Alcohol prevention: What can be expected of a harm reduction focused school drug education programme?

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Drugs: Education, Prevention and Policy: 2012, 19(2), p. 102–110.

In Australia, alcohol outcomes from a secondary school harm reduction curriculum covering legal and illegal drugs strengthened the case that such education can not only curb harms, but also reduce consumption. Results suggest this approach might offer a more fruitful focus for education about commonly used substances than simply promoting non-use.

Summary The featured report documented post-programme alcohol-related outcomes from a small study evaluating a harm reduction model of drug, alcohol and tobacco education in Australian secondary schools. Three schools were allocated to the tested programme and a fourth to act as a control school which carried on with normal lessons. All schools had pupil populations within the average range of socioeconomic status.

Of 930 year-eight pupils (typically 13 years old) in the schools, 521 completed a baseline assessment after approval had been obtained from the pupils and their parents. Later that school year the first set of 12 harm reduction lessons was implemented by the schools' own teachers, after which pupils completed a follow-up assessment. Another ten lessons were delivered the following year after which 318 pupils completed the final follow-up, typically when they were aged 14–15 years. Programme teachers were trained for two days in each year of the programme.

The tested curriculum incorporated learning strategies which aimed to: enhance knowledge; enhance negotiation skills; involve participants in rehearsing problem-solving and problem-prevention strategies; and engage them in deconstructing social pressures and perceived norms about levels of drug use. The curriculum was also informed by research which has identified social competence, problem-solving, autonomy and a sense of purpose as key attributes of resilient young people, and which has highlighted the importance of interactive and applied learning strategies in social and emotional learning.

Main findings

At issue was whether compared to the control school, pupils in schools which implemented the harm reduction lessons improved more (or deteriorated less) in respect of their alcohol-related behaviour, attitudes and knowledge between the baseline and the final assessments. Knowledge scores in relation to alcohol, tobacco, cannabis and other illicit drugs improved by 33% among programme pupils but only 18% in the control schools, a statistically significant advantage for the programme schools. Similarly there was a statistically significant advantage in respect of changes in the frequency of talking to parents about alcohol, which increased by 46% in the programme schools but fell slightly in control schools. The great majority of programme pupils recalled receiving more than one lesson on alcohol, but only a third of control pupils. However, the already highly responsible attitudes to drinking in both programme and control schools changed little and no more in the programme schools.

The proportion of pupils who had drank at least one full drink increased by slightly less in the programme schools (from 16% to 33% versus 20% to 43%), but this difference was not statistically significant. Neither was there any significant difference in the rise in the proportions who had drunk at least 50g or just over 6 UK units at one sitting. However, estimated total yearly consumption increased little in programme schools (from 148g to 205g) but rose significantly more steeply in the control school (from 79g to 308g). Similarly with the increase in the proportions who had drank in order to get drunk and in the number of times pupils had experienced alcohol-related social or health harms; average harm scores increased from 1.6 to 3.6 in programme schools but from about 1 to 5.2 in the control school.

The authors' conclusions

The programme is most appropriately evaluated against its harm reduction objectives. On average it curbed the age-related increase in total alcohol consumption but not the increase in the proportion who risked harm by drinking heavily on a single occasion. The reason for this seemed to be that the curriculum exerted its greatest impact on pupils who usually drank in a low-risk manner at the start of the programme: their consumption increased by 131%, whereas the consumption of the low-risk control drinkers increased by 302%. In contrast, the programme did not persuade pupils who had already drunk heavily on a single occasion to curb their consumption any more effectively than usual lessons. Relative to the control school, the programme did however reduce drinking with a view to getting drunk and the average number of alcohol-related harms experienced by the pupils.

Judged instead against traditional abstinence objectives, the programme would not have been considered a success since it did not curb the increase in the proportion of pupils who drank.

The programme was also better at enhancing knowledge and encouraging pupils to talk to their parents about drinking, but did not lead to relatively more responsible attitudes to drinking.

These results however derived from a few schools and relatively few pupils, and many pupils did not join the study. Nevertheless the findings are consistent with studies that have shown school drug education which focuses on harm reduction can reduce consumption, risk and harm. The study also suggested that this can be achieved with a curriculum that does not focus solely on alcohol, even when it does not deter pupils from starting to drink. A curriculum covering all drugs may be easier for schools to find the time for than several focusing on different substances.

FINDINGS The curriculum tested in the featured study was based in part of the Australian alcohol harm reduction curriculum SHAHRP. Like the featured curriculum, in both Australia and Northern Ireland SHAHRP curbed the growth in alcohol-related problems and also meant pupils drank less. These results further strengthen the promise of harm reduction education on drinking noted by a research review associated with guidance on alcohol education from the National Institute for Health and Clinical Excellence issued in 2007. For commonly used substances like alcohol in Australia and in the UK, harm reduction may offer drug education a more realistic and culturally appropriate target for its limited classroom time and one which now has some solid research support. Such issues were addressed in the NICE guidance, which stressed that education should be adapted to its cultural context. For the UK the most salient point was that "alcohol use is considered normal for a large proportion of the population [and] a 'harm reduction' approach is favoured for young people".

One possibly significant finding in the featured study is the increase in the times pupils spoke to their parents about alcohol after the harm reduction lessons. An abstinence-oriented approach would have posed these 14–15-year-olds the choice of hiding their drinking (and even their interest in drinking) or risk being seen to have contravened the no-drinking rule. Harm reduction opens up opportunities for discussion

which admit to drinking, making it possible to enrol parents in helping such drinking as does occur, occur more safely.

The same study has produced similar results in respect of smoking. Compared to pupils in the control school, pupils in the three schools which implemented the harm reduction curriculum were no less likely to take up smoking, but those who did smoked fewer cigarettes and experienced fewer associated harms. Over the previous 12 months, smokers in the harm reduction schools had smoked 37% fewer cigarettes at the final follow-up than they had at the start of the study, while smokers in the control school had smoked 268 times more. Corresponding figures for numbers of harms experienced were 28% fewer versus seven times more.

In the absence of random allocation of schools, it remains possible that the results of the featured study were due to differences between programme and control schools and pupils. Against this is the coherence in the findings suggestive of the intended harm reduction impact. Another major limitation is that barely more than half the pupils in the schools joined the study and only a third could be followed up, leaving a sample presumably characterised by parents willing to have their children receive special education on drinking and drug use, also willing to have them repeatedly questioned about substance use in the context of a study, and whose children tended to be available for and willing to be followed up. How the programme would have fared among the other two thirds of pupils is unknown. Finally, at this stage we do not know what happened in respect of the other substances covered by the curriculum.

For more on harm reduction education and on the UK policy and practice context see the most recent Findings analysis of the SHAHRP curriculum.

Thanks for their comments on this entry in draft to research author Richard Midford of Charles Darwin University in Australia and to Blaine Stothard, Independent Consultant in Health Education based in London, England. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

Last revised 09 July 2013. First uploaded 05 July 2013

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