Evaluation of *High on Life*: A secondary school-based alcohol and other drug intervention initiative

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DISCLAIMER

This report was prepared by Velma McClellan, Director of Research & Evaluation Services Ltd.

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SUMMARY OF RESULTS

This report provides the results of an evaluation of *High on Life* (HOL), a secondary school-based alcohol and other drug (AOD) intervention initiative. HOL was originally conceived, developed and trialled in Wanganui in 2003 to 2004 and was later adopted and implemented in the Taranaki region.

The information collected for the evaluation comes from five main sources:
1. Stakeholder interviews, namely key contacts or spokespeople for the HOL initiative in the Wanganui and Taranaki secondary schools and the AOD agencies' clinicians who provided the on-site, small group intervention (SGI) sessions for students with AOD issues.
2. Official Ministry of Education stand-down, suspension, exclusion and expulsion data specific to drug-related incidents for Wanganui, Taranaki and New Zealand as a whole.
3. Hand-written registers in which relevant characteristics of the students who participated in the on-site SGI sessions were recorded.
4. Students who participated in the SGI sessions.
5. A review of the literature.

The objectives of the HOL initiative were:
1. to reduce AOD-related harm to students
2. to provide a vehicle for schools and the AOD agencies to work together effectively in response to students' AOD issues
3. to strengthen school-based initiatives providing early professional AOD support for students with AOD-related issues
4. to provide continuing education opportunities for teachers and school staff regarding AODs, and best practice to address issues
5. to help establish a consistent AOD access point for students.

HOL was designed to operate at two main levels:
- A whole-of-school approach that complements the drug education component of the health and physical education curriculum.
- A complementary AOD clinical support strand provided by a range of regionally based external AOD agencies whose clinicians facilitate on-site, clinical and educative support sessions for students identified as having problematic AOD use. The guided self-change model used in the sessions is non-prescriptive and based on the principles of motivational interviewing, cognitive behavioural intervention and the stages of change model (Sobell and Sobell 1993).

KEY FINDINGS

The uptake of the initiative in both the Wanganui urban area and the Taranaki region was high, with all four urban schools in Wanganui and 11 of the possible 13 schools in Taranaki actively participating.

Prior to the launch of HOL, in Wanganui and subsequently in Taranaki, drug-related suspension rates were high in these regions compared with the national rate. Within six months of introducing the initiative to Wanganui schools, drug-related suspensions fell from a high point of 6.0 per 1,000 students

to a rate of 1.3. In Taranaki the response was equally dramatic, with the rate falling from 8.0 to 2.4 per 1,000 students in the space of six to eight months.

All four Wanganui schools and six of the 11 Taranaki schools built the HOL SGI process into their drug-related management systems and policies. This process required students to attend on-site SGI sessions as a condition of their returning to school following a stand-down or suspension for drug-related misdemeanours. HOL's SGI process adopted by the schools fits well with guidelines put forward by the Ministry of Health in 2000 and with the Ministry of Youth Development's assertion that the harm minimisation approach is the overall objective of effective drug education (Allen & Clarke 2003).

Of the 133 students who participated in the SGI sessions for whom data were recorded by the AOD clinicians (64 in Wanganui and 69 in Taranaki), the majority were female (62 percent), 70 percent were between the ages of 14 and 15 years, 67 percent were Year 10 and 11 students, and 53 percent were Māori.

In Wanganui, self-referral was a far more common point of entry into the HOL SGI process than it was in Taranaki. In Taranaki, 'shoulder-tapping' by school staff and disciplinary action were the more frequent points of entry.

Schools were largely unable to provide specific evidence of positive changes in the learning outcomes and classroom behaviour of the SGI students as a result of their attendance at these sessions. However, four key HOL contact people spoke of students who they observed had made noticeable improvements.

The 19 students who filled in evaluation forms indicated that they found value in participating in the SGI sessions, in that they had learned to take better care of themselves and they had given them a chance to make changes to their AOD use. Of the 19 students, the majority indicated that they were getting into trouble less now and that things had generally improved for them at home and at school.

The AOD clinicians assessed the quality and level of engagement of students who participated in HOL's SGI sessions as mostly excellent to very good. A small minority of students' participation was considered fair to poor. These same students' attendance tended to be poor or inconsistent.

WHERE TO FROM HERE?

At the time of this evaluation all four of the Wanganui urban secondary schools and over three-quarters of the 11 Taranaki schools remained strongly committed to HOL. Overall perceptions of what was needed in 2006 and thereafter to sustain the momentum achieved thus far revolved around schools' concerns about the programme's sustainability with regards to the external AOD agencies' capacity to cope with the demand from schools for their services. Four Taranaki schools had experienced first-hand difficulties in maintaining the clinical service in their schools. This was reportedly due to competing external demands for agencies' services.

Schools in both regions, mainly the single-sex schools, expressed regret about the lack of choice for same-gender AOD clinicians.

Two schools expressed a preference for the SGI sessions to be more closely sequenced rather than on the current once-per-week basis, suggesting it would be more appropriate to work intensively with the students while they are in the throes of dealing with the immediate consequences of their rule-breaking actions. However, this type of change may not be feasible given the other work commitments of external AOD agencies and given that the process of change on which the initiative is based takes time.

There were clear differences between the two regions with respect to the level of awareness among students and school staff generally. In Taranaki, the proportion of students who self-referred was quite low compared with that in Wanganui, where it was the main source of referral. This feature suggests that a relatively low level of awareness about the HOL initiative exists among students in Taranaki. In Wanganui, HOL was driven by an intersectoral collective of community agencies including schools. The collective approach adopted in Wanganui appears to have been largely a community action approach, which may help to explain the seemingly higher level of awareness and knowledge of HOL within the four Wanganui schools generally. In contrast, the Taranaki initiative was driven largely by one highly motivated Ministry of Education staff member. This suggests that an intersectoral, community action approach is now called for in Taranaki to maintain the momentum achieved thus far and to promote further the HOL initiative to the wider school community, including students' parents.

RECOMMENDATIONS

The HOL evaluation has provided a promising good-practice model for New Zealand schools. The following recommendations are for those schools and their communities that are concerned about the AOD-related harm incurred by their students (including suspension) and that wish to implement the HOL initiative.

- There needs to be buy-in across the sectors. As such, it is important to establish an intersectoral steering group to drive the HOL initiative (or a similar type of whole-of-school approach) that will enhance the schools' and their communities' engagement.
- Principals are important 'change agents', so need to be the first port of call when planning this type of initiative.
- A whole-of-school approach is important. As such, time needs to be invested before the commencement of the project to ensure that there is wide buy-in from school staff, boards of trustees and parents.
- The HOL approach can be promoted to the school and community as an effective model to reduce harm and promote more positive outcomes for young people with AOD issues.
- A collaborative relationship between the health and education sectors needs to be fostered.
- Schools need to provide up-skilling for their guidance counsellors and social workers in evidence-based AOD intervention so that schools are not entirely reliant on external providers – for instance, training in the use of the *Smashed 'n Stoned?* programme.
- Schools and communities need to consider the needs of Māori students and any influences, both societal and within the school, that may be contributing to a higher rate of representation in suspensions.

1. INTRODUCTION

This report presents the results of an evaluation of the *High on Life* (HOL) initiative implemented in secondary schools in urban Wanganui and the Taranaki region. The evaluation was undertaken by Research & Evaluation Services, New Plymouth on behalf of the Alcohol Advisory Council of New Zealand (ALAC), with the cooperation of the Ministry of Education's Wanganui office. The evaluation programme was commissioned and funded by ALAC.

1.1 WHAT IS *HIGH ON LIFE*?

The HOL initiative is a secondary school-targeted alcohol and other drug (AOD) education intervention originally conceived, developed and piloted in Wanganui between 2003 and 2004 and subsequently adopted and implemented in the Taranaki region during 2004.

The objectives of the HOL programme over this period were:

1. to reduce AOD-related harm to students
2. to reduce AOD-related suspensions
3. to assist schools and AOD agencies to work together effectively in response to students' AOD issues
4. to provide early professional AOD support for students with AOD-related issues.

1.2 DEFINITIONS

The following definitions of the terms *stand-down, suspension, exclusion* and *expulsion* used throughout the report were taken from the Ministry of Education's website (www.minedu.govt.nz).

Stand-down

Stand-down is the formal removal of a student from school for a specified period. The stand-down is limited to no more than five school days in any given term and a maximum of 10 days in any one school year. Students can return to school automatically following completion of the specified stand-down period.

Suspension

Suspension is a formal procedure whereby a student is removed from a school by the principal and cannot return until such time as the school's board of trustees decides whether to lift the suspension with or without conditions, extend the suspension, or in the case of a very serious misdemeanour exclude or expel the student.

Exclusion

This term refers to the formal removal of an under-16-year-old student from a school with the requirement that the student enrol elsewhere.

Expulsion

Expulsion is the formal removal of a student who is aged 16 years or over. The student may or may not seek to enrol at another school.

Alcohol and drug abuse

Werner (1995) found the term 'abuse' in relation to adolescents' usage of substances to be problematic in terms of identifying just what level of consumption constitutes abuse in this age group. Werner (1995) considers the 'consequence-based definition' a potentially useful definition because it perceives all negative consequences arising from a young person's drug use as warranting their referral to remedial AOD intervention services (Donovon and Jessor (1983) as cited by Werner 1995, p337). These problems would include drug-related stand-downs, suspensions and expulsions from school.

Early intervention

According to Klitzner et al (as cited in Werner 1995, p336), early intervention generally falls somewhere between prevention and treatment along the continuum of substance abuse care, and ALAC describes early intervention as:

'An approach that aims to reduce alcohol-related harm through timely identification and tailored advice and support for those at risk of harm due to their hazardous use of alcohol'.

As such, early intervention targets individuals rather than the public at large, or sub-groups within the general population, for instance students. Users of early intervention services consist of individuals whose pattern of substance use is indicative of abuse, whose behaviour as a result of use is having deleterious consequences, or in the case of adolescents specific risk factors are apparent as a result of substance abuse.

1.3 THE STRUCTURE OF THE EVALUATION REPORT

The evaluation encompasses both the Wanganui and Taranaki HOL initiatives.

The results of the evaluation are mainly presented in a narrative form.

Following this introductory section, Section 2 describes the evaluation methods.

Section 3 presents a brief review of the literature that provides context and outlines the rationale on which the HOL initiative was founded.

Section 4 outlines the development, implementation and operation of HOL in the Wanganui and Taranaki regions, and examines the similarities and differences between the two prototypes.

Section 5 examines the utilisation patterns of HOL's on-site, small group intervention (SGI) sessions in both regions.

Section 6 describes the overall impact of HOL using Ministry of Education official statistics, stakeholder and student feedback and impact-related data emanating from the student-targeted SGI sessions.

The final section of the report raises the question 'where to from here?' and presents recommendations arising from the findings drawn from the evaluation.

Tables other than those presented in the result-related sections can be found in Appendix A. The evaluation data collection instruments are presented in Appendix B of the report.

2. THE EVALUATION OBJECTIVES AND METHODS

2.1 EVALUATION OBJECTIVES

The evaluation objectives are to:

1. determine if the HOL programme has been effective in reducing stand-downs, suspensions and early school departures in the Wanganui and Taranaki regions' secondary school student population
2. determine the numbers of students who were identified or self-identified as having current AOD-related problems
3. determine the numbers of those same students who opted to participate in the programme's SGI sessions
4. determine if the HOL SGI approach has improved the participating students' educational and social outcomes in terms of improved attitudes to school and studies and improved school attendance
5. determine how effectively HOL operated during the course of the programme; identifying its operational strengths and weaknesses and ways in which it could be improved
6. determine the level of satisfaction with the HOL programme among the various participant groups, mainly the students who participated in the SGI sessions, the clinicians who facilitated the SGI sessions (the AOD clinicians) and the schools' key HOL contact people.

2.2 DATA COLLECTION METHODS

The evaluation involved the following steps:

Review of the literature

The review of the literature aimed to examine some of the published literature relating to the development, implementation and evaluation of the HOL school-based AOD initiative, including its SGI component. These issues include: levels of, and influences on, AOD use among young people in New Zealand; numbers of drug-related stand-downs, suspensions, exclusions and expulsions from secondary schools; Ministry of Education drug education guidelines for schools; and schools' retention of students during their compulsory years of education. The majority of the published research documents were accessed by ALAC's project manager for the HOL evaluation and provided to the author by ALAC's library staff. Review articles (including systematic reviews and meta-analyses) were given priority, as these were considered to be most suitable for the purposes and scope of the literature review. Ministry of Education reports and other documents were also used.

Compilation of student stand-down and suspension data

The Ministry of Education Wanganui office compiled the original calculations and graphics on which the evaluation is based. All the statistical data were analysed using Microsoft Excel spreadsheets and charts were generated using the same software.

Age-standardised suspension rates per 1,000-student population were calculated to compare the two sub-populations (the Wanganui and Taranaki regions) with the national average and to provide comparisons between the baseline years 2000 to 2004 (pre-HOL) and the post-HOL years 2004 to 2005. In addition all suspension data were calculated by school semester.

The suspension data were also calculated by age, gender, ethnicity, primary cause of disciplinary action and board of trustees' disciplinary action outcomes relating to AOD misdemeanours for the Wanganui and Taranaki regions.

The numbers of stand-downs and exclusions were also calculated for the Wanganui and Taranaki regions for the pre- and post-HOL years.

Development of data collection instruments

The following data collection instruments were developed in consultation with ALAC and the Ministry of Education:

- A student register for those who participated in the SGI sessions.
- A survey questionnaire for key HOL contact people.
- A survey questionnaire for the AOD clinicians.
- A student evaluation questionnaire for obtaining feedback from students who participated in the SGI sessions.

The survey questionnaires consisted of a mix of closed and open-ended questions with some Likert rating scales.

Copies of the four data collection instruments are presented in Appendix B of this report.

Maintenance of student registers for SGI sessions

In Taranaki all five AOD clinicians and the three school staff members who facilitated/assisted with facilitating SGI sessions were asked to maintain a register of students who attended the SGI sessions (a copy of the register is presented in Appendix B of this report). All agreed to do so. They recorded information outlining the students' demographic characteristics (age, school year, sex and ethnicity), the type of referral (e.g. the result of a disciplinary measure or self-referral), the type of drugs involved, the number of sessions the student attended and the perceived quality of students' participation in the group sessions.

In Wanganui the register was filled in retrospectively by the two Wanganui AOD clinicians from their written records. The difference was due to the later inclusion of Wanganui into the evaluation and the earlier start date of its HOL initiative.

Response rates

All but one of the five Taranaki AOD clinicians maintained the evaluation student registers routinely for nine of the 11 schools participating in the HOL initiative. However, one facilitator only recorded the requested information in the last of the four 2005 semesters. The number of students who attended the SGI sessions is as a result incomplete. The AOD clinician has since left his former employment and it was not possible to identify all the missing data.

The Taranaki student registers covered the period 12 May to 30 November 2005. The requested details were provided for a total of 68 students.

The Wanganui student registers extended over the period 2 February to 8 September 2005. The requested details were provided for 64 students.

Owing to the differences in the data collection periods (approximately six months for Taranaki compared with a seven-month period for Wanganui) and the incomplete nature of the datasets, it was not possible to make direct comparisons between the two regions' SGI data.

Interviewing stakeholders

The following two stakeholder groups were interviewed for the process evaluation:

The key HOL contact people

All the participant schools in Wanganui and Taranaki identified one staff member to act as a key contact person for the HOL initiative. The personnel selected to act as key HOL contact people in the schools included staff members such as school deans, student counsellors, resource teachers for learning and behaviour (RTLBs), principals and deputy principals.

The key HOL contact people in Taranaki were interviewed twice during the 2004 school year – between May and June for the first round of interviews and between October and December for the follow-up interviews.

The AOD clinicians

The above interview phasing also applied to the interviews with the AOD clinicians in the Taranaki schools.

In Wanganui, both the key HOL contact people in the schools and the AOD clinicians were interviewed just once as (1) the decision to include Wanganui in the evaluation was not made until June 2004 and (2) Wanganui's HOL had a one-year start over the Taranaki HOL initiative. The interviews in Wanganui were conducted in September 2004.

Obtaining HOL student participant feedback

As noted above, a questionnaire was specifically designed to capture feedback from those students who participated in the HOL SGI sessions. Only students who participated in SGI sessions in the Taranaki region were given the opportunity to provide this type of feedback given the later inclusion of Wanganui into the evaluation programme as explained in the preceding sub-section.

At the concluding session of the six SGI sessions, the Taranaki-based AOD clinicians agreed to ask the students who had attended the final HOL session whether they wished to participate in the evaluation.

The questionnaire explained the aims of the survey and assured the confidentiality of the students' responses. Students' names and personal identifiers were not asked for. However, all the evaluation forms were coded with the Ministry of Education's unique numeric code for data entry and coding purposes. Students who consented to completing a questionnaire were also given individual envelopes in which to seal their responses to maintain their anonymity. These students returned their completed questionnaires in the sealed envelopes to the AOD clinician, who subsequently placed these into

another large stamped and return-addressed envelope addressed to Research & Evaluation Services in New Plymouth.

Student evaluation response rate

Of the 65 students who attended the SGI sessions in the Taranaki region's secondary schools, 19 completed post-intervention evaluation forms.

While reasons for non-response were not requested, data from the HOL student register suggest that some students' attendance at the sessions was erratic (see Section 5 for further detail regarding student attendance). This may have contributed to the low response rate. The low response rate may also be due to some AOD clinicians having not routinely asked all students to fill in evaluation forms and students opting not to complete them. As a consequence of the low response rate it is not possible to draw any real conclusions from this particular evaluation method.

2.3 ANALYSIS OF EVALUATION DATA

The data arising from the SGI participant registers were entered into a Microsoft Excel database and analysed using this same software.

All other data were subjected to manual content analyses.

2.4 CONFIDENTIALITY AND ANONYMITY ASSURANCES

Both written and verbal assurances were given to all the evaluation participants that their names and other personal identifiers, including those of their schools, would not be used in any reporting arising from the research. The analyses that follow respect that assurance.

3. BACKGROUND LITERATURE REVIEW

This section of the report summarises information gathered from a brief review of the literature. The main aim of the review was to provide a context to some of the issues, rationale and concepts relating to the foundation of the HOL initiative. In particular it examines:

- the levels of AOD usage among young New Zealanders, with a focus on the school-aged population
- Ministry of Education policy and advice to schools with regards to drug education, the management of drug-related incidents and those students stood down, suspended, excluded or expelled in response to drug-related misdemeanours
- the concept and principles of the early intervention approach on which HOL is based
- the effectiveness of programmes and services based on the early intervention approach, with particular emphasis on those targeted at young people.

3.1 AOD USE BY YOUNG PEOPLE IN NEW ZEALAND

Recent national surveys suggest that while most young New Zealanders are healthy, a significant number engage in risky behaviours that have the potential to impact considerably on their health and wellbeing (Ministry of Health 2004: Adolescent Health Research Group 2003; ALAC 2003; Wilkins et al 2002). In particular, the regular and heavy consumption of AODs (mainly tobacco and marijuana) by young people is of concern given the possible serious health and social consequences associated with these substances.

These same national studies show experimentation with drugs commonly starts in early adolescence. In the case of alcohol, ALAC's annual drinking monitoring surveys indicate that the age at which experimentation with alcohol begins is trending downwards. In 2002, the average drinking age among 14- to 17-year-olds was 14.5 years. By 2003 the average age had dropped to 13.6 years (Parliamentary Library 2003).[1]

Several New Zealand studies, including the two longitudinal birth cohort research programmes – the Dunedin Multidisciplinary Health and Development Study and the Christchurch Child Development Study – suggest that young people's experimental drug use quickly turns into regular usage, particularly the use of alcohol, tobacco and marijuana (Adolescent Health Research Group 2003; ALAC 2003; Wilkins et al 2002; Ministry of Health 1998; Casswell 1996; Stanton 1996). For example, the Dunedin Multidisciplinary Health and Development Study found that the percentage of participants classified as 'drinkers' (having their own glass, not just a sip) increased from just over 20 percent at age nine to well over 90 percent at age 18. By age 18, 85 percent had a drink at least once a month and more than half had a drink at least once a week, with the amounts of alcohol consumed also increasing with age (Casswell 1996).

[1] This downward trend is consistent with overseas studies. For example, a study by Muck et al (2001) of adolescent substance use and abuse in the United States suggests that the age at which young people are first introduced to drugs decreased over the four decades preceding the millennium. In the 1960s the average age at which young people first experimented with drugs was 18 years and over. Between the late 1970s and early 1980s introduction commenced between the ages of 15 and 17 years and from the late 1980s through the 1990s it was down to younger than 15 years.

There is some evidence suggesting that adolescents are more susceptible to developing substance dependency syndromes (Winters 1999 as cited by Muck et al 2001). Young substance abusers are less likely to self-refer for treatment and are commonly referred by a parent, school officials or the criminal justice or child welfare system (Muck et al 2001; Battjes et al 2004). As a group, they more commonly face barriers to accessing treatment services (Winnard et al 2005; Gilvarry 1998) and on presenting for therapy exhibit co-morbid psychiatric disorders, mainly depression and anxiety disorders (Gilvarry 1998). Substance use disorders that include alcohol and cannabis abuse have also been associated with suicide attempts and completed suicides in young people under the age of 25 years (Beautrais 2003). Battjes et al (2004) also contend that once in treatment, young substance abusers are more likely to drop out prematurely.

Heavy/Binge drinking

New Zealand's national studies suggest that many young New Zealanders drink at risky levels (ALAC 2005: Ministry of Health 2004; Adolescent Health Research Group 2003; ALAC 2003; Wilkins et al 2002). The Youth2000 survey, for example, found that by age 13 over a third of secondary school students (41 percent of males and 28 percent of females) had drunk five glasses or more of alcohol in one four-hour sitting.

The recent 2003 ALAC *Youth Drinking Monitor* (YDM) survey of 14- to 17-year-olds found a lower and decreasing proportion of young 'heavy drinkers', 25 percent in 2003 down from 33 percent in 2002 (ALAC 2003). The YDM survey also showed much greater gender differences among its 14- to 17-year-old study population compared with the 2001 national drug survey, with the proportion of males drinking heavily nearly double that of females, 63 percent and 37 percent respectively.

Onset of alcohol consumption and different drinking patterns

ALAC's 2003 YDM survey found that over two-thirds (69 percent) of Māori 14- to 17-year-olds had 'really started drinking' before the age of 15 years compared with 46 percent of Pasifika young people and 58 percent of 'other'[2] ethnic groups. Of the current drinkers, 48 percent of Māori compared with 45 percent of Pasifika youth and 30 percent of 'other' ethnic groups were more likely to report having drunk five or more glasses of alcohol at their last drinking occasion.

3.2 DRUG-RELATED MISDEMEANOURS IN NEW ZEALAND SECONDARY SCHOOLS

Sections 13 to 17 of the Education Act 1989 provide schools with a range of responses to the 'gross misconduct' of their students. These responses include the use of stand-downs and suspensions. The Act also requires schools to: tailor their responses to fit the seriousness of the offence; ensure that the situation is well managed and according to the 'principles of natural justice'; seek to minimise disruption to the student's education; and facilitate the student's return to school at an appropriate time (Ministry of Education 2000). Stand-downs and suspensions are tools available to schools in responding to AOD-related misconduct. Where students are caught in possession of illicit drugs, the Police must be notified.

[2] Including European/Pakeha young people.

There is some concern about the higher-than-average rate of suspensions for Māori and Pasifika secondary school students. For example, a national study conducted by Glynn (1997) showed a disproportionate school suspension and expulsion rate for Māori and Pasifika students between 1992 and 1997 (cited in Ministry of Education 2003, p137). Glynn found that in 1997, Māori students accounted for 44 percent of all suspensions, despite Māori as a population group accounting for 16 percent of the total secondary school population. The Māori suspension rate per 1,000 students was 3.6 times higher than that of Pakeha. Nearly a third (32 percent) of the Māori suspensions involved females.

One of the Ministry of Education's overarching goals for New Zealand education is to reduce systematic under-achievement in education. In the Ministry's *Statement of Intent 2005-2010* (2005) it notes that despite learning achievement gains in recent years, significant disparities remain between Pasifika and Māori students and 'other' ethnic groups. The Ministry also points to the high level of stand-downs and suspensions among Māori students in particular as indicative of and reflecting too many Māori students' early departures from school and their under-achievement compared with Pakeha.

As well as this, Barnes' (2001) international research shows a direct correlation between student AOD use and poor school attendance, below-average learning outcomes and disruptive classroom behaviour (cited in Ministry of Education 2003, p137).

3.3 EARLY SCHOOL LEAVING

New Zealand parents are required to have their children enrolled in a school between the ages of six and 16 years. However, it is possible to apply for an early leaving exemption under the Education Act. Between 2003 and 2005, 4,000 15-year-olds left school via this process (Corrigan 2006).

The impacts of students leaving school early have been studied in relation to early exemptions.[3] For example, a control group study undertaken by the Ministry of Education in Wanganui followed up 130 students who left secondary school and who subsequently were nominated to go on to a free tertiary youth training programme that caters for trainees with low school qualifications. The study's findings are consistent with international research and show that compared with students who left school with low qualifications at 16 or 17 years of age, those who left school at age 15 typically had shorter stays on the youth programme, earned fewer National Qualifications Framework credits and had poorer labour market outcomes in terms of going on to employment or accessing further training (Corrigan 2006).

This study reinforces the efforts of educators to retain students in school until age 16 and beyond. It cites evidence of better health outcomes, lower criminality, higher lifetime earnings and higher self-rated happiness for students successfully retained in compulsory schooling.

[3] These are not necessarily related to students' AOD use.

3.4 SCHOOL-WIDE AOD POLICIES

Schools' AOD policies include: school rules about AODs; processes for the delivery of drug education to students; processes for the delivery of support and intervention to students who are at high risk of experiencing AOD-related problems; and clear discipline processes.

International evidence suggests that schools where rules relating to drug misdemeanours are 'clearly formulated' and are also made known to students experience a lower proportion of students who regularly smoke tobacco and drink alcohol (Maes and Lievens 2003). It appears that 'having clear and fair rules is a characteristic of effective schools (having an effect on academic achievement and social behaviour)', which seems concomitantly to have an effect on reducing risky behaviours (Cochran cited in Maes and Lievens 2003, p525).

The Ministry of Education advises New Zealand schools that they are within their rights to forbid drugs on their premises from legal, educational and safety perspectives. However, the Ministry suggests there are several positive approaches that can be taken to address issues around drugs. These include offering pastoral care rather than excluding or expelling students who are using AODs (Ministry of Education 2000).

The Ministry of Education also indicates that drug education is an essential component of New Zealand's compulsory health and physical education curriculum. Mounting research evidence suggests that school-aged children are being increasingly exposed to a wide assortment of drugs, especially tobacco, alcohol and cannabis. The Ministry sees such drugs as having serious deleterious effects on student users' health and wellbeing (Ministry of Education 2000).

In its official guidelines to school principals and schools' boards of trustees the Ministry of Education (2000) outlines what it considers are the essential components of 'a quality drug education programme'. Essentially, it suggests a school-wide AOD policy with elements that include:

- the development of a 'whole-of-school' drug education policy
- the delivery of classroom health education programmes
- professional development for staff teaching classroom health programmes
- the use of appropriate community agencies and resources to support the health curriculum
- the development of procedures for handling drug-related incidents in schools
- providing effective interventions.

The Ministry of Education also acknowledges schools' right to adopt a 'zero tolerance' approach in their drug education programmes. This model advises students not to take drugs at all and to 'say no' to drugs at all times. However, the Ministry expresses a preference for, and strongly endorses, schools using the Ministry of Health's National Drug Policy's 'harm minimisation' approach that:

> '… aims to minimise the adverse health, social and economic consequences of drug use without necessarily ending such use for people who cannot be expected to stop their drug use immediately. The primary goal of this approach is a net reduction in drug-related harm rather than becoming drug-free overnight, although harm minimisation strategies often lead to a reduced number of people who use drugs over time.' (Ministry of Education 2000, p26)

While endorsing the National Drug Policy's harm minimisation model, the Ministry of Education hastens to add that this support does not imply a sanctioning of drug use. Rather it acknowledges that:

- drug use is common among some young people
- drug use exposes others, including their peers, to potentially harmful situations and drug-taking behaviours
- students' parents may condone their children's use of drugs.

3.5 SCHOOL-BASED AOD EDUCATION AND PREVENTION PROGRAMMES

The evidence suggests there are a number of key components in effective prevention and education approaches.

School settings

Schools are seen as appropriate settings for AOD education/primary prevention programmes (Faggiano et al 2005; Winnard et al 2005; Maes and Lievens 2003; Ministry of Education 2000). Faggiano et al (2005) suggest three reasons why schools are particularly suitable for delivering primary drug education to young people:

1. Experimentation with drugs, particularly tobacco use, commonly begins in early adolescence, consequently it is important to start education before their attitudes to and expectations of drug use become firmly established.
2. All young people attend school, therefore schools offer the most systematic and effective way of reaching the majority of school-aged children and adolescents.
3. Most countries provide health education as part of their schools' teaching curricula.

School climate

The climate in the school may be an important influence on the AOD consumption patterns among young people. Research involving 29 Flemish secondary schools found a strong correlation between truancy and repetition of classes (indicators of alienation and poor academic achievement) and students' regular smoking and drinking behaviour (Maes and Lievens 2003). A large component of the variation was found to be a characteristic of the schools they attended. The researchers suggested that:

'This finding may indicate that smoking and drinking [alcohol] related behaviours are stimulated not only by the larger number of "problematic" pupils, but also by a certain school climate the characteristics of which we could not directly measure. Some schools seem not able to provide meaning and a sense of belonging for the pupils.' (Maes and Lievens 2003, p525)

Interactive and non-interactive programmes

One of the key findings from the Ministry of Youth Development's literature review on effective drug education for young people is that its effectiveness is increased when its delivery is interactive (Allen & Clarke 2003). This is in accord with international reviews of drug education in schools. For instance, Tobler et al's (2000) systematic review of 207 universal school-based drug prevention programmes makes the distinction between what they term 'interactive' and 'non-interactive' drug education approaches.

The non-interactive universal prevention approach typically employs the standard didactic teaching model that is delivered to students in the classroom by a teacher or other suitably trained service

provider. This approach aims to impart knowledge about the long-term physical and psychological impacts of drug use to help prevent young people moving from experimental to regular use of drugs.

The interactive approach also aims to impart AOD-related prevention knowledge, but in addition includes a life skills' development component. This component seeks to equip students with generic safety, social development and refusal skills. The aim of this is to give them confidence and enable them to say 'no' to drugs without losing face with their peers or others who may be encouraging them to take drugs. Students are also provided with opportunities to communicate with one another and exchange ideas and are also encouraged to practise their newly acquired refusal skills.

Tobler et al's (2000) review found that, irrespective of study design, interactive prevention programmes, particularly those focused on specific types of drug, were significantly more effective in reducing cigarette, alcohol and marijuana use than the non-interactive interventions. The interactive approach was found to be particularly effective in schools located in low socio-economic areas and in those with high minority group student populations.

Faggiano et al (2005) carried out a systematic review of 32 randomised-control studies of school-based illicit drug prevention programmes. Life skill development programmes were effective in deterring early-stage drug use, but only in the short term. However, few of the studies had included longer-term follow-up, which the research team saw as a serious methodological flaw.

Another Cochrane review of 57 primary prevention programmes did, however, find a significant 7 percent reduction in Native American students' weekly alcohol drinking behaviour, compared with the control group, three and a half years after their having attended a school- and community-based skill development training programme (Shinke 2000, cited in Foxcroft et al 2002, p8).

3.6 EARLY AOD INTERVENTION APPROACHES

As well as the universal drug education component of HOL, there is an early intervention component that targets individual students identified as at risk of or experiencing AOD problems. This component of HOL comprises a brief SGI that provides individual support and treatment referrals where necessary. The SGIs are provided within the confines of the school setting. The review will now briefly examine the rationale for locating HOL's AOD intervention within the school environment.

Adolescents – access barriers to remedial services

Compared with conventional health/treatment services for AOD issues, school-based early intervention programmes are designed to provide easier and earlier access to help for students.

The New Zealand Youth2000 survey found half of the 9,699 student respondents identified barriers to their accessing health services. Winnard et al (2005) divided the barriers into two separate categories. The first category, the internal/young person category, included personal characteristics, for example shyness, not wanting to make a fuss, and not wanting to be bothered. The second category, external/health service-related barriers, included concerns about cost and privacy and not feeling at ease with the health care provider.

Winnard and his colleagues (2005) suggest that providing collaborative health and support services in schools is the best way to address issues of this nature and is an important step towards getting young

people to take responsibility for their own health care. They also believe that on-site school services will be helpful in reducing failure to attend outpatient appointments, which they suggest is relatively common in this age group.

Engaging and retaining adolescents in remedial services

School-based early intervention may also help schools to engage and retain young people.

Gilvarry (1998) suggests that engaging and retaining young people generally presents a particular challenge for health services. She argues that since those who drop out of services have worse prognoses and outcomes than those who are retained, it is essential that every effort be made to engage and retain them. Gilvarry makes the point that young people whose behaviour is seriously delinquent, academically backward and antisocial and who come from dysfunctional family backgrounds are much more likely to withdraw prematurely from an intervention service.

Those who continue to attend and complete an intervention even when their family and academic backgrounds are similar tend to have better outcomes than those who prematurely withdraw. Gilvarry suggests that collaboratively developed services that provide young people with easy access, for example the one-stop-shop service model, or are sited in close proximity to schools, for instance, serve to reduce attrition and promote better outcomes.

3.7 HOL'S EARLY INTERVENTION APPROACH

We now consider the particular constructs and principles on which HOL's brief SGI is based, mainly the guided self-change model, which utilises motivational interviewing and cognitive behavioural therapy techniques to promote positive change in young people's AOD use.

The guided self-change model

This approach draws on the Prochaska and Di Clemente 'stages of change' model, which acknowledges that the process of change requires investment from the person making the changes and has several stages (cited in Werner 1995, pp340-341). The model is represented in the form of a wheel consisting of six phases commencing with the entry point for the process of change, namely:

The pre-contemplation stage – at this stage the adolescent is not thinking of changing their drug use behaviour as they do not consider that they have a problem.

The contemplation stage – Werner perceives this stage as one in which the adolescent is in a state of ambivalence, where they begin to weigh up the risks and benefits of their drug use but make no definite commitment to change.

The determination stage – in which the subject indicates that they may need to change their drug-using behaviour.

The action stage – the adolescent engages in actions that indicate they are prepared to make a change to modify their drug-using behaviour. However, making the decision to change seldom goes without challenges to sustain the goal.

The maintenance stage – efforts are required on a daily basis to maintain the goal and prevent relapse (the sixth stage) into the former pattern of behaviour.

Werner points out that the change process on which the model is based is rarely linear, hence the addition of the relapse stage. The motivational focus of the SGI means that young people who are still in the pre-contemplation stage (are not yet thinking about or worried about their drug use) can begin to move through the stages and make better decisions.

The cognitive behavioural technique

According to Muck et al (2001) 'behavioural approaches [including cognitive behavioural techniques] focus on the underlying cognitive process, beliefs and environmental cues associated with the adolescent's use of drugs and alcohol and teach the adolescent coping skills to help him or her remain drug free' (p148). The therapeutic techniques used in either residential or outpatient settings aim to 'unlearn' the young person's existing behaviour with regards to drug taking and enable them to learn 'alternative, prosocial' ways to cope with their lives. Approaches based on this approach vary but commonly include teaching specific skill sets such as AOD refusal skills, enhanced communication skills, both verbal and non-verbal, assertiveness training, and negotiation and conflict resolution skills.

Muck et al's (2001) comparative overview of AOD treatment models for adolescents and Copeland et al's (2001) randomised case control study of 229 young Australian cannabis abusers indicate the effectiveness of cognitive behavioural interventions compared with other treatment approaches.

Motivational interviewing

Rollnick and Miller (1995) define motivational interviewing as 'a directive, client-centred counselling style for eliciting clients to explore and resolve ambivalence' (cited in Borsai and Carey 2000, p728).

The clinician works to motivate the person through the stages of change and into positive action. Werner (1995) contends that:

'To motivate a [person] implies an ability to increase the likelihood that the [person] will follow a recommended course of action toward change. Motivation refers to the probability that a person will enter into, continue and adhere to a specific change strategy. As such, attempts to motivate [the subject] should focus on what they do not say, and need to be specific to one behaviour or action' (p339).

Effectiveness of motivational interviewing

Motivational interviewing appears to be one of the most effective early intervention approaches for reducing AOD use in young people (Borsai and Carey 2000; Burke 2003; McCambridge and Strang 2005; Gates et al 2006). For example, Burke's (2003) review found that at follow-up, 51 percent of participants had reduced their alcohol intake. This compared with 37 percent of those not receiving treatment or the standard treatment regime. Improved social impacts were also observed for the clients who reduced their alcohol consumption.

A second systematic review conducted by Gates et al (2006) of 17 randomly controlled trials of drug prevention interventions for young people in non-school settings included two motivational interviewing

interventions. One of these two interventions (McCambridge and Strang 2005) showed a significant reduction in the *frequency* of self-reported cannabis use (from 15.7 down to 5.4 times per week) in the intervention group. Those in the intervention group also reduced the *quantity* of cannabis they used compared with the control group (cited in Gates et al 2006, p9). The number of days cannabis was smoked also showed a significant reduction compared with the control group. However, Gates et al concluded that while motivational interviewing showed benefits in this case, there were insufficient studies included in the review to enable them to endorse the approach unconditionally.

Tait and Hulse's (2003) systematic review of 11 brief interventions for adolescents included six that were founded on the motivational interviewing approach. They concluded from this review that motivational interviewing was particularly effective in reducing young people's AOD consumption. However, this approach and the other brief intervention approaches had limited effects on reducing cigarette use and on reducing consumption among multiple drug users.

4. DEVELOPMENT, IMPLEMENTATION AND DELIVERY OF *HIGH ON LIFE*

This section of the report outlines the main factors influencing the development of HOL and looks at the way it has operated, firstly in Wanganui where it was established and later in Taranaki where it was subsequently adopted. It also describes the way in which HOL has operated in schools and outlines its core components. The section concludes with an analysis of feedback received from participating schools and AOD clinicians in relation to the perceived effectiveness of the processes used to promote and deliver the HOL programme.

4.1 FACTORS INFLUENCING THE OVERALL DEVELOPMENT OF HOL

Since 2000, drug-related misdemeanours have been the single most common reason for student suspensions in New Zealand secondary schools. Between January 2000 and 31 December 2004, 31 percent of the 23,126 suspensions in secondary schools were drug related (see Tables 1 and 2, Appendix A).

Drug-related suspensions in the Wanganui area's secondary schools prior to the introduction of HOL accounted for 33 percent of all suspensions. This figure was similar to the national norm of 35 percent. In Taranaki, pre-HOL drug-related suspensions represented 52 percent of the region's total suspensions (see Tables 1 and 2, Appendix A).

However, a more rigorous way of looking at the suspension issue is to examine standardised comparisons between regions and with the national average. During the latter part of 2003, staff in the Ministry of Education's Wanganui office began to recognise patterns in the Wanganui region's secondary school suspension rates per 1,000 students. The Ministry found that over the 2000 to 2004 period, the drug-related suspension rate for Wanganui schools was higher than the national per annum average (7.7 compared with 5.3 per 1,000 students). Further analysis showed that by the middle of 2004 the Taranaki region's drug-related suspension rate had also increased to a point where it was almost double the national rate (see Tables 1 and 2, Appendix A).

4.2 EARLY DEVELOPMENT PHASE OF HOL IN WANGANUI

Towards the conclusion of the 2003 school year, Mark Corrigan, Special Education Facilitator at the Ministry of Education's Wanganui office, began to explore ways to reduce drug-related suspensions in the Wanganui area. He conducted this exploratory work in consultation with other local agencies directly involved in working with young people and youth-specific AOD issues.

In the early part of 2004, various other community agencies were invited to look at ways to address the area's high drug-related suspension rate. The HOL initiative was subsequently developed by a consortium of local agencies that included representatives from the Ministry of Education, the Wanganui District Health Board's AOD Service and its Public Health Unit, the Youth Services Trust, the Taumata Hauora Trust (CAYAD) and Wanganui's four urban secondary schools.

Two groups – the HOL Steering Group and the HOL Working Group – were formed as a result of the wider consultation meeting, the former to oversee the development and implementation of the initiative and the latter to ensure that key decisions arising from the Steering Group were put into action.

Since only one 0.6 full-time equivalent (FTE) youth-specific AOD clinician, supported by the Early Intervention Clinician, was available to work in schools during the 2004 and 2005 school years, the Wanganui HOL Steering Group recognised the need to limit its focus to Wanganui's four urban secondary schools. However, the Steering Group was hopeful that another AOD clinician might be employed in the future to work with the region's intermediate and rurally based schools.

The HOL initiative was subsequently launched in Wanganui's four urban secondary schools in April 2004. The main activities undertaken by the HOL Steering Group to launch the programme included:

- recognising and supporting the role of local AOD clinicians in providing on-site clinics or SGI sessions in the four schools
- introducing the HOL programme and the AOD clinicians at school assemblies
- holding a parent information-sharing forum
- distributing a student-targeted HOL wallet card to all students, alerting them to the availability of the on-site AOD support service and the contact details of the AOD clinicians should they wish to contact them regarding questions or concerns of their own, a family member's or a friend's AOD use. The card also provided an assurance of confidentiality
- promoting HOL's key messages.

The HOL key messages

The following key messages were developed by the Ministry of Education's Wanganui office and were promoted to the Wanganui and Taranaki secondary school principals at the time the initiative was launched in the respective regions.

- For all students – increasing awareness and making choices/decisions about AODs i.e. growing up in a drug-using world. The health curriculum is important and effective here. Schools' health classes will cover drug education early in the year (i.e. following its initiation in the schools).
- For the students with an AOD problem – providing access to one-on-one or SGI sessions in schools, which includes using the ALAC *Smashed 'n Stoned?* resource. Students know of the ways to opt into this help without fear of punishment.
- For the school staff – changing the way they respond to AOD issues. Helping students to change and an emphasis on retaining students in schools.
- For Police and AOD staff – ongoing recognition of their role to support schools in practical ways.

4.3 HOW HOL OPERATES

The Wanganui HOL initiative was designed to operate at two main levels:

- A whole-of-school approach that complements the drug education component of the health and physical education curriculum.
- Recognise and promote the role of the AOD clinical support strand provided by a range of regionally based external AOD agencies whose clinicians facilitate on-site, clinical and educative support sessions for students identified as having problematic AOD use. The

approach used in the sessions is non-prescriptive and based on the guided self-change model, which incorporates motivation enhancement, goal-setting and cognitive behavioural principles.

HOL key operational components have included:

The on-site SGI sessions

Students who participated in Wanganui's on-site SGI sessions entered either through self-referral or through referral from school pastoral staff or parents.

Described as a 'brief intervention approach', the SGI sessions comprised six separate one-hour sessions facilitated by an AOD clinician on a weekly basis. The SGI was adaptable for use with either a small group or individuals. As such, students could attend these sessions on an individual basis or they could opt to participate in the SGI session work. The first of the six sessions involved an individual assessment of the referred student's needs, followed by four separate one-hour sessions over a four-week period. The sixth and final session involved a follow-up of each participant to see how things were going for them and to determine whether they required additional support.

The AOD clinicians

As noted above, the on-site SGI sessions were largely facilitated and run by trained AOD clinicians from external AOD agencies in most instances (all four schools in Wanganui and seven schools in Taranaki) and school guidance counsellors in two other Taranaki secondary schools.

The key HOL contact people

All four Wanganui and the 11 Taranaki schools that opted to adopt the HOL approach identified one staff member to act as a key contact person for the HOL initiative and the evaluation. These personnel included a principal, deputy principals, deans, school counsellors, and RTLBs whose responsibilities included teaching and overseeing health studies. The key HOL contact people's responsibilities specific to HOL were:

- acting as the key person in schools for students regarding HOL
- liaising with the external agencies, AOD clinicians, public health nurses and deans about HOL referrals
- promoting HOL to staff and students
- generally overseeing the implementation of HOL in the schools.

The *Smashed 'n Stoned?* resource

The *Smashed 'n Stoned?* resource comprises a set of four booklets and certificates of achievement. The booklets are for students who are engaged in risky use of substances to work through with the guidance of a counsellor. The resource provides the structure for the SGI sessions. Since April 2005 the AOD clinicians in both Wanganui and Taranaki have used the resource in their individual or group sessions with students on the HOL programme.

The *Smashed 'n Stoned?* resource is based on the guided self-change model developed by the Sobells in Canada (Sobell and Sobell 1993). It was adapted in 2004 from the earlier ALAC resource *Smashed or Stoned.* It is designed for use with 13- to 18-year-old New Zealanders whose AOD use places them at risk. ALAC recommends that the resource be used by a trained counsellor working with three to six

young people, but it can also be used by a counsellor working with a young person on an individual basis.[4]

The *Smashed 'n Stoned?* resource was introduced by ALAC to both the Wanganui and Taranaki regions' key HOL contact people via a one-day drug education training workshop. Wanganui's two AOD clinicians and Taranaki's three AOD clinicians attended part or all of the training day according to their training needs. The training was divided into two parts – the whole day was for non-AOD clinicians such as school counsellors, who required more time to learn about specific AOD interventions and the theories on which these are based. The latter part of the training was the practical component i.e. how to use the resource with young people. This part of the training was attended by all the training participants including the AOD clinicians. Combining the two groups was considered appropriate given HOL's intersectoral/community approach. Feedback on the value of the training day was generally positive. The clinicians identified that the models used in *Smashed 'n Stoned?* are in accordance with the theoretical and practical approach that all but one person employed as part of their normal daily practice.

The AOD clinicians saw *Smashed 'n Stoned?* as an appropriate, visually appealing and useful resource that the student participants could call their own. The resource was seen as encouraging and promoting young people in decision-making (a skill that was seen as lacking). The certificates included in each of the resource's booklets and the certificate of completion presented at the end of the programme were also seen to promote a sense of achievement among participants.

4.4 THE INTRODUCTION OF HOL TO THE TARANAKI REGION

In July 2004 Mark Corrigan of the Ministry of Education's Wanganui office approached each of Taranaki's 13 secondary schools to alert them to the region's comparatively high rate of drug-related suspensions and to moot the idea of bringing the HOL initiative to Taranaki. The response was generally positive, with the majority of schools embracing the concept of having on-site professional help and support for students identified as having AOD problems or known to be at risk of developing problems. The schools similarly accepted the 'harm minimisation' model on which HOL is founded when assured that HOL respects the rights of all schools to maintain their 'no drugs at school' policies.

Taranaki's HOL initiative was modelled on the Wanganui prototype (see sub-section 4.3 above). It was officially launched in Taranaki on 11 March 2005 by Judge Andrew Becroft. HOL was subsequently taken up by 11 of Taranaki's 13 secondary schools in April 2005, just over 12 months after its implementation in Wanganui's secondary schools.

The HOL objectives and mode of the AOD service delivery remained largely the same as those operating in the Wanganui urban area. The main differences between the Wanganui prototype and the Taranaki HOL initiative up until December 2005 were as follows:

- The AOD on-site support service in Wanganui between 2004 and 2006 was limited to just four urban schools, whereas Taranaki's HOL programme involved 11 secondary schools

[4] This evaluation was not required to evaluate the acceptability or effectiveness of *Smashed 'n Stoned?*, although some comment was received during the course of the evaluation. An independent evaluation is currently underway.

over a much larger geographical region – from New Plymouth city in the north to central Taranaki, across to coastal Taranaki and extending to Hawera in the south.

- In Wanganui the two AOD clinicians were employed by Good Health Wanganui. In Taranaki the four AOD clinicians came from three separate agencies; two were staff members of Taranaki District Health Board's Child and Adolescent Mental Health Service based in New Plymouth, another was an employee of Mahia Mai a Whai Tara in Waitara, and the fourth worked from the Raumano Health Trust in Patea. However, in two of the 11 schools the AOD support services were either solely provided or supplemented by school staff members – a student counsellor in one instance and an RTLB in the other.
- Unlike HOL in Wanganui, where the initiative was overseen and driven by a steering group, HOL in Taranaki was largely steered from Wanganui by the Ministry of Education. As noted earlier, the Wanganui HOL Steering Group included representation from several external agencies. Collectively these agencies provided an intersectoral, multidisciplinary team approach to the development, implementation and overall promotion of HOL. The evaluation suggests that Wanganui's intersectoral approach resulted in a relatively high level of awareness of the HOL initiative among students, the school communities and parents. In contrast, the 11 schools in Taranaki reported a low level of awareness of HOL in all quarters (see the following section for further detail regarding HOL awareness levels).

4.5 WHAT STAKEHOLDERS LIKED BEST ABOUT THE HOL INITIATIVE

Thirteen of the 15 secondary schools and five of the AOD clinicians in the two regions considered HOL had worked particularly well in a number of areas. The most frequently mentioned strong points of HOL are outlined below.

Access to on-site AOD help for 'at risk' students

All Wanganui's four schools and eight of the 11 Taranaki HOL participant schools were appreciative of having cost-free, external specialised help come into schools to work with students whose AOD-related behaviour had brought them into conflict with the schools' 'no drugs at school' policies. Eleven of these schools' key HOL contact people appeared pleased to have a non-punitive option to offer offending students to help them address their AOD-taking problem. Two of the schools' key HOL contact people considered their schools' previous approach as 'draconian' or 'quite harsh'.

The on-site service had been added as another step in the schools' usual disciplinary responses to students who disobeyed their schools' 'no drugs at school' policies. Often this new step followed either a stand-down or a suspension. In the latter cases it largely followed the student returning to school after having a mandatory blood test to prove they were drug free. Schools that had traditionally referred offending students to off-site AOD agencies considered the on-site option superior, as they believed it generally improved attendance.

The pastoral approach

All 15 schools and the five AOD clinicians in the two regions wholeheartedly supported HOL's aim to support and maintain offending students in school and to prevent early departure. These people generally saw retention in school as a protective factor. Students 'cast out' for what tended to be a one-off offence was seen as likely to drive them into the 'very drug culture that we want to keep them away from' or which had brought about their AOD problem in the first place. Others liked the approach

because it ‘makes them [the students] work through the consequences of their AOD-related behaviour for themselves’. It was also seen to ‘help them make sensible choices’.

The three schools that considered they did not ‘really have a drug problem’ indicated that they had traditionally taken a pastoral approach on the few occasions when a student was identified as having an at-risk hazardous AOD problem. Two had reported having referred students to external agencies in the past. All three had expressed interest in using the HOL approach should problems arise in the future, prior to the official launch of HOL in Taranaki. One of these same schools had in fact approached the external AOD agency assigned to it during the course of 2005 but had reverted to using its own school counsellor on encountering a slow response from that particular agency.

The intersectoral/collaborative approach

Ten schools’ key HOL contact people commended the collective, collaborative approach that HOL provides, because it has openly acknowledged that AODs are an issue for all schools. Others appreciated that they could ‘share the burden’ with external specialists. Bringing in ‘different people’ also meant that schools were seen to be willing to help student offenders and that school staff were not seen as ‘heavy disciplinarians’.

The *Smashed ‘n Stoned?* resource

Three of the schools’ key HOL contact people liked the structured approach of the resource, which gets students to look at their problematic AOD use. One of the school’s guidance counsellors who had personally run SGI sessions liked the resource because it encouraged students to set ‘positive and achievable goals’ and stimulated the idea that they might need to make changes.

While the AOD clinicians generally liked the *Smashed ‘n Stoned?* Resource, they indicated that they had deviated from using it where necessary and according to the needs of the students. In general, the resource was considered a useful SGI guideline because, for the most part, it complemented their own professional approach which was based on the same philosophical and theoretical principles as *Smashed ‘n Stoned?*.

The inclusion of the *Whare Tapa Wha* concept of health in the *Smashed ‘n Stoned?* resource was considered a useful and appropriate way to have students look at the impact of their AOD use on the four areas of wellbeing, namely family/whanāu, spiritual, emotional and mental and physical wellbeing.

The AOD clinicians

Six schools (three in Wanganui and three in Taranaki) saw the AOD clinicians as a particular strength of HOL and noted that their students ‘really like them’. In Wanganui the praise was quite high indeed for one clinician in particular, who was described as ‘excellent’ and having ‘good rapport with students’ and was generally credible and likeable.

The wallet cards

Three schools particularly liked the HOL wallet cards. They continued to promote the cards actively by keeping them on the reception desks or in the counsellors’ and deans’ offices. However, one Taranaki AOD clinician noted that not one call had resulted from the use of the wallet card. Some teachers also saw the wallet card as something that students either quickly discarded or lost.

4.6 WHAT STAKEHOLDERS LIKED LEAST ABOUT THE HOL INITIATIVE

Stakeholders from six schools were very satisfied with the way HOL had been promoted and the way in which it had worked for their schools since its implementation. The remaining stakeholders noted the following aspects of HOL that they had liked least.

Supply for on-site clinical support exceeded demand

One Wanganui school and one south Taranaki school, while generally happy with the HOL concept, noted that the schools' demand for the external clinical support exceeded agencies' capacity to supply. One south Taranaki school's key HOL contact person said that their school was left 'high and dry' during the second semester. The agency that had provided the service in the south Taranaki region over the first semester was unable to continue to do so due to other workload commitments. From the outset, this service was said to have expressed reservations about becoming involved in HOL as it lacked an AOD clinician with the specialist skills to work with adolescents. With groups of students lined up to participate in the SGI sessions, the south Taranaki school's student counsellor had been obliged to fill the gap left by the exited service. The school was disappointed, as the first semester SGI sessions had looked promising.

Two other schools saw a potential risk that the 'whole thing [HOL] will fall over' should any one of the external agencies pull out. Members of Wanganui's HOL Steering Group acknowledged that the agency providing the on-site service in Wanganui was 'quite stretched'. This meant that the group's aim to 'roll out' the service to rural schools in the Wanganui region could not be fulfilled with the existing resources. However, this resource gap has been filled and the three rural schools are now receiving consistent AOD services.

Gender issues

Taranaki had no female AOD clinicians while Wanganui had no male AOD clinicians. Schools in both regions, especially single-sex schools, were concerned about the lack of choice in the gender of the AOD clinicians. The girls' schools saw potential risk from the perspectives of both the AOD clinicians and the female students. One school had responded to these potential problems by having a female teacher sit in with the male AOD clinician during the SGI sessions. However, this response was also seen to have its drawbacks: on the one hand it compromised the students' right to privacy, while on the other it had the potential to compromise the teacher should they hear something they felt morally bound to report to the school. While two of Taranaki's AOD clinicians mentioned the gender issue, neither identified having experienced any problems during the delivery of the SGI sessions.

Philosophical differences between schools and HOL

Four schools expressed reservations about the 'harm minimisation' approach underpinning both the AOD clinicians' work with students and the HOL initiative in general. One school considered that HOL 'sends a weak message' because it thought it implied that 'experimentation with drugs is okay when it is not'… 'All drug use is bad for developing brains'.

One AOD clinician saw a conflict between some boards of trustees' rule that 'students must remain drug-free at all times, including the weekends' (as implied by the 'drug free test' requirement) and the alternative view that 'what people do in their own time is their own business'. Those holding the latter

view felt that clinicians had an obligation to promote knowledge and strategies that minimise the potential harmful effects of AOD and equip young people to make informed choices.

While three schools appeared to like the terms *High on Life* and *Smashed 'n Stoned?*, a minority found them offensive. One AOD clinician did not like either terminology, which he thought 'trivialised the intent'.

SGI sessions timed wrongly

Two schools indicated a preference to have the SGI sessions held sequentially within a five-day school week rather than on a weekly basis. Both the schools' key HOL contact people thought that the weekly sessions tended to undermine the momentum for students and consequently the usefulness of the intervention. This problem was said to be further exacerbated when an AOD clinician cancelled one session, causing a lapse of two weeks between sessions. Students in one situation where this had occurred were said to have lost interest in attending any further sessions.

Lack of protocols and guidelines

When the first phase of stakeholder interviews was carried out (June through to July 2005), three Taranaki schools reported that one agency's AOD clinician was slow to respond to their first group of student referrals. In one school the referral had been made in April but by June it had yet to get a response from this particular clinician. All three schools felt there was a definite need for protocols/guidelines to support the HOL initiative so that everyone would know what was expected of each other.

Some schools not fully engaged in HOL

In Wanganui, one stakeholder considered that schools had not fully bought into HOL's broader whole-of-school approach. Schools were seen as quite willing to take up the free clinical support service but unwilling to do anything over and above this to support students or the initiative in the broader sense. These stakeholders told of schools which (1) failed to promote a 2005 poster design competition initiated and promoted by the HOL Steering Group, despite having incentives that would benefit schools and (2) failed to include 'after ball' AOD advice for schools and parents in the schools' newsletters. These stakeholders were of the opinion that schools' failure to pick up and run with these complementary activities was indicative of the health and education sector having quite different agendas. They contended that Education considers Health's agenda 'too idealistic', while Health sees Education's agenda as 'too narrow'.

4.7 SUGGESTED STRATEGIES TO IMPROVE AND ENHANCE HOL

Schools' key HOL contact people and the AOD agencies suggested a number of ways to improve HOL. Their suggestions largely revolved around the idea of promoting greater awareness of and support for HOL.

Find ways to better promote the HOL concept and uptake

Seven schools and two AOD agencies from both Taranaki and Wanganui felt there was potential to (1) promote greater public awareness of the HOL initiative, particularly among parents, and (2) increase schools' uptake of and commitment to the initiative generally. Two stakeholders suggested calling on some 'good front people', such as Judge Andrew Becroft, to help raise HOL's profile in the region. Both

recalled Judge Becroft as having done 'a great good job' of promoting the initiative to insiders at the Taranaki HOL launch in March 2005.

One key HOL contact person suggested that HOL's profile might be lifted if it were to have a presence at school and wider community events. This approach, they noted, had been successfully used by the *Students against Drunk Driving* (SADD) initiative. Another considered that more promotional work was required to lift HOL's profile among students to help 'kids see the value of it for them'.

Six teachers considered that more AOD training was needed for teachers. They also wanted opportunities for the schools' key HOL contact people to come together now and then so that they could learn from each other and share information on how HOL was going in their respective schools. Joining forces would also give them a chance to 'self-review' and to identify and discuss what resources were needed to promote HOL better.

Three teachers, one AOD clinician and one other stakeholder saw a need for specific promotional resources to support the HOL initiative, for example posters, leaflets, balloons and drug education-related DVDs for use in the SGI sessions (this type of DVD was also suggested by several students in their evaluation forms following completion of the SGI sessions). One person saw resource gaps in the AOD area, for instance on 'binge drinking' and the side effects of cannabis use in young people.

One key HOL contact person in a Taranaki school described another potentially useful strategy to increase students' awareness of the support offered by HOL. Their school had appointed a student HOL ambassador, a 13-year-old ex drug-user who had 'turned his life around'. 'The kids know him and what he has done…He is often the first point of contact.'

Increase the capacity and enhance the delivery of the on-site intervention service

Stakeholders in Wanganui were generally hopeful that more AOD clinicians might be brought on board to increase the capacity of what one person described as a 'special and important service'. The training and recruitment of Māori AOD clinicians was also considered vital in servicing schools in Wanganui with high Māori rolls. Those who promoted this idea felt it would then be possible to develop a relationship with the local kura kaupapa schools and promote the HOL concept there. Should these efforts prove successful, it was likely that te reo-specific resources would be necessary to support the on-site service. Wanganui contributors also aspired to have the service extended to rural and intermediate schools in the district.

Wanganui service providers saw a continued need for AOD training to support teachers because 'it's [AOD's] such a huge issue' for young people and for schools generally. Two Wanganui schools also suggested increasing the involvement of the AOD clinicians in prevention-focused education in the classroom. While the teachers acknowledged that AOD education is best taught by the classroom teacher, they nevertheless felt that 'new faces' would help to increase the impact and student uptake of the AOD education messages. They also felt that involvement of AOD clinicians in AOD education in the classroom would provide an opportunity for the clinicians to establish rapport with the students and promote greater awareness of the HOL initiative.

Three Taranaki key HOL contact people suggested that the SGI sessions would work better for schools if two AOD clinicians worked together. These schools had experienced difficulties with one agency that had cancelled sessions due to other commitments. The three schools indicated it was important to have a back-up person to take over should the need arise. They felt the service must be reliable and regular for the SGI sessions to be effective.

5. UPTAKE OF THE ON-SITE SMALL GROUP INTERVENTION

The following analysis is based on data extracted from the student SGI session participant registers that were maintained by the AOD clinicians for evaluation purposes. The data are not consistent for reasons explained in Section 2 of this report, therefore direct comparisons between the two regions could not be made. What the data show, however, is the level of schools' usage of HOL's SGI on-site service. The section concludes with an assessment of the level and quality of the students' engagement in the SGI sessions based on the AOD clinicians' assessments.

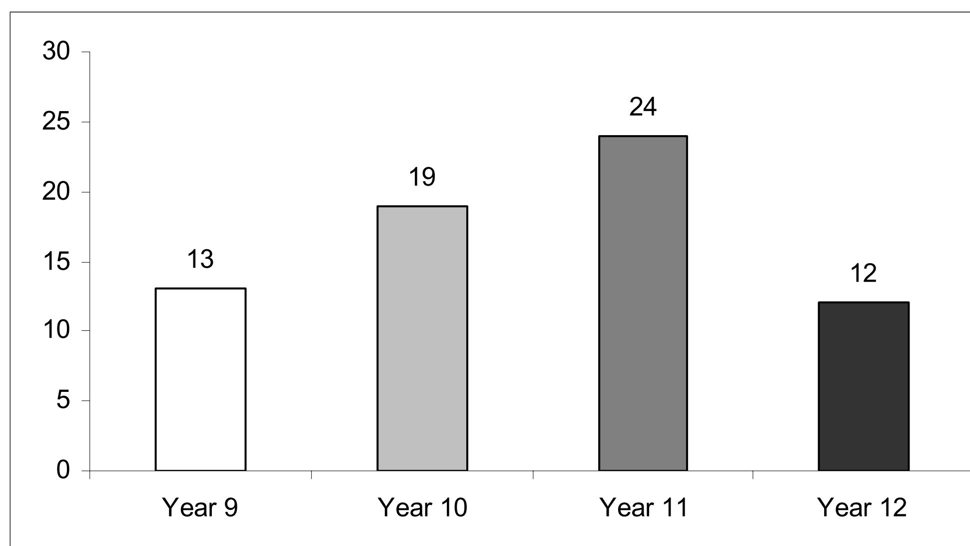
5.1 CHARACTERISTICS OF STUDENT PARTICIPANTS IN SGI SESSIONS

A total of 64 students attended the Wanganui SGI sessions between 2 February and 8 September 2005. In Taranaki a total of 69 students attended one or more of the six SGI sessions between 12 May 2005 and 30 November 2005. No student AOD-related incidents were reported during 2005 in two of the 11 schools that originally 'signed up' with HOL, nor did any students in either of these two schools express a desire to participate in an SGI session (i.e. self-refer). One of the 11 schools reported just one student AOD-related incident. That student was seen by an AOD clinician on a one-to-one basis. Information about this student was not recorded in a student register, therefore the analysis specific to the student registers is based on 68 students from 10 of the 11 HOL participant schools.

By school year

Just over one-third (35 percent) of the students who participated in the SGI sessions in Taranaki schools were Year 11 students and 28 percent were in Year 10 (Figure 1).

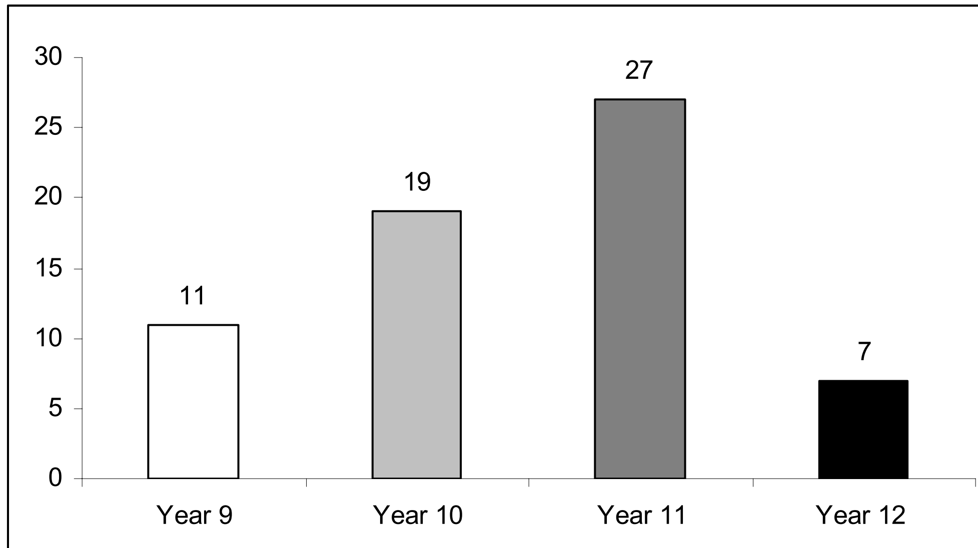
Figure 1: Number of Taranaki SGI session participants by school year, 12 May-30 November 2005 (n=68)



Source: Student SGI session register

In the Wanganui urban area, 42 percent of the SGI session participants were in Year 11 and a further 30 percent were in Year 10. Proportionately, Year 12 students were the smallest group at 11 percent (Figure 2).

Figure 2: Number of Wanganui SGI session participants by school year, 2 February-8 September 2005 (n=64)

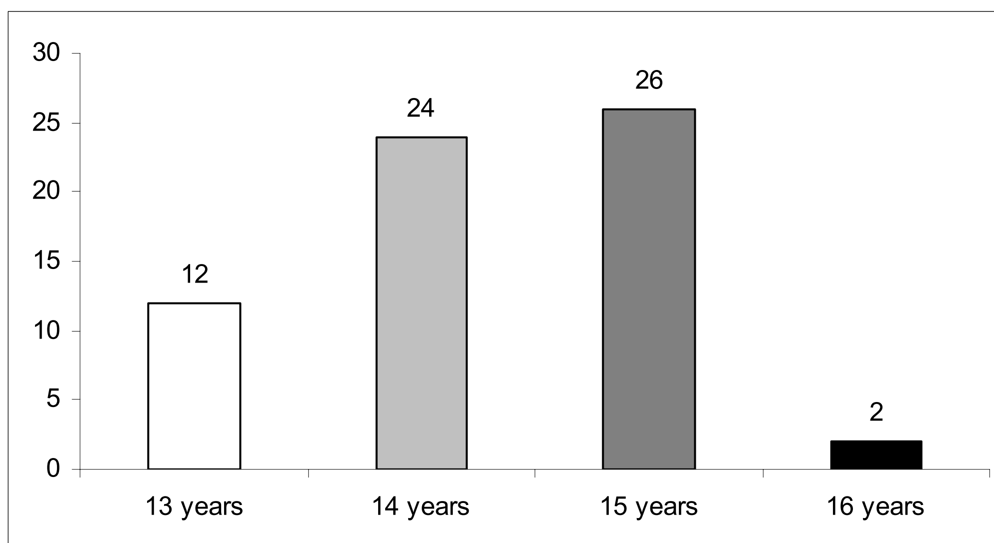


Source: Student SGI session register

By age

Figure 3 shows that of the 64 students in Taranaki for whom age was recorded, most were either 15- (42 percent) or 14-year-olds (36 percent). Nineteen percent were younger (13 years) and only two students were older (age 16 years).

Figure 3: Number of Taranaki SGI session participants by age, 12 May-30 November 2005 (n=64*)

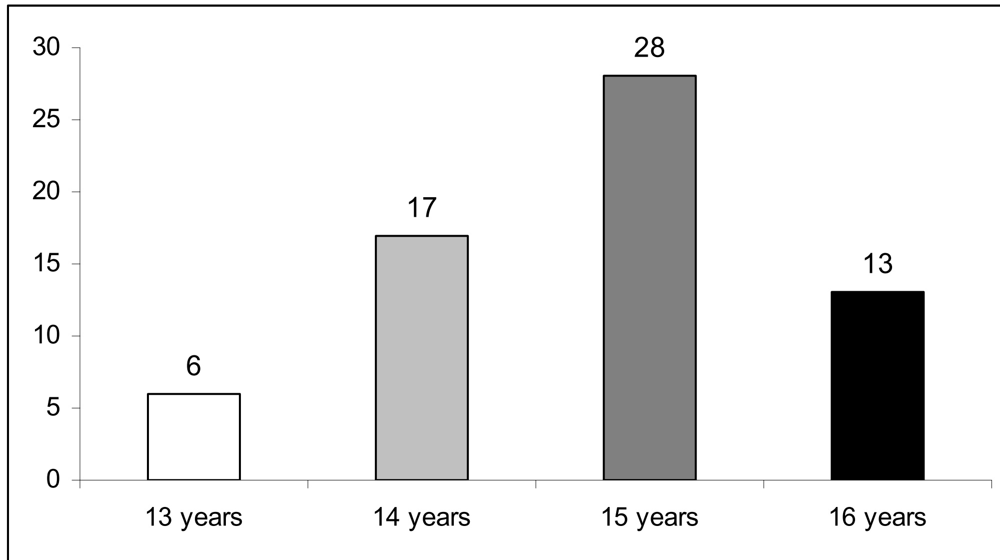


Source: Student SGI session register

* The student's age was not recorded in four instances

Of the 64 Wanganui SGI session participants, most (44 percent) were age 15. Age 14 years was the next most common age group. The youngest and the oldest age groups were proportionately smaller, 9 percent and 20 percent respectively.

Figure 4: Number of Wanganui SGI session participants by age, 2 February-8 September 2005 (n=64)

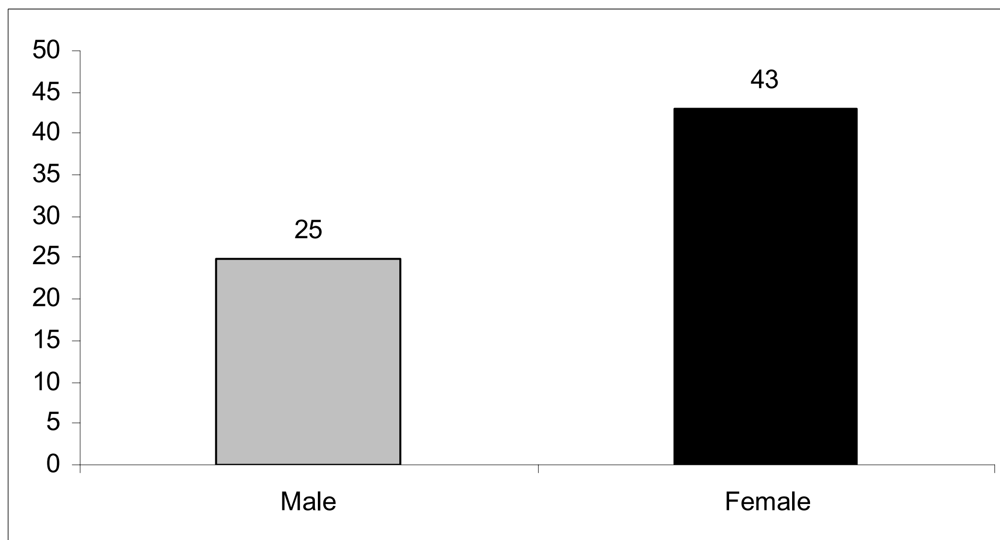


Source: Student SGI session register

By gender

The majority of the SGI session participants in the Taranaki region were female (63 percent).

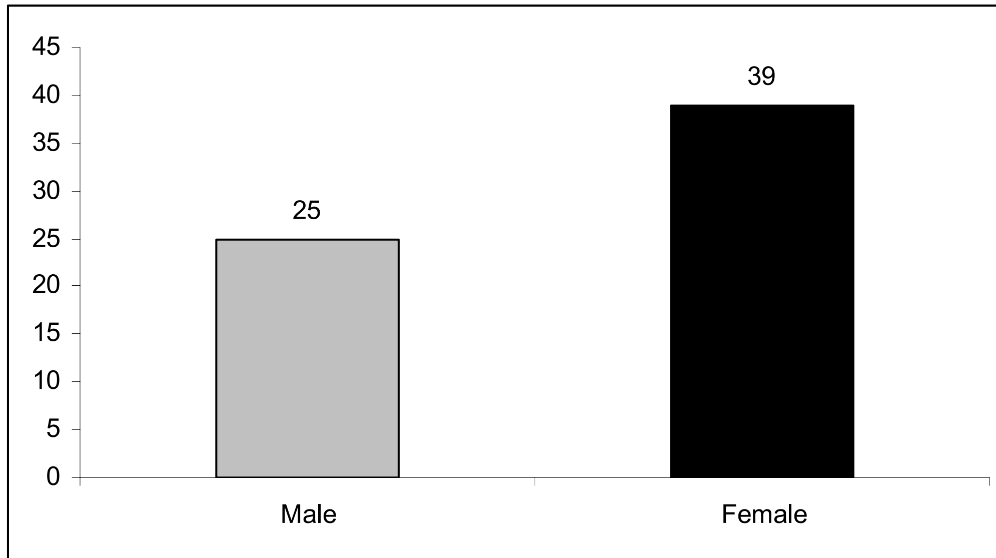
Figure 5: Number of Taranaki secondary student participants in SGI sessions by sex, 12 May-30 November 2005 (n=68)



Source: Student SGI session register

In Wanganui the pattern was similar – 61 percent of the 64 SGI session participants were female (Figure 6).

Figure 6: Number of Wanganui SGI session participants by sex, 2 February-8 September 2005 (n=64)

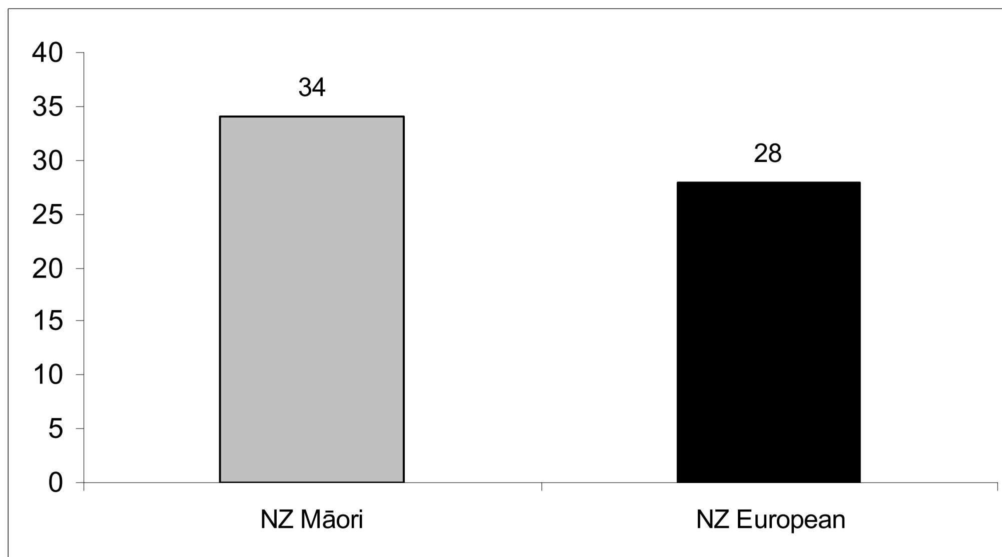


Source: Student SGI session register

By ethnicity

Just over half (55 percent) of the Taranaki SGI session participants were New Zealand Māori while 45 percent were New Zealand European (Figure 7).

Figure 7: Number of Taranaki SGI session participants by ethnicity, 12 May-30 November 2005 (n=62*)

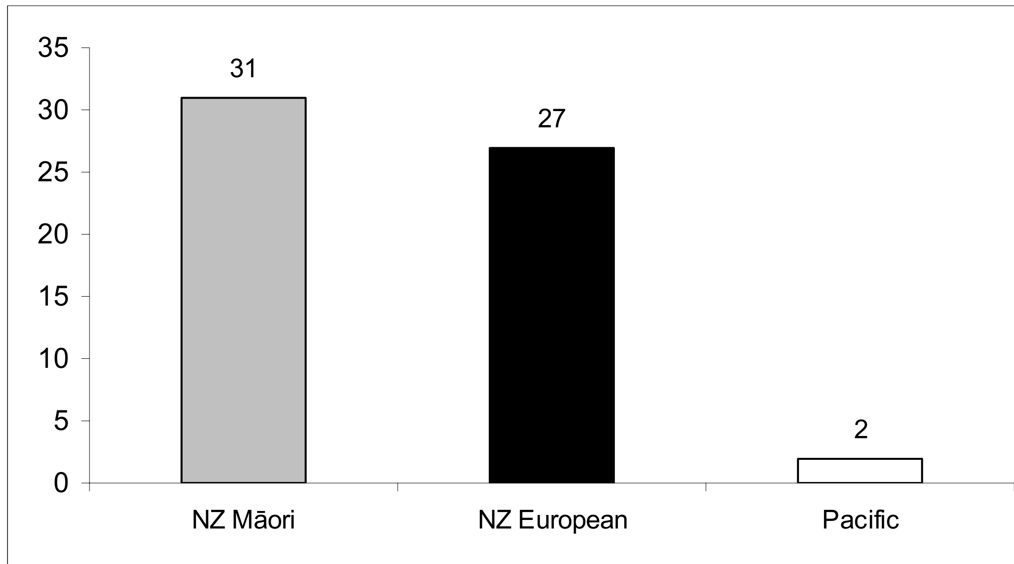


Source: Student SGI session register

* The student's age was not recorded in six instances

The ethnicity of three SGI session participants was not recorded in the Wanganui HOL student registers. Of the remaining 61 SGI session participants, 51 percent were New Zealand Māori, 46 percent were New Zealand European and 3 percent (two individuals) were of Pacific origin (Figure 8).

Figure 8: Number of Wanganui SGI session participants by ethnicity, 2 February-8 September 2005 (n=61*)



Source: Student SGI session register

* The student's age was not recorded in three instances

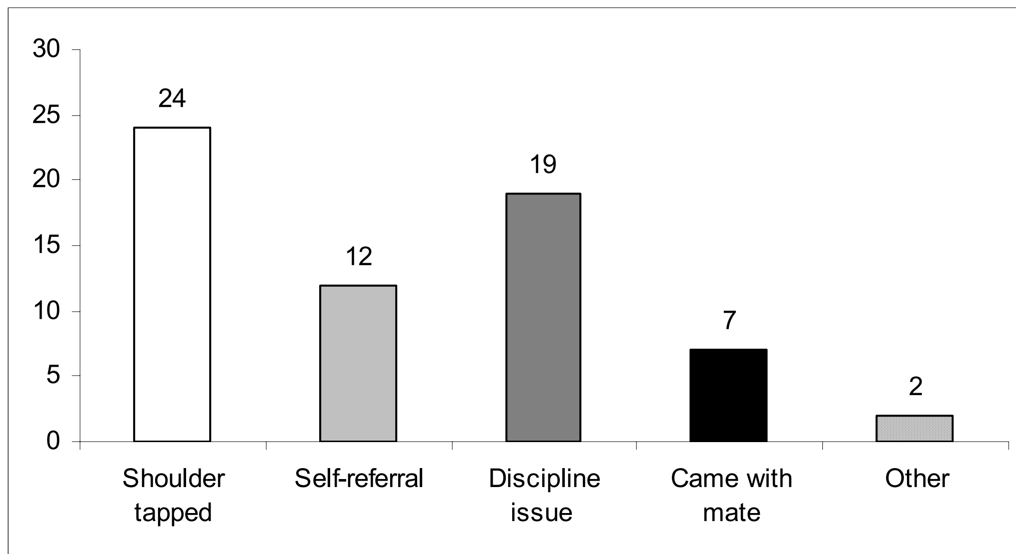
By source of referral

In Taranaki, 'shoulder tapping'[5] by teachers was the most common way in which students came to participate in the SGI sessions (36 percent). The second most frequent referral source (30 percent) occurred in schools where HOL had become part of the schools' drug-related disciplinary process. In these schools students had been either stood down or suspended and were permitted to return to school following their observance of conditions laid down by the schools' boards of trustees – participation in the SGI sessions being one of these conditions. A further 19 percent self-referred to participate in the SGI sessions (Figure 9).

There were obvious gender differences in the referral sources. Just over two-thirds (68 percent) of the male referrals resulted from a disciplinary action, compared with just 13 percent of the female referrals. More of the shoulder-tapped referrals were female (49 percent) compared with 12 percent of males. Females also more frequently self-referred (27 percent) compared with 12 percent of males.

[5] Shoulder tapping occurred when a student with known AOD issues was either directed, as part of a disciplinary measure, or recommended by a school's principal or teacher that they would benefit from attending the SGI sessions.

Figure 9: Number of Taranaki SGI sessions by source of referral, 12 May-30 November 2005 (n=64*)

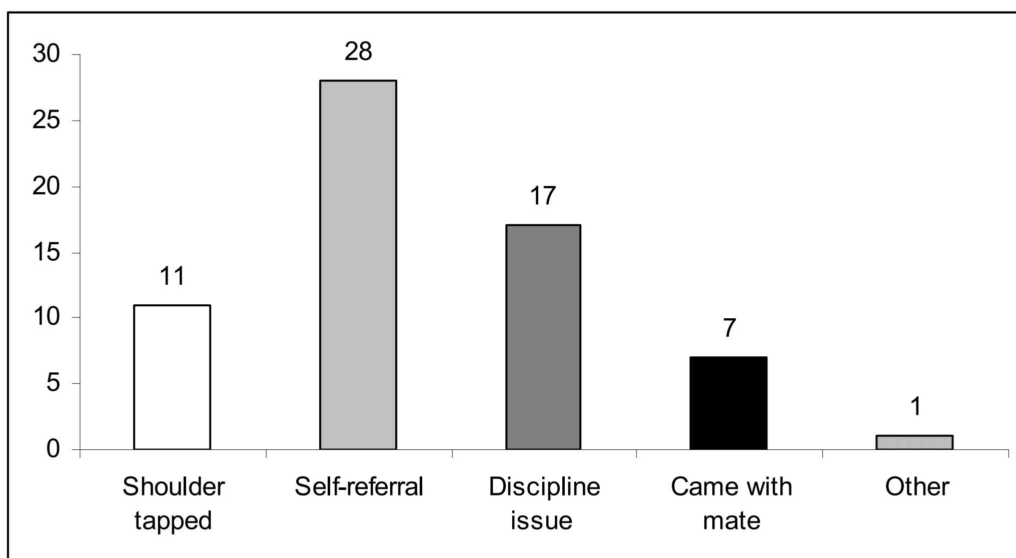


Source: Student SGI session register

* The student's age was not recorded in four instances

In Wanganui the pattern was quite different. Self-referral was the most common source of referral (44 percent). One of the AOD clinicians in Wanganui observed that females were more likely to self-refer than males. The analysis of the SGI register data proved their assessment correct. Just on half (49 percent) of the 39 female SGI session participants self-referred compared with 32 percent of the 25 male participants. Slightly more females came to support a friend (n=5) compared with just two males (Figure 10).

Figure 10: Number of Wanganui SGI session participants by source of referral, 2 February-8 September 2005 (n=64)



Source: Student SGI session register

Figure 10 also shows that disciplinary-related referrals (27 percent) were the second most frequent source of referral followed by shoulder tapping (17 percent). Males were more commonly referred to

HOL as part of a disciplinary action, 44 percent of all male referrals compared with 18 percent of female referrals.

5.2 TYPES OF DRUG INVOLVED LEADING TO HOL PARTICIPATION

In the Taranaki schools the drug most commonly identified in the SGI student registers as having led to students' participation in the SGI sessions was cannabis (76 percent of the 68 SGI session participants). Alcohol was the second most commonly identified substance (66 percent).[6] The third highest drug category was 'other'; in all cases this other drug was tobacco.

In the four Wanganui urban schools, cannabis was also the most common drug identified as having led to students' involvement in the SGI sessions (67 percent); next was alcohol (45 percent) followed by solvents (14 percent).

5.3 PERCEIVED QUALITY OF STUDENTS' PARTICIPATION IN HOL

The AOD clinicians were asked to rate the quality of students' engagement in the SGI sessions. In both regions the level of engagement generally ranged between excellent and good, with very few at the lower end of the rating scale (fair and poor). The Wanganui AOD clinicians more frequently assessed the students' engagement level as excellent (30 percent) compared with 19 percent in Taranaki. However, Taranaki AOD clinicians more frequently assessed students' engagement levels as 'very good' (44 percent) compared with 28 percent in Wanganui (Table 1).

Table 1: Quality of students' engagement in SGI sessions by region

Region	**Quality of students' engagement (percentage)**				
	Excellent	Very good	Good	Fair	Poor
Wanganui (n=60*)	30%	28%	33%	8%	-
Taranaki (n=63**)	19%	44%	14%	13%	10%

Source: Student SGI session register

* Not recorded in four instances

** Not recorded in five instances

[6] In most instances there was more than one substance involved i.e. students were commonly identified as having issues with both alcohol and cannabis.

6. IMPACT AND EFFECTIVENESS OF *HIGH ON LIFE*

HOL originally took shape in Wanganui at the end of 2003 in response to what the Ministry of Education's Wanganui office then identified as a markedly higher per 1,000 students rate of drug-related suspensions in the Wanganui and Taranaki regions compared with the New Zealand average. Although a reduction in stand-downs, suspensions and early departures from school was never an explicit aim of the HOL initiative, the desire to reduce what the Ministry perceived as a negative indicator was implicit in each of the three HOL programme objectives (the objectives are presented in Section 1). However, the evaluation was required to determine whether the HOL initiative had been effective in reducing AOD-related suspensions. Stand-down and expulsion data are also considered to determine if any shifts in disciplinary action patterns have occurred since HOL was initiated in Wanganui and Taranaki. Impact and effectiveness feedback from the stakeholder interviews and SGI session participants concludes this section of the evaluation report.

6.1 IMPACT ON SUSPENSION RATES

Decreased suspension numbers

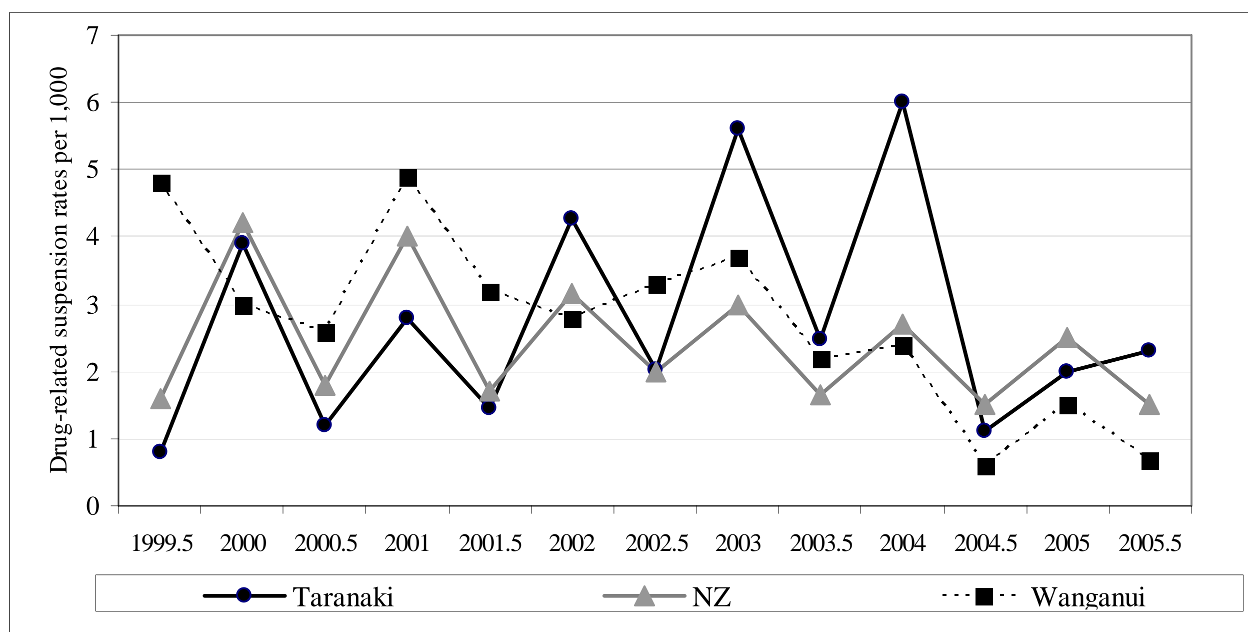
Drug-related suspension numbers reduced steeply in both Wanganui and Taranaki during the first semester of 2004, from 14 at the start of 2004 down to two by the end of that same semester. In Taranaki, numbers also sharply declined from 51 down to nine, over exactly the same period (Table 2, Appendix A).

Decreased suspension rates

In Wanganui the age-specific drug-related suspension rate per 1,000 students also dropped sharply once the HOL initiative was initiated early in the first semester of the 2004 school year, from the high point of 6.0 per 1,000 students at the beginning of the 2004 school year to 1.3 by the start of the second semester in that same year. Since that initial drop the rate has remained low (Figure 11 and Table 3, Appendix A).

In Taranaki the suspension rate also decreased four-fold from 8.0 per 1,000 students in the second semester of 2004 to 2.4 by the first semester in 2005 (Figure 11, Table 3, Appendix A). However, this drop in suspensions occurred in the school semester immediately after the introduction of the initiative to principals, but prior to HOL's actual introduction to the region's secondary schools. The Ministry of Education's Mark Corrigan attributes the decrease prior to HOL's physical arrival in Taranaki's secondary schools to an increase in awareness of the higher-than-average suspension rates in this region after discussions took place between himself and the Taranaki school principals in July 2004. It was at that meeting that Taranaki's comparatively high drug-related suspension rate was first pointed out to the region's principals and the HOL concept and the possibility of introducing it to Taranaki secondary schools were also raised.

Figure 11: Suspension rates per 1,000 students by semester in Wanganui, Taranaki and New Zealand, 1999.5-2005.5



Source: Ministry of Education, Wanganui office

When the suspension data are aggregated into the periods prior to the introduction of HOL and post-HOL, it can be seen that the rate per 1,000 secondary students in the Wanganui urban area more than halved following the introduction of HOL, while the rate in the Taranaki region was nearly half what it was pre-HOL. Wanganui and Taranaki rates by the post-HOL period reached a point where both were lower than the national drug-related suspension rate (Table 2).

Table 2: Drug-related suspension rates per 1,000 secondary school students per annum pre- and post-HOL, for Wanganui and Taranaki regions compared with New Zealand

Wanganui		Taranaki		New Zealand	
Pre-HOL 1/2000-7/2004	Post-HOL 4/2004-12/2005	Pre-HOL 1/2000-7/2004	Post-HOL 7/2004-12/2005	Pre-HOL 1/2000-12/2004	Post-HOL 4/2004-12/2005
7.5	3.2	6.6	3.6	5.4	4.1

Impact on suspensions versus stand-downs

The pattern of disciplinary action in relation to drug-related misdemeanours in schools has changed in both the Taranaki and Wanganui regions' secondary schools since the introduction of HOL (Table 3). Pre-HOL, Wanganui and Taranaki both had higher proportions of drug-related suspensions (53 percent and 67 percent respectively) compared with drug-related stand-downs. However, over the post-HOL period in Wanganui, standing students down was the more commonly applied drug-related disciplinary measure (78 percent). Suspending students continued to be the most frequent form of discipline used to deal with students' drug-related misdemeanours (79 percent). However, it should be kept in mind that numbers for these forms of disciplinary action in both regions have dropped dramatically, especially in Taranaki.

Table 3: Numbers and percentages of pre- and post-HOL drug-related stand-downs versus suspensions for Wanganui and Taranaki secondary schools

	Wanganui		**Taranaki**	
Pre- and post-HOL suspensions vs stand-downs	**n**	**%**	**n**	**%**
Pre-HOL stand-downs	70	47	97	33
Pre-HOL suspensions	80	53	195	67
TOTAL	**150**	**100**	**292**	**100**
Post-HOL stand-downs	57	78	12	21
Post-HOL suspensions	16	22	44	79
TOTAL	**73**	**100**	**56**	**100**

Source: Ministry of Education, Wanganui office

Impact on drug-related exclusions and expulsions

Lifting a suspension on the basis of certain conditions was the most common outcome following a drug-related suspension in New Zealand secondary schools between 2000 and 2005. Nationally 44 percent of all secondary schools' boards of trustees applied this option. Exclusion and expulsion and extending the suspensions were the second most common outcomes, with a quarter adopting the latter and a further quarter applying the former form of discipline (Table 4).

Table 4: Drug-related disciplinary outcomes by New Zealand (January 2000-December 2005)

	Drug-related disciplinary outcomes							
	Lift		**Lift with conditions**		**Extend**		**Expel/Exclude**	
Area	n	%	n	%	n	%	n	%
NZ (n=7,346)	335	5	3,245	44	1,861	25	1,905	26

Source: Ministry of Education, Wanganui office

Pre-HOL, Wanganui and Taranaki secondary schools showed similar disciplinary patterns. Both were more likely to extend drug-related suspensions, especially in Wanganui, compared with the national rate. However, expulsion in both regions pre-HOL, as for New Zealand as a whole, was the second most common disciplinary measure used for drug-related misdemeanours (Table 5).

Table 5: Pre-HOL drug-related disciplinary outcomes in Wanganui (January 2000-31 March 2004) and Taranaki (January 2000-30 June 2004)

	Drug-related disciplinary outcomes							
	Lift		Lift with conditions		Extend		Expel/Exclude	
Area	n	%	n	%	n	%	n	%
Wanganui (n=80)	4	5	10	13	41	51	25	31
Taranaki (n=195)	1	1	60	31	73	37	61	31

Source: Ministry of Education, Wanganui office

Post-HOL, the pattern of drug-related disciplinary outcomes changed dramatically in both regions, although by December 2005 their disciplinary approaches looked considerably different from each other (see Table 6) and from New Zealand as a whole (see Table 3). Nearly three-quarters of Taranaki's boards of trustees' disciplinary outcomes were extended, compared with 33 percent of Wanganui's and 25 percent nationally.[7]

Table 6: Post-HOL drug-related disciplinary outcomes in Wanganui (April 2004-December 2005) and Taranaki (July 2005-December 2005)

	Drug-related disciplinary outcomes							
	Lift		Lift with conditions		Extend		Expel/Exclude	
Area	n	%	n	%	n	%	n	%
Wanganui (n=18)	-	-	4	22	6	33	8	44
Taranaki (n=42)	-	-	6	14	31	74	5	12

Source: Ministry of Education, Wanganui office

In terms of exclusions and expulsions, the proportion increased from 31 percent pre-HOL to 45 percent post-HOL in Wanganui, whereas in Taranaki the proportion expelled or excluded decreased from 31 percent to 12 percent, slightly less than half the national average.

6.2 STAKEHOLDER VIEWS REGARDING THE IMPACT OF HOL

Key HOL contact people in both Wanganui and Taranaki schools were largely not able to say whether the behaviour and learning outcomes of the students who had attended SGI sessions had improved as a consequence of their participation. Six people attributed this lack of knowledge to their lack of awareness about who had and who had not attended the SGI sessions. However, four of the key HOL contact people had seen evidence of students' learning outcomes and behaviour improving since attending the SGI sessions. Examples given included:

- students' attendance at one Taranaki school had reportedly changed for the better
- in Taranaki, one school had observed less evidence of drug use
- in another school, the behaviour of all SGI participants was seen to have improved. A parent of one of the students had personally thanked the school for intervening

[7] Data supplied by the Ministry of Education suggest that most students given extensions to their drug-related suspensions eventually return to school.

- in both Taranaki and Wanganui, many students were seen to have enjoyed attending the SGI sessions, with several described as having 'got something out of it'
- in one of the Wanganui schools, participation in the SGI sessions had reportedly helped raise the self-esteem of students whose self-esteem was normally low.

Was it effective in reducing suspensions?

Key HOL contact people were shown a six-point scale ranging from 'very effective' to 'not effective at all' with a 'not sure' category and asked to rate the effectiveness of HOL in helping to reduce suspensions and early school departures. Two Wanganui schools rated HOL (mainly the on-site AOD support service) very effective and one rated it effective. One person selected the 'neutral' option.

In Taranaki two key HOL contact people rated the approach 'very effective' while another considered it 'effective'. Four rated HOL 'not particularly effective' while a further four were unsure.

One of the key HOL contact people considered that a reduction in the number and rate of suspensions was an inadequate indicator for measuring effectiveness. It was suggested that reduced exclusions and expulsions would be a better measure.

What impact did it have on school policy?

The key HOL contact people were asked if their schools had made any changes to their drug-related management policies since the introduction of HOL. None of Wanganui's four schools reportedly had made any changes to what they described as their 'no drugs in school' policies. However, all four appeared to have dropped what one described as their former 'knee jerk' reaction. Pre-HOL, students caught with drugs would have been immediately stood down, suspended or expelled (the last for particularly serious cases, namely supply of drugs on school property). Stand-down and suspension remained disciplinary options, but since HOL's introduction the schools required offending students to work with an AOD clinician either in an on-site SGI session or on an individual basis as a condition of their returning to school.

In Taranaki three of the 11 schools indicated they had officially changed their student drug misdemeanour management policies. Three had 'unofficially changed' their policies by requiring students who were stood down or suspended for drug-related misdemeanours to attend the HOL SGI sessions as a condition of their return to school. Five schools had not made any changes. Three of these five schools considered their schools had 'no real drug problems' (see Section 4.5: *The Pastoral Approach* for further explanation). The schools that had changed their policies either officially or unofficially had, like Wanganui, incorporated the on-site SGI service as one step in their return to school conditions.

6.3 STUDENTS' SGI SESSION FEEDBACK

The first section of the evaluation survey form presented a range of statements designed to assess what impact the SGI session work had on participants with regards to their schooling and home life and at a personal level.

Table 7 below suggests that all 19 students either strongly agreed or agreed that the SGI component of HOL had helped them 'to think about how to take better care [of themselves]'.

Agreement was similarly strong with the statements 'It gave me a chance to think about my alcohol and drug use' and 'It gave me a chance to make changes to my alcohol and drug use'. Of the 19 students, 18 either strongly agreed or agreed with these two statements.

Table 7: Participants' level of agreement/disagreement with SGI impact-related statements (question 1) (n=19)

Statements	Strongly agree	Agree	Disagree	Strongly disagree
It helped me to think about how to take better care of myself.	2	17	-	-
I'm getting into less trouble.	2	12	5	-
Things have improved for me at school.	6	6	5	2
Things have improved for me at home.	3	8	6	1
It gave me a chance to think about my alcohol and drug use.	7	11	1	-
It gave me a chance to make changes to my alcohol and drug use.	3	15	1	-
I liked the *Smashed 'n Stoned?* books.	8	7	3	1

Source: SGI session participant survey

Table 7 also shows that the statements 'Things have improved for me at home' and 'Things have improved for me at school' generated a relatively strong level of agreement, with over half of the students either strongly agreeing or agreeing with these two statements.

The SGI participants were also asked to rate their level of agreement or disagreement with a second set of statements regarding the perceived value of HOL for them as individuals (Table 8).

Table 8: SGI participants' level of agreement/disagreement with impact-related statements (question 2) (n=19))

Statements	Strongly agree	Agree	Disagree	Strongly disagree	Not answered
It made it easy for me to get help with my alcohol and drug use.	3	12	4	-	-
I learnt more about the impact of alcohol and drugs on my life.	7	11	1	-	-
School felt more supportive.	3	6	8	2	-
I liked the wallet card.	6	4	1	1	7

Source: SGI session participant survey

Seven of the 19 students strongly agreed with the statement 'I learnt more about the impact of alcohol and drugs on my life', while a further 11 agreed with the statement. Only one student disagreed (Table 8).

The 'School felt more supportive' statement produced the strongest level of disagreement, with eight of the participants selecting the 'disagree' option and an additional two circling the 'strongly disagree' option.

Most of the seven students who did not rate 'I liked the wallet card' indicated that they had never seen or could not recall the HOL wallet card. Of the 12 who had seen the card, six strongly agreed that they liked the wallet card while four agreed. Two students appeared not to like the card.

How useful was the SGI experience?

Students were asked to rate their experiences in HOL's SGI sessions. Most indicated having found the HOL group sessions either 'very useful' (seven) or 'useful' (10). Two students did not respond to this question.

Would you recommend it to friends who might need it?

Seventeen of the 19 students indicated they would advise their friends to take part in the HOL SGI sessions.

How could it be improved?

Students were asked how the HOL programme (SGI sessions) could be improved. They suggested the following improvements:

- Show a video or movies about AOD education (three).
- Provide more information about what's in drugs (two).
- Provide some food and drink at the sessions (one).
- Encourage more students to seek help (one).

7. CONCLUSION

The debut of HOL in the Wanganui and Taranaki regions' secondary schools has been impressive. The uptake of the initiative in both regions has been relatively high, with all four urban schools in Wanganui and 11 of the possible 13 schools in Taranaki originally 'signing up' to participate. The majority of the regions' schools appear to have embraced it wholeheartedly, as evidenced by the dramatic decreases in drug-related suspension rates from the time that HOL was first mooted with the schools' principals prior to its official introduction to each of the regions' schools. Within six months of the initiative being introduced to Wanganui schools, drug-related suspensions fell from 2.4 to 0.6 per 1,000 secondary school students. In Taranaki the response was equally striking, with the rate falling from 8.0 to 1.1 per 1,000 students in the space of six months.

7.1 DECREASED SUSPENSION RATES

The decrease in the Taranaki secondary schools' drug-related suspension rate is particularly interesting in that it occurred several months prior to the official launch of the HOL initiative in the Taranaki region's schools. In July 2004 Taranaki secondary school principals were alerted to their schools' relatively high rate of drug-related suspensions compared with the national rate. They were also alerted to the HOL initiative that Wanganui urban schools were currently trialling in response to their similarly high drug-related suspension rate. The subsequent drop in the Taranaki drug-related suspension rate prior to the introduction of HOL coincided with the Taranaki secondary school principals' pre-HOL launch meeting.

All the schools, even the three schools in Taranaki that considered they did not have a drug problem, embraced a less punitive, pastoral approach to dealing with drug-related incidents in their schools. The schools' key HOL contact people and those from the AOD agencies providing the SGI support to schools generally considered it better to keep students at school whenever and wherever possible. Turning students out of school by expelling or excluding them was seen to push them into the very drug culture from which everyone wanted to keep them away. However, in keeping with Ministry of Education guidelines (2000) regarding the management of drug-related incidents, most schools upheld their right to maintain their 'no drugs at school' policies.

7.2 CHANGED DRUG-RELATED MANAGEMENT PROCEDURES

All four Wanganui secondary schools and the majority of the Taranaki schools have built the HOL SGI process into their drug-related management systems and policies. This process now requires students to go through the schedule of on-site SGI sessions as one of the conditions of their returning to school. These conditions usually follow either a stand-down or suspension for a drug-related incident and generally include a drug test that shows the student to be drug free. This approach also fits with Ministry of Education (2000) guidelines that suggest that schools seek to manage students' drug-related misdemeanours in accordance with the 'principles of natural justice' and pastoral care and to do this in such a way as to minimise disruption to the students' education and prevent early school leaving.

There is evidence that both regions' schools have also changed their drug-related disciplinary patterns in other ways. In Wanganui, stand-downs have become the most common form of disciplinary action – from 47 percent of all disciplinary actions pre-HOL to 78 percent post-HOL. Taranaki, in contrast, has

reversed its former pattern, with the proportion of stand-downs dropping from 33 percent pre-HOL to 21 percent post-HOL. In Wanganui, post-HOL suspensions have become the less favoured option whereas in Taranaki suspensions remain the most common course of disciplinary action and these are more than twice as likely to be extended compared with Wanganui (see Table 5 for further information). The proportion of students expelled or excluded from school as a consequence of drug misdemeanours was higher post-HOL in Wanganui but lower in Taranaki.

7.3 SGI PROCESS – HOW EFFECTIVE?

One of the aims of HOL was to raise awareness among students and staff generally that help and support were available for those wanting help with AOD problems. Of the 133 students (64 in Wanganui and 69 in Taranaki) who participated in the SGI sessions, and for whom data were available, most were female (62 percent), were between the ages of 14 and 15 years (70 percent), were Year 10 and 11 students (67 percent) and were Māori (53 percent).

In Wanganui, self-referral was a far more common point of entry to the HOL SGI process than it was in Taranaki. In Taranaki, 'shoulder tapping' and disciplinary action were the more frequent points of entry. The higher proportion of self-referrals in Wanganui suggests a high level of awareness among teachers and students there. In Taranaki, the key HOL contact people generally considered that awareness of HOL at a whole-of-school level was very low, whereas in Wanganui it was perceived to be quite high.

In general, the key HOL contact people in both regions were not able to say whether participation in the SGI process had improved students' learning outcomes or behaviour while in school. However, a few had observed desirable changes among some students who had completed the SGI sessions. The 19 students who filled in evaluation forms following the SGI sessions indicated they had found value from their participation while they had also learned to take better care of themselves. The majority of the 19 students signalled that their participation in the SGI sessions had given them a chance to make changes to their AOD use, while a high proportion indicated that they were getting into trouble less than before and that things had improved for them at home and at school.

The AOD clinicians perceived the quality and level of students' engagement in the SGI process to be largely excellent to very good. However, the quality of a minority of students' participation was considered only fair to poor. The attendance of this latter group also tended to be poor and inconsistent.

7.4 PERCEIVED VALUE OF ON-SITE AOD INTERVENTION SERVICES

The international and New Zealand literature reviewed for this evaluation suggests that schools are appropriate settings for drug education and primary prevention AOD intervention programmes such as HOL (Faggiano et al 2005; Winnard et al 2005; Maes and Lievens 2003; Ministry of Education 2000). As a group, adolescents often face either external (cost and travel) or personal psychological (shyness and indifference) barriers to accessing remedial or treatment services (Gilvarry 1998; Winnard et al 1995).

Most (11) schools saw the on-site AOD service as superior to their referring students with AOD issues to hospital-based, outpatient AOD agencies as they had done pre-HOL. When comparing their pre- and post-HOL experiences, both schools and the AOD clinicians found that having access to an on-site

AOD service had improved students' attendance at this type of service. Schools were largely appreciative of having access to an on-site, cost-free AOD clinical service for students whose AOD use was perceived either by the schools or the students themselves as problematic.

7.5 WHERE TO FROM HERE?

HOL has been clearly effective in lowering drug-related suspension rates in the Wanganui and Taranaki regions' secondary schools. The HOL concept has also been clearly embraced by those schools that have incorporated it into their disciplinary and pastoral support processes. The majority of schools in both regions were very appreciative of having outside agencies provide specialist AOD support on-site, free of charge for their students with AOD issues. However, schools were generally concerned about the capacity of the agencies providing the service to match the demand for the SGI. Four schools experienced difficulties in accessing one or more of the services because of the competing demands for the external agencies' services. Many considered the agencies were currently 'stretched to capacity'; consequently they were concerned that their continued access to the service was potentially vulnerable. There is a need to ensure that services will continue to be provided.

Three Taranaki schools expressed concern about the lack of female AOD clinicians available to work with female students. Two of these schools were girls-only schools. In Wanganui this situation was the reverse. In some boys' schools key HOL contact people saw a need for male clinicians, particularly a Māori male clinician given the higher proportion of Māori students involved in drug-related incidents in Wanganui schools.

Two schools suggested that the sequencing of the five SGI sessions should be more intense or closer together rather than the one-per-week schedule that has largely been followed in both regions. The thought is that there is a need to reach and work with students while they are in the throes of dealing with the immediate consequences of their rule-breaking actions. However, given that the agencies providing the SGI service are already stretched and have other work commitments inside their own agencies, it is difficult to see how the closer timing of the SGI sessions could be accommodated as things currently stand.

Finally there appears to be a need in the Taranaki region to implement the HOL initiative differently. In Wanganui, HOL was from the start largely driven by a consortium of cross-sectoral community agencies, whereas in Taranaki it was steered by a very committed and resourceful Wanganui-based Ministry of Education representative. There appeared to be very little community awareness of the HOL initiative in Taranaki as a consequence, particularly among parents and among school staff and the student populations generally. A community action approach similar to that taken in Wanganui has the potential to raise awareness generally in the Taranaki region. Should this occur there is a greater likelihood of achieving greater regional parity in terms of having students self-refer to the SGI process. Appointing an intersectoral steering group would have the added advantage of providing schools with an opportunity to share ideas, achieve greater school buy-in, identify additional and ongoing training needs and support resources, improve referral and monitoring processes, and generally maintain the momentum achieved so far.

7.6 RECOMMENDATIONS

The HOL evaluation has provided a promising good-practice model for New Zealand schools. The following recommendations are from those schools and their communities that are concerned about the AOD-related harm incurred by their students (including suspension) and that wish to implement the HOL initiative.

- There needs to be buy-in across the sectors. As such, it is important to establish an intersectoral steering group to drive the HOL initiative (or a similar type of whole-of-school approach) that will enhance the schools' and their communities' engagement.
- Principals are important 'change agents', so need to be the first port of call when planning this type of initiative.
- A whole-of-school approach is important. As such, time needs to be invested before the commencement of the project to ensure that there is wide buy-in from school staff, boards of trustees and parents.
- The HOL approach can be promoted to the school and community as an effective model to reduce harm and promote more positive outcomes for young people with issues with AOD.
- A collaborative relationship between the health and education sectors needs to be fostered.
- Schools may also wish to up-skill their in-house guidance counsellors and social workers in evidence-based AOD intervention so that schools are not entirely reliant on external providers – for instance, training in the use of the *Smashed 'n Stoned?* programme.
- Schools and communities need to consider the needs of Māori students and any influences, both societal and within the school, that may be contributing to a higher rate of representation in suspensions.

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APPENDIX A: TABLES

Table 1: Number of total suspensions in secondary school by semester for Wanganui, Taranaki and New Zealand secondary schools, 2000-2005.5

Semester	Wanganui	Taranaki	NZ
2000	37	37	2,388
2000.5	29	28	1,591
2001	54	24	2,154
2001.5	30	27	1,815
2002	21	59	1,967
2002.5	39	45	1,683
2003	27	53	2,119
2003.5	22	39	1,679
2004	37	90	2,092
2004.5	23	27	1,660
2005	21	52	2,298
2005.5	10	38	1,680
TOTAL	**350**	**519**	**23,126**

Source: Ministry of Education, Wanganui office

Table 2: Number of drug-related suspensions in secondary schools by semester for Wanganui, Taranaki and New Zealand, 1999.5-2005.5

Semester	Wanganui	Taranaki	NZ
1999.5	14	5	377
2000	10	19	978
2000.5	6	8	410
2001	20	15	939
2001.5	3	11	406
2002	6	32	771
2002.5	11	11	498
2003	11	36	754
2003.5	5	19	411
2004	14	51	690
2004.5	2	9	380
2005	6	16	791
2005.5	2	19	351
TOTAL	**110**	**251**	**7,756**

Source: Ministry of Education, Wanganui office

Table 3: Suspension rates per 1,000 secondary school students by semester for Wanganui, Taranaki and New Zealand, 1999.5-2005.5

Semester	Wanganui	Taranaki	NZ
1999.5	4.8	0.8	1.6
2000	3.0	3.9	4.2
2000.5	2.6	1.2	1.8
2001	4.9	2.8	4.0
2001.5	3.2	1.5	1.7
2002	2.8	4.3	3.2
2002.5	3.3	2.0	2.0
2003	3.7	5.6	3.0
2003.5	2.2	2.5	1.6
2004	2.4	6.0	2.7
2004.5	0.6	1.1	1.5
2005	1.5	2.0	2.5
2005.5	0.7	2.3	1.5

Source: Ministry of Education, Wanganui office

APPENDIX B: DATA COLLECTION INSTRUMENTS

EVALUATION QUESTIONS FOR SCHOOLS' KEY *HIGH ON LIFE* CONTACT PEOPLE

Name of school …………………………………………………………………………………………..

Interviewee's name and position ……………………………………………………………………….

Date of interview ………………….

1 In what way is the current *High on Life* approach different from what was happening in your school prior to its introduction?

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1a Has your school made any changes to its policy regarding the management of students' drug related misdemeanours since the introduction of *High on Life*?

Yes… ☐ 1

No…. ☐ 2

1b What specific changes were made?

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The *High on Life* initiative has provided a range of training and information support. For instance, training provided for:

- **Health and PE teachers in effective drug education for all students**
- **"Practical People" like Deans, DPs, and guidance counselling staff**
- **Guidance counsellors and alcohol and drug advisors and educators regarding the *Smashed and Stoned?* resource and**
- **All teachers via a presentation at each school's staff meeting.**

2 How satisfied is your school with the information and training that has been provided to support the *High on Life* initiative in schools?

Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied	Not sure
☐ *1*	☐ *2*	☐ *3*	☐ *4*	☐ *5*	☐ *6*

2a Is there anything in particular that you wish to comment on regarding any of these training sessions?

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3 How effective has the *High on Life* approach been generally in raising students' awareness of the help available through the *High on Life* initiative should they want it?

Very effective	Effective	Neutral	Not particularly effective	Not effective at all	Not sure
☐ *1*	☐ *2*	☐ *3*	☐ *4*	☐ *5*	☐ *6*

3a Can you explain why you chose that particular option?

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4 From what you've seen and heard, how effective have the *High on Life* clinical sessions been in helping to improve the learning outcomes of those students who have attended them?

Very effective	Effective	Neutral	Not particularly effective	Not effective at all	Not sure
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

4a Can you explain why you chose that particular option?

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5 From what you've seen and heard, how effective do you feel the *High on Life* clinical sessions have been in helping to improve the overall behaviour of students who have attended them?

Very effective	Effective	Neutral	Not particularly effective	Not effective at all	Not sure
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

5a Can you explain why you chose that particular option?

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6 Has *High on Life* been effective in helping to reduce stand-downs, suspensions and early school departures in your school?

Very effective	Effective	Neutral	Not particularly effective	Not effective at all	Not sure
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6

6a Can you explain why you chose that particular option?

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7 What has the school liked most about the *High on Life* approach?

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8 Is there anything about the *High on Life* approach that the school doesn't like?

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9 Are there any areas where the *High on Life* approach could be improved?

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10 Do you have any additional comments to add about the initiative?

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Thank you for your time and feedback

PROCESS EVALUATION QUESTIONS FOR ALCOHOL AND DRUG SERVICE AND SCHOOL ADVISORS

Name:………………………………………………………………………………

Organisation:……………………………………………………………………

1 What has been your involvement in the *High on Life* programme?

2 Have you found the introductory presentation and information provided about the *High on Life* programme informative?

3 Did you attend the *Smashed 'n Stoned?* training session run by ALAC on 1 March?

4 Was it relevant to the way you plan to or are working with students on the *High on Life* programme?

5 Are you using/will you be using the *Smashed 'n Stoned?* resource in the schools' small group intervention sessions? **Probe – ask for reasons for their decision.**

6 How are you finding the *High on Life* school-based approach as a way of working with students with alcohol and drug problems?

7 How many students are you currently working with on the *High on Life* programme?

8 How engaged are those students who are currently participating in the small group intervention process?

9 Do you think it is/going to be an effective way of working with young people of this age group? If not, how would you prefer to be working with them and why?

10 Do you feel supported by the school staff in your *High on Life* work? If not, what are the issues for you here?

11 What do you particularly like about the *High on Life* programme?

12 What do you like least about the programme?

13 How could the *High on Life* process be improved?

14 Do you have any other comments about the programme?

PROCESS EVALUATION QUESTIONS FOR SCHOOL'S KEY *HIGH ON LIFE* CONTACT PERSON

Name of school ………………………………………………..

Interviewee's name & position ……………………………………………………..

Date of interview ……………..

1 School staff will have first heard about *High on Life* through your principal and a presentation by Ministry of Education staff at a staff meeting. How did you find that introductory presentation and the information provided about *High on Life*?

[a] What was most informative?

[b] What was least informative?

[c] What other information could have been included?

2 To what extent did the initial information elicit the support of the school's staff for the *High on Life* initiative?

3 On the 28th of February this year, a Massey University curriculum education development advisor ran a *High on Life* training day for schools, which covered drug education specifically. Did you or any other staff members attend this training day? If so, has it since been used to assist them to teach drug education?

4 To your knowledge, have the school's health and PE teachers covered drug education in this year's teaching programme?

5 Did you or any other staff member attend the *High on Life Practical People* training day **(in New Plymouth 16 March and South Taranaki 11 April)**? Has what was learnt that day been used to help set up the processes for *High on Life* in your school?

6 ***High on Life* involves both a whole school approach, primarily through the drug education component of the health and physical education curriculum, and an intervention approach for those students with alcohol and drug issues.** How are you finding the *High on Life* approach as a way of working with students generally?

7 Do you think students with alcohol and drug issues will have the confidence to opt into the *High on Life* small group intervention programme?

8 How is the school finding the small group intervention approach as a way of working with students with alcohol and drug issues?

9 What is the process that your school is using to make referrals to the A&D service covering your school?

10 Do you feel supported by other school staff in your *High on Life* work?

11 What are your expectations of the programme?

12 What do you like most about the *High on Life* programme?

13 What do you like least about the *High on Life* programme?

14 Are there any areas where the programme could be improved?

15 Do you have any further comments about the programme?

STUDENT FEEDBACK: *HIGH ON LIFE* ALCOHOL AND DRUG PROGRAMME

What did you think about the *High on Life* programme? What you think is important and will help us to make it even better for future students.

You don't have to fill in the form if you don't want to. Don't put your name or contact details on the questionnaire.

When you have finished filling in the questions please seal the form into the stamped, addressed envelope supplied and hand it back to the person who gave you this form. Thanks ☺

Smashed 'n Stoned?

Q1 Here is a range of statements about the *Smashed 'n Stoned?* part of the *High On Life* programme.
(Please circle the relevant number.)

		Strongly agree	Agree	Disagree	Strongly disagree
A	**It helped me to think about how to take better care of myself.**	1	2	3	4
B	**I'm getting into less trouble.**	1	2	3	4
C	**Things have improved for me at school.**	1	2	3	4
D	**Things have improved for me at home.**	1	2	3	4
E	**It gave me a chance to think about my alcohol and drug use.**	1	2	3	4
F	**It gave me a chance to make changes to my alcohol and drug use.**	1	2	3	4
G	**I liked the *Smashed 'n Stoned?* books.**	1	2	3	4

Anything else? ……………………………………………………………………………………………………

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Q2	**Would you advise your friends to take part in *Smashed 'n Stoned?*** (*Please circle the relevant number.*)	Yes	No
		1	2

Why? ………
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High on Life

Q3. Here is a range of statements about the *High on Life* programme. (*Please circle the relevant number.*)

		Strongly agree	Agree	Disagree	Strongly disagree
A	**It made it easy for me to get help for my alcohol and drug use.**	1	2	3	4
B	**I learnt more about the impact of alcohol and drugs on my life.**	1	2	3	4
C	**School felt more supportive.**	1	2	3	4
D	**I liked the wallet card.**	1	2	3	4

Anything else? ………………………………………………………………………………………………
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Q4	**Rate your experience of *High on Life*.** (*Please circle the relevant number.)*	Very useful	Useful	Not very useful	Useless
		1	2	3	4

Q5 How do you think the *High on Life* programme could be improved?

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Thanks for answering this questionnaire. Don't forget to seal your completed questionnaire and give it to the *High on Life* person who gave you this form, to be posted.

SMALL GROUP INTERVENTION STUDENT REGISTER

Instructions re completion of register form for evaluation purposes

Fieldname	What's required?
High on Life (HOL) school and student ID number	The number assigned to the first student in your school will be 001, the second 002, the third 003 etc.
Student's age and year level	Age and year level at the time when student is first entered on the register
Gender	Tick the appropriate box
Primary ethnicity	Tick one box only
Circumstances leading to referral	Tick one box only. If 'other' ticked give a key word explanation (3 or 4 words only).
Date of student's referral to A&D advisor	Date when the student first referred/started individual/group sessions with school's A&D counsellor.
Primary presenting issues	May need to tick more than one box. If the option 'other' chosen give a keyword explanation (3 or 4 words only).
End date of SGI (incl. follow-up session)	Record date when student completed intervention sessions and the total number of sessions attended overall including the final follow-up session.
Assessment of quality of student's participation in the SGI	Tick the appropriate box indicating how well the student participated in the 'course'. The emphasis here is on the quality of their participation not on the perceived outcome (e.g. changed behaviour re alcohol and drug taking). The latter issue will be pursued in the evaluation's stakeholder interviews.

Please send completed forms to the evaluator to the following address:

Velma McClellan
Research & Evaluation Services Ltd
PO Box 994
New Plymouth

STUDENT SMALL GROUP INTERVENTION EVALUATION REGISTER

Name of school: NP Girls High (Ministry of Education number = no.)

Student ID No.	Student's age and year level when first registered	Gender M or F (tick box)	Primary ethnicity (tick box)	Circumstances leading to referral (tick box)	Date student started sessions with A&D advisor	Primary presenting issues	Total number of SGI sessions attended (incl. follow-up)	Assessment of quality of student's engagement in SGI
001	Year Age	☐M ☐F	☐NZM ☐Eur ☐PI ☐Other (please specify)	☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand-down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other (please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments (please specify)
002	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other (please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments (please specify)

003	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)
004	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)
005	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)

006	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)
	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)
	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)

	Year Age	☐M ☐F		☐ Self referral ☐ Shoulder tapped ☐Discipline incident ☐Post-suspension ☐Post stand down ☐Came with mate ☐Other (please specify)		☐Alcohol ☐Cannabis ☐Solvents ☐Support for mate ☐Family use ☐Other please specify)		☐Excellent ☐Very good ☐Good ☐Fair ☐Poor ☐ Comments please specify)
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