

SWAP : Student Wellbeing Action Partnership

Drug Education

IMPORTANT INFORMATION

This paper was prepared for partial fulfilment of the Postgraduate Diploma in Educational Studies (Student Welfare), Faculty of Education, University of Melbourne, 2006. It has been written in accordance with the ethical standards of confidentiality and anonymity of the persons and organisations involved and has been further modified for online use. The purpose of this paper is to provide educators with general information and examples of issues related to student wellbeing and does not necessarily represent the views of CEOM or the University of Melbourne. CEOM and the University of Melbourne do not accept liability for inaccuracies, misrepresentations, omissions or errors in information referenced in the paper or the citations. CEOM and the University of Melbourne gratefully acknowledges the author for making the action research available for public use.

School Profile

Sector – Catholic

Type – Primary / Co-educational

Setting –Metropolitan

Size – 251-500 students

Abstract

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

The area of drug education was one that we had not fully developed over time at the school. Whilst there were policies, practices and programs that were apparently effective and relevant, a systematic audit and evaluation was required. We wanted our practice to be embedded in the wider context of wellbeing. An awareness of current systemic requirements together with our vision and mission of developing life-long, resilient learners supported the need for action.

With an awareness of the historical changes that place drug education within a wellbeing context a shared understanding of wellbeing in the broader context was developed. This context provided the basis for an investigation that aimed at determining the effectiveness of current practice. Data was gathered to determine the appropriate elements for inclusion in our School Drug Education Plan (SDEP). Staff surveys, student focus groups and senior student surveys were used to obtain information from key stakeholders. The data gathered from these three sources indicated that current practice, protocols and policies were effective. Programs and practices in the areas of resilience, relationships, self-esteem and curriculum were identified as essential foundations in effective drug education. This information was then mapped onto a SDEP which outlined four overarching themes for the twelve principles of effective drug education.

The first action cycle provided positive affirmation of current practice. It also provided a starting point for further cycles to address the areas of concern identified during the process. Further cycles will identify and address 'gaps' in our SDEP and investigate parental involvement.

Introduction

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

Over a number of years School X had developed policies, practices and programs to meet its role and responsibility to provide drug education. Although current practice was viewed as somewhat effective and relevant, a review was timely and needed.

The welfare and wellbeing programs and policies of the school, together with the Life Education program, combined to form a drug education strategy of sorts. However, this approach was not embedded within the broader context of student wellbeing. The school was aware of the need to equip our students to face a future in a community where drugs are present. The National School Drug Education Strategy (NSDES) recognises the need for an effective drug education strategy stating that "it is vital that Australian young people and those who move and interact with them have the information, strategies and skills to prevent or reduce the harm that can arise from their own drug use or the drug use of others" (Department of Education, Training and Youth Affairs, 1999, p. 2). Our work in this area had stagnated. The lack of action was perhaps, in part, due to the many other systemic, mandated changes in areas such as numeracy and literacy. However action in this area could wait no longer. We also knew that it was essential that the strategy be designed to take into account our local needs so that it would be "responsive to the cultural and social needs of the school community" (Cahill, 2006, p. 174).

Context

The school is a parish primary school located on two campuses in the suburbs of Melbourne with Prep-Year 4 (12 classes) located at Campus A and senior grades-Years 5 and 6 (5 classes) two kilometres away at Campus B. Students, in our enrolment of over 400, come from a variety of backgrounds. Over recent years, due to the proximity to the CBD, property values had risen dramatically and this had a profound effect on the socio-economic profile of the area. The number of large migrant families decreased and the number of families eligible for Education Maintenance Allowance (EMA) has decreased from 33% to 25% and this trend seemed likely to continue.

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

Author's Position and Role

I held the positions of Deputy Principal and Student Welfare and Wellbeing Coordinator at the school and was also a member of the Leadership Team. In my position I was responsible for overseeing many of the intervention and prevention policies and programs that support our students. My role initially (8 years ago) had more of a "welfare" focus and was more intervention and post-vention. Research, increasing awareness and understanding and systemic changes had seen my position evolve to include wellbeing and prevention as well as intervention and post-vention. I had been part of many changes in the way we worked with our students and families as we constantly strived to provide them with the skills and abilities to be informed and active members of society. One of the major areas of change in education has been in the area of drug education. In my role I became aware that while meeting basic requirements in the area of drug education, a review of this area was needed. I

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

Goals / Initial Aims

Our school vision and mission statements were based on developing the whole child and encouraging critical, life-long learners who are active in the wider community (School X, 2005). Our initial aim recognised the need to develop our School Drug Education Strategy to meet systemic requirements that “schools prepare children for healthy and fulfilling lives and in contributing to drug prevention efforts across the school years” (Nelson, 2005). Subsequently, the following school goals were set:

Long term goals

- To develop a School Drug Education Plan/Program (SDEP, formerly known as an Individual School Drug Education Strategy) for the school.
- To develop a sequential and comprehensive School Drug Education program that is embedded in a whole-school approach to wellbeing.

Short term goals

- To conduct an audit and evaluation of current programs, policies and practices to determine their appropriateness for inclusion in our SDEP.
- To develop a plan and timeline for implementation of our SDEP.

I planned to achieve the first short-term goal of auditing and evaluation through a collaborative action research process.

Collaborative group

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

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

Reconnaissance

Over the three decades much work has been done in the area of drug education at both federal and state government levels as it has been recognised that drug use affects our students.

Approaches to drug education have changed over time. The focus has shifted from dealing with self-esteem and resistance of peer pressure (without being drug specific) toward prevention and to the current approach of harm minimisation. The National Drug Education Strategy Plan (1993-1997) established three key goals that were to underpin individual state approaches to drug education and highlighted that drugs included the licit and illicit and the effects were both direct and indirect (Department of Education, 1998a, p. 7). Ballard, Gillespie and Irwin (1994) developed the "Principles for Drug Education in Schools" and in doing so provided a framework for drug education nationally. These principles acknowledged that effective drug education must be based on sound research, involve appropriate consultation and be consistent with curriculum theory and practice (Foreword).

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

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

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

(Department of Education, 1998, p. 3)

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

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

In 2005, the Department of Education and Training (DET) announced a review of drug education in order to align it with the new School Accountability and Improvement Frameworks. The process of review and planning of an ISDES was to become part of "whole school planning and improvement". The new national principles together with this realignment would see the ISDES become a School Drug Education Plan (SDEP).

In 2006 the Catholic Education Commission of Victoria (CECV) informed schools of the changes to the ISDES to align it with our School Improvement Frameworks. The previous three-year cycle was to become a four-year cycle

to be known as a School Drug Education Plan (SDEP). The SDEP was now to be included in each school's strategic plan in the area of improving student engagement and wellbeing. The fundamental components of the ISDES remain. Harm minimisation is still the foundation. The SDEP is organised into four key themes:

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

(Cahill & Meyer, 2004, p. 9).

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

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

There are a variety of resources available to support the development of our SDEP. DE&T provides Senior Program Officers to support schools. I made contact with our CEOM representative to provide expertise and guidance. The *Initiatives and Programs* section of the Victorian DET website also provides excellent resources and states that "effective drug education aims to:

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

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

The resources *One and All* (middle primary) and *The Big Move* (senior primary), *Get Real* and *Get Wise* are examples of programs that meet these aims. *The Framework for Student Support Services* (DE&T, 1998b) also provides support in the area of student wellbeing. These programs and resources have at the centre, the resilient student. Resilience as stated by Wolin and Wolin in *One and All* is "the ability to bounce back from adversity..." (Department of Education, Science and Training, 2005, p. 2) to "rebound and spring back after hard times" (Fuller, 2001 in Department of Education, Science and Training, 2005, p. 2). When this concept is married with a message of harm minimisation we are well on our way to equipping our students for the future as "the strengthening of social competencies, emotional intelligence and resilience.... is associated with the prevention of substance abuse" (Department of Education, Science and Training, 2005 p. 2).

Action cycle

Cycle one of the project was to focus on "Auditing and evaluating current practices and programs to determine appropriateness for inclusion in our SDEP".

I was aiming at a process of "self reflective inquiry" (Carr & Kemmis 1986 p. 162; Cohen, Manion & Morrison, 2000, p. 227) using a schoolwide action research approach. This approach was intended to enable the staff to examine, reflect and change what was actually happening and identify an area of concern based on the collection, organisation and interpretation of school data. Data from external sources could be added to inform future directions and actions, forming a cyclic action.

Calhoun (1993, p. 243) identifies three areas of focus in this approach. Firstly the staff of the school work collaboratively to find solutions to areas of concern and, as they do this, their confidence and ability increases. Secondly, the process is inclusive of and equitable for all students. Thirdly, the scope of the inquiry is widened and is therefore more informative and accurate when all stakeholders are involved. In our case this meant that staff, students and parents were all participants. Calhoun (1993) emphasises the importance of a team sharing "the responsibility for keeping the process moving" (p. 243). The Core Team would be responsible for implementing both the short and long-term goals with the Leadership Team as consultants.

Plan

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

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

In early 2006, at a Leadership Planning Day, drug education was placed on the agenda for second term. At the next two Leadership Team meetings I outlined the proposed long and short term goals. A general explanation of the rationale driving the project from both a personal and professional point of view was given. The introduction to the staff was explained and at this point I asked for feedback. All were in agreement with the need to place drug education into a broader context which is supported by Cahill stating that "the evidence suggests drug education programs are best positioned in a broader health and personal development curriculum" (Cahill, in press, p. 6).

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

A Core Team would be established with representation from staff and parents. Involvement of outside agencies and experts in this area from both CEO and DET would be sought. Data would be gathered from the major

stakeholders to form a profile of the school in relation to the effectiveness of current practice. This concept formed part of the original ISDES.

Action

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

The PowerPoint presentation "Student Welfare and Wellbeing" was intended to place drug education within a broader context of wellbeing. Informal discussions with colleagues and knowledge gained from my reading had made me conscious of the fact that we did not have a common and clearly articulated focus on wellbeing as primary prevention. We had some positive and effective programs at the school; however they need to be "drawn together". I presented a brief history of the move from post-vention and dealing with a few "troubled" children, toward a research driven adoption of primary prevention policies and programs involving all leading to a discussion of the importance of a 'whole-school' approach. Six of my colleagues volunteered to work with me in the long-term.

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

During that week, correspondence from the Catholic Education Commission of Victoria (CECV) informed us that the ISDES was now to be renamed a SDEP. My planned PowerPoint presentation on drug education needed to reflect this development. This session was held during our staff meeting and included information from both DET and CECV. It defined harm minimisation and discussion followed about this and concepts of resilience, relationships, connectedness and the links to wellbeing. The discussion was very positive with people drawing connections to theory, research and current practice and I think all felt affirmed in what was actually happening in their classrooms. At this point, I asked the staff to list all the things they could think of that contributed to our drug education strategy in the broader sense. Two of my core team acted as scribes and the final list comprised over 70 items.

The Core Team met again and discussed the possible ways we could evaluate the list and decided on a rating system. I suggested a 0-5; '0' being ineffective and '5' being highly effective. We discussed that some of the items were grade specific and therefore debated their inclusion. We decided that we would include them as they were important components of that grade's program. However, as they may not be familiar to all staff, it was suggested we have an 'N/A' rating rather than have them marked as ineffective due to lack of familiarity. All agreed. We discussed the clarity of each and adjusted them accordingly. This resulted in a final list of 59. Once we were all satisfied that the list was clear, I asked that each member trial the survey on one of their colleagues to ensure it could be understood. Feedback to me was that the survey was easily understood and so it was distributed to other

staff members. The accompanying memo explained that responses would be anonymous as well as the date and point of return. At the conclusion of our meeting, I explained our next step; focus groups.

The survey results were collated and at the same time I conducted the three focus groups. The planned questions were only ideas to highlight areas that I wanted to consider in the group. They were not rigorously followed in each group and discussion took a particular direction based on responses and feelings of the students. I covered the planned areas but in different ways. The ages of the students also impacted on the questioning. As a staff we determined that our program had elements of self-esteem, relationships, belonging, being healthy, keeping safe and resilience. The information gathered from each was later written as reflective notes.

During my research I also found a survey for Upper Primary students that was specifically about drug education. It was part of the DET resource *Guidelines for Reviewing Drug Education in Victorian Schools*. We decided it was appropriate to survey our senior students and so the survey was distributed and completed.

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

In the week prior to the next Core team meeting, I had distributed to each member a copy of the *Evaluation of School Drug Education Program/ Plan – Unpacked*. This was to enable familiarity with the themes of the SDEP. We aimed to categorise our practices into the four themes of:

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

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

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

Observe

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

The first indicator that the project had begun on a positive note and that there was an understanding of wellbeing, was the informal positive feedback from colleagues following the PowerPoint presentation. I heard the terms resilience and wellbeing used in the following days. The comments directly after included "Now I understand why

we need to address these issues". The drug education PowerPoint provoked much discussion. Harm minimisation was explained as the foundation of drug education. Discussions identified that this concept was not new to us. We are already practising harm minimisation in our Sunsmart Policy. This analogy aided understanding. There was also discussion about the core concepts of resilience, relationships, connectedness and the links to wellbeing and effective drug education. There was a realisation that drug education is more than the Life Education van and the health units of work. This was evident when we could list more than 70 practices that contribute to our current program.

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

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

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

Major themes emerged from these discussions. The importance of the relationship between student and teacher was a common thread. The senior students noted that teachers talk informally to them "taking an interest in you" (Appendix 11a), whilst the middle school students saw the relationship as supportive and caring with teachers "wanting the best for you". The junior students noted that "teachers say hello to you".

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

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

Another common theme was that of conflict resolution and strategies that were modelled and taught. The students spoke of teachers giving them ideas and support, of learning actual strategies such as "using a strong voice" and they commented on posters displayed around the school conveying positive social skills and values. Each group

voiced a positive view of programs and policies that help them learn about being safe, happy and healthy, providing a positive indication that current practice was effective. The students also stated that they knew they could approach a teacher at anytime.

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

Students were able to list medical, physical, psychological and social reasons for drug use indicating their awareness. The survey also revealed an understanding by all students as to why people choose not to take drugs with reasons such as harmful physical effects and psycho-social reasons such as "wrecking your life and causing trouble" listed. Students were able to state what they had learnt about drugs with 70% saying they had learnt of the negative effects. 80% of students could list issues that they wanted to know more about which indicated that they were interested in the topic. Responses indicated a wide range of interest areas such as reasons people take drugs and why do people make or sell drugs if they are bad?" These responses provided information that could be used in future planning. Students were also interested in "how to say no" suggesting that we could strengthen our focus on strategies to develop problem solving, decision-making, assertiveness skills.

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

Reflect

"Change is a process, not an event" (Marsh, 2000, p. 390) and this has certainly been the case over the last few months at School X. I believe that understanding this view of change has enabled me to facilitate this process effectively. The process began with the establishment of a common understanding of and need for welfare, well-being and drug education. This was placed in a context to enable the staff to see the 'why' of drug education. The importance of seeing the change as necessary, accepted and understood by all staff is a condition needed for change. (Langdon & Marshall, 1998, p. 215).

In asking for volunteers, I was taking a risk that no one would step forward and that this could undermine the process thus creating a barrier. Our backup plan, of asking each level for representation, was fortunately not needed.

I was aware that I would be seen to be 'the expert' but hoped that the process I would lead, would enable each member to be involved in the planning and implementation of the process. I also encouraged the teachers to see that whilst I had knowledge about the theory, they indeed were the experts in classrooms. This enabled members to feel in control and Langdon and Marshall (1998) see this as an important condition for change to occur. (p. . 215). I also felt that there was "trust in me as a change agent" (Langdon & Marshall p. 216) and despite my knowledge in the area, I felt I conveyed verbally and non-verbally that I did not have all the answers.

The process was organised into steps with each stage clearly defined to members. Our meetings had a clearly stated purpose as either information sharing or problem solving. Information was distributed before meetings to enable preparation and thought. Each member brought a different perspective and this enabled us to be more informed as we placed each of the 59 practices into the SDEP framework. The value of the team approach was obvious in the meetings as we came to a new understanding based on professional dialogue. I was able to appreciate the different opinions and ideas shared, seeing the value diversity offered the process.

The Core Team demonstrated their commitment by their attendance at meetings, completion of tasks on time and by active participation in discussions. They have agreed to continue to work together towards our long-term goal which is a commitment of 6-12 months. This is testament to the relationships that have developed and as Fullan says it is "quality relationships amongst organisational members as they evolve, that makes for long term success."(Fullan,1999, p. 13). As the leader of this group, I had to be mindful of not overloading and pushing the staff at a very busy and pressured time of year, as this could result in creating a barrier to change. It is for this reason that we adjourned the process until the beginning of 2007.

In reflecting on my own role as an agent of change, I used a "Consultation Skills Inventory" to evaluate my performance and surprised myself by being 'ok' in most areas. I realised that I need to be more concise in my responses, improve my open-ended questioning and be more forthright on challenging ineffective solutions. These were areas that I had worked on throughout my studies and in which I had seen some improvement.

Of the many roles a change agent needs to use, I felt that there were three that were particular strengths throughout the process: "relationship expert", "administrator" and "teacher" (cited in 476 858, 2006). My role as "relationship expert" was evident in the relationships I have created in the past and was demonstrated by the willingness of my Core and Consultative Teams to support and participate in this project. I was active throughout the process consciously using the skills of listening, questioning and observation. I liaised with the Core Team formally and informally and facilitated the sharing of information amongst the whole staff with regular updates at our staff meetings.

The role of "administrator" was a strength. I was able to initiate, publicise and implement the audit and evaluation of drug education at School X whilst being inclusive of the whole staff. Through the use of groups such as the Leadership Team and the Core Team, I have developed internal networks as well as external networks to assist us in the process. My studies had enabled me to develop skills of clarifying goals and identifying needs. This is most important in providing a flexible plan for change.

My role as "teacher" was emerging, as I became more conscious of and confident with the process of change itself. In being able to anticipate, expect and understand concepts such as resistance and barriers, I was better prepared to use these as positives and not let them detract from the process. My awareness of the skills of working successfully with groups was increasing with experience. My skills in data collection and interpretation improved and this was evidenced by the "user friendly" nature of the staff survey. I became aware of the valuable insight effective data collection can offer. We were clearly able to see how effective the staff thought each practice was giving us evidence to include each in our SDEP. The focus groups provided an opportunity for me to 'talk' to the students, something we often do not have time to do. By not taking notes, I was actually able to hear and see more enabling a better understanding of their feelings. This was an affirming and positive experience and I came away from each group feeling that the children really were getting the messages we intended. As this was such informative and positive experience, I have asked the students for their permission to feedback the information gained in general terms, to the staff. Each group was happy for this to occur.

I felt pleased with the process and results. The team worked collaboratively and respectfully through a process that we believe was transparent. Each staff member was able to and did contribute as we worked towards developing a SDEP to enhance the wellbeing of our students.

Conclusion

The initial cycle of action has resulted in a clear understanding by staff of the need to include current positive practices into our SDEP.

Our Core Team developed a positive strong relationship, which will enable us to move to another cycle and towards our long-term goal. This particular group of staff has not worked so closely before, so this was a definite achievement. We developed common understandings and shared beliefs.

Throughout the process we became more aware of the need to be flexible and not merely complete this audit cycle and begin developing the SDEP. We came to realise that we must identify any areas of weakness by examining our practice and programs in relation to the four themes, twelve principles of the SDEP. Once identified these 'gaps' would need to be addressed. This might involve professional development, using Senior Program Officers from DET and looking at resources such as *Talking Tactics* and *Get Real*. This process will form the starting point for a second cycle. Only after we have completed this step will we be in a position to develop a timeline and curriculum for our SDEP.

The Core Team believed that it was important for all staff to become familiar with the SDEP and has suggested possible ways in which this could happen. The involvement of parents was identified as a major consideration for our planning as collaborative community partnerships are essential to an effective SDEP. DET acknowledges this point stating that, "parents have a critical role to play in building the resilience of their children and helping them become healthy active members of the community" (Department of Education & Training, 2006 p. 1).

The Core Team plans to reconvene in early February 2007 to begin a second cycle in our process of developing an effective drug education plan for School X. The commitment made by the staff to develop our SDEP recognises that we need to work on many levels, focus on short and long term goals and strategies and to work collaboratively as a school and wider community to effectively address the issue of drug education. (Department of Education & Training, 2003, Foreword).

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