KIT-PLUS
RESEARCH PROJECT
keeping in touch with
young people in schools

Strengthening pastoral care to reduce secondary students' harm from tobacco

File Number: 17415

FINAL REPORT
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Prepared by

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Edith Cowan University

SDERA
SCHOOL DRUG EDUCATION & ROAD AWARE
Helping to keep young people safer

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healthway

Final Report to Healthway

File Number:
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44 Hall, M. KIT-Plus Research Project. Presentation to the Investigator meeting, Perth, WA. 28 August 2009.

45 Bruce, K., & Hall, M. (2009). Factors influencing teachers' implementation of a pastoral care program to reduce students' harm from tobacco. *Australian Health Promotion Association 18th National Conference: Make health promotion a priority: Evidence, advocacy & action*. Perth, WA. 17-20 May 2009. Poster presentation.

46 Coe, C., Bruce, K., & Hall, M. (2009). The KIT-Plus Research Project: Meeting the challenge of school-based activities for drug use prevention and intervention. *Alcohol and Drug Foundation Queensland (ADFQ) 2009 Australian Winter School Conference*. Brisbane, Queensland. 25-27 May 2009. Oral presentation.

47 Hall, M., Coe, C., Paki, D. (2011). What students tell us about 'Keeping in Touch' to reduce smoking, drinking and drug use. *Australian Health Promotion Association, 20th National Conference: Health Promotion and Determinants of Health – Strengthening Action.* Cairns, Queensland 10-13, April 2011. Oral Presentation.

48 Bruce, K. and Hall, M. (2011) Case studies investigating the factors influencing school staff's implementation of an adolescent drug-use prevention program. *Australian Health Promotion Association, 20th National Conference: Health Promotion and Determinants of Health – Strengthening Action.* Cairns, Queensland 10-13 April, 2011. Oral Presentation.

49 Bruce, K. and Hall, M. (2011) The KIT Plus Research Project: Training approachable school staff to respond to students seeking help about drug-related issues. *Australian Drug Foundation 6th International Conference on Drugs and Young People*. Melbourne, Victoria. May, 2011. Oral Presentation.

SUMMARY

The Child Health Promotion Research Centre (CHPRC) in collaboration with School Drug Education and Road Aware (SDERA) received funding from Heathway in 2008 to evaluate the effectiveness the KIT-Plus program: a pastoral care program that aims to reduce high school students' harm from the use of tobacco and other drugs. The program trained high school staff in a range of strategies that focused on intervening early in a student's use of drugs. This three-year (2008-2010) trial of the program was conducted in 21 Western Australian secondary schools (including 9 country schools). Schools were randomly assigned to the intervention condition (n=12) and the comparison condition (n=9).

The KIT-Plus program comprised four key stages:

1. Year 9 students were asked to anonymously identify 'approachable' school staff. Identified staff were invited to a two-day KIT-Plus training session.
2. At the KIT-Plus training session, participants were informed of general drug use issues and how they may impact on young people, trained in communication methods to help students in need of support, introduced to models and frameworks designed to support students through brief interventions, and introduced to a school plan that implements KIT-Plus strategies by individual staff, in school guidelines, and with community partnerships.
3. At one-month and two-months post-training intervals, training attendees were provided with one-on-one coaching sessions to encourage their use of the KIT-Plus strategies. A third coaching session was made available via an online reflection survey.
4. Collegial support among the trained, school-based team was fostered in training and coaching sessions.

In 2008 and 2009, 64 staff from the 12 schools allocated to the intervention condition of KIT-Plus Research Project were involved in the KIT-Plus trainings and coaching sessions. Participating staff included classroom teachers, teacher

assistants, school nurses, school chaplains, school psychologists, student services managers, Aboriginal and Islander Education Officers and Year/House leaders.

Data were collected at baseline and again at two points after the program was implemented from an initial cohort of 637 Year 9 students from the study schools. Surveys and one-on-one interviews were used to explore students': connection to their school, teachers and peers; drug use and perceptions of harm from drug use; and student-staff interactions concerning drug use and other personal issues.

Trained staff were asked to complete pre and post implementation surveys and to maintain a 12 month log of their interactions with students about drug-related issues.

Preliminary findings of the study are as follows:

- After accounting for baseline differences, there appear to be no differences in the number of students who were interviewed reporting they would speak to a staff member if they were thinking about changing their smoking status, between intervention and comparison group schools. When the students were in Year 11, approximately 35% reported they would talk to a school staff member if they were thinking about changing their smoking status.
- At KIT-Plus schools, the proportion of interviewed students nominated school staff for who students who smoke would talk to about reducing smoking, remained stable at 35% of students in 2009 and 2010 (35%) while nominations of school staff decreased from students attending comparison schools from 35% in 2009 to 28% in 2010. This finding is encouraging given more interviewed students in KIT-Plus schools than at any other time point reported they had ever smoked (49%) and /or their friends smoke (74%).
- Nominations by students in KIT-Plus schools for the school nurse as the person they would talk to about smoking rose from 74% in 2008 to 87% in 2010. Comparatively, students attending schools not receiving the

intervention nominated the school nurse as providing smoking-related pastoral care decreased from 91% in 2008 to 85% in 2010.

- More than half of the students interviewed had experience accessing pastoral care services at their school for themselves or a friend. While the total number of interviewed students suggesting improvements in pastoral care services were required at their school was small, more intervention students than comparison students said there was nothing to improve in the pastoral care services at their school.
- Most student suggestions for how to support students to reduce smoking were related to information and advice about smoking (including quitting) and support and encouragement to reduce smoking.
- Almost all students found the pastoral care services they had experienced in their school helpful. However, satisfaction with their discussion with pastoral care staff was lowest for Year 9 students. At post test 2, a greater proportion of students in KIT-Plus schools indicated that they found their discussion with pastoral care staff to be helpful, than students attending comparison schools.
- The 55 staff that completed a follow-up interview and coaching session four weeks after training were satisfied with the KIT-Plus intervention. Most staff reported the strategies were helpful when discussing issues with students (84% of the 45 staff who returned their first log record sheet).
- All 45 staff who returned a log record three months after the training had used at least one of the KIT-Plus strategies in an interaction with a student. Over the duration of the study, these 45 staff provided information in their logs on a total of 324 interactions they had with a student about a drug-related issue. During at least 95% if the interactions staff reported they felt confident and capable to help the student. The KIT-Plus strategies most used by staff in their interactions with students were the LATE model (79% of interactions), motivational interviewing (73%) and the drug triangle (61%).
- Approximately 90% of staff replying to the online survey selected an electronic newsletter as their preferred 'other training need' in addition to the KIT-Plus training, preferring this resource over online training (favoured

by 46%) online discussion forum (14%) networking event (58%), curriculum training (64%), and advanced motivational interviewing course (57%).

- While only 32% of staff who responded to the post test survey reported involvement in whole school actions, 85% reported their school offers support services for students to reduce smoking. The difficulty schools face in providing such services that are helpful for students is demonstrated in only 58% of staff reporting the services provided at the school are helpful.
- Of the 34 staff who returned a post-test survey, 77% reported they were more confident to talk with students about drug-related issues than before the KIT-Plus training and 23% felt about the same confidence as before the training. Additionally, 85% reported they felt more skilled to talk with students after the KIT-Plus training.
- Both CHPRC and SDERA have used the findings of the KIT-Plus research project to strengthen existing programs delivered to schools to promote the health and wellbeing of young people.

Further analyses of data are being undertaken by the researchers to identify successful aspects of the program that can be used in future policy and practice for pastoral care, addressing drug use and promoting the health and wellbeing of young people.

1. INTRODUCTION

In 2006, the Child Health Promotion Research Centre (CHPRC) commenced the formative phase of a five-year Healthway funded project for *Capacity Building in Tobacco Control Research*, entitled "Optimising School Nurse Involvement in Youth Based Tobacco Control Programs". The primary goal of this program was to enhance and extend the investigative and capacity building component of CHPRC's youth-based tobacco control research. The program aimed to examine, prioritise and test promising areas of research and successful interventions in youth tobacco control. The focus of such studies included harm minimisation strategies targeting 11-17 year olds and strategies that encouraged involvement from teachers, parents, health services teams and, in particular, school nurses. The program was designed to build capacity in youth tobacco control at three tiers: firstly, at university based institutions through formal research training by university researchers and students; secondly, at schools through the training of school nurses, school health promotion practitioners, pastoral care staff and teachers; and thirdly, at health and education agencies through the dissemination of the findings to key stakeholders and decision makers in school health promotion and smoking cessation lobbies.

The formative phase required a review of international, national, and more specifically regional evidence of successful youth tobacco control programs. From this review a model was developed to strengthen the capacity of school nurses, health service teams, and teachers in tobacco control and harm minimisation strategies. The review provided the model with grounding in theory and practice, and relevance within the context of Western Australia. During this phase, four key activities were carried out:

- A systematic literature review was conducted assessing the role of school nurses and health service teams in tobacco control programs to collect evidence on effective educational strategies to support their work, and to

determine potential barriers to their involvement in drug control and harm minimisation programs.

- An advisory committee of key stakeholders in tobacco control, school based health promotion, youth support/education, and nursing were invited to form a Delphi panel to review and refine the school-based nursing strategies for tobacco control/cessation, taking into account their relevance to Western Australia.
- Interviews were conducted with school nurses, principals, deputy principals, health education teachers and other selected staff (n=50) to identify their attitudes regarding the effectiveness of current and proposed school policies and procedures regarding tobacco control and harm minimisation.
- A survey of 229 students (Year 8, 9, 10) from 10 secondary schools was conducted to identify their preferred tobacco control strategies, and to assess their attitudes and reservations about talking to school nurses and other health service professionals on issues of tobacco control and harm minimisation.

Findings of the Formative Phase

A lack of evidence to validate a tobacco control intervention focused solely on school nurses:

Despite increasing calls for more school nurse involvement in youth tobacco and other drug control programs (Fritz, Wider, Hardin, & Horrocks, 2008; Houghton, 2003; Humphries, 2002; LaSala & Todd, 2002; Sarna & Bialous, 2005; State Government of Victoria, 2004), our literature review revealed little empirical evidence (D. Fritz et al., 2008; Pbert et al., 2006; Tingen et al., 2006) to support this argument. There was also a lack of consensus on the most appropriate strategy to enhance their role and ensure a sustained impact on smoking cessation among young people (Fergus, Rowe, & McAllister, 2002; Gervais, O'Loughlin, Dugas, & Eisenberg, 2007; Williams, McDermitt, Bertrand, &. Davis, 2003). Although a meta-analysis has indicated that nursing interventions can be effective (Rice & Stead, 2004), and numerous studies have pointed to the proactive role that nurses could

potentially play in tobacco related interventions for young people (Barnes, Courtney, Pratt, & Walsh, 2004; Cameron et al., 1999; DeBell & Everett, 1998; Fergus et al., 2002; Hamilton, O'Connell, & Cross, 2004; Jairath, Mitchell, & Filleon, 2003; Ross, 1999; Williams, McDermitt, Bertrand, & Davis, 2003), overall there have been few studies evaluating the impact of school nurse initiatives on tobacco cessation (Buckley & White, 2007; Hamilton, O'Connell, & Cross, 2004; Sarna & Lillington, 2002). The majority of studies instead report on their impact in terms of increased skill and self-perceived competency among school health professionals (Buckley & White, 2007; Sanci et al., 2002) and increased student academic outcomes (Bonaiuto, 2007; Caldart-Olson, 2007; Wicklander, 2005). Moreover, while a recent review of the role of nurses provides some evidence that smoking prevention strategies employed by school nurses can improve social support and self efficacy to reinforce non-smoking or quitting among children (Jairath et al., 2003) and that institutional settings such as schools can be important entry routes for intervention (Gervais et al., 2007), further studies demonstrate that the success of this approach will require a significant change in the current role of school nurses to allow them to play a more pro-active role in health promotion. Such a process would have to be supported by major middle and upstream changes in policy (Fritz, 2000; Hamilton, O'Connell, & Cross, 2004; Houghton, 2003; Humphries, 2002; Sarna & Bialous, 2005).

The role of the school nurse already includes caring, correcting, educating and preventative roles, and it continues to evolve (Allensworth & Bradley, 1996). While both the Australian Departments of Health (Eureka Strategic Research, 2005) and Education (Department of Education Science and Training, 2004) are keen to change the role of school nurses from a clinical model to a preventative health promotion model, and a number of state health departments have taken a lead in this field (Barnes et al., 2004; State Government of Victoria, 2004), there has still been no clear definition or delineation of the school nurse’s role and responsibilities. This results in a number of key operational, attitudinal, knowledge based, skill based and training based barriers that continue to thwart the effective integration of school nurses into school drug education policies and practices (Downie, Chapman, Orb, & Juliff, 2002; Simmons, 2002).

The existence of major barriers to school nurse involvement in tobacco and other drug prevention and harm minimisation programs:

The literature review indicated that while secondary school nurses in Australia emphatically believed their primary role is in health promotion and education (Downie et al., 2002; Guzys & Kendall, 2006), treatment of emergency cases, referrals and first aid continues to account for the majority of their work (Sarna, Wewers, Brown, Lillington, & Brecht, 2001; Wewers, Kidd, Armbruster, & Sarna, 2004). Key perceived issues with them adopting a more proactive role were lack of time (Klein, Portilla, Goldstein, & Leininger, 1995), resources (Houghton, 2003), and training (Fagan, 1995; Hope & Hart, 1995; Jairath et al., 2003; Sarna & Bialous, 2005; Wewers et al., 2004; Whitmarsh, 1997) – views also reported by nurses in the UK (Wicklander, 2005).

Other studies noted isolation from colleagues due to the ongoing need for school nurses to attend multiple schools (Oberklaid, 1990; Periard, Knecht, & Birchmeier, 1999), lack of support from school administrators (Humphries, 2002), role ambiguity and role strain due to conflicts between work expectations and professional practice (Smith & Firmin, 2009), as well as continued smoking among school nurses (Sarna et al., 2001), as factors affecting the success of school nurse involvement in health promotion interventions. Interviews with school nurses from 19 metropolitan and rural schools supported these findings, within WA. Lack of time, financial and material resources and interest from school principals and deputy principals in tobacco cessation programs, respectively, were reported as the key barriers (Child Health Promotion Research Centre, 2007). However school nurses are eminently placed to act as a bridge between health and education (Wicklander, 2005). While 15 out of the 19 school nurses had received training to support the delivery of smoking cessation strategies, with the majority participating in either the Keep Left or Smarter than Smoking Programs, and nine having received training in counselling and/or motivational interviewing, over half the school nurses reported an absence of whole-school involvement, lack of interest by the school in tobacco cessation programs, minimal communication/collaboration between teachers and school

nurses on tobacco related curriculum and a limited involvement in the development of school health promotion policy (CHPRC, 2007).

Interestingly, when the 17 administrative staff (principals and deputy principals) were asked about the types of tobacco control strategies the school delivered the majority referred to health education programs (n=13) and school policy (n=5), while only two reported school nurse involvement. In the majority of cases, school administrators saw smoking as a punitive issue rather than a health promotion issue, with the level of punishment increasing with the number of times the student was caught smoking (CHPRC, 2007). Only 25% of administrative staff reported that students caught smoking the first time were offered counselling by the school nurse, while for subsequent offences less than 10% of students were offered counselling, with parent notification and/or suspension being the preferred options (CHPRC, 2007). Evidence shows that cessation programs offered in lieu of punishment when caught smoking can detract from program success as the student often doesn't want to be involved and may not be motivated to quit (Logan & Carlini-Marlatt, n.d.). Students may also see smoking as resistance to authority and devise ploys to avoid being caught (Fergus et al., 2002). Thus the existing barriers between school nurses and health promotion interventions has led the research team to re-assess the value of focusing the proposed intervention solely on school nurses, suggesting instead the need to focus the intervention on a broader school pastoral care team, in line with current Government policy (DEST, 2004, 2007).

The value of pastoral care and the building of resiliency in youth based tobacco and other drug cessation and harm minimisation programs:

Past research has consistently shown that having friends who smoke is one of the strongest risk factors affecting smoking among secondary school students (Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004; Chassin, Presson, Sherman, & Edwards, 1990; Fergus et al., 2002; Leatherdale, Cameron, Brown, & McDonald, 2005; Poland et al., 2006; Zhu, Liu, Shelton, Liu, & Giovino, 1996). Individual factors, such as low self esteem and having parents or older siblings who smoke, undoubtedly have a major impact on adolescents' uptake of smoking (Fergus et al.,

2002; Fritz, 2000; Kansanterveyslaitos (KTL) National Public Health Institute, 2004; McDermott et al., 1992). However, it has been increasingly argued that the 'social context' is a key factor in adolescent experimentation or risk behaviour, and smoking should be viewed as a practice that is linked to where, when and with whom adolescents smoke (Aloise-Young, Hennigan, & Graham, 1996; Fergus et al., 2002; MacDonald, 2004; Poland et al., 2006; Semer et al., 2005). From this perspective, the more normative and acceptable smoking is in a school/community, the more positive the adolescent's social image of smoking is likely to be and hence the more prone they are to smoke (Cleveland & Wiebe, 2003; Evans, Powers, Hersey, & Renaud, 2006; Sanchez del Mazo, 2005; Unger & Rohrbach, 2002). Thus, whole school approaches to pastoral care that build resiliency in youth, aimed at enhancing concepts of self-knowledge through group discussion, healthy risk taking, and empowerment, are more likely to help adolescents become confident individuals with the personal strengths to cope with and/or overcome risks and to take an active stance towards an obstacle or difficulty (Brendtro & Larson, 2004; Doll & Lyon, 1998; Horn, Dino, Kalsekar, & Mody, 2005; Kitano & Lewis, 2005; Nadge, 2005).

Evidence indicates that a substantial number of adolescents undertake risky health behaviours (Shanklin et al., 2007). Rather than merely informing youth of the risks associated with smoking and other drug use, interventions should focus on harm minimisation (Hamilton, Cross, Resnicow, & Hall, 2005) by strengthening the social competence and problem solving abilities of youth, and building a sense of connection to school (Hearn, Campbell-Pope, House, & Cross, 2006; Oredein, Foulds, Edwards, & Dasika, 2008). The school setting is important as a protective factor against drug use and is important for the delivery of interventions relating to drug use and for reducing vulnerability to drug use (Edmonds, Sumnall, McVeigh, & Bellis, 2005). Two large scale longitudinal studies on youth resiliency have been fundamental in the identification of internal and external protective factors, and more specifically in the role which schools can play in enhancing the protective nature of learning environments (Doll & Lyon, 1998; Resnick et al., 1997).

In addition to the importance of individual factors and social relationships with peers (Beyers et al., 2004; Giarelli, 1999; Mason & Windle, 2001; McDermott et al., 1992; Oredein et al., 2008; Zhu et al., 1996), numerous studies have examined the relationship that a student's connection to their school and its staff can have on reducing drug use among students and other problem behaviours (Begg, 1999; Buckley & White, 2007; Cahill, Wyn, & Shaw, 2004; Doll & Lyon, 1998; Farrington & Welsh, 2003; Flay, 2000; Henderson & Milstein, 2003; McNeely, Nonnemaker, & Blum, 2002; Nadge, 2005; Smith, Gaffney, & Nairn, 2004). Our survey with students similarly highlighted the importance of student-staff relations (CHPRC, 2007). While the majority (86%) of students surveyed felt school-based support for smoking cessation was important, just over half (58%) thought other students who smoked would talk to the school nurse about their smoking (CHPRC, 2007). On the contrary, when asked who would they go to for advice, the survey indicated student preferences varied across schools (and included favoured teachers, school counsellors, chaplains, school nurses, and peer leaders), and their choice was closely related to their level of trust and connectedness with the staff member (CHPRC, 2007) - a finding supported by exploratory research by the WA Department of Education (Department of Education and Training, 2005).

Research is indicating the importance of key learning experiences on students' wellbeing and resilience. Particular importance was attributed to the personal qualities that make certain teachers and pastoral care staff more successful in providing these key learning experiences (Ayres, Dinham, & Sawyer, 2000; Fuller, 1998; Nadge, 2005; Rowe & Rowe, 2002). However, there remains an absence of specific resiliency fostering teaching strategies in schools (Guzys & Kendall, 2006; Henderson & Milstein, 2003). Given the importance of student-staff relations in fostering positive behaviour in students, perhaps a more effective strategy for capacity building in tobacco and other drug control would be to involve the 'locally-coordinated' selection of a pastoral care team from each school. This team could include preferred teachers, pastoral care workers, school nurses and/or other health service team members, identified by the students as being more approachable or with whom they have a stronger connection.

The current attitudes of school principals and key stakeholders towards tobacco and other drug prevention and harm minimisation programs:

While 16 of the 19 schools in the CHPRC formative study described themselves as health promoting schools, only four of the schools reported addressing smoking as a specific component of their health promoting policy (CHPRC, 2007). The research team's interviews with school administrators (n=17) and other health education teachers (n=14) found that tobacco was not considered a major issue compared with other illicit drugs and alcohol, or problems such as sexual health, nutrition and physical activity. School administrators showed limited interest in a health promotion intervention aimed solely at tobacco control (CHPRC, 2007). This general attitude, which has also been found in a UK review of pastoral care (Best 2002), was confirmed in the findings of the Delphi Study conducted in the formative phase, in which key stakeholders ranked harm minimisation strategies using motivational interviewing and individual/group counselling, as opposed to simply anti-smoking messages and punitive strategies, as important in cessation interventions. Nevertheless, they felt collaboration with other school 'leaders' or 'champions' on broader drug use and health promotion issues was also a useful strategy (CHPRC, 2007). A pastoral care position, guidelines, process for evaluation and measures for effectiveness would also assist in defining school responsibilities (Department of Education and Training, 2005).

Implications of the formative study findings for the development of a tobacco and other drug control intervention

While the concept of adolescent smoking cessation interventions, and particularly harm minimisation (HM) has gained increasing support in health promotion (Balch, 1998; Engels, Knibbe, de Vries, & Drop, 1998; Gillespie, Stanton, Lowe, & Hunter, 1995; Gillespie, Fisher, Stanton, & Lowe, 1998; Houston, Kolbe, & Eriksen, 1998; Lamkin, Davis, & Kamen, 1998; Stanton & Smith, 2002; Sussman, 2001; Sussman, Dent, Severson, Burton, & Flay, 1998), because natural cessation among adolescents is a relatively rare occurrence (Fergusson & Horwood, 1995; Sussman, 2001; Sussman et al., 1998) even though many adolescents would like to quit (MacDonald,

2004; Shanklin et al., 2007; Sussman et al., 2004), and the development of adolescent cessation programs has been established as appropriate and acceptable to teenagers (Gillespie et al., 1995; Gillespie et al., 1998), research supporting adolescent cessation programs remains sparse, and few studies have used experimental designs (Gervais et al., 2007; Sanchez del Mazo, 2005; Sussman, 2001). As most HM programs have targeted adults or current users, little is known about the application of HM principles to programs dedicated to primary and secondary prevention of tobacco use among adolescents, most of whom have not initiated use or are in the early stages of habit formation (Logan & Carlini-Marlatt, n.d.; Sussman et al., 2004). For adolescents, potential HM strategies include reducing recruitment and delaying initiation, increasing cessation, decreasing the risks of active smoking by reducing the number of cigarettes smoked, and preventing progression through social contact (not necessarily through use of the drug) into use of other drugs, and reducing exposure to environmental tobacco smoke (Russell, 1993).

The Smoking Cessation for Youth (SCYP) trial conducted by the Child Health Promotion Research Centre was one of the first studies conducted that successfully tested smoking HM strategies with students 14-17 years (Hamilton et al., 2005). Yet as the findings from our formative study indicate, for HM programs to be successful there is the need to develop and trial a more 'flexible model' aimed at strengthening the capacity of school pastoral care teams (including, teachers, school nurses, health service teams and pastoral care workers), that are interactive in their delivery method (Tobler, Lessard, Marshall, Ochshorn, & Roona, 1999), encouraging the development of supportive and protective school communities through the facilitation of caring relationships, high expectation messages, and meaningful participation and contribution (Benard, 1996; Nadge, 2005) echoed in UK review of research (Best 2002).

The key focus for the KIT-Plus study was to investigate interventions that address adolescent smoking, with particular emphasis on the involvement of pastoral care staff. Pastoral Care staff are a resource available in Western Australian schools devoted to the health and welfare of students, and the use of these staff provides a

sustainable structural intervention to meet the needs of students who already smoke (Lamkin et al., 1998). Their involvement would provide a movement away from reliance on curriculum prevention-only approaches, towards a more comprehensive combination of prevention and cessation (Sussman, 2001; Sussman et al., 2004). Recent research suggests schools that provide counselling and education for students caught smoking, rather than discipline-only approaches, may have lower smoking rates (Hamilton, Cross, Lower, Resnicow, & Williams, 2003). Pastoral care staff, including school nurses, are ideally situated to contribute to counselling/education practices (Fritz et al., 2008; MacDonald, 2004) and opportunities are available for such staff to address students' lack of health knowledge or skills and provide individualised and tailored attention, including brief smoking cessation counselling (Bradley, 1997). However, lack of knowledge and counselling skills have previously been cited as barriers to school staff involvement in smoking and other drug cessation and HM programs (Abba, 2001; Best 2002; Department of Education and Training, 2005; Fritz et al., 2008; Giarelli, 1999; Lawendowski, 1998; Schubiner, Herrold, & Hurt, 1998).

By focussing the proposed intervention on strengthening the capacity of a team of pastoral care leaders to assist adolescents to examine their health-compromising behaviours in a non-judgemental manner (Levy, Vaughan, & Knight, 2002; Resnicow et al., 2002), this study aimed not only to increase the impact and reach of the intervention, but also the sustainability of the effect (Hawe, Noort, King, & Jordens, 1997). Brief interventions based on motivational interviewing (Miller & Rollnick, 1991) and group discussions can be useful for adolescents because they are brief, non-confrontational and respectful of adolescents' decision-making abilities (Lawendowski, 1998). These techniques were tested with school nurses as part of the SCYP Project to help students consider the benefits of and barriers to quitting, and provide resources and support to prepare students for quit attempts (Hamilton, O'Connell, & Cross, 2004).

The Keeping in Touch (KIT) Plus Research Project has been a partnership between Edith Cowan University's CHPRC and the School Drug Education and Road Aware

(SDERA) Project, located within the WA Department of Education. The *Keeping in Touch* resource was initially developed by SDERA and is now distributed nationally by the Australian Government Department of Education, Employment and Workplace Relations and aims to assist school staff to manage and respond to drug use issues in their school. The *KIT-Plus* Research Project has built on this existing resource by providing additional support to assist schools to build positive connections between students and staff and to help staff prevent and respond to drug issues at school. Our intervention was underpinned by research showing that, in addition to parental figures, significant adults such as teachers and pastoral care staff can play an important role in reducing and preventing students' drug use. This project aimed to enhance the skills of school staff, increase students' connectedness to school staff and school and ultimately to decrease students' harm from smoking and other drug use.

2. OBJECTIVES

The aim of the KIT-Plus Research Project was to implement and evaluate the effectiveness of a systematic pastoral care intervention designed to encourage and facilitate positive behaviour in students, particularly the reduction of smoking and other drug use. The intervention was delivered by trained secondary school staff identified by students as approachable. This intervention was compared to practices currently used to address student behavioural needs in Western Australian schools. The intervention was school needs-based and attempted to build, via training and coaching, the capacity of these identified staff to respond effectively to student needs.

The outcome objectives of the project listed below were modified from those listed in the original proposal. Difficulties encountered while recruiting schools and students led to application to (Appendix 1) and subsequent approval (Appendix 2) by Healthway to change the objectives of the research.

The final objectives of the project were:

1. To determine if intervention students would be more likely to speak to a staff member at their school if they were thinking about changing their smoking status than comparison group students. (Student interviews)
2. To determine if intervention students perceive that vulnerable students in their school would speak to staff members at school if they were thinking of changing their smoking status more frequently than would comparison students who were also considered vulnerable to smoking. (Student interviews)
3. To determine if intervention students were more aware of the availability and nature of services provided by the pastoral care team than comparison students. (Student interviews)
4. To explore student perceptions of the types of pastoral care services available, to what extent such services were available, to what extent the

services helped them or others and what other services did they and other students need. (Student interviews)

5. To explore student perceptions of the types of pastoral care services available, to what extent the services helped them or others and what other services they and other students needed to help them to reduce their **harm from tobacco use**. (Student interviews)
6. To explore intervention group staff perceptions of their satisfaction with and use of the intervention, and what else they perceived they needed in a pastoral care program to reduce secondary students' harm from tobacco. (Pastoral Care Team staff survey and staff interviews)
7. To determine if intervention schools had developed and implemented a plan for the delivery of pastoral care services that offered support for students to quit, reduce or not start smoking.
8. To determine if intervention group pastoral care staff believed the capacity building intervention helped them to engage with greater numbers of vulnerable students and more often, and that during these sessions they felt more confident and capable to deal with/prevent student problems than did comparison pastoral care staff. (Pastoral Care Team staff survey and staff interviews)
9. To determine if intervention group pastoral care staff, principals, and education policy makers perceived the intervention to be an effective means of both strengthening the skills and capacity of pastoral care staff and providing them with improved support resources, to enable them to play a more active role in behaviour management, particularly tobacco use cessation. (PCT staff survey / interview, School principal interview, stakeholder interview)
10. To determine if the pastoral care intervention was sustainable. (SDERA uptake)
11. To determine if the intervention satisfied students who have given consent to be interviewed. (Student interviews)

3. PROGRESS

3.1 Project Management

A multi-disciplinary team has been responsible for overseeing this project, supported by an advisory committee (established as part of the Tobacco Control Research Development Grant conducted by the CHPRC) comprising experts in the fields of primary and secondary education, mental health, drug education and child health research. Team members included:

Assoc Prof Margaret Hall	Child Health Promotion Research Centre, ECU
Mr Bruno Faletti	School Drug Education and Road Aware
Dr Robyn Johnston	Child Health Promotion Research Centre, ECU
Ms Felicity Stephens	Child Health Promotion Research Centre, ECU
Prof Donna Cross	Child Health Promotion Research Centre, ECU
Dr Greg Hamilton	Canterbury District Health Board, NZ
Ms Therese Shaw	Child Health Promotion Research Centre, ECU
Dr Sharyn Burns	Child Health Promotion Research Centre, ECU
Ms Laura Bond	Telethon Institute for Child Health Research
Ms Jeanette Hasleby	Department of Education, WA
Mr Grant Akesson	Drug and Alcohol Office, Dept of Health
Ms Sharon McBride	Office of Child and Adolescent Health, Dept of Health
Ms Tommy Cordin	Child Health Promotion Research Centre, ECU
Ms Kaashifah Bruce	Child Health Promotion Research Centre, ECU
Ms Patricia Cardoso	Child Health Promotion Research Centre, ECU
Ms Laura Thomas	Child Health Promotion Research Centre, ECU
Ms Dionne Paki	Child Health Promotion Research Centre, ECU
Ms Catriona Coe	School Drug Education and Road Aware

3.2 Study Design

Kit-Plus was a three-year, group-randomised, intervention trial (2008-2010) conducted with 21 government secondary schools in country and metropolitan areas in WA. Data were collected from a cohort of Year 9 students tracked through to Year 11, their teachers in each year, and other pastoral care staff. Due to the logistics of conducting the trial in regional schools, the intervention was delivered in five phases. An intervention phase commenced for students when teachers from their school attended the KIT-Plus training. The study design for this research is presented in Table 1 (student study design) and Table 2 (staff study design).

Table 1 Study design - students

Condition	Baseline Year 9 (Term 3 2008)	Intervention Phase 1 2008	Intervention Phase 2&3 2009	Intervention Phase 4&5 2009-10	Post test 1 Year 10 (Term 3 2009)	Post test 2 Year 11 (Term 2&3 2010)
Intervention n=12 schools	O_1	X_1	X_1	X_1	O_2	O_3
Comparison n=9 schools	O_1	X_2			O_2	O_3

O=Observation, X_1 = KIT-Plus materials and training; X_2 = SDERA *Keeping in Touch* resource only (available to all schools since 2006).

Table 2 Study design – staff (intervention only)

2008 - 2010										
Survey Base-line	KIT-Plus Training	Colleg-ial Support	Phone Inter-view 1	Log 1	Phone Inter-view 2	Log 2	Online Survey	Log 3	Survey Post-Test	Log 4
Wk 0	Wk 0	On-going	Wk 4	Wk 4	Wk 9	Wk 14	Wk 18	Wk 24	Wk 29	Wk 34
O_1	X_1	X_2	X_3 & O_2	O_3	X_4 & O_4	O_5	X_5 & O_6	O_7	O_8	O_9

O= Observation (Data Collection Instruments)
X=Intervention
Note: Phone interviews and online survey fulfil a data collection and coaching component.

3.3 Sample and Recruitment

Recruitment of schools was conducted from March to August 2008. The selection criteria for schools to participate in this project were:

- an enrolment of 100 or more students in Year 8 in 2007; and
- be a Department of Education, WA school.

A total of 13 metropolitan schools and eight regional schools were recruited to the study.

Metropolitan sample

Recruitment of the metropolitan sample required schools to be located in the Perth metropolitan area and not serviced by a School Drug Education and Road Aware (SDERA) Regional Consultant. This excluded schools in the Peel region of the Fremantle-Peel education district that were serviced by a Regional Consultant. A database of Western Australian schools was obtained from the Department of Education (DoE). The DoE derived socio-economic index (SEI) score was used as a measure of socio-economic status. This score is determined from census data provided by parents of students attending each school. Prior to random selection, Perth metropolitan schools that met the selection criteria (51 schools) were stratified by school population size and socioeconomic status. Schools were randomly selected from within eight strata identified in Table 3 to recruit a sample of 16 metropolitan schools.

Table 3 Stratified random sampling frame for metropolitan schools target

	School size	**Intervention schools**	**Comparison schools**
Low DoE Socioeconomic Index	Small	3	2
	Large	2	1
High DoE Socioeconomic Index	Small	2	1
	Large	3	2

The principal of each school was sent a letter (Appendix 3) followed by a telephone call inviting their school to take part in the study. If schools declined, they were replaced by another school within the same stratum. This process was followed until the list of 51 available schools was exhausted. At this time, 13 schools had agreed to participate (25.5%), 23 had declined (45.1%) and 15 were yet to provide a response (29.4%) after multiple follow-up attempts.

Most schools that declined to participate cited "the current climate in schools at present" as the reason for non-participation. Western Australian government schools teachers were engaged in industrial negotiations about education standards, pay and conditions in schools for most of 2008. The Teachers Union had imposed restrictions on teachers participating in activities outside normal duties. More specifically, schools were reluctant to ask staff to take on additional workloads and were unable to find relief teachers to cover staff attendance at training sessions. Further, involvement in other programs was a barrier to what they otherwise saw as an important and timely project (Table 4).

Table 4 Reasons for school refusal to participate in this study

	Metropolitan schools	**Country schools**	**Total**
No reason provided	9	5	14
Too much going on / involved in too many projects	9	-	9
Industrial action	4	-	4
Staffing issues	2	-	2
Too many research requests	1	-	1
More involvement than they could take onboard	-	2	2

*NB: some schools provided more than one reason for declining participation

After a principal indicated interest in participating in the project, the name of a staff member to coordinate the project within the school was requested. A letter of agreement was sent to the principal confirming participation and outlining the commitment of both the school and the Child Health Promotion Research Centre in the project activities (Appendix 4).

Country sample

Due to the small number of schools with 100 or more students enrolled in Year 8 in 2007 in the regional sample (n=17) and differences between geographical regions, the sampling method differed for country schools. DoE school regions were paired based on geographic location and urbanicity and each region pair was randomly assigned to the intervention and comparison conditions (Table 5).

Table 5 Allocation of regional schools to intervention conditions

Intervention	Pilbara	Bunbury	Narrogin	Esperance	Geraldton
Comparison	Kimberley	Warren-Blackwood	Northam	Albany	Kalgoorlie

Schools with 100 or more students enrolled in Year 8 in 2007 were added to the sample pool (n=17) and stratified by DoE region. Schools were randomly listed within regions to provide the order in which schools were approached to participate in the project. Schools were invited to participate using the method described above for metropolitan schools: invitation letter followed by telephone recruitment. In the country sample, six schools declined to participate (35%) leading the investigators to revise the inclusion criteria to schools with greater than 50 students enrolled in Year 8 in 2007 and to include the Peel education region in the country sample pool. Country schools cited similar reasons to metropolitan schools for declining to participate. A further 15 schools were thus added to the sample pool. In total, eight country schools agreed to participate (25%), seven (21.9%) declined to participate, four (12.5%) were undecided and a further 13 (40.1%) were yet to be contacted at the time of recruitment closing.

Limitation – Challenges in recruiting schools

The power calculations for this study determined 30 schools were required to measure the project effects. After five months of school recruitment and a higher than expected "no response" from parents for active consent for students to participate, the Investigators agreed this target of 30 schools and 100 students per school would be unlikely given the large effort expended to recruit the 21 schools that had agreed to participate at this time. It was decided the best way to progress

was to request approval from Healthway to change the study methodology to focus more on staff and student qualitative outcomes than quantitative measures (Appendix 1).

In August 2008, Healthway provided approval for the Child Health Promotion Research Centre to progress with this project involving 21 schools and with the alternate research objectives presented in Section 2 of this report (Appendix 2).

With the recruitment of Geraldton Senior High School into the study in 2009, the number of participating schools was increased to 22 (13 intervention and 9 comparison schools). The recruitment of this additional school allowed follow-up of the 2008 Year 9 cohort of students from John Willcock College, where the student enrolment ceases at Year 9 and most of the students move into Year 10 at Geraldton Senior High School.

Table 6 lists the study schools by intervention condition and metro/regional classification.

Table 6 Participating study schools

	Intervention	**Comparison**
Metro	Coodanup CC (and Mandurah SC in 2010)	Mirrabooka SHS
	Warwick SHS	South Fremantle SHS
	Governor Stirling SHS	Darling Range Sports College
	Ellenbrook SC	Melville SHS
	Ballajura CC	Rossmoyne SHS
	Lynwood SHS	Thornlie SHS
	Leeming SHS	
Regional	Karratha SHS	Broome SHS
	Tom Price SHS	Northam SHS
	Australind SHS	Kalgoorlie-Boulder SHS (replaced by Eastern Goldfields College in 2010)
	John Willcock College (and Geraldton SHS)	
	Collie SHS	

In order to maximize participation rates for the final student data collection in 2010, principals at a further two schools were approached to allow follow-up of

participating students who had moved to their school from a study school. The recruitment of Eastern Goldfields College allowed follow-up of 22 of the Year 9 cohort of students from Kalgoorlie-Boulder Community College where the student enrolment ceases at Year 10. Mandurah Senior College also agreed to the follow-up of nine participating students who had moved to this school from Coodanup Community College at the start of 2010.

3.4 Consent

In 2008, all Year 9 students at participating schools were invited to participate in the study. Active parental consent was required by the DoE's Research and Policy Unit. A letter outlining the project with individual parent and student consent forms attached was mailed to parents of all Year 9 students at their home address (Appendix 5). Almost 4000 consent letters were mailed to parents of Year 9 students in 2008.

In total, 722 (18%) parents provided consent and 258 (7%) parents refused consent for their son or daughter to complete the student questionnaires. Three quarters of parents (n=2975, 75%) did not respond to up to four rounds of consent and information letters distributed between April and August 2008 and thus could not be included in this study.

3.5 Instruments

Three instruments developed in 2008 for this study were used at baseline (2008), post test 1 (2009) and post test 2 (2010):

- Self-complete student questionnaire;
- Semi-structured student interview; and
- Self-complete staff questionnaire.

Two instruments developed in 2008, were used to monitor implementation of the intervention by school staff during 2009 and 2010:

- Staff-student interaction log record; and
- Semi-structured interview with staff who attended intervention training.

All instruments were designed to measure the objectives of the study. Key measures of the study objectives were identified in the literature and where necessary new items were written. Many items in the instrument had been pilot-tested and used in previous CHPRC research. A panel of experts were asked to review the KIT-Plus instruments for face and content validity. The panel comprised professionals in the areas of health promotion, research and/or education. An iterative review process followed to develop an instrument ready for pilot testing or administration. A description of the development of the instruments, including reliability data, can be found at Section 3.5 of the 2008 KIT-Plus Research Project Annual Report to Healthway.

3.5.1 Student questionnaire

Students were surveyed using a self-complete questionnaire. The questionnaire was designed to determine students': connectedness to school, teachers, family and peers; drug use and perceptions of harm from drug use; educational outcomes; and levels of interaction with staff about drug use and other personal issues. The student questionnaire, developed in 2008 for the baseline data collection, was used without modification at post test 1 in 2009 and post test 2 in 2010 (Appendix 6).

Intervention school students at baseline, and comparison school students at post test 1, were asked during the administration of the questionnaires to complete an extra question on a separate green coloured page (Appendix 7). This question asked students to nominate school staff they would talk with if they had a personal issue of concern. Neither identification numbers nor student names were placed on this sheet. Students were informed that the school principal would see a compiled list of nominated staff.

3.5.2 Semi-structured student interview

A semi-structured interview protocol (Appendix 8) was developed in 2008, based on the study objectives. It was designed to further explore students' perceptions of student-staff interactions, barriers and enablers to these interactions and students' suggestions on how to enable greater utilisation of staff when required to assist with students' personal issues. The same interview protocol was used at the post test 1 and post test 2 student data collections.

3.5.3 Staff questionnaire

The baseline staff survey (Appendix 9), administered to intervention school staff prior to their participation in the KIT-Plus training, comprised of items based on a theoretical model for capacity building. The survey was designed to gather information about staff attitudes towards pastoral care, demographic characteristics in pastoral care and drug education, as well as characteristics which influence intervention implementation.

This instrument was updated for post test administration in 2009 and 2010 (Appendix 10) to include new questions asking school staff about their involvement in whole school actions concerning pastoral care and/or drug related issues, how the KIT-Plus training had influenced their confidence and skills when talking with students about pastoral care and/or drug related issues and questions aimed at eliciting comments about the training itself.

3.5.4 Staff-student interaction log record

A log record (Appendix 11) was developed in 2008 for intervention school staff to record their interactions with students about personal issues, particularly related to drug use. Staff were also asked to record the KIT-Plus strategies used in their interactions. No identifying data on students was collected. Intervention school staff were asked to keep a log of their interactions with students for a total of four consecutive school terms from 2008 to 2010, depending on when they attended the KIT-Plus training.

3.5.5 Semi-structured staff interview

A qualitative staff telephone discussion/interview, designed as a coaching session to encourage staff in the use of the KIT strategies, was developed in 2008 to follow-up intervention school staff at one month after attending a KIT-Plus training session (Appendix 12). In 2009, a second staff telephone discussion/interview was developed to follow-up intervention school staff at nine weeks after attending a KIT-Plus training session (Appendix 13). The interview script maintained the coaching focus of the first telephone discussion/interview to encourage staff in the use of the KIT strategies, and also incorporated additional questions to capture staff involvement in whole school actions relating to pastoral care activities and school drug education guidelines or policy in their school since attending the KIT-Plus training.

3.5.6 Online staff survey

The third follow-up with intervention school staff occurred approximately 18 weeks after attending a KIT-Plus training. An online survey using Survey Monkey software (Appendix 14) gave staff the opportunity to self-reflect on the KIT-training and their implementation of KIT strategies during their interactions with students and also their involvement in whole school actions relating to pastoral care activities and school drug education guidelines or policy in their school. Questions were also included to assess changes in the confidence and skills of staff when talking with students about drug issues or other issues of personal concern.

3.6 Data Collection

3.6.1 Student questionnaire

Trained personnel from the CHPRC at Edith Cowan University administered **baseline** student questionnaires and interviews at 21 study schools in October and **November 2008 to Year 9 students** for whom parental consent had been provided.

Post test 1 student questionnaires and interviews were administered to the same cohort of students, in **Year 10 in September 2009**, at 18 study schools. At two of the regional study schools, the post test 1 student data collection was administered

concurrently with the KIT-Plus training in November/December 2009. One metro study school refused to participate in the post test 1 student data collection, citing staff reluctance to take on the extra load associated with the data collection. In a letter to the principal of this school in March 2010, which included a copy of the new SDERA resource for the school and for staff who had participated in the KIT-Plus training in 2009, an invitation was given to contact the KIT-Plus project coordinator if they wished to participate in the post test 2 data collection. No further contact has taken place with this school.

Post test 2 student questionnaires and interviews were administered over a period of four months from **May to August 2010 to students in Year 11** at 21 schools comprising 19 study schools and two schools that had been approached to allow follow-up of participating students who had moved to those schools at the start of 2010.

Other than the contact letter to schools prior to data collection - which in 2010, as a result of the rescheduling of the data collection for this year was different from the previous two years - in almost every respect, the procedure outlined below was identical for the baseline, post test 1 and post test 2 student data collections.

School principals were sent a letter (Appendix 15) describing how the student questionnaires and interviews would be administered in their school with minimal disruption to the classes and minor administrative help required from the school. A date was suggested and school principals were asked to fax back information as to whether or not the date was suitable and also to nominate a school project coordinator who would help with the administration on the day. Once the school project coordinator had been identified, a list of students for whom parental consent to participate in the data collection was provided and was sent for confirmation as to their enrolment at the school.

As a result of delays in recruiting schools into the study and the resultant impact on the timing of the baseline student data collection and staff training in intervention schools, the timing of the first post test data collection was moved from 2008 to

2009. This necessitated a rescheduling of the post test 2 data collection to 2010 when the student cohort were in Year 11. On advice from the ECU Ethics Officer, a letter (Appendix 16) was sent to the Department of Education WA outlining the changes to the data collection schedule and approval was provided to continue with the post test 2 data collection in 2010.

In 2010, separate letters were sent to school principals in intervention (Appendix 17) and comparison (Appendix 18) schools to provide details as to how the student questionnaires and interviews would be administered in their school. An outline of the rescheduling of the post test 2 data collection was also provided and schools were asked to confirm if they were still happy to be involved in the data collection with the Year 11 cohort. Assistance was also sought in contacting the parents of participating students by letter sent home (Appendix 19), via the school, explaining the change to the data collection schedule and reminding students that they could withdraw from the data collection if they wished to do so. Schools were also asked to nominate a school project coordinator and once identified (Appendix 20), as in 2008 and 2009, a list of students for whom parental consent to participate in the data collection had been provided in 2008 was sent for confirmation as to their enrolment at the school.

Prior to the scheduled date of the data collection, school project coordinators were emailed a final list of students for the questionnaires and a second list for the names of students who would be involved in the one-on-one interviews.

Students were released from their classrooms for questionnaire administration in a central location in the school. The administration followed a strict procedural and verbal protocol (Appendix 21) which staff from the CHPRC had been trained to deliver as part of a two hour training session (Appendix 22). CHPRC administrators of the survey were asked to complete an evaluation sheet to record how the procedures were carried out at the school (Appendix 23). All CHPRC questionnaire administrators held a Working with Children Check.

The number of students participating in the study varied from school to school (range 8 to 92 students). To minimise disruption to students not participating in the study, students with consent to complete the questionnaire were gathered in a central location (e.g. library, spare classroom). The CHPRC administrator(s) remained in the central location with the students to help with behaviour management and respond to questions during the administration. The school project coordinator was given the option of remaining in the central location, as many were committed to their own classrooms. Confidentiality was maintained by the use of identification numbers on questionnaires (students were asked to remove the name label on the cover envelope once they had completed their questionnaire) and school staff who were present were asked not to walk around the classroom nor look at students' responses. Students were asked to place their completed questionnaire in the envelope provided and seal the envelope. These envelopes were then collected by the administrator(s) and delivered immediately to the CHPRC at ECU. Students were given a *Kids Helpline* card and advised to contact the *Kids Helpline* or an adult they trust at the school, if the questionnaire raised any issues for them. In appreciation of the time taken to complete the questionnaire, all students were given a small gift (a *Smarter than Smoking* sticker in 2008 and a small ECU promotional gift in 2009 and 2010). The questionnaire took students between 10 and 20 minutes to complete.

Follow-up of students absent from school at the time of the questionnaire administration was carried out by the school's project coordinator. The absent students' questionnaires, a page of instructions on how to complete the questionnaire, *Kids Helpline* cards, the small gift, and a reply-paid envelope were left with the school project coordinator from each school. On the student's return to school, the school project coordinator was asked to have the student complete the questionnaire, remove the name label from the en, seal envelope in the reply-paid envelope and take it to the school project coordinator for posting to the CHPRC.

Approximately three weeks after the questionnaire was administered, a reminder was sent to school project coordinators asking again to follow-up 'absent' students.

In 2008, replacement copies of the student baseline questionnaire, instructions on how to complete the questionnaire, *Kids Helpline* cards, *Smarter Than Smoking* stickers and reply-paid envelopes were included in the letter to the Project Coordinator. Three weeks later a second follow-up letter was faxed to school project coordinators to prompt the return of 'absent' questionnaires. In 2009 and 2010, encouragement from the ECU KIT-Plus project coordinator, initially via email and later by telephone, to school project coordinators was used to follow-up these 'absent' students' questionnaires.

In 2010, due to the small numbers of participants at two of the more distant regional schools (8 students and 16 students) and the high cost of travelling to these schools to collect a small amount of data, a different process of administrating the student questionnaires was followed. After a phone discussion with the school principal at both of these schools and subsequently with each of the school coordinators, it was proposed that the surveys would be posted to the school coordinator with clear instructions on how to administer the surveys to the participating students and return the competed surveys to CHPRC. On agreement from the school principals, at the start of Term 3, 2010, the student surveys were posted to the school coordinators. For the return of the completed surveys, the coordinators were asked to ensure that the name labels attached to the surveys were removed prior to posting back and to return the check list of the participants in the separate reply-paid envelope that had also been provided.

At one of the two schools, a completed survey was returned for six of the eight eligible students. Two of the students had refused to participate.

At the other school involved in this process, the return of completed surveys was not successful. In 2010, this school had opened a new upper school campus at a different location in the town. The nominated school coordinator was stationed at the lower school campus which appeared to cause problems in her being able to coordinate the administration of the surveys to the 16 participating Year 11 students, located on the upper school campus. The survey administration was delayed throughout Term

3, despite numerous phone calls and emails from the CHPRC KIT-Plus coordinator. However, contact with the school coordinator at the start of Term 4 revealed that the surveys had been administered at the end of Term 3 and posted back in the reply-paid envelope that had been provided. These surveys were never received by CHPRC. Many phone calls to the school and the ECU mail room were made in an endeavour to locate the envelope of surveys, without success.

3.6.2 Semi-structured student interview

One-on-one semi-structured interviews were conducted by trained CHPRC staff on the same day as the questionnaire administration in a private room (usually an office or spare classroom) at the school and audio-taped with the respondent's permission. The administration followed a strict procedural and verbal protocol (Appendix 21), which staff from the CHPRC had been trained to deliver as part of a two hour training session. All CHPRC interviewers held a Working with Children Check.

At baseline, students for whom consent was provided to participate in the interview phase of the research were listed in random order for each school and 20% or a minimum of 10 one-on-one interviews (to maintain anonymity of responses) were completed with students. At post test 1, one-on-one interviews were conducted with students who had completed an interview in 2008. At post test 2, one-on-one interviews were conducted with students who had completed an interview in 2008 and/or 2009. To achieve the desired 10 interviews per school, the CHPRC staff conducting the interviews accessed a backup list of 10 students, made up of randomly selected students with parental consent to participate in the interviews. The interviews took approximately 10 to 15 minutes to complete and consisted of open-ended questions, including 16 main topic questions and 29 sub-questions. In appreciation of the time taken to complete the interview, all students were given a small ECU promotional gift.

In 2010, at the two distant regional schools, where the school principals agreed to the school coordinator assisting with the data collection, the post test 2 student interviews were conducted by telephone with the eligible students at school and in

school time. The school coordinators were asked to schedule interviews at 20 minute intervals with the students on the list that they had been emailed in advance, at times that would be least disruptive to students and their teachers. Each coordinator faxed through a schedule for a nominated day with a phone number to ring in a private interview room where the student would be waiting. This process worked well with four interviews being conducted at one of the schools and six interviews at the other school.

3.6.3 Staff questionnaire

Intervention school staff who attended a KIT-Plus training session were given an information letter, a consent form (Appendix 24) and a baseline staff questionnaire (Appendix 9) prior to the commencement of the training session. The questionnaire took approximately ten minutes to complete and staff were asked to seal the questionnaire in the blank envelope provided. Approximately one year after attending the KIT-Plus training, school staff were mailed a post-test questionnaire (Appendix 10) and asked to complete the questionnaire and mail it to CHPRC in the reply paid envelope provided.

3.6.4 Staff-student interaction log record

Intervention school staff were provided with a booklet of log sheets (Appendix 11) to record staff-student interactions occurring after the KIT-Plus training session. At the end of the KIT-Plus training, staff were given the log booklet, instructions for log completion and a gift voucher to compensate them for their time. Staff were asked to complete the log booklet for a total of four school terms, apart from the staff at the two regional schools whose staff were trained at the end of 2009. At these two schools, due to poor return rates of log books suggesting that little would be gained by pursuing log book returns over four terms, staff were asked to complete the log booklet for a total of three school terms.

Towards the end of each term, staff were mailed a reminder letter and a reply-paid envelope asking for the return of their completed log booklet. On receipt of the log booklet at ECU, the pages detailing staff interactions with students were

photocopied, new pages were added for staff to continue recording further interactions with students in the following term and the booklets were returned to staff for their personal records and reflection.

Follow-up with school staff to return log booklets was by fax, mail or email in the last week of each school term and a reminder was also included at the end of each telephone discussion/interview. A second gift voucher was sent to staff after two terms of log booklet completions to encourage staff to continue completing and returning the log booklets for a further two terms.

3.6.5 Semi-structured staff interview

School staff attending the KIT-Plus training provided availability and contact information to participate in the one-month follow-up telephone discussion/interview (Appendix 12). The discussions, which averaged 20 minutes in duration, were designed as both a data collection and a coaching session to encourage staff in the use of the KIT strategies and to provide opportunities for staff to ask questions and seek guidance from the interviewer. All discussions were conducted by either the SDERA KIT trainer or one of three KIT-Plus Research Project staff from CHPRC. A second telephone discussion/interview (Appendix 13) was conducted with intervention staff approximately nine weeks after training. An email was sent to participating staff to schedule a date and time for the telephone discussion/interview. Two to three days prior to the interview date, a list of questions to be asked in the telephone discussion/interview was emailed to the participants with a reminder of the date and time, and an opportunity for staff to reschedule if the time was no longer suitable.

3.6.6 Online staff survey

An email explaining the purpose of the online survey and providing the link to the Survey Monkey website (Appendix 14) was sent to intervention school staff who had attended a KIT-Plus training. A reminder email was sent two weeks later to staff who had not completed the survey (Appendix 25).

3.7 Intervention

A review of brief interventions used for drug use incidents for high school students identified the School Drug Education and Road Aware (SDERA) *Keeping In Touch* (KIT) resource and training, and CHPRC's *Keep Left*, School Nurses resource as key resources developed and used in Western Australian. The SDERA and CHPRC partnership on this research project aimed to evaluate a systematic pastoral care intervention designed to encourage and facilitate positive behaviour in students, particularly with regards to reducing smoking and other drug use, which was delivered by trained secondary school staff identified by students as very approachable. Recommendations from an evaluation of KIT in Western Australia by Midford, Wilkes and Young (2005) suggested that more than one staff from each school should attend the KIT training and follow-up to the KIT training could also help to enhance implementation of the KIT strategies. The KIT-Plus intervention developed for this research project and used as the intervention to be tested, responded to this feedback from previous users.

The KIT-Plus intervention comprised four key stages:

1. Year 9 students were asked to anonymously identify 'approachable' school staff. Identified staff were invited to a two-day KIT-Plus training session.

2. At the KIT-Plus training session, participants were informed of and/or trained in:

- general drug use issues and how they may impact on young people;
- communication methods to help students in need of support;
- models and frameworks designed to support students through brief interventions; and
- how to develop a school plan that implements KIT-Plus strategies through individual staff, in school guidelines (policy level) and with community partnerships.

3. One-month and two-months after attending the KIT-Plus training, training attendees were provided with one-on-one coaching sessions to encourage their use

of the KIT-Plus strategies. A third coaching session was made available via an online reflection survey.

4. Collegial support among the trained, school-based team was fostered in training and coaching sessions.

Identification of a school-based team – approachable staff

Identification of a school-based team that included staff identified by students as approachable was lead by the CHPRC research team during baseline student data collection by way of student completion of the Green Page in their baseline questionnaire (Appendix 7). A list of staff nominated by students was compiled from the Green Pages and sent to metro (Appendix 26) and rural (Appendix 27) school principals inviting them to submit names of staff who could be invited to attend the KIT-Plus training. Invitations for staff to participate in training were included in the letters to school principals. The recruitment of school staff to attend the KIT-Plus trainings in regional schools during 2009 proved to be more difficult than the recruitment of the metropolitan schools and 2009 contact was initially via email and telephone.

KIT training and resource

Outcomes of the KIT training included:

- Understanding and awareness of drug issues
- Recognising students in need of support
- Practise using models and frameworks for responding appropriately and supporting students through brief interventions and referral.

Capacity building training

Feedback from the Phase 1 training was used to develop the KIT-Plus one day capacity building training (Appendix 28). The first KIT-Plus one day training, held on 13th March 2009, was subsequently replaced by a half day session in subsequent trainings. The decision to reduce the length of the training from three to two full days was in part to support regional schools where Principals had spoken of the difficulty in finding staff to cover teacher relief.

The content of the capacity building component of the KIT-Plus training was informed by the World Health Organisation's (Smith, 2006) capacity building in health promotion model, suggesting that to increase the likelihood of an intervention being implemented, actions be included to improve:

- Individual (staff) capacity
- Organisational (whole school) capacity
- The development of partnerships.

Many such strategies are addressed in the KIT training, but the capacity building components of the training required participants to group with their school colleagues to plan how the KIT strategies could be implemented at these three levels in their school. To commence this planning exercise, school groups were asked to identify what parts of the KIT training they found "connect with, extend, challenge", their school's activity in pastoral care for responding to drug use incidents and activities that support the prevention of drug use by students.

The school groups were then asked to consider how they could implement KIT strategies to address the three levels of capacity building by identifying actions they could take as individuals and as a school (Appendix 29). For example:

Individual Capacity

- KIT training review – share KIT training strategies with other staff using the 'tips sheet' (Appendix 30)
- Use additional motivational interviewing information (Appendix 31) and 'Keep Left' motivational interviewing activities for students (Appendix 32)
- Consider and share with other school staff, the 'characteristics of school staff that make them approachable' from student data report
- Use the discussion starters from the 'tips sheet' with students (Appendix 30)
- Collegial support – talk with colleagues about the KIT-Plus training and using the models and strategies learnt at the training.

Organisational capacity

- Establish a project team / school health team
- Encourage and establish a whole school approach to drug issues in the school, using the:
    - Pastoral care assessment (Appendix 33)
    - SDERA's "Getting it Together" – policy development and guidelines for responding to drug incidents
- Inform all school staff of the results of the student data report
- Conduct a capacity measuring activity (Appendix 34) to identify strengths and needs in the school's response to a whole school approach to drug use, including:
    - School environment – KIT-Plus strategies match the school
    - Processes – planning and resources, partnerships
    - People – project teams skills and motivation, leadership

Developing partnerships

- Work with community agencies
- Work with parents using activities in the 'Keep Left' guide (Appendix 32)

The logistics of scheduling schools and staff to attend training sessions, particularly in regional areas where access to relief teaching staff was limited, resulted in the

staggering of the KIT-Plus training sessions from October 2008 and throughout 2009. Six training sessions, two to three days in duration, were conducted over this time period with a total of 64 staff from 13 intervention group schools. The KIT-Plus trainers facilitated two trainings for metropolitan schools and travelled to four regional locations to conduct trainings. The multiple training dates resulted in five phases of school staff training as outlined in Table 7 below.

Table 7 Phases of KIT-Plus training

Phase	**Metro/ Regional**	**KIT-Plus training dates**	**Intervention schools** (n=13)	**School staff attendees** (n=64)
1	Metro	27th & 28th October 2008 (KIT) and 13th March (KIT-Plus)	3	9
2	Metro	5th, 6th & 13th March 2009	4	17
3	Regional	2nd & 3rd April 2009	2	12
4	Regional	28th & 29th July 2009	2	11
5	Regional	26th & 27th November and 2nd & 3rd December 2009	2	15

School staff who attended the trainings included Student Services staff, Year Leaders, Student Services Managers, School Psychologists, School Chaplains, School Nurses, Aboriginal and Islander Education Officers (AIEO), learning area leaders, classroom teachers and teacher assistants.

The KIT training sessions were led by the SDERA KIT trainer, Ms Catriona Coe. Additional training in the KIT-Plus capacity building and planning component of the intervention was provided by the CHPRC presenter, Associate Professor Margaret Hall. Logistical assistance was provided by additional staff from CHPRC and from SDERA, including SDERA regional coordinators at the regional training sessions.

Training costs (venue, catering, presenter, materials and teacher relief) were met by the SDERA project through national funding from DEEWR for the KIT program. Costs for accommodation and travel relating to the training sessions in regional centres were met through the KIT-Plus Research Project's Healthway funding. The CHPRC's KIT-Plus researchers completed all staff recruitment for the training.

Coaching sessions

The SDERA KIT trainer and CHPRC research staff who attended the trainings led the coaching session (Appendix 12) for each of the attendees one month after the KIT-Plus training and again nine weeks after the training (Appendix 13). The coaching sessions were conducted by telephone and were designed to give the school staff member the opportunity to self-reflect on the KIT-Plus training and their implementation of KIT-Plus strategies in staff-student interactions. Staff were encouraged to continue / start using the strategies presented at the KIT-Plus training. Staff were referred to the KIT trainer if they had specific drug-related questions that were not easily answered. A third coaching session was provided 20 weeks after training using an online reflection survey. This survey listed common responses to questions in the two telephone coaching sessions. Respondents were asked to indicate how much they agreed/disagreed with the statements about their use of and satisfaction with KIT-Plus strategies and training.

Comparison School Training

Comparison school principals were told when their school was recruited into the study that at the completion of the final student data collection, interested staff from their school would be offered the opportunity to attend a KIT-Plus training session. An invitation to a two day training conducted in Kalgoorlie in May 2010, and in the metro area in June 2010 was included in the letter (Appendix 18) sent with the interim school report (Appendix 35) to the comparison school principals. Schools were encouraged to promote the training amongst pastoral care and other staff. A list of staff nominated by participating Year 10 students when they were surveyed in 2009 as being someone they are likely to approach to discuss personal issues, was also provided to the principal.

Support for the training included: a copy of the *Keeping in Touch* resource provided at no cost; funding for a replacement teacher for two days when staff attended the training; and travel and accommodation costs for regional schools. Four staff from two comparison schools (two with accommodation and travel support provided by

SDERA) attended the training session in Perth. Two staff from one regional study school attended the training in Kalgoorlie.

School reports

A summary report of descriptive statistics for student-reported relationships at school, drug use, attitudes to drug use, student-staff interactions, bullying behaviour and characteristics of approachable staff identified in student interviews, was distributed to the 21 study schools in December 2008. Two versions of the reports were prepared, one summarising data collected in metropolitan schools (Appendix 36) and one summarising data collected in regional schools (Appendix 37). In March 2010, interim reports were prepared for schools in the intervention group (Appendix 38) and in the comparison group (Appendix 35). The report for intervention schools (Appendix 38) included information about teacher satisfaction with and use of the KIT-Plus strategies.

A report was included with the letter (Appendix 17 & 18) to all study school principals outlining the 2010 student data collection. Also included with the letter to principals at intervention schools was a school copy of the new SDERA resource, *Getting it Together: Whole School Approach to Drug Education*. Staff at intervention schools who had attended one of the KIT-Plus training sessions were also sent a copy of the interim report as well as a personal copy of *Getting it Together: Whole School Approach to Drug Education*.

3.8 CHPRC and SDERA Partnership

Strengthening of the partnership between the CHPRC researchers and the School Drug Education and Road Aware (SDERA) to implement and evaluate the intervention was a highlight of this research project. Effective collaboration was fostered through teamwork between CHPRC and SDERA staff.

Collaborative activities included: organising and conducting the intervention training sessions; review of the SDERA school drug education policy resource, “Getting it

Together" by the KIT-Plus Research Project Chief Investigator using questions and concerns raised by school staff during the KIT-Plus telephone discussion/interviews and at the training sessions; regular contact between the KIT-Plus Research Project Chief Investigator and the Manager of SDERA to update on the progress of the study; CHPRC contribution to the SDERA 2010 annual report with a summary of the progress of the KIT-Plus Research Project; the inclusion of an item on the KIT-Plus Research Project in the SDERA newsletter (November 2010); co-presenters of four oral presentations on the KIT-Plus project at national conferences; and ongoing contact between the KIT-Plus Research Project Chief Investigator and the SDERA Manager to investigate ways of translating the findings of the KIT-Plus Research Project into the planning and development of services provided by SDERA to all Western Australian schools.

3.9 Data Management and Analyses

All staff and student survey data collected in 2008, 2009 and 2010 were entered into SPSS 15. Log record booklet data were also been entered into SPSS 15. Student interviews and staff telephone discussions have been transcribed verbatim and coded in QSR NVivo 8. All data have been cleaned.

Data on a number of measures collected from students and staff are presented in this report. The impact of the intervention was assessed according to the objectives of the study. Data items and themes used in analyses of the student data are presented in Table 8. Data items and themes used in analyses of the staff data are presented in Table 9.

The following student characteristics were also used in the analyses:

- Smoking status of the student (student questionnaire items 10, 11,12)
- Gender of the student (student questionnaire item 22)
- Whether the student was ATSI (student questionnaire item 23)
- Smoking behaviour of friends (student questionnaire item 19a)

Table 8 Student data used in the analyses

#	Objective description	Student Interview items	Objective-item themes
1	Intervention students would be more likely to speak to a staff member at their school if they were thinking about changing their smoking status than comparison group students.	**4a**	*Talking to staff about changing smoking status*
2	Intervention students perceive that vulnerable students in their school would speak to staff members at school if they are thinking of changing their smoking status more frequently than do comparison students who are also considered vulnerable to smoking.	**8a, 9a, 10a**	*Perceptions about other students who smoke talking to staff about changing smoking status*
3	Intervention students are more aware of the availability and nature of services provided by the pastoral care team than comparison students.	**12a-e**	*Health and student services:* • *Helping* • *Accessing* • *Reasons*
4	Explore student perceptions of: • the types of pastoral care services available *(12 – as described above)*; • to what extent have the services helped them or others *(13a)*; • what other services do they and other students need *(14)*	**13a, 14**	*Improving ways school staff help can help students*
5	Explore student perceptions of: ***(specific to smoking)*** • the types of pastoral care services available; • to what extent have the services helped them or others; • what other services do they and other students need to help them to reduce their **harm from tobacco use**	**15a**	*Students' needs from staff to quit or smoke less*
11	The intervention satisfies students (who have given consent to be interviewed).	**13b-c**	*Helpfulness of sharing concerns with a staff member*

Table 9 School staff data used in the analyses

#	Objective description	Staff Data items
6	Explore intervention group PCT staff perceptions of their satisfaction with and use of the intervention, and what else they perceive they need in a pastoral care program to reduce secondary students harm from tobacco.	Staff interviews, log records and online survey
7	Intervention schools have developed and implemented a plan for the delivery of pastoral care services that offer support for students to quit, reduce or not start smoking.	Project records, online survey, post test survey
8	Intervention group pastoral care staff believe the capacity building intervention helped them to engage with greater numbers of vulnerable students and more often, and that during these sessions they felt more confident and capable to deal with/prevent student problems than did comparison pastoral care staff.	Log records
9	Pastoral care staff, principals, and education policy makers perceive the intervention to be an effective means of both strengthening the skills and capacity of pastoral care staff and providing them with improved support resources, to enable them to play a more active role in behaviour management, particularly tobacco use cessation.	Online survey
10	The pastoral care intervention is sustainable (measured by the ability of the SDERA team to continue to support the practices and strategies tested in this study).	

Further analyses of the quantitative and qualitative student data and staff data are continuing in 2011. Master of Public Health (research) student, Kaashifah Bruce is collating case studies on the 13 intervention schools using teacher data for her research project. She will submit her thesis in June 2011.

3.10 Ethics approval

Ethics approval to conduct the study was received from the ECU Ethics Committee and the Western Australian Department of Education in March 2008.

3.11 Summary of tasks completed in 2010

The following tasks were completed in 2010:

- **Study schools were approached to confirm their participation** in the third and final student data collection and informed of a change to the data collection schedule that would involve students in Year 11 instead of Year 10. Schools were also asked to assist with distributing a **letter to parents and students** to explain the change to the timing of the data collection and remind them of their option to withdraw from the study.

- **Permission was granted from an additional regional school** to allow follow-up of students into Year 11 from a study school that only offered enrolment to Year 10. Permission was also granted from **an additional metro school** where a number of participating students from a nearby study school had moved at the start of 2010.

- **Instrument development.** With the exception of the baseline staff questionnaire, which was updated in 2009 for the post test 1 administration, and the development of the online reflection survey for school staff utilising Survey Monkey technology, all instruments developed in 2008 were used in 2009 and 2010 in identical form or with minor alterations.

- **Data collection** was conducted with Year 11 students from 21 study schools from May to August 2010. A total of 393 students completed post test 2 questionnaires and 179 students participated in a one-on-one interview. Various levels of staff data collection from school staff at the six regional intervention schools were conducted throughout 2010, including telephone interview/discussions, online survey, post- intervention staff surveys and staff completion of log records.

- **Delivery of the two day KIT-Plus program** by the SDERA KIT trainer was offered to the nine comparison schools after most of the final student data had been collected, and was conducted in May in Kalgoorlie and June in Perth. Four staff from two comparison schools (two with accommodation and travel

support provided by SDERA) attended the training session in Perth. Two staff from one regional study school attended the training in Kalgoorlie.

- **Delivery of one half-day training** by the SDERA KIT trainer and the CHPRC presenter in March to 13 staff from the CHPRC to showcase ideas and strategies from the KIT-Plus program.

- **Data management and analyses**: All 2010 student and staff survey data and staff log records have been entered into SPSS 15, student and staff interview data have been transcribed and coded in QSR NVivo 8. Analyses of student and staff data have been conducted and results are presented in Section 4 of this report.

- **The strengthening of the partnership between the CHPRC researchers and the School Drug Education and Road Aware** (SDERA) to implement and evaluate the intervention has continued throughout 2010.

- **Three abstracts were submitted for oral presentations at national conferences in 2011** to present findings from student and staff data. The AHPA conference in Cairns, Queensland and Australian Drug Foundation's 6th International Conference on Drugs and Young People in Melbourne.

- **The final report to Healthway** has been written.

3.12 Next stages of the research

Data management and analyses

Analyses of the quantitative and qualitative student and staff data have been conducted in 2010 and are presented in Section 4 of this report. The 21 study schools will be provided with a summary of the baseline, post test 1 and post test 2 student data in 2011. Further analyses will be conducted in 2011 to support findings to be presented in proposed publications and at conference presentations.

As described above, Master of Public Health (research) student, Kaashifah Bruce is collating case studies on the 13 intervention schools using teacher data. She will submit her thesis in June 2011.

Translation of research into practice

During 2011, the partnership between CHPRC and SDERA will continue to be fostered to determine successful aspects of the intervention that can be used in practice.

Strategies developed in the KIT-Plus intervention that school staff have found successful have been used to inform the development of a number of CHPRC school health promotion interventions that are being tested in schools.

Publications and seminars

Dissemination of the findings of the research will made in publications and at seminars and conferences. To date, three conference presentations are confirmed for 2011. A number of journal publications using teacher and student data are planned.

4. RESULTS

4.1 Response Rates

In total, 70 schools were approached in order to recruit 21 schools (12 intervention group schools and 9 comparison group schools) that agreed to participate in the study (30% response rate). Reasons for non-participation included the school was already involved in too many special projects and the school was experiencing industrial action where teachers were not participating in activities outside normal duties.

Data were collected at three time points from students over the three years of the study – baseline (September 2008), post test 1 (September 2009) and post test 2 (May 2010).

Parents of a total of 3955 Year 9 students who attended the 21 study schools in 2008 were contacted at baseline (n=2328 in intervention schools and n=1627 in comparison schools), and consent was received for 722 of these children representing a **consent rate of 18%** (n=477, 20% of the students contactable in the intervention group and n=245, 15% of those contactable in the comparison schools). Only 7% of the sample pool returned an active 'no consent' form with the remaining 75% not returning a form.

In 2008, 637 Year 9 students (mean age of 14 years) returned the baseline survey and 181 students also participated in an interview. The same students were tracked to Year 10 in 2009 when 544 students (mean age 15 years) returned a survey and of these, 197 students also participated in an interview. In 2010, 393 students (mean age 16 years) returned a survey and 179 completed interviews, achieving a **final response rate at post test 2 of 54% of students who gave consent at baseline completing a survey and 25% of students completing an interview** (Table 10).

Not all students participated in interviews at each data collection: 71 students completed interviews in all three years of the study (approximately 36%); 46 students completed an interview in 2008 and 2009; 19 students completed interviews in 2008 and 2010; and 38 students completed interviews in 2009 and 2010.

Table 10 Student response rates over time

	Consent given at baseline	Baseline	Post-test 1	Post-test 2
Student surveys				
Total	722 100%	637 88%	544 75%	393 54%
Comparison	245 100%	217 89%	198 81%	154 63%
Intervention	477 100%	420 88%	346 73%	239 50%
Student interviews				
Total	722 100%	181 25%	197 27%	179 25%
Comparison	245 100%	71 29%	86 35%	72 29%
Intervention	477 100%	110 23%	111 23%	107 22%

4.2 Characteristics of schools

In total, 57% of the schools could be characterised as below average socio-economic advantage (SEIFA index below 100 – six of the 12 intervention schools were below average SES; six of the nine comparison schools were below average SES). The median number of secondary students in 2007 in the study schools was 765 students (786 for intervention schools and 757 for comparison schools), with a range of 254 to 1599 students enrolled at the school.

4.3 Characteristics of students

Table 11 presents a summary of characteristics for all students who completed surveys at the three data collections. Table 12 presents the characteristics of the students who completed interviews.

Table 11 Characteristics of students (student survey data)

Characteristics of all student participants	Year 9 2008 (n=637)		Year 10 2009 (n=544)		Year 11 2010 (n=393)	
	C (n=217) n(%)	I (n=420) n(%)	C (n=198) n(%)	I (n=346) n(%)	C (n=154) n(%)	I (n=239) n(%)
Demographics						
Aboriginal or Torres Strait Islander (ATSI)	10 (6)	24 (6)	8 (4)	19 (5)	1 (1)	8 (3)
Non-ATSI	206 (95)	393 (93)	190 (96)	326 (94)	153 (99)	231 (97)
Female	106 (49)	229 (54)	95 (48)	176 (51)	78 (51)	132 (55)
Male	111 (51)	190 (45)	102 (52)	170 (49)	76 (49)	107 (45)
Geography						
Metro	165 (76)	289 (69)	149 (75)	228 (66)	124 (80)	155 (65)
Rural	52 (24)	131 (31)	49 (25)	118 (34)	30 (19)	84 (35)
Smoking						
Participant:						
Smoked in past four weeks	13 (6)	41 (10)	19 (9)	45 (13)	18 (12)	31 (13)
Smoked but not recently	38 (18)	82 (19)	49 (25)	84 (24)	26 (17)	70 (29)
Never smoked	166 (76)	297 (71)	130 (66)	217 (63)	110 (71)	138 (58)
Participants' friends:						
Few to all friends smoke	113 (52)	208 (50)	134 (68)	245 (71)	97 (63)	179 (74)
No friends smoke	104 (48)	212 (50)	64 (32)	101 (29)	57 (37)	60 (25)

Table 12 Characteristics of students who completed an interview (student survey data)

Characteristics of students who completed an interview	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C (n=71) n(%)	I (n=110) n(%)	C(n=86) n(%)	I (n= 111) n(%)	C (n= 72) n(%)	I (n=107) n(%)
Demographics						
Aboriginal or Torres Strait Islander (ATSI)	5 (7)	7 (6)	5 (4)	5 (1)	1 (1)	2 (2)
Non-ATSI	66 (93)	102 (93)	79 (92)	104 (94)	71 (99)	98 (96)
Female	31 (44)	57 (52)	44 (51)	59 (53)	35 (49)	60 (56)
Male	40 (56)	53 (48)	40 (46)	51 (46)	37 (51)	40 (37)
Geography						
Metro	49 (69)	62 (56)	57 (66)	68 (61)	52 (72)	65 (61)
Rural	22 (31)	48 (44)	27 (31)	42 (38)	20 (28)	35 (33)
Smoking						
Participant:						
Smoked in past four weeks	6 (8)	15 (14)	8 (9)	17 (15)	10 (14)	14 (13)
Smoked but not recently	20 (28)	18 (16)	25 (29)	25(23)	10 (14)	38 (36)
Never smoked	45 (63)	77 (70)	53 (62)	69 (62)	52 (72)	55 (51)
Participants' friends:						
Few to all friends smoke	42 (62)	62 (60)	40 (66)	72 (79)	27 (63)	46 (74)
No friends smoke	26 (38)	42 (40)	21 (34)	19 (21)	16 (37)	16 (26)

Figure 1 illustrates interview student reports on having 'never' smoked. Figure 2 illustrates the smoking behaviour of interview students' friends.

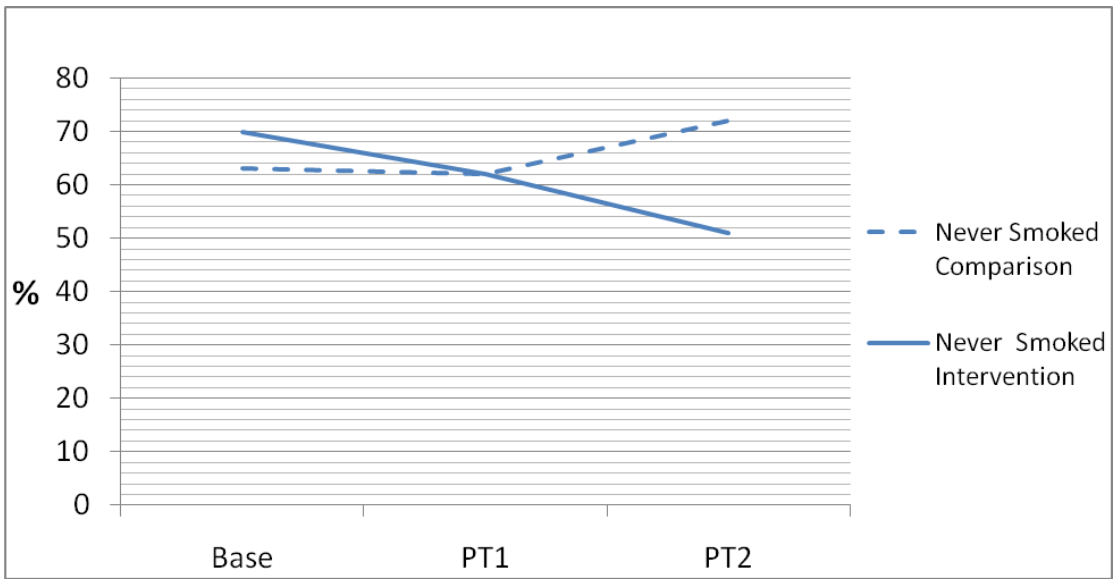

Figure 1 Interviewed students' smoking behaviour

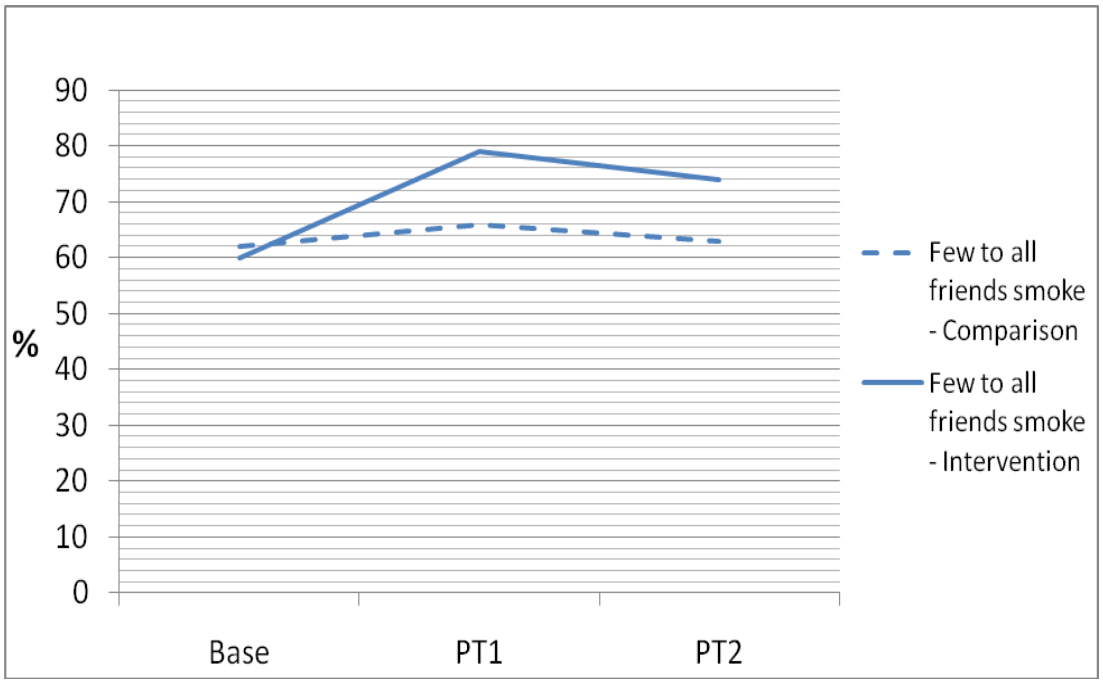

Figure 2 Interviewed students - smoking behaviour of friends

4.4 Findings of the study – student data

The study objectives addressed in analyses of student data are:

Objective 1 To determine if intervention students would be more likely to speak to a staff member at their school if they were thinking about changing their smoking status than comparison group students. (Student interviews)

Objective 2 To determine if intervention students perceive that vulnerable students in their school would speak to staff members at school if they were thinking of changing their smoking status more frequently than would comparison students who were also considered vulnerable to smoking. (Student interviews)

Objective 3 To determine if intervention students were more aware of the availability and nature of services provided by the pastoral care team than comparison students. (Student interviews)

Objective 4 To explore student perceptions of the types of pastoral care services available, to what extent such services were available, to what extent the services helped them or others and what other services did they and other students need. (Student interviews)

Objective 5 To explore student perceptions of the types of pastoral care services available, to what extent the services helped them or others and what other services they and other students needed to help them to reduce their **harm from tobacco use**. (Student interviews)

Objective 11 To determine if the intervention satisfied students who have given consent to be interviewed. (Student interviews)

Objective 1 - Talking to staff about changing smoking status

To determine if intervention students would be more likely to speak to a staff member at their school if they were thinking about changing their smoking status than comparison group students. (Student interviews)

Interviewed students were asked who they would speak to about changing their smoking status and were encouraged to nominate more than one person, role or occupation. In Table 13, student responses have been collapsed into four general groups of family, friends, other health professionals and school staff. A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 1). 'Family (immediate and extended)' consistently received the highest nomination from both intervention and comparison group students (Figure 3). 'Friends' received the second highest nominations for whom students thought they would talk to about changing their smoking except for one instance. In 2008, 'School staff' received 6% nominations more than 'Friends' from students attending intervention schools. 'Health professionals' external to school settings, including online forums and telephone help lines, comprise the fourth group. Student nominations for this group were relatively few and varied between intervention and comparison groups. In each year a few students were unsure who they would talk to, felt they could talk to anyone, or felt they wouldn't need to talk to anyone.

At each data collection point, more students attending intervention schools said they would talk to 'School staff' about changing their smoking status than students attending comparison schools.

The most commonly nominated staff roles that interview students said they would speak to about smoking were teachers and student services staff, including the chaplain, psychologist or school nurse (Table 14).

After accounting for baseline differences, there appear to be no differences in the number of students who were interviewed reporting they would speak to a staff

member if they were thinking about changing their smoking status, between intervention and comparison group schools. When the students were in Year 11, approximately 35% reported they would talk to a school staff member if they were thinking about changing their smoking status.

Table 13 Who students say they would talk to about changing their smoking status (Interview item 4a)

Who students would talk to about changing their smoking status*	**Year 9 2008** (n=181)		**Year 10 2009** (n=197)		**Year 11 2010** (n=179)	
	C (n=71) n(%)	**I** (n=110) n(%)	**C** (n=86) n(%)	**I** (n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Student unsure	-	1	1	2	1	1
Anyone	1	4	-	4	2	2
Family (immediate and extended)	48 (68)	71 (64)	62 (72)	67 (60)	53 (74)	77 (72)
Friends	39 (55)	48 (44)	48 (56)	62 (56)	40 (56)	61 (57)
Health professionals	9	7	8	7	5	10
No one	-	2	4	5	4	3
School staff	25 (35)	55 (50)	38 (44)	56 (50)	23 (32)	40 (37)

*students could nominate more than one person, role or profession

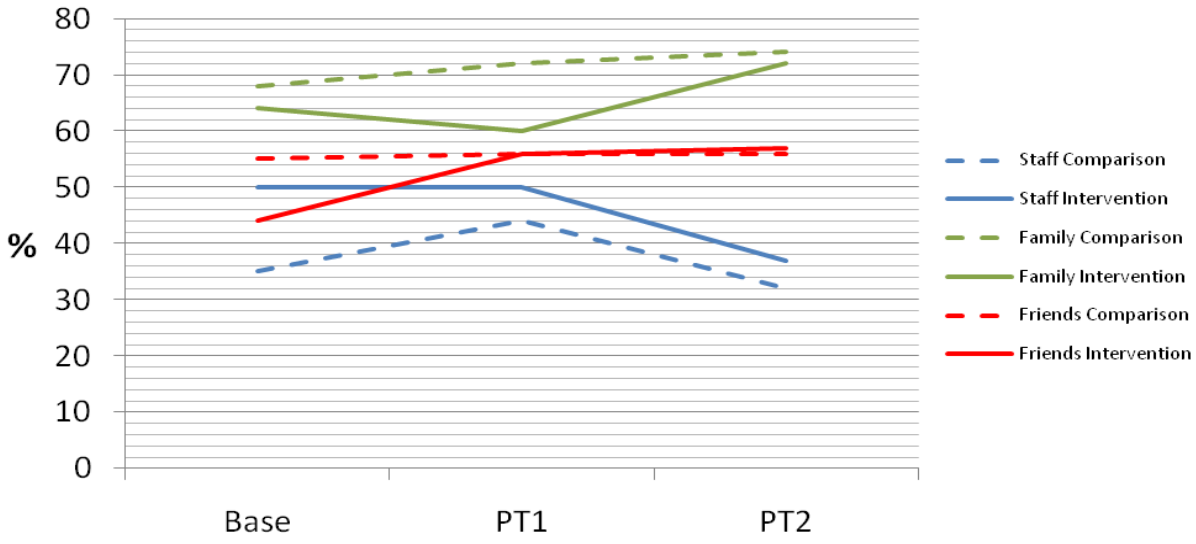

Figure 3 Who students would talk to about changing their smoking

Table 14 Student nominations for school staff they would talk to about changing their smoking status (interview item 4a)

School staff students would talk to about changing their smoking status*	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C (n=71) n(%)	I (n=110) n(%)	C (n=86) n(%)	I (n= 111) n(%)	C (n= 72) n(%)	I (n= 107)n (%)
Administrative staff						
Deputy principal	1	3	2	1	1	-
Principal	1	3	1	1	-	2
Staff						
Staff	5	8	4	13	4	1
Student services						
Chaplain	8 (11)	10 (9)	7 (8)	11 (10)	6 (8)	11 (10)
Counsellor or Psychologist	4 (6)	8 (7)	6 (7)	10 (9)	3 (4)	9 (8)
Nurse	4 (6)	9 (8)	10 (12)	9 (8)	2 (3)	7 (6)
Student services	1	5	1	-	-	3
Year coordinator	3	7	1	2	1	1
Teachers						
Advocate	-	-	-	-	-	1
Drama	-	-	-	-	-	1
English	1	2	-	-	-	-
Form or home room	2	1	-	-	-	-
Health and sport	2	6	7	1	1	1
Teachers	1 (1)	10 (9)	7 (8)	21 (19)	8 (11)	12 (11)
Maths	-	-	1	-	-	-
Physics	-	-	-	-	-	1
Society and environment	-	1	1	-	-	-
Total nominations (%)	33 (46)	73 (66)	48 (56)	69 (62)	26 (36)	50 (46)

*students could nominate more than one person or role

Objective 2 - Student perceptions of who students that smoke would talk to about changing their smoking status

To determine if intervention students perceive that vulnerable students in their school would speak to staff members at school if they were thinking of changing their smoking status more frequently than would comparison students who were also considered vulnerable to smoking. (Student interviews)

Interviewed students were asked who they thought students that smoke would talk to about changing their smoking status. 'Friends' were consistently nominated across each data collection by both intervention and comparison students as the most likely group that students who smoke would engage for support and advice about changing their smoking (Table 15). 'School staff' and 'Family (immediate and extended)' fluctuated in receiving the second highest nominations. Despite steady increases for nominations of Friends and Family, nominations for School staff remained stable in 2009 and 2010 (35%) from students attending intervention schools while they decreased from students attending comparison schools from 35 per cent in 2009 to 28 per cent in 2010 (Figure 4). This finding is encouraging given more intervention students than at any other time point reported they had ever smoked (49%) and a few to all of their friends smoke (63%) (Table 15). A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 2).

Table 15 Student nominations of who students that smoke would talk to about changing their smoking status (interview item 8a)

Who students think other students who smoke would talk to* about changing their smoking status	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C(n=71) n(%)	**I**(n=110) n(%)	**C** (n=86) n(%)	**I**(n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Student unsure	3	6	6	9	4	3
Adults	1	2	-	-	-	-
Family (immediate and extended)	31 (44)	37 (34)	35 (41)	39 (35)	33 (46)	40 (37)
Friends	36 (51)	58 (53)	60 (70)	67 (60)	52 (72)	78 (73)
Health professionals	6	3	4	11	7	7
No one	3	4	3	6	1	4
School staff	34 (49)	54 (49)	30 (35)	39 (35)	20 (28)	38 (35)
Someone who has quit	1	2	2	-	-	1

*students could nominate more than one person, role or profession

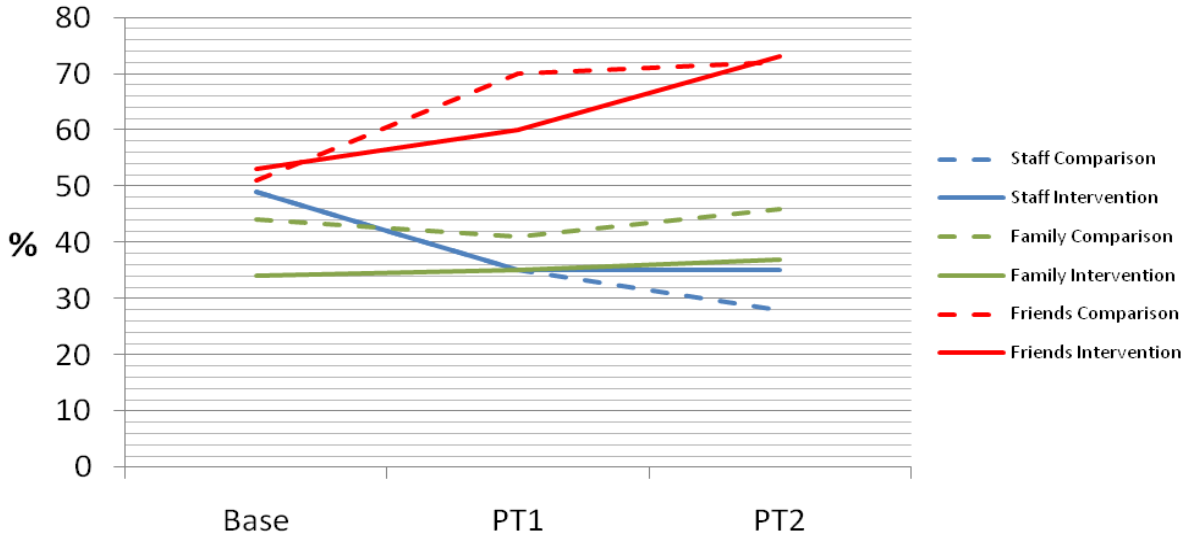

Figure 4 Who students <u>who smoke</u> would talk to about changing their smoking

Participants were prompted to identify which staff roles students who smoke would go to about changing their smoking (Table 16). At post test 1 and post test 2 a greater proportion of students attending intervention schools than comparison schools identified staff roles they thought students who smoke would talk to than students attending comparison schools. A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 2).

Table 16 Student nominations for school staff who students that smoke would talk to about changing their smoking status (interview item 8a)

School staff students would talk to about changing smoking*	Year 9, 2008 (n=181)		Year 10, 2009 (n=197)		Year 11, 2010 (n=179)	
	C (n=71) n(%)	I (n=110) n(%)	C (n=86) n(%)	I (n= 111) n(%)	C (n= 72) n(%)	I (n= 107) n(%)
Administrative staff						
Deputy principal	1	4	2	1	-	2
Principal	1	1	-	4	-	-
Staff						
Staff	8	8	6	4	3	6
Student services						
Chaplain	6 (8)	11 (10)	2 (2)	10 (9)	5 (7)	9 (8)
Counsellor or Psychologist	9 (13)	9 (8)	4 (5)	7 (6)	2 (3)	5 (5)
Nurse	9 (13)	8 (7)	5 (6)	4 (4)	4 (5)	11 (10)
Student services	1	7	1	3	1	5
Year coordinator	5	4	1	2	2	2
Teachers						
Art	-	-	-	1	-	1
English	-	1	1	1	-	-
Form or home room	1	-	-	-	-	-
Health and sport	1	4	5	-	1	2
Teachers	8 (11)	14 (13)	5 (6)	11 (10)	11(15)	8 (7)
Science	-	-	1	-	-	-
(who is a) Smoker	-	-	-	-	-	2
Total nominations (%)	51 (72)	71 (64)	34 (40)	48 (43)	29 (40)	53 (49)

*students could nominate more than one person or role

Interview students were asked what proportion of students in their year group who smoke would talk to school staff (Table 17). The majority of participants from both intervention and comparison schools consistently thought that 'few or not many' students who smoked would talk to staff about changing their smoking status. Throughout the study, students attending comparison schools who thought that students who smoked would NOT speak to school staff increased from 14 per cent (n=10) in 2008 to 21 per cent (n=15) in 2010. Students attending the intervention schools who thought that students who smoked would NOT speak to school staff dropped from 21 per cent (n=21) in 2008 to seven per cent (n=8) in 2010.

Table 17 Proportions of students (that have smoked in the last 4 weeks) that would talk to school staff about changing their smoking status (interview item 9a)

Proportion of students who would talk to staff about changing smoking	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C (n=71) n(%)	**I** (n=110) n(%)	**C** (n=86) n(%)	**I** (n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Student unsure	2	9	4	3	3	4
A quarter	1	4	3	5	5	9
All of them	1	1	-	1	-	-
Few or not many	34 (47)	55 (50)	55 (64)	75 (68)	40 (55)	71 (66)
Half	14 (20)	16 (15)	13 (15)	14 (13)	9 (12)	14 (13)
Most	4	2	-	2	-	1
None	10 (14)	23 (21)	10 (12)	9 (8)	15 (21)	8 (7)
Three quarters	1	1	-	-	-	-

Additionally, for students who had friends that smoked, fewer intervention students said no students who smoke would talk to staff (Table 18).

Table 18 Student (friends smoke) estimates on the proportion of students that smoke that would talk to school staff about changing their smoking status (interview item 9a)

Proportion of students who would talk to staff about changing smoking	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C (n=42) n(%)	**I** (n=62) n(%)	**C** (n=40) n(%)	**I** (n= 72) n(%)	**C** (n= 27) n(%)	**I** (n= 46) n(%)
Few or not many	10 (24)	17 (27)	9 (22)	21 (29)	7 (26)	25 (54)
Half	4 (10)	1 (2)	5 (12)	2 (3)	4 (15)	3 (6)
None	4 (10)	2 (3)	5 (12)	2 (3)	6 (22)	4 (9)

Comparison (n) and intervention (n) are for students from these groups that reported having 'some' or 'all' friends that smoke.

Participants were probed for reasons to explain why students who smoke would speak to staff about changing their smoking status. Sub-themes for their responses included:

- desire to quit
- existing relationship with staff
- staff experience (helping others to quit, personal experience with smoking or quitting, professional training)
- for information (advice, health, referral), no one else or someone to talk to
- staff characteristics

These themes are demonstrated in the following quotes from students who were interviewed (Tables 19, 20, 21).

Table 19 Year 9 students (2008) give reasons why students in their year would talk to school staff

"They'd probably talk to a staff member because they **don't think they can trust anyone else**. Because with that sort of thing you want help but **you don't want the other person getting too involved** as if they know you or something … Parents … get really involved and they're going to be all over you … whereas with counsellors **they can still help you but they're not going to be over [you]** …" Yr 9 (2008) female student, intervention metro school, friends smoke
"Because **[the staff] care and they try and keep it as confidential** as they can and they want to try and find the best possible answer for you." Yr 9 (2008) female student, comparison metro school, friends smoke

Table 20 Year 10 students (2009) give reasons why students in their year would talk to school staff

"Because the staff would have **experience in [talking to kids about and handling those] kinds of situations**. They would give them **good information**." Yr 10 (2009) female student, comparison rural school
"Maybe because their friends have realised how much addiction they have had and they don't want them to get worse, they actually warn them that you should talk to someone and probably the **teachers are the safest person they could go to**, to talk to them about it." Yr 10 (2009) female student, intervention metro school, friends smoke

Table 21 Year 11 students (2010) give reasons why students in their year would talk to school staff

"Maybe they could be scared to confront their parents about [smoking], so I think it is just like **another opinion from an adult with less … harm [to the relationship]** … because it is like someone you are not related to. Yr 11 (2010) female student, intervention rural school
"Just because **they have all the facts** that everyone else doesn't really [have]. With the teacher it is a **bit more confidential**, like you don't have to see them all the time, like you see your friends all the time and they go, *'Why are you changing smoking or smoking less?'*". Yr 11 (2010) female student, intervention metro school

Objective 3 - Student awareness of availability and nature of pastoral care services

To determine if intervention students were more aware of the availability and nature of services provided by the pastoral care team than comparison students. (Student interviews)

Interviewed students were also asked about staff roles that provide health and student services at their school (Table 22). Nominations for Nurses rose from students attending intervention schools from 74 per cent (n=82) in 2008 to 87 per cent (n=94) in 2010. Comparatively, students attending schools not receiving the intervention nominations for Nurses as staff who provide pastoral care decreased from 91 per cent (n=65) in 2008 to 85 per cent (n=61) in 2010.

Interestingly, participant nominations for Chaplains as staff who provide pastoral care increased among students attending comparison schools from 56 per cent (n=40) in 2008 to 65 per cent (n=47) but experienced a slight decrease (1%) in nominations from students attending intervention schools. Student perceptions on Counsellors or Psychologists providing pastoral care rose slightly among students attending intervention schools (1%) between 2008 and 2010. During the same time, student perceptions decreased slightly (1%) between 2008 and 2010 for comparison schools.

Table 22 Student perceptions on health and student service providers at their school (interview item 12a)

Student perceptions on health and student services staff who provide pastoral care*	**Year 9, 2008** (n=181)		**Year 10, 2009** (n=197)		**Year 11, 2010** (n=179)	
	C (n=71) n(%)	**I** (n=110) n(%)	**C** (n=86) n(%)	**I** (n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Health services						
Dentist	1	-	-	-	-	-
Health services	1	1	3	2	-	-
Nurse	65 (91)	82 (74)	80 (93)	92 (82)	61 (85)	94 (87)
Student services						
Aboriginal education support staff	-	1	2	1	-	-
Chaplain	40 (56)	65 (59)	69 (80)	69 (62)	47 (65)	62 (58)
Counsellor or Psychologist	34 (48)	61 (55)	52 (60)	60 (54)	34 (47)	60 (56)
Student services	3	7	2	13	2	7
Year coordinator	27 (38)	35 (31)	43 (50)	48 (43)	28 (39)	41 (38)
Youth worker	-	-	-	-	1	1

*students could nominate more than one staff role

Interview participants were asked how pastoral care services helped students. The most common reason given from students was to "Talk with and listen to students", this perception increased by more than 20 per cent among comparison students from 35 nominations (49%) in 2008 to 54 nominations (75%) in 2010. Although 'Talk with and listen to students' remained the most common reason given from students attending intervention schools, the number of nominations decreased from 60 (54%) in 2008 to 56 nominations (52%) in 2010. A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 3).

Table 23 Student perceptions on how health and student services at their school help students (interview item 12b)

Student perceptions on the purpose of pastoral care services*	**Year 9, 2008** (n=181)		**Year 10, 2009** (n=197)		**Year 11, 2010** (n=179)	
	C (n=71) (%)	**I** (n=110) (%)	**C** (n=86) (%)	**I** (n= 111) (%)	**C** (n= 72) (%)	**I** (n= 107) (%)
Student unsure	10	13	5	10	6	10
Information and advice	10	17	11	2	-	-
Illness and injury services	18 (25)	17 (15)	31 (36)	39 (35)	27 (38)	35 (33)
Health promotion	4	5	5	6	1	3
Support students as needed	20 (28)	31 (28)	34 (39)	14 (13)	4 (6)	15 (14)
Behaviour management	-	2	-	-	-	-
Build relationships with students	2	-	-	-	2	7
Parent mediation	-	1	-	1	-	-
Talk with and listen to students	35 (49)	60 (54)	41 (48)	60 (54)	54 (75)	56 (52)
Unhelpful	-	-	-	1	-	1

*students could nominate more than one purpose

When asked about the availability of pastoral care staff (Table 24) the most common responses from participants were 'Anytime' and 'Out of class time (i.e. recess or lunch)'. A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 3).

Students were asked why they thought students would need pastoral care services. Common themes (Tables 25, 26, 27) for their responses included:

- relationship issues with other students, friends and/or family
- substance use
- mental health and emotional matters

A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 3).

Table 24 Student perceptions on the availability of health and student services at their school (interview item 12c)

Student perceptions on availability of pastoral care services*	**Year 9, 2008** (n=181)		**Year 10, 2009** (n=197)		**Year 11, 2010** (n=179)	
	C (n=71) n(%)	**I** (n=110) n(%)	**C** (n=86) n(%)	**I** (n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Student unsure	5	9	8	15	8	12
Available anytime						
Anytime	30 (42)	41 (37)	36 (42)	41 (37)	29 (40)	37 (34)
-Appointment	5	7	14	16	7	19
-In class time (with staff permission)	-	6	6	10	5	7
-Out of class time (i.e. recess and lunch)	14 (20)	22 (20)	17 (20)	29 (26)	19 (26)	17 (16)
-Permission staff (during class time)	-	-	1	-	-	-
-When pastoral staff available (i.e. on site/duty)	8 (11)	11 (10)	11 (13)	14 (13)	7 (10)	18 (17)
Rarely available						
Rarely available	2	2	2	7	4	11

*students could nominate more than one type of availability

Table 25 Year 9 students (2008) give reasons why students access pastoral care staff

"**Fights, disagreements with other students and bullying**. I don't think anyone would tell staff if they were smoking because … they don't want anyone to know apart from their friends…" Yr 9 (2008) male student (friends smoke), intervention metro school
"If they've got **family problems at home or problems with friends** or they're just **feeling down** because maybe a family member died or whatever." Yr 9 (2008) female student (friends smoke), intervention metro school
"The **nurse if you hurt yourself** if you are not feeling well, you can go there." *"What about any others?"* "You can see the **counsellor with a psychological problem**." *"Any other health services you are aware of, do you have chaplain? What could students see her for?"* "They could see her for a **chat to talk about school, home life, friends or any topic or discussion**." Yr 9 (2008) female student (friends smoke), comparison metro school
"Problems at **school, drugs and alcohol. Friends, teachers and parents and home** problems." Yr 9 (2008) female student (friends smoke), comparison metro school

Table 26 Year 10 students (2009) give reasons why students access pastoral care staff

"Most of [the students] see [pastoral care staff] about the school, like **bullying and teasing**. But most [students] would also see [staff] about **smoking, even though it's not a big thing**. Mainly bullying and teasing." Yr 10 (2009) male student, intervention rural school
"Everything I reckon. I don't think they would talk to them about drug use, but the **normal friend problems, family issues, arguments, fights, and maybe physical problems**. **Anything sexual they would probably talk to the nurse about.**" Yr 10 (2009) female student (friends smoke), intervention rural school
"I guess for the **nurse, health issues**. It would probably be **classroom issues for the Year Coordinators**, the **chaplain … [and] psychologist, problems they are having at home or bullying**." Yr 10 (2009) female student (friends smoke), intervention rural school
"… **most students if they have a problem they either go straight to a teacher**, or they talk to the student counsellors who are supposed to be like the student body or something." Yr 10 (2009) Aboriginal male student (student and friends smoke), comparison rural school
"Well, I know the **nurse … is more physical injuries**, or they have a cut or something… The **[psychologist] would be more emotional problems**." *"And what do you see the role of the chaplain?"* "I see the **chaplain** as someone who I think is more in general, like **if any students were to have any kind of problems, they would go to the chaplain**. I think his role is just overall looking after students." *"What about the **Year Coordinators** do you think they have a role in Health Services?"* "No… [they're role is] looking after students **academically**." Yr 10 (2009) male student, comparison metro school

Table 27 Year 11 students (2010) give reasons why students access pastoral care staff

"Just **general problems** that belong to the school society and relationships with friends, drugs, alcohol and different stuff like that." Yr 11 (2010) male student, intervention rural school
"You can see the school counsellor… [about] **family issues**." *"is there anything else?"* "You can talk to her about **anything**." Yr 11 (2010) female student (students and friends smoke), metro intervention school
"I think anything, people go there for **bullying** … for probably **smoking**. People go there if they have problems with their **family**, problems with their **friends**, just anything." Yr 11 (2010) female student (friends smoke), comparison metro school
"So, firstly the nurse, what kind of things could you go to him or her for?" "Probably if you are sick or something … Or **confidential stuff … like sexual activity and that sort of thing, personal things**." *"What sort of things would you go to the chaplain for?"* "If you were **feeling depressed or you want help** … or even **things to help you with your life** … anything really." Yr 11 (2010) female student, comparison metro school

Objective 4 - Student experiences accessing pastoral care services

To explore student perceptions of the types of pastoral care services available, to what extent such services were available, to what extent the services helped them or others and what other services did they and other students need. (Student interviews)

More than half of the students interviewed had experience accessing pastoral care services at their school for themselves or a friend (Table 28). For those students who had accessed the pastoral care services, issues around relationships (bullying and fighting) and mental health were the most common reasons for students seeing a staff member (Table 29). A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 4).

Table 28 Student experience with pastoral care services at their school (interview item 13a)

Students or their friends accessed pastoral care services	**Year 9 2008** (n=181)		**Year 10 2009** (n=197)		**Year 11 2010** (n=179)	
	C (n=71) n(%)	**I** (n=110) n(%)	**C** (n=86) n(%)	**I** (n= 111) n(%)	**C** (n= 72) n(%)	**I** (n= 107) n(%)
Experience accessing pastoral care staff	45 (63)	62 (56)	47 (64)	71 (64)	38 (53)	63 (59)
No experience accessing pastoral care staff	21 (30)	42 (38)	37 (43)	40 (36)	28 (39)	26 (24)
Student unsure	2 (3)	3 (3)	-	-	6 (8)	6 (6)

Table 29 Student nominations for reasons they or their friends accessed student services at their school (interview item 13a)

Reasons* students gave for accessing pastoral care services for themselves or their friends	Year 9, 2008 (n=181)		Year 10, 2009 (n=197)		Year 11, 2010 (n=179)	
	C (n=45) n(%)	**I** (n=62) n(%)	**C** (n=47) n(%)	**I** (n=71) n(%)	**C** (n=38) n(%)	**I** (n=63) n(%)
Behaviour						
Anger and behaviour management	1	-	3	1	-	1
Bullying	7 (16)	3 (5)	4 (8)	6 (8)	1 (3)	8 (13)
Disagreements and fighting	2 (4)	4 (6)	4 (8)	7 (10)	2 (5)	5 (8)
Emotional and mental health						
Emotional and mental health	3 (7)	3 (5)	4 (8)	6 (8)	3 (8)	5 (8)
Spiritual support	-	-	1	-	-	-
Puberty or physical matters						
Period	-	-	1	-	-	-
Teen pregnancy	-	-	1	-	2	-
Relationships						
Boyfriend or girlfriends	1	-	-	-	-	-
Family or home life	2 (4)	1 (2)	2 (4)	4 (6)	2 (5)	7 (11)
Friends	1	1	-	2	-	-
School life or career choices						
School or career choices	2	1	2	1	1	5
Substance use						
Alcohol	-	-	-	-	-	1
Cigarettes	2	1	1	1	-	-
Other drugs	-	1	-	-	-	-
Total nominations (%)	21 (47)	15 (24)	23 (49)	28 (39)	11 (29)	32 (50)

*participants could provide more than one response to this question
Comparison (n) and intervention (n) are for students from these groups that reported having had experience (or their friends did) with pastoral care services at their school.

Table 30 describes students' perceptions of the availability of pastoral care services to them. A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 4). When asked about the availability of pastoral care staff the most common responses from participants were 'Anytime' and 'Out of class time (i.e. recess or lunch)'.

Table 30 Student perceptions on the availability of health and student services at their school (interview item 12c)

Student perceptions on availability of pastoral care services*	Year 9, 2008 (n=181)		Year 10, 2009 (n=197)		Year 11, 2010 (n=179)	
	C (n=71) (%)	**I** (n=110) (%)	**C** (n=86) (%)	**I** (n= 111) (%)	**C** (n= 72) (%)	**I** (n= 107) (%)
Student unsure	5	9	8	15	8	12
Available anytime						
Anytime	30 (42)	41 (37)	36 (42)	41 (37)	29 (40)	37 (34)
-Appointment	5	7	14	16	7	19
-In class time (with staff permission)	-	6	6	10	5	7
-Out of class time (i.e. recess and lunch)	14 (20)	22 (20)	17 (20)	29 (26)	19 (26)	17 (16)
-Permission staff (during class time)	-	-	1	-	-	-
-When pastoral staff available (i.e. on site/duty)	8 (11)	11 (10)	11 (13)	14 (13)	7 (10)	18 (17)
Rarely available						
Rarely available	2	2	2	7	4	11

*students could nominate more than one type of availability

When students who had used their school's pastoral care services were asked about what they thought could be improved (Table 31), the most common theme in their responses was that 'nothing needed improving'. While the total number of interviewed students suggesting improvements in pastoral care services were required at their school was small, more intervention students than comparison student said there was nothing to improve in the pastoral care services at their school (Figure 5). A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 4).

Table 31 Student nominations for areas of pastoral care services needing improvement at their school (interview item 14a)

Areas of pastoral care services needing improvement	Year 9 2008 (n=181)		Year 10 2009 (n=197)		Year 11 2010 (n=179)	
	C (n=45) n(%)	**I** (n=62) n(%)	**C** (n=47) n(%)	**I** (n=71) n(%)	**C** (n=38) (n%)	**I** (n=63) n(%)
Student unsure	5	10	8	5	14	14
Nothing to improve	26 (58)	34 (55)	19 (40)	33 (46)	11 (29)	28 (44)
Staff characteristics	2 (4)	3 (5)	4 (8)	10 (14)	2 (5)	6 (9)
Student accessibility to staff	3 (7)	3 (5)	6 (13)	12 (17)	6 (16)	12 (19)
Support session	13 (29)	13 (21)	13 (28)	16 (22)	9 (24)	15 (24)

*participants could provide more than one response to this question
Comparison (n) and intervention (n) are for students from these groups that reported having had experience (or their friends did) with pastoral care services at their school.

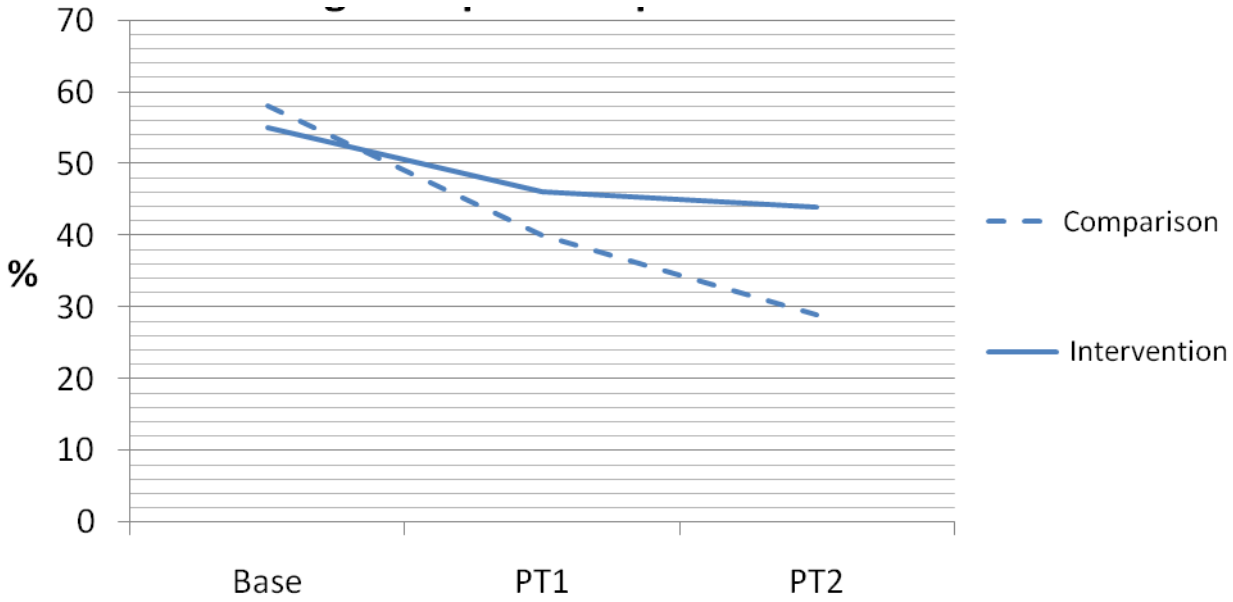

Figure 5 Nothing to improve in pastoral care services

The theme of improving the 'manner or characteristics of staff' providing pastoral care services is demonstrated in the following quotes (Table 32) from Year 9 students who were interviewed.

Table 32 Suggestions from Year 9 (2008) students for improving the *'manner or characteristics of staff'* providing pastoral care services

"If you are connected with them really well **you could easily tell them [what has happened]** with more [freedom] instead of being embarrassed … you could swear or let your anger out and tell them more specifically." *"Is that a trust thing?"* "Yes, **[getting to] know them over a period of time**..." *"So, it's just that sort of knowing people? You feel more comfortable."* "Yes." Year 9 male student (student and friends smoke), intervention rural school
"Probably a better tone [when speaking to students] … not like the teacher's tone that she usually uses. She should be not acting like a teacher but like **someone [a student] could trust**." Year 9 female student, intervention metro school
"**Supportive** things, like **information and listening** to them." Year 9 male student, comparison rural school
"**Understanding** from the staff member." Year 9 female student, comparison metro school

The theme of improving 'accessibility' to pastoral care staff is demonstrated in the following quotes (Table 33) from Year 10 students who were interviewed.

Table 33 Suggestions from Year 10 (2009) students for improving *'accessibility'* to pastoral care staff

"Probably **a bit more time** to sort [the matter] out, you can have **as many sessions [with the counsellor) as you want or need**." *"But did you have to pursue that? Did you want to pursue it or did you want them to follow you up?"* "I wanted to pursue it, but [the staff] asked, "Do you really need more time?" and stuff like that." *"And you think if they had been available more it would have been helpful?"* "Yes." Year 10 female student, intervention rural school
"Maybe in some classes you could have some **time to actually explain to the teacher and tell them what is going on** and stuff. [You] could write it down on a piece of paper and give it to the counsellor or something." Year 10 female student, comparison metro school
"Maybe if I had gone to my House Leader instead of breaking down in class. If I had just gone to him to start off with and said, 'Look I am having a few problems…'" *"Is there anything the school could have done to help, did you know you could have gone to the House Leader?"* "I **didn't know you could talk to the House Leaders for those reasons**, I just thought they were there for sport." *"OK, so if you were more aware … about who you can go to for what type of help?"* "Yes." Year 10 female student, intervention rural school
"Probably similar to before, if we knew where to go for these troubles. We don't really know much about counselling and things [at this school]." Year 10 female student, comparison metro school
"It is **very hard to get an appointment** to see the psychologist because she is not here most of the time." *"So she is very limited in her availability?"* "Yes." *"So improving, making her hours more flexible to students?"* "Yes." Year 10 male student, comparison metro school

The theme of improving 'pastoral care sessions' is demonstrated in the following quotes (Table 34) from Year 11 students who were interviewed.

Table 34 Suggestions from Year 11 (2010) students for improving '*pastoral care sessions'*

"I remember **the Deputy got involved and everyone got kind of scared off**, because they don't really need to get involved with that because like our Deputy just yells at us. **Getting [other] staff involved isn't good**, [it should be left] with the chaplain, the counsellor or the nurse." Year 11 female student, intervention metro school
"[My friend] had to go to see the student counsellor. When she got called up to go everyone in the classroom sort of knew why and so **it wasn't really that private**." *"OK, so what do you think they could have done."* "They could have let her know a different way, like maybe gone to her and talked to her … and then taken her." *"OK, something that was less obvious?"* "Yep." Year 11 female student, intervention metro school
"Maybe if they **got some of her friends involved**, or just got them to sit and talk with her." Year 11 female student, comparison metro school
"If I had the opportunity to **just talk to one person about it** [rather than in a group session] ... that way they can only focus on how you feel in your situation, I think that would be good." Year 11 female student, intervention metro school

Objective 5 - Pastoral care services to reduce harm from tobacco use

To explore student perceptions of the types of pastoral care services available, to what extent such services were available, to what extent the services helped them or others and what other services did they and other students needed to help them to reduce their harm from **tobacco use**. (Student interviews)

Students were asked what they thought students who smoked would need to reduce or quit smoking. Most student responses were related to information and advice about smoking (including quitting) and support to reduce smoking (Table 35). A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 5).

Table 35 Student thoughts on what students who smoke need to reduce or quit smoking (interview item 15a)

What* students who smoke need to reduce or quit smoking	Year 9, 2008 (n=181)		Year 10, 2009 (n=197)		Year 11, 2010 (n=179)	
	C (n=45) n(%)	**I** (n=62) n(%)	**C** (n=47) n(%)	**I** (n=71) n(%)	**C** (n=38) n(%)	**I** (n=63) n(%)
Student unsure	6	15	9	9	-	-
Information and advice						
Class lesson or school assembly	-	2	1	-	-	-
Consequences of smoking	7	13	7	6	6	5
Information and advice	33 (73)	46 (74)	31 (66)	40 (56)	15 (39)	31 (49)
Quit plan or strategies	12 (27)	15 (24)	10 (21)	8 (11)	5 (13)	4 (6)
- Incentives	-	2	-	-	-	2
- Nicotine patches	9 (20)	10 (16)	8 (17)	9 (13)	5 (13)	10 (26)
Referrals	6	5	8	5	6	2
Resources	9 (7)	16 (24)	8 (17)	21 (30)	3 (8)	13 (21)
Student character						
Student character	3	8	10	21	14	16
Support and encouragement						
Family	7	10	7	12	4	8
Friends	9 (20)	12 (19)	20 (43)	19 (27)	9 (27)	24 (38)
Others with similar experiences	4	5	2	5	-	-
School and staff	19 (42)	26 (42)	21 (45)	15 (21)	10 (26)	12 (19)
- Continued or regular contact	2	13	3	1	2	-
Someone to talk to	9	10	5	11	7	5
Support and encouragement	33 (73)	56 (90)	47 (100)	59 (83)	34 (89)	49 (77)

*participants who answered this question could nominate more than one strategy

Comparison (n) and intervention (n) are for students from these groups that reported having had experience (or their friends did) with pastoral care services at their school.

All students who smoked and had friends who smoke, that had accessed pastoral care services at their school suggested that information and advice and support and encouragement would help reduce smoking (Table 36). This finding varied slightly from students who didn't smoke, but their friends smoke (Table 36).

Table 36 What students with smoking experience think will help reduce smoking (interview item 15a)

Strategies that students that smoke (and their friends smoke) think will help reduce smoking	Year 9, 2008 (n=107)		Year 10, 2009 (n=118)		Year 11, 2010 (n=101)	
	C (n=2) n (%)	**I** (n=3) n(%)	**C** (n=1) n(%)	**I** (n=1) n(%)	**C** (n=2) n(%)	**I** (n=2) n(%)
Information and advice	2 (100)	3 (100)	1 (100)	1 (100)	-	2 (100)
Support and encouragement	2 (100)	3 (100)	-	1 (100)	2 (100)	2 (100)
Strategies that students that don't smoke (but their friends do) think will help reduce smoking	**Year 9, 2008** (n=107)		**Year 10, 2009** (n=118)		**Year 11, 2010** (n=101)	
	C (n=7)	**I** (n=8)	**C** (n=6)	**I** (n=9)	**C** (n=6)	**I** (n=13)
Information and advice	4 (57)	8 (100)	4 (67)	6 (67)	1 (17)	6 (46)
Support and encouragement	7 (100)	6 (75)	5 (83)	9 (100)	5 (83)	10 (77)

Comparison (n) and intervention (n) are for students from these groups with smoking experience that reported having had experience (or their friends did) with pastoral care services at their school.

Common themes are demonstrated in the following quotes from students who were interviewed. The theme of 'information and advice' as a strategy to reduce smoking is demonstrated in the following quotes (Table 37) from Year 9 students who were interviewed.

Table 37 Year 9 (2008) students with smoking experience talk about how 'information and advice' could help reduce smoking

"Lots of **support**, maybe a bit of a **schedule like how much to cut down on**. **[Make a quit]** plan." Year 9 male student (student and friends smoke), comparison metro school
"**Probably talking, sometimes pamphlets** so teachers can show you what will happen [when you smoke]." Year 9 Aboriginal female student (student and friends smoke), intervention rural school
"Some **good advice and the willingness to [quit]**." *And so the staff member would need to talk with them and how would they be best to talk with them?* "Probably like **one on one and be at their level**. **Talk to them like an adult**." *Do they need to be happy or serious?* "Serious but kind of happy and joking around as well." *What about information and pamphlets and setting goals and what of those sorts of things might be helpful?* "Just like the information they give you would be helpful I reckon." *How often do you think they need to see them?* "Probably once a week and see what their progress is like." Year 9 male student (friends smoke), intervention rural school
"Advice and **give them suggestions on how they could cut down or quit and offer them other services that they know of that could help them as well**." Year 9 female student (friends smoke), intervention metro school

The theme of 'information and advice' as a strategy to reduce smoking is demonstrated in the following quotes (Table 38) from Year 10 students who were interviewed.

Table 38 Year 10 (2009) students with smoking experience talk about how 'information and advice' and 'support and encouragement' could help reduce smoking

"Information about smoking or information and a picture that shows what smoking can do to you. Plus legal [information] … so if someone smokes and they are under age, then **it shows them how much trouble they can get in with the law**." Year 10 Aboriginal male student (student and friends smoke), comparison rural school

Table 39 continued

"Definitely **support from the teacher**. Like the teacher making sure how they are going and stuff and **maybe if the teacher has overcome smoking, some suggestions on how to get over it**." Year 10 male student (friends smoke), comparison rural school
"Probably a person they can trust. And a little routine like **activities, to distract them [from their cravings], other ways to cope with quitting**." Year 10 female student (friends smoke), intervention metro school
"I don't think pamphlets would help, **I think time would be better**." *Time talking with someone from within or outside of the school?* "I don't know, it depends on the individual person because **some people like to speak to people they know and some people like to speak to people they don't know**." Year 10 female student (friends smoke), intervention rural school
"Well, it depends on what kind of person you are. Most of the people I would know would just like the talking bit [instead of pamphlets]. Just to have **someone to encourage them to stop instead** of them [saying], "I am going to stop" and giving up [quitting] because there is no one behind them." Year 10 female student (friends smoke), intervention rural school

The theme of 'support and encouragement' as a strategy to reduce smoking is demonstrated in the following quotes (Table 39) from Year 11 students who were interviewed.

Table 40 Year 11 (2010) students with smoking experience talk about how 'support and encouragement' could help reduce smoking

"[Staff] would need to be supportive … be helpful to them and understanding as well. Just let them know **they are always there if [student] need to talk** or need anything." Year 11 female student (student and friends smoke), intervention metro school
"**Friends to back them up … supportive parents**. A strong motive, like a strong reason to quit. Because if there is no reason to quit, why would you? … I think **regular meetings with staff would help** just to check up." Year 11 male student (student and friends smoke), comparison rural school
"They need like **a friend with them** to approach someone who understands what they are going through." *So that is support, any information and that sort of thing?* "There is always information in the nurse's office in Student Services, but maybe **make it more available** so you don't have to go in there to get it." Year 11 female student (they don't smoke but their friends do), intervention rural school
"Well, I guess like to the student **it would be hard to go and approach staff about [smoking], because it would be like admitting you have the problem**. So, they would need **support from … their friends** and stuff." Year 11 female student (doesn't smoke but friends do), intervention metro school

Objective 11 - Student perceptions on the helpfulness of pastoral care services at their school

To determine if the intervention satisfied students who have given consent to be interviewed. (Student interviews)

Students who had experience (or their friends) accessing pastoral care services were asked how helpful they found their experience (Table 41). Almost all students found the pastoral care services helpful. However, satisfaction with the discussion with pastoral care services was lowest for Year 9 students. Overall, a greater proportion of students' reports from intervention schools indicated that they found their discussion with pastoral care staff to be helpful, than students attending comparison schools, at post test 2 (Figure 6). A detailed list of themes and sub-themes can be found in Appendix 39 (Objective 11). Common themes are demonstrated in the following quotes from students who were interviewed.

Table 41 Helpfulness of pastoral care services (interview item 13b)

Helpfulness* of pastoral care services	**Year 9, 2008** (n=181)		**Year 10, 2009** (n=197)		**Year 11, 2010** (n=179)	
	C (n=45) n(%)	**I** (n=62) n(%)	**C** (n=47) n(%)	**I** (n=71) n(%)	**C** (n=38) n(%)	**I** (n=63) n(%)
Student unsure	1	1	1	1	-	-
Helpful						
Discussion was helpful	39 (87)	53 (85)	45 (95)	69 (97)	34 (89)	63 (100)
Staff characteristics during discussion was helpful	24 (53)	35 (56)	31 (66)	34 (48)	25 (66)	39 (62)
Unhelpful						
Parental involvement was unhelpful	-	-	1	-	1	-
Staff characteristics during discussion was unhelpful	1 (2)	2 (3)	-	-	-	3 (5)
Discussion was unhelpful	1 (2)	-	1 (2)	-	3 (8)	9 (14)

*participants who answered this question could give more than one answer
Comparison (n) and intervention (n) are for students from these groups that reported having had experience (or their friends did) with pastoral care services at their school.

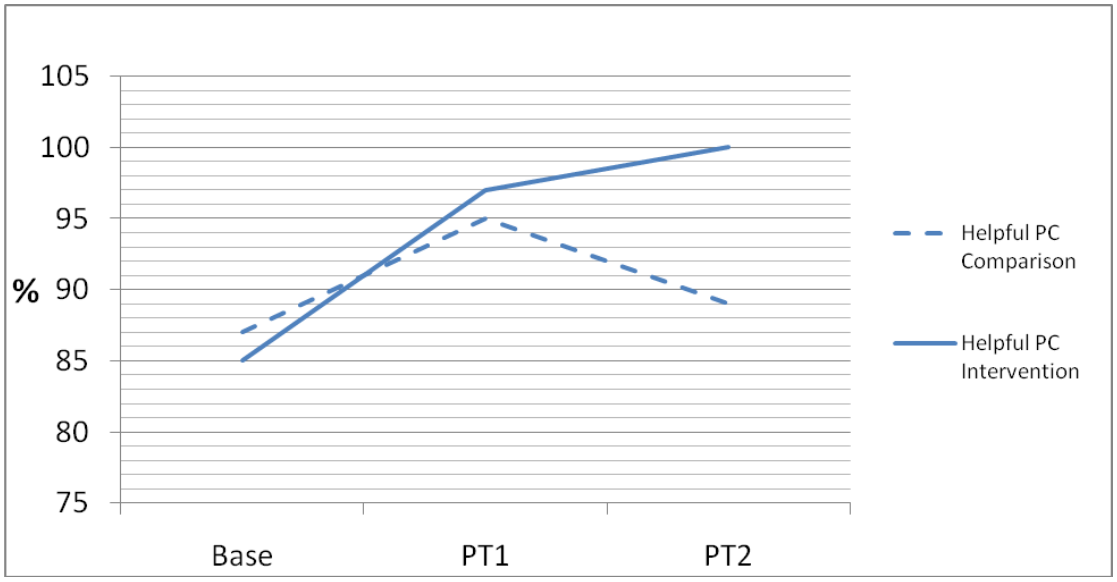

Figure 6 Helpfulness of Pastoral Care Services

Year 9 students describe how a discussion with pastoral care staff was helpful in the following quotes from students who were interviewed (Table 42).

Table 42 Year 9 students (2008) describe the helpfulness of pastoral care services at their school

"At the beginning of last year I was getting a bit bullied, I told one of my teachers and they told my house leader. **He came and talked to me and the person who was bullying me and it stopped**. So, he has helped quite a lot." Year 9 female student (friends smoke), intervention rural school
"My friend got to go to the smoking class and **I think she is not smoking as much**." Year 9 Aboriginal male student (friends smoke), comparison rural school
"I have a friend who is suffering from depression and **she's a lot happier now** 'cos she went to the counsellor." Year 9 female student, intervention metro school
"My friend goes to counselling and whenever she comes back she **seems happy and like she has got everything off her chest** and stuff." Year 9 female student, comparison metro school

Year 10 students describe how a discussion with pastoral care staff was helpful in the following quotes from students who were interviewed (Table 43).

Table 43 Year 10 students (2009) describe the helpfulness of pastoral care services at their school

"They are there to talk to and they are understanding. And they like **open your eyes to what you are doing** and stuff." Year 10 female student (student and friends smoke), intervention metro school
"They **give you some advice on how to deal with that issue**, or they point you in the right direction." Year 10 female student, intervention rural school
"… it is **easy to tell your problems** [to the psychologist] so you can figure out what you might be able to do to try and **forget about what is going on in your mind**." Year 10 female student, comparison rural school

Year 10 students describe how a discussion with pastoral care staff was helpful in the following quotes from students who were interviewed (Table 43).

Table 44 Year 11 students (2010) describe the helpfulness of pastoral care services at their school

"They **helped me get through a tough time** with my family. I have always got permission, if I get upset in class to just walk out … When the incident first happened I could come [into the health or student services centre] whenever I wanted to be alone. It was good." Year 11 female student (friends smoke), comparison metro school
"[You can] just talk to them. My mate was going through a rough patch, she has lost a family member and **it made her feel at ease and more relaxed**." Year 11 female student (student and friends smoke), intervention rural school
"The **nurse and the chaplain have helped me by giving me ideas and talking to me** … I would hold [what was going on] in and it would build up. And they helped me by talking to me and **keeping it to themselves without telling anyone** ..." Year 11 female student, intervention rural school
"They like **listen to the problems that I have**." Year 11 male student, comparison metro school

4.5 Staff response rates

Data were collected 59 staff at 13 intervention schools who had attended a KIT-Plus training in 2008 or 2009 (Table 45). A further 5 people attended the training but did not participate in the evaluation. Between two and eight staff from each school attended the two-day KIT-Plus training.

Table 45 Staff data collection response rates

	Staff Survey		**Logs**					**Discussion/Interview**		
	Pre-	Post-	1st	2nd	3rd	4th	5th	1st	2nd	3rd (online)
Staff completions TOTAL	59	34	50	42	31	23	3	55	49	30
	100%	58%	85%	71%	53%	39%	5%	93%	83%	51%
Staff completions Metro schools (n=7 schools)	26	11	26	19	15	12	3	25	23	12
	100%	42%	100%	73%	58%	46%	12%	96%	88%	46%
Staff completions Regional schools (n=6 schools)	33	23	24	23	16	11	0	30	26	18
	100%	70%	73%	70%	48%	33%	0	91%	79%	55%

4.6 Characteristics of staff

Participating school staff worked in the following roles (staff could nominate more than one role):

14 classroom teachers

18 year/house leaders

3 teacher assistants

3 school nurses

6 school chaplains

2 school psychologists

5 student services managers

2 Aboriginal and Islander Education Officers

2 Head of Department/Learning Area

3 specialist program coordinator/youth worker

1 deputy principal

More than half of the participants were female (59%) and almost half (49%) of the group were aged less than 40 years. Eighty percent of the staff had been employed in their current school for five years or less.

4.7 Findings of the study – school staff data

The study objectives addressed in these preliminary analyses of staff data are:

Objective 6 To explore intervention group staff perceptions of their satisfaction with and use of the intervention, and what else they perceived they needed in a pastoral care program to reduce secondary students' harm from tobacco. (Pastoral Care Team staff survey and staff interviews)

Objective 7 To determine if intervention schools had developed and implemented a plan for the delivery of pastoral care services that offered support for students to quit, reduce or not start smoking.

Objective 8 To determine if intervention group pastoral care staff believed the capacity building intervention helped them to engage with greater numbers of vulnerable students and more often, and that during these sessions they felt more confident and capable to deal with/prevent student problems than did comparison pastoral care staff. (Pastoral Care Team staff survey and staff interviews)

Objective 9 To determine if intervention group pastoral care staff, principals, and education policy makers perceived the intervention to be an effective means of both strengthening the skills and capacity of pastoral care staff and providing them with improved support resources, to enable

them to play a more active role in behaviour management, particularly tobacco use cessation. (PCT staff survey / interview, School principal interview, stakeholder interview)

Objective 10 To determine if the pastoral care intervention was sustainable. (SDERA interview)

Objective 6 – Satisfaction with and use of the KIT-Plus intervention

To explore intervention group staff perceptions of their satisfaction with and use of the intervention, and what else they perceived they needed in a pastoral care program to reduce secondary students' harm from tobacco. (Pastoral Care Team staff survey and staff interviews)

Of the 59 staff who attended the training, all responded positively to the training and resources provided to them. The 55 staff who completed a four week follow-up interview and coaching session were satisfied with the intervention. Most staff reported the strategies were helpful when discussing issues with students (84% of the 45 staff who returned their first log record sheet). All 45 staff who returned a log record three months after the training had used at least one of the KIT-Plus strategies in an interaction with a student.

At one month follow-up to training, staff reported the KIT-Plus training:

- Was very informative, useful, worthwhile and highly relevant
- Was a good motivator to take action when they got back to school
- Reinforced what many were already doing but the KIT-Plus strategies gave them a structured framework to use which they thought was very beneficial
- Made them feel more confident and skilled to deal with students' drug-related issues
- Was a good opportunity for them to network with staff from their own school as well as other schools
- Provided them with practical and easy information
- Provided them with strategies which were also applicable to other areas of their teaching or life in general and that;
- The small group interactions were useful for their learning

Approximately 90% of staff replying to the online survey selected an electronic newsletter as their preferred other need in addition to the KIT-Plus training, preferring this resource over online training (favoured by 46%) online discussion forum (14%) networking event (58%), curriculum training (64%), and advanced motivational interviewing course (57%). Table 46 provides an overview of staff feedback on their use of KIT-Plus.

Table 46 Staff feedback on their use of KIT-Plus

	Data source	Number of respondents*	Response	% of respondents
Satisfaction with KIT-Plus				
Strategies (see Table 47)	Interview 1	55	Strategies are helpful	100%
Strategies - How discussion went with students (see Table 48)	Log 1	45	Very satisfied Moderately satisfied	16% 68%
Strategies - How discussion went with students:	Online survey	30		
- "Student was comfortable talking with me"			All conversations Most conversations	38% 58%
- "I was not lecturing "			All conversations Most conversations	57% 44%
- "I was not judgemental"			All conversations Most conversations	54% 38%
- "I felt I provided all I could for the student"			All conversations Most conversations	48% 44%
Training – Training was helpful to talk over issues with students	Log 1	45	Very helpful Moderately helpful	37% 48%
Follow-up discussion	Post-test survey	34	Very helpful Somewhat helpful	21% 59%
Use of the intervention				
KIT-Plus strategies used	Log 1	45		
Motivational Interviewing			Strategy used	73%
LATE			Strategy used	82%
Drug Triangle			Strategy used	57%
Other			Strategy used	42%
Other needs				
Training	Post-test survey, Online survey		See common responses in Table 48	
Resources and information				
Networking with other schools				
Funding				

*Total number of staff trained, n=59

Staff satisfaction with KIT-Plus strategies

Overall, staff reported being satisfied with the KIT-Plus intervention (Table 47) at the 9 week follow-up to the training.

Table 47 Staff describe how using KIT-Plus strategies increases their confidence in supporting students

… it **focuses on students** so that you are **asking pertinent questions**.
It helps me to feel like **I have a skill, a tool**, and I can use that and it might help and sometimes the child is still not even wanting to make a change. **It certainly helps me** and I need to use that with the kids, but **it helps me personally as a professional to feel that I know I am hopefully doing the right thing**.
The main way [KIT-Plus strategies help] is that **it gives me direction**. **[The conversation] is natural with the kids** … it just flows.
I am **getting information better**. I am **getting a better response from the students** …
Your time is better used because you have got a model to work with. **You can go straight [to the point]** rather than … flounder around. [The model helps] … to **organise things in your head**.
I think because it is helping, **it always makes you seem more professional**.
It is probably because you have just got that [KIT-Plus] background and it is more about your **confidence**.
You come across confident and you know where it is going, and I think that puts [the student] at ease. **You are not being nosy, you are not there to judge, and they pick it up straight away**.

Staff satisfaction with KIT-Plus strategies

When asked how happy they were with how the discussion progressed, staff again reported being satisfied with the KIT-Plus intervention (Table 48) at the 9 week follow-up to the training.

Table 48 Staff describe how using KIT-Plus strategies facilitates positive discussions with students

Actually very happy. I can't say the outcome was totally positive, but I do know that **it has kept the door open for them to come back because it wasn't about condemning, or saying what [the student] was doing is wrong.**
It was **non-confrontational** … as soon as they recognised that the [discussion] is not about the fact they are using [drugs], **it is about why they are using [drugs]**. Then it was **a very unguarded discussion** … compared to what it could have been.
It has been helpful because I have got the sheet of paper in front with all the models on there and it is just, every now and then I have a look at it and **it gives me ideas on how to talk with students and help the process** …

Common themes for other pastoral care needs for staff from staff post-test survey and online survey

When asked what else was needed in a pastoral care program to reduce secondary students harm from smoking, common themes from staff included:

- Training
- Networking with other schools
- Funding for teacher relief
- Resources and information

The following quotes from staff provide suggestions for future program development (Table 49).

Table 49 Staff suggestions for KIT-Plus training and resource development

Area of need	Suggested strategies
Training	• "Spreading the training across 3 full days rather than 2." • "Providing more training around referral and actions to take after discussions particularly when there is a lack of services within the school." • "Training more staff within their school to increase support to address drug use/pastoral care issues at a whole-school level." • "Revisit the training." • "Skill practise on motivational interviewing." • "More of the same and updated training on everything covered."
Networking with other schools	• "For staff who attend the training by themselves, pairing them up with someone from another school to provide them with collegial support and discuss progress with using the training strategies" • "It would have been good to 'buddy' with another person from a different school and share experiences. I am the only person at my school using the KIT-Plus strategies. Apart from the phone calls, it's hard to judge how I am going."
Funding for teacher relief	• "More funding to provide staff with the time to develop of a school drug policy (whole-school action)." • "Lack of time to complete KIT-Plus surveys, telephones discussions etc." • "Lack of time to discuss the KIT-Plus training with other staff as there is so much happening at the school." • "[More] funding to cover teacher relief."
Resources and information	• "Resources on: adolescent drug use statistics, more general information (books etc), motivational interviewing, outside agencies [for referral] and information on 'where to now ideas and time frame [on when] to reconnect with that student'." • "Information on how to promote the KIT-Plus training to the school principal." • "Not enough collaboration between teachers and nurses/student services team."

Objective 7 – Whole-school action plans

To determine if intervention schools had developed and implemented a plan for the delivery of pastoral care services that offered support for students to quit, reduce or not start smoking.

Examples of whole school strategies reported by staff attending the KIT-Plus training are presented in Table 50.

Table 50 Staff reports on ways they used KIT-Plus strategies at their school (online survey Q19)

[In the process of] **re-establishing, health and wellbeing committee**.
Used in **dealing with SAER** [students at educational risk].
Mainly to get students switched back onto school. **I spoke to a student using these strategies and she has returned to school fulltime and is doing well**.
Took the information to the **staff meeting** once, but have been unable to implement it further due to other distractions within the school.
[Used in building] **community links, parent engagement, and pastoral care activities**.

While only 32% of staff who responded to the post test survey reported involvement in whole school actions, 85% reported their school offers support services for students to reduce smoking. The difficulty schools face in providing services that are helpful for students is demonstrated in only 58% of staff reporting the services provided at the school are helpful.

Table 51 Staff responses on using KIT-Plus to develop whole school activities

Whole-school activity	Data source	Number of respondents	Response	% of respondents
School KIT-Plus action plan developed at training	Project records	13 schools	Yes	46% (6 schools)
Whole school actions from KIT-Plus training	Post-test survey	35	Involved in whole school action	32%
Discussed KIT-Plus content with other staff	Online survey	30	Yes	41%
Involved in whole school action	Online survey	30	Yes	31%
School offers support services to help students to reduce smoking:	Post-test survey	34		
- Offered to students			Yes	85%
- Used by students			Yes	62%
- Services are very helpful			Yes	9%
- Services are moderately helpful			Yes	49%

Objective 8 – Staff confidence and skills to work with students and their problems

To determine if intervention group pastoral care staff believed the capacity building intervention helped them to engage with greater numbers of vulnerable students and more often, and that during these sessions they felt more confident and capable to deal with/prevent student problems than did comparison pastoral care staff. (Pastoral Care Team staff survey and staff interviews)

When staff responded to questions about their interactions or discussions with students in their log records, in 97% of interactions staff felt confidant talking with the students. In 95% of the interactions they reported they had enough knowledge when talking with students. The KIT-Plus strategies most used by staff in their interactions were the LATE model (79% of interactions), motivational interviewing (73%) and the drug triangle (61%) (Table 52).

Of the 34 staff who returned a post-test survey, 77% reported they were more confident to talk with a student about drug-related issues than before the KIT-Plus training and 23% felt about the same confidence as before the training. Additionally, 85% reported they felt more skilled.

Table 52 Staff reports on interactions with students

Engagement with vulnerable students reported in log records	Number of interactions between staff and students*	% of 'yes' responses about students
During interaction with students:		
Talked about tobacco	208	65%
Talked about alcohol	236	72%
Talked about other drugs	212	67%
Characteristics of students:		
Male	324	46%
Female	324	46%
Both males and females in a group	324	7%
ATSI	318	13%
Details of student discussion:		
Length of discussion was 15 minutes or less	320	45%
Group discussion	323	27%
Single student	318	73%
Student initiated discussion	318	44%
Staff initiated discussion	318	36%
Student referred by another teacher	318	20%
KIT-Plus strategy used:		
Motivational interviewing	222	73%
LATE	247	79%
Drug Triangle	210	61%
Other	124	36%
Staff perceptions of discussion:		
Staff felt they helped the student in some way	303	94%
Staff felt confidant when talking with the students	306	97%
Staff felt they had enough drug-relate knowledge when talking with the students	288	95%
Staff felt they could talk easily with students	306	96%

*Data recorded in log sheets by 45 school staff who attended the KIT-Plus training

Objective 9 – Staff satisfaction with the KIT-Plus intervention

To determine if intervention group pastoral care staff, principals, and education policy makers perceived the intervention to be an effective means of both strengthening the skills and capacity of pastoral care staff and providing them with improved support resources, to enable them to play a more active role in behaviour management, particularly tobacco use cessation. (Pastoral Care Team staff survey and staff interviews)

Examples of how the KIT-Plus intervention has strengthened the skills and capacity of pastoral care staff are listed below. Staff reported using KIT-Plus training in the following situations (Table 53):

- Pastoral care or students
- Classroom
- Personal life
- With other staff
- With parents

Table 53 Areas staff reported using skills obtained through KIT-Plus training (online survey Q15)

Area	Staff experience of using KIT-Plus strategies
Pastoral care	• "Other pastoral care issues relating to social and emotional problems that students present with." • "It makes me feel that I am doing the right thing even if other staff make me feel like I should not get involved and that does happen but I'm not sure why, [their] ignorance I guess." • "I am more likely to raise the subject of drugs and alcohol use with a student." • "Talking to students about behavioural issues." • "Not just use these skills for drug use, but behaviour issues."
In the classroom	• "Classroom strategies/interactions."
Personal life	• "Personal life, [with] family members." • "I am no longer judgemental."
With other staff	• "Encouraged other staff members at the school to approach conversations using some of the techniques shown." • "[Supporting] with staff that have issues with students."
With parents	• "In any confidential meetings between parents and students or just students these strategies are excellent." • "Use the models with parents as well to demonstrate how they can view a situation possibly a bit differently."

See also Appendix 40 for a full list of comments from KIT-Plus trained staff on the strengths, weaknesses and recommendations for the KIT-Plus intervention.

Objective 10 – Sustainability of the KIT-Plus intervention

To determine if the pastoral care intervention is sustainable. (SDERA uptake)

Both CHPRC and SDERA have used the findings of the KIT-Plus research project to strengthen existing programs delivered to schools to promote the health and wellbeing of young people.

5. EFFECT OF RESEARCH ON PROFESSIONAL DEVELOPMENT

This project has provided training opportunities for a significant number of CHPRC staff and students and at Edith Cowan University.

The Project Director has developed project and personnel management and financial skills as she has overseen the implementation of this project according to the objectives of the research.

This project has also provided many student volunteers and research assistants with opportunities to develop their skills on a range of tasks including labelling and packing questionnaires, preparation of questionnaires for data entry, administration of student questionnaires, one-on-one student interviews, qualitative analyses and general administrative tasks.

In 2010, a second year ECU student completed a 60 hour placement (one day per week over 8 weeks) on the KIT-Plus Project data. During this time she used NVivo to thematically analyse student responses from student interviews conducted 2008-2010 on *Why and how many young people their age they thought smoked cigarettes, drank alcohol and used other drugs*. The student's work provided the basis of the report included at Appendix 41.

In 2008, a Masters student (Kaashifah Bruce) commenced her research utilising the staff data collected as part of this study. Her research, exploring the characteristics of staff who implement the strategies of the KIT-Plus intervention, has continued into 2009 and 2010 and will be completed in 2011. Ms Bruce's Candidacy presentation is included in this report at Appendix 42.

Importantly, this study has built the capacity of 64 secondary school teachers and staff to enhance their pastoral care skills to deliver early intervention for young people concerning drug use issues. The feedback from these teachers on all aspects

of the intervention has been promising. The following unsolicited feedback from rural and remote school administrators specifically about the training supports the important effect this research project has had on rural/remote schools.

Table 54 School administration feedback about the effect of the KIT Plus training on their staff

"Just some important feedback for you – the PD offered to our teachers a few weeks ago at XXXX SHS was one of the most engaging forums that the Teachers involved have experienced. They have come away with some new thinking and are very enthusiastic about their work ahead. Congratulations for developing such a meaningful experience." XXXX Principal
"I spoke with the Deputy XXXXX on the weekend who said that the teachers were all raving about the fantastic PD – the best they have ever done – and still filled with enthusiasm when they returned to school. She said it was amazing to hear all the plans they have."

6. IMPLICATIONS FOR HEALTH PROMOTION / TRANSLATION OF RESEARCH INTO PRACTICE

The study supports the importance of expanding the traditional pastoral care team in schools and strengthening their capacity. The student interviews indicated that students were more inclined to approach a staff member based on their characteristic traits rather than their position in the school. Students also approached staff because they were available, would listen, and presumed he/she possessed knowledge on the topic and on how to help them. Therefore, this data indicates that all staff are in a position to implement and sustain school health programs that have a pastoral care approach, and their increased capacity to communicate with students may have a positive effect on youth tobacco control.

The KIT-Plus Research Project has the potential to significantly impact on these factors in a positive way by:

- Determining strategies which assist schools in making it easier for students to approach staff if they have a concern about smoking;
- Determining which characteristics have the greatest impact on staff approachability;
- Determining strategies which enable schools to facilitate positive behaviour in students;
- Further exploring the role pastoral care teams play in adolescents' health;
- Demonstrating strategies which develop pastoral care teams' skills to respond positively to interactions with students; and
- Determining the role of health or student services provided by schools as perceived by students.

This research project has reached six rural/remote schools. Successful aspects of intervention implementation in these locations will be important for future capacity building programs in similar schools.

The KIT-Plus Research Project is a partnership between CHPRC researchers and SDERA practitioners. SDERA is the leading group delivering drug education training and resources to staff in Western Australian schools. The results of this research can provide direction for the planning and development of services provided by SDERA.

The KIT-Plus Research Project in 2008, 2009 and 2010 has built the individual capacity of early career researchers, school staff and SDERA staff. Organisational capacity has been developed in schools, SDERA, and the CHPRC.

The partnership between CHPRC and SDERA in this research project facilitates the translation of research into practice. For example, the recruitment of approachable staff and the importance of assessing school capacity to implement KIT-Plus strategies and using a capacity building framework to plan for implementation is being put into practice in KIT trainings. Preliminary findings of the research have been presented to National School Drug Education Strategy stakeholders Australia-wide (Appendix 43). Furthermore, school nurses are being informed about the findings of the *Strengthening Pastoral Care to Reduce Secondary Students' Harm from Tobacco Project,* by Sharon McBride from the Department of Health's Children and Adolescent Health Service (KIT-Plus Associate investigator) in order to influence practice.

7. COMMUNITY BENEFITS FROM THE RESEARCH

This study is one of the first longitudinal research projects to specifically target school staff nominated by students as people they would approach to discuss personal issues. In 2008 and 2009, these selected staff received Keeping in Touch training to develop their understanding of the impact they can have in reducing smoking and other drug use behaviours amongst Western Australian adolescents.

This study has also provided a means of encouraging school staff and students to play an active role in the prevention and reduction of smoking and other drug use, through user friendly materials and accessible and effective professional development.

Future benefits of this study include:

- Improving schools' and the community's knowledge of smoking and other drug use intervention program planning, dissemination, implementation and evaluation;
- Improving schools' capacity to implement health promotion programs that address smoking and other drug use at a whole-school level; and
- Ultimately, improving the academic achievement (e.g. improved attendance), mental, social and physical health of young people.

8. PARTNERSHIPS

This study has facilitated a mutually beneficial partnership between the Child Health Promotion Research Centre (CHPRC) at Edith Cowan University, the Western Australian Department of Education (DoE) and School Drug Education and Road Aware (SDERA). The partnership formed through this project has already led to joint CHPRC and SDERA professional development workshops for intervention school staff related to drug use reduction and management. The results presented in this report were shared with these partners at the KIT-Plus Investigator meeting held on 28 August 2009 (Appendix 44). A further meeting is planned for 2011 to discuss the translation of these findings into meaningful practice for all education systems and sectors in WA.

The advisory committee established for the Tobacco Capacity Research Development Project has contributed to this study. This group comprises representatives from the Department of Education WA, School Drug Education and Road Aware and the Department of Health. This advisory committee provided input into the design of the intervention and represent a large number of Western Australian school-based organisations who have the potential to translate the findings of this study into future policy and practice.

9. PUBLICATIONS AND SEMINARS

A systematic plan for dissemination of this project's findings in association with key collaborators in School Drug Education and Road Aware and the Department of Education and Training has commenced and will be further developed throughout 2011. The successful components of this project can be incorporated into the already established *Keeping in Touch* resource. The results of the study will be disseminated to all participating schools and will be made available to other interested groups via public forums, local media, conference presentations, project reports and research papers in peer-review journals.

To date, two oral presentations and one poster presentation have arisen from this research project.

Hall, M. (2008). KIT-Plus Research Project. Presentation to the National School Drug Education Strategy stakeholders meeting, Perth, WA. 13 November 2008 (Appendix 43). Oral presentation (30 minutes)

Bruce, K., & Hall, M. (2009). Factors influencing teachers' implementation of a pastoral care program to reduce students' harm from tobacco. Australian Health Promotion Association 18th National Conference: Make health promotion a priority: Evidence, advocacy & action. Perth, WA. 17-20 May 2009. Poster presentation. (Appendix 45)

Coe, C., Bruce, K., & Hall, M. (2009). The KIT-Plus Research Project: Meeting the challenge of school-based activities for drug use prevention and intervention. Alcohol and Drug Foundation Queensland (ADFQ) 2009 Australian Winter School Conference. Brisbane, Queensland. 25-27 May 2009. Oral presentation (30 minutes) (Appendix 46)

A summary of the progress of the KIT-Plus Research project was provided to the School Drug Education and Road Aware partners in 2010 for inclusion in their August 2010 Newsletter and also in the SDERA 2010 annual report. Further promotion of the project has arisen from articles published in the ECU publication *Cohesion* in 2008 and 2009.

For 2011, abstracts for two oral presentations on the KIT-Plus Research Project at the Australian Health Promotion Association 20th National Conference in April 2011 in Cairns, Queensland have been accepted for Hall, Coe and Paki (Appendix 47) and Bruce (Appendix 48).

What Students Tell us About 'Keeping in Touch' to Reduce Smoking, Drinking and Drug Use, will present findings from student data collected over the three years of the KIT-Plus Project.

Case studies investigating the factors influencing school staff's implementation of an adolescent drug-use prevention program, will present case studies for three of the KIT-Plus intervention schools.

A further abstract for an oral presentation by Kaashifah Bruce (Appendix 49) has been accepted by the Australian Drug Foundation's 6th International Conference on Drugs and Young People in May 2011 in Melbourne.

The project investigators will take advantage of future opportunities to present on the KIT-Plus Research Project as they arise, and are planning for publications, including journal articles for peer-reviewed publications, after further analyses have been conducted in 2011.

10. REFERENCES

Abba, K. (2001). A review of drug prevention work and its evaluation in Stockport. Retrieved 01/10/2009, from www.cph.org.uk/showPublication.aspx?pubid=34

Allensworth, D., & Bradley, B. (1996). Guidelines for adolescent preventative services: A role for the school nurse. *Journal of School Health, 66*(8), 281-283.

Aloise-Young, P., Hennigan, K., & Graham, J. W. (1996). Role of the self-image and smoker stereotype in smoking onset during early adolescence: a longitudinal study. *Health Psychology, 15*(6), 494-497.

Ayres, P., Dinham, S., & Sawyer, W. (2000). *Successful senior secondary teaching*. Canberra: The Australian College of Education.

Balch, G. I. (1998). Exploring perceptions of smoking cessation among high school smokers: Input and feedback from focus groups. *Preventive Medicine, 27*, A55-A63.

Barnes, M., Courtney, M. D., Pratt, J., & Walsh, A. M. (2004). School-Based Youth Health Nurses: Roles, Responsibilities, Challenges, and Rewards. *Public Health Nursing, 21*(4), 316-322.

Begg, B. (1999). Developing resilient school communities. *Learning Matters, 4*(1), 17-20.

Benard, B. (1996). From research to practice: the foundations of the resiliency paradigm. *Resiliency in action, 1*(1), 1-6.

Best , R. (2002). Pastoral care & personal-social education: A review of UK research undertaken for the British Education Research Foundation. Retrieved 05/10/2009, from http://www.ttrb.ac.uk/browse2.aspx?anchorId=17790&selectedId=17983&menu=17837

Beyers, J. M., Toumbourou, J. W., Catalano, R. F., Arthur, M. W., & Hawkins, J. D. (2004). A cross-national comparison of risk and protective factors for adolescent substance use: the United States and Australia. *Journal of Adolescent Health, 35*(1), 3-16.

Bonaiuto, M. (2007). School nurse case management: Achieving health and educational outcomes. *The Journal of School Nursing, 23*(4), 202-209.

Bradley, B. J. (1997). The school nurse as health educator. *Journal of School Health, 67*(1), 3-8.

Brendtro, L. K., & Larson, S. (2004). The resilience code: finding greatness in youth. *Reclaiming Children and Youth, 12*(4, Health Module), 194-200.

Buckley, E., & White, D. (2007). Systematic review of the roles of external contributors in school substance use education. *Health Education, 107*(1), 42-62.

Cahill, H., Wyn, J., & Shaw, G. (2004). Section 5: Literature review. In *Translating caring into action: an evaluation of the Victorian Catholic Education Student Welfare Professional Development Initiative* (pp. 29-40). Melbourne: Australian Youth Research Centre, The University of Melbourne.

Caldart-Olson, L. (2007). Strenghtening the school nurse role. *NASN School Nurse, 22*(6), 6-7.

Cameron, R., Brown, S., Best, A., Pelkman, C., Madill, C., Manske, S., et al. (1999). Effectiveness of a social influences smoking prevention program as a function of provider type, training method, and school risk. *American Journal of Public Health, 89*(12).

Chassin, L., Presson, C. C., Sherman, S. J., & Edwards, D. A. (1990). The natural history of cigarette smoking: Predicting young-adult smoking outcomes from adolescent smoking patterns. *Health Psychology*, 701-716.

Child Health Promotion Research Centre. (2007). *Optimising school nurse involvement in youth based tobacco control programs: Formative Report*. Perth: Edith Cowan University.

Cleveland, H. H., & Wiebe, R. P. (2003). The moderation of adolescent-to-peer similarity in tobacco and alcohol use by school levels of substance use. *Child Development, 74*, 279-291.

DeBell, D., & Everett, G. (1998). The changing role of school nursing within health education and health promotion. *Health Education, 3*, 107-115.

Department of Education and Training. (2005). Caring for our children - exploratory research into pastoral care in Western Australian public schools. Retrieved 05/10/2009, from http://bswb.det.wa.edu.au/content/pastoral-care-extra-curricular-activities/caring-for-our-children-2013-exploratory-research-into-pastoral-care-in-western-australian-public-schools

Department of Education Science and Training. (2004). *Principals for school drug education*. Canberra: DEST.

Department of Education Science and Training. (2007). *National School Chaplaincy Programme*. Canberra: DEST.

Doll, B., & Lyon, M. (1998). Risk and resilience: implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*, 348-363.

Doll, B., & Lyon, M. A. (1998). Risk and resilience: Implications for the delivery of educational and mental health services in schools. *School Psychology Review, 27*(3), 348.

Downie, J., Chapman, R., Orb, A., & Juliff, D. (2002). The Everyday Realities of the Multi-Dimensional Role of the High School Community Nurse. *Australian Journal of Advanced Nursing, 19*(3), 15-24.

Edmonds, K., Sumnall, H., McVeigh, J., & Bellis, M. (2005). *Drug prevention among vulnerable young people*. Liverpool: National Collaborating Centre for Drug Prevention.

Engels, R. C., Knibbe, R. A., de Vries, H., & Drop, M. J. (1998). Antecedents of smoking cessation among adolescents: Who is motivated to change? *Preventive Medicine, 27*, 348-357.

Eureka Strategic Research. (2005). *Youth Tobacco Prevention Literature Review*. Canberra: Department of Health and Ageing.

Evans, D., Powers, A., Hersey, J., & Renaud, J. (2006). The influence of social environment and social image on adolescent smoking. *Health Psychology, 25*(1), 26-33.

Fagan, R. (1995). Health of the Nation targets: where school nurses find constraints on achievement. *Nursing Standard, 9*(48), 36-40.

Farrington, D. P., & Welsh, B. (2003). Family-based prevention of offending: a meta-analysis. *Australian and New Zealand Journal of Criminology, 36*, 127-151.

Fergus, D., Rowe, J., & McAllister, M. (2002). An insight into young people's smoking habits and efforts to quit. *Youth Studies Australia, 21*(1), 35-39.

Fergusson, D. M., & Horwood, L. J. (1995). Transitions to cigarette smoking during adolescence. *Addictive Behaviors, 20*(5), 627-642.

Flay, B. R. (2000). Approaches to substance use prevention utilising school curriculum plus social environment change. *Addictive Behaviors, 25*(6), 861-885.

Fritz, D., Wider, L., Hardin, S., & Horrocks, M. (2008). Program strategies for adolescent smoking cessation. *The Journal of School Nursing, 24*(1), 21-27.

Fritz, D. J. (2000). Adolescent smoking cessation: How effective have we been? *Journal of Pediatric Nursing, 15*(5), 299-306.

Fuller, A. (1998). *From surviving to thriving: promoting mental health in young people*. Melbourne: Australian Council of Educational Research.

Gervais, A., O'Loughlin, J., Dugas, E., & Eisenberg, M. (2007). A systematic review of randomized controlled trials of youth smoking cessation interventions. *Drugs, Health and Society, 6*(1), ii1-ii26.

Giarelli, E. (1999). Prevention of smoking among adolescent girls: Health promotion strategies for nurses. *Journal of School Nursing, 15*(1), 23-28.

Gillespie, A., Stanton, W., Lowe, J. B., & Hunter, B. (1995). Feasibility of school based smoking cessation programs. *Journal of School Health, 65*(10), 432-437.

Gillespie, A. M., Fisher, K. J., Stanton, W. R., & Lowe, J. B. (1998). Australian students' preferences for school-based smoking cessation programs. *International Quarterly of Community Health Education, 17*(4), 361-373.

Guzys, D., & Kendall, S. (2006). Advocating for a harm-minimization approach to drug education in Australian schools. *The Journal of School Nursing, 22*(5), 259-263.

Hamilton, G., Cross, D., Lower, T., Resnicow, K., & Williams, P. (2003). School policy: What helps to reduce teenage smoking? *Nicotine and Tobacco Research, 5*(4), 507-513.

Hamilton, G., Cross, D., Resnicow, K., & Hall, M. (2005). A school-based harm minimization smoking intervention trial: outcome results. *Addiction, 100*, 689-700.

Hamilton, G., O'Connell M., Cross D. (2004). Adolescent Smoking Cessation: Development of a School Nurse Intervention. *The Journal of School Nursing, 20*(3), 169-175.

Hawe, P., Noort, M., King, L., & Jordens, C. (1997). Multiplying Health Gains: the critical role of capacity-building within health promotion programs. *Health Policy, 39*, 29-42.

Hearn, L., Campbell-Pope, R., House, J., & Cross, D. (2006). *Pastoral care in education*. Perth: Child Health Promotion Research Unit, Edith Cowan University.

Henderson, N., & Milstein, M. M. (2003). *Resiliency in Schools: Making It Happen for Students and Educators* (2 ed.). California: Corwin Press Inc.

Hope, M. A., & Hart, K. (1995). *Perspectives of Victorian school health nurses*. Melbourne: Centre for Adolescent Health.

Horn, K., Dino, G., Kalsekar, I., & Mody, R. (2005). The impact of Not on Tobacco on teen smoking cessation: End-of-program and evaluation results 1998-2003. *Journal of Adolescent Reseach, 20*(6), 640-661.

Houghton, C. (2003). A Mentoring Program for New School Nurses. *Journal of School Nursing, 19*(1), 24-29.

Houston, T., Kolbe, L. J., & Eriksen, M. P. (1998). Tobacco-use cessation in the 90's - not "adults only" anymore. *Preventive Medicine, 27*, A1-A2.

Humphries, J. (2002). The school nurse and health education in the classroom. *Nursing Standard, 17*(17), 42-45.

Humphries, J. (2002). The school nurse and health education in the classroom. *Nursing Standard, 16*(17), 42-45.

Jairath, N., Mitchell, K., & Filleon, B. (2003). Childhood smoking: the research, clinical and theoretical imperative for nursing action. *International Nursing Review, 50*(4), 203-214.

Kansanterveyslaitos (KTL) National Public Health Institute. (2004). About youth smoking cessation. Retrieved 9 Feb, 2006, from http://www.ktl.fi

Kitano, M. K., & Lewis, R. B. (2005). Resilience and Coping: Implications for Gifted Children and Youth At Risk. *Roeper Review, 27*(4), 200.

Klein, J. D., Portilla, M., Goldstein, A., & Leininger, L. (1995). Training pediatric residents to prevent tobacco use. *Pediatrics, 96*, 326-331.

Lamkin, L., Davis, B., & Kamen, A. (1998). Rationale for tobacco cessation interventions for youth. *Preventive Medicine, 27*, A3-A8.

LaSala, K., & Todd, S. (2002). Preventing youth use of tobacco products: the role of nursing. *Pediatric Nursing, 26*(2), 143-154.

Lawendowski, L. (1998). A motivational intervention for adolescent smokers. *Preventive Medicine, 37*, A39-A46.

Leatherdale, S. T., Cameron, R., Brown, K. S., & McDonald, P. W. (2005). Senior student smoking at school, student characteristics, and smoking onset among junior students: a multilevel analysis. *Preventive Medicine, 40*, 853-859.

Levy, S., Vaughan, B. L., & Knight, J. R. (2002). Office-based intervention for adolescent substance abuse. *Pediatric Clinics of North America, 49*(2), 329-343.

Logan, D., & Carlini-Marlatt, B. (n.d.). Smoking and adolescence: some issues on prevention and cessation. Retrieved 25/09/2009, from http://www.mentorfoundation.org/prevention_perspectives.php?pg=2&id=

MacDonald, P. (2004). Understanding smoking behaviour in children and adolescents. *Paediatric Nursing, 16*(3).

Mason, W., & Windle, M. (2001). Family, religious, school and peer influences on adolescent alcohol use: a longitudinal study. *Journal of Studies on Alcohol, 62*(1), 44-53.

McDermott, R., Sarvela, P., Hoalt, P., Bajracharya, S., Marty, P., & Emery, E. (1992). Multiple correlates of cigarette use among school students. *Journal of School Health, 62*, 146-150.

McNeely, C. A., Nonnemaker, J. M., & Blum, R. W. (2002). Promoting school connectedness: Evidence from the national longitudinal study of adolescent health. *Journal of School Health, 72*(4), 138-146.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Nadge, A. (2005). Academic care: building resilience, building futures. *Pastoral Care, 23*(1), 28-33.

National Health and Medical Research Council. (1996). *Effective School Health Promotion: Towards Health-promoting Schools*. Canberra: National Health and Medical Research Council.

Oberklaid, F. (1990). It's time: the future of school health in Australia. *Journal of Pediatric and Child Health, 26*, 244-251.

Oredein, T., Foulds, J., Edwards, N., & Dasika, J. (2008). Motivating adolescent smokers to quit through a school-based program: The development of Youth Quit2Win. *Adolescent Smoking and Health Research, Chapter V*, 171-190.

Pbert, L., Osganian, S., Gorak, D., Druker, S., Reed, G., O'Neill, K., et al. (2006). A school nurse-delivered adolescent smoking cessation intervention: A randomized controlled trial. *Preventive Medicine, 43*(312-320).

Periard, M. E., Knecht, L. D., & Birchmeier, N. (1999). A state association surveys school nurses to identify current issues and role characteristics. *Journal of School Nursing, 15*(4), 12-18.

Poland, B., Frohlick, K., Haines, R. J., Mykhalovskiy, E., Rock, M., & Sparks, R. (2006). The social context of smoking: the next frontier in tobacco control? *Tobacco Control, 15*, 59-63.

Resnick, M. D., Bearman, P. S., Blum, R. W., Bauman, K. E., Harris, K. M., Jones, J., et al. (1997). Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278*(10), 823-832.

Resnicow, K., DiIorio, C., Soet, J. E., Borrelli, B., Hecht, J., & Ernst, D. (2002). Motivational Interviewing in Health Promotion: It Sounds Like Something is Changing. *Health Psychology, 21*(5), 444-451.

Rice, V. H., & Stead, L. F. (2004). Nursing interventions for smoking cessation (Review). *Cochrane Database of Systematic Reviews*.

Ross, S. K. (1999). The clinical nurse specialist's role in school health. *Clinical Nurse Specialist, 13*(1), 28-33.

Rowe, K. J., & Rowe, K. S. (2002). *What matters most: evidence-based findings for key factors affecting the educational experiences and outcomes for girls and boys throughout their primary and secondary schooling*. Melbourne: ACER.

Russell, M. A. H. (1993). Reduction of smoking-related harm: The scope for nicotine replacement. In N. Heather, A. Wodak, E. Nadelman & P. O'Hare (Eds.), *Psychoactive drugs and harm reduction: from faith to science*. London: Whurr publishers.

Sanchez del Mazo, S. (2005). Youth smoking cessation - What can we do? Retrieved 28/09/2009, from http://www.fhi.se/SiteSeeker/ShowCache.aspx?resid=1984210012&q=youth+smoking+cessation&il=sv&hitnr=1&url=http%3a%2f%2fwww.fhi.se%2fsv%2fVart-uppdrag%2fAlkohol-narkotika-dopning-och-tobak-ANDT1%2fTobak%2fTobaksavvanjning%2fUngdomar-och-tobaksavvanjning%2f&uaid=B55AAF3A3D73558A4E3AAB2D64879D8A%3a3132312E3232312E3231382E323239%3a5245589930822534831

Sanci, L., Toumbourou, J. W., San, V., Rowland, B., Hemphill, S., & Munro, G. (2002). *Drug education approaches in secondary schools*. Melbourne: DrugInfo Clearinghouse.

Sarna, L., & Bialous, S. (2005). Tobacco control in the 21st centruy: a critical issue for the nursing profession. *Research and Theory for Nursing Practice, 19*(1), 15-24.

Sarna, L., & Lillington, L. (2002). Tobacco: An emerging topic in nursing research. *Nursing Research, 51*, 245-253.

Sarna, L., Wewers, M. E., Brown, J. K., Lillington, L., & Brecht, M. L. (2001). Barriers to tobacco cessation in clinical practice: report from a national survey of oncology nurses. *Nursing Outlook, 49*, 166-172.

Schubiner, H., Herrold, A., & Hurt, R. (1998). Tobacco cessation and youth: The feasibility of brief office interventions for adolescence. *Preventive Medicine, 27*, A47-A54.

Semer, N., Ellison, J., Mansell, C., Hoika, L., MacDougall, W., Glansky, S., et al. (2005). Development and evaluation of a tobacco cessation motivational program for adolescents based in physical attractiveness and oral health. *Journal of Dental Hygiene, 79*(4), 1-17.

Shanklin, S., Brener, N., L, K., Griffin-Blake, S., Ussery-Hall, A., Easton, A., et al. (2007). Youth risk behavior surveillance - Selected Steps communities, United States, 2007. Retrieved 01/10/2009, from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5712a1.htm

Simmons, D. R. (2002). Autonomy in practice: a qualitative study of school nurses' perceptions. *Journal of School Nursing, 18*(2), 87-94.

Smith, A., Gaffney, M., & Nairn, K. (2004). Health rights in secondary schools: student and staff perspectives. *Health Education Research, 19*(1), 85-97.

Smith, BJ. WHO Health Promotion Glossary: New terms. *Health Promotion International*. 2006. **21**(4), 340-5

Smith, S., & Firmin, M. (2009). School nurse perspectives of challenges and how they perceive success in their professional nursing roles. *The Journal of School Nursing, 25*, 152-162.

Stanton, W. R., & Smith, K. M. (2002). A critique of evaluated adolescent smoking cessation programmes. *Journal of Adolescence, 25*, 427-438.

State Government of Victoria. (2004). *An evaluation of the Victorian Secondary School Nursing Program*. Victoria: University of Ballarat and the School of Nursing, La Trobe University.

Sussman, S. (2001). School-based tobacco use prevention and cessation: Where are we going? *American Journal of Health Behaviour, 25*(3), 191-199.

Sussman, S., Dent, C. W., Severson, H., Burton, D., & Flay, B. R. (1998). Self-initiated quitting among adolescent smokers. *Preventive Medicine, 27*, A19-A28.

Sussman, S., McCuller, W., Zheng, H., Pfingston, Y., Miyano, J., & Dent, C. (2004). Project EX:A program of empirical research on adolescent tobacco use cessation. *Tobacco Induced Diseases, 2*(3), 119-132.

Tingen, M., Waller, J., Smith, T., Baker, R., Reyes, J., & Treiber, F. (2006). Tobacco prevention in children and cessation in family members. *Journal of the American Academy of Nurse Practitioners, 18*, 169-179.

Tobler, N., Lessard, T., Marshall, D., Ochshorn, P., & Roona, M. (1999). Effectiveness of school-based drug prevention programs for marijuana use. *School of Psychology International, 20*(1), 105-137.

Unger, J. B., & Rohrbach, L. A. (2002). Why do adolescents overestimate their peers' smoking prevalence? Correlates of prevalence estimates among California 8th-grade students. *Journal of Youth and Adolescence, 31*, 147-153.

Wewers, M. E., Kidd, K., Armbruster, D., & Sarna, L. (2004). Tobacco dependence curricula in U.S. baccalaureate and graduate nursing education. *Nursing Outlook, 52*, 95-101.

Whitmarsh, J. (1997). School nurses' skills in sexual health education. *Nursing Standard, 11*(27), 35-41.

Wicklander, M. (2005). The United Kingdom national healthy school standards: A framework for strengthening the school nurse role. *The Journal of School Nursing, 21*(3), 132-138.

Williams, R., McDermitt, D., Bertrand, L., & Davis, R. (2003). Parental awareness of adolescent substance use. *Addictive Behaviors, 28*(4), 803-809.

Williams, R. J., McDermitt, D. R., Bertrand, L. D., & Davis, R. M. (2003). Parental awareness of adolescent substance use. *Addictive Behaviors, 28*, 803-809.

Zhu, B., Liu, M., Shelton, D., Liu, S., & Giovino, G. A. (1996). Cigarette smoking and its risk factors among elementary school students in Beijing. *American Journal of Public Health, 86*(3), 368-375.

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42 Bruce, K. *Factors influencing school staff implementation of a pastoral care program designed to reduce students' harm from tobacco and other drugs.* Masters by Research Candidacy Proposal. Seminar presentation slides.

43 Hall, M. (2008). KIT-Plus Research Project. Presentation to the National School Drug Education Strategy stakeholders meeting, Perth, WA. 13 November 2008. Oral presentation

44 Hall, M. KIT-Plus Research Project. Presentation to the Investigator meeting, Perth, WA. 28 August 2009.

45 Bruce, K., & Hall, M. (2009). Factors influencing teachers' implementation of a pastoral care program to reduce students' harm from tobacco. *Australian Health Promotion Association 18th National Conference: Make health promotion a priority: Evidence, advocacy & action*. Perth, WA. 17-20 May 2009. Poster presentation.

46 Coe, C., Bruce, K., & Hall, M. (2009). The KIT-Plus Research Project: Meeting the challenge of school-based activities for drug use prevention and intervention. *Alcohol and Drug Foundation Queensland (ADFQ) 2009 Australian Winter School Conference*. Brisbane, Queensland. 25-27 May 2009. Oral presentation.

47 Hall, M., Coe, C., Paki, D. (2011). What students tell us about 'Keeping in Touch' to reduce smoking, drinking and drug use. *Australian Health Promotion Association, 20th National Conference: Health Promotion and Determinants of Health – Strengthening Action.* Cairns, Queensland 10-13, April 2011. Oral Presentation.

48 Bruce, K. and Hall, M. (2011) Case studies investigating the factors influencing school staff's implementation of an adolescent drug-use prevention program. *Australian Health Promotion Association, 20th National Conference: Health Promotion and Determinants of Health – Strengthening Action.* Cairns, Queensland 10-13 April, 2011. Oral Presentation.

49 Bruce, K. and Hall, M. (2011) The KIT Plus Research Project: Training approachable school staff to respond to students seeking help about drug-related issues. *Australian Drug Foundation 6th International Conference on Drugs and Young People*. Melbourne, Victoria. May, 2011. Oral Presentation.

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Bruce, K. and Hall, M. (2011) The KIT Plus Research Project: Training approachable school staff to respond to students seeking help about drug-related issues. *Australian Drug Foundation 6th International Conference on Drugs and Young People*. Melbourne, Victoria May, 2011. Oral Presentation