



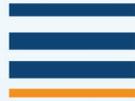
Health Programme
2008-2013

Together for Health



Strategies towards
responsible Alcohol
Consumption for
Adolescents in Europe

PH Zürich



Zurich University of Teacher Education
Research Group of Public Health
and Special Educational Needs

Evaluation

TAKE CARE

Strategies towards responsible Alcohol Consumption for Adolescents in Europe

Walter Kern-Scheffeldt
Esther Kirchhoff
Liliane Pfister
Michael Fraiss

November 2012

This publication arises from the project TAKE CARE which has received funding from the European Union in the framework of the EU Health Programme 2008-2013.

This document does not represent the point of view of the European Commission. The interpretations and opinions contained in it are solely those of the authors.

Index

Acknowledgements	5
Executive Summary	6
1 Initial Situation	9
1.1 Object of the Evaluation	9
1.2 Task of Evaluation	10
1.3 Issues of Evaluation	11
1.4 Structure of the Report	11
2 Practice-based Project TAKE CARE	12
2.1 Multilevel Approach with Orientation towards Social Environment	12
2.2 Interventions	13
2.2.1 Adolescents: ro.pe-Training®	13
2.2.2 Parents: Homeparty	14
2.2.3 Key-Persons: Key-Training	14
2.2.4 Employees in Retail: First-Rate Retailer Tools	15
2.3 Implementation of Interventions in different Countries	15
3 Methods of Evaluation	17
3.1 Theoretical Foundation and Starting Point	17
3.2 Quantitative Data-Collection	17
3.3 Development of the Instruments and Conduct of the Data-Collection	19
3.4 Evaluations Instruments	19
3.5 Interpretation of Data	20
4 Design of Evaluations and Description of Test Samples	21
4.1 Ro.pe-Training®: Target Group Adolescents/Young Adults	21
4.1.1 Ways of Access to Adolescents	24
4.1.2 Self-reports of the Adolescents at the Beginning of the Training	24
4.1.3 Main Activities/Educational Background	25
4.1.4 Migration Background of Adolescents	26
4.1.5 Alcohol Consumption: Categorising the Adolescents into Groups of Consumption and cumulative Value	26

4.2	Homeparties: Target Group Parents	32
4.2.1	Ways of Access to Parents	33
4.3	Key-Trainings: Target Group Key-Persons	33
4.4	First-Rate Retailer Tools: Target Group Retailers	37
4.5	Evaluation of the Achievement of the Target Group	39
4.5.1	Adolescents/Young Adults	39
4.5.2	Parents, Key-Persons and Retailers	40
5	Results of the Evaluation	41
5.1	Do the Adolescents reduce the Consumption of Alcohol as a Result of the ro.pe-Trainings®?	41
5.2	Is the Compliance with the Laws on Alcohol encouraged?	45
5.2.1	Is the Legislation on the Consumption of Alcohol known and is this Knowledge encouraged?	46
5.2.2	Personal Attitude and Obligation towards the Law	47
5.3	Has the Knowledge about the Effects and Risks of Alcohol been improved?	49
5.4	Is the Competence of the Adolescents in Handling difficult Situations improved, especially when Dealing with a risky Consumption of Alcohol?	50
5.5	Are Parents, Key-Persons and the Employees in Retail empowered in an effective Handling of a risky Consumption of Alcohol by Adolescents?	51
5.6	How satisfied are the Participants with the Interventions?	53
6	Country-specific Results	54
6.1	Is there any Reduction of the Consumption of Alcohol by the Adolescents as a Consequence of the ro.pe-Trainings®?	55
6.2	Is the Compliance with the Legislation of Alcohol supported?	57
6.2.1	Is the Legislation regarding the Consumption of Alcohol known and is this Knowledge improved?	57
6.2.2	Personal Attitudes and Obligation towards the Law	59
6.3	Is the Knowledge about the Effects and Risks of Alcohol improved?	62
6.4	Is the Competence of the Adolescents in Handling risky Situations, especially in Handling risky Consumption of Alcohol improved?	63
6.5	Are the Parents, Key-Persons and the Employees in Retail supported in an effective Handling of the risky Consumption of Alcohol by Adolescents?	65
6.6	How is the Satisfaction of the Participants of the Trainings with the Interventions?	67

7 Benchmark Figures and Recommendations	69
8 Annex	73
8.1 Details about the Analysis of Alcohol Consumption of the Adolescents	73
8.1.1 Consumption Groups	73
8.1.2 Cumulative Value	75
8.1.3 Difference Value	76
8.2 Scales and Wording of Items	78
Impressum	83

Acknowledgements

This publication is related to the TAKE CARE project, which has been supported financially by the European Union as part of the Public Health Programme 2008-2013. We would like to thank the European Union and the Zurich University of Teacher Education for making this evaluation report possible.

Also, we would like to thank the steering group of the TAKE CARE project, especially Mr. Klaus Nothdurfter, Youth Office, Autonomous Province Bolzano/South Tyrol, for hands-on feedbacks.

Special thanks shall be expressed to the central project coordination at the Coordination Office of Drug-related Issues of the Regional Authority Westfalen-Lippe, Mr. Wolfgang Rometsch and Mrs. Nadja Wirth and their team, for the support in organising and the constructive expert-discussion.

We do also thank all partners from different countries, from Belgium, Cyprus, Denmark, Germany, Greece, Ireland, Italy, Portugal, Slovakia and Slovenia, for the inspiring cooperation.

Finally, we would like to thank Carsten Hinz and his team for the attentive oral and written translation.

Executive Summary

Initial Situation

During the past 15 years, a self-contained juvenile drinking culture has been developing in European countries, which differs from the drinking cultures of the adults. Whereas with adults the consumption of alcohol is integrated in everyday life, the drinking patterns of some of the adolescents occur in form of an episodic risky consumption of alcohol.

This form of risky drinking behaviour at the vulnerable developmental age of children and adolescents comes along with multiple negative consequences. That is why the World Health Organisation at a Ministerial Conference on Youth and Alcohol in February 2001, as well as the EU-Council of Ministers of Health in their recommendations on the consumption of alcohol by children and adolescents recommended in 2001, to reduce the dissemination and frequency of highly risky drinking habits among young people significantly, to inform adolescents better about alcohol and to create a supporting environment.

The European Pilot Project TAKE CARE

The practice-based project TAKE CARE, which has been supported financially by the European Union as part of the Public Health Programme, takes on these problems. The project addresses young people in the age groups of 12 to 21 years, who have been noticed because of a risky consumption of alcohol. The young people are to be made aware of their drinking behaviour, learn to estimate risks and be motivated to reduce their alcohol consumption. Also, compliance with the national legislation, e.g. with youth laws, should grow. The guiding thesis of the project is that interventions in a defined social environment (district, small town...) with a systematic approach on four levels and a connexion, which can be experienced in time, reinforce each other. Therefore, the adolescents and young adults, who consume riskily, the parents and key-persons, who have a special relation with the adolescents, and the employees of shops, who sell alcoholics, are incorporated. In order to reach this general goal, the adolescents shall train their risk competence and parents shall be boosted in their education competence by a reflection of their attitudes and the transfer of knowledge. Key-persons shall be supported in addressing the consumption of alcohol at adolescents and run constructive talks. The employees in retail shall be informed, motivated and trained, so that the problem is identified and the legal norms are complied with consequently. TAKE CARE here implements predominantly behaviour-related instruments, especially at the adolescents. Simultaneously, structural, condition-related instruments are incorporated by the interventions at the employees in retail.

With a run-time between March 2010 and November 2012, this approach has been implemented exemplarily in ten countries¹ of the European Union.

1 Belgium, Cyprus, Denmark, Germany, Greece, Ireland, Italy, Portugal, Slovakia, Slovenia.

Data and Methods of Evaluation

The evaluation of the pilot project focuses on the impact of the project and its four interventions with young people, parents, key persons and retailers. Indicators that should confirm the goal-achievement have been the number of participants, who have been reached, their satisfaction with the interventions as well as – the most important information – the change of attitudes and behaviour.

The evaluation relies on questionnaires-surveys in all four target-groups of the ten participating countries. The participating adolescents, as the main target group, have been given questionnaires at the start, at the end of the ro.pe-Training[©] and three months later. Similarly, the key-persons have been surveyed three months after the key-training. Follow-up surveys have been conducted in order to measure possible changes throughout the intervention. Parents and employees in retail have been both interviewed at the end of the intervention.

Results

According to the project application, in total 1,550 persons should have been participating in the interventions (400 adolescents, 500 parents, 150 key-persons and 500 alcohol-retailers). With 1,690 participants reached (440 adolescents, 474 parents, 176 key-persons and 600 retailers) there have been 9 % more participants than planned originally.

For the adolescents, the consumption of alcohol has been significantly reduced, especially at the group of adolescents, who consumed alcohol riskily at the start of the training. 44.4 % of them reduced the amounts of alcohol and/or the frequency of drinking. With 33.6 % the consumption remained stable on a low level. 21.5 % drank more, 12.8% of them have been under the age of 16, who at the time of re-interviewing, for example, had drunk only 1-2 glasses every once in a while.

The acceptance of the national youth law among the adolescents has been improved. The willingness to comply with the laws has been on a high level after the interventions with the other target groups.

The satisfaction of the adolescents, parents, key-persons and employees in retail with the interventions has been at high values.

Parents, key-persons and the employees in retail have been able to improve their competences in handling the consumption of alcohol by adolescents as a consequence of the interventions.

Discussion

Overall, the evaluation showed that the developed interventions and used methods are qualified for accessing the target groups and for improving their competences regarding the handling of juvenile consumption of alcohol. The interventions have been implemented successfully, sometimes with small adjustments through the responsible local expert institutions. The multilevel approach of TAKE CARE is demanding and complex. It requires a careful analysis of the situation and the needs in the selected social environment and a good cooperation at site. A solid project management and sufficient human resources are basic conditions. Because of the high satisfaction with the intervention, it can be assumed that the attitudes and the behaviour regarding the consumption of alcohol, in terms of a health-concerned handling, can be encouraged further through mouth-to-mouth propaganda in the defined social environment. Yet, this requires a continuous implementation of the instruments for a reliable offer. This is why the standards and joint quality guidelines for TAKE CARE have been recorded in the manual.

1 Initial Situation

1.1 Object of the Evaluation

This final report contains all findings, which have been gathered during the scientific monitoring of the practise-based project „TAKE CARE – Strategies for a responsible consumption of alcohol by adolescents in Europe“² by the evaluation team of the Research Group Health and Special Pedagogical Needs of the University of Teachers Education Zurich/Switzerland.

The origin of the project TAKE CARE is based on the EU action-plan for the reduction of alcohol-related damages. Two major international studies prove these problems with the consumption of alcohol at young age epidemiologically: The HBSC-study (2009/2010)³ showed that 21% of the 15-year-olds consume alcohol every week. In the ESPAD-Report (2011)⁴, 45% of the 15-year-olds reported, having consumed significant amounts of alcohol in the past 30 days. Behind these epidemiological figures, there are concrete problems: For example, children and adolescents consume at public spaces ensuing disorderly conduct, vandalism and violence. Furthermore significant acute health impairments arise by the consumption of alcohol. The increase of consumption has different reasons: In most European countries the prices for alcoholic beverages have decreased drastically, so that even for adolescents larger amounts of alcohol are affordable (RAND, 2009)⁵. Also, the insufficient compliance of the legal age-limits by the retailers of alcohol made it easier for the adolescents to purchase alcohol. Here, 78% of the pupils reported that it is easy to buy beer; with hard liquors it has been 56% of the pupils (ESPAD, 2007).

The concrete idea of the practise-based project TAKE CARE has been developed during a workshop of the European Network for practice-oriented prevention of addiction euro net⁶. The initial idea was to combine proven and tested single interventions in different target groups and integrate them in a multilevel project. This combination of the target groups in a common social environment promised a higher effectiveness. The Coordination Office for Drug-related Issues of the Regional Authority Westfalen-Lippe took over the central coordination of the international pilot project as the project executing organization. Ten European countries contributed to the pilot project. In addition to funding from the countries, the pilot project has been funded by the Health Programme 2008-2013 of the European Commission.

During the run-time of the project between March 2010 and November 2012 the project manual TAKE CARE has been drafted, tested in the partner countries, worked over according to the feedback from the countries and intermediate results of the evaluation, and finalized at the end of the project. The international collaboration with ten partner countries made it possible to create a common base in the project on the EU-level, in order to transfer the project approach to other EU-countries after the pilot period.

2 See www.project-take-care.eu (visited 21.09.2012).

3 WHO European strategy for child and adolescent health and development. Copenhagen, WHO Regional Office for Europe, 2009/2010.

4 ESPAD-Report, Substance Use Among Students in 36 European Countries, 2011.

5 RAND Europe (2009). The affordability of alcoholic beverages in the European Union. Understanding the link between alcohol affordability, consumption and harms. Available at: http://ec.europa.eu/health/ph_determinants/life_style/alcohol/documents/alcohol_rand_en.pdf (visited 26.09.2012).

6 See <http://www.euronetprev.org/> (visited 21.09.2012).

The overall goal of the practise-based project TAKE CARE is the reduction of the consumption of alcohol by adolescents and young adults in Europe. These goals shall be achieved by a multilevel approach, as mentioned above, which is related to the social environment. The interventions, which have been developed, target the adolescents on the one hand, but also parents, key-persons with a meaningful relation to the adolescents and employees in retail of the very social environment (small town, urban quarter, etc.), on the other hand. The main target group are adolescents at the age between 12 and 21 years, who have been consuming alcohol before the legal age or who have been noticed for a risky consumption of alcohol beyond the legal age. TAKE CARE addresses the prevention of the consumption of alcohol before the legal age and the support of a responsible handling of alcohol beyond the legal age, so that the risk of an addiction of alcohol, damages to the health and deviant behaviour related with that can be minimised.

The adolescents are trained in increasing their risk competences. Parents and key-persons receive support, so that they can develop a clear and reflected attitude towards consumption of alcohol by young people. Retailers, caterers and owners of kiosks as well as their employees receive information and training regarding everyday sales situations. Such approach shall not only decrease the critical use of alcohol by adolescents and young adults, but also influence the social and cultural attitudes of the social environment of young people towards the consumption of alcohol; this way the main goal can be achieved in a more sustainable way.

1.2 Task of Evaluation

The evaluation team went with the pilot project from November 2010 to the end in November 2012. The task of the evaluation has been to record the effect of the implemented approach and to answer certain questions (cf. chapter 1.3).

During the development of the interview design, the expert institutions of the ten countries which implemented the project were included; the participants of the interventions were involved according to a participatory approach. Consequently, the following statements in this text rely on the talks and feedbacks from the partners in the ten countries, but also on the evaluation of the questionnaire surveys for all four target groups in all ten countries.

The project goals of the practice-based project as well as the overall satisfaction with the interventions and the interventional approach are the centre of the evaluation. This results in the following questions:

1.3 Issues of Evaluation

The questions that have become relevant to the evaluation derived from the EU application of the practice-based project and are as follows:

1. How have the target groups been accessed? Up to which extent and by which ways of access have the persons specified by the TAKE CARE manual been gained for the interventions? (cf. chapter 4.5)
2. Did the consumption of alcohol by the adolescents decrease after the ro.pe-Training[©]? (cf. chapter 5.1)
3. Is the compliance with the legislation on alcohol encouraged? (cf. chapter 5.2)
4. Is the knowledge about the effects and risk of alcohol improved? (cf. chapter 5.3)
5. Is the competence of adolescents in handling risky situations, especially dealing with risky consumption of alcohol, improved? (cf. chapter 5.4)
6. Are the parents, key-persons and employees in retail empowered for an effective handling of risky consumption of alcohol by adolescents? (cf. chapter 5.5)
7. What about the satisfaction of participants of the trainings with the interventions? (cf. chapter 5.6)

1.4 Structure of the Report

After a more detailed description of the practice-based project TAKE CARE (chapter 2) and the methods of the evaluation (chapter 3), chapter 4 provides a description of the sampling as well as answers to the first questions listed above. Afterwards, the presentation of the evaluation results is divided into two parts: Chapter 5 highlights the results from a superior perspective. In this chapter the ten countries are considered one group. This allows answers to the question which effect the TAKE CARE project had on all ten countries in an overall view. This chapter is structured according to the questions above and summarises, in sub-chapters, the answers from the perspective of the target groups, which have been specifically interviewed concerning the respective content matter.

An international project, such as TAKE CARE, becomes vivid, because the testing can take place in different country-specific contexts. These differences show in the country-specific results. In chapter 6 these results are presented, the differences sometimes are statistically relevant. For the evaluation it was not possible to elicit systematically differences in preconditions and implementation. Therefore the results are not interpreted but presented for interested people.

In chapter 7, there are recommendations and final conclusions.

2 Practice-based Project TAKE CARE

The practice-based project TAKE CARE consists of interventions for adolescents, parents, key-persons and employees in retail. The innovative element in Europe is the combination of the different levels (so-called multilevel approach), the close range and concentrated sequence of the different interventions and their implementation in a defined social environment, with the main goal, namely getting a stronger and sustainable influence on the problematic consumption of alcohol by young people.

2.1 Multilevel Approach with Orientation towards Social Environment

The project TAKE CARE, as a multilevel approach is designed according to the social environment of young people⁷.

- **Multilevel approach:** In this project the concept of the multilevel approach is understood as the simultaneous implementation of interventions on four different levels, i.e. four target groups – at adolescents and young adults, parents, key-persons of young people and at employees in retail. This approach relies on the results of the evaluated German project SeM – Secondary prevention of addiction in a multilevel approach. The implementation has been adapted to the local needs by a qualitative best practice analysis in all participating countries. The idea of the interaction of the four levels is to achieve a high effectiveness regarding a responsible handling of alcohol and a reduction of risky consumption of alcohol among young refugees and asylum seekers. It can be assumed that the simultaneous implementation of different approaches with the same message on different levels may result in synergy effects, so that a higher effect can be achieved than with a project, which is designed and implemented for only one target group⁸.
- **Orientation towards social environment:** In order to achieve this impact, a specific social environment is elicited for the implementation of the project – a district, an urban quarter or a community/small town. It shall be tried to reach the target group within the selected social environment in order to increase the likelihood that the effects in the various target groups influence each other positively.

7 Some passages under 2.1 have been taken from the final manual of TAKE CARE. At the time of completing this evaluation report, it was not known, in which way the manual of TAKE CARE will be available. We kindly ask readers to find out about this.

8 Cf. For instance a well-evaluated project with a multilevel approach: <http://www.esski.ch/esski-1> (visited 08.10.2012).

2.2 Interventions

TAKE CARE implements both behavioral interventions as well as structural measures. The behaviour-related measures aim to raise the awareness of the target groups for problematic elements of the behavior in order to create conditions for a change in behavior, support the conscious and responsible decision-making regarding challenging and even risky situations. The main goal is to increase the compliance with the legislation on the consumption of alcohol on all levels (in all target groups) and to support an attitude, which respects the consumption of alcohol beyond the legal age, but targets a handling, which is responsible and pleasure-oriented instead of damaging.

Next, the interventions shall be described briefly, in accordance with the manual.

2.2.1 Adolescents: ro.pe-Training[©]

The ro.pe-Training[©] is a group offer in the prevention of addiction for young people between 12 and 21 years, who consume alcohol in a risky way. The four-days training (in case of need 2x2 days) with overnight stays teaches adolescents in an experience-based way the handling of risky situations and aims to encourage individual competences related to alcohol. In doing so, the following methods are used:

- Adventure-based counselling/training of risk competences: As the name ro.pe-Training[©] already reveals, climbing is used as an element of adventure-based counselling. This approach is based on the concept of obtaining competencies while enjoying ecstatic situations and taking pondered risks⁹. The adolescents are guided into risky situations (with practices on the ground and at climbing, for instance by abseiling from rocks and cliffs) and they should experience their personal feelings consciously, learn about their limits and, become aware of the point, at which a „calculable risk“ turns into a „danger“, in an „incalculable risk“. These experiences are reflected and, in a next step, transferred to situations with a risky consumption of alcohol. The interventions, here, intend to improve the self-monitoring of the consumption of alcohol and to make alternative experiences of risks available. It is important at this part of the training, to work together with a certified rock-climbing coach (also, because of liability). If climbing is not possible, other risky situations (for example, diving) can be chosen.

9 Koller, Gerald (2007). Erkenntnisse und Konsequenzen für die Praxis. In: Einwanger, Jürgen (Hrsg.) (2007). Mut zum Risiko. Herausforderungen für die Arbeit mit Jugendlichen. München

- Psychoeducative part: At first, the adolescents deal with some topics (for example, knowledge on effects and risks of alcohol and the relevant legislation) in different, at best interactive communication methods. Subsequently, connections to the personal dealing with alcohol shall be established. With this information and reflections processes of creating awareness shall be triggered at adolescents and young adults, which then shall have a positive impact on the level of behaviour regarding the consumption of alcohol.
- Perception of the environment (action-oriented perception exercises): By way of pictures they shot and/or short videos, adolescents show each other findings on the topic „This, in my environment, has something to do with the consumption of alcohol“. If the technical conditions allow, the pictures and short films can be put on YouTube or Facebook.

The core of this methodological approach is that adolescents and young adults are not addressed in a moralising way about the topic of alcohol, but that the need of experiencing risks is included in the rock-climbing and discussed in relation to alcohol in an open way in the group.

2.2.2 Parents: Homeparty

At the Homeparty, parents invite other parents (friends, neighbours) and an expert for the prevention of addiction to their home. In addition to the knowledge transfer (effects and risks of the consumption of alcohol, reasons for consumption, legislation on youth protection), it is about reflecting the attitude of parents towards the topic of consumption and role models by using interactive methods and encouraging decision-making skills, so that the consumption of alcohol by adolescents is dealt with constructively and effectively (discussing consumption of alcohol, setting limits). This low-threshold intervention, which was based on the idea of Tupperware parties worked well even for parents, who have been difficult to access by traditional approaches in the prevention of addiction.

2.2.3 Key-Persons: Key-Training

The key-training is a training for so-called “key-persons”. Key-persons are persons who have contact to youngsters with risky alcohol consumption and are accepted by them. This target group includes persons like youth workers, streetworkers, teachers, voluntary working pupils or trainers and experts with special focus on youth protection. The aim of the key-training is to trigger a critical reflection of young people with the consumption of alcohol and be able to identify adolescents of the target group of the ro.pe-Training[©] in order to transfer them into the training.

In addition to factual knowledge on addiction, drugs and law, the key-training also teaches basics of the communication method of Motivational Interviewing. This method has been adapted to the needs of key-persons for this project.

2.2.4 Employees in Retail: First-Rate Retailer Tools

“First-Rate Retailer Tools” is training for retailers, who sell alcoholic beverages. This training can take place in form of a long intervention of 1-2 hours, for example, in professional schools or classes of employees in retail. However, the training can also be run individually in form of short interventions of 5 to 30 minutes for owners and employees at the spot in their shops.

This training gives retailers information on laws and tools about handling situations, when adolescents want to buy alcoholic beverages. The retailers are seen as partners in reaching the project goal, that is to reduce the abuse of alcoholic beverages among youngsters. The basic attitude towards the retailers is that this cannot happen without their help.

2.3 Implementation of Interventions in different Countries

The practice-based project TAKE CARE has been conducted in ten European countries.

These have been:

- Belgium: Centra voor Alcohol- en andere Drugsproblemen (CAD), Limburg.
- Cyprus: Centre of Education about Drugs and Treatment of Drug Addicted Persons, Kenthea, Paphos.
- Denmark: SSP & Forebyggelse, Esbjerg Kommune.
- Germany: Diaconia of the Parish District Herford.
- Greece: Organisation Against Drugs OKANA, Athens/Kos.
- Ireland: Health Service Executive Health Promotion Department, Navan/Co. Meath.
- Italy: Youth Office, Autonomous Province Bolzano/South Tyrol, Bolzano/Brixen.
- Portugal: Instituto Europeu para o Estudo dos Factores de Riscos nas Crianças e nos Adolescentes IREFREA, Coimbra.
- Slovakia: Research Institute for Child Psychology and Pathopsychology, Prevensia V & P, Bratislava.
- Slovenia: Regional Centre of Public Health and Health Promotion, Maribor.

A first draft of the manual has been drafted by the project coordinators together with the partners in the different countries for the pilot project. This manual described the concept of the TAKE CARE project and its implementation. The experts from the partner countries have been taught the different methods of the interventions in several workshops. To adapt the project to the local conditions and implement them successfully, interviews were conducted by the method of RAR (Rapid Assessment and Response). RAR is an instrument, suitable to explore a problem-setting in the field of public health to get basic information for potential interventions.

Through the manual and common trainings a common base was built to implement the project in a similar way.

Yet, for various reasons, there have been differences in the implementation of the interventions in different countries. Significant differences in the structural implementation of the interventions, for example, regarding the time concept of certain elements of the interventions or the location, are presented in the description of the test sample in chapter 4.

Additionally, some differences became obvious, linked to the complexity of the project and limited resources of the evaluation in the partner countries. In the following some differences shall be explained, which might have influenced the implementation of the interventions:

- Other projects and campaigns, which run parallel, have an impact on the fact, how TAKE CARE is perceived and maybe disappears among other offers.
- The selection of the social environment is very relevant for the number and characteristics of the recruited target persons.
- The order, when implementing the interventions, lead to differences in the recruitment of the different target groups. This concerns the question, which target group opens up the access to which other target group.
- Each course for groups has a specific and unpredictable dynamic. This group dynamic has an influence on the implementation of the intervention. For example, some countries have been confronted with a situation, in which adolescents consumed alcohol during the ro.pe-Training[®]. How the experts in prevention dealt with this situation, has been influenced by their different attitudes and professional background, especially regarding the professional consequences have been drawn from that (for instance, raising the issue, working it through, stopping the training, etc.).

Because of the variations in implementing the elements of the projects and the whole project, this evaluation cannot act on the assumption of a controlled or controllable design (see chapter 3.2).

3 Methods of Evaluation

3.1 Theoretical Foundation and Starting Point

For the evaluation, well-established methods of social science are taken into consideration, in order to meet the demand of high data quality and achieve an adequate description of the evaluated object. But at the same time, the evaluation of TAKE CARE is „practice-oriented“, so that the circumstances in the participating countries and the needs of the different social environments can be taken into account appropriately.

The evaluation of TAKE CARE has the following starting points and functions¹⁰:

- The goal-oriented approach, which focuses on the identification of project-goals and an evaluation of the achievement of these goals.
- The participatory approach, which is characterised by the incorporation of the participating/affected interest groups (stakeholder).

The evaluation process has been, because of the participatory design, organised in a way that the countries have been incorporated into the draft of the questionnaires. Also, the evaluation during the conduct of the project gave some feedback on the degree to which the target groups have been accessed. This interactive process, among others, showed a lack of a binding definition of „risky consumption“ by children and adolescents under 16 years and a certain arbitrariness in interpreting this term, which is very relevant for defining this target group.

3.2 Quantitative Data-Collection

As explained before, it has been a challenge to come up with a survey design, which nevertheless made a systematic data-collection in all ten countries possible. Therefore, it has been agreed to run the quantitative collection of relevant information with questionnaires. This questionnaire survey is the basis of the results as presented in this evaluation report¹¹.

The survey took place in all four target groups of TAKE CARE in all ten participating countries. This means, adolescents have been surveyed, who attended the ro.pe-Training®, parents, who participated in a Homeparty, key-persons with a special relationship to the local youth, who have been trained in the key-training and finally, retailers have been surveyed, who got to know the materials and contents of the First Rate Retailer Tools some target groups provided longitudinal information through re-interviewing.

10 Cf. Stockmann, 2007; and Fitzpatrick, J.L., Sanders, J.R., & Worthen, B.R. (2004). Program Evaluation: Alternative Approaches and Practical Guidelines. Boston et al.: Pearson Fitzpatrick.

11 Another additional project with a qualitative method of survey has been also funded by the University of Teachers Education, Zurich, but has not been part of this evaluation report and is, therefore, not been used here.

This methodology has been chosen for several reasons:

- The quantitative approach, which is supported by closed questions in a questionnaire-format, allows a rather wide survey. Therefore, the effects of the interventions can be investigated from the different perspectives of the different target groups. The closed questions lead to a relatively standardised and, therefore, comparable content of the statements in the countries.
- The complexity of the approach of the project, with an analysis of the effects of all four interventions, required a streamlined and informative instrument on the one hand, which, on the other hand, was easy to handle administratively and could be implemented easily language-wise (for example, a re-translation of open answer-texts would have increased the input and complexity drastically).
- The data-collection could only be organised with the help of the heads of the interventions. This „indirect“ way of survey makes it necessary to build instruments that are „test-leader unspecific“, so that the statements can be compared among all sites.
- A more open, but less systematic approach in data-collection would have reduced the controllability of the data-collection and, consequently, the comparability even more. Yet, more relevant has been that the personal and financial efforts for the translations would have over-stretched the financial resources. The actual funding for the evaluation required a cost-efficient procedure with as little manpower requirements as possible, in the data-collection in the ten countries and in the evaluation of the data.

This design and the implementation of the data-collection (see chapter 3.3) make it obvious that the evaluation of TAKE CARE is all about the scientific monitoring of a practice-based project, not about a mere research project with a solid scientific design. For example, because of the limited financial and personal resources at the evaluation team, as well as at the partner in the countries, it has not been possible to run a control-group design, especially for test samples of the adolescent participants of the training.

This to a certain extent uncontrollable initial point will be the underlying tone in the interpretation, especially of the country-specific figures. In order to fathom the margin of interpretation, it has been a major concern of the evaluation team to receive multiple feedback on the qualitative level, in constant contact with partners in the countries and the central steering group.

3.3 Development of the Instruments and Conduct of the Data-Collection

Questionnaires have been drafted for the quantitative part of the evaluation for all target groups. It is a condition of the participatory approach of the evaluation, that these instruments are developed in collaboration of the participating partners in the countries. Therefore, during a project workshop before the start of the implementation of the project instruments have been proposed and discussed, and also ideas and suggestions of the partner countries have been picked up. Additionally, this course of action allowed to train the partners in the organisation and implementation on site. Afterwards, the drafted questionnaires have been translated into the respective national languages and used in the interventions. After filling in the questionnaires anonymously, the participants put them in envelopes themselves and closed those, so that these envelopes could be collected by the head of the intervention and send to the evaluation team of the PH Zürich for evaluation.

The collaboration with the partners and the central project coordination proved to be utterly constructive and productive. It is thanks to the efforts of partners in the countries, that the feedback in the re-interviews has been satisfactory high.

3.4 Evaluations Instruments

The idea of the survey design has been to receive information about the behaviour, attitudes and knowledge of the participants of the interventions, as well as about any changes, in form of a self-report.

The goal has been to select theoretically well-established and empirically valid instruments, which also can be used for all target groups in a comparable way. The instruments are merged in a short questionnaire, which can be used in everyday practice and does not require much time. Another demand has been to select instruments, with a behaviour-based wording and, therefore, reflect the actual behaviour and especially potential changes in behaviour quite accurately. Furthermore, it has been important to use an easy language, in order to match the assumingly wide-spread levels of language skills of the participants of the intervention.

The selected and relevant instruments are explained in detail in the attachment, in the annex, chapter 8.2. Here the origin of the instruments, the wording and the texts for the answers are presented. The drafted short questionnaires have been used in the longitudinal survey identically in large parts.

The information value and validity of these self-reports is discussed intensively. It would be too much for this evaluation report to pick up on this discussion here. Yet, certain arguments are mentioned at some places in the chapter on the results, so that the validity of the statements and potential limitations can be thought through. This perspective is indispensable for an interpretation of the results and effects especially the self-reports of the adolescents on their consumption of alcohol in this report.

3.5 Interpretation of Data

With each question, the evaluation and interpretation of the quantitative data material has been undertaken in three steps. This way of conduct can be also seen in the presentation of the results in this report:

- At first, the available data are presented in a descriptive and well-written way and regarding the averaging and spreading (standard deviation) and the percentages in all countries. These results and their interpretation can be found mainly in chapter 5.
- At questions regarding the extent of changes between the start of the training and the end (T1 to T2) or between training and re-interviewing (T1 or T2 to T3) χ^2 -tests and analyses of variance with repeated measurement are used. Changes, which are tested in an analyses of variances, are reported in the evaluation report and considered significant in practice, if the changes reach the interference-statistically significance ($\alpha < .05$) as well as a medium level of strength of effects ($\eta^2 \geq .06$, cf. Bortz, 2005, p. 259¹²). These results and their interpretation can also be found mainly in chapter 5.
- In further steps of the evaluation the country-specific figures are presented descriptively. Sometimes, with a multi-factor analysis of variance, it can be examined, whether the nationality or the sex (intermediate subjective factors), the age (covariate) or other factors are relevant for the variance in the averaging or in the figures of changes. These results and their interpretation can be found regarding the access of the target groups in chapter 4, regarding other questions in chapter 5 and 6.

12 Bortz, J. (2005). Statistik für Human- und Sozialwissenschaftler (6. edition). Heidelberg: Springer.

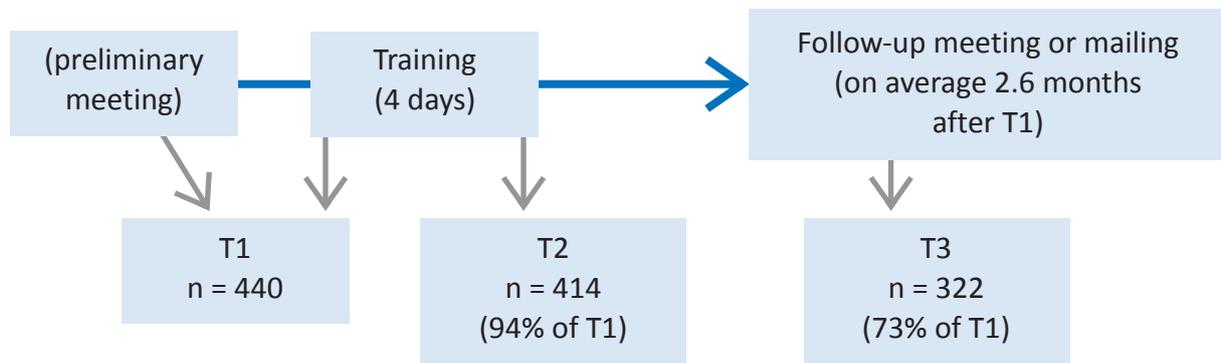
4 Design of Evaluations and Description of Test Samples

Next, the evaluation-design of each target group is highlighted. Also, the return figures are shown and test samples are described. This description of the test samples is presented in detail for the single countries already in this chapter.

These reports also answer the question, to which extent the partners in the different countries have been successful in accessing the target groups, quantitatively as well as regarding to certain characteristics of the test sample, as mentioned in the manual of the project. Chapter 4.5 summarised this.

4.1 Ro.pe-Training[©]: Target Group Adolescents/Young Adults

Figure 1. Design of survey and return figures in the target group of adolescents/young adults¹³.



The quantitative target value according to the project application for the EU have been 40 adolescents in each country, this means 400 adolescents in all 10 countries. This figure has been reached or exceeded in seven of ten countries (overall 440 evaluation sheets have been returned at the beginning of the training = 10% more than the target value), in three countries missed by a margin (38 and 39 participants, cf. Table 1).

The 440 adolescents have been taken care of in 38 trainings (cf. Table 1). This results in an average number of participants of 12 persons per training (minimum: 4 participants, maximum: 20 participants). In total as well as in seven of ten countries, more young men than young women participated in the trainings. In Belgium both sexes have been represented almost equally. In Greece and Portugal, on the other hand, there have been more young women in the trainings.

13 T1 = questionnaire survey at the start of the training or the preliminary meeting;
T2 = questionnaire survey at the end of the training;
T3 = questionnaire survey at a re-interview, on average 2.6 month after the start of the training or preliminary meeting.

Table 1. ro.pe-Trainings®: number of conducted courses and return of questionnaires at T1, sorted by country and sex.

Country	Number of courses	Usable questionnaires	Return T1	
			Female	Male
Belgium	4	39	20	19
Cyprus	3	39	10*	25*
Denmark	5	43	19	24
Germany	3	40	14	26
Greece	3	43	26	17
Ireland	6	60	22	38
Italy	2	38	9	29
Portugal	5	49	29	20
Slovakia	3	43	15*	27*
Slovenia	4	46	15	31
Total	38	440	179*	256*

Note: * Missing specification of sex: Cyprus 4 persons, Slovakia 1 person.

In total, about half of the participants have been younger than 16 years, this means in all participating countries younger than the legal age for the consumption of alcohol. More than one third of the participants have been 16 or 17 years old, which means that in six of ten countries they have already been legal to consume at least low-percentage alcohol. About one fifth have been 18 years or older; from this age on, in all participating countries they have been legal to drink high-percentage alcohol. In all three age-groups there have been more young men than young women in total (cf. Table 2).

However, the countries differed in the age-groups, which were represented in the trainings (cf. Table 2, not analysed with inferential statistics):

- Relatively young participants: In Cyprus, Germany, Greece, Italy and Slovakia the age-group of the under 16-year-olds is represented relatively more than the other age-groups. In Cyprus, Germany, Greece and Italy, also the age-group of the 16- to 17-year-olds is represented proportionally high; only in Italy, few young adults at the age of 18 and older participated.
- Relatively uniformly spread over the ages: In Portugal, both of the two young age-groups are represented equally strong, the oldest group less strong. Denmark addressed slightly more 16- to 17-year-olds than younger than 16-year-olds, as well as a little number of over 18-year-olds.
- Relatively older participants: In Belgium, Ireland and Slovenia, the age-groups of the 16- to 17-year-olds and over 18-year-olds are represented especially well.

Table 2. Number of adolescents at T1, sorted by country and sex.

Country	Minimum legal age for				
	Younger than 16 years	16 to 17 years	18 years and older	Low-percentage alcohol	High-percentage alcohol
Belgium (n=39)	3	17	19	16	18
Cyprus (n=38)	22	16	0	17	17
Denmark (n=42)	13	21	8	16	18
Germany (n=40)	31	9	0	16	18
Greece (n=43)	28	15	0	18	18
Ireland (n=60)	15	24	21	18	18
Italy (n=36)	22	8	6	16	16
Portugal (n=48)	19	18	11	16	18
Slovakia (n=42)	41	1	0	18	18
Slovenia (n=46)	8	23	15	18	18
Total (n=434)	202 (47%)	152 (35%)	80 (18%)		

Note: With 6 adolescents, there is no information about their age.

The adolescents have been interviewed at three times of measurement. A first survey (T1) took place at the beginning of the training (sometimes at a preliminary meeting), a second survey (T2) immediately after the ro.pe-Training[®]. The re-interviewing (T3) took place one to three months after the end of the training (see above, Figure 1). The following remark about the span between training and follow-up survey: The beginning of the implementation has been in September 2011, with a run-time to June 2012. This created a situation, in which most countries scheduled the ro.pe-Training[®] to the second half of the project run-time, because of the approaching cold season, namely to spring/summer 2012. This timing made it impossible to keep the original planned time interval between T2 and T3. Therefore, the longitude has been generally reduced to one to three months between the end of the training and the re-interviewing.

With a response rate of 94% of usable evaluation sheets at the end of the training (T2) and 73% at the follow-up survey, the response rate was high (cf. Table 3). The missing evaluation sheets at T2, 26 in total, have usually been drop-outs and in only very rare cases the received evaluation sheets could be simply not analysed.

The return during the re-interviews varied a lot between different countries. According to the opinion of the partners in those countries, the main reason has been the beginning holiday season.

Table 3. Adolescents: Return of questionnaires at T2 and T3.

Country	Return T2		ReturnT3		Male	Female
	Usable questionnaires	Ratio compared to T1	Usable questionnaires	Ratio compared to T1		
Belgium	38	97%	25	64%	15	10
Cyprus	39	100%	6	15%	4	2
Denmark	40	93%	37	86%	19	18
Germany	39	98%	25	63%	8	17
Greece	43	100%	39	91%	25	14
Ireland	54	90%	45	75%	13	32
Italy	37	97%	29	76%	7	22
Portugal	41	84%	36	73%	21	15
Slovakia	43	100%	41	95%	15*	25*
Slovenia	40	87%	39	85%	15	24
Total	414	94%	322	73%	142*	179*

Note: *Missing information about sex: Slovakia 1 person.

4.1.1 Ways of Access to Adolescents

The draft manual suggested to gain access to adolescents and young adults, who have been noticed because of their consumption of alcohol, via key-persons, for example via street workers, who addressed the adolescents in public/during their leisure-time; via institutions, such as (children's) hospitals, schools or counselling centres; via individual persons, who had been trained in key-training and who had special contacts with adolescents (for instance, coaches in a sports club, representatives of communities (church), staff of youth facilities; via parents, who became aware of the offer through PR work.

4.1.2 Self-reports of the Adolescents at the Beginning of the Training

(cf. Table 4)

now showed that a significant part of the adolescents have been transferred by an institutional-professional way of access: A majority of participants (n=280) learned about this offer at school, another part through „other adults“ (n=98), who might also be assumed to be key-persons working in institutions, on the one hand, but also key-persons, who work outside of established institutions and who might have been trained in a key-training. But also the mouth-to-mouth propaganda via participating adolescents already showed some effect, because 58 participants reported to have learned about the training from friends or other young people. A small majority reported that they became aware of the offer through parents (n=14) or media (flyers, newspapers, TV, ..., n=2).

Table 4. How adolescents learned about the ro.pe-Training© (self-report, multiple answers possible).

Country	Through schools/at workplace	Through other adults*	Through friends/peers	Through my parents	Through flyer, Facebook, Internet, TV, newspaper, ...
Belgium	37	2	0	0	0
Cyprus	17	5	21	2	1
Denmark	22	25	1	0	0
Germany	36	0	3	0	0
Greece	19	7	15	2	0
Ireland	29	23	6	2	0
Italy	31	3	3	0	1
Portugal	37	10	2	0	0
Slovakia	35	2	1	4	0
Slovenia	17	19	6	4	0
Total	280	96	58	14	2

Note: *in particular: streetworkers, prevention centre; sports coach, and so on.

4.1.3 Main Activities/Educational Background

With about 80% of the test sample of adolescents, their main activity was known. Because of the importance of the way of transfer via schools, it is not surprising that almost all adolescents, at the beginning of the training, reported to attend a school (general education or extra-occupational vocational training school, in few cases university): This has been true for 191 participants of the total test sample of the under 16-year-olds (94.6% in this age-group), 127 participants in the age-group of 16- to 17-year-olds (83.6%) and 61 young adults older than 18 years (76.3%). Only very little participants, namely 8 participants, spread over all the age-groups, reported being unemployed. For 20%, there has been no information about the current educational or professional background.

Because of the format of the questions, the educational background during the mandatory time at school unfortunately could not be analysed enough. For the post-mandatory time at school, the set-up of the categories would allow a differentiation into vocational education (vocational training, vocational training school) vs. general education (secondary school) for some countries; however, as this option of differentiation is not available through all countries, the evaluation report abstains from using the educational variable as a criterion for evaluation.

4.1.4 Migration Background of Adolescents

Only a small minority reported, speaking another language than the dominating national language at home (n = 31, this is 7% of the participants at T1; for 8 countries, none in Portugal and Slovakia). The chosen format of questions does not allow concluding, whether the migration background in the test sample is represented in a valid way and, consequently, only this small number of participants has been of foreign origin, or whether a different format of questions would have come up with different numbers. Therefore the evaluation report refrains from using the origin variable as a criterion for evaluation.

4.1.5 Alcohol Consumption: Categorising the Adolescents into Groups of Consumption and Cumulative Value

At this point the alcohol consumption of the participating youngster is described, because this allows to show to which extent the target group has been reached. This description is done by the categorisation of the adolescents into groups of consumption and by analysis of the so-called cumulative value (the description follows below).

The target group of adolescents has been defined in the draft manual as „adolescents, who have been noticed for a risky consumption of alcohol.“ This is in accordance with the selective-preventive approach of intervention of the project. During the project it became obvious that both, at the project and the implementation level as well as at the scientific level it was unclear what is meant by “risky consumption”¹⁴. A definition for these different age-groups had to be specified. The project-coordinators set up age-specific limits for low-risk and risky consumption (details in annex chapter 8.1.1)¹⁵.

The evaluation adopted this suggestion of a definition and divided the adolescents, who participated in a ro.pe-Training[®] into the three consumption-groups of tee-totalling, low-risk and risky consuming adolescents, based on two statements on the amount and frequency of drinking¹⁶ shows the frequency of the three consumption patterns at the start of the training (T1), classified by the three age groups¹⁷.

14 At the time of conducting the project, especially for the age-group of the 12– 16/18-year-olds, there has been no definition by WHO or other organisations, what “low-risk” or “risky” consumption actually means.

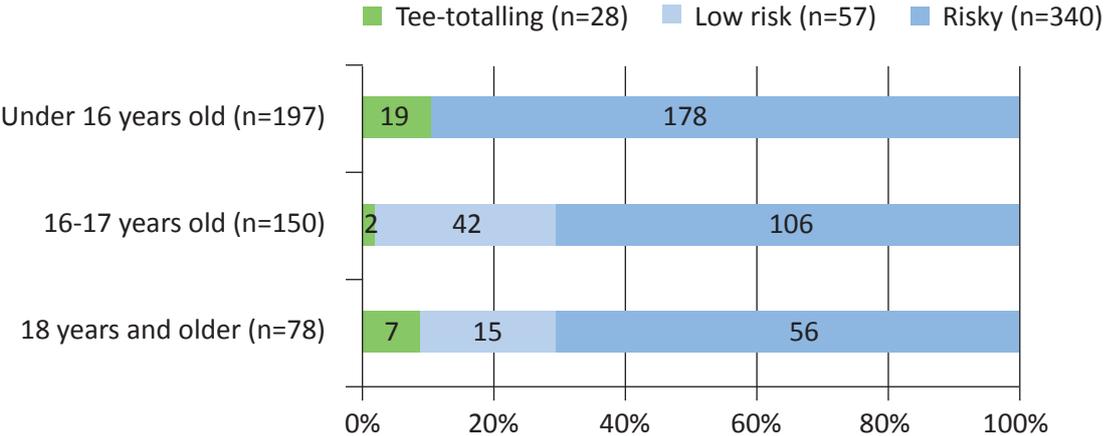
15 During the duration of the project, the definition of the target group of the adolescents has not only been specified regarding the consumption of alcohol, but it has also been proposed to incorporate as criteria the experience of intoxication as well as bio-psycho-social characteristics (for instance, problems at school, low socio-economic status, consumption of illegal drugs, personal mental diseases or those of an important attachment figure). The questionnaire for the adolescents does not ask for these criteria. Therefore, the evaluation does not take them into account.

16 Items from: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., & Monteiro, M.G. (2001). AUDIT – The Alcohol Use Disorders Identification Test (2nd ed.). Geneva: World Health Organization.

17 A few adolescents could not be classified, because of data that were missing or could not be interpreted.

It became clear that the heads of the interventions in the ten countries have been majorly successful in bringing adolescents, who consume riskily, to the rope-Training®: A major part of 90% of the adolescents in the age-group of the under 16-year-olds reported a drinking behaviour that has been defined as risky. In the age-group of the 16- to 17-year-old participants, this percentage has been at 72%. In total there has been a percentage of 80% of adolescents (340) in the training, who consume riskily.

Figure 2. Number of adolescents/young adults in the three consumption-groups in each age-group, total test sample at T1 (n=425)¹⁸.



Note: A few young people could not be assigned due to missing or non-interpretable information.

Other adolescents, at the beginning of the training, reported a drinking behaviour that has been defined as low-risk. This consumption-group has been set up for the two age-groups of the older than 16-year-olds, and contained among the 16- to 17-year-olds 28% of the participants, at the over 18-year-olds a percentage of 19%. Finally, there has been a small percentage of participants, who, at the beginning of the training, reported not drinking any alcohol at all. This affects 10% of the under 16-year-olds, 1% of the 16- to 17-year-olds, as well as 9% of the over 18-year-olds. This means, that about 20% of the participants have been taken into the training, who should have never been noticed for their risky consumption of alcohol according to their self-reports¹⁹.

18 Total sample = All adolescents who participated in the respective questionnaire survey;
 longitude sample = All adolescents who participated in both questionnaire survey T1 and T3;
 sample of the adolescents, who consume riskily = Reduction of the total sample to those adolescents who showed a risky consumption pattern at the start of the training (T1).

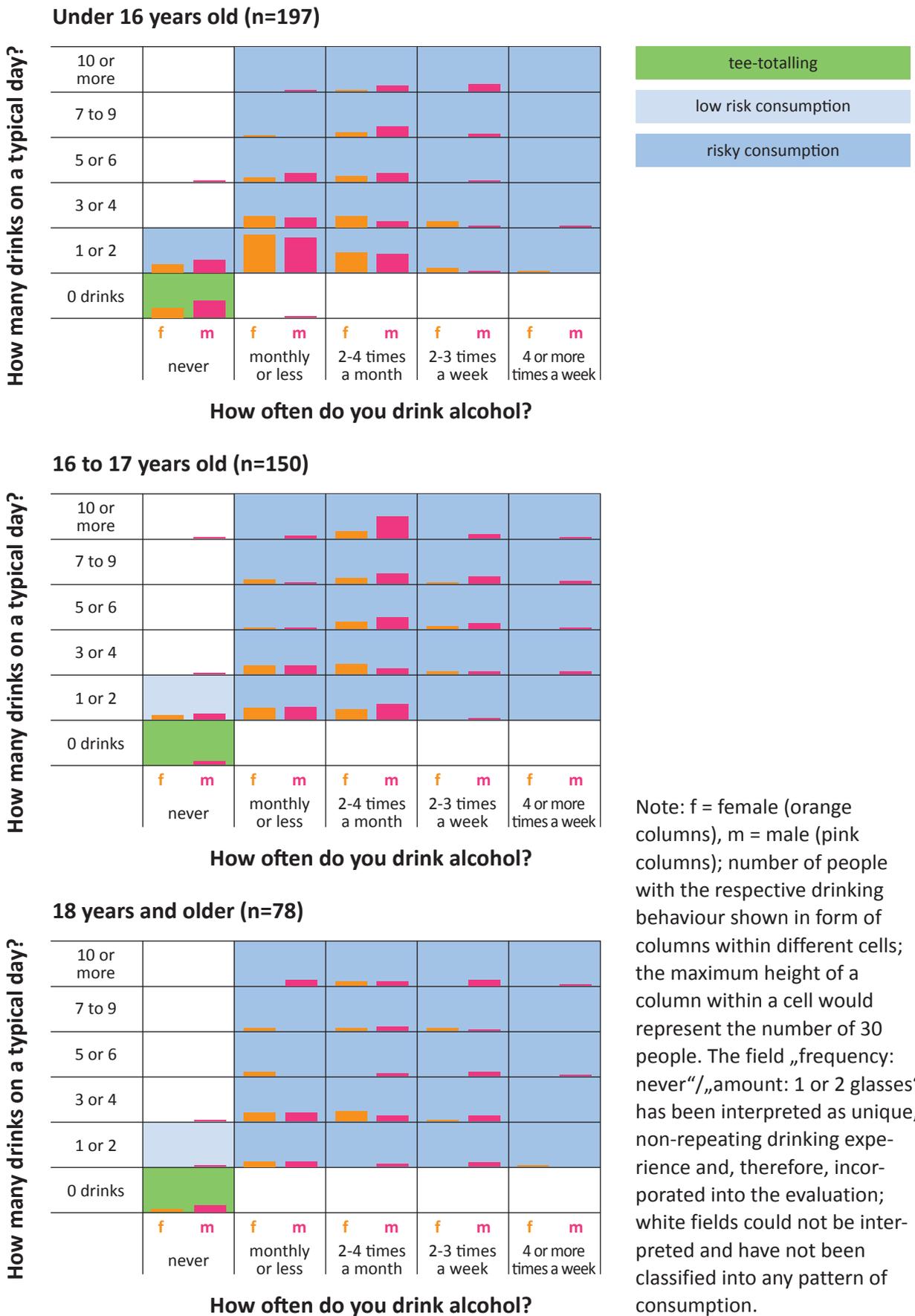
19 The percentages in the longitude test sample at T1 have almost been identical with the percentages of the total test sample. Therefore, the longitude test sample regarding alcohol consumption can be considered representative for the total test sample.

It should be critically noticed, regarding these self-reports, that incorrect answers may occur, with too low, but also, too high answers. Such bias can be explained by different factors. These may be no clear idea about the individual amount of drinking, as a joke or because of a personal background (such as religion), when the report on the consumption of alcohol is, even in an anonymous survey, put into the context of a strongly sanctioned infringement of rules.

When asked, the partners in the different countries reported that they have been or become aware during the training, that adolescents participated in the training, who drank none or little alcohol and who, therefore, did not belong to the original target group. Yet, the heads of those interventions decided to keep those adolescents in the training, because very often there has been a peer effect behind it: A friend of the adolescent brought her/him along.

Figure 3 shows the frequencies of different drinking behaviours at the beginning of the training in detail, for the three-age-groups and divided by gender. It becomes obvious, that young men for all countries report drinking more than young women: The areas of risky consumption are covered more by men (higher pink columns) than by women (few high orange columns). This image also supports the finding that the consumption among the participants of the training is higher in the older age-groups than in the under 16-year-olds: The participants, who are older than 16 years, spread out relatively even over all areas; the participants under 16 years have larger parts in the fields at the bottom left.

Figure 3. Self-reported frequency and amount of drinking on a typical day at the start of the training (T1): numbers of mention, for the total test sample, sorted by age-groups and sex.



The following Table 5 shows, how the participants have been spread over the three consumption groups in the different countries.

Table 5. Frequency of consumption-groups at the beginning of the training (T1), in each country.

Country	Tee-totalling	Low-risk	Risky
Belgium	2 (5%)	10 (27%)	25 (68%)
Cyprus	1 (3%)	5 (13%)	33 (85%)
Denmark	0 (0%)	2 (5%)	41 (95%)
Germany	5 (14%)	4 (11%)	28 (76%)
Greece	0 (0%)	2 (5%)	40 (95%)
Ireland	1 (2%)	6 (10%)	52 (88%)
Italy	13 (42%)	2 (7%)	16 (52%)
Portugal	2 (4%)	7 (14%)	40 (82%)
Slovakia	5 (12%)	0 (0%)	37 (88%)
Slovenia	0 /0%	19 (41%)	27 (59%)
Total	29 (7%)	57 (13%)	339 (80%)

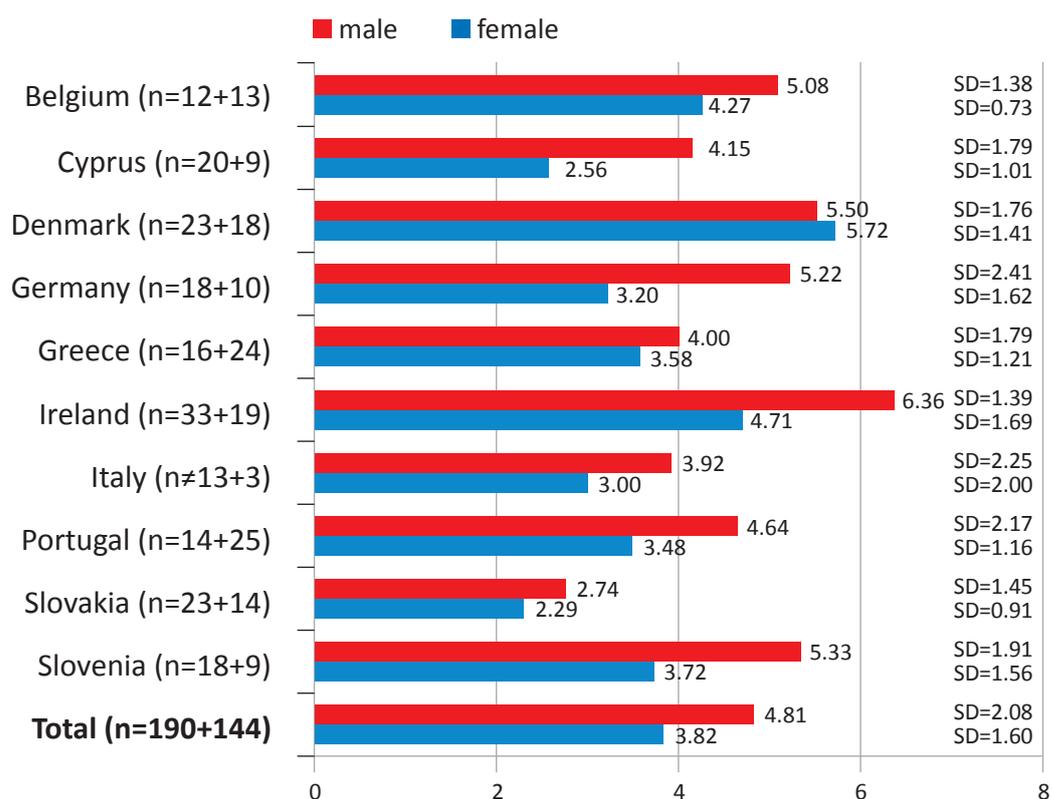
Note: bold = corrected residua in χ^2 - test over +2/under -2 as a hint for a significant deviance of certain countries from the overall percentage.

The countries differed regarding the share of the three consumption patterns at the beginning of the training significantly (total test sampleT1: χ^2 (18) = 127.811, $p < .001$): Denmark and Greece showed a very high percentage of adolescents, who consume riskily. In Italy and Slovenia, on the other hand, these consumption-groups have been represented comparatively little. Belgium and Slovenia showed a comparatively high percentage of adolescents with low-risk consumption, Italy, finally, stands out because of a comparatively high percentage of tee-totalling adolescents. Overall, the countries had a different success in getting adolescents, who consume riskily, for the ro.pe-Training®. Potential reasons are named in chapter 2.3.

Eventually, one last way of evaluation has to be introduced. This is about the so-called cumulative value of the drinking rate, which is calculated per person with the two items of drinking frequency and amount on a typical day (more specific information in the attachment, chapter 8.1.2). These cumulative values make it possible, to represent the drinking rate in only one figure, so that there is an easy way to measure the changes later.

In the following figure, country-specific figures are presented for the main target group, that is risky drinking youngsters, divided into young women and young men.

Figure 4. Cumulative values of the drinking behaviour of the risky consuming adolescents (n=334), at T1, sorted by country and sex.



Note: The first figure in brackets is the sample size of young men, followed by the sample size of young women.

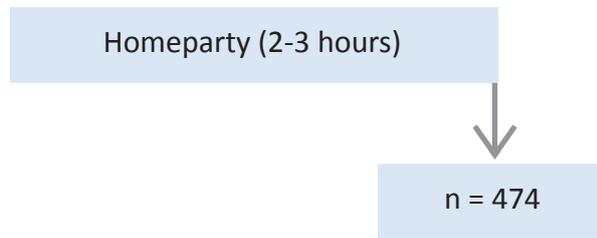
The average values and their standard variations in Figure 4 show a relatively wide variation of the drinking rate, which existed, at the beginning of the training, for the risky consuming adolescents and young adults when comparing the different countries, but also within the countries^{20,21}. The variance-analytical evaluation brought up a significant and strong main effect of the nationality ($F(9,313) = 7.199, p < .001$, partially $\eta^2 = .171$) as well as a significant and approximated medium main effect of the sex ($F(1,313) = 19.005, p < .001$, partial $\eta^2 = .057$): It has been Denmark and Ireland that stood out with their higher amounts of drinking of the participants in the training, who consumed riskily. The young men reported significantly more drinking than young women (also, within the different countries, with the exception of Denmark). The covariate of age, similarly, showed a significant effect of medium strength ($F(1,313) = 41.465, p < .001$, partial $\eta^2 = .117$): The cumulative value increased with the age, this means, older participants, at the beginning of the training, drank significantly more than the younger participants.

20 The values of the longitude sample at the beginning of the training is presented in the next chapter, which picks on the changes of behaviour between beginning of the training and re-interviewing. In seven out of ten countries the cumulative averages values remained similarly high as shown here, even if only the longitude sample is taken into consideration. Only in Germany and Greece, the cumulative values for the longitude sample at the beginning of the training have been slightly lower. This is, because the adolescents in these countries, who participated in the re-interviewing, showed statistically significantly low cumulative values, compared to their colleagues, who did not participate any more.

21 Additional remark: The figure of the cumulative values has to be looked at age-specific, for the classification of the consumption-groups. For instance, the participants from Slovenia on average report a comparatively high cumulative value; yet, these participants are 18-year-old or older to a large part; therefore the reported drinking behaviour for a significant part of young adults counts as low-risk.

4.2 Homeparties: Target Group Parents

Figure 5. Survey design and returns of the parents group.



The aspired quantitative target value for parents, which is 50 parents and other relatives per country or 500 parents in total, has been missed for all countries by 5 % with 474 people. The number of participants per country differed between 26 and 80 people (cf. Table 6). The average number of participants per Homeparty has been 8 people.

Table 6. Parents at Homeparties: Number of organised meetings and return of questionnaires, for each country.

Country	Number of Homeparties	Meetings	Return of questionnaires		
		on invitation of parents in private rooms	Usable sheets	Women	Men
Belgium	5	0	50	31	19
Cyprus	4	4	43	43	0
Denmark	5	3	50	36*	11*
Germany	8	5	80	63	17
Greece	7	5	52	46	6
Ireland	6	0	36	31*	4*
Italy	6	0	26	20	6
Portugal	5	0	33	28	5
Slovakia	6	2	50	36	14
Slovenia	7	5	54	39	15
Total	59	24	474	373*	97*

Note: *Missing information about gender: Denmark 3 persons, Ireland 1 person.

The average age of parents has been 44 years (SD = 6 years; Min = 21 years, Max = 72 years). 85% of the parents reported to live with a partner, 10% explicitly said that they do not live with a partner (both sex with similar percentages; 20 missing answers).

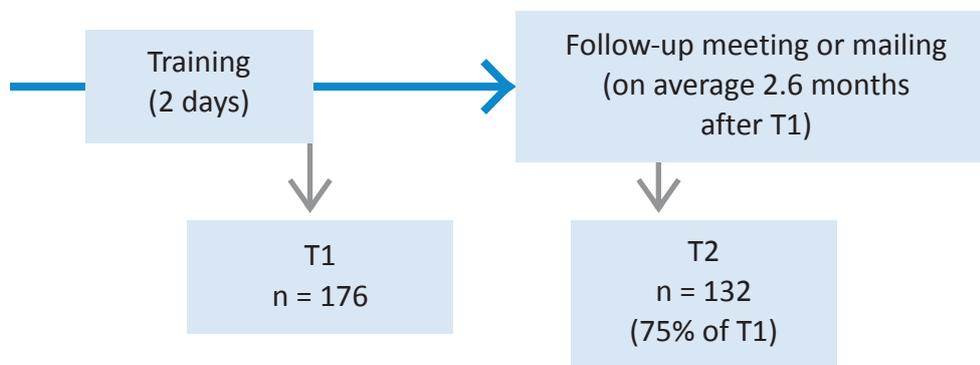
4.2.1 Ways of Access to Parents

According to the draft manual and the multilevel approach the target group ideally consisted of parents, whose children/adolescents had participated in the ro.pe-Training®. According to the feedback of half of the partners this group has a percentage of 27% in the pilot project.

Table 6 also shows the frequency, how often the intervention has been implemented in a way loyal to the manual, which means a meeting by invitation of parents in their private rooms. This has been successful with 24 meetings. In the other 35 meetings, at least one structural element has been not complied with, may it that the invitation did not come from the participating parents, but from the experts centre, may it that it was held in a public space (for example, classroom, premises of experts centre).

4.3 Key-Trainings: Target Group Key-Persons

Figure 6. Survey design and return numbers in the target group of key-persons.



The aspired number of 150 participants in total or 15 participants in each country has been exceeded with 176 persons for all countries by 17%. The number of participants in each country has been at least 14 people; sometimes these people took part in two courses of the key-training.

Table 7. Key-persons in key-training: number of organised courses and return of evaluation questionnaires for each country, at the end of the training (T1).

Country	Return of questionnaires			
	Number of courses	Usable sheets	Women	Men
Belgium	1	15	15	0
Cyprus	2	17	15	2
Denmark	1	16	5*	10*
Germany	2	30	26	4
Greece	2	16	9*	6*
Ireland	1	19	11	8
Italy	1	15	7*	7*
Portugal	2	19	17	2
Slovakia	1	15	9	6
Slovenia	1	14	14	0
Total	14	176	128*	45*

Note: *Missing information about sex: Denmark, Greece, Italy, 1 person each.

The average age of participants has been 37 years (SD = 11 years). There has been no difference in age between women and men.

A vast majority of participants learned about the key-training through a recommendation at their workplaces (cf. Table 8), whereas about one third of the participants (sometimes additionally) have become aware of it through other people in their environment. A minority learned about this offer from electronic media, such as Internet or Facebook, or from TV or newspapers.

Table 8. Key-persons: place of becoming aware of the key-training, in each country.

Country	Recommendation at the workplace	Recommendation of other people	Internet, Facebook, TV, etc.	Newspaper, magazine	Other
Belgium	12	3	0	1	0
Cyprus	15	1	0	0	0
Denmark	10	2	0	1	2
Germany	6	16	0	2	2
Greece	8	7	2	2	1
Ireland	18	0	0	1	0
Italy	5	8	0	2	4
Portugal	17	2	1	0	0
Slovakia	7	7	0	0	1
Slovenia	7	2	4	0	1
Total	105	48	7	9	11

Similarly, a majority of 75% (n=134) reported, that they have contacts with adolescents and young adults in their professional function. Much smaller is the percentage of 27% (n=48), who have to do with adolescents as volunteers.

The re-interviewing (T2) collected information about the experiences of the key-persons with applying the techniques that they had learned. The re-interviewing took place on average 2.6 months after the training (SD = 1.6 month, n =121). Table 9 shows the re-turn numbers, separately for each country.

Table 9. Key-persons in key-training: Return of questionnaires in the re-interview (T2), for each country.

Country	Usable Sheets	Return compared to T1	Woman	Men
Belgium	11	73%	11	0
Cyprus	6	35%	5	1
Denmark	13	81%	4	9
Germany	23	77%	19	4
Greece	16	100%	9*	6*
Ireland	12	63%	7	5
Italy	6	40%	2	4
Portugal	19	100%	17	2
Slovakia	13	87%	8	5
Slovenia	13	93%	13	0
Total	132	75%	95*	36*

Note: *Missing information about sex: 1 person from Greece.

The answers in the re-interview again confirmed the picture that the key-persons, trained in the pilot project, chiefly initiated to talk with young people about the consumption of alcohol in the professional environment (cf. Table 10): About two thirds of the interviewees stated that they have contacts with young people during their work, and usually more in form of individual talks, so that they could apply the techniques of Motivational Interviewing. About 20-25% reported having approached young people also out there, in the street, in a park or during leisure activities. These open, unplanned contacts are part of the concept of TAKE CARE, i.e. approaching adolescents and young adults in a non-institutional space and then, if possible, address the topic on consumption of alcohol.

Table 10. Experiences of key-persons out there: Where and how did you approach young people after the key-training? (n=132 for 100%).

Location of meeting	Frequency
Individually, at my workplace	87 (66%)
Outdoor, in small groups (2-4 people)	36 (27%)
Outdoor, in larger groups (> 4 people)	27 (20%)
Outdoor, individually (for example, in a park, in the street)	22 (17%)
At an event with many people (for example, party, disco)	21 (16%)

Note: Multiple answers have been possible.

Further analyses show (not explained in detail here), that more than half of the answering key-persons have been able to talk with up to five young people about their consumption of alcohol, between the key-training and the re-interviewing, 25% with up to 10 young people and another 25% with more than 10 young people. Overall, the dialogue has been more with young men than with young women. More than 75% of the key-persons reported of having approached adolescents, who had not yet reached the legal age for the consumption of alcohol; however, more than one third of the key-persons also talked to young people, who had already exceeded this age.

For about half of the key-persons, their young dialogue partners have only been noticed for a risky consumption of alcohol to a certain extent. For the other half of the key-persons, at least half or even more of the conversations have been triggered by a risky consumption of alcohol by the young people. About 75% of the key-persons have been successful in sparking some interest for the ro.pe-Training[®] with up to five young people; 25% even with more than five young people.

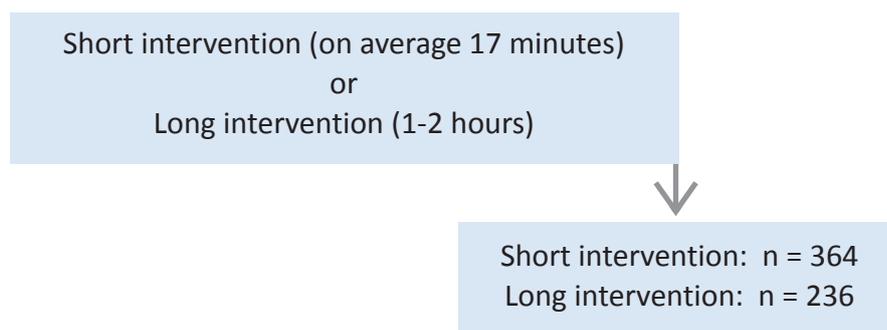
Unfortunately, the key-training has been conducted often only in the middle or towards the end of the practice period in the different countries, after some parts of the ro.pe-Trainings[®] had already taken place. Therefore, the key-persons could only be used to a certain extent for the recruitment of adolescents during the run-time of the project.

4.4 First-Rate Retailer Tools: Target Group Retailers

These interventions could be conducted as short interventions, right in the shops (small shops, kiosks, pubs, supermarkets, ...) or as a long intervention, as part of the continuous learning in form of a 2-hours-training. For those two interventions, two questionnaire-formats have been developed and used by the prevention experts differently:

- At the long intervention, the participants filled in the questionnaires as a self-report.
- At the short interventions, an abbreviated form of the questionnaire has been used. The expert asked those questions orally and wrote down the answers of the participants on the sheet.
- If due to the situation of the intervention, it has not been possible or reasonable to ask those questions, the prevention experts just filled in the form, where they described the locations, which they have been visiting (type of shop, content and duration of intervention).

Figure 7. Survey design and return numbers at the target group of retailers and employees in retail.



The aspired number of 500 participants all together or 50 participants in each country has been exceeded by 20 % with 364 people per short intervention and 236 people per long intervention. The countries varied in, whether they concentrated on long or short interventions or conducted both.

Table 11 shows the return of questionnaires, separately for each country and for both formats. This target group has been slightly more accessed with the short interventions than with the long interventions. The main difference between the countries has been, which type of interventions they used: Germany and Cyprus focused mainly, on organizing long interventions for groups. Belgium, Portugal and Slovakia organized long interventions and also approached the target groups with short interventions in their shops. Denmark, Greece, Ireland, Italy and Slovenia mainly approached the retailers and their sales staff with short interventions directly in their shops.

The average age of the female participants at the long interventions has been at 30 years (SD = 12 years), with the short interventions at 36 years (SD = 12 years). The average age of the male participants at the long interventions has been at 23 years (SD = 9 years), with short interventions at 33 years (SD = 12 years).

Long interventions have been usually held as part of continuous learning events in shops or as a school lesson in vocational schools. A major part of the repertoire of the manual could be implemented in these trainings. The participants of the long interventions have been majorly sales staff from larger shopping centres (in all countries: n = 131), or from pubs, night clubs or other restaurants (n = 81), but comparatively less employees in retail from small shops, such as kiosks or petrol stations (n = 20).

Table 11. Interventions for First-Rate Retailer Tools: number of organized trainings (in terms of long interventions) and return of evaluation questionnaires (long and short interventions), for each country.

Country	Number Long I.	Usable Evaluation Sheets		Women*		Men*	
		Long-I.	Short I.	Long-I.	Short I.	Long-I.	Short I.
Belgium	3	49	30	13*	11	35*	19
Cyprus	2	39	13	30	3	9	10
Denmark	0	0	51**	0	--**	0	--**
Germany	2	72	0	41*	0	30*	0
Greece	1	7	44	3	12	4	32
Ireland	0	0	51	0	25	0	26
Italy	1	4	57	2	30*	2	16*
Portugal	6	38	36	8	8	30	28
Slovakia	2	22	31	21	19	1	12
Slovenia	1	5	51	2	30*	3	20*
Total	18	236	364*	120	138*	114	164*

Note: Long I. = long intervention of 1 to 2 hours; Short I. = short intervention of 5 to 30 minutes; *in part missing information about sex; **Unfortunately lost in the mail, therefore also missing numbers for the sex.

Short interventions lasted on average 17 minutes (SD = 8 minutes, Min. = 7 minutes, Max. = 45 minutes). The sales staff in small shops has been more accessed with short interventions (n = 69), the same is true for pubs of different types (n = 149); the employees in retail of larger shopping centres could be accessed with short interventions to a certain extent (n = 56). At this, the TAKE CARE repertoire from the manual has been explain differently often, namely the especially created TAKE CARE material in 94% of the meetings (n=283), the information about the country-specific legislation regarding the consumption of alcohol in 85% of the meetings (n=257), and information about health risks of the consumption of alcohol in the young age and about consumption trends in 75% of the meetings (n = 226).

Potential options for handling difficult sales situations have been explained in 64% of the meetings (n = 192), but only with 8 persons (3%) explored and practiced in a role play. Finally, in 47% of the meetings (n = 143) alternative measures for avoiding difficult sales situations have been presented (changing the room layout, pricing, advertisement, etc.).

Employees and temporaries have been trained in short and long interventions relatively evenly (nshort = 185, nlong = 208). For owners and branch managers, there have been pre-dominantly short interventions (for all countries: nshort = 117, nlong = 17).

4.5 Evaluation of the Achievement of the Target Group

The heads of the interventions in the ten countries have been successful in reaching or even exceeding the aspired target figure for the pilot project in three out of four target groups. For the target group of parents the intended number was slightly below. After all, the quantitative goals have been majorly achieved, sometimes with major efforts.

Within certain target groups, there have been different criteria, which persons should be gained for the interventions. Next, there will be an intermediate upshot about these criteria:

4.5.1 Adolescents/Young Adults

According to the selective-preventive project approach, adolescents and young adults, who drink riskily, shall be gained for the ro.pe-Training[®]. The definition, which consumption of alcohol, regarding amount and frequency, in different age-groups of adolescence and young adulthood could be regarded as “risky”, has become more precise during the run-time of the project. At the end of the project it can be summed up that based on the provisional definition, it was successful in 80% of the cases, to gain for the training adolescents, who consume riskily. The statements on the consumption of alcohol have been taken from the self-reports of the adolescents.

Preliminary meetings can be helpful in getting a clearer picture of the initial situation of the adolescents.

According to the approach of the project, adolescents should be gained for the training via different institutional and non-institutional ways. Through the multilevel approach, which also trains parents and key-persons about handling the consumption of alcohol by adolescents, especially the non-institutional way of access should be improved. It became clearer that adolescents have been more and more attracted at meetings in their leisure-time, for example, at evening events, at a youth club or in the street, or by mouth-to-mouth propaganda of other adolescents. Still, overall in the pilot project the transfer through the school has been predominant.

The practice-based project aims to make responsible and let them play an active role in creating awareness about the consequences of the consumption of alcohol, not only institutions, such as schools and experts centres, but also volunteers and other key-persons, community based in the environment of young people. Consequently, the TAKE CARE project is committed to the approach of participation and empowerment. This may be unfamiliar and new, in some contexts. A clearer sequence planning of the project, especially an earlier use of the key-training, might help in making this attitude more popular and, that way, improving the retrieval via non-institutional ways of adolescents, who consume riskily.

4.5.2 Parents, Key-Persons and Retailers

For the Homeparties, according to the approach of the project, especially parents, whose children consume alcohol, should be gained, and here explicitly parents, whose children participated in the ro.pe-Trainings[®]. The goal of the key-training is to win over key-persons, who have contacts with adolescents in a non-institutional sphere, from the environment of consuming adolescents, who consume riskily. The points of retail, which have been trained by the First-Rate-Retailer-Tools, should be the very places, where adolescents, who consume riskily, come along. This orientation of the multilevel approach towards social environments makes it possible that after the training the adolescents return to an environment, which shares the message, namely a responsible handling of alcohol – which also means tee-totalling before the legal age –, but also an understanding of challenge and risk. The evaluation showed that, at least on the level of parents, these closer links within the social environment have been established piece by piece. There are only oral statements of the experts about the linkage: These persons and points of retail have been found out by explicit insisting at the adolescents, who then have been reached by the interventions.

The innovation of the TAKE CARE project is the multilevel approach. This shall result in an intensification of the attitudes and opinions that should be communicated by different ways and informations. This changed attitude should make it easier for the adolescents to regulate their consumption and, if necessary, reduce.

A careful and continuous analysis of the situation is the condition for a successful multi-level approach. This is in order to really find the relevant persons in the selected social environment. Asking the adolescents and networking with other local institutions, clubs, youth organisations and peer groups makes it much easier to find and motivate the key-persons, the parents and the employees in retail.

5 Results of the Evaluation

The main task of the evaluation has been to describe the effects of all tools in comparison to the initial point. In the following, this is explained for the complete group of all ten countries. The results are based on the statements of the participants of the interventions, immediately after the end of the interventions. However, for the target groups of the adolescents and key-persons, there has also been information about changes between the intervention and the re-interviewing. The results are organised according to the questions above. If not mentioned otherwise, the named average values are related to a four-level scheme for answers from 1 (do not agree at all) to 4 (agree completely).

5.1 Do the Adolescents reduce the Consumption of Alcohol as a Result of the ro.pe-Trainings[®]?

Whether the central goal of the project has been achieved, which is motivating riskily consuming adolescents for a reduction of their alcohol consumption, this will be analysed according to the self-reported drinking behaviour of the adolescents at the beginning of the training, compared with the drinking behaviour at the re-interviews.

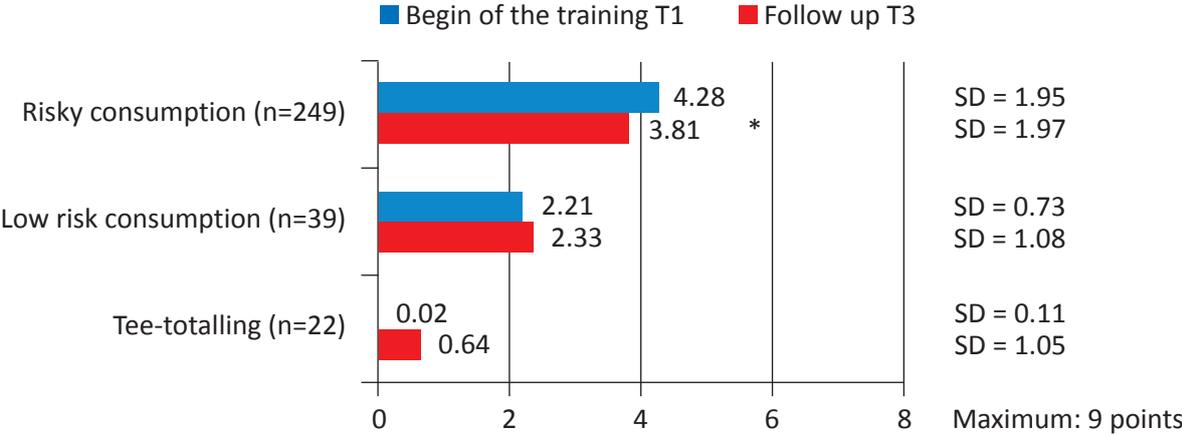
Comparison of the self-reported Drinking Behaviour at the Beginning of the Training and at the Re-interviews

In the re-interviews, which took place on average 2.6 months after the ro.pe-Training[®], 310 adolescents reported about their current consumption of alcohol. 249 of these adolescents (80%), at the start of the training, belonged to the group of adolescents, who consume riskily, as mentioned in chapter 4.1.

Next, it will be explained, which changes of the drinking behaviour of the adolescents have been detected at the time of the re-interview, compared with the time of the start of the training. This relies on the forms of presentation (consumption-groups, cumulative values), which have already been introduced.

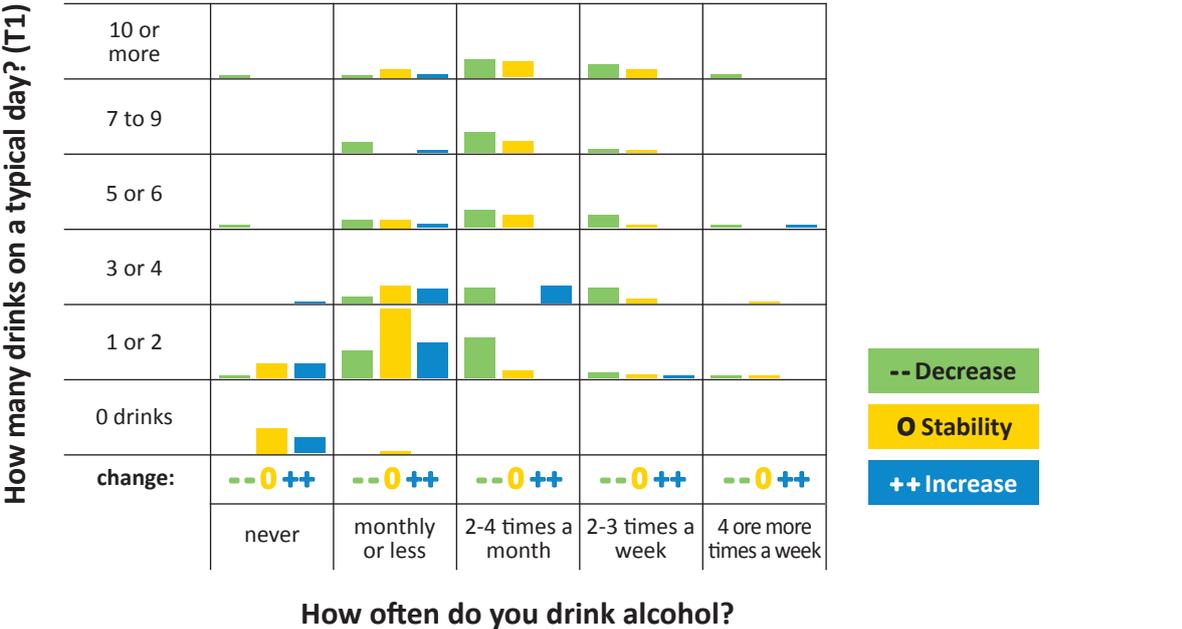
Figure 8 shows the averages changes in the drinking behaviour of the three consumption-groups. The average reduction of the consumption of alcohol by the adolescents, who consumed riskily at the beginning of the training, has been statistically relevant. The cumulative values in this group have been reduced significantly and relevantly between the start of the training and the re-interview ($F(1,248) = 21.352, p < .001, \eta^2 = .079$). The reduction concerns the frequency of drinking or the amount, or both. The average increase at the number adolescents, who reported that they have a low-risk consumption or alcohol at the beginning of the training or who were tee-totalling, has not been statistically relevant.

Figure 8. Consumption of alcohol of adolescents at the start of the training (T1) and in the re-interview (T3), calculated as cumulative value of drinking frequency and amount, separately for the three consumption-groups.



Note: * = p < 0.05.

Figure 9. Frequency of reduction (--, green columns), stability (0, yellow columns) or increase (++ , blue columns) in the cumulative value of self-reported drinking behaviour, sorted by drinking behaviour at the training start (T1), longitude sample (n=310).



Note: The hight of a column represents the number of persons with the respective status of changes; the maximum height of a column would represent the number of 34 people.

A difference value between the beginning of the training and the re-interviews has been calculated per adolescents, in addition to the cumulative value²²; with this difference value it can be determined in a differentiated way, how many adolescents reduced their drinking according to their self-reports, how many remained stable and how many adolescents showed an increased consumption (regarding amount and/or frequency of drinking). This analysis refines the analysis of the average value, as described above, regarding the statement, which adolescents reduced their drinking.

Figure 9 shows a differentiated picture regarding the original amount and frequency of drinking²³. Table 12 shows the frequency of the three potential directions of changes, separately for the three original consumption-groups.

Both images show that the reduction happened especially among the group of adolescents, who originally drank riskily and who, therefore, have been of especial interest as the core target group of the project. For this group, the ratio of reduction with 45% has been exceeding the increased with 22% by far. The 112 adolescents, who consumed riskily originally and have reduced their drinking behaviour, represent one third of the test sample during the re-interview. A supplementary analysis showed, 16 of these originally riskily consuming adolescents changed over to the zone of low-risk consumption; two of them even reported of tee-totalling in the re-interview. Yet, 94 of the adolescents, who consumed riskily originally and reduced their drinking, still remained in the risk zone with their new consumption patterns. The ratio of 34% of stable cases among this group of originally riskily drinking adolescents has also been remarkable.

Table 12. Stability or changes of drinking behaviour between T1 and T3, in dependence of the classification into a consumption-group at the start of the training, longitude sample (n=310).

Classification consumption-group at the start of the training			
	Risky consumption	Low risk consumption	Tee-totalling
Reduction of drinking (n=120, 39%)	112 (45%)	8 (21%)	0 (0%)
Stability of drinking (n=120, 39%)	84 (34%)	23 (59%)	13 (62%)
Increase of drinking (n=70, 23%)	54 (22%)	8 (21%)	8 (38%)
Total	250 (100%)	39 (100%)	21 (100%)

With adolescents, who originally reported of having a low-risk consumption of alcohol or who have been tee-totalling, there have even been increases. However, the extent of the increase of the consumption has been statistically not relevant, as Figure 8.

22 The exact calculation of this difference value is described in chapter 8.1.3.

23 Yet, these presentations do not reveal, to which extent there have been reductions or potential increases.

Facing the fact that, on average, amount and frequency of consumption of alcohol by adolescents increase with the age and analysed in a cross-cutting way (cf. results from the HBSC study 2009/2010 in Table 13²⁴), the reported reductions, as well as the stabilities, can be looked at positively in the sense of a non-increase.

Table 13. Increase of consumption of alcohol by adolescents, results from HBSC study 2009/2010.

	11-year-olds	13-year-olds	15-year-olds
Consumption of alcohol at least once a week	2%	8%	21%
At least two cases of strong drunkenness	2%	9%	32%

Could the changes in drinking for the adolescents, who consumed riskily originally, have been predicted by other characteristics of those adolescents? This shall be answered by additional analyses. It has been searched for other relevant variables with a linear regression, by taking into consideration different, independent variables step-by-step. Here, the difference value of the drinking behaviour has been selected as a dependent variable.

From this, the following, practically relevant effects and trends have been arising:

- The higher the cumulative value has been at the start of the training (i.e. the more the adolescent had been drinking at the start of the training), the bigger has been the reduction ($r = -.398$, corrected $r^2=15.5\%$, $F(1,247)=46.469$, $p < .001$). On the one hand, adolescents, who drank more, of course had a bigger “potential” of reduction; on the other hand, eventually, this actually happened according to their reports. Adolescents, who drank stronger, reduced their drinking more than those, who drank less (but still risky).
- Has there been any additional, seasonal increase in drinking or a seasonally lower reduction, because the re-interviews took place only in the summer or holiday season? About one third of the adolescents participated in the training between summer and September 2011; another third in October 2011 to March 2012, the last third between April and June 2012. Consequently, the re-interviews for the first cohort of adolescents took place between autumn 2011 and June/July 2012, some during the summer holiday season. The additional variable „date of filling in the re-interview forms“ resulted in an effect of low significance ($\Delta r^2=.014$, $\Delta F(1,244)=4.230$, $p < .05$) in a way, that later dates of the re-interview lead to higher increased and lower reductions ($\beta=.120$).

24 WHO European strategy for child and adolescent health and development. Copenhagen, WHO Regional Office for Europe, 2009/2010.

- Did variables of personality, attitudes or opinions make an additional difference? When integrating additional variables at different dates of survey (risk competence, self-efficacy and self-esteem²⁵ at T1, T2 and T3; attitudes towards the laws at T2; satisfaction with the training and self-evaluation of the improvement of competences in handling the consumption of alcohol at T2), only two of them explained an additional variance of the modification in drinking, even though with a low strength of this effect: The higher the self-esteem has been at the end of the training (T2), the stronger has been the reduction ($\Delta r^2=.023$, $\Delta F(1,222)=6.322$, $p < .05$, $\beta=-.128$), also, the stronger the willingness to comply with the laws has been at the end of the training, the stronger has been the re-duction ($\Delta r^2=.036$, $\Delta F(1,221)=10.419$, $p = .001$, $\beta=-.196$).

Conclusion: The self-reported consumption of alcohol has been reduced between the start of the training and the re-interview, especially with those adolescents, who drank riskily before. It can be assumed that the ro.pe-Training[®], at least at some cases, contributed to these aspired changes. The number of stable consumption patterns has been relatively high, especially with the low-risk or not at all consuming adolescents. This can be interpreted as a preventive effect of the interventions.

However, about 20% of the adolescents increased their consumption of alcohol. It would be to high an expectation on the project to prevent all increase of alcohol consumption. Since alcohol consumption rises with increasing age, an impact of the interventions could be that the increase in alcohol consumption of an individual youngster be lower than it would be without the intervention. The project is explicitly designed for risky drinking adolescents. Abstinent youngsters who have been integrated in the group could, as a side effect, be animated to drink alcohol.

5.2 Is the Compliance with the Laws on Alcohol encouraged?

The TAKE CARE project takes place in a public-political sphere. With its orientation, it supports efforts by the state to enforce the legislation of the consumption of alcohol. The conditions for a compliance of these laws are that the population is familiar with them, but also that people take an affirmative attitude towards those laws and feel obliged to them. Another aspect of how the compliance with the laws can be encouraged externally is the prohibition of the sales of alcohol to adolescents below the legal age, together with controls at the points of retail. The following parts of the evaluation focus, from the perspective of all target groups, on the knowledge regarding the legislation and on their attitudes in terms of a personal obligation and responsibility of compliance^{26,27}.

25 Wording of items see chapter 8.2.

26 Pay attention to the country-specific regulations, put together in chapter 4.1, Table 2.

27 Wording of items see chapter 8.2.

5.2.1 Is the Legislation on the Consumption of Alcohol known and is this Knowledge encouraged?

The question about the country-specific age-regulations regarding the consumption of alcohol has been asked to all target groups. Table 14 shows the number of correct or partially correct answers. Because of the interview at the end of the training, for the adolescents changes in knowledge could be analysed. The figures reveal that the correct and partially correct knowledge of the adolescents increased²⁸. With the parents, the key-persons and the employees in retail, who participated in a long intervention, at the end of the training, the percentage of people, who answered completely correct, has been at 86 to 90%. However, the employees in retail, who only participated in a short intervention, this percentage has been lower, with only 74% of completely correct answers, and basically on the same level as those of the adolescents at the start of the training.

Table 14. Knowledge of all target groups regarding the legislation on the consumption of alcohol.

		Known	Partly known*	Not known
Adolescents	T1	303 (74%)	66 (16%)	39 (10%)
	T2	328 (85%)	41 (11%)	18 (5%)
Parents		407 (88%)	45 (10%)	11 (2%)
Key-persons		153 (88%)	14 (8%)	6 (3%)
Employees in retail	Long-I.	213 (95%)	7 (3%)	5 (2%)
	Short-I.	223 (77%)	51 (18%)	14 (5%)

Note: *In countries, which have two different age-limits for low- and high-percentage alcohol, there had to be two answers.

Intermediate conclusion: The knowledge of the retailers about the country-specific legal age-limits was clearly increased by interventions, which lasted at least 1-2 hours, compared to shorter interventions; it then reached a high level of familiarity of about 90%.

For a sustainable transfer of knowledge, settings with time frames and conditions, which allow an undisturbed explanation and repetition, are suited much better.

28 Converted into a continuous measure of correct answers, a statistically relevant increase of knowledge could be detected (T1: M=0.83, SD=0.32, T2: M=0.90, SD=0.25, F(1,382)=26.718, p < .001, $\eta^2 = .065$), in a analysis of variances with repeated measurements.

5.2.2 Personal Attitude and Obligation towards the Law

These analyses can be confirmed by the answers before and after the training, for the adolescents. For the other target groups, the attitude has been assessed only once, namely at the end of the intervention.²⁹ Table 15 presents a descriptive statistic for all target groups.

The ro.pe-Training[®] has been able to change the attitude of the adolescents towards the law in the aspired way: Between the start and the end of the training, the consent with the laws regarding the consumption of alcohol by adolescents being adequate ($F(1, 406)=41.579$, $p < .001$, $\eta^2=.093$) increased significantly and relevantly, as well as the willingness to try to comply with those laws ($F(1, 395)=26.199$, $p < .001$, $\eta^2=.062$). After all, the interventions have been able to encourage a higher agreement and obliging attitude towards the law.

Nevertheless, the adolescents' approval of trying to comply with the law has been somewhat hesitant, even at the end of the training (pay attention to the spread of the answers, in addition to the standard deviation). Yet, this is not really surprising, taking into account the (partly illegal) consumption of alcohol by the adolescents.

With effect powers below .06, the differences between sexes, the consumption groups as well as the age, have been too small and too little relevant to be mentioned here. Or, to put it another way, which is of more interest here: Even adolescents with a risky consumption of alcohol at the start of the training changed from a hesitant approval regarding the appropriateness of the laws to a more convinced attitude and expressed a stronger will to comply with them, because of the training.

More interestingly, the hesitant approval regarding the appropriateness of the laws also showed for parents and retailers: The means at the end of the training, regarding the standard deviation, has been widely spread at the parents and the sales staff in long interventions, also in the direction of a disapproval; similarly, the approval of the employees in retail after a short intervention has not been very high.

29 Wording of items in the attachment, chapter 8.2.

Table 15. Evaluation of the appropriateness of the laws regarding the consumption of alcohol, as well as the willingness to comply with them, for all target groups.

		Laws are appropriate			Willingness to comply with them or support adolescents in doing so		
		M	SD	n	M	SD	n
Adolescents	T1	3.04	0.68	391	2.81	0.85	401
	T2	3.27	0.67	391	3.00	0.74	401
Parents		3.04	0.89	416	3.55	0.60	413
Key-persons		3.12	0.76	161	3.56*	0.42	173
Employees in retail	Long-I.	3.14	0.82	234	3.28	0.67	232
	Short-I.	85%		307	98%		307

Note: The format of answers has been in all target groups, but the sales staff in short interventions, from 1 to 4, cf. attachment chapter 8.2; for sales staff in short interventions it has been yes/no. Therefore the ratio of yes-answers is given here. *The wording for the key-persons also included the project goals of TAKE CARE and their role as key-persons.

The question for the key-persons has been slightly different. Namely, how much they agree with the project goal of TAKE CARE and the role of the key-person³⁰. The approval with the project goal has been high, for the key-persons at the end of the training and – not further explained here – also in the re-interviews. This means, the key-persons expressed a high engagement for the project, which continued after the training had ended.

Two additional questions relate to the dilemma of the shops, which sell alcohol. On the one hand there is the legislation on public health policies, which should be complied with under threat of punishment. On the other hand there is the shop's interest in optimal sales. The survey contained two questions for the participants of long interventions, whether they saw any advantage for the business to comply with the laws (M = 3.36, SD = 0.72) and whether they thought that the shops could build up a better reputation by participating in the TAKE CARE project (M = 3.15, SD = 0.79)³¹.

Both average values express a significant approval for all countries; however, there has been a remarkable spread, also in the direction of a hesitant attitude. For the participants of short interventions, who replied with yes or no to the same questions, there has been a clearer approval, with 84% yes, for the opinion that the shop will have an advantage when complying with the laws, an even more, with 96% yes for the opinion of an improved reputation, if the shop participates in the TAKE CARE project.

30 The wording here concerned the project goals, where adolescents below the legal age aspire tee-totalling, those above the legal age, aspire a responsible handling of alcohol and key-persons support this by a constructive communication.

31 Exact wording of items, see chapter 8.2.

Conclusion: For all target groups, it became obvious, that the attitude towards the laws regarding the consumption of alcohol, on average has been approving, but also, that there has been a remarkable ratio of sceptical voices.

Whether the sceptics among the parents, the key-persons and the employees in retail would prefer a less strict or a stricter legislation, remains unclear.

The finding in the target group of the parents and the retailers that they are paying attention to the enforcement of the laws at the adolescents, has been quite distinct. For the adolescents, the personal attitude to try to comply with the law has been improved. Similarly, the key-persons agreed with the related project goals of TAKE CARE.

Overall, it can be said that there is an attitude, which is characterised by responsibility and commitment, especially at the target groups of parents, key-person and sales staff. This attitude has been improved by the interventions, as the increase among the adolescents shows.

5.3 Has the Knowledge about the Effects and Risks of Alcohol been improved?

According to public-health psychological concepts, such as the trans-theoretical model³² the knowledge about a matter (risk, processes, mechanisms, ...) is a necessary and beneficial condition for a change of behaviour. Only this knowledge really enables people to make up their mind about their behaviour. Also, they receive arguments that motivate them during the process of a change of behaviour. Therefore, in the psycho-educative part of all TAKE CARE interventions, there is a knowledge transfer on the consumption of alcohol at the young age.

The questionnaires for adolescents and parents contained six factual questions³³. Table 16 lists the average numbers of correct answers, for adolescents at the beginning and at the end of the training, for parents only at the end.

A significant and relevant growth of knowledge between the beginning and the end of the training could be shown for the adolescents ($F(1, 395)=24.963$, $p < .001$, $\eta^2 = .059$). The parents, on average, answered about five questions correctly.

32 Cf. Naidoo, J., & Wills, J. (2010), *Lehrbuch der Gesundheitsförderung* (2. Ed. Of the German version): Amberg: Frischmann, pp. 227.

33 Wording of items at chapter 8.2.

Table 16. Knowledge about effects and risks of alcohol, for adolescents and parents.

		M	SD	n
Adolescents	T1	4.43	1.05	390
	T2	4.69	0.90	390
Parents		4.92	0.76	402

Note: 1 point for each correct answer, max. 6 points.

Conclusion: Changes of behaviour can be influenced by a growth of knowledge. The increase, which can be observed at the adolescents throughout the training, and the satisfying knowledge of the parents at the end of the training, allows to assume that this important public-health-psychological aspect in the interventions has been paid enough attention to. The knowledge regarding the effects and risks of the consumption of alcohol is improved.

5.4 Is the Competence of the Adolescents in Handling difficult Situations improved, especially when Dealing with a risky Consumption of Alcohol?

The TAKE CARE relies on an idea of men, which recognised the experience of risks and the passion for challenges as a need of people, which can also mean fun. Consequently, the project is structured in a way, which offers the adolescents, who consume alcohol, alternative experiences, which have the character of challenges and risks without danger, so that this can be an example of how to handle risky situations. The goal is, that the participants of the interventions transfer the experiences and insights of the adventure-based part of the training to the situation of consuming alcohol, so that these experiences and insights may guide their behaviour.

Several questions in the evaluation sheets for adolescents address the handling of risky situations, especially situations with (risky) consumption of alcohol.

Koller (2007) has developed an approach which allows young people risk experiences and ecstatic experiences to live in a positive and constructive way³⁴. With four questions for each person a value in the scale of general risk competence has been calculated and investigated from the start of the training (T1) via the end (T2) to the re-interviews (T3).

34 Koller, Gerald (2007). Erkenntnisse und Konsequenzen für die Praxis. In: Einwanger, Jürgen (Hrsg.) (2007). Mut zum Risiko. Herausforderungen für die Arbeit mit Jugendlichen. München.

35 Wording of items in chapter 8.2.

The evaluation showed that the general risk competence has been increased significantly and relevantly, as a consequence of the training (T1: $M = 3.03$, $SD = 0.59$, T2: $M = 3.29$, $SD = 0.56$); also, it remains on a level at T3 ($M = 3.22$, $SD = 0.57$), which is still higher than the original one at T1 ($F(1, 305)=31.038$, $p < .001$, $\eta^2 = .092$).

Secondly, at the end of the training, there have been three questions, and in the re-interview one, on a further self-assessment concerning the increase of competences in dealing with a (risky) consumption of alcohol³⁶. The three addressed levels of becoming aware of the drinking behaviour, the increase of knowledge about and strategies for handling the consumption of alcohol are important elements of a responsible and successful dealing with alcohol and a more responsible attitude towards risky situations of drinking. At the end of the training, the adolescents agreed that their competences have been strengthened – even if, as the average value in addition to the spread reveals, more hesitant ($M = 3.18$, $SD = 0.70$). This – on average – positive assessment stays in the re-interview – with a hesitant share –, so that adolescents were able to deal better with a risky consumption of alcohol after the training ($M = 3.27$, $SD = 0.85$).

The goal of the project, namely to increase the risk competences, has been influenced positively, regarding generally risky situations (for example, climbing), but also regarding the individual consumption of alcohol. Still, some adolescents voiced some scepticism regarding the handling of alcohol.

5.5 Are Parents, Key-Persons and the Employees in Retail empowered in an effective Handling of a risky Consumption of Alcohol by Adolescents?

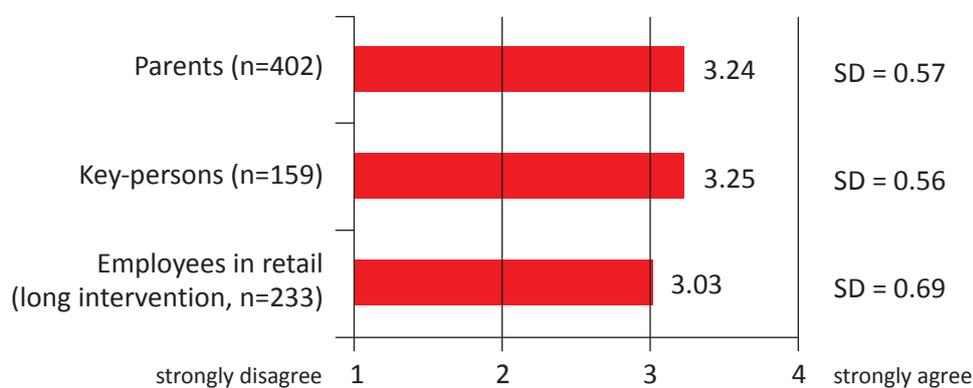
The goal of TAKE CARE is, to train the competences in handling of consumption of alcohol at people from the environment of the adolescents. In addition to knowledge about effects and risks of the consumption of alcohol at the young age, parents, key-persons and the employees in retail have been supported in developing an attitude that enables them to motivate adolescents for a less risky consumption of alcohol, in constructive and respectful talks and in awareness of the need for risks and challenges. This is expressed by the term of „effective handling“ with the alcohol consuming adolescents (for instance, in situations during education for parents, in sales situations for sales staff, and in contacts with adolescents, who consume riskily, at the job or during voluntary work).

36 Wording of items in chapter 8.2.

In order to find out, whether parents, key-persons and employees in retail feel supported in running talks with their children and young people regarding the consumption of alcohol, several questions have been asked and the answers converted into a scale value³⁷. It was about reporting, whether the knowledge about the consumption of alcohol has been increased and the strategies regarding the communication with adolescents, who consume alcohol, has been improved; similar to the previous chapter for the adolescents.

The evaluation in Figure 10 shows that the parents and key-persons predominantly agree with the sentence that the interventions helped them to feel more up to the situation. The approval of employees in retail in long interventions is less significant.

Figure 10. Evaluation of the target groups regarding the gain of strategies and options for an effective handling of the consumption of alcohol by adolescents.



The employees in retail commented on another element of the interventions, namely the material, which has been drafted for the interventions and which contains information about the legislation and strategies for handling difficult situations. The participants had to assess to which extent this material has been helpful in getting along better at work, especially in difficult situations.³⁸ Whereas the participants of the long interventions consider it, sometimes hesitant, useful, with an average value of 3.09 and a relatively wide spreading (SD = 0.76), the materials have been received relatively positive in the short interventions, with a percentage of 90%.

Parents, key-persons and employees in retail felt empowered by the interventions to handle alcohol-related difficult situations with adolescents more effectively, with knowledge and improved strategies. This opinion has been less dominant with the employees in retail than with the other two target groups.

³⁷ Wording of item in chapter 8.2.

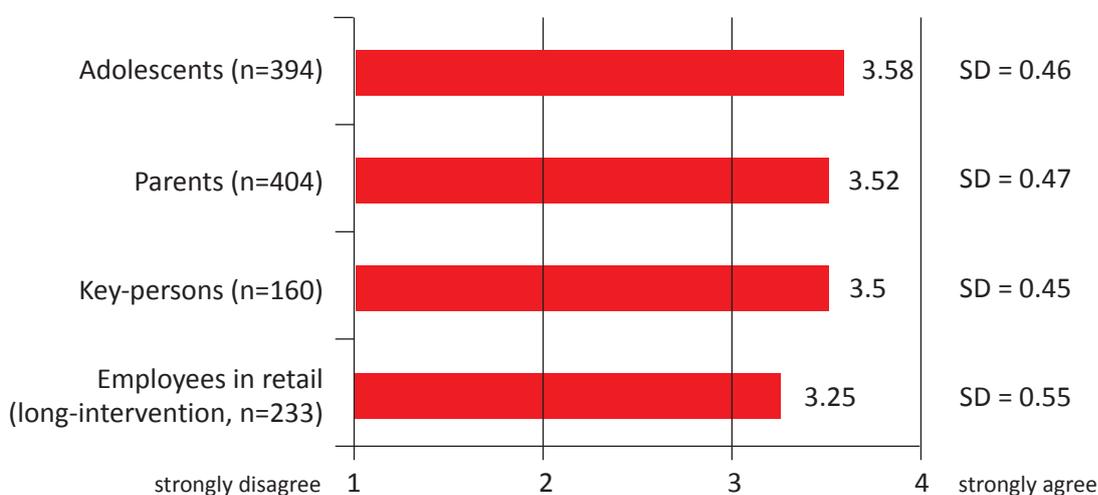
³⁸ Wording of item in chapter 8.2.

5.6 How satisfied are the Participants with the Interventions?

Right after the interventions, adolescents, parents, key-persons and employees or managers in retail gave a general feedback on the interventions. The questions of interest here are about the general assessment, how much the participants profited from the interventions and trusted in the organisation team and the present experts, and how much they would recommend the interventions to friends, colleagues or other volunteers in youth-work. With these answers another scale value was calculated³⁹.

The approval of all target groups, with a relatively narrow spreading, has been quite obvious, as Figure 11 shows.

Figure 12. Evaluation regarding the general satisfaction with the interventions, for all target groups at the end of the training.



There are a number of other hints, which underpin the high satisfaction with the trainings:

The high return rate in the re-interviews of the adolescents and key-persons indicates a high cohesion with the project (73% return at the adolescents and 75 % return at the key-persons).

250 adolescents (77%) also reported in the re-interview that the ro.pe-Training[®] has been a topic among their friends. Because of the high satisfaction, it can be assumed that the training has been a topic with positive connotations.

The key-persons, who had contacts with participants after the ro.pe-Training[®] clearly agreed with the statement, that the adolescents have been talking positively about the ro.pe-Trainings[®] (M = 3.36, SD = 0.55).

39 Wording of items in chapter 8.2.

The high return rate in the follow-up survey indicates that the adolescents and key-persons were highly connected with the project (73% returns from adolescents, 75% returns from key-persons). The general satisfaction with the interventions can be described as very high with all target groups.

6 Country-specific Results

In this chapter, the country-specific descriptive statistics for the questions discussed in chapter 5 are explained and partly tested for significant differences with an analysis of variances. If not mentioned otherwise, the average values again relate to a format of answers with four levels, from 1 (do not agree at all) to 4 (agree completely).

The description of the relevant differences will be kept quite schematic and brief: The tables list the descriptive characteristic values; the explanation of the tables give the characteristic values for potential effects are given. The countries, which have been noticed in the posthoc-tests for especially high of low values, are marked bold in the tables. Usually, these differences are not commented any further.

For the target group of the key-persons, and for specific forms of interventions for the employees in retail (long versus short interventions), in each country only a few numbers of participants have been recruited. These country-specific values are presented. However, it would not be acceptable to run an inference-statistical analysis on these differences between these small groups of countries.

Consequently, the presentation illustrates the variations between the different countries for single questions. Yet, possible statistically relevant differences between different countries are hard to interpret: As shown in chapter 2.3, in spite of the common base of the manual and the trainings of the experts, there have been differences in implementing the project. Because of the limited financial resources for the evaluation, these differences can only be analysed and categorised systematically to a certain extent. If there have been differences between the countries, as reported in this chapter, it has not been possible to put them into context with some of the few systematically recorded differences of the implementation in the countries and, through this, find a clear base for an interpretation. On the contrary, these statements must remain hypothetically, which is why apart from the presentation of the significant differences there will be now interpretations, in the following.

6.1 Is there any Reduction of the Consumption of Alcohol by the Adolescents as a Consequence of the ro.pe-Trainings©?

Table 17. Descriptive statistics on the cumulative values of the drinking behaviour (frequency and amount of drinking) of the adolescents, who have originally been drinking riskily, at the start of the training (T1) and at the re-interview (T3), sorted by countries.

Country	n	Start of the training (T1)		Re-interview (T3)	
		M	SD	M	SD
Belgium	16	4.91	1.13	3.94	1.12
Cyprus	6	2.67	1.21	3.33	1.03
Denmark	36	5.53	1.59	5.69	1.45
Germany	15	4.00	2.62	3.73	2.22
Greece	36	3.47	1.23	2.58	1.16
Ireland	40	5.76	1.71	5.23	1.66
Italy	11	3.27	1.74	4.18	3.34
Portugal	31	3.77	1.65	3.00	1.37
Slovakia	36	2.61	1.27	2.50	1.40
Slovenia	22	4.98	1.87	3.34	1.58
Total	249	4.28	1.95	3.81	1.97

Note: interaction for time of measurement *country: $F(9,228) = 3.282$, $p = .001$, partial $\eta^2 = .115$; bold = relevant differences between the means within that country (this is, no crossing of the confidence intervals).

Whereas the adolescents from Greece, Portugal and Slovenia report a relevant reduction of the consumption of alcohol, in the other countries, either the variability of the individual progress has been bigger or the sample in those countries has been too small, so that the reported reductions have not been relevant statistically. Also, the recorded increases in three countries have either been too little (Denmark) or based on too small samples (Cyprus and Italy), so that statistically they are not relevant.

Table 18. Frequency of stabilities and changes of drinking behaviour, for each country.

Country	-- Reduction amount and frequency of drinking	- Reduction amount and/ or frequency of drinking	0 Stability	+ Increase amount and/or frequency	++ Increase amount and frequency
Belgium	4	8	9	1	1
Cyprus	0	0	2	4	0
Denmark	2	3	23	6	3
Germany	1	4	12	3	3
Greece	6	18	11	2	1
Ireland	6	14	9	13	2
Italy	1	4	12	4	3
Portugal	4	17	10	5	
Slovakia	0	14	15	9	2
Slovenia	7	8	16	5	3
Total	31	90	119	52	18

Note: Because of the small samples in the sub-categories, there has not been any inference-statistic analysis.

6.2 Is the Compliance with the Legislation of Alcohol supported?

6.2.1 Is the Legislation regarding the Consumption of Alcohol known and is this Knowledge improved?

Table 19. Knowledge of the adolescents regarding the legislation on the consumption of alcohol, at the start of the training (T1) and at the end (T2), sorted by countries.

Country	Start of the training (T1)			End of the training (T2)		
	Known	Partly known*	Not known	Known	Partly known*	Not known
Belgium	34 (90%)	4 (11%)	-	37 (97%)	1 (3%)	-
Cyprus	13 (36%)	-	23 (64%)	27 (79%)	-	7 (21%)
Denmark	24 (60%)	9 (25%)	7 (18%)	23 (72%)	2 (6%)	7 (22%)
Germany	32 (82%)	4 (10%)	3 (8%)	35 (90%)	3 (8%)	1 (3%)
Greece	43 (100%)	-	-	43 (100%)	-	-
Ireland	52 (100%)	-	-	46 (98%)	-	1 (2%)
Italy	6 (16%)	27 (73%)	4 (11%)	10 (29%)	22 (65%)	2 (6%)
Portugal	22 (54%)	17 (42%)	2 (5%)	32 (78%)	9 (22%)	-
Slovakia	37 (88%)	5 (12%)	-	38 (91%)	4 (10%)	-
Slovenia	40 (100%)	-	-	37 (100%)	-	-
Total	303 (74%)	66 (16%)	39 (10%)	328 (85%)	41 (11%)	18 (5%)

Note: *In countries, which had two different age limits for low- and high percentage alcohol, there had to be two answers. Interaction for time or measurement *country: $F(9,358)=10.283$, $p < .001$, partial $\eta^2 = .205$; bold = relevant differences among the average values within in one country (this means no overlapping of the confidence intervals).

Table 20. Knowledge of parents and key-persons regarding the legislation on consumption alcohol, sorted by country.

Country	Parents			Key-persons		
	Known	Partly known*	Not known	Known	Partly known*	Not known
Belgium	49 (98%)	1 (2%)	-	14 (100%)	-	-
Cyprus	35 (85%)	-	6 (15%)	13 (81%)	-	3 (19%)
Denmark	36 (74%)	12 (24%)	1 (2%)	9 (60%)	6 (40%)	-
Germany	62 (78%)	18 (22%)	-	23 (77%)	4 (13%)	3 (10%)
Greece	50 (98%)	-	1 (2%)	16 (100%)	-	-
Ireland	34 (94%)	-	2 (6%)	19 (100%)	-	-
Italy	23 (92%)	1 (4%)	1 (4%)	11 (73%)	4 (27%)	-
Portugal	18 (67%)	9 (33%)	-	19 (100%)	-	-
Slovakia	47 (94%)	3 (6%)	-	15 (100%)	-	-
Slovenia	53 (98%)	1 (2%)	-	14 (100%)	-	-
Total	407 (88%)	45 (10%)	11 (2%)	153 (88%)	14 (8%)	6 (3%)

Note: *In countries, which had two different age limits for low- and high percentage alcohol, there had to be two answers. Effect of the nationality at the parents: $F(9,390)=3.525$, $p < .001$, partial $\eta^2 = .075$); bold = statistically significantly high figures, in comparison of all countries. Key-persons: Because of sometimes too small samples, there has been no inference-statistical analysis in the sub-categories.

Table 21. Knowledge of the employees regarding the legislation on the consumption of alcohol, sorted by countries.

Country	Long interventionen			Short interventionen		
	Known	partly known*	Not known	Known	partly known*	Not known
Belgium	48 (98%)	1 (2%)	-	25 (86%)	3 (10%)	1 (4%)
Cyprus	28 (90%)	-	3 (10%)	4 (36%)	-	7 (64%)
Denmark	-	-	-	-	-	-
Germany	67 (96%)	3 (4%)	-	-	-	-
Greece	6 (100%)	-	-	44 (100%)	-	-
Ireland	-	-	-	51 (100%)	-	-
Italy	3 (75%)	1 (25%)	-	13 (28%)	31 (68%)	2 (4%)
Portugal	34 (90%)	2 (5%)	2 (5%)	15 (42%)	17 (47%)	4 (11%)
Slovakia	22 (100%)	-	-	31 (100%)	-	-
Slovenia	5 (100%)	-	-	40 (100%)	-	-
Total	213 (95%)	7 (3%)	5 (2%)	223 (77%)	51 (18%)	14 (5%)

Note: *In countries, which had two different age limits for low- and high percentage alcohol, there had to be two answers. Because of sometimes too small samples, there has been no inference-statistical analysis concerning the differences between the countries.

6.2.2 Personal Attitudes and Obligation towards the Law

Table 22. Evaluation of the adolescents regarding the appropriateness of the laws on the consumption of alcohol, for T1 und T2, sorted by countries.

Country	n	T1		T2	
		M	SD	M	SD
Belgium	38	3.24	0.43	3.45	0.55
Cyprus	34	3.09	0.67	3.35	0.85
Denmark	40	3.05	0.56	3.13	0.52
Germany	38	2.84	0.89	3.13	0.74
Greece	43	3.28	0.45	3.56	0.59
Ireland	53	2.91	0.69	3.19	0.59
Italy	32	2.56	0.96	2.88	0.90
Portugal	41	3.27	0.59	3.46	0.55
Slovakia	42	3.02	0.64	3.17	0.62
Slovenia	40	3.10	0.63	3.30	0.56
Total	401	3.04	0.68	3.27	0.67

Note: Effect of the nationality: $F(9,380)=3.201$, $p < .001$, $\eta^2 = .070$; bold = statistically significantly high figures, in comparison of all countries.

Table 23. Willingness of the adolescents to try to comply with the law, for T1 and T2, sorted by countries.

Country	n	T1		T2	
		M	SD	M	SD
Belgium	38	2.84	0.86	3.13	0.78
Cyprus	30	2.93	0.91	3.12	0.85
Denmark	40	2.70	0.94	2.80	0.82
Germany	38	2.50	0.98	2.68	1.02
Greece	42	2.95	0.66	3.12	0.50
Ireland	52	2.56	0.85	2.87	0.63
Italy	30	2.88	0.78	2.97	0.80
Portugal	41	3.02	0.79	3.34	0.57
Slovakia	42	2.93	0.87	2.98	0.56
Slovenia	38	2.86	0.74	3.07	0.70
Total	391	2.81	0.85	3.00	0.74

Note: Effect of nationality: $F(9,370)=2.414$, $p < .05$, $\eta^2 = .055$; bold = statistically significantly high figures, in comparison of all countries.

Table 24. Evaluation of the parents on the appropriateness of the laws on the consumption of alcohol and the willingness to make the own children to comply with them.

Country	Laws are appropriate			Willingness to make the children to comply with the laws		
	M	SD	n	M	SD	n
Belgium	3.73	0.51	40	3.54	0.51	39
Cyprus	2.91	1.01	44	3.48	0.66	44
Denmark	2.51	0.73	45	3.18	0.81	44
Germany	3.15	0.73	72	3.76	0.43	72
Greece	3.19	0.73	48	3.47	0.65	49
Ireland	2.97	0.93	30	3.46	0.58	28
Italy	2.00	1.07	22	3.73	0.70	22
Portugal	2.78	0.89	27	3.44	0.51	27
Slovakia	2.95	0.85	40	3.51	0.51	39
Slovenia	3.52	0.62	48	3.80	0.41	49
Total	3.04	0.89	416	3.55	0.60	413

Note: Effect of the nationality for the appropriateness of the laws: $F(9,396)=7.373$, $p < .001$, $\eta^2 = .144$; effect of the nationality for the willingness to champion the compliance with the laws: $F(9,393)=3.827$, $p < .001$, $\eta^2 = .081$. Bold = statistically relevant high or low figures, in comparison of all countries.

Table 25. Evaluation of the key-persons regarding the appropriateness of the laws on the consumption of alcohol, as well as on the appropriateness of the project goals of TAKE CARE and the roles of the key-persons, at the end of the training (T1), sorted by countries.

Country	Laws are appropriate			Project goals of TAKE CARE and roles of the key-persons make sense		
	M	SD	n	M	SD	n
Belgium	3.64	0.50	14	3.49	0.40	15
Cyprus	3.29	0.47	17	3.78	0.29	17
Denmark	2.73	0.70	15	3.49	0.53	15
Germany	3.07	0.69	30	3.46	0.39	30
Greece	3.40	0.63	15	3.69	0.37	15
Ireland	3.21	0.63	19	3.38	0.46	19
Italy	2.93	0.47	14	3.29	0.41	14
Portugal	2.00	0.59	18	3.44	0.39	19
Slovakia	3.80	0.45	5	3.82	0.28	15
Slovenia	3.93	0.27	14	3.93	0.19	14
Total	3.12	0.76	161	3.56	0.42	173

Note: Because of too small samples, there has been no inference-statistical analysis for the country-effect.

Table 26. Evaluation of the employees in retail (long interventions) regarding the appropriateness of the laws on the consumption alcohol, as well as the willingness to comply with the law, sorted by countries.

Country	Laws are appropriate			Willingness to comply with the law		
	M	SD	n	M	SD	n
Belgium	3.23	0.63	48	2.79	0.72	47
Cyprus	3.36	1.04	39	3.59	0.50	39
Denmark	--	--	--	--	--	--
Germany	2.97	0.79	71	3.53	0.61	70
Greece	3.14	0.38	7	3.57	0.53	7
Ireland	--	--	--	--	--	--
Italy	1.50	0.58	4	4.00	0.00	4
Portugal	3.11	0.83	38	3.08	0.49	38
Slovakia	3.32	0.65	22	3.09	0.68	22
Slovenia	3.60	0.55	5	3.60	0.55	5
Total	3.14	0.82	234	3.28	0.67	232

Note: Because of sometimes too small samples, there has been no inference-statistical analysis concerning differences between the countries.

Table 27. Evaluation of the employees in retail (long interventions) about advantages for the business, if the law is complied with and the TAKE CARE project is supported, sorted by countries.

Country	Advantages for the business, if the laws are complied with			Better reputation, if TAKE CARE is supported		
	M	SD	n	M	SD	n
Belgium	3.15	0.75	3.15	2.91	0.63	45
Cyprus	3.58	0.76	3.58	3.79	0.41	38
Denmark	--	--	--	--	--	--
Germany	3.55	0.61	65	2.99	0.94	67
Greece	3.14	0.69	7	3.29	0.49	7
Ireland	--	--	--	--	--	--
Italy	4.00	0.00	4	3.00	0.82	4
Portugal	3.42	0.72	38	3.19	0.70	37
Slovakia	2.95	0.38	22	3.05	0.49	22
Slovenia	2.20	0.45	5	2.60	1.52	5
Total	3.36	0.72	226	3.15	0.79	225

Note: Because of sometimes too small samples, there has been no inference-statistical analysis concerning differences between the countries.

Table 28. Various personal and business-related evaluations of the employees in retail (short interventions) regarding the laws on the consumption of alcohol, percentage of yes-answers, sorted by countries.

Country	Laws are appropriate	Willingness to comply with the laws	Advantages for the business, if laws are complied with	Better reputation for business, if TAKE CARE is supported
Belgium (n=29)	97%	100%	90%	86%
Cyprus (n=13)	69%	77%	62%	100%
Denmark (n=1)	100%	100%	100%	100%
Germany	--	--	--	--
Greece (n=35-44)	89%	100%	68%	97%
Ireland (n=50-51)	100%	100%	98%	100%
Italy (n=44-46)	54%	100%	83%	98%
Portugal (n=36)	78%	97%	94%	97%
Slovakia (n=28-31)	84%	90%	82%	86%
Slovenia (n=49-51)	100%	100%	80%	96%
Total	85%	98%	84%	96%

Note: Because of sometimes too small samples, there has been no inference-statistical analysis concerning differences between the countries.

6.3 Is the Knowledge about the Effects and Risks of Alcohol improved?

Table 29. Knowledge of adolescents about the effects and risks of alcohol, at T1 and T2, sorted by countries.

Country	n	T1		T2	
		M	SD	M	SD
Belgium	36	4.67	1.12	4.94	0.79
Cyprus	32	4.44	1.24	5.13	0.75
Denmark	40	4.08	1.02	4.43	0.75
Germany	36	4.14	0.72	4.17	0.94
Greece	42	4.43	1.04	4.79	0.87
Ireland	52	4.71	1.00	4.58	0.89
Italy	31	4.06	1.03	4.42	1.03
Portugal	41	4.61	1.07	4.95	0.63
Slovakia	42	4.45	0.89	4.67	0.95
Slovenia	38	4.53	1.18	4.84	1.05
Total	390	4.43	1.05	4.69	0.90

Note: 1 point for each correct answer, max. 6 points. Interaction country *time of measurement: $F(9, 369)=2.389$, $p < .05$, $\eta^2 = .055$; bold = relevant differences between the means within that country (this is, no overlapping of the confidence intervals).

Table 30. Knowledge of parents on the effects and risks of alcohol, sorted by countries.

Country	M	SD	n
Belgium	5.13	0.76	40
Cyprus	5.08	0.86	40
Denmark	4.68	1.01	44
Germany	5.01	0.40	71
Greece	4.90	0.78	48
Ireland	5.11	0.79	28
Italy	4.62	0.59	21
Portugal	4.44	1.05	27
Slovakia	4.82	0.73	38
Slovenia	5.09	0.51	45
Total	4.92	0.76	402

Note: 1 point for each correct answers, max. 6 points. No statistically relevant differences between the countries.

6.4 Is the Competence of the Adolescents in Handling risky Situations, especially in Handling risky Consumption of Alcohol, improved?

Table 31. Descriptive statistic on the general risk competence, for T1, T2 and T3, sorted by countries

Country	n	T1		T2		T3	
		M	SD	M	SD	M	SD
Belgium	25	3.11	0.48	3.51	0.52	3.39	0.48
Cyprus	6	3.17	0.38	3.58	0.41	3.50	0.42
Denmark	34	3.05	0.49	3.35	0.42	3.08	0.60
Germany	22	3.08	0.59	3.35	0.44	3.23	0.45
Greece	38	2.69	0.61	3.13	0.76	3.24	0.65
Ireland	41	3.18	0.48	3.18	0.49	3.16	0.55
Italy	25	3.03	0.71	3.17	0.63	3.07	0.66
Portugal	36	3.15	0.65	3.33	0.60	3.16	0.70
Slovakia	39	2.82	0.49	3.15	0.51	3.15	0.43
Slovenia	38	3.20	0.64	3.49	0.44	3.49	0.43
Total	304	3.03	0.59	3.29	0.56	3.22	0.57

Note: Interaction time of measurement *country: $F(9,284)=2.602$, $p < .01$, partial $\eta^2 = .076$; bold = relevant differences between the average values within that country (this is, no overlapping of the confidence intervals).

Table 32. Gain in competences of adolescents in handling a (risky) consumption of alcohol, T2 and T3, sorted by country.

Country	Scale value (3 items) at T2			Single item at T3		
	M	SD	n	M	SD	n
Belgium	3.13	0.69	36	3.40	0.58	25
Cyprus	3.55	0.67	33	3.67	0.52	6
Denmark	2.80	0.67	31	3.00	1.00	35
Germany	2.74	0.88	38	3.35	0.73	24
Greece	3.74	0.42	43	3.92	0.27	39
Ireland	3.15	0.45	54	2.98	0.94	43
Italy	3.05	0.70	35	2.93	1.04	27
Portugal	3.71	0.44	41	3.69	0.47	36
Slovakia	2.92	0.58	42	2.92	0.90	39
Slovenia	2.91	0.65	39	3.18	0.79	39
Total	3.18	0.70	392	3.27	0.85	313

Note: Effect of nationality on the scale value T2: $F(9, 371)=14.411$, $p < .001$, $\eta^2 = .259$; for single items T3: $F(9, 292)=6.251$, $p < .001$, $\eta^2 = .16$. Bold = especially high figures in comparison of all countries.

6.5 Are the Parents, Key-Persons and the Employees in Retail supported in an effective Handling of the risky Consumption of Alcohol by Adolescents?

Table 33. Evaluation of the parents and key-persons regarding the gain of competences in dealing with adolescents and their consumption of alcohol, sorted by countries.

Country	Parents: gain of competences in handling the children and their consumption of alcohol			Key-persons: gain of competences regarding the communication with adolescents		
	M	SD	n	M	SD	n
Belgium	3.18	0.58	40	3.00	0.52	15
Cyprus	3.44	0.49	42	3.63	0.62	17
Denmark	3.06	0.57	45	3.04	0.41	14
Germany	3.07	0.55	64	2.86	0.52	21
Greece	3.49	0.47	48	3.57	0.30	14
Ireland	3.37	0.63	28	3.33	0.44	18
Italy	2.83	0.69	21	2.82	0.45	12
Portugal	3.42	0.42	27	3.74	0.38	19
Slovakia	3.02	0.56	38	3.04	0.50	15
Slovenia	3.48	0.47	49	3.33	0.49	14
Total	3.24	0.57	402	3.25	0.56	159

Note: for parents effect of the nationality: $F(9,382) = 5.508$, $p < .001$, $\eta^2 = .115$. Bold = statistically relevantly high figures, in comparison of all countries. For key-persons: Because of the too little samples no inference-statistical evaluations have been calculated for country effect.

Table 34. Evaluation of the employees in retail (long interventions) about the gain of competences in handling adolescents, who drink alcohol, sorted by countries.

Country	M	SD	n
Belgium	2.84	0.57	49
Cyprus	3.54	0.55	38
Denmark	--	--	--
Germany	2.72	0.75	71
Greece	3.07	0.61	7
Ireland	--	--	--
Italy	2.50	0.41	4
Portugal	3.33	0.50	38
Slovakia	2.93	0.51	21
Slovenia	3.80	0.27	5
Total	3.03	0.69	233

Note: Because of the sometimes too little samples, the differences between the countries have not been evaluated inference-statistically.

Table 35. Sales staff: Feedback about the use of TAKE CARE materials at everyday work, separated for long and short interventions: „These materials are helpful to me ...“

Country	Long interventions			Short intervention		
	Average value from too items*			Ratio of yes-answers		
	M	SD	n	Item 1*	Item 2*	n
Belgium	2.91	0.59	49	86%	69%	29
Cyprus	3.59	0.55	39	85%	54%	13
Denmark	--	--	--	--	--	(lost)
Germany	2.61	0.84	68	--	--	--
Greece	3.29	0.49	7	98%	93%	42
Ireland	--	--	--	94%	98%	50/48
Italy	2.75	0.50	4	59%	51%	41
Portugal	3.33	0.60	38	100%	100%	36
Slovakia	3.55	0.53	22	100%	97%	29
Slovenia	3.50	0.87	5	90%	94%	51
Total	3.09	0.76	232	89%	85%	297/295

Note: *wording of item: 1) „... at my work“; 2) ... „handling difficult situations better“. Because of the sometimes too little samples, the differences between the countries have not been evaluated inference-statistically.

6.6 How is the Satisfaction of the Participants of the Trainings with the Interventions?

Table 36. General satisfaction with the interventions, of the adolescents (at T2) and the parents, sorted by countries.

Country	Adolescents (T2)			Parents		
	M	SD	n	M	SD	n
Belgium	3.74	0.28	37	3.52	0.43	40
Cyprus	3.74	0.49	33	3.53	0.44	42
Denmark	3.60	0.50	31	3.33	0.59	45
Germany	3.42	0.51	39	3.59	0.41	64
Greece	3.80	0.30	43	3.61	0.38	48
Ireland	3.37	0.39	54	3.49	0.46	29
Italy	3.51	0.57	35	3.32	0.65	21
Portugal	3.79	0.37	41	3.56	0.45	27
Slovakia	3.48	0.50	42	3.43	0.49	39
Slovenia	3.48	0.46	39	3.66	0.43	49
Total	3.58	0.46	394	3.52	0.47	404

Note: For adolescents: effect of the nationality ($F(9, 373)=6.346$, $p < .001$, $\eta^2 = .133$; bold = statistically relevantly high figures, in comparison of all countries; additional effect for interaction sex *country: $F(9, 373)=3.457$, $p < .001$, $\eta^2 = .077$; in Germany and Slovakia, young men have been more satisfied with the training than young women, in Slovenia this has been just the other way round. For parents: No statistically relevant effects detected.

Table 37. General satisfaction of the key-persons (T1) and of the employees in retail (long interventions) with the interventions, sorted by countries.

Country	Key-persons (T1)			Employees in retail		
	M	SD	n	M	SD	n
Belgium	3.09	0.48	15	2.99	0.48	49
Cyprus	3.45	0.50	17	3.60	0.50	38
Denmark	3.31	0.56	14	--	--	--
Germany	3.55	0.30	21	3.00	0.55	71
Greece	3.60	0.37	14	3.26	0.56	7
Ireland	3.52	0.46	18	--	--	--
Italy	3.49	0.38	13	3.50	0.19	4
Portugal	3.86	0.26	19	3.57	0.40	38
Slovakia	3.40	0.38	15	3.30	0.41	21
Slovenia	3.64	0.44	14	3.87	0.18	5
Total	3.50	0.45	160	3.25	0.55	233

Note: Because of the sometimes too little samples, the country effect has not been evaluated inference-statistically.

Table 38. Statements of the key-persons on the feedbacks of the adolescents after the ro.pe-Training[®] in the re-interview.

They talked quite positively about their experiences in the ro.pe-Training [®]			
Country	M	SD	n
Belgium	3.00		1
Cyprus	3.67	0.52	6
Denmark	3.27	0.47	11
Germany	2.75	0.71	8
Greece	3.64	0.50	11
Ireland	3.25	0.45	12
Italy	3.00	0.00	6
Portugal	3.85	0.38	13
Slovakia	3.38	0.52	8
Slovenia	3.20	0.42	10
Total	3.36	0.55	86

Note: Because of the sometimes too little samples, the country effect has not been evaluated inference-statistically.

7 Benchmark Figures and Recommendations

The empirical results in the previous chapters showed the pleasant effects of the TAKE CARE project. All of the aspired goals of the project have been achieved. TAKE CARE contributes to 1) a reduction of the consumption of alcohol and 2) an increase of competences in dealing with risk and individual consumption of adolescents and young adults who consume riskily. The project creates encouragement of the personal and social skills of young people and the participating parents. It improves the knowledge and results in changes of attitudes and behaviour to some extent at the key-persons and the staff, who works in the area of the sales of alcoholic beverages.

The following final thoughts explicate some important benchmark figures of the TAKE CARE project, which made the project distinctive, but which also have a challenging character. Recommendations, which – if kept in mind – will contribute to a success of the project, are allocated to each benchmark figure.

The statements are based on the analysis of the effects, on the one hand, and on the feedbacks in telephone interviews with the collaborating country-partners on the other hand.

TAKE CARE is an ambitious and complex Project.

- A great deal of attention should be paid to the profiles of the person, who is in charge of the project. This person must have networking skills, but also skills in project management beyond different levels. Additionally, they should have enough practical knowledge and experiences. Furthermore, it is helpful, if the persons in charge are structurally linked to the social context of the project site.
- It is recommendable, for improvement of competences and for lobbying, to organise a monitoring or lobbying group that consists of key-persons from the administration, practitioners and experts for the area of public health and prevention. Representatives of parental and youth organisations, business associations and other participating are also helpful for a successful project.
- The planning period before the start of the project should be as concrete as possible and should fix a binding schedule, so that all energies can be concentrated and synergy effects can be used.

The multilevel Approach offers a noteworthy and remarkable Surplus for Practitioners.

- TAKE CARE realises a multilevel approach related to the social environment. This kind of social work concentrates on activities in the living environment; multiple target groups (levels) in the same living environment are addressed simultaneously. In the TAKE CARE project this approach showed to be effective because important synergies can be triggered. Several feedbacks of the country partners showed that a multilevel approach shows impact, using the criteria of Best Practice.

An Analysis of the Situation and Needs of the selected social Environment is indispensable for a successful Concept and Implementation of the Project in a specific Context.

- This analysis of the situation and needs is the base and design principle for the whole planning and implementation of the project.
- This analysis serves as a test, whether at all and to which extent the selected social environment suits the TAKE CARE project.
- This analysis features information for the identification of the aspired target groups. Who are they? Where do we meet them? How can they be addressed?
- Also, this analysis generates the indicators, which shall be applied when evaluating the successful implementation. These indicators are a guideline, when making cautious decisions for a continuation of possible termination during the project.

TAKE CARE includes aspects that might not be delivered easily to certain people or experts, for example the concept of risk competence regarding the consumption of alcohol. The TAKE CARE projects take a step towards correcting and differentiating socially and culturally based opinions; it aims to transfer knowledge and increase the awareness for potentially damaging consequences of the risky consumption of alcohol. The positions and attitudes are new to a certain extent and, therefore, create some resistance. With the multilevel approach, the TAKE CARE project transforms the „individual problem of a risky consumption of alcohol“ to a „social problem“ that affects everyone in the environment of adolescents and young adults.

- In order to build up and specifically promote the acceptance of the project in the general public and among experts, a continuous, long-term and proactive communication and a participation of the affected public are necessary.
- The public relations work, at best, should be carried out with an incorporation of the social networks.

The Planning and Implementation requires a binding Time-concept, which, of course, can be adapted flexibly during the Conduct of the Project, whilst still being loyal to the Master Plan.

- There should be a binding time concept before the start of the operational phase.
- Part of this time concept should be a reasonable suggestion about the order, in which the target groups should be addressed.
- A kick-off meeting makes sense in order to guarantee the processing-quality of the project. Continuous meetings of all participating heads of interventions ensure a continuous and joint further development of attitudes and ideas.

TAKE CARE requires quality control. So that TAKE CARE can establish itself in the field of prevention of addiction, it is recommendable to guarantee a quality control.

- It should be thought of setting up a platform for communication and exchange of experiences on an international level. This could be done via Facebook or other existing platforms quite cost-saving. This could be the platform, where tips and tricks can be exchanged.
- It should be considered, if TAKE CARE can have a long-term quality control as part of the European network for prevention euro net⁴⁰.
- This quality control protects the approach of the project against simplifications in practice, which might wash out the innovative character of the multilevel approach.
- Possibly, a certification should be aspired on the international level, or any other form of a label, which assures the loyalty towards the approach of the project.
- There has to be a professional introduction of the approach of the project and the different interventions. Because the heads of the interventions become agents of the project goals and a specific attitude of the project, the training of these heads of interventions cannot fall short.

40 See <http://www.euronetprev.org/> (visited 21.09.2012).

TAKE CARE can be run successful even with minor structural Adaptations in the Context of an Intervention.

The pilot project shows, that changes must not touch the core of the project and the attitudes to be transferred.

- A quality control of the project has to tackle the question, which elements of the interventions and guidelines for the structural implementation are really core characteristics that cannot be neglected or circumvented.
- Right now, no empirical knowledge exists of how the local and national differences and conceptual divergences effect the implementation. In order to test this adequately, a controlled project and evaluation design has to be established, which has to be more in accordance with scientific standards.

The close intertwining⁴¹ between the different levels of the approach requires much more efforts already before the project. Yet, this is worthwhile. In this present evaluation the design did not allow any collection of data, which show – empirically confirmed – a synergy effect. However, in terms of best practice, several feedbacks from the partners in the different countries show that the multilevel approach makes sense according to their professional experiences. To verify this, there is further need for research.

- A well-structured time concept, which is adapted to local situation, also can optimise the planned procedure.
- The goals can be achieved easier, if the key-persons can live up to their function, especially in addressing and winning over adolescents already at the start of the project.

It has to be wished that the future heads of the interventions of the TAKE CARE projects can keep up enough stamina, in order to respond the multiple challenges on different levels creatively.

This evaluation report ends with the conclusion that the TAKE CARE project (targeted at current concerns within the field of Public Health) is attractive for professionals and can achieve the aspired effects. Therefore, we wish for a successful future for TAKE CARE.

41 For example, information can be found in a project with a multilevel approach: <http://www.esski.ch/esski-1> (visited 08.10.2012).

8 Annex

8.1 Details about the Analysis of Alcohol Consumption of the Adolescents

8.1.1 Consumption Groups

The classification into the three consumption groups of 'tee-totalling', 'low-risk consumption', and 'risky consumption' is based on a definition, which was proposed by the central project coordinators. These can be found in the toolbox on the project homepage www.project-take-care.eu. This classification of the three consumption groups for different age-levels can be found in a publication of the Belgian Vereniging voor Alcohol- en andere Drugproblemen vzw (VAD)⁴² and the international definition by WHO from 2010⁴³. The following threshold values for low-risk and risky consumption have been defined:

- Under 16-year-old, every consumption of alcohol is considered risky. There is no low-risk measure of the consumption of alcohol for this age-group.
- At the age of 16 and 17 years, boys are considered consuming low-risk with a maximum of two alcoholic standard drinks per day, girls with a maximum of one to two alcoholic standard drinks per day. These amounts are considered low-risk, if they are not consumed more often than two days per week and this only, if this does not happen every week. Those who exceed these thresholds, either in terms of amount or frequency, counts as drinking riskily.
- For the 16- and 17-year-olds the consumption of spirituous beverages is classified as risky.
- Older than 18 years, borrowing from the WHO, young men are considered low-risk, who drink a maximum of 24 g of pure alcohol (approximately two to three standard drinks) per day; young women, who drink a maximum of 12 g pure alcohol (approximately one to one-and-half standard drinks) per day. These amounts are considered low-risk, if they are not consumed more often than three days per week⁴⁴. Those, who exceed these threshold values, either in amount or frequency, count as consuming riskily.

42 See: <http://www.vad.be/media/38169/richtlijnen%20voor%20aanvaardbaar%20alcoholgebruik%20%20definitie%20binge%20drinken%20finaal.pdf> (visited 04.10.2012).

43 WHO (2010): mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health-settings. Mental Health Gap Action Programme. Version 1.0., S. 60

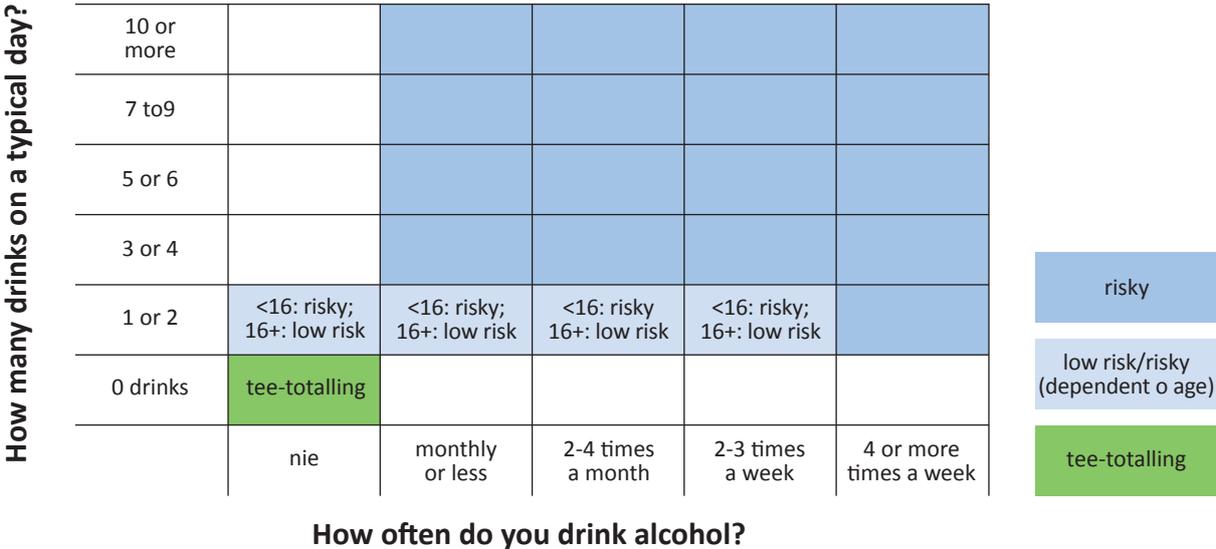
44 These guidelines of the WHO assume a maximum of five days per week, which count for the specified amounts, for the definition of low-risk consumption. The proposal for the definition here lowered the maximum threshold for the frequency, in order pay tribute to the still on-going psychological and physical developments with young adults.

The evaluation operationalised the definition proposal, based on two pieces of information on the amount and frequency of drinking from the WHO-Instruments⁴⁵.

It has been found that the response format of the instrument AUDIT, that is wide spread in research of alcoholism, does not equivalently reproduce the definition of the project coordination. In order to operationalise the project goals, the evaluation had to assign responses of the AUDIT-questions in low risk or risky consumption to identify the target group of risky drinking adolescents. Because of the response formats the evaluation had two possibilities: Either risky drinking adolescents are included in the low-risk drinking group or low-risks are included in the high risk group. The evaluation decided for the last one, so that it is possible that there are some adolescents in the group of risky drinkers that actually are low-risk-consumers by the definition of the project coordination.

Figure 12 shows this division into the three consumption groups, schematically with colours green, light blue and blue⁴⁶. Pay attention to the age-related different classification of low-risk to risky consumption in the light-blue areas⁴⁷.

Figure 12. Categorisation of consumption groups, based on statements on the amount and frequency of drinking and the age of the adolescents.



Note: <16/<18 = for adolescents under 16/18; 16+/18+ = for adolescents at the age of 16/18 years and older.

45 AUDIT: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., & Monteiro, M.G. (2001). AUDIT – The Alcohol Use Disorders Identification Test (2nd ed.). Geneva: World Health Organization.

46 The white sections contain data, which could not be interpreted and therefore not classified to any consumption pattern, with one exception: The field „frequency: never“/„amount: 1 or 2 glasses“ is interpreted as unique, non-repeating drinking experience and therefore integrated in the evaluation.

47 The different limits for young women and young men over 18 years could not be taken into consideration specifically, because the selected format of questions of the AUDIT did not allow this division.

8.1.2 Cumulative Value

In order to have a cumulative value and, at the same time, a continuous measure regarding the drinking behaviour at hand, the so-called cumulative value has been calculated for each person with the two AUDIT items of the amount and frequency of drinking on a typical day⁴⁸.

The cumulative value resulted from the encoding of the choices for answers, which then have been added. The encoding of choices for answers on the frequency of drinking has been done in accordance with the AUDIT manual and began with the value 0 in each case. The self-reported amounts of drinking on a typical opportunity for drinking does not have the choice to answer “0 glasses” according to the manual (which is due to the normal wording), but starts with „1-2 glasses“. In contrast of the manual, for these answers the encoding 1 to 5 has been used, not 0 to 4: 1 = 1-2 glasses, 2 = 3-4 glasses, 3 = 5-6 glasses, 4 = 7-9 glasses, 5 = 10 glasses and more. That way, each choice for an answer receives a number, which „makes a difference“ at the calculation of the cumulative value of the drinking behaviour. The potential minimum sum has been zero⁴⁹, the potential maximum sum nine (cf. Figure 13).

Figure 13. Potential cumulative values related to frequency and amount of drinking.

How many drinks on a typical day?	10 or more		6	7	8	9
	7 to 9		5	6	7	8
	5 or 6		4	5	6	7
	3 or 4		3	4	5	6
	1 or 2	1	2	3	4	5
	0 drinks	0				
	never	monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
						How often do you drink alcohol?

⁴⁸ Wording of the items, see chapter 8.2.

⁴⁹ There have been persons, who „never“ drank according to their self-report and who (consequently) did not answer the question about the amount of drinking on a typical opportunity, but left it blank. These persons have been calculated with the cumulative value 0 and the missing answer been interpreted as „0 glasses“.

8.1.3 Difference Value

In order to detect the individual trends of the consumption behaviour even more differentiate, the individual flows have been examined even closer. It has been recorded, how many adolescents reduced their consumption and how many increased it. This is presented as follows (Figure 14):

- Reduction: frequency and amount of drinking at T3 has been lower than at T1, marked light green or green⁵⁰
- Stability: frequency and amount of drinking at T1 and T3 have been the same, marked orange⁵¹
- Increase: frequency and amount of drinking at T3 have been higher than at T1, light blue or blue⁵²
- Some patterns of answers are difficult to interpret, whether they stand for stability or changes (marked white). They are not incorporated into the further evaluations.

Figure 14 shows that more than one third of the adolescents (35%), who answered at the start of the training and at the re-interview and whose answer-behaviour remained stable, this means they reported a similar drinking behaviour at both points of being interviewed. 21% report increase on one or both dimensions of the frequency and amount of drinking, 38% reductions on one or both dimensions. This means, the total of adolescents, who reduced their drinking, and those with stable drinking patterns, has been bigger each than the number of those adolescents, who increased their drinking during the observation period as a consequence of the intervention.

50 Reductions are represented by negative figures in the labelling of the axes.

51 Stabilities are represented by the figure 0 in the labelling of the axes.

52 Increases are represented by positive figures in the labelling of the axes.

Figure 14. Occurrence of increases, stabilities and reductions of the drinking behaviour, calculated as a difference between the answers at T1 and T3. See the text for explanations.

Differences T3 minus T1, in change of "answer field of questionnaire"

Difference: How many drinks on a typical day?	Difference: How often do you drink alcohol?								Total (n = 310)	
	-4	-3	-2	-1	0	+1	+2	+3		
+4	0	0	0	1	0	1	0	1		
+3	0	0	0	1	0	2	0	0		
+2	0	0	0	1	3	3	1	0	6% n = 18	++ Increase on both dimensions
+1	0	0	0	5	21	10	0	0	15% n = 47	+ Increase on one dimension
0	0	2	8	42	110	23	0	0	35% n = 110	Stability
-1	0	0	2	12	22	3	2	0	28% n = 87	- Decrease on one dimension
-2	0	0	2	11	10	2	1	0	10% n = 31	-- Decrease on both dimensions
-3	0	0	0	2	2	1	0	0	5% n = 17	Difficult to interpret: + Increase on one dimension - Decrease on the other dimension
-4	1	0	0	1	1	0	0	0		

Table 39. Occurrence of stabilities and changes of the drinking behaviour, sorted by consumption-groups at the start of the training.

Consumption groups at the start of the training	-- Reduction amount and frequency of drinking		- Reduction amount and/or frequency of drinking		0 Stability		+ Increase amount and/or frequency of drinking		++ Increase amount and frequency of drinking	
	Risky (n=250, 100%)	31 (12%)	82 (33%)	83 (33%)	43 (17%)	11 (4%)				
Low risk (n=39, 100%)	0	8 (21%)	23 (59%)	5 (13%)	3 (8%)					
Tee-totalling (n=21, 100%)	--	--	13 (62%)	4 (19%)	4 (19%)					
Total (n=310, 100%)	31 (10%)	90 (29%)	119 (38%)	52 (17%)	18 (6%)					

Note: bold = descriptively highlighted ratios. In chapter 5 and 6 the percentages of this table are presented in a simplified way for the different consumption-groups.

8.2 Scales and Wording of Items

Table 40. Overview of the question-items from the questionnaires for all target groups which have been used in the evaluation report.

Scale	Wording of item	Format of answers (incl. values of answers)	Source
Drinking behaviour of adolescents (T1, T3).	<p>*A „drink“ here is approximately one glass or one bottle of beer or must (25 - 33 cl), a bottle of alcopops (27 cl), a glass of wine (10 - 12.5 cl) or a glass of high spirits (4 cl).“</p> <p>„How often do you take an alcoholic beverage*?“</p> <p>„How many alcoholic beverages* do you drink on a typical day, if you are drinking?“</p>	<p>never (0)</p> <p>1x month or less (1)</p> <p>2-4x per month (2)</p> <p>2-3x per week (3)</p> <p>4x or more per week (4)</p> <p>1 or 2 (1)</p> <p>3 or 4 (2)</p> <p>5 or 6 (3)</p> <p>7 to 9 (4)</p> <p>10 or more (5)</p>	<p>AUDIT: Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., & Monteiro, M.G. (2001). AUDIT – The Alcohol Use Disorders Identification Test (2nd ed.). Geneva: World Health Organization.</p>
Self-efficacy. All target groups, same wording.	<p>„I always find a solution for difficult problems, if I try enough.“</p> <p>„If obstacles occur, I find ways to carry out my points.“</p> <p>„Even with sudden incidents, I believe that I can deal with them quite well.“</p> <p>„I can find a solution for any problem.“</p> <p>„What ever happens, I can handle it.“</p>	<p>completely true (4)</p> <p>more or less true (3)</p> <p>hardly true (2)</p> <p>not true at all (1)</p>	<p>General expectance of self-efficacy, by Matthias Jerusalem and Ralf Schwarzer, reduced to five items, German and English version at http://userpage.fu-berlin.de/health/germscal.htm bzw. http://userpage.fu-berlin.de/~health/selfscal.htm (visited 08.10.2012).</p>

Scale	Wording of item	Format of answers (incl. values of answers)	Source
Self-esteem. All target groups, identical wording.	<p>„All in all, I am satisfied with myself.“</p> <p>„Once in a while, I do think that I am worth nothing at all.“</p> <p>„I have a number of good characteristics.“</p> <p>„I can do many things as good as most of the other people, too.“</p> <p>„I am afraid that there is not much that I can be proud of.“</p> <p>„From time to time, I feel so useless.“</p> <p>„I consider myself a valuable human being; at least I am not less valuable than others.“</p> <p>„I wished I could have more self-respect.“</p> <p>„All in all I tend to think of myself as a loser.“</p> <p>„I found a positive attitude towards myself.“</p>	<p>agree completely (4)</p> <p>agree (3)</p> <p>do not agree (2)</p> <p>do not agree at all (1)</p>	<p>In German: Von Collani, G., & Herzberg, P.Y. (2003). Eine revidierte Fassung der deutschsprachigen Skala zum Selbstwertgefühl von Rosenberg. Zeitschrift für Differentielle und Diagnostische Psychologie, 24 (1), 3-7.</p> <p>In English: Rosenberg, M. (1965). Society and the adolescent self-image. Princeton, NJ: Princeton University Press.</p>
Knowledge regarding the legislation on the consumption of alcohol. All target groups, identical wording.	<p>In countries with one age limit for the consumption of alcohol: „In country XY* it is legal to buy and drink alcohol from the age of ... years.“</p> <p>In countries with two different age limits for the consumption of low and high percentage alcohol: „In country XY* it is legal to buy and drink alcohol, such as beer, wine and sparkling wine from the age of ... years.“ „In country XY* it is legal to buy and drink alcohol, such as spirituous beverages and alcopops from the age of ... year.“</p> <p>*Questionnaire adapted to each country.</p>	<p>Age has been filled in in handwritten figures.</p>	<p>Self-developed.</p>
Evaluation regarding the appropriateness of the laws regarding the consumption of alcohol. All target groups, identical wording.	<p>„The laws regarding the consumption of alcohol by adolescents are appropriate.“</p>	<p>agree completely (4)</p> <p>agree (3)</p> <p>do not agree (2)</p> <p>do not agree at all (1)</p>	<p>Self-developed.</p>

Scale	Wording of item	Format of answers (incl. values of answers)	Source
<p>Willingness to comply with the laws or to support the adolescents in complying with them.</p> <p>All target groups, sometimes wording differs.</p>	<p>Adolescents: „I am trying to comply with these laws.“</p> <p>Parents: „I am trying to make my child/my children complying with these laws.“</p> <p>Key-persons: „The goals of the TAKE CARE project are: (1) responsible handling of alcohol, from the age at which the consumption is legal. (2) Tee-totalling before this legally determined age. These goals of the TAKE CARE project make sense to me.“ „My role as a „key-person“ is: direct, empathic and motivating talks with young people, who drink alcohol. This goal makes sense to me. “ „My role as a „key-person“ is: motivating young people to reflect on the consumption of alcohol. This goal makes sense to me.“</p> <p>Employees in retail (short and long intervention): „I am trying very much to comply with these laws.“</p>	<p>agree completely (4) agree (3) do not agree (2) do not agree at all (1)</p>	<p>Self-developed.</p>
<p>Knowledge regarding the risks and effects of alcohol.</p> <p>All target groups, identical wording.</p>	<p>„Are the following statements true or not?“</p> <p>„Alcoholic beverages contain calories that increase the weight.“*</p> <p>„Regular consumption of alcohol at the young age can lead to swift addiction and withdrawals.“*</p> <p>„Consumption of alcohol can reduce the learning aptitudes.“*</p> <p>„Consumption of alcohol increases the physical fitness.“**</p> <p>„Consumption of alcohol helps against being shy and self-conscious.“*</p> <p>„Many people drink in order to escape problems, such as solitude or depressions.“*</p> <p>Correct answer: * yes/ ** no“</p>	<p>yes (1) no (0)</p>	<p>Self-developed.</p>

Scale	Wording of item	Format of answers (incl. values of answers)	Source
Risk competence. Adolescents.	In the last three months ... (T1, T3)/ in the ro.pe® Training... (T2) „I like being confronted with risky situations, because they are a challenge to me.“ „I was capable of overcoming risky situations.“ „I overcame risky situations better than I thought.“ „I was having fun, when dealing with risky situations.“	agree completely (4) agree (3) do not agree (2) do not agree at all (1)	Self-developed.
Competence in handling the personal consumption of alcohol. Adolescents.	„During the training I became more aware of my consumption habits.“ „The experiences and information from the training helped me to gain better strategies in handling alcohol.“ „The experiences and information of the training enlarged my knowledge on alcohol.“	agree completely (4) agree (3) do not agree (2) do not agree at all (1)	Self-developed.
Competences in dealing with risky consumption of alcohol by adolescents. Parents, key-persons and employees in retail, sometimes different wording.	Parents: „The talks helped me to gain better strategies in dealing with my child/my children.“ „I enlarged my knowledge about alcohol.“ „The meeting motivated me to reconsider my attitude towards alcohol and consumption of alcohol.“ Key-persons: „The training helped me to gain information and strategies for successful talks with adolescents.“ „I enlarged my knowledge about alcohol.“ „The training helped me to build up more confidence in addressing the topic alcohol/ consumption of alcohol with young people.“ In the re-interview: „The training helped me to gain information and strategies for successful talks with young people.“ „The training enabled me to address the topic alcohol/consumption of alcohol with young people.“ „The technique „key“ enabled me to trigger young people to reflect their consumption of alcohol“. Employees in retail (long interventions): „The training helped me to get along better with difficult situations at work.“	agree completely (4) agree (3) do not agree (2) do not agree at all (1)	Self-developed.

Scale	Wording of item	Format of answers (incl. values of answers)	Source
Benefit of the materials for the employees in retail.	„These materials helped at my work.“ „These materials helped in getting along better with difficult situations.“	agree completely (4) agree (3) do not agree (2) do not agree at all (1)	Self-developed.
Satisfaction with the interventions. All target groups, sometimes wording differs.	Adolescents: „I profited from ro.pe [©] -Training.“ „I trusted the heads of the training.“ „It has been cool to participate in the training.“ „I would recommend the ro.pe [©] -Training to friends.“ Parents: „I profited from the Homeparty for handling my child/my children.“ „I trusted the expert, who was present.“ „I would recommend the Homeparty to friends.“ Key-persons: „I profited from the Key-training for dealing with young people.“ „I trusted the experts, who were present.“ „I would recommend the training to other professionals/volunteers, who work with similar target groups.“ Employees in retail (long interventions): „I profited from the training and can deal better with difficult situations at work now.“ „I trusted the expert, who was present.“ „I would recommend the training to other people, who have a similar work as me.“	agree completely (4) agree (3) do not agree (2) do not agree at all (1)	Self-developed.

Impressum

Authors:

Walter Kern-Scheffeldt, Esther Kirchhoff, Liliane Pfister, Michael Frais.

Zurich University of Teacher Education, Research Group of Public Health
and Special Educational Needs.

http://www.phzh.ch/de/Forschung/Gesundheit_und_besondere_paedagogische_Beduerfnisse

Project management:

Landschaftsverband Westfalen-Lippe (LWL), Dezernat 50, Koordinationsstelle Sucht

https://www.lwl.org/LWL/Jugend/lwl_ks/Praxis-Projekte/Take_Care_Start/take-care

Supported by:

Health Programme 2008 - 2013, European Commission, Directorate-General for Health
and Consumer Protection.

http://ec.europa.eu/health/index_en.htm

Layout:

Susanne M. Reimann, Graphic-Art-Design.

<http://www.graphic-art-design.ch>

Production:

Adobe-PDF.

Copyright:

© November 2012.

Walter Kern-Scheffeldt, Esther Kirchhoff, Liliane Pfister, Michael Frais.

Zurich University of Teacher Education, Research Group of Public Health
and Special Educational Needs.