

# **Drinking among young Europeans**

by

Wolfgang Settertobulte, Bjarne Bruun Jensen  
and Klaus Hurrelmann



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## **EUROPEAN HEALTH21 TARGET 12**

### **REDUCING HARM FROM ALCOHOL, DRUGS AND TOBACCO**

By the year 2015, the adverse health effects from the consumption of addictive substances such as tobacco, alcohol and psychoactive drugs should have been significantly reduced in all Member States

*(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)*

### **Abstract**

The Health Behaviour in School Children-aged (HBSC) survey is carried out regularly in a large number of countries in WHO's European Region. This document presents a review of the data on alcohol consumption obtained by this research project. It has been commissioned specially for the WHO European Ministerial Conference on Young People and Alcohol (Stockholm, 19–21 February 2001).

The survey data refer to various forms of alcohol consumption by young people (experimentation, regular use and excessive use) and to the harm related to alcohol. The document includes a preliminary analysis of the trends identified.

Alcohol consumption is not an isolated issue in people's lives. The data on alcohol consumption are therefore related to such other factors as the family, the school and the availability of alcoholic beverages.

This review concludes by addressing the question of what schools can do to limit the harm caused by alcohol. The concept of a health-promoting school is explained, and practical experience from the Health Promoting Schools project is described.

### **Keywords**

ALCOHOL DRINKING  
ADOLESCENCE  
HEALTH PROMOTION  
SCHOOLS  
EUROPE

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# Chapter 1

## Introduction

In global terms, Europe is the continent with the highest alcohol consumption. In some European countries, alcohol-related deaths are estimated to account for 6% of total mortality (Harkin et al., 1997). Alcohol consumption is responsible for a large number of disadvantages and adverse effects on government budgets, such as productivity losses through reduced output and alcohol-related diseases. It also imposes burdens on the health service and the welfare, legal and transport sectors. When seen against a background of the figures for the harm it causes, alcohol is now regarded as the most dangerous psychoactive substance.

Alcohol consumption is already alarming among adolescents. Young people, including girls, are drinking more, especially beer. In addition, new alcoholic beverages – so-called “alcopops” (soft drinks mixed with alcohol) – are coming onto the market, which are produced specifically for this target group.

Alcohol dependence is one of the most prevalent mental diseases throughout the world. The resultant alcohol-related diseases, such as cardiovascular and gastrointestinal diseases, make up a large part of the disease burden among the adult population in western industrialized countries. Of course, the proportion of young people with alcohol dependency is initially small – alcohol-related diseases do not occur, as a rule, until later in life. But the foundations for misuse of alcohol and other psychoactive substances are laid in childhood and adolescence.

A knowledge of data on the prevalence of alcohol consumption in children and adolescents is of considerable importance for the development of preventive measures. If these are to be successful, they must be specifically tailored to each of the target groups. General epidemiological data are not sufficient for this purpose: information on age-, sex- and region-specific consumption patterns are of much more use. Equally, the various contributing factors identified to date help with work on the specific underlying problems that often act as triggers or reinforcements of alcohol consumption.



## Chapter 2

# Prevalence of alcohol consumption in adolescence

Reliable and comparable data on the frequency and intensity of young people's alcohol consumption are difficult to obtain, on an international scale. The methodological standards applied in the corresponding surveys are too disparate. The data presented below come mainly from one of the few international comparative studies that are strictly oriented along common methodological approaches. The "Health Behaviour in School-aged Children" (HBSC) study is a cooperative research project by the World Health Organization (WHO). The aim of the study is to contribute to a better understanding of the health-related attitudes and behaviours of young people and to investigate the conditions in which they are developed. Since 1982, the HBSC project office has been planning and coordinating four-year surveys in an increasing number of countries. Selected research teams from individual Member States are responsible for carrying out national studies in accordance with guidelines laid down for sampling, methodology and data processing. The surveys are carried out using an internationally standardized questionnaire, which is translated into the various languages. The target groups are children and adolescents aged 11–15 years in a representative sample of schools.

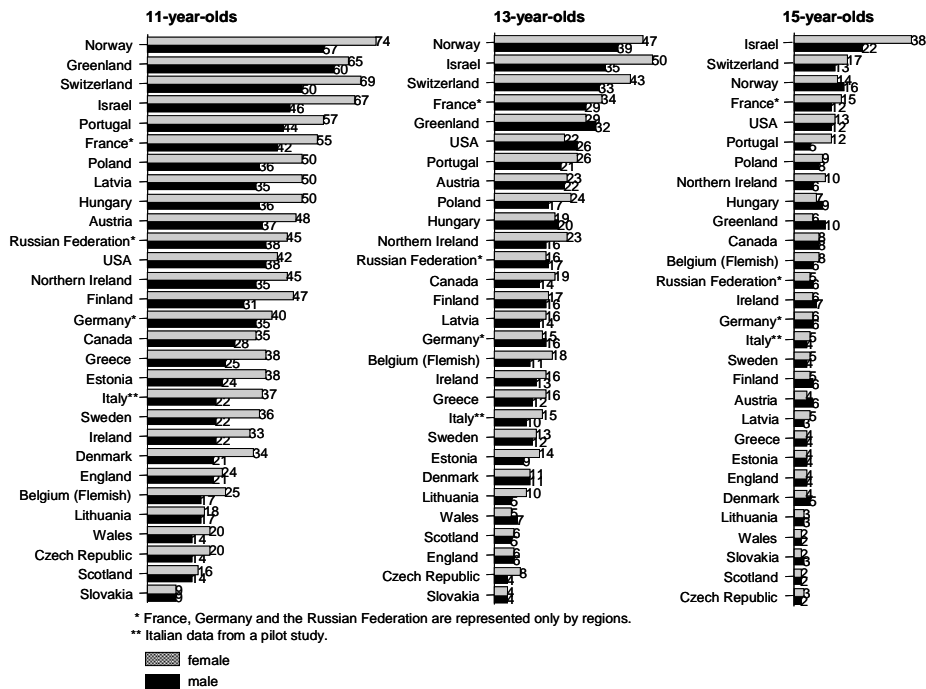
These studies are designed both for the purpose of health reporting and to help expand the knowledge base about the conditions in which health-related attitudes and behaviours arise and are developed. Considerable importance is attached to the subject of risk behaviour and substance use. The data yield indications about the cultural influences on the healthy growth of young people and show the extent to which health policy and preventive efforts contribute to different behaviour patterns in the participating regions.

Adolescents in each of the 28 participating countries were questioned about their alcohol consumption. They were asked whether they had ever tried alcoholic drinks, how frequently they drank various alcoholic drinks at present, and how often they had experience of being drunk.

## Alcohol experimentation

Fig. 1 shows an international comparison, by the three age groups surveyed, of the proportions of adolescents who have no experience with alcohol in their life to date.

Fig. 1. Students who report never having had a drink (%)



Source: Currie et al. (2000).

In most countries, more than 50% of 11-year-old children have already tried alcoholic drinks at least once. As might be expected, the proportion of those who have never drunk falls steadily in subsequent age groups, so only a few countries have more than 10% of 15-year-old adolescents with no previous alcohol experience. Norway, Israel and Switzerland have the most abstainers in all age groups, but here, too, the proportions fall with increasing age. On the other hand, the United Kingdom, the Czech Republic, Slovakia, Lithuania and Denmark are noteworthy for particularly low figures of abstainers among adolescents. The differences between countries disappear almost completely, however, among 15-year-old adolescents.

The ranking of abstinence rates clearly reflects cultural influences in the various countries. In those with a strongly religious abstinence movement,



markedly fewer adolescents have had experience of alcohol at an early age. Only in Israel, where a relatively high proportion of adolescents surveyed come from an Islamic culture, is there still a relatively high proportion of abstainers among 15-year-olds. On the other hand, in countries where moderate alcohol consumption is part of the everyday culture, the vast majority of 11-year-olds have already had such experience. In these countries, some 95% of 13-year-olds and almost all 15-year-olds have tried alcohol at least once in their lives.

With a few exceptions, marked gender differences in experience with alcohol are seen only among 11- and 13-year-olds. In every case, boys have tried alcohol more often. The larger the proportion of abstainers in a country, the larger this gender difference is, too. In all countries, it is clear that more boys than girls admit to having experience of alcohol. This is possibly an indicator of broader cultural tolerance of alcohol consumption by boys. In 15-year-olds, the observed gender differences have almost disappeared: they persist only in Israel and Portugal.

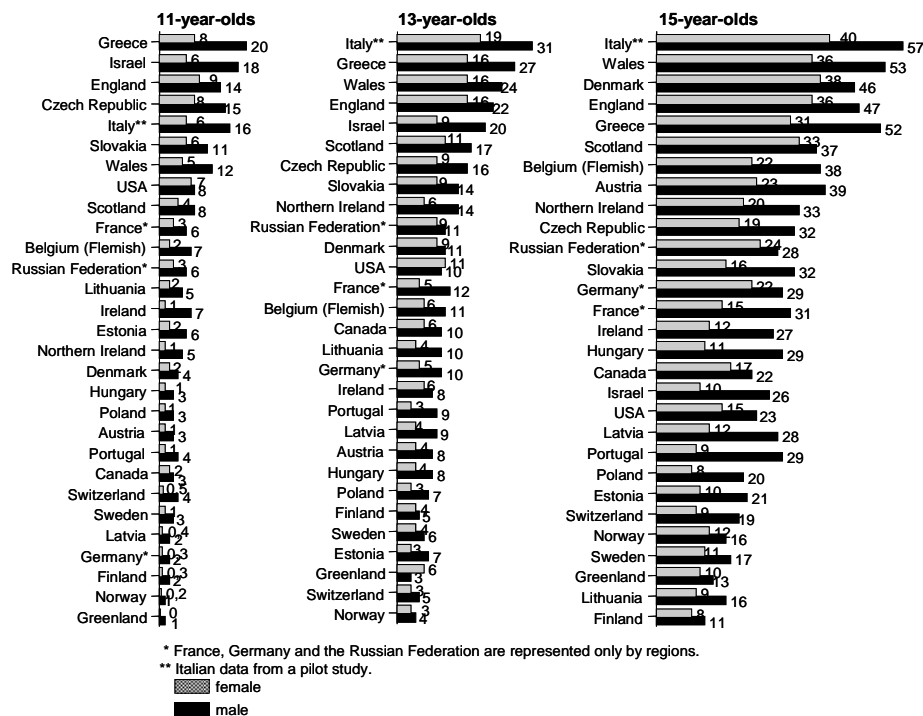
Nowadays, young people are introduced to alcohol consumption at an early age. This happens first through the media and advertising or in the family. Alcohol is a natural component of many social occasions. Adolescents gradually grow into this accepted culture of enjoying alcohol and learn the meanings of drinking on social occasions. The data show how strongly experimenting with alcohol is part of the culturally accepted phases of development in adolescence in most central European countries and in North America. It is to be presumed that these experiences are not initiated by children and adolescents themselves; in the vast majority of cases, they are provoked by parents or other adults. There are, however, clear differences with regard to the generally accepted age for such experiences. Alcohol consumption by children under 11 years is tolerated in only a few countries, but the first experience of alcohol is part of the social “standard” for most 13-year-olds.

## **Regular consumption of alcohol**

The frequency of consumption of various alcoholic beverages was assessed in the HBSC study in terms of regular consumption at least once a week. Questions covered three groups of beverages: beer, wine and spirits. The difficulty of making an international comparison of drinking habits among adolescents arises from the specific regional characteristics of the supply of various beverages with different alcohol contents. In England, for instance, the questions covered the various individual types of beer available, while in Greece ouzo consumption was surveyed and in France questions dealt with champagne. To improve comparability, these findings are further collated in Fig. 2 below.

In the overwhelming majority of countries, regular alcohol consumption does not yet play a substantial role among 11-year-olds. With a few exceptions, average rates are under 5%. The figures are particularly low in Norway, Finland, Germany, Latvia and Switzerland, where there is virtually no regular alcohol consumption among 11-year-old girls. On the other hand, some countries (such as Greece, Israel, the Czech Republic, Slovakia and the United Kingdom) have a strikingly high rate of consumption in this age group. The rates increase to a moderate extent in the group of 13-year-olds, but the ranking of countries remains almost the same. Only Germany and Denmark have above-average rises, while in Israel the proportion increases only slightly. Among 15-year-olds, alcohol consumption is customary among most young people in all countries. The proportions of adolescents who regularly drink each week show clear difference between the countries, however. The rates are highest in the United Kingdom, Belgium, Denmark, Austria and Greece, whereas only relatively few 15-year-olds drink regularly in Poland, Estonia, Switzerland, Norway, Sweden, Greenland, Lithuania and Finland.

Fig. 2. Students who report drinking beer, wine or spirits once a week or more (%)



Source: Currie et al. (2000).

Like the abstinence rates presented above, boys in all the participating countries are noteworthy for substantially more frequent alcohol consumption. The exceptions to this observation are Greenland and the United States of America, with slightly higher rates for girls in the 15-year-old age group (Nic Gabhainn & Francois, 2000).

The frequency of alcohol consumption does not necessarily describe misuse of this substance. Regular consumption of small quantities of alcohol is far more a part of normal behaviour in the adult world. In addition, the possibility cannot be excluded that some of these figures relate to consumption of small quantities of alcohol in the context of religious ceremonies.

## Perceived drunkenness

The first occasion of “getting drunk” is a life event of similar importance to initiation into alcohol consumption. Information on the frequency of episodes of drunkenness, in relation to lifetime prevalence, is given below. Frequent episodes of drunkenness are also an indicator of hazardous alcohol use, because even a single overdose entails a multitude of health risks.

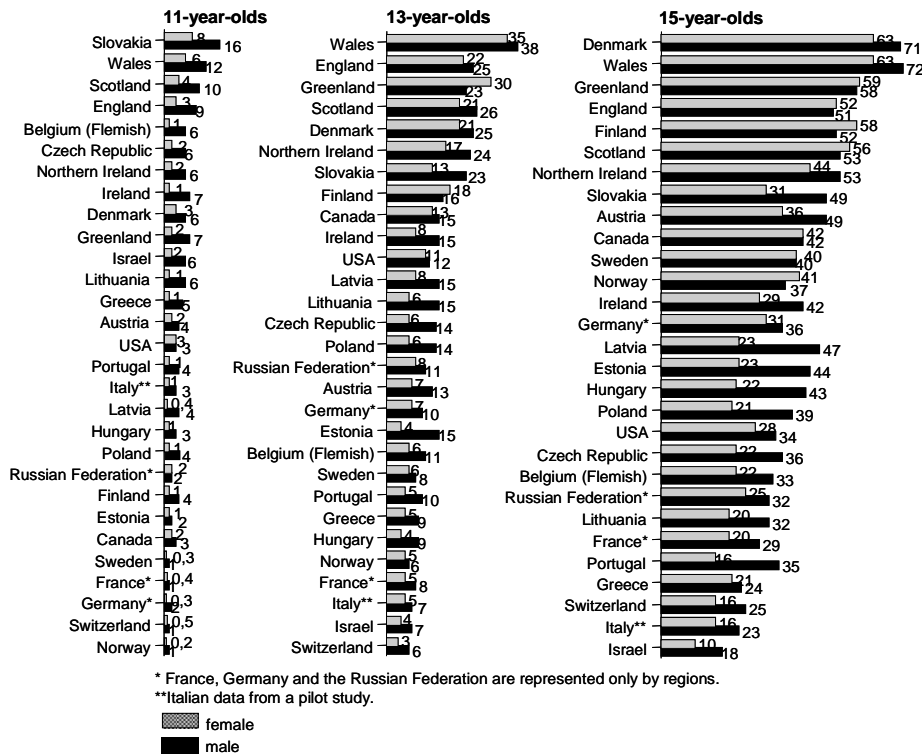
The rates of reported drunkenness increase steeply across age groups (Fig. 3): those who report being drunk twice or more comprise up to 12% of 11-year-olds, 37% of 13-year-olds and 67% of 15-year-olds. This is illustrated in the case of Latvia, where rates rise from 2% of 11-year-olds through 11% of 13-year-olds to 33% of 15-year-olds, or the United States, where the respective rates are 3%, 12% and 31%. While for students in most countries a steady increase over the age groups is apparent, for some countries the major difference is between 13- and 15-year-olds: in Sweden, the rates change from 7% to 40%, and in Austria 10% of 13-year-olds and 42% of 15-year-olds report having been drunk twice or more.

In some countries, students maintain their relative standing in relation to drunkenness across age groups. Switzerland, Israel, Portugal, Greece and France are consistently among the lowest, while Northern Ireland, England, Scotland and Wales are consistently high. Again, this reflects a clear geographical pattern, with students from Mediterranean countries reporting low levels of drunkenness, in sharp contrast to those from countries making up the United Kingdom. For 15-year-olds being drunk ten times or more, the pattern is maintained: over 20% of 15-year-old Northern Irish, Danish and Welsh students reported having been drunk at least ten times.

In terms of gender differences, boys report more frequent drunkenness than girls at all ages. In general, the rates are very low for 11-year-old girls, and the differences between boys and girls tend to be greater for older age groups. In Estonia, 11% more 13-year-old boys than girls report having been

drunk twice, and in the Slovak Republic the difference is 10%. Other differences in this age group are smaller. At 15 years, gender differences are typically more substantial: many exceed 10%, and in three countries they are greater than 20%; Estonia (21%), Hungary (21%) and Latvia (24%).

Fig. 3. Students who report having been drunk twice or more often (%)



Source: Currie et al. (2000).

In all countries, boys report more frequent drunkenness than girls at 11 years. Among 13-year-olds, more girls than boys report having been drunk twice or more in only two countries (Greenland and Finland), while at 15 years the same pattern emerges in Greenland, England, Norway and Scotland. The differences are relatively minor, with the exception of 13-year-olds from Greenland. At 13 years, 7% more girls than boys from Greenland report having been drunk twice or more, and this mirrors their data for daily smoking, weekly smoking, weekly beer drinking and weekly drinking among 13-year-olds. However, all gender differences in having been drunk ten or more times favour girls, with substantially more 15-year-old boys than girls in many countries reporting that they have been drunk that often. The

percentage difference exceeds 10 points for Finland, Greenland, Ireland and Scotland (Nic Gabhainn & Francois, 2000).

## Changed patterns of alcohol consumption

A comparison between the representative HBSC surveys carried out in 1994 and 1998 reveals that, in most participating countries, regular alcohol use among adolescents in west European countries shows a clear downward trend, while in eastern Europe figures for regular alcohol consumers are rising. For episodes of drunkenness, on the other hand, the frequency is increasing among young people in general. These trends are shown for individual countries in Table 1.

Table 1. Trends (1994–1998) in the frequency of regular alcohol consumption and episodes of drunkenness in 13- and 15-year-old boys and girls (increase/decrease in %)

	Alcohol at least once a week				Drunkenness twice or more often			
	13-year-olds		15-year-olds		13-year-olds		15-year-olds	
	Male	Female	Male	Female	Male	Female	Male	Female
Austria	-10	-5	-4	-3	-3	-2	+3	+6
Belgium (Flemish)	-3	-1	-6	-3	-2	0	+2	+6
Canada	-2	-2	-3	-13	0	+1	+3	+4
Czech Republic	-2	+1	-6	0	+1	-1	0	+3
Denmark	0	0	+6	+5	0	0	+6	-4
Estonia	0	+2	+7	+5	+8	+2	+18	+13
France	-13	-8	-9	-3	+1	+2	+5	+7
Finland	-4	-1	-5	-1	-4	+3	+6	+1
Germany	+5	+1	+4	+4	+3	0	-2	-5
Hungary	0	0	+5	+3	+1	-1	+6	+2
Israel	-2	+2	+2	-1	+2	+3	+10	+4
Latvia	+2	+2	+8	+4	+5	+4	+12	+2
Lithuania	+2	0	+2	+3	+7	+2	+5	+3
Norway	+2	+2	+6	+5	+1	+3	+7	+12
Poland	-3	-1	-2	-1	+1	0	+5	+3
Russian Federation	0	+1	+7	+13	+3	+3	+11	+13
Slovakia	-3	+3	-1	+6	+1	+4	+3	+11
Sweden	-1	0	-2	0	+6	+3	+13	+18
Switzerland	+1	+2	+15	+6	+1	+1	+3	+3
United Kingdom (Northern Ireland)	-6	-14	-13	-11	+7	+2	+9	+8
United Kingdom (Scotland)	-4	-6	-4	+1	0	-2	0	+5
United Kingdom (Wales)	-7	-6	+1	-9	+4	+6	+11	+4

Owing to methodological factors, only very broad conclusions can be drawn from the differences shown in Table 1. Confidence intervals are such that only differences of more than 2% are to be considered as reliable. In

addition, the fact that this comparison relates to only two points in time precludes an interpretation of long-term trends. However, this comparison of two successive generations of adolescents shows up clear differences in a number of countries.

The proportion of regular drinkers among 13-year-olds is falling. This is particularly evident in Austrian and French boys and Northern Irish girls. Only in Germany has the proportion risen slightly. In most countries, the frequency of episodes of drunkenness has remained unchanged in 13-year-old adolescents. Only in Austria has there been a slight fall. It is striking, however, that the sharpest increases are to be seen in countries where the absolute frequency was relatively low. This applies in particular to eastern European countries, but the frequency of episodes of drunkenness has also increased among 13-year-olds in Sweden, Northern Ireland and Wales. The increases among boys are greater than those among girls, the only exception being adolescents in Wales.

Among 15-year-olds, too, there is a downward international trend in regular alcohol consumption. In Northern Ireland, the rates declined by as much as 13% in boys and 11% in girls. An equally large fall was seen in Canadian girls. On the other hand, the rates increased in eastern Europe (with the exception of the Czech Republic) and in Switzerland. There are clear increases in experience of drunkenness among 15-year-olds. This is most evident in Sweden and Estonia, as well as in other eastern European countries (again with the exception of the Czech Republic). While there is no clear gender pattern in the decrease or increases in regular alcohol consumption, the rates of increase of experience of drunkenness are generally larger in boys than in girls.

In the reported trends, two developments are apparent: on the one hand, the pattern of alcohol consumption appears to be changing in western European industrialized countries. Irregularly smaller amounts are consumed increasingly frequently, but larger amounts are drunk on specific occasions. Clearly, this is increasingly done with the intention of getting drunk. This behaviour is known as "binge drinking". Secondly, the differences between the participating countries show the effects of health policy efforts on prevention, as well as the consequences of more intensive advertising and, especially in eastern Europe, a stronger trend towards alcohol use as part of increasing overall economic prosperity. The interrelations between these two developments are examined in more detail in the following chapter.

## Chapter 3

# Causes of alcohol consumption and associated factors

Numerous research projects are concerned with identifying the causal factors and repercussions of alcohol consumption by adolescents. The aim of such work is to identify appropriate entry points for prevention. The causes and reasons for adolescent alcohol use and abuse are to be found in the interplay of various genetic, mental, social and lifestyle factors. The most important known causes and correlates are presented below.

### Social strata

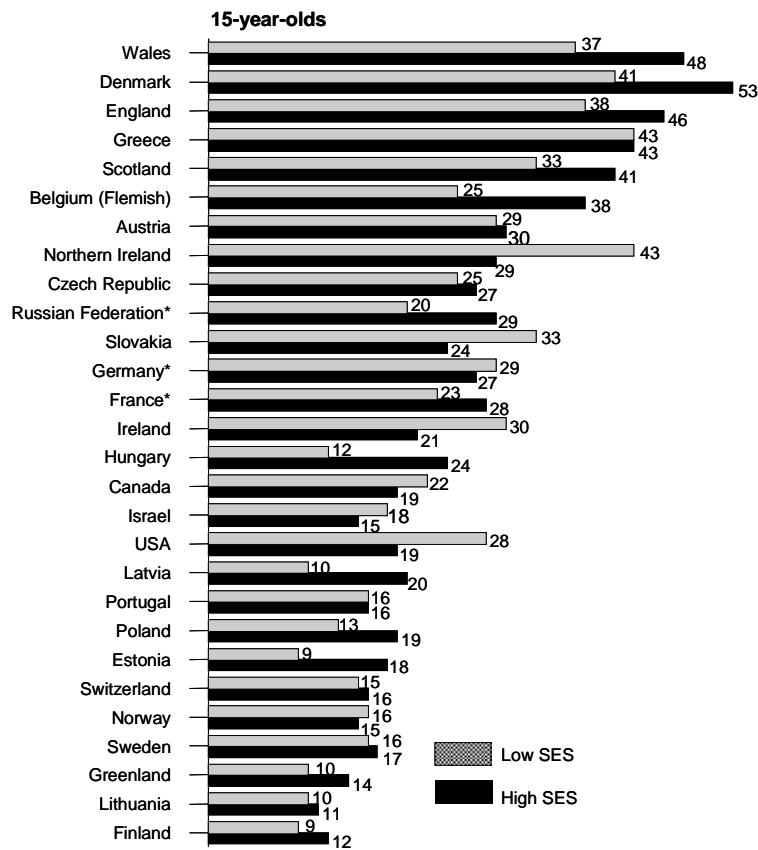
Among adults, alcohol consumption and abuse are frequently seen in connection with social position. The fact of being socially disadvantaged is regarded as a “trigger” for increased alcohol consumption. A study from the Netherlands showed, however, that this is not the case in adolescents: alcohol and drug consumption was found to be the same in all groups classified by socioeconomic status (SES), a measure constructed from the educational level and occupational status of both parents (Tuinstra et al., 1998).

In the HBSC study, a similar question was taken up in international comparative terms. Adolescents were asked for their assessment of the financial situation of their families. Those who reported a particularly good and particularly bad financial situation were subsequently compared in terms of their regular alcohol consumption. In many countries, the frequency of regular alcohol consumption among adolescents varies with social class. This relationship is not apparent, however, in comparisons between countries. Fig. 4 shows the differing frequency of alcohol-consuming adolescents aged 15 years, depending on their assessment of the financial situation of their families.

In countries with comparatively low rates of regular alcohol consumption among 15-year-olds, there are no statistically significant differences between the social groups. Similarly, no clear differences are seen in Greece, Austria, the Czech Republic, Germany and Portugal. In the

United Kingdom (with the exception of Northern Ireland), as well as in Denmark, Belgium, the Russian Federation, France, Hungary, Latvia, Poland and Estonia, adolescents from financially better off families consume alcohol more frequently. On the other hand, in Northern Ireland and the Republic of Ireland, as well as in Slovakia, Canada, Israel and the United States, it is mainly adolescents from financially disadvantaged families who drink more. In international comparisons, the rates of adolescents with frequent experiences of drunkenness follow those for regular consumption. Here, too, the same social differences are seen in the countries.

Fig. 4. Students from families with high versus low socioeconomic status (SES) who report drinking alcoholic beverages once a week or more (%)



\* France, Germany and the Russian Federation are represented only by regions.

Source: Currie et al. (2000).

The reasons for the differences between countries are difficult to interpret. A number of factors could be advanced as explanations: for instance, specific subcultural behaviour patterns, which are adopted by the



underprivileged, in particular, but also especially drastic social differences that increase the pressure on the socially disadvantaged and thus lead to increased compensatory alcohol use. In conclusion, however, it can merely be said that alcohol consumption in adolescents is not a necessary consequence of social inequity, but rather a general social problem.

## Parents and family

With regard to children's dealings with alcohol, parents and the family are of particular importance, for several reasons. In most cases, the introduction to alcohol consumption takes place in the family, mainly at family events such as birthdays, marriages and anniversaries. But children's continuation of alcohol consumption is also dependent on a number of family factors, both risk factors and those with a protective effect. Studies on the influence of the family have shown that this generally has an effect already in childhood and, with a certain degree of latency, determines affinity towards alcohol in adolescence. The research carried out to date has mainly looked at genetic factors, parents' behaviour models, style of upbringing and communication patterns in the family.

Both the affinity to use psychoactive substances, such as alcohol, and the individual risk of dependency are co-determined, to a certain extent, by the genetic make-up of the individual. The Virginia Twin Study of Adolescent Behavioural Development (Maes et al., 1999) showed that moderate alcohol consumption is influenced to the greatest extent by environmental factors, while heavy alcohol abuse and alcohol addiction are co-determined to a significant degree by genetic factors. The alcohol consumption of parents themselves, through its intensity and frequency, is a decisive co-determinant of children's alcohol consumption. For instance, where parents consume alcohol frequently, alcoholic beverages are more available, since they are present in larger quantities at various places in the household. Equally, alcohol is consumed on more frequent occasions in these families, so the children have more opportunities to try alcohol. The educational influence of parents – with regard to advocating moderate and controlled enjoyment of alcohol, as well as giving warnings about the potential health hazards – is questionable in cases where the parents themselves tend towards alcohol misuse. Sermons about abstinence and morality are scarcely credible in this context. As a rule, actual behaviour is accompanied by a higher tolerance or even an ideology supportive of the consumption of alcohol and of other psychoactive substances.

Children learn at an early age which substances are used for which purposes, and which effects they generate. Even pre-school children in their role-play imitate the ritual of proposing a toast, the heightening of convivial behaviour and the effects of getting tipsy, thereby developing latent

expectations concerning their own consumption at a later date. In this sense, parents provide the first models of alcohol consumption.

The misuse-promoting effects of parental alcohol misuse are seen, however, even before childhood and adolescence. During gestation and the lactation period, children of alcohol-dependent mothers are subject to a markedly higher risk of physical and mental disorders (Petermann, 1995). In addition, where one or both parents have alcohol problems, there is an increased likelihood of the development of behavioural disorders, since the family situation is frequently characterized by problems such as parental disputes, financial need, unemployment, aggression and violence or other social defects. Co-morbidity among parents, such as depression, is frequently found and poses an additional developmental risk to children. A German cohort study has shown that children of parents with high alcohol consumption also, for their part, have more experience of alcohol. Even the abstinent children of alcohol-consuming parents consider it likely that they, too, will drink alcohol in future (Freitag, 1995).

An increased risk of conspicuous alcohol consumption by children has been demonstrated for various characteristics of family composition. For instance, children in single-parent families, and especially in those where the parents are divorced, drink more, and more often, than those from "complete" families. The number of siblings and their consumption behaviour also play a role. Where older siblings drink alcohol more frequently, this increases the likelihood of alcohol consumption by younger children (Dielmann et al., 1993).

Many aspects of family life have an effect on children's alcohol consumption. Particular reference is made in this regard to the relationship with parents (Duncan et al., 1995; Foxcroft & Lowe, 1995). An excessively permissive style of upbringing increases the likelihood of alcohol misuse in children. Among adolescent drug users, one common feature is negative intra-family communication marked by criticism and reproaches. These adolescents often see their fathers as hostile and dismissive (Hawkins et al., 1992). On the other hand, where adolescents' relationships with their parents are good and marked by trust and mutual respect, and where there are lively exchanges of views, alcohol consumption by adolescents is lower than in families where these relationships are negative or disrupted.

Where conflicts in family communication are dealt with in a constructive way, children learn social skills and conflict management competences that they can later use in tackling their own problems. This is seen as being helpful in withstanding group pressure and avoiding destructive solutions to problems; it is therefore an important factor in the avoidance of alcohol misuse. Not least, this will also enable parents to have an influence on the composition of their children's circle of friends, and hence also an indirect one on their children's dealings with addictive substances.

## School

Although drinking, unlike smoking, does not take place during the actual time spent at school, variables related to the school must be recognized as having a clear influence. The frequency and intensity of alcohol use are independent of adolescents' intelligence or academic capabilities. However, several studies show a clear relationship between alcohol consumption and poor performance at school (Hawkins et al., 1992). A German study by Nordlohne (1992) showed that both drinking and smoking among adolescents can be predicted by experiences of poor performance at school. In this context, alcohol serves primarily to compensate for the emotional stress related to these experiences of poor performance. Unmet expectations by parents and the resulting family conflicts, for instance, therefore also play an important role here.

From existing studies, it is clear that there is a relationship between school performance and alcohol consumption, with drinking to be seen as both the result and the cause of school failure. Scholastic shortcomings, negative attitudes towards school, and conspicuous behaviour are often the triggers and consequences of alcohol misuse. This underlines the compensatory function attributed to alcohol.

As an institution, the school has a great influence on the behaviour of schoolchildren: apart from the family and groups of friends, it is the place where they spend the main part of their time. The school is the most important setting for socialization. It is therefore to be expected that factors which describe how a school's social and aesthetic atmosphere is perceived may be used as predictors of alcohol consumption among schoolchildren. To that end, the HBSC study put forward various school variables which can be used to describe the perception of the school as an institution and the children's own scholastic performance and related stress levels. Table 2 shows how these variables are associated with the frequency of previous experiences of drunkenness.

The overall relationship to school, as expressed in the variables "liking school" and "school is boring", varies for both sexes and in all age groups with the frequency of past drunkenness. The association is, in general, somewhat stronger among boys. Frequent alcohol misuse is evidently associated with dislike of school. The association between school performance and the frequency of alcohol misuse occurs predominantly in the older age groups. It is interesting that there is no gender effect here. The associations found suggest that, the older students are, the more their poor school performance is compensated for by alcohol misuse. The pressure imposed by school work is only weakly and ambiguously associated with alcohol misuse.

Table 2. Associations between frequency of drunkenness and school variables

	11		13		15	
	Boys	Girls	Boys	Girls	Boys	Girls
Liking school	-.16	-.10	-.21	-.18	-.19	-.19
School is boring	.15	.11	.22	.21	.24	.26
Academic achievement	-.09	-.06	-.14	-.13	-.17	-.16
Pressured by school work	.12	.07	.11	.08	.07	.10
Rules at my school are too strict	.12	.09	.17	.15	.14	.12
Rules at my school are fair	-.12	-.09	-.20	-.19	-.19	-.18
My school is a nice place to be	-.11	-.10	-.17	-.18	-.16	-.16
Teachers treat us fairly	-.12	-.06	-.17	-.15	-.16	-.16
Teachers help when it is needed	-.10	-.06	-.13	-.11	-.11	-.09
Teachers are interested in me as a person	-.06	-.05	-.12	-.11	-.12	-.11
Teachers expect too much	.10	.07	.12	.12	.10	.09
School mates are kind and helpful	-.06	-.05	-.06	-.05	-.03	-.02
School mates accept me as I am	-.03	-.03	.00	.00	-.03	-.02
Parents are ready to help in case of problems	-.07	-.07	-.08	-.12	-.07	-.11
Parents encourage me to do well at school	-.05	-.04	-.05	-.06	-.04	-.04
Parents expect too much	.08	.06	.10	.10	.08	.08

Pearson correlations

There are mainly intermediate and strong statistical associations between the frequency of drunkenness and such variables as the perception of the social climate at school. It may therefore be assumed that 13- and 15-year-olds report less drunkenness if they find the rules at school to be fair and assess their school as a nice place to be. This is particularly relevant in the age group of 13-year-olds. Boys and girls appear to be similar in this regard. The perception of school rules as too strict proves to be a predictor for frequent drunkenness in 13- and 15-year-olds. Equally, associations can be found with the support received from teachers.

Where students feel they are treated fairly by their teachers, they also report less drunkenness. The association with helpful and empathic teachers is somewhat weaker but still apparent. On the other hand, where students feel their teachers expect too much, this is associated with more frequent drunkenness. The associations between factors that describe the atmosphere at school and alcohol misuse point to ways in which the school can contribute as a setting for prevention of this type of behaviour. In comparison with other risk factors mentioned, the school accounts for only a small proportion of the predictability of alcohol problems, but as a publicly accessible setting for prevention it is of decisive importance.

Surprisingly, factors describing the social relations between students have no effect on the frequency of alcohol misuse. Equally, parents' school-related behaviour (such as their willingness to help or their expectations

concerning school performance) are only weakly or not at all associated with the frequency of drunkenness.

## Peers and subcultures

All the predictors of alcohol consumption and misuse among adolescents mentioned above are surpassed by the normative influence on behaviour and attitudes exercised by the peer group (Jones & Heaven, 1998). Membership of a group in which most members consume alcohol frequently and extensively leads to a situation where the individual also tends to adopt this behaviour. As a drug with social effects, alcohol is an integral part of adults' conviviality and bonding in all countries and cultures. This cultural model is imitated by adolescents in their groups.

As adolescents grow older, the family becomes less important for the socialization process, while the influence of a person's group of friends increases. This is part of the normal process of growing away from parents. In this phase, young people between 12 and 18 years old typically come together in more or less fixed groups, in which adult behaviour is practised. Within these groups, a subcultural identity is frequently formed which helps to distinguish their members from the culture and norms of the parent's generation.

Belonging to a special group of people is expressed by using symbols. Special patterns of behaviour and attitudes are taken as symbols of a subcultural identity the young people feel committed to (e.g. "A real Punk has to be drunk"). These behaviour patterns are often risk behaviours like alcohol misuse. Different groups of adolescents have different mixtures of behaviour patterns that are used for self-description. While alcohol consumption (as part of the main culture in most western countries) can be found in almost every cultural subgroup, there are preferences for particular drugs in different subcultural groups. Smoking is more frequent in some groups than in others. Some groups use deviant behaviour to express their personal independence and their resistance to authority.

It seems obvious that alcohol consumption in adolescence is part of the regular communication processes inside peer groups and adolescent subcultures. Engagement in peer subcultures and the resulting experimentation with alcohol can be considered a developmental task in this stage of life. Consuming alcohol to an extent that does not deviate from the norm is thus a sign of social behaviour, and it is more frequent in close-knit groups than in others. On the other hand, alcohol misuse that exceeds the normal extent is often an expression of disturbed social behaviour and evidence of a tendency towards delinquency (Maggs & Hurrelmann, 1998).

## Availability, advertising and legal restrictions

National and local governments exercise influence over alcohol consumption, and not only among adolescents, at three levels: the availability of alcohol or regulations governing to whom it may be sold, where and how it is sold, and the price and taxation of alcoholic beverages. A number of studies show that high taxation – and hence a high price for alcoholic beverages – has a decisive influence on amounts consumed. Where alcohol can only be obtained in a few places, its availability is limited and less is therefore drunk. Raising the minimum age for the purchase and consumption of alcohol reduces the frequency of alcohol-related accidents and other categories of conspicuous behaviour in adolescents. Strict control over the sale of spirits, e.g. exclusively in special retail outlets, also reduces alcohol consumption.

Stricter laws also change social norms and society's tolerance of alcohol consumption. This also results in a reduction of the amounts of alcohol generally consumed (Hawkins et al., 1992). The extent and degree to which such measures are implemented in the various countries is marked by the cultural and historic conditions found at the outset, such as the predominant religious orientation of the population and the related rights and traditions, the framework within which social policy is pursued, and the power of the corresponding interest groups.

The legal limitations on the age at which alcoholic beverages can be purchased and consumed by the public vary, even within the European Community. While the vast majority of countries listed in Table 3 require a minimum age of 18 years, and the United States and Lithuania demand 21 years, in Germany, Austria, Belgium, France, Hungary and Switzerland a minimum age of 16 years is laid down, at least for low-alcohol beverages. Greece and Portugal have no set age limit. These limits are enforced with different degrees of strictness in the individual countries, so they are actually only rough guidelines. The influence of age limitations on alcohol consumption by adolescents cannot therefore be directly determined.

The sale of alcoholic beverages has different traditional roots in the various countries. Only in a few countries are there strict restrictions on sales, over and above the age limitation. Canada, Finland, Greenland, Lithuania, Sweden and the United States are the only countries where there are clear bans on sales in publicly accessible places. In many countries, however, the law requires special licences for sales. In most countries, alcohol beverages such as beer and wine are available in supermarkets and petrol stations, as well as in almost all public facilities. In all countries, the retail trade is obliged to implement the legal age limitations.

Table 3. Country policies on alcohol (status 1997)

Country	Sale of alcoholic beverages <sup>1</sup>						Legal age for buying alcoholic beverages (years)	Average cost of 1 litre of beer (Euro)	Alcohol advertisement banned or restricted <sup>2</sup>									
	A	B	C	D	E	F			A	B	C	D	E	F	G	H	I	
Austria							16 <sup>3</sup>	1.46										
Belgium (Flemish)							16	1.15										
Canada							18–19 <sup>3</sup>	2.34										
Czech Republic							18	0.38										
Denmark							15	0.86										
Estonia																		
Finland							18	2.93										
France							16	1.07										
Germany							16 (18 <sup>5</sup> )	1.00										
Greece							NR <sup>6</sup>	1.90										
Greenland							18	11.0										
Hungary							16	0.36										
Ireland							18	2.90										
Israel							18	2.15										
Latvia							18	1.10										
Lithuania							21	1.00										
Norway							18	3.50										
Poland							18	1.12										
Portugal							NR <sup>5</sup>	1.00										
Russian Federation							18	0.32										
Slovakia							18	0.65										
Sweden							18–20	3.30										
Switzerland							16 (18 <sup>5</sup> )	1.96										
United Kingdom:																		
England							18	4.70										
Northern Ireland							18	5.20										
Scotland							18	4.70										
Wales							18	4.70										
United States	3	3	3	3	3	3	21 <sup>3</sup>	2.49	3	3	3	3	3	3	3	3	3	3

<sup>1</sup> Alcoholic beverages sold: in supermarkets (A), at public events (B), in petrol stations (C), in bars or restaurants (D), in liquor stores (E), licensed stores only (F).

<sup>2</sup> Advertisement for alcoholic beverages prohibited: on television/radio (A), in newspapers/magazines (B), in cinemas (C), at sporting events (D), on billboards/in public places next to educational and health care institutions (E), in any public area (F), when targeting young people (G), for beverages with an alcohol content above a certain level (H), unless it includes a health warning or preventive message (I).

<sup>3</sup> Depending on laws in the federal states.

<sup>4</sup> No information available.

<sup>5</sup> Different restrictions for spirits.

<sup>6</sup> Not restricted.

Like smoking, regular alcohol consumption is also affected by the price of the product concerned. In this context, due account should be taken not only of the variation in the price of alcohol, but also of the increase or reduction in the average purchasing power of adolescents. When considering the temporary misuse of alcohol in the form of binge drinking, however, price clearly plays a subordinate role.

The proportion of adolescents who consume alcohol apparently mirrors a country's industrial development. In addition to the question of output, it is presumably also the associated consumer orientation in eastern European countries which is leading to such steep rises in consumption figures in adolescents. In addition to the factors mentioned above, media uptake and the related exposure to the direct and indirect advertising play a major role here. In most countries, restrictions on the advertising of alcoholic beverages are based on voluntary self-limitation by the industry. In the meantime, advertising in specific youth media (such as young people's magazines) is banned in many countries. The placing of posters in the immediate vicinity of schools, health facilities and establishments for young people is also extensively avoided.

Further legal regulations exist only in few countries. Belgium, Lithuania, Norway, Poland and Sweden, for instance, have passed almost total bans on advertising, the only exceptions still being the sponsoring of sport and cultural events. In Denmark, France, Germany, Hungary and Switzerland, there are regulations governing the content of advertisements. Adolescents must not be explicitly targeted by advertising in these countries. Only in France is advertising accompanied by a health warning.

Like tobacco advertising, advertising for alcoholic beverages has an effect on young people's behaviour. The orientation of advertising messages towards an adolescent lifestyle, including that of young women, appears to partly responsible for the increasing consumption that is being seen and for the differences in rates of consumption between girls and boys. Strict advertising restrictions, such as shown in Table 3 for Belgium, Poland and Sweden, for instance, are accompanied by a change in drinking habits in these countries: regular alcohol consumption is falling. However, this effect can only be expected in conjunction with other legal measures to protect adolescents, such as restrictions on sales, age limitations and price increases.

There clearly remains a great deal to be done to reach the target of a significant reduction in alcohol-related health damage, as laid down in the European Charter on Alcohol (WHO, 1996). The Charter proposes various strategies to contain alcohol consumption – such as general education about the health risks of drinking, appropriate preventive measures in childhood and adolescence, and limiting the availability of alcoholic beverages by means of legal regulations and taxation. International comparisons show, however, that the governmental implementation of restrictive measures is not enough to reduce alcohol consumption by adolescents.



## Conclusions for the development of promising prevention strategies

The data presented above on the prevalence of alcohol consumption in adolescents indicate that, in addition to the numerous young people who are abstainers or only occasional drinkers, a significant number of adolescents show problematic consumption patterns already at a young age. Very few young people's first experience of alcohol is at the age of 15 years or later. As a rule, initiation of alcohol consumption takes place very early in life in nearly all the countries that are participating in the HBSC survey. By their sixteenth year, more than two thirds of all adolescents have had experience of the taste and the physical and mental effects of alcohol, as well as of its social effects and its acceptance by society. Expectations of these effects arising from such experience characterize later consumption behaviour and, in positive cases, lead to a strengthening and stabilization of alcohol consumption. Efforts should therefore be made to design prevention strategies that take effect before this age.

It would appear sensible to begin the prevention of substance use at a very early age. The aim should be to have an effect, at an early stage, on health-related attitudes, convictions and competences and to offer attractive alternative behaviours. In this context, children who already regularly consume alcohol before the age of ten years are very hard to reach with preventive measures. Very early and often wholly problematic drinking is attributable either to the strongly unfavourable influence of parents or to a complex mass of related problems, so that individual preventive efforts have a poor prognosis. Systemic therapeutic interventions are far more necessary here.

With a lifetime prevalence of alcohol consumption approaching 100%, complete abstinence cannot be a serious goal of preventive measures. Instead, efforts should be made to enable adolescents to deal with alcohol in a deliberate and moderate manner and, above all, in one that is appropriate to the prevailing situation. Studies on the ways in which preventive measures have an effect make it clear that it is particularly important to take account of the multifaceted social function of alcohol consumption. Many advertising messages convey precisely these social aspects such as relieving stress, promoting contact, improving mood and maximizing status. These messages are taken up differently by boys and girls. In certain cultural contexts, boys are therefore at somewhat greater risk from alcohol, since there is an association, in terms of content, between alcohol consumption, strength and manliness. Gender-specific prevention, which pays attention to the different causes and functions of drinking among boys and girls, is long overdue.

Current research into prevention is based on the assumption that only a combination of individual- and context-focused measures lead to successful

changes of behaviour. In terms of reducing alcohol consumption, this means combining the effects of the legal conditions described above with intensive efforts towards the obligatory prevention of certain types of behaviour. The more knowledge about the etiology and correlations of alcohol misuse is incorporated into the corresponding preventive measures, the more successful they will be. In recent preventive approaches, the fact that individual substance misuse is seen as an attempt to meet normative developmental demands and stressful events not only helps transfer appropriate coping strategies but also has a favourable influence on behavioural intentions, on people's expectations of their ability to affect their own lives, and on their behaviour itself. Previously, interventions concentrated solely on the knowledge or attitudes of young people. Recent overview studies on the effects of prevention programmes testify to this development (Tobler & Stratton, 1997).

Prevention is particularly effective when it provides training in how to resist social influences, develops people's general problem-solving skills and promotes pro-social, interactive capabilities such as competence in stress control. In this context, what matters is the way in which prevention is imparted: according to Tobler and Stratton (1997), interactive, participatory programme approaches are more successful than those oriented towards non-interactive, traditional methods that rely on instinct. This is particularly true for adolescents.

The best place to implement prevention programmes is in schools, where the vast majority of children and adolescents can be reached. Numerous models are available for doing this, but they have so far only been implemented in an unsystematic way. In many cases, it is left to the personal motivation of individual teachers to engage in preventive work. In schools, however, attention must be paid to the contextual conditions in which programmes are implemented. Research on this problem is currently only at the initial stage. Most models of the etiology of substance consumption point to the example that close social links with the school, and hence identification with it, have a protective effect against substance consumption. At the same time, however, expectations of scholastic performance and stress lead to greater vulnerability. This means that the success of preventive measures depends on how positively or negatively the students concerned assess their school environment and how well they cope within it.

## Chapter 4

# Examples of alcohol-related projects in Health Promoting Schools

This section offers examples of how schools can tackle the question of alcohol as an important part of their everyday life and work. Emphasis is placed on referring to experience gained in the course of the Health Promoting School project, which has now been running in Europe for ten years (Burgher et al., 1999).

The chapter is divided into three parts: firstly, some of the central concepts and principles related to the Health Promoting School are presented; then a number of specific examples are given of schools that have worked with the question of alcohol as part of their projects; and the final section summarizes a few of the most important future challenges facing schools when they work on the health aspects of alcohol use.

### **The Health Promoting School – some principles**

The European Network of Health Promoting Schools took stock of the situation for the first time at a conference entitled “The Health Promoting School – an investment in education, health and democracy”, which was held in Halkidiki, Greece, in 1997. This conference was attended by 375 politicians, researchers, teachers, professional health workers, etc. It produced a final resolution (WHO, 1997) emphasizing that:

- the Health Promoting School is an investment both in education and in health;
- health is regarded in a social perspective, from which young people are seen as persons closely involved in an interactive process with a dynamic environment;
- the focus is on the development of both visions and action on the part of the agents involved in the life of the school.

On this basis, the Health Promoting School is aiming at action and change, and the goal is for pupils to improve their skills and competences in relation to health in such a way that they can change their own lives and conditions in their environment. This emphasis on change is made explicit in the conference resolution in the form of ten principles, which are seen to be fundamental for fruitful investment in teaching, health and democracy for the coming generations. The ten principles are set out under the headings of democracy, equity, empowerment and action competence, the school environment, the curriculum, teacher training, measuring success, collaboration, communities, and sustainability.

Of course, these ten principles can and must be operationalized in the cultural context of the participating countries and their schools. Even so, together they indicate a common foundation for development of the Health Promoting School. These principles and the way they are interconnected are briefly presented below.

### **The components of the Health Promoting School – the example of alcohol**

The model used here (Jensen, 2001) presents a number of general components in the Health Promoting School that are also significant in terms of working with the issue of alcohol. Furthermore, emphasis has been placed on including factors related explicitly to the principles contained in the conference resolution referred to above.

The overall aim of the work of the school is for pupils to develop skills and competences that enable them to act in relation to their own lives and the conditions in their environment. In this connection, the resolution states that the overall aim is the development of pupils' "empowerment and action competence", noting that "the Health Promoting School improves young people's abilities to take action and generate change". In other words, action and change are central concepts here.

Teaching contributes to pupils' development of these skills, which in turn should enable them to take action on their own lives and living conditions (Fig. 5). In relation to the use of alcohol, this is partly a question of pupils being able to control their own alcohol consumption, so they do not damage themselves or others, and partly of their seeing alcohol as a product that often makes a positive contribution to their culture. They have to develop the strength of character to be able to say no or yes on their own behalf, and to withstand pressure from their surroundings. In addition, teaching should aim to build up pupils' competence with regard to changing conditions in their environment; this might involve making rules for parties held in connection with the school, creating the opportunities for exciting leisure-time activities, establishing a support network in case things go wrong, etc.

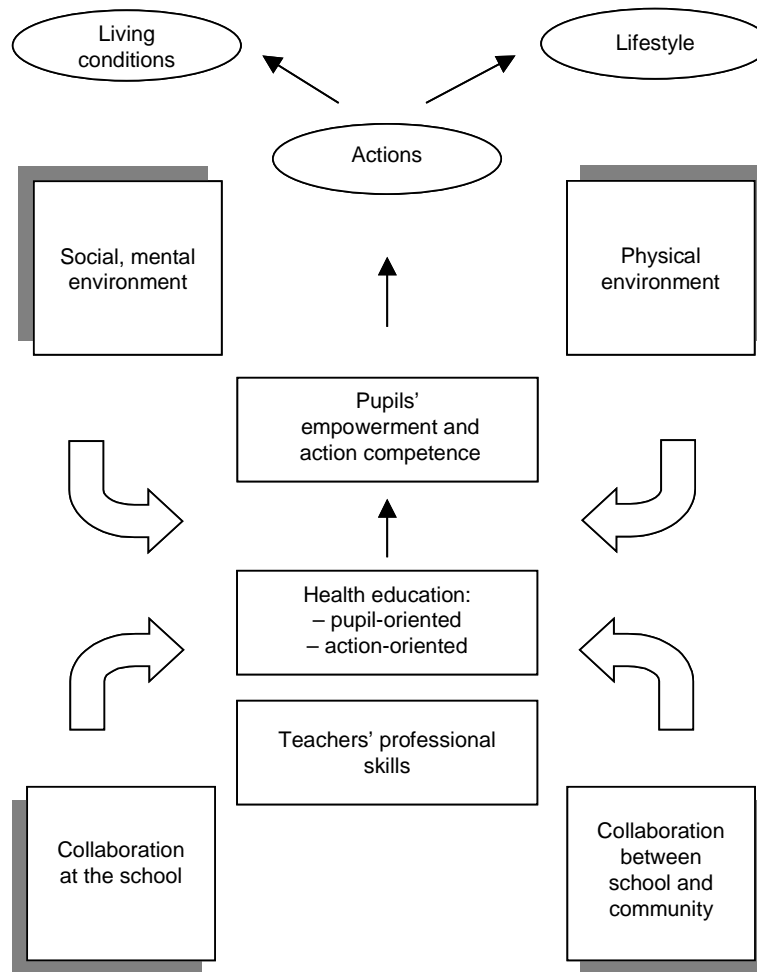
One precondition for pupils' developing this competence is that teaching is made relevant and organized in such a way that they feel a sense of ownership concerning the topics and themes they are working with. The principles set out in the resolution also therefore highlight the importance of the curriculum and teacher training. Teaching should be organized in such a way that it is "... relevant to the needs of young people, ... as well as stimulating their creativity".

To this end, teachers have to possess a range of important professional skills. On the one hand, they have to have a store of professional knowledge, in this case about the use and abuse of alcohol. In other words, teachers must possess insights into such areas as the effects of alcohol, the root causes of various types of alcohol use and abuse, strategies promoting health, preventive measures, and the solutions to alcohol-related problems. At the same time, teachers must be able to use different teaching methods, so that pupils themselves become actively involved in carrying out investigations, formulating visions and initiating actions. The acquisition of professional skills and teaching competences by teachers is thus a decisive precondition for empowering pupils and developing their action competence. This also applies in the case of alcohol-related topics. In other words, the professional (academic and educational) skills of the teachers are – as Fig. 5 shows – the basis on which teaching rests.

However, teachers' qualifications are not the only precondition for effective teaching. Even though teaching and teacher skills are regarded as central elements in the Health Promoting School, it is important to stress that these in turn are subject to a number of different conditions related to the external framework. These conditions, which appear in the resolution under the headings of "School environment", "Collaboration" and "Communities", can either promote or obstruct the aims of teaching. In this model, the arrows from the four boxes indicate that these factors influence teaching and pupils' health and skills. For this reason, efforts must be made to develop them, so that they can promote as much as possible those learning processes and the development of competence which are the aims of the Health Promoting School.

In terms of the school environment, a distinction is made between the physical and psychosocial environment. Does the physical environment of a school, for instance, allow for flexible teaching processes and for working in both large and small groups? Have pupils been involved in formulating rules for social behaviour in their class and in their school? These questions indicate what is covered by the two boxes relating to the school environment. Rules and requirements concerning the school environment may in some cases be laid down by the ministry of education or the school management. However, there is no doubt that rules, values and requirements which the pupils have helped to develop and formulate, in cooperation with their teachers and others, have a much greater impact on pupils' lives than those laid down from outside. The key word here is "ownership".

Fig. 5. Important components of the Health Promoting School



Source: Based on Jensen (2001).

In relation to the question of alcohol, this might involve the pupils working on visions and ideas about how to run social occasions and parties at school. What do the pupils themselves think is acceptable, and in their opinion what kind of behaviour falls outside the boundary of acceptable social behaviour? The teachers, too, must develop a common perception of the way they will react in various situations – if pupils turn up drunk to a school party, for example.

The boxes dealing with collaboration distinguish between cooperation within a particular school and cooperation with the surrounding society. Interdisciplinary cooperation at the school – between teachers in different

subjects and between teachers and professional health workers – is a condition for comprehensive treatment of a variety of health themes. In turn, such interdisciplinary teaching is a necessary condition, if pupils are to build up a coherent set of perceptions concerning health topics and about how to influence the conditions that affect their health. For example, a biology teacher might deal with alcohol in one particular way, while in social studies and in the creative subjects teachers would bring out completely different aspects. Together they help contribute to the study of alcohol as a product which, for better or worse, forms part of our culture in a variety of ways. And together they help promote the ability of the pupils to tackle situations in which they face the use of alcohol and alcohol-related problems.

Cooperation between the school and the local community opens up many exciting dimensions. Experts from the local area (technical experts, politicians, people in advertising, doctors, artists, etc.) can be drawn into the teaching offered by the school, adding a very valuable and inspiring authentic touch. On the other hand, the community may also benefit from the work done by the school, if the pupils help to call attention to health matters in the local community and perhaps make suggestions or help to launch particular courses of action. By investigating real-life conditions in the school district, pupils can gain insights into health-related matters in far more relevant ways than teaching within the four walls of the school normally allows for. The conference resolution emphasizes this function, in which pupils and teachers become active agents in the local community: “... young people themselves are more likely to become active citizens in their local communities. Jointly, the school and its community will have positive impact in creating a social and physical environment conducive to better health.”

When working on the use and abuse of alcohol, thinking of the local community as a cooperative partner is an obvious move. Experts who are concerned with alcohol in various social situations can contribute to teaching by throwing light on the many roles that alcohol plays in our culture. The pupils can go out “hunting” in the local area, to find and describe all the various situations in which alcohol appears. The observations thus collected may form the starting point for a subsequent class discussion of questions relating to alcohol, with the aim of preparing pupils for the fact that they will run into alcohol in many different situations, both in their present lives and in the future. Role-play and drama can be used to help prepare the kind of behaviour called for in these situations. And important discussions may be launched if pupils present these problems for parents or selected groups in the local community – in the form of presentations, drama, exhibitions and the like, held at the school itself or out in the community (e.g. at the local library).

The above model emphasizes that teaching is a central activity of the Health Promoting School, and it also illustrates a number of factors in the

social framework that affect the development of pupils and the teaching itself. On the other hand, it is also clear that teaching itself can play an important part in shaping, changing and modifying these framework factors. Examples of the latter include cases where the work done in class leads to pupils setting up ethical rules that will apply to behaviour in the classroom or the social environment of the school. In other words, there is a close and reciprocal relationship of influence between the teaching at school and the action competence of the pupils, on the one hand, and a number of factors relating to the school environment and cooperative partners, on the other.

When presenting the model and its various elements, particular emphasis has been placed on the active participation of pupils. There is no doubt that the most unequivocal conclusion, reached by all countries and schools involved in the European Network of Health Promoting Schools, was that active involvement of pupils is absolutely decisive if the work and teaching of the school are to make their mark on the pupils' actions and behaviour. For this reason, pupils must be regarded as active and visionary partners in the development of the Health Promoting School – and thus also in the teaching about alcohol offered in schools.

In the following sections, three different cases are presented, illustrating different examples of pupils' active involvement in the school's work on alcohol-related issues. Furthermore, emphasis is given to projects in which parents have also become involved.

### **Case 1: Development of school policy**

At this particular school, sixth-grade (12-year-old) pupils had said they would like to know more about alcohol. Not that any of the pupils drank alcohol yet, but they were aware that they would soon enough become acquainted with alcohol, since it forms part of the culture surrounding puberty. Moreover, some of them knew a number of the older pupils who had already started experimenting with alcohol. Together with their teacher, they agreed to devote 12 lessons a week for three weeks to the project, and they also agreed that the project should lead to a set of proposals concerning the way in which the pupils in the class should deal with the question of alcohol.

The pupils were asked to examine four different areas: (1) facts about the effects of alcohol; (2) the reasons why people drink; (3) action which could be taken by the pupils themselves; and (4) what alternatives to the present situation one could imagine – or wish for.

The results of WHO's survey into children's health (the HBSC study) were discussed as an introduction to the project (Currie et al., 2000). This



investigation, which showed that 21% of girls and 25% of boys aged 13 had been drunk at least twice, both surprised and scandalized the pupils.

The pupils were then asked to formulate a number of questions to which they wanted the project to provide answers. Each pupil was to write 10–20 different questions, after which they worked in groups reading their questions aloud to each other. The groups were then asked to identify the five most important questions on which the members of the group could agree. These questions were, for example: Why do people drink? What happens if you have to be “pumped out”? How much do people a little older than ourselves drink? Do people ever have accidents as a result of alcohol? What exactly does alcohol do to one, physically and mentally?

A discussion of the HBSC study and of the questions they themselves had formulated led the pupils to suggest that they should carry out a more thorough investigation of the situation at their own school. They decided to focus on the older pupils and designed a questionnaire which they handed out to pupils in the seventh, eighth and ninth grades at the school – six classes in all, two in each year. The pupils’ questionnaire consisted of the following questions:

- A. Do you drink?
- B. Have you ever been drunk?
- C. How old were you when you got drunk for the first time?
- D. Who do you drink with?
- E. What do you drink most: beer, wine or spirits?
- F. What do your parents think about your drinking?
- G. How much do you drink at a party?
- H. Can you enjoy yourself at a party without drinking?
- I. Does alcohol make you either funny or violent?
- J. Can you say “Stop” when you have had too much to drink?
- K. Have you ever had an accident as a result of alcohol?
- L. Why do you drink?
- M. Have you ever been pumped out?
- N. Have you ever thought that it can be dangerous to drink too much alcohol?

The sixth-grade pupils collated the results in bar charts and tables, and then the debate really took off. The results were exciting precisely because they revealed both facts and attitudes related to young people and alcohol in their own local area. Furthermore, the results described the attitudes held by young people only one to three years older than themselves, offering a picture of an age group which these pupils were approaching.

The investigation revealed, for example, that 11% of pupils in the seventh grade, 14% in the eighth grade and all those in the ninth grade admitted they drank. The age at which pupils had been drunk for the first

time was around 13 years in all the classes. None of the pupils in the seventh and eighth grades had had an accident of any sort, whereas eight pupils from each of the two ninth-grade classes answered that they had fallen off their bicycles.

The results of this investigation turned out to be real inspiration for the work of the class and helped to make the whole project more relevant for the pupils. Moreover, many of the pupils were personally acquainted with some of the older pupils involved in the investigation. Not least, the fact that 16 pupils had fallen off their bicycles surprised the teacher and pupils in the sixth grade and started a lively discussion.

Looking for the causes of why people drink, the pupils cut out advertisements and made displays showing those which they found to be best and most effective. Then they tried to design an advertisement themselves, which forced them to think about what it is advertisers appeal to when they try to manipulate us to drink more. This part of the project helped to develop the pupils' critical thinking skills with regard to various things that influenced them, including advertising.

Legislation in a number of different countries was investigated, and it was found that there were considerable differences in the minimum age for serving young people with alcoholic drinks in public places. In some countries in Europe, for example, the limit is 16 years, and in the United States it is 21 years.

The price of beer, wine and spirits was discussed as a factor behind the consumption of alcohol. In this connection, the pupils made a graph showing how many bottles of beer could be bought for an average worker's wage, seen in a historical perspective. The figures revealed that there had been a very sharp rise in this number from 1940, when the hourly rate would buy four bottles of beer, to the present day, when the same worker would be able to buy 23 bottles for his hourly rate.

In terms of actual measures to be taken, the pupils developed a set of rules for their own approach to alcohol and to parties. As a first step, they each made their own set of rules; these were then discussed in smaller groups, which agreed a common set of rules and then presented their proposals to the class. Finally, the class as a whole decided on a common set of rules. These rules included the resolution that pupils would not drink in the sixth and seventh grades but would reserve the right to start in the eighth grade.

The pupils invited their parents to an evening meeting at the school, at which they presented their own investigations and analyses and their proposals for a set of alcohol rules for the class. There then followed a general discussion by both parents and pupils, concluding with the adoption of a set of rules which would apply in the coming school year. Despite the

fact that the pupils had been nervous about facing all the parents, the evening passed off very well and the parents made a number of extra proposals, such as that pupils should look after each other at parties and similar gatherings. The pupils learned a lot from the whole project – not least from having to present their results to others – and were both surprised and impressed by the fact that the adults took them so seriously.

The teacher, the pupils and the parents were all aware that things move fast at this age (13–14 years), and that the rules that had been agreed might quickly turn out to be insufficient or inappropriate. For this reason, the most important agreement reached during the evening was that at every parents' meeting, or at least every six months, the rules would be taken up again with a view to possible revision. In other words, the work done by the pupils had started a process that would continue.

## **Case 2: Seventh-grade pupils work with an action-oriented alcohol project**

At this particular school, those taking part in the project were the pupils in a seventh-grade class (13–14 years old), their parents, their teachers, and the county alcohol consultant. For a period of six months, the pupils worked on the subject of drinking habits and the various contexts in which alcohol appears in society. During the project, a number of evening meetings were held for parents, teachers and pupils, at which various topics were discussed and the parents played an "alcohol game" with their children. The county consultant worked as a facilitator and took part in all the general meetings.

The pupils had expressed an interest in working with this topic, as they had reached an age at which parties and drinking had become attractive. The parents were interested for the same reasons, but in addition they had had the opportunity to discuss with the teachers the latest results from WHO's HBSC study (Currie et al., 2000).

The study was carried out at the pupils' own school in the fifth, seventh and ninth grades, as part of the county's own Health Promoting Schools project. The pupils were able to compare the figures from their own school with the average figures for the whole country, and also with figures from other European countries. The figures for weekly consumption attracted special attention and were eagerly discussed. These revealed that, in their part of the country, more boys than girls drink every week, and that 11% of 13-year-old boys drink beer, 2% drink wine and 3% drink spirits every week.

The county's own investigation revealed that the part of the country in which the school was situated matched the national average in terms of the consumption of beer and wine by young people, but that their consumption of spirits was above average. One of the reasons for this is possibly the fact

that this part of the country is close to the German border, and that many people buy spirits in Germany, where prices are lower than in Denmark.

The parents were worried by the results of this investigation, and this was one of the reasons why they decided to take an active part in the project. In this case, the HBSC investigation was an important source of inspiration for parents' active involvement in the work being done by the class about drinking habits.

As part of this work, the pupils had to do an assignment in which they expressed their attitude to a number of actual situations related to the use of alcohol. The aim was to get the pupils thinking, so that later they would be able to make suggestions as to how they themselves would act in alcohol-related situations. The pupils were asked to write down their answers to the following questions.

*State your position on the following issues or situations, explaining what your opinion is and why. It is important that you present arguments for your views. You are welcome to refer to examples from your own experience.*

- A. Imagine that you live in a society without alcohol and other stimulants.  
*What would be different?*
- B. Many people think that drink and parties belong together  
*Why? And what do you think?*
- C. Marianne tells you that she gets teased because her father will not allow her to drink.  
*What would you say to her?*
- D. You are at a party and do not feel like drinking.  
*How would you say no?*
- E. *Do boys and girls become just as drunk if they drink the same amount?*
- F. Many parents become nervous when their children begin to drink.  
*What do you think such parents are afraid of?*
- G. Henrik is throwing a party. He and Jacob begin a drinking contest.  
*Why would they do this? What do you think about it?*
- H. Peter is boasting to some of his classmates about how much he drank last Friday. You had been with him at the time and know that he is greatly exaggerating.  
*What do you do?*

- I. People lose their inhibitions when they drink.  
*Is that a good thing or a bad thing?*

The pupils' responses formed the basis for discussions in groups and in the class as a whole, which in turn led to a number of questions being selected for further work.

The culmination of the project was a 24-hour seminar in which all the pupils and their parents participated, along with their teachers and the county consultant. This seminar was designed so that the pupils and their parents came to discuss the question of alcohol from completely different angles.

For example, at the beginning of the seminar some of the parents were asked to tell three stories involving the use of alcohol, one of which was to be true while the others were imaginary. The pupils then had to guess which of them was the true one. In this way, the groups were provided with a common frame of reference in the shape of a number of experiences and stories, which could be used later on when there was a need to refer to examples that shed light on the problem under discussion. This exercise also made the parents credible in the eyes of the pupils, since they had so openly spoken about some of the problems they themselves had experienced with the use of alcohol.

For some of the group tasks, pupils and parents were distributed in such a way that pupils were not with their own parents. These group tasks were used to identify and discuss situations and problems related to the use of alcohol: topics such as traffic accidents, rows, violence, divorce and sexual behaviour were used to exemplify negative consequences of drinking. Social occasions, family festivities and parties were discussed and identified as situations in which alcohol often made a positive contribution to the social atmosphere. Later on, parties became an important focus of the discussions.

One of the tasks assigned to the groups was to send the youngest member out to buy beer in a shop, petrol station, etc. At the time, a law had recently been passed in Denmark forbidding the sale of alcoholic drinks to young people under 15 years. As it turned out, representatives of seven of the eight groups came back with beer without any problem, which sparked off a lively discussion about the advantages and limitations of legislation as a tool. The pupils who were sent out to buy beer were all 13 years old.

To round off the seminar, pupils and teachers were put into separate groups to discuss and reach consensus on the main points of an agreement about how pupils should behave when holding parties in their parents' absence. The pupils' groups suggested, for example, that: (a) they should be allowed to bring along 3–4 bottles of beer; (b) parties should be allowed to go on until 2 a.m.; and (c) they should feel more responsible for each other.

The parents also made a series of suggestions: in their view, pupils could take along one beer each, should come home before midnight, etc.

When the groups had presented their proposals, they retired again to discuss them all with a view to reaching some compromise agreement. In the concluding plenary session, agreement was reached on a number of points, such as that each pupil could take along two bottles of beer to a party, that parties should stop at 12.30 a.m., and that one should never abandon a friend who was feeling ill. In general, the theme of social responsibility and of pupils looking after each other was a central point in the discussion, and one that was clearly important to everyone. This agreement was subsequently written down and signed by both parents and pupils. At the same time, it was decided to put the agreement on the agenda of the parent-teacher meeting to be held six months later, where the contents of the agreement would be discussed with a view to possible adjustments.

Of course, this project is no guarantee that problems will not arise later on, or that the written agreement will be observed to the letter. Its effect lies rather in the fact that it brought into the public domain a topic that is often difficult for parents and children to discuss, providing a theme which everyone found it exciting to be involved in. In this way, a better understanding was created between the parents, and between the parents and their children, an understanding which is one of the conditions for developing common values and responsibility in the class and in the school.

### **Case 3: The use of HBSC data as an integrated element of teaching**

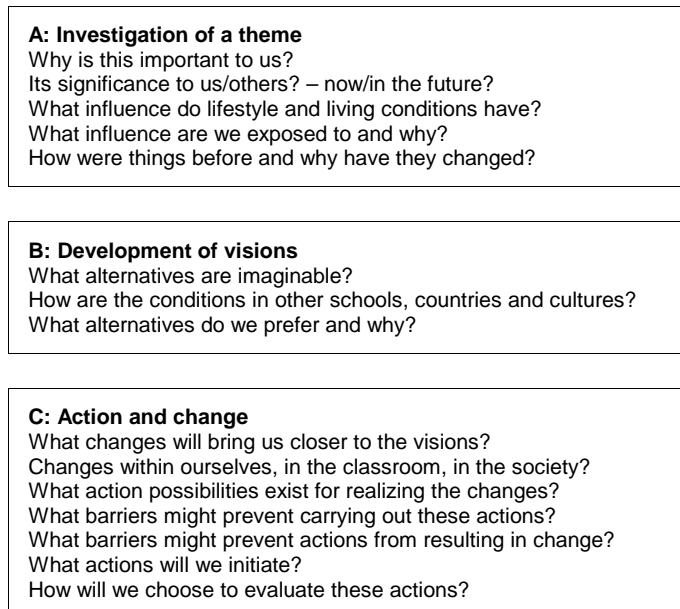
At one of the schools, the teachers had been working for some time with the so-called “IVAC” (Investigations–Visions–Actions–Changes) approach to health education (Jensen, 1997). This is a tool that emphasizes the importance of working in an action- and pupil-oriented way. The various lines of approach are illustrated in Fig. 6: under each of the three main headings, a number of questions have been formulated that pupils and their teachers can use as inspiration.

The first box in the model deals with reaching a common perception of the actual issue one is working with. The pupils have to be actively involved in choosing the subject and to come up with an answer to why this subject is important to them. This is perhaps the most important precondition, if the project is to build up pupils’ ownership and thereby influence their practice, behaviour and actions.

They must also work with the historical dimension. In order to assess how present conditions or a given trend have been influenced, it is important to understand which factors have contributed (over time) to their development.

In brief: an approach aimed at bringing about changes makes it necessary to look at conditions in a development perspective.

Fig. 6. The IVAC (Investigations–Visions–Actions–Changes) approach



A social science perspective is also important, in order to clarify the causes behind the problem. Even if the problem manifests itself in the classroom or the school, the underlying causes will often prove to lie outside these parameters. Societal observation methods, where health and environmental problems are portrayed in the economic, cultural and social structures in which they develop, are important here.

The second box deals with developing visions about how the conditions that one is working with and would like to change could look in the future. This area deals with pupils developing ideas, perceptions and visions about their future life and the society in which they will be growing up.

According to the third box, it is also important that imagination is allowed to flourish and generate a wealth of possible actions towards attaining some of the visions that have been drawn up. It is of great importance that all suggestions are brought forward for discussion. The different actions are discussed in relation to their effect and the barriers that might arise, and finally a decision is reached about which action(s) will be carried out.

In this case, pupils from a seventh-grade class (13 years) decided to focus on alcohol, as this was a subject that was beginning to interest more and more of them and their parents too. They worked with both the investigation and the vision phases, and then in the action phase they considered structures of power, actions and strategy.

In the investigation phase, they analysed alcohol from a biological, sociological, cultural and historical perspective. From materials developed by the National Board for Health, they learned about alcohol-related diseases and accidents. They also discovered that alcohol consumption is dependent on the economic conditions in society: among other aspects, they analysed the consumption of alcohol during the last century and made comparisons with trends in society's economic conditions, unemployment rates, etc. By interviewing people from different countries (including Ethiopia, Turkey, Wales and Yugoslavia) who were living in the local area, they explored how alcohol is used differently within different cultures and religions. They also looked at how a number of factors might influence their own consumption. Peer pressure, advertising, loneliness, unhappiness, and social events were among the factors which were discussed. A number of role-plays helped the students to clarify the mechanisms behind these causes (which we are all subject to).

Their vision dealt with how to create a society and a school where people had a balanced and responsible behaviour in relation to drinking, where alcohol could be viewed as a positive contribution to the culture, and where no people harmed themselves or others as a consequence of alcohol consumption. They discussed what such a society would look like, and how to make sure that all citizens (children as well as adults) have equal opportunities for living a stimulating and exiting life. Lastly, they envisaged a society (and a school and a family) where nobody would feel excluded or alone.

One of the actions that the pupils decided to carry out was to set down some advice for their parents about how they – according to the pupils – should act towards their own children in connection with alcohol. The pupils felt that their parents had a misinformed and wrong idea about what was going on among their own children. The seven pieces of advice were:

1. Young people also have an opinion on alcohol.
2. Have faith in young people and in your children.
3. It is not your problem if other children drink.
4. Allow the children to go to parties, nothing will happen.
5. Allow children to taste alcohol.
6. Allow them to have a pre-party at home.
7. Allow children to drink alcohol with a low percentage.



The content of these seven statements can of course be discussed, but that is not the point here. Instead, the point is to illustrate how pupils' own ideas can be used as a stimulating and fruitful starting point for a general debate involving pupils, parents and the teacher. The pupils' tangible action consisted in planning a parent evening. They called their parents to a meeting with the aims of presenting their work, their ideas and their advice, and then discussing the whole topic.

All the parents came to the meeting, and the seven suggestions presented by the pupils were used as a starting point for debate in smaller groups between pupils and parents. The pupils had formed the groups in advance, to make sure that parents were not in the same group as their children. Following the group work, it was the parents' turn to comment on the pupils' presentation, and a lively discussion developed.

After that evening, the parents said they had learned a lot about their children's attitude to alcohol, and several acknowledged that they changed their views on the basis of the pupils' presentation and other parents' comments. The evening did not end with great agreement on when, how and how much to drink, but rather with a greater understanding. All agreed that it had been a very stimulating experience.

In this case, the teacher's role as a supervisor, consultant and "critical friend" – asking pupils provoking questions about alcohol – was crucial for the whole process and for pupils' learning. The challenge is to strike a balance: on the one hand, pupils are involved as active partners and are taken seriously, but at the same time the teacher has an important role to play as a partner in the dialogue and the whole process. Without qualified counterparts, pupils will not be able to develop their own attitudes and understanding.



# Chapter 5

## Future challenges

The examples given above point to a number of challenges which must be faced by health education and Health Promoting Schools in the future. This is true both in general and more specifically in relation to teaching about drinking and problems related to alcohol. These challenges are relevant to a problem that is being increasingly recognized, namely that people – including young people – apparently seem to act contrary to the knowledge they possess, at all events if one compares their health behaviour and practice, on the one hand, and their knowledge about what is healthy and unhealthy, on the other.

The first challenge is centred around the principle of the active involvement and participation of pupils. It has been argued in this document that it is necessary to involve pupils, if teaching is to leave its mark on their actions and behaviour. This means that teachers must be able to tackle complex situations, in which pupils are involved as independent decision-makers, while teachers cannot relinquish their responsibility for developing pupils' competences relevant to the area in question. So far as alcohol is concerned, this means that the pupils among other things develop insights in this field.

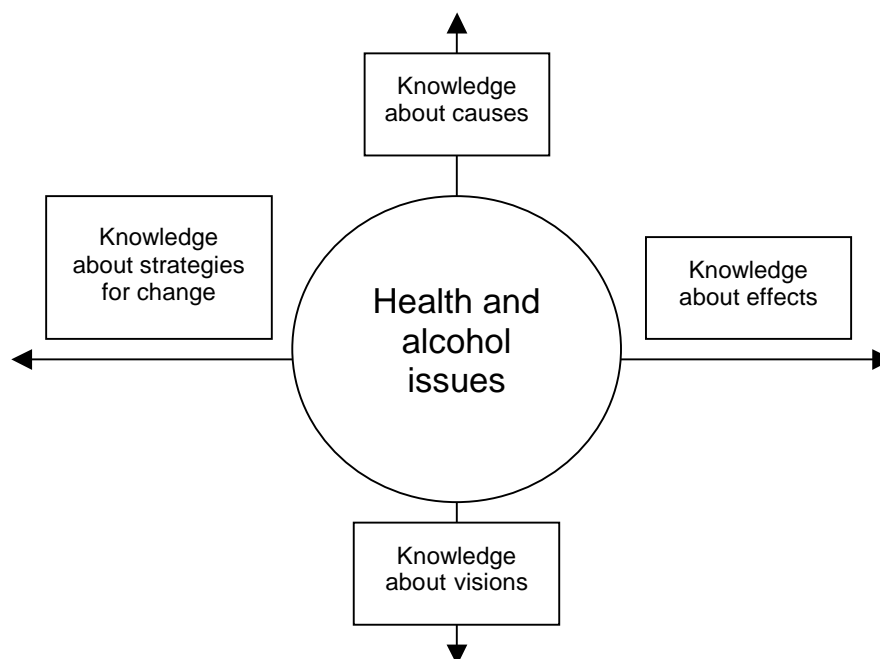
The question must therefore be posed as to what kinds of health-related knowledge or insights concerning the use of alcohol health education should attempt to propagate. Should it, for example, be knowledge about which kinds of behaviour entail the greatest risk of illness later in life; or about why some societal conditions lead to increased health, whereas others lead to alcohol abuse; or about how we are constantly affected by advertising and other influences? Or it is perhaps the case that, when we are working with the question of alcohol use, the knowledge element is more or less irrelevant or unimportant?

In any discussion about the content of the basic knowledge to be imparted by health education and Health Promoting Schools, the starting point should of course be taken from reflections about the overall aim of the activity. This part of the paper argues that developing the student's ability to act and change is the main goal, and that this has consequences in terms of the demands for knowledge and insight to be developed by students. The

core of a health-related approach should therefore in essence be action-oriented. This point of departure has considerable repercussions on the type of knowledge that will be focused on in the planning, implementing and evaluation phases.

At the outset, four different aspects of such action-oriented knowledge can be illustrated using the model in Fig. 7 (Jensen, 2000). The four dimensions illustrate different perspectives of knowledge within which a given health topic could be viewed and analysed.

Fig. 7. Four dimensions of health-related knowledge and insight



*The first dimension: What kind of problem is it? – knowledge about effects*

The first dimension deals with knowledge about the existence and spread of health problems. These are the health-related effects of conditions in the environment, lifestyles, social relations, etc. This type of knowledge can be about the consequences of a given behaviour or of acid rain or poor air quality in city districts or workplaces. Or it could be about how bullying in a school affects students' health and wellbeing. In the area of alcohol, it includes knowledge about what the substance alcohol does to our body and mind, how alcohol affects our behaviour in areas such as driving, sex or social events, and which effects related to alcohol are good and which are bad.

This type of knowledge will typically enable us to account for statements such as “If we do this, then that might happen” or “If the conditions or circumstances are these, then the risk of that will increase”.

This knowledge is of course important, because it arouses concern and awakens attention; indeed one could claim that it creates the starting point for being willing to act. So this can be one of the prerequisites for developing pupils’ empowerment and action competence. On its own, however, it does not help explain why we have a particular set of problems or even how we can contribute to solving them. This form of knowledge is mainly of a scientific nature. Standing alone, it can risk contributing simultaneously to arousing concern and inducing action paralysis among pupils.

*The second dimension: Why do we have the problems we have? – knowledge about causes*

The next aspect deals with the causative dimension of health problems: why and under what conditions do we become ill, which factors threaten or improve our quality of life, etc. By causes we mean the associated societal factors underlying our behaviour: why is smoking more common in certain social groups, which aspects of our living conditions have a major effect on whether use of alcohol leads to abuse? What contributes to the fact that a taxi driver is almost twice as much at risk of dying of a heart disease as an architect? Why is unemployment connected with greatly increased illness and risk of death in our societies? What conditions in a school, for example, contribute to whether bullying takes place? Who bullies in schools, and what is the cause of it?

In the area of alcohol, this dimension deals with identifying and discussing the factors that affect our alcohol consumption. Advertisements, social pressure from peers, expectations, loneliness, unemployment and low self-esteem could be mentioned as examples of such factors.

Many explanations for the increasing health inequalities in Europe are to be found within this dimension. Such knowledge relates mainly to the sociological, cultural and economic areas.

*The third dimension: How do we change things? – knowledge about strategies for change*

This dimension includes the actual process of change. It covers knowledge about how to control one’s own life, how to influence the environment at the school, and how to contribute to changing the living conditions in society. Which psychological mechanisms are at work when one participates in a group that is trying to get its members to live their lives in a particular way or maybe even change their ways of living? And how do we tackle the situation if we are trying to change the surrounding structures

in school, at work or in the local society through different channels? Who do we turn to, how do we go about it, and who could we ally ourselves with?

With regard to alcohol, this dimension could be about developing a shared social responsibility, developing rules for accepted behaviour among pupils in a class, working with adults (e.g. parents) on organizing social events after school, etc.

All this area of knowledge is central and decisive for action-oriented health education within a democratic Health Promoting School. It also includes knowledge about how to structure cooperation, how strategies are organized, how power relations are worked out and analysed, etc. These important fields of knowledge relate especially to psychological and sociological studies.

It is extremely important to think about knowledge concerning the scope of the problem, and not just about causes, when developing strategies for change. The different dimensions of knowledge should be seen in connection with each other, in relation to the health conditions the students are working on.

*The fourth dimension: Where do we want to go? – knowledge about alternatives and visions*

The fourth and last dimension deals with the need to develop one's own visions. One important prerequisite for the will and ability to act and change is that one has real possibilities – including the necessary support and surplus energy – to develop and shape one's own dreams and ideas for the future in relation to one's own life, work, family and society.

This dimension could include knowledge about conditions at a neighbouring school or about how issues are tackled in other cultures, both near and far, since knowledge about these conditions can be a good source of inspiration for developing one's own visions. Perhaps a school in the neighbourhood has had success with planning parties for older pupils with no – or restricted – alcohol consumption. The pupils from that school could be invited to present their ideas and experiences. Or some parents of pupils in other classes may have developed ideas about how to discuss and envision alcohol-related issues in close relationship with their children. These parents could be invited to present their ideas at a meeting involving all pupils and parents in a class.

In terms of Fig. 7, traditional health information would be placed along the axis of the first dimension – related to knowledge about the effects of health conditions. In this type of information the scientific approach is dominant, and attention is focused on students acquiring knowledge about

the fact that we have serious health problems, about how quickly they are evolving, what behaviour that leads to risks of illness, etc.

This type of knowledge as such does not necessarily promote actions, or even pupils' empowerment and action competence, especially when it stands alone. In fact, such knowledge can create a great sense of worry and, if not followed up by knowledge about causes and strategies for change, can perhaps be directly associated with breaking down commitment, thus contributing to action paralysis.

All aspects of health knowledge should therefore be thoroughly thought through from the perspective of action and change, and similar methods and techniques must then be developed for use in schools' teaching. A democratic Health Promoting School is therefore not without basic health knowledge and insight. On the contrary, it indicates that the new "landscape" of knowledge and insight will become more extensive and more coherent.

In this section we have tried to argue for the need to develop alternatives to the traditional, moralizing, behaviour-modifying health information – also in the area of alcohol education. It is a challenge for teachers, researchers and teacher trainers to further describe and develop the contours of a democratic and action-oriented alcohol education. We have especially emphasized that such an alternative should be built on a qualified professional foundation.

We have tried to give an indication of the content of this foundation, stressing that the principle of including students as active partners during the pedagogical process does not make the content of health and alcohol education superfluous, but rather means that it has to be rethought from an action perspective. This interdisciplinary insight should mainly entail an awareness of the connection between health, alcohol, people, culture and society.

This does not, however, mean that demands on teachers are lessened, or that a teacher's knowledge of health and alcohol issues should play a less important role. Maybe even the opposite is true. The teacher should both be in a position to act as an adviser and, from his or her own experience and talent, be able to perceive today's conditions and problems related to alcohol from an interdisciplinary and action-oriented point of view.

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