlying evidence should be relevant to the problems and issues affecting those involved(professionals, policymakers, drug users, their families);
- methods should be transparent, reliable and transferable and all appropriate evidence should be considered in the classification process;
- experience in implementation, adaptation and training should be systematically collected and made available;
- contextual factors should be studied by modelling different prevalence levels so as to assess the impact of an intervention on the population; and
- evidence of effectiveness and feasibility of implementation should both be considered for the broader decision-making process.'
  http://www.emcdda.europa.eu/best-practice/about

Translated to alcohol education, 'best practice' would entail a number of development and implementation steps: conducting formative research to assess the problem, the environmental and situational context and the resources available and needed to respond to the problem; developing initiatives which use the available evidence and assess its relevance to the problem and the target group(s); taking account of the realities (experience) of implementing educational interventions; considering the effects of an intervention on different social groups (e.g. age, gender, ethnicity, socio-economic differences) and the cultural relevance of the programme; considering the effectiveness of the intervention. There is a large body of literature on school based alcohol education programmes. Evaluation studies come mainly from the USA with some research stemming from the UK, Australia and Europe and very little from elsewhere. However, it is possible to glean useful insights on what constitutes 'good practice' from the studies and to propose some guidelines which may be generalisable to different social and cultural settings.

4. 'Good practice' in alcohol education: insights from the literature

Drawing on the published literature, this section considers some of the key elements of good practice and provides illustrative examples. Five main aspects of good practice are discussed.

4.1 A universal or targetted programme?

Delivery of prevention programmes (those aiming to prevent or delay onset of use, and in some cases to minimise harmful use) have been characterised as universal (delivered to all young people in the target group), selective (aimed at population groups considered to be vulnerable or at risk, such as people living in deprived communities) or indicated (for individuals showing signs of engaging in high risk behaviours such as truancy or getting into trouble with the law or because they are the children of dependent parents). Decisions about whether to develop a universal or targetted programme depend on a large number of factors, for example, available resources, perceptions of the problem, the situational context. The extent to which a programme may stigmatise an individual or group is one important consideration – often given as a good reason for universal screening and intervention – and may be a reason why some schools, communities or individuals are reluctant to engage in programmes aiming to screen for and intervene in young people's alcohol use or problem use. The integration of alcohol issues into wider health or lifestyle programmes is one possible solution which has received attention. Although sometimes alcohol, drugs and smoking are addressed in the same programme, alcohol education is less often embedded in general health programmes. In this paper the focus is on programmes where alcohol is the sole issue or an important element of programmes covering more than one substance.

4.2 Theoretically informed

There is considerable value in drawing on theoretical insights to develop, implement and evaluate programmes. Theories can provide clues about which groups or which individuals are more likely to engage in harmful drinking and about the factors which influence drinking behaviour (models of behaviour) as well as provide suggestions for how to go about preventing onset of drinking or influence and change drinking behaviour (theories of change). Darnton (2008) draws attention to the distinction between behavioural models and theories of change. Whereas models of behaviour help to identify the underlying factors which may influence behaviour – such as peer influence, parental behaviours, environmental conditions – theories of change suggest how behaviour may change and be changed. Both types of theories are important for educational programmes but, as Darnton (2008:1) comments,

> .. an understanding of behaviour alone provides insufficient clues on which to base effective processes for changing behaviour. Theories of change suggest intervention techniques which can be effective in bringing about change, as well as broad approaches to intervention design, implementation and evaluation which can underpin effective policy planning and delivery.

Alcohol education programmes are likely, therefore, to need different theories at different stages of development, implementation and evaluation. Although not all programmes are theory based, a variety of models of behaviour and theories of behaviour change underpin many educational programmes. Some of these are regarded more favourably than others. For instance, while information giving is part of most programmes, this tends to be linked to a 'deficits' model – which suggests something lacking in the target group or individual – and has been largely discredited as effective on its own. Psychosocial theories are considered to inform the most effective approaches (Botvin and Griffin 2007). These theories underpin contemporary prevention programmes which focus on teaching social resistance skills, normative education and competence enhancement. According to Botvin and Griffin (2007), meta-analytic studies have found that some of the most effective interventions are those which combine social resistance skills and competence enhancement approaches.

The 'social norms' approach is one example of a psychosocial theory informing intervention which has gained popularity in recent decades. This approach aims to counter perceived misconceptions regarding alcohol consumption by peers. The intervention seeks to bring behavioural and/or attitudinal perceptions into alignment with the 'actual' use and attitudes of peer groups. McAlaney et al. (2011) comment that the evidence from social norms studies – mainly with college students in the USA - is that the approach can be equally effective in European and Australian contexts. In one Australian study, 'The Social Norms Analysis Project' (SNAP) carried out in schools in rural areas, self-report data were used to identify misconceptions and develop school specific messages. (cited in McAlaney et al. 2011). The messages focussed on stating the positive behaviour of the majority and avoided any negative content or scare tactics. In

one project, students in the intervention group reported a significant reduction in drunkenness compared to the control group and a reduction in misperception of perceived frequency of drinking and drunkenness. McAlaney et al. (2011: 84) comment that, overall the projects did not bring about large behaviour changes within the time frame of the study but that the social norms projects,

> .. demonstrate that behaviour change must first be pre-dated by perception change, as witnessed in both the UK and Australian projects, and that mass behaviour change will only occur after several years of sustained social norms campaigning.

In sum, educational programmes are commonly underpinned by more than one theoretical perspective used to inform the programme design and the development of the materials and activities; and there is general agreement that it is important to use theory as well as available evidence to inform the development of all stages of initiation, implementation and evaluation of school-based programmes. A more detailed discussion of the range of theoretical frameworks which may inform alcohol education programmes is beyond the scope of this paper but may be found elsewhere (Darnton, 2008).

4.3 Stand-alone or multi-component programmes

The inclusion of a school-based education component in multi-component programme approaches has been noted as key to reaching young people and often school-based delivery is at the heart of the multi-component effort with supporting peer, parent and community components (e.g. Project Northland, Perry 1996). Peer education is based on theories of social influence, social learning and inoculation and on the premise that peer influence may be stronger than teacher or parent influences at least at some points in a child's life. Community involvement is informed by theories of availability and access to alcohol, flagging up the importance of the wider environment and the possible advantage of programme components that include, for example, trade and police collaboration to reduce the sale of alcohol to under-age youngsters or youth services collaboration to provide appropriate, alternative alcohol-free leisure activities.

The drive to engage parents in alcohol education efforts has resulted in both the inclusion of parent components as a main part of a school-based education programme and the development of parenting programmes which include issues around alcohol consumption but also have a wider purpose to address a range of associated problems – for instance, drug use, violence, poor communication skills (Petrie et al., 2007). There is some lack of agreement regarding the value of components added to classroom-based delivery. McBride et al. (2004) suggest that the evidence supports the use of classroom-based programmes over comprehensive programmes because of the practical aspects of implementation - classroom programmes are cost and time-effective and require less external expertise – and because the available research does not permit assessment of the value of individual components within a multi-component programme. Other research supports the inclusion of additional components and 'parenting'

components, in particular, have received considerable attention. Programmes such as Strengthening Families Programme which are the core of the intervention rather than an added component (but include school collaboration) have been assessed as promising (Allen et al., 2007; Velleman, 2009b; Foxcroft and Tsertsvadze, 2011).

Parenting programmes are based on the premise that families (in particular parents) have an influence over children's substance use and that their influence continues, even if weakened by peer influence, into the teenage years (Cuijpers 2003). Although initially intended to be implemented universally, often these programmes are delivered selectively, the emphasis being on poor communities or problem families. They rarely focus solely on one substance; they frequently include alcohol, tobacco and illicit drugs and sometimes also general relationship factors such as communication and anti-social behaviour – so they offer a good example of an integrated substance use/health/social approach. The findings of one systematic review illustrate the nature and outcomes of these programmes.

Petrie et al. (2007) conducted a systematic review of parenting programmes which aimed to prevent or reduce substance use among young people, age under 18 years. The review selected 46 reports on 20 studies which were RCTs, controlled trials, and controlled before/after studies; 5 were on alcohol alone; 10 were on a combination of substances. Most studies took place in the USA. Parenting interventions varied greatly and included, parenting skills training, homework tasks which require parental involvement, booklets mailed to parents, home visits and home based facilitator sessions. Interventions were categorised as those which: a) identified and addressed pre-cursor behaviour in primary school children; b) focussed on transition between primary and secondary; c) focussed on adolescents. The outcomes were variable and reflected the impact of a wide range of factors on achieving the desired results. For instance, one primary school study found a significant reduction in alcohol use and misuse for children with no prior use; but a significant increase (4%) in use and misuse by children drinking prior to intervention. Three alcohol specific programmes targetted at transition students had different outcome findings: one showed a significant reduction in use (13% less initiation and 16% less use in previous month) at 3.5 year follow up; one did not show any significant effects; the third found a significant reduction in mean alcohol use in one school but not in another.

There are many reasons why differences may occur – the primary school study mentioned above, for instance, indicates the importance of pre-intervention drinking status. Foxcroft and Tsertsvadze (2011), in a review of 12 trials evaluating universal family-based alcohol misuse prevention programs in young people, noted the following: the outcomes varied with respect to their definition (e.g., lifetime alcohol use, heavy weekly drinking, mean number of drinks, proportion of alcohol users, weekly drinking, frequency of alcohol use, alcohol initiation, lifetime drunkenness, alcohol composite index), and the period to which they pertained (e.g., past month, past 7 days, past year, ever). Thus, individual characteristics, circumstances and lifestyles; parental background; environmental factors – the school context and culture, the local community; and

the definition of the problem and desired outcomes set in the programme may all contribute towards the outcome and all need consideration in initiating new alcohol education programmes.

Despite the variable results, Petrie et al. (2007) conclude that the evidence is sufficient to support parenting programmes as an effective approach in reducing substance misuse. Key features of successful programmes appear to be that they:

- Emphasise development of social skills and sense of personal responsibility
- Include active parental involvement
- Have a focus on maintaining (building) family relationships and communication
- Focus on issues other than substance use (as well as including substance use).

4.4 Delivery and implementation fidelity

Clearly, there is enormous variation in who delivers the programme, what is delivered, how much is delivered (dosage), and how the programme is delivered. It is not possible in a short article to cover fully all the issues which arise in delivery. Dosage is important although deciding the frequency and duration of exposure depends on the programme aims, methods and on practical factors such as cost and available resources. What is generally agreed is that 'booster' sessions or programmes delivered in phases are more likely to sustain positive outcomes. In the next two sections, who delivers the programme and how it is delivered (programme fidelity) are discussed briefly. Finally, an example of one large European study, 'Unplugged', is given to illustrate what might be delivered.

In classroom contexts, interventions delivered by adults other than teachers have been assessed as ineffective. In one application of programme DARE (discussed in 4.5), delivery of the programme by the police was reported as a reason for failure. A review by Jones *et al*. (2007) identified nine classroom-based programmes taught by external contributors, including adult health educators, uniformed police officers, research project staff, college age instructors, certified school psychologists and Life Education Centre staff. The majority of the programmes identified had inconsistent effects on alcohol use and only one culturally tailored programme for Native American students demonstrated evidence of medium- to long-term effects. The peer approach, although frequently part of programmes, has been subject to considerable criticism – for instance, that it lacks good evidence and relies on dogma. A review by Mellanby *et al*. (2000) highlights the many methodological and implementation issues which make the assessment of effectiveness difficult. Mellanby et al. cite one study (Perry et al., 1989), carried out in four countries, which found no difference between peer and adult led groups in knowledge or attitudes. On the contrary, research by Botvin *et al* (1984; 1990; cited in Mellanby *et al*. 2000), which evaluated an intervention aimed at substance use by school pupils in New York, found that peer led groups reported less drinking and showed a greater increase in knowledge about alcohol than adult led groups. Although the evidence is weak, the conclusion from Melanby et al.'s review is

that peer led intervention may result in more positive changes in health behaviour than adult led intervention.

In considering the success of interventions, implementation fidelity – delivery of the programme as intended by those who developed it - is important. As Carroll et al. (2007) contend:

> It is only by making an appropriate evaluation of the fidelity with which an intervention has been implemented that a viable assessment can be made of its contribution to outcomes, i.e., its effect on performance. Unless such an evaluation is made, it cannot be determined whether a lack of impact is due to poor implementation or inadequacies inherent in the programme itself.

In the 'Unplugged' programme (discussed below) the low level of implementation was suggested as one reason why the parental and class peer components did not seem to increase effectiveness (Faggiano et al., 2008). Other obstacles encountered in the trial period of the programme, and which could be adjusted, were the duration of the lessons and the content of some tasks (e.g. some role-plays) or materials (e.g. information on drugs). There is frequent mention in the literature of reasons why a programme may not be run as intended. Problems arising from the time needed to deliver an intervention and give it priority in an already full curriculum, from the need for teacher training to deliver the intervention, and from the need to ensure that the materials or activities are relevant to the target group are only some of the frequently reported barriers to implementation fidelity.

In a review of implementation studies in the field of prevention and promotion targeting children and adolescents, Durlak and DuPre (2008) identified 23 significant factors influencing implementation fidelity. The factors were grouped into five categories: community level, provider characteristics, innovation characteristics, factors relevant to the prevention delivery system: organizational capacity, and factors related to the prevention support system. The lessons for practice are that evaluation of implementation is an essential part of assessing the extent to which a programme has achieved its objectives. The issue of implementation fidelity has implications also for adjusting programmes to fit different local and cultural contexts. This is discussed in section 4.5.

'Unplugged' is an example of a universal programme, evaluated in seven European countries (Belgium, Germany, Spain, Greece, Italy Austria, and Sweden). It includes alcohol and other drugs and is mainly classroom delivered with a family component and a peer component. It aims to delay drug initiation and/or the transition from experimental to regular use for students age 12-14. The intervention was conducted between October 2004 and January 2005 in 78 schools; 65 schools acted as controls. The programme did not influence alcohol use but was evaluated as successful in reducing alcohol misuse - episodes of drunkenness - at 3 and 18 months post intervention. Parental and peer components did not increase effectiveness. The duration of the lessons and the

content of some tasks were noted as barriers to delivery and the evaluation emphasised the importance of programme fidelity (Faggiano et al., 2007; 2008; 2010; Carla et al. 2011). Programme design was informed by the comprehensive social influence approach. The main characteristics of the 'Unplugged' curriculum are:

- It is based on the social influence model, being interactive, integrating life-skills elements and normative beliefs.
- It consists of 12 units, each designed to be carried out within 1 or 2 school lessons. The 12 units address knowledge and attitudes, interpersonal skills development, and intrapersonal skills development.
- It contains information that covers a broad range of substances: tobacco, alcohol and illicit drugs, cannabis.
- It has a peer-led intervention, involving selected students as supporters and supervisors of the classroom activities. Peers (a) monitor classmates' application of the programme instructions in real life; and (b) provide feedback from the class to the teacher. This was implemented through a series of seven short meetings, organized by the students.
- It has a family component, which aimed to provide the students' parents with educational tools supporting the school prevention. Three interactive parents' workshops, lasting two to three hours each, were held in the evenings; they were conducted by staff / experts not employed by the school.
- It has training for teachers delivered through a 2-5 day module. The module provided specific training in interactive school work, in addition to instructions on using the programme materials.

The evaluation of 'Unplugged' addressed programme fidelity and intervention outcomes. A monitoring system was set up to assess fidelity of programme delivery, implementation of parents' workshops and peer-led intervention. The intervention was assessed using a randomised control trial study design. Data were gathered prior to the intervention, at 3 months and at 18 months following intervention.

4.5 Programme transfer and cultural relevance

Often programmes developed in one country are transposed to, or adapted for, use in other countries. There is still a lot of work to be done to understand the issues faced in programme translation to different cultural settings, especially in implementing 'western' programmes in 'developing' countries.

The balance between fidelity of delivery (discussed in 4.4)) and relevance, acceptability to the target group and appropriate to the social context are especially important when an intervention developed in one cultural or geographical setting is transferred to another group or another country (e.g. Allen et al., 2007). Project DARE, for example, has been implemented in several countries despite considerable scepticism about its effectiveness (Ennett et al. 1994; Lloyd et al., 2000). Speculating on why the programme may have failed in Brazil (where it is very popular), Shamblen *et al*. (2014) point to lack of cultural competence as a possible explanation. They suggest that:

- the intervention was almost identical to the curriculum implemented in the United States

- many Brazilian students (particularly those from lower socio-economic backgrounds and those attending public schools) had to work full-time to support their families so they attended school as time permitted
- the poverty gulf in Brazil between the rich and poor is greater than in the United States and a greater proportion of Brazilian youth live in abject poverty and in neighbourhoods with severe drug, crime, and gang problems
- relations between the federal military police and youth are very poor and many youth do not trust the police (who deliver the DARE programme).

Other programmes have been successfully transferred across countries. For instance, a slightly modified version of SHAHRP, an Australian programme, was implemented successfully in nine post primary schools in Belfast, Northern Ireland (Keane 2012; McKay et al. 2012). The 'Strengthening Families Programme' was initially developed in the USA as an indicated programme for substance-abusing parents and their children, six to ten years of age. It was then adapted as a universal programme for children aged 10-14 – the 'Iowa Strengthening Families Programme'. This programme has been adapted further for use in European countries and with different population groups. It has demonstrated the need for cultural adaptation which takes account of language, narrators, realism, acceptability of exercises/games, perceived religiosity and ethnic representativeness. Commenting on the adaptation of the programme to suit the UK context, Allen et al. (2007: 550) noted that,

> the challenge is to adapt the material and format without compromising theoretical and conceptual integrity and therefore potential effectiveness.

Since 2003, the Strengthening Families Programme has been culturally adapted for use in 17 countries; (e.g. See reports from Sweden: Skarstrand, 2008; Honduras: Vasquez et al. 2010; Italy: Ortega et al., 2012).

Durlak and DuPre (2008) review the debate regarding the extent to which adaptation can be permitted or encouraged to suit local and cultural needs without compromising programme fidelity too much. They conclude that,

> The prime focus should be on finding the right mix of fidelity and adaptation … and this cannot be determined without measuring each of these dimensions during implementation. Unfortunately, it is unclear in most studies of implementation exactly which components are reproduced faithfully, or exactly how the intervention is being altered in its new context (Durlak and DuPre 2008:341).

5. What constitutes 'good practice' in school-based alcohol education?

Despite disagreement in the literature regarding whether education 'works' or not, few question the provision of education about alcohol as part of the school curriculum, whether on its own or as part of substance use/abuse education or within a more general health / behavioural approach. School based alcohol interventions are extremely heterogeneous and evaluations of interventions

have highlighted the difficulties in drawing conclusions about effectiveness. However, the conclusion that alcohol education does not work – or is ineffective in changing behaviour – is challenged by the findings of several well-implemented and evaluated programmes. In particular, what differs is the expectation about what educational intervention should achieve in order to be seen as effective. Where the central message is 'no use' or 'delayed use' effectiveness is less likely than where messages are based on harm reduction, reduced amount or frequency of consumption or reduction in drunkenness/ binge drinking. Evaluations clearly point to the value of booster sessions, phased or continuing intervention, to the need for trained deliverers and to the need for cultural competency in designing and implementing programmes. There is little support for interventions led by adults other than teachers and doubts regarding the value of added components – community, peer and family intervention - although programmes such as Strengthening Families Programme which are the core of the intervention rather than an added component have been assessed as promising.

Evidence for what is considered to be good practice derives mainly from a highly selected group of evaluated programmes. A considerable number of school-based alcohol education programmes have not been satisfactorily evaluated. The criteria usually specify randomised controlled trials, studies having a longitudinal or repeated cross-sectional design with experimental or quasi-experimental design or structured single-group designs with pre- and post- test assessments. This results in the exclusion of a large number of studies – although some of these may contain useful insights and important lessons for development and implementation. Reviews of alcohol education programmes have generally found a limited number of studies that have met the selection criteria regarding study design and procedures. For instance, Foxcroft *et al.* (2008) identified over 600 relevant papers/ reports/ dissertations but only 56 papers met the quality inclusion criteria – an increase, however, of 23 studies compared to a previous review carried out by the same author. Of the 56 papers, 84% were from the USA; 32 interventions included drugs other than alcohol (a feature of many interventions). The selective nature of the evidence and the fact that it relies on findings from a small number of countries means that consideration of cultural fit and transferability are extremely important. Although it may make sense to base new initiatives on proven programmes, the need to ensure that the programme is appropriate and acceptable in the specific context is paramount.

Characteristics of effective programmes have been suggested by some reviewers (e.g. Cuijpers, 2003; Botvin and Griffin, 2007). Botvin and Griffin (2007) offer nine key components and characteristics of effective prevention programmes. They are:

1. guided by a comprehensive theoretical framework that addresses multiple risk and protective factors
2. provide developmentally appropriate information relevant to the target age group and the important life transitions they face
3. include material to help young people recognise and resist pressures to engage in drug use

4. include comprehensive personal and social skills training to build resilience and help participants navigate developmental tasks
5. provide accurate information regarding rates of drug use to counter the perception that it is common and normative
6. are delivered using interactive methods
7. are culturally sensitive and include relevant language and audio visual content
8. include adequate dosage to introduce and reinforce the material
9. provide comprehensive interactive training sessions for providers

The need to evaluate programmes, and to develop the evaluation framework, tools and procedures simultaneously in planning the programme, is an additional necessary ingredient of good practice if programme providers are to understand why the programme, or aspects of the programme, are successful or not.

5.1 Practice Implications

There is no one template for good practice which will suit all alcohol education development needs. However, the experience from past initiatives and the evidence from evaluated programmes can provide useful insights. In considering 'best practice' in alcohol education, it may be helpful to use some broad guidelines within which to assess the relevance of findings from the literature to local conditions and to each specific context. Planning to develop and implement an alcohol education programme requires consideration of:

- ***The problem***: alcohol use, problem use, alcohol-related behaviour
- ***The target group***: characteristics of the target group, the immediate and wider social environment
- ***The message*** which is best suited to tackle the identified problem, is most likely be accessible and acceptable to the target group, and is based on best available evidence of effectiveness; (prevention/delay of use; harm reduction - influencing drinking pattern and drinking behaviour)
- ***The intervention***: based on theory and on available evidence, which intervention design/content/mode of delivery/ dosage is most likely to prove effective
- ***The resources*** needed to deliver the programme successfully and availability of these resources – e.g. time on the curriculum, training for teachers, peers or others delivering the programme
- ***Components added to classroom delivery***: the likelihood that added components will be worthwhile – e.g. community, family, peer components.
- ***Cultural relevance***: the appropriateness of the intervention to the culture/ target group/ specific community and school environment; appropriatenes of the programme materials and procedures: language, narrators, realism, acceptability of exercises/games, ethnic and religious representativeness etc.
- ***Evaluation:*** the inclusion of programme evaluation from the start.

Role of Funding and Conflict of Interest:

This paper was funded by ICAP as part of a project to develop an Alcohol Education Guide website. The author was part of a team considering criteria for good practice in developing and implementing school-based alcohol education programmes. An initial draft paper reviewed the literature in more detail. This paper is based on that. ICAP did not contribute to the first draft paper or to this paper in any way. The paper is solely the work of the author.

The author is a member of ICAP research advisory group.

6. References

Allen D., Coombes L. and Foxcroft D.R. (2007) Cultural accommodation of the Strengthening Families Programme 10–14: UK Phase I study *Health Education Research* 22 (4):547–560

Babor, T.F., Caetano, R., Casswell, S., et al. (2010). *Alcohol: No ordinary commodity: Research and public policy*. Oxford: Oxford University Press.

Biesta G. (2009) *Good education: What it is and why we need it*. Inaugural Lecture, The Stirling Institute of Education, University of Stirling. http://www.ioe.stir.ac.uk/documents/GOODEDUCATION--WHATITISANDWHYWENEEDITInauguralLectureProfGertBiesta.pdf

Botvin G.J., Griffin K.W. (2007) School-based programmes to prevent alcohol, tobacco and other drug use *International Review of Psychiatry* 19(6): 607-615

Cairns G., Purves R., Bryce S. et al.(2011) *Investigating the effectiveness of education in relation to alcohol: A systematic investigation of critical elements for optimum effectiveness of promising approaches and delivery methods in school and family linked alcohol education*. Institute for Social Marketing, University of Stirling and the Open University http://alcoholresearchuk.org/downloads/finalReports/FinalReport_0083.pdf accessed March 2015

Carla M.P., Faggiano F., Bellocco R., Galanti M.R. (2011) Effects of a school-based prevention program on European Adolescents' patterns of alcohol use *Journal of Adolescent Health* 48 (2): 182-188

Carroll C., Patterson M., Wood S., et al (2007) A conceptual framework for implementation fidelity (2007) *Implementation Science* 2: 40

Cuijpers P. (2003) Three decades of drug prevention research *Drugs: education, prevention and policy*, 10 (1): 7-20

Darnton A. (2008) Government Social Change. *Reference report: An overview of behaviour change models and their uses*. London: University of Westminster

http://www.civilservice.gov.uk/wp-content/uploads/2011/09/Behaviour_change_reference_report_tcm6-9697.pdf accessed March 2015

Durlak J.A. and DuPre E.P. (2008) Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation *American Journal of Community Psychology* 41:327–350

Ennett S.T., Tobler N.S., Ringwalt C.L., Flewelling R.L. (1994) How effective is drug abuse resistance education? A meta-analysis of Project DARE outcome evaluations *American Journal of Public Health* 84 (9): 1394-1401

Faggiano, F., Richardson, C., Bohrn, K., Galanti, M.R., the EU-Dap Study Group, (2007) A cluster randomized controlled trial of school-based prevention of tobacco, alcohol and drugs use: the EU-Dap design and study population. *Preventive Medicine* 44, 170–173.

Faggiano, F., Galanti M.R., Bohrn K. (2008) The effectiveness of a school-based substance abuse prevention programme: EU-Dap cluster randomised controlled trial *Preventive Medicine* 47, 537-543

Faggiano F., Vigna- Taglianti F., Burkhart G. *et al*. (2010) The effectiveness of a school-based substance abuse prevention program: 18-Month follow-up of the EU-Dap cluster randomized controlled trial *Drug and Alcohol Dependence* 108 (1) 56-64

Foxcroft D, Ireland D, Lowe G, Breen R (2008) Primary prevention for alcohol misuse in young people (Review) *Cochrane Database of Systematic Reviews* Issue 3

Foxcroft D.R.and Tsertsvadze A. (2011) Universal multi-component prevention programs for alcohol misuse in young people (Review) *Cochrane Database of Systematic Reviews* Issue 9, Art. No. CD009307 DOI: 1002/14651858.CD009307

Jones L., James M. Jefferson T. et al. (2007) *A 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 18 years old* Centre for Public Health, Liverpool John Moores University

Keane M. (2012) Reducing alcohol-related harm: evaluation of a SHAHRP intervention *Drugnet Ireland* 42: 14

Lloyd C, Joyce R, Hurry J, Ashton M. (2000) The effectiveness of primary school drug education *Drugs-Education Prevention and Policy* 7(2)**:** 109-126.

McAlaney J., Bewick B. & Hughes C. (2011) The international development of the 'Social Norms' approach to drug education and prevention *Drugs: education, prevention and policy*, 18(2): 81–89

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

McKay M.T., McBride N.T., Sumnall H.R. & Cole J.C. (2012) Reducing the harm from adolescent alcohol consumption: results from an adapted version of SHAHRP in Northern Ireland *Substance Use and Misuse* 17 (2): 98-121

Mellanby A.R., Rees J.B. and Tripp J.S. (2000) Peer- led and adult- led school health education: a critical review of available comparative research *Health Education Research* 5(5): 533-545

Midford R., Cahill H., Ramsden R. *et al*. (2012) Alcohol prevention: What can be expected of a harm reduction focused school drug education programme? *Drugs: education, prevention, policy* 19(2): 102-110

Ortega E., Giannotta F., Latina D. and Ciairano S. (2012) Cultural adaptation of the Strengthening Families Program 10-14 to Italian families *Child and Youth Care Forum* 41 (2): 197-212

Perry C.L., Williams C.L., Veblen-Mortenson S., et al. (1996) Project Northland: Outcomes of a communitywide alcohol use prevention program duringearly adolescence *American Journal of Public Health* 86 (7): 956- 965

Petrie J., Bruun F. and Byrne G. (2007) Parenting programmes for preventing tobacco, alcohol or drugs misuse in children under 18: a systematic review *Health Education Research* 22(2): 117-191

Shamblen S.R., Courser M.W., Abadi M.H. et al. (2014) An international evaluation of DARE in São Paulo, Brazil *Drugs: education, prevention, policy* 21 (2): 110-119

Skarstrand E., Larsson J. and Andreasson S. (2008) Cultural adaptation of the Strengthening Families Programme to a Swedish setting *Health Education* 108 (4): 287-300

Teesson M, Newton NC, Barrett EL. Australian school-based prevention programs for alcohol and other drugs: A systematic review. *Drug Alcohol Rev* 2012;31:731–736

Vasquez M., Meza L., Almandarez O. *et al*. (2010) Evaluation of a strengthening families (Familias Fuertes) intervention for parents and adolescents in Honduras *Southern Online Journal of Nursing Research* 10 (3):

Van Der Kreeft P., Wiborg G., Galanti M.R. *et al*. (2009) 'Unplugged': A new European school programme against substance abuse *Drugs: education, prevention and policy* Vol. 16, No. 2 , Pages 167-181

Velleman R. (2009a) *Influences on how children and young people learn about and behave towards alcohol*. York: Joseph Rowntree Foundation

Velleman R. (2009b) *Alcohol prevention programmes. A review of the literature* York: Joseph Rowntree Foundation

World Health Organization (2009) *Evidence for the effectiveness and cost-effectiveness of interventions to reduce alcohol-related harm* Copenhagen: WHO Regional Office for Europe.