Education and Health - Archive

First published in 1983, the journal has an impressive archive that contains a range of subjects of interest to those concerned with young people's healthy development. Please visit our website for indexes of articles and editors (www.sheu.org.uk/archive.htm). Although an abstract of each article is not available, the following extracts provide a 'flavour' of the material available from 1983.

Trends 1983-2003

A series of reports showing trends, from 1983-2003, in young people's health-related behaviour. Data comes from a sample of nearly 300,000 young people between the ages of 12-15 from across the UK. Printed from 1983-2003, including post and packaging (contra band).

Trends: Young People's Food Choices: attitudes to healthy eating and weight control 1983-2001 (p.6)
Trends: Young People and Smoking: attitudes to cigarettes 1983-2001 (p.10)
Trends: Young People and Alcohol: attitudes to drinking 1983-2001 (p.15)

Young People in 2002 (17th in the series)
The latest edition of the annual report of lifestyles and behaviours of 37,150 young people between the ages of 12 and 13 years old.

No Worries? Young people and mental health
A study of the worries and concerns that affect young teenagers in our society, based on data collected by the Unit between 1991 and 1997.

Healthy School Surveys
School survey for selected years. Each book surveys a variety of topics, and includes questionnaires for policy review and action, lesson themes, photocopiable worksheets and case studies.

Healthy Eating
Each book has 48 pages and has at least four pages with teaching plans and alongside the relevant worksheets. Each book can be purchased separately at £14.50 each. Complete set £74.70

Cash or credit card purchase only. No contra band.

SHEU publications

"Education and Health" is published by SHEU, an independent organisation, which provides research, evaluation and publishing services to all those concerned with the health and social development of young people. SHEU incorporates the Schools Health Education Unit, founded in 1975 by John Buckingham. To date, the Unit has supported over 3,000 health-related behaviour surveys involving over 650,000 young people across the UK. The Unit is pleased to relate correspondence to SHEU, Bessemer House, Bessemer Road, Exeter, UK

SHEU News is available on the internet at: www.sheu.org.uk

The following titles are a selection from the publications list:

Please contact: enquiries@sheu.org.uk for prices.

Acknowledgments

The SHEAHR program is funded by Healthway, the Western Australian Health Promotion Foundation.

The SHEAHR program was written by Helen Callin from the Youth Research Centre, Margaret Shearman, formerly from the Youth Research Centre, and Fiona Farrington from the National Drug Research Institute were contributing writers of the program.

The SHEAHR 2000 lessons were written by Fiona Farrington from the National Drug Research Institute.

A well developed program... seems to be an important way of influencing students drug use experiences while meeting education goals and keeping classroom time and costs to a minimum.

Harm minimisation approach
The School Health and Alcohol Harm Reduction Project (SHEAHR) is a new alcohol education program that not only helps students to reduce the harms associated with drug use, but also helps them to reduce the harms associated with drinking.

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Fiona Farrington was a Project Officer at the National Drug Research Institute, Curtin University, Perth, Australia.

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Research evidence

The SHEAHR program is based on research and evidence and draws on the findings from several earlier studies conducted in Australia and overseas (Dielman: 1994; Dielman et al: 1998; Australian Drug Foundation: 1994; McLeod: 1997).

The SHEAHR study aimed to change young people’s health behaviour through a classroom education approach. To do this effectively, the researchers incorporated research evidence and best practice approaches from the health and education fields.

Summary of the research basis

The following summary of the research basis of SHEAHR is based on a comprehensive systematic literature review of the area (McBride: 2002a; McBride: 2003), and will assist others in understanding the critical elements of the SHEAHR intervention and can also be used as a guide to assess the quality of other drug education resources. The summary contains the following sections: Timing and Programming, Content and Teaching Methodology and Teacher Training.

Timing and Programming

Inculcation: Inculcation requires that initial lessons be taught immediately prior to students initiating the behaviour of interest, in this case drinking alcohol. Lessons that provide knowledge and skills immediately prior to the behaviour can give students a solid basis as they enter into, for example, alcohol use situations. Prevalence of alcohol use data were used to determine the place and phase of the SHEAHR program. The use of local prevalence data can also assist in defining the appropriate...
timings of the initial phase of other health related programs.

Relevance: Relevance requires that an additional phase of lessons be taught at a time when the students are initiating the behaviour of interest. The immedi-
ate relevance of practical knowledge and skills during this phase in the stu-
dent development makes it more likely that students will apply new information and skills to their new behaviour. As with the above evidence based component, prevalence of alco-
hol use data were used to define the placement of phase two and three of SHAHRP.

Transition period between primary and secondary school: Practical con-
considerations play an important part in this component (particularly so for research studies in schools). Students are likely to remain in the same school for a number of years, teachers are more specialised in the delivery of alcohol education, programs can be easily administered and in research terms an intervention in one setting helps to assist with follow-up for survey purposes.

Entry into secondary school also rep-
resents a milestone in the maturity of students, however, the prevalence of the behaviour of interest is not a stronger guide to the placement of an intervention.

In the context of developmentally appropriate school health curriculum: Drug education should be embedded in the context of a developmentally appro-
priate curriculum, have a sound curriculum basis, be placed alongside other related health issues and should include the flexibility to target drug issues as they become pertinent to students. Pro-
gress-conducted in isolation, or ad hoc programs, have limitations and can potentially have a negative effect on student drug use behaviour.

Booster sessions over time: In the past, the research literature suggested that 30 to 40 hours of classroom lessons were required to impact on students health behaviours. More recent research suggests that booster sessions over a number of years, which develop and reinforce long-term changes, can lead to behaviour change. This means that less classroom time is

required to have an impact on behaviour. However, the lessons need to incorpo-
rate the following content and teaching methodology components to be effective.

Content and Teaching Methodology
Based on the experiences of young people/young people involved in the development of the intervention: It is very important that the content, sce-
narios and style of an intervention be based on the experiences and interest of the young people that it is trying to influence. The SHAHRP and SHAHRP II conducted focus groups with young people and piloted the draft intervention with young people to ensure that their experiences were reflected in the classroom lessons. The involvement of young people in the development of a program helps to increase its relevance as well as stu-
dents’ interest and involvement in the program.

Provides accurate normative information: Research suggests that presenting age related usage norms helps students to develop realistic understanding of usage rates among peers. Findings suggest that young people often have exaggerated notions of usage rates and presenting accurate normative informa-
cation can assist in modifying behaviour if these norms are relatively low. In the first phase of SHAHRP the use of normative information was partic-
ularly useful.

Adopt a harm minimisation approach rather than being based solely on non-use goals: This issue is particularly rele-
vant for alcohol, when initiation of use occurs at a young age, when large amounts of alcohol are con-
sumed during drinking occasions and when social norms and expectations are from drinking. Risks and harms associated with the

use of alcohol can be linked to the students own use or other peoples use of alcohol. A goal of harm minimisation provides both drinkers and non drinkers with strategies for reducing the harms of harm occurring, and in reducing the potential harms involved after the event, as well as incorporating important non-use and delayed use strategies.

Research suggests that skills should be based and inter-
active: Skills based teaching which involves students in practical activities increases stu-
dents interest and learning. Teaching methods that allow students to practice behaviours that are relevant to their experi-
ence, in a low risk situation, using realistic scenarios, provide young people with important practice that they can take with them to real life situations. Programs that are interactive and provide a high level of activi-
ity in proportion to other aspects, such as lecture-style teaching, are more effective in gaining students interest and promoting student learning and subsequent behaviour change.

Programs should incorporate utility and self-efficacy: Self-efficacy evi-
dence that knowledge and attitude based programs have little effect on behaviour change. Nevertheless, the delivery of knowl-
edge as part of a skills-training approach is necessary (being an integral part of a program). The type of knowledge provided, however, needs to be relevant to the students, needs to be appli-
cable to their life experiences and needs to be of immediate practical use to them (thus the importance of talking to students prior to and during the development of a teaching program).

Teacher training
Research suggests that teachers of health and drug education often lack adequate training and inexperience when teaching drug education and other controversial health issues.

Teacher training should involve interactive modelling of activities: Research suggests that teacher training that involves the interactive modelling of a program’s activities increases teachers confidence and ability to teach the program. This type of training allows teachers to experience and iden-
tify classroom management and practical issues associated with the program as well as providing them with a model of good practice particu-
larly in relation to debriefing and discussion around key issues.

Research Issues
Although less important in the context of teaching, following the research considerations were adopted as part of the SHAHRP and SHAHRP II research studies: fidelity of imple-
mentation (how well and how much of the program was taught) was mea-
sured and incorporated into analysis and understanding of change; mea-

sures of program success were based on realistic student experiences. The research was conducted over a long time period to allow for delays in behaviour change; and analysis incor-
porated stratification for previous use.

The Alcohol Program
In addition to the research evi-
dence, the SHAHRP researchers conducted a series of focus groups with secondary school students to identify young people’s 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 situations experi-
enced by young people. Health education teachers from a variety of schools were also involved in the development process and in modifying activities based on their teaching of the program. This has helped refine the program so that it is a useable and acceptable resource for teachers and students.

Three phases
The SHAHRP lessons are con-
ducted in three phases with eight

lessons in the first year of the secondary school (13 years), five booster lessons in the following year during phase two, and four additional booster lessons in phase three, two years later (16 years). Phase one of the program is targeted immediately prior to student’s initial experiences with drinking. Phase two then allows the students to gain alcohol harm reduc-
tion skills and strategies immediately prior to the adoption of a new behaviour. Phase two provides rein-
forcement of knowledge and skills, during a time when most students are experimenting with alcohol, en-

sure that instruction is immediately rele-
vant. This period of experimentation often exposes teenagers to a higher level of risk due to the type of drinking generally under-
taken (binge drinking) and their relative inex-
perience in handling the changes brought about by drinking in themselves and in others (Room: 1998; Lang et al: 1996; Aus-


The third and final phase of the pro-
gram is conducted when prevalence data indicates a rise in alcohol use...

...the first phase of the program should target students when the majority of them are not yet regular consumers of alcohol, the second phase should target students when the majority have recently initiated alcohol use and the third phase when prevalence data indicates a rise in alcohol use...

Support the delivery of SHAHRP lessons and a colourful student work-
book in phase one and two of the program, the student activities and prac-
tical activities con-
ducted during the program.

Access local data
The prevalence of alco-
hol initiation and use often

varies between localities and

countries, this suggests that
teachers who are inter-
ested in using the SHAHRP

program target the different

phases to meet the needs of their specific context (Pitts, 1997; Maggs, &

Schulenburg, 1998; Shope et al, 2001; McBride et al, 2001). The best way of doing this is to access local alcohol use preva-

cence data from district or state health department.

Keep in mind that the first phase of the program should target students when the majority of them are not yet regular consum-
ers of alcohol, the second phase should target students when the majority have recently initiated alcohol use and the third phase when prevalence data indicates a rise in alco-
hol use (usually in the mid to late teens).

Students awareness
The SHAHRP lessons provide utility knowledge sufficient to allow students to develop an awareness of situations with alcohol related risk, and skills training to enable students to make better informed choices that minimise harms when in such situations.

The main SHAHRP study involved sur-
veying students (n=2500) at regular periods during and after the program to determine knowledge, attitudes and the consumption of alcohol (total and risky), context of use, harm associated with own use of alcohol and
harm associated with other people's use of alcohol. These results were compared to a group of control students who received regular alcohol education during phase two. Control students provided a variety of alcohol education to their students including the following resources: Rethinking Drinking, How Will You Feed Tomorrow, WA-305ylabes and pilot lessons from the School Drug Education Project.

The results

The summary of results provided in Table 1 shows that the SHARHP program had an impact on alcohol-related knowledge, attitudes and behaviours early in the programs with some maintenance of impact one year after the second phase of the program had been completed (note that results for phase three and beyond are not yet available).

Although these results show the statistical difference between the two groups, the practical significance of the program is demonstrated through the percentage difference in support of the program. The percentage difference indicates the SHARHP students had:

- Greater alcohol-related knowledge, lower level of total and risky consumption, and lower levels of harm associated with alcohol use.

Table 1: The results of the SHARHP Study to date

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