SHAHRP

School Health and Alcohol Harm Reduction Project

Teaching Manual

Reducing alcohol use and harm with young people

INTRODUCTION TO THE SHAHRP PROGRAM

What is SHAHRP?

The School Health and Alcohol Harm Reduction Project (SHAHRP) is a program available for use in schools and other settings that, if implemented as documented, can reduce risky drinking and alcohol related harm in young people.

SHAHRP is the first school alcohol harm reduction program in the world to assess its participants for behavioural outcomes. The program has been proven to be markedly successful in improving the knowledge, attitudes and, most importantly, drinking behaviours of young people. The SHAHRP program was researched, developed, implemented and evaluated by the National Drug Research Institute, Curtin University, Perth, Western Australia.

Since its commencement, SHAHRP has received several awards for its work in reducing alcohol-related harm in young people. SHAHRP is used by teachers and others both nationally and internationally.

Previous alcohol education in schools

School alcohol education programs are often criticised for not impacting on young people's behaviour. This is partly because, in the past, school alcohol education has tended to focus exclusively on abstinence or 'just say no'. SHAHRP is based on the realistic assumption that most high school students will drink or find themselves in situations where others are drinking. Rather than aiming for abstinence, SHAHRP focuses on reducing the level of alcohol related harms in young people who drink or socialise with others who are drinking. However, not using alcohol is embraced as a valid and important harm reduction strategy.

Why does the SHAHRP program work?

The SHAHRP program is based on the experiences of young people. During the formative development of the program, SHAHRP researchers conducted a series of focus groups with young people to identify their alcohol use experiences, alcohol related harms that are of particular concern to young people, harm reduction strategies used by young people, and educational approaches likely to be effective with young people. Therefore the SHAHRP program materials have a basis in the reality of alcohol-related situations experienced by young people.

The SHAHRP program is evidence-based. During program development, particular attention was given to ensuring that SHAHRP incorporated the latest evidence by including results from systematic literature reviews of school drug education.

A pilot of the SHAHRP program was tested by teachers and students prior to full implementation. Modifications to the program were made based on teachers' and students' comments, to ensure SHAHRP was workable in real life situations.

Details of the SHAHRP program

The SHAHRP lessons are conducted in two phases with eight lessons (60 minutes each) in the first year of the program (Phase One) and seven booster lessons (50 minutes each) in the following year (Phase Two).

Phase One of the program is targeted at students prior to a time when a high proportion of them have started experimenting with alcohol. This allows the students to gain alcohol harm reduction skills and strategies immediately prior to the adoption of a new behaviour.

Phase Two provides reinforcement and additional knowledge and skills during a time when most students have started experimenting with alcohol, ensuring that information is immediately relevant. This period of experimentation often exposes teenagers to a higher level of risk due to the type of drinking generally undertaken (bingeing) and their relative inexperience in handling the changes brought about by alcohol in themselves and in others.

The SHAHRP program components include:

Training: Training was conducted before each phase of the original SHAHRP study. During Phase One, teachers/facilitators were provided with an overview of the study behavioural outcomes, evidence-based components, and interactive modeling of each Phase One activity. Phase Two training provided interactive modeling of Phase Two activities. Trainers who are experienced in interactive techniques are recommended as SHAHRP teachers/facilitators.

Manual: The manual provides specific written guidance for teachers and facilitators. The manual includes detailed and structured lesson plans including sample questions to help facilitate discussion and debriefing of activities, coaching points to aid in the management of the activities, and background information about alcohol-related issues.

Student workbooks: Student workbooks are available for each phase to stimulate and engage students' interest, provide information, encourage students to further explore issues and to record what they have learned as a way of consolidating practical activities.

Trigger: The SHAHRP Trigger features scenarios that young people may experience in alcohol use situations and is used to prompt discussion about how to minimize the harms associated with alcohol use.

The SHAHRP manual and student workbooks, as well as other program details, are available on the SHAHRP website at ndri.curtin.edu.au/shahrp.

Results

After Phase One (8 x 60 minute lessons, 13 year olds) intervention students had significantly greater knowledge, significantly safer attitudes, consumed less alcohol and experienced significantly less harm associated with their own use of alcohol than the control group.

After Phase Two (7 x 50 minute booster lessons in the following year, 14 year olds) intervention students continued to have significantly greater knowledge and safer alcohol-related attitudes than the control group. In addition, intervention students consumed less and experienced less harm associated with their own use of alcohol than the control group.

One year after the completion of Phase Two (no lessons, 15 year olds) students maintained a significantly greater knowledge, significantly safer attitudes, significantly less harm from their own use of alcohol and also showed significantly less harm from other people's use of alcohol than the control group.

	Baseline (12 year olds)	After Phase 1 (13 year olds)	After Phase 2 (14 year olds)	Year after Phase 2 (no lessons) (15 year olds)
Knowledge		√	√	√
Attitudes		√	√	√
Consumption		√	√	
Context of use	√			
Harm associated with own use	√	√	√	√
Harm associated with others' use				√

√ Significant statistical difference between control and SHAHRP students in favour of the SHAHRP program.

SHAHRP behavioural results

Over the period of the SHAHRP study (from baseline to final follow-up 32 months later), young people who participated in SHAHRP:

- Consumed 20% less alcohol.
- Were 19.5% less likely to drink to harmful or hazardous levels.
- Had 10% greater alcohol related knowledge.
- Had safer alcohol-related attitudes.
- Experienced 33% less harm associated with their own use of alcohol.
- Experienced 10% less harm associated with other people's use of alcohol.

Immediately after Phase One and Phase Two of the program respectively, young people:

- Consumed 31.4% and 31.7% less alcohol.
- Were 25.7% and 33.8% less likely to drink to risky levels.
- Experienced 32.7% and 16.7% less harm from their own use of alcohol.

Maximising behaviour change in students

To maximise effectiveness when using the SHAHRP program it is important to teach the program as closely as possible to how it is documented in the teacher manual. The student change that came about in the main study was based on teaching the program to at least eighty percent as documented. The study teachers also received training in the delivery of the program to students. Two days of training were conducted for Phase One and one day of training for Phase Two. The training involved an overview of the research background and program development. In addition, teachers participated in each activity to model how the activity should be done and to allow teachers to assess implementation and management requirements.

Why focus on alcohol?

Within a period of about 10 years, young people change from individuals who have never had an alcoholic drink to individuals who, as an age group, are the heaviest drinking section of the population.

Young people consume more alcohol and experience more acute alcohol related problems than any other age group, and the potential for harm associated with alcohol use increases on each occasion with an increase in the number of standard drinks consumed. More years of life, quality of life, and productivity are lost from acute alcohol-related harm in young people than are lost from chronic diseases caused by alcohol use in older consumers.

Alcohol is linked to the three leading causes of death among young people worldwide: unintentional injuries, homicide and suicide.