Drug Education

IMPORTANT INFORMATION
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<th>School Profile</th>
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<td>Sector – Catholic</td>
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<td>Type – Primary / Co-educational</td>
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<td>Setting – Metropolitan</td>
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Abstract

Primary Schools have a crucial role to play in drug education. Our students are affected, directly or indirectly, by licit and illicit drug use. Schools must provide skills, strategies and knowledge to minimize the harm that is associated with drug use.

The area of drug education is one that we have not developed over time at the school. Whilst there are policies, practices and programmes that are effective and relevant, an audit and evaluation was required. Current practice needed to be embedded into a wider context of wellbeing. An awareness of current systemic requirements together with our vision and mission of developing life-long, resilient learners supported the need for action.

A shared understanding of wellbeing in the broader context was developed. This together with an awareness of the historical changes that place drug education within a wellbeing context occurred. This provided the basis for investigation that aimed at determining the effectiveness of current practice. The data gathered would then determine the appropriateness for inclusion in our Drug Education Plan.

Staff surveys, student focus groups and senior student surveys were used to obtain information from key stakeholders. The data gathered from the three sources indicated that current practice, protocols and policies were effective. Resilience, relationships, self-esteem and curriculum were identified as part of our programmes and practices and therefore as essential foundations in effective drug education.

This information was then mapped onto a Drug Education Plan (DEP) which outlined the four themes that overarch the twelve principles of effective drug education.
Action Cycle One provided positive affirmation of current practice. It also provided a starting point for further cycles to address the areas of concern identified during the process. Further cycles will identify and address ‘gaps’ in our DEP and investigate parental involvement.

Introduction

“Primary schools can play a very important role in preparing children for healthy and fulfilling lives and in contributing to drug prevention efforts across the school years.” (Department of Education, Science and Training, 2005, p 2)

School X has over the years developed policies, practices and programmes that work towards its role of drug education. However whilst current practice is somewhat effective and relevant, a review is timely and needed.

The welfare and wellbeing programmes and policies together with the Life Education programme combined to form a drug education strategy of sorts. However, this is not embedded within a broader context of wellbeing, thus failing to meet the requirements of state and national strategies. We must be aware of the need to equip our students to face a future in a community where drugs are present. The National School Drug Education Strategy (NSDES) recognises the importance of a strategy stating that “it is vital that Australian young people and those who move and interact with them have the information, strategies and skills to prevent or reduce the harm that can arise from their own drug use or the drug use of others” (Department of Education, Training and Youth Affairs, 1999, p2). We have remained stagnant in this area. The lack of action is perhaps in part due to the many other systemic changes such as numeracy and literacy that have been mandated. However action in this area can wait no longer. It is also important that the strategy be individually designed taking into account local needs and context. Cahill (in press) supports this stating that programmes must be “responsive to the cultural and social needs of the school community.”(p 174).

Context

The school is a parish primary school located on two campuses in the suburbs of Melbourne. Our grades Prep-Year 4 (12 classes) are located at Campus A and our senior grades-Years 5 and 6 (5 classes) are two kilometres away at Campus B. Our current enrolment of over 400 comes from a variety of backgrounds. Over recent years, due to the proximity to the CBD, property values have risen dramatically and this has had a profound effect on the socio-economic profile of the area.

The number of large migrant families has decreased. The number of families eligible for Education Maintenance Allowance (EMA) has decreased from 33% to 25% and this trend seems likely to continue.

Our staff comprises full-time and part-time, teaching and non-teaching staff. There are 19 full-time teachers, including Principal, Deputy Principal, and classroom and specialist staff. There are 10 part-time teachers, two full-time office staff, two support staff and one school services officer.

Goals / Initial Aims

The need to develop our Drug Education Strategy in line with systemic requirements that “schools prepare children for healthy and fulfilling lives and in contributing to drug prevention efforts across the school years” (Nelson, 2005) was identified. Similarly, our school vision and mission statements are based on developing the whole child and encouraging critical, life-long learners who are active in the wider community (School X, 2005). Subsequently, the following goals have been set:
LONG TERM GOALS
- To develop a Drug Education Plan/Programme (DEP, formerly known as an Individual Drug Education Strategy) for the school.
- To develop a sequential and comprehensive drug education programme that is embedded in a whole-school approach to wellbeing.

SHORT TERM GOALS
- To conduct an audit and evaluation of current programmes, policies and practices to determine their appropriateness for inclusion in our DEP.
- To develop a plan and timeline for implementation of our DEP.

To initiate this project, I will implement one action cycle to achieve the first short-term goal of auditing and evaluation.

Author’s Position and Role

I am the Deputy Principal and Student Welfare and Wellbeing Coordinator at the school. I am also a member of the Leadership Team.

In my position I am responsible for overseeing many of the intervention and prevention policies and programmes that support our students. My role initially (8 years ago) had more of a welfare focus and was more intervention and post-vention. Research, increasing awareness and understanding and systemic changes have seen my position evolve to include wellbeing and prevention as well as intervention and post-vention when needed. I have been part of many changes in the way we work with our students and families as we constantly strive to provide them with the skills and abilities to be active members of society. One of the major areas of both systemic and government change has been in the area of Drug Education. In my role I became aware that whilst meeting basic requirements, a review of this area was needed.

I recommended to the Leadership Team in mid 2005, as we set our strategic plan for 2005-2007 that we review, evaluate and develop our approach and strategy for drug education. My studies would provide the perfect vehicle to undertake this journey. The team was enthusiastic and supportive. As such, I am the initiator of this project.

COLLABORATIVE GROUP

In developing an ISDES (now DEP) a Core Team was required to take responsibility for programme and policy implementation. This Core Team formed the collaborative group I have worked with. The Leadership Team consisting of the Principal, Level, Curriculum and Subject Coordinators were a consultative group. Members of this group were not part of the Core Team so as not to make the group ‘top heavy’. I aimed for balanced representation and my participation in the Core Team represented the Leadership group.

Members of the Core Team were volunteers from the staff. As part of the process I presented an information session and at the end of it explained the goals and asked for volunteers. I had hoped for a minimum of four and was pleasantly surprised that six expressed interest. The members of the Core Team consist of a Year 6 teacher, a Year 5/6 teacher, a Year 4 teacher, a Year 2 teacher, two Prep teachers and myself. This group provided membership from each area of the school. Age, sex, experience, background and interests are diverse which added value to our team and the process. It is anticipated that the team will work collaboratively to deliver both the short and long-term goals.
RECONNAISSANCE

Over the past 35-40 years, much work has been done in the area of Drug Education at both federal and state government levels as it has been recognised that drug use affects our students.

Approaches to drug education have changed over time. The focus has shifted from dealing with self-esteem and resistance of peer pressure (without being drug specific) toward prevention and to the current approach of harm minimisation. The National Drug Education Strategy Plan (1993-1997) established three key goals that were to underpin individual state approaches to drug education and highlighted that drugs included the licit and illicit and the effects were both direct and indirect (Department of Education, 1998, p7). Ballard, Gillespie and Irwin (1994) developed the “Principles for Drug Education in Schools” and in doing so provided a framework for drug education nationally. These principles acknowledged that effective drug education must be based on sound research, involve appropriate consultation and be consistent with curriculum theory and practice (Foreword).

Victoria’s response to this national plan began with the Premier’s Drug Advisory Council in December 1995. The “Turning the Tide” drug reform strategy was born and it involved three main departments; Departments of Human Services, Justice and Education. This was innovative as three separate departments were working towards a comprehensive approach to drug use and misuse in our community. The strategy aimed at embedding drug education into core curriculum, developing resources and establishing supportive links and relationships in and outside the school.

Schools were to develop and implement an ISDES, to “enhance and sustain drug education in schools...in order to contribute to the minimisation of the harm associated with drug use by young people” (Department of Education, 1998, p iv). Ballard, Gillespie and Irwin’s work informed the state based ISDES. The ISDES involved: -

- the establishment of a core team to develop and implement the strategy
- provision of professional development
- consultation with the wider school community
- identification of areas of focus
- developing strategies to implement, monitor and evaluate the strategy.

(Department of Education, 1998, p3)

It was hoped that this approach would see schools and communities owning the process and result in a consistent and comprehensive programme targeted at local contexts.

Concepts of collaboration, organisational partnerships, resilience, relationships, connectedness, comprehensive curriculum, welfare and wellbeing continue to underpin initiatives and programmes on drug education. In response to changing needs and continuous improvement and research, the original principles were revised to form “Principles for School Drug Education 2004”. These updated principles provide a framework of core concepts and values to support effective drug education in schools. They incorporate the most recent research, which sees the development of resilience as crucial to the health and well being of our students and the importance of drug education being placed within a broader, comprehensive curriculum programme. The principles have a focus on prevention and harm minimisation.

In 2005, the Department of Education and Training (DET) announced a review of drug education in order to align it with the new School Accountability and Improvement Frameworks. The process of review and planning of an ISDES was to become part of “whole school planning and improvement”. The new national principles together with this realignment would see the ISDES become a Drug Education Plan (DEP).
In 2006 the Catholic Education Commission of Victoria (CECV) informed schools of the changes to the ISDES to align it with our School Improvement Frameworks. The previous three-year cycle was to become a four-year cycle to be known as a Drug Education Plan (DEP). The DEP was now to be included in each school's strategic plan in the area of improving student engagement and wellbeing. The fundamental components of the ISDES remain. Harm minimisation is still the foundation. The DEP is organised into four key themes:

- comprehensive and evidence based practice
- positive school climate and relationships
- targeted to needs and context
- effective pedagogy

(Cahill and Meyer, 2004, p9)

Cahill and Meyer (2004) incorporated each of the twelve principles into the four key themes. These are closely linked with the original four goals of an ISDES. The concepts of core team, use of resources and personnel to support the development of effective drug education remain despite the name change.

Other schools are at various stages in their drug education strategy. Most Catholic schools have not yet used the DEP so I have contacted officers in the Regional DET office to help develop my understanding. As there are definite connections to the ISDES I have also spoken to a colleague who has lead the development, review and evaluation of an ISDES. I was able to learn a great deal about the process as well as gain information about the curriculum component of drug education. Their starting point was different and they began with developing an understanding of harm minimisation before beginning to develop their ISDES. They have used the programme “Get Real” which is a harm minimisation approach to drug education as they had identified this particular programme as best meeting their needs. Their experience has provided me with some valuable insights about the strengths of the programme. They also used a programme called “Talking Tactics” which is an interactive programme that facilitates open communication between children and parents which is “the essential element in helping to reduce young people’s substance use and can protect them from difficult life events” (Department of Education & Training, 2002, foreword). I have heard about this programme during informal networking opportunities with all comments being positive. The information gathered from these two sources will provide starting points for us when we begin looking at the many resources that are available in order to develop sequential curriculum programmes. The importance of matching programme to need is crucial.

There are a variety of resources available to support the development of our DEP. DET provides Regional Wellbeing and Drug Education Officers to support schools. I have made contact with our representative to provide expertise and guidance. The Student Wellbeing section located of the Sofweb website provides excellent resources and states that “effective drug education aims to:-

- develop resilience
- promote the personal safety of students in their social environment
- develop drug specific knowledge, skills and information”

(Department of Education & Training, 2006, p 1)

The resources One and All (middle primary) and The Big Move (senior primary), Get Real and Get Wise are examples of programmes that meet these aims. The Framework for Student Support Services also provides support in the area of student wellbeing. These programmes and resources have at the centre, the resilient student. Resilience as stated by Wolin and Wolin in One and All is “the ability to bounce back from adversity…” (Department of Education, Science and Training, 2005, p 2) to “rebound and spring back after hard times” (Fuller, 2001 in Department of Education, Science and Training, 2005, p2). When this concept is married with a message of harm minimisation we are well on our way to equipping our students for the future as “the strengthening of social competencies, emotional intelligence and resilience….. is associated with the prevention of substance abuse” (Department of Education, Science and Training, 2005 p2).

ACTION CYCLE ONE
Cycle one of the project was to be one of “Auditing and evaluating current practices and programmes to determine appropriateness for inclusion in our DEP”.

I was aiming at “self reflective inquiry” (Carr & Kemmis 1986:162, Cohen, Manion & Morrison, 2000, p 227) using a schoolwide action research approach. This approach enables the staff to examine, reflect and change what is actually happening. An area of concern is identified. Data is collected, organised and interpreted internally. Data from external sources is added to inform future directions and actions, forming a cyclic action.

Calhoun (1993, p243) identifies three areas of focus in this approach. Firstly the staff of the school will work collaboratively to find solutions to areas of concern and, as they do this, their confidence and ability increases. Secondly, the process is inclusive of and equitable for all students. This concept is aligned with current research that requires drug education be prevention based. Thirdly, the scope of the inquiry is widened and is therefore more informative and accurate when all stakeholders are involved. In our case this means that staff, students and parents are all participants.

Calhoun (1993) emphasises the importance of a team to “share the responsibility for keeping the process moving”. (p 243) The Core Team will be responsible for implementing both the short and long-term goals with the Leadership Team as consultants.

PLAN

In this cycle, I intended to achieve my short-term goal of conducting an audit and evaluation of current programmes and practices to determine their appropriateness for inclusion in our DEP (ISDES).

The process began in mid 2005 as our Leadership Team formed the strategic plan for the next two years. I completed some initial background research to familiarise myself with the history of this initiative and its current requirements. I began to network amongst my colleagues in other schools and have collegial discussions about best practice and innovation. The aim of this was to increase not only my understandings but to initiate supportive relationships. In accordance with a new commitment to Student Wellbeing the Catholic Education Office Melbourne (CEOM) asked that schools complete a Student Wellbeing Implementation Plan (SWIP). This was to outline our focus areas for the year Drug Education was included in this. My studies provided valuable insights into the area of drug education, working collaboratively, partnerships and the process of change.

In early 2006, at a Leadership Planning Day, drug education was placed on the agenda for second term. At the next two Leadership Team meetings I outlined the proposed long and short term goals. A general explanation of the rationale driving the project from both a personal and professional point of view was given. The introduction to the staff was explained and at this point I asked for feedback. All were in agreement with the need to place drug education into a broader context which is supported by Cahill stating that “the evidence suggests drug education programmes are best positioned in a broader health and personal development curriculum” (Cahill, in press, p176).

Two information sessions were planned for the staff. The first was related to understanding the broad context of welfare and wellbeing. The second presentation was specifically related to Drug Education. I hoped that these sessions would provide a shared and an up to date starting point for audit and evaluation.

A Core Team would be established with representation from staff and parents. Involvement of outside agencies and experts in this area from both CEO and DET would be sought. Data would be gathered from the major
stakeholders to form a profile of the school in relation to the effectiveness of current practice. This concept formed part of the original ISDES.

ACTION

A staff meeting in August 2006 was to ‘set the scene’ for the actual beginning of the project with the staff. At previous meetings I had pre-empted the review we were about to undertake in light of our strategic plan and my studies.

The Powerpoint presentation “Student Welfare and Wellbeing” was intended to place drug education within a broader context of wellbeing. Informal discussions with colleagues and knowledge gained from my reading had made me conscious of the fact that we did not have a common and clearly articulated basis of wellbeing as being the focus of primary prevention. We have some positive and effective programmes at the school, however they need to be “drawn together”. A brief history of the move from post-vetion and dealing with a few “troubled” children, toward a research driven adoption of policies and programmes of primary prevention involving all was presented. A discussion of the importance of approaches needing to be ‘whole-school’ followed. I outlined the general process and asked for volunteers to work with me in the long-term. Six of my colleagues volunteered.

The Core Team met for the first time as a group at lunchtime a few days later. At this meeting I explained the session planned for the staff meeting on Drug Education and how the team could participate. It was decided that I would begin the brainstorming activity with two of the team acting as scribes. We also then discussed ways of gathering information as I explained some of the possibilities. We decided on a rating survey using the information to be gathered in the brainstorm activity. The team thought that conducting focus groups would give us some extra information. I suggested two groups, one made up of Year 5 and 6 students and the other made up of Year 3 and 4 students. One of the team suggested having a group with some Year 2 students as we would then have a perspective from the junior, middle and senior areas of the school. The other members and I thought this would be a good idea, although we felt the Year 2 students would have to be carefully selected to ensure they would not be overwhelmed.

During that week, correspondence from the Catholic Education Commission of Victoria (CECV) informed us that the ISDES was now to become a DEP. This required reading and research to clearly understand how and why the change had occurred and how it would impact on the project for our staff. My research revealed that the changes were not too dramatic and that, in essence, the DEP was very similar to the ISDES.

My planned Powerpoint presentation on Drug Education needed to reflect this development. This session was held during our staff meeting and included information from both DET and CECV. The presentation defined harm minimisation and discussion followed about this and concepts of resilience, relationships, connectedness and the links to wellbeing. The discussion was very positive with people making connections between theory/research and current practice and I think all felt affirmed in what was actually happening in their classrooms. At this point, I asked the staff to list all the things they could think of that contributed to our Drug Education strategy in the broader sense. Two of my core team acted as scribes and the final list comprised over 70 items.

The Core Team met again and discussed the possible ways we could evaluate the list and decided on a rating system. I suggested a 0-5; ‘0’ being ineffective and ‘5’ being highly effective. We discussed that some of the items were grade specific and therefore debated their inclusion. We decided that we would include them as they were important components of that grade’s programme. However, as they may not be familiar to all staff, it was suggested we have an ‘N/A’ rating rather than have them marked as ineffective due to lack of familiarity. All agreed believing our results would be more reflective of the situation. We discussed the clarity of each and adjusted them accordingly. This resulted in a final list of 59. Once we were all satisfied that the list was clear, I
asked that each member trial the survey on one of their colleagues to ensure it could be understood. Feedback to me was that the survey was easily understood and so it was distributed to other staff members. The accompanying memo explained the anonymity as well as the date and point of return. At the conclusion of our meeting, I explained our next step; focus groups.

The survey results were collated and at the same time I conducted the three focus groups. The planned questions were only ideas to highlight areas that I wanted to consider in the group. They were not rigorously followed in each group and discussion took a particular direction based on responses and feelings of the students. I covered the planned areas but in different ways. The ages of the students also impacted on the questioning. The focus questions were deliberately not drug specific as an effective drug education programme only becomes specific in the senior primary years. As a staff we determined that our programme had elements of self-esteem, relationships, belonging, being healthy, keeping safe and resilience. The information gathered from each was later written as reflective notes. During my research I also found a survey for Upper Primary students which was specifically about drug education. It was part of the DET resource “Guidelines for Reviewing Drug Education in Victorian Schools” and we decided it was appropriate to use this survey with our senior students.

Our Core Team met briefly again and I presented the information gathered from the three data sources—staff survey, focus groups and student survey. We decided to report this back to the whole staff and would decide when and how at our next meeting. Having concluded that the staff thought that all 59 current practices were somewhat to highly effective we needed to complete the audit and evaluation by placing each into our DEP.

We met one morning and as our group was depleted in number due to illness, we made a collective decision to continue with half the group. In the week prior to the meeting, I had distributed to each member a copy of the “Evaluation of School Drug Education Programme/ Plan – Unpacked”. This was to enable familiarity with the themes of the DEP. We aimed to categorise our practices into the four themes which are: -

- comprehensive evidence based practice
- positive school climate and relationships
- targeted to needs and context
- effective pedagogy

(Department of Education & Training, 2006, p1-8.)

There was much professional dialogue as we placed each of the 59 practices into each of the four themes. Once this had been completed I asked for volunteers to present our process and progress to the staff at the next staff meeting. It was agreed that we would all present with each taking responsibility for a particular part of the session. This indicated that our first short term goal had been achieved.

Observation

During this cycle I wanted to involve all stakeholders, however as a team and in consultation with our Principal, we decided to involve only staff and students in the initial cycle. The reason for this was that parents have not had input or in-servicing in this area, particularly in relation to the broader context of drug education in a framework of resilience and wellbeing. Opportunities had been offered over the last eight years for parents to attend information sessions and these had been poorly attended with less than 5% of families attending. It was felt that in order for parents to participate we would have to run a number of sessions to enable an understanding before asking for evaluation. We decided that these sessions were best run as part of the development phase of our DEP. Parents provide valuable insight and will be involved in later cycles; it may be that a third cycle focuses on parent involvement.

The first indicator that the project had begun on a positive note and that there was an understanding of wellbeing was the informal positive feedback from colleagues following the PowerPoint presentation. I heard the terms
“resilience” and “wellbeing” used in the days following the meeting. The comments directly following included “now I understand why we need to address these issues”. The Drug Education presentation provided much discussion. Harm minimisation was explained as the foundation of drug education. Discussions identified that this concept was not new to us. We are already practising harm minimisation in our Sunsmart Policy. This analogy aided understanding. There was also discussion about the core concepts of resilience, relationships, connectedness and the links to wellbeing and effective drug education. There was a realisation that Drug Education is more that the Life Education van and the health units of work. This was evident when we could list more than 70 practices that contribute to our current programme.

The staff survey provided valuable information. Indicators from this survey support the inclusion of all 59 practices/programmes into our DEP. Given the high return rate of 86%, results are reflective of group feeling that all 59 practices are ‘somewhat’ (ranking 3) to ‘highly’ (ranking 5) effective. Some practices were rated ‘N/A’ due to these programmes being grade-specific and new, such as “Learning to Read, Reading to Learn”. Many staff are unfamiliar with these which suggested to our Leadership Team that we should encourage sharing about them. Activities such as Life Education sessions and support material were ranked by 90% of respondents as being effective and highly effective. This supports the inclusion and value of this expert, external resource in our future plan. The importance of the relationship between teachers and students was ranked as a highly effective component of drug education by 80% and ranked as effective by the remaining 20%. Research supports this citing that “teachers are critical to effective drug education” (Cahill and Meyer, 2004, p 47).

Our protocols to respond to drug related incidents include asthma, allergy and first aid plans and procedures. These areas were rated by all staff as effective to highly effective, providing reason for inclusion in our DEP. Areas of developing positive attitudes and discipline were rated by 96% as effective to highly effective supporting our belief that these areas are vital to drug education. All respondents rated our current curriculum programmes in the areas of health education as effective to highly effective supporting inclusion into our DEP.

The focus groups provided another positive indicator that current practice is effective. I spoke to these groups in terms of being healthy, safe and happy at school rather than in terms of resilience and well being so that language and concepts were clearly understood.

A number of major themes emerged from these discussions. The importance of the relationship between student and teacher was a common thread. The senior students noted that teachers talk informally to them “taking an interest in you”, whilst the middle school students saw the relationship as supportive and caring with teachers “wanting the best for you”. The junior students noted that “teachers say hello to you”.

The importance of praise and encouragement was also a consistent theme with students recalling times of “having their name on the board or being rewarded or getting a Student of the Week certificate or performing at assemblies”. All groups also acknowledged encouragement when they had ‘tried’, rather than only when they had succeeded totally. The body language, animated tones and smiles were testament to the importance of these practices from the students’ perspective.

A theme of effective health curriculum in a broader sense was also apparent through the groups. Each was able to name a variety of programmes or activities that they had covered such as Growing Pains, Bike Safety, Fire Safety, Healthy Food, Taking Medicine, Belonging and I Am Special. The answers became more specific with the younger children recounting actual learnings. Students also noted that they felt “looked after and cared for” when they were sick or hurt. They all knew our safety and first aid procedures.

Another common theme was that of conflict resolution and strategies that were modelled and taught. The students spoke of teachers giving them ideas and support, of learning actual strategies such as “using a strong voice” and
they commented on posters displayed around the school conveying positive social skills and values. Each group voiced a positive view of programmes and policies that help them learn about being safe, happy and healthy, providing a positive indicator that current practice is effective. The students also stated that they knew they could approach a teacher at anytime.

The survey distributed to Year 5 and 6 students was drug specific to reflect the senior primary programme. Results show that students could name both legal and illegal drugs, with 85% listing painkillers and medications. It is important to note that no one in the Year 6 group included alcohol or tobacco as legal drugs but rather classed them as illegal drugs. While this may be explained by the media campaigns against use of these drugs, it is vital for our staff to be aware of the students’ understanding in this area.

Students were able to list medical, physical, psychological and social reasons for drug use indicating their awareness. The survey also revealed an understanding by all students as to why people choose not to take drugs with reasons such as harmful physical effects and psycho-social reasons such as “wrecking your life and causing trouble” listed. Students were able to state what they had learnt about drugs with 70% saying they had learnt of the negative effects. 80% of students could list future learnings which indicated that they were interested in the topic. Responses indicated a wide range of interest areas such as “how to say no”, “reasons people take drugs” and “why do people make or sell drugs if they are bad?” These responses provide information that can be used in future planning for these children and others.

The data collected provided a range of evidence that supports the effectiveness of our current practices. Government requirements in Drug Education are based on a premise of prevention, with curriculum and practices as indicators of success. This is supported by Fuller (Department of Education, Science and Training, 2003, p 53) who states “the overall message from prevention research is that schools can prevent the onset, severity and duration of problematic substance use, bullying, violence and mental health problems by undertaking a process of developing a culture that promotes resilience” The Core Team therefore concluded that all 59 practices should be included in our DEP framework. This indicates the success of our first cycle.

Conclusion

The initial cycle of action has resulted in a clear understanding of the need to include current practice into our DEP.

Our Core Team has developed a positive strong relationship, which will enable us to move to another cycle and towards our long-term goal. This particular group of staff has not worked so closely before, so this is a definite achievement. This is due to the common understanding and shared belief of wanting to provide the best for our students and understanding that drug education, as part of wellbeing, is crucial to this.

Throughout the process we became more aware of the need to be flexible and not merely complete this audit cycle and begin developing the DEP. Whilst all cycles contribute to the end result of a DEP, there are particular areas that need to be addressed as part of its development. We now realise that we must identify any areas of weakness by examining our practice and programmes in relation to the four themes and twelve principles of the DEP. Once identified these ‘gaps’ must be addressed. This may involve professional development, using Regional Officers from DET and looking at resources recommended to us such as Talking Tactics and Get Real. This will form the starting point for a second cycle. This second cycle was not planned in my initial proposal but now must be included. Only after we have completed this step will we be in a position to develop a timeline and curriculum for our DEP.
The Core Team feels it is important for all staff to become familiar with the DEP and has suggested possible ways in which this could happen. The involvement of parents must be a major consideration for our future cycles as collaborative community partnerships are essential. The DET acknowledges this stating that, “parents have a critical role to play in building the resilience of their children and helping them become healthy active members of the community” (Department of Education & Training, 2006 p 1).

The Core Team plans to reconvene early next year to begin a second cycle in our process of developing an effective drug education plan for the school. The commitment made by the staff to develop our DEP recognises that we need to work on many levels, focus on short and long term goals and strategies and to work collaboratively as a school and wider community to effectively address the issue of drug education. (Department of Education & Training, 2003, Foreword).
References


Government Department of Education, Science & Training


