Executive summary

This report is the result of a cannabis needs assessment undertaken by Regional Public Health, Hutt Valley Health, to ascertain the usage of cannabis by young people in Kapiti and Wairarapa areas and the services and education programmes that are available for this age group.

The main findings from the 3,988 completed questionnaires by 13-17 year old students (2,020 Wairarapa, 1,968 Kapiti) undertaken in 1999 were:

Usage

? 70% of respondents had not tried cannabis. Of the 30% of respondents in both areas who have tried cannabis about 11% in the Wairarapa and 13% in the Kapiti region reported that they considered themselves as "someone who uses cannabis now" (For this report these users are known as current users).

? The percentage of respondents who have tried cannabis increases with age. Among 16 year old respondents overall, about 19% were current users and 50% had never used.

? Current cannabis use among Maori is higher than for any other ethnic group. 17% of those who identified as Maori or Maori/European and 18% of those who had originally identified as Maori were current users of cannabis. Pacific island peoples' current usage is 14%, slightly higher than the 12% average for the whole sample.

Reasons for use

? The main reasons given for choosing to take cannabis were that it made respondents "feel good" or because they wanted to be "spaced out / stoned". Non-cannabis users identified the risk to health as being the major reason for not taking cannabis.

Recent use

? Among those who had tried cannabis, about 40% had not used it at all in the preceding four weeks - leaving 60% who had used the drug. Over a third had used it between one and four times and about 8% had used it 20 times or more.

? Density of use increased with age with about 10% of 15 year old cannabis users reporting very heavy usage in a four week period.

Age of first use

? Respondents had tended to try cannabis for the first time at age 13 or older. However, about 19% of all those who had tried cannabis had done so by the age of 12.

? Furthermore, of those who had tried the drug by the age of 12, about 60% reported being current users.

Obtaining cannabis

? The most common source of cannabis was from other students or from some other person outside either school or family. Dealers were used relatively little by younger respondents but, by 16, around a quarter of all cannabis was obtained from dealers.

? Overall, the majority of cannabis used by respondents had been given or shared, presumably in social situations. The percentages of respondents who bought cannabis increased with age so that, at age 16, about a third had bought it.

Information Requirements

? The vast majority of respondents stated that they did not require any further information about cannabis usage, other illegal drugs or help and support for students with drug problems. However, about 15% of all respondents, including those who had never used the drug, did feel that they would like some more information.

Recommendations

It is recommended that:

? Cannabis education/information transfers are best targeted at younger students, from Year 7 on. Strategies need to be developed to address this age group.

? Cannabis education programmes supported by Regional Public Health need to be consistent with the 'harm minimisation' policy framework as adopted by the National Drug Policy, and Ministry of Education Drug Education guidelines.

? Cannabis education programmes address the issues raised by the school co-ordinators survey, particularly in helping schools to develop workable drug policies, in accordance with the new curriculum guidelines.

? Drug education programmes have a health focus. This recommendation is for policy development and as a future research question. This health focus needs to be clearly differentiated from debates around decriminalisation.

? Programmes be developed that are specifically aimed at young Maori. Ideally, these would be 'by Maori - for Maori' in design, implementation and evaluation.

? The sensitivity of Kapiti schools to cannabis needs assessments be allayed, by Regional Public Health, through education and consultation.

? Regional Public Health build on the positive Kapiti and Wairarapa stakeholders' interest and commitment on this issue through formal networking support and advocacy, and in presenting back to all stakeholders the findings and recommendations of this report.

? The findings and recommendations of this report are raised by Regional Public Health with relevant politicians (central and local).

? Regional Public Health has a media strategy for presenting the findings and recommendations of this report.

? Future regional planning and lobbying efforts emphasise the lack of, in the Wairarapa and Kapiti regions, specific drug-related agencies that have a youth orientation.

? Staff of Regional Public Health be encouraged to have built into their personal development programmes ongoing training in computer-based data analysis and in preparation, analysis and presentation of qualitative and quantitative data for report writing and particularly in questionnaire design and development.

? Further research be carried out on

a) focusing on the 'core group' of cannabis users, i.e. those who first use cannabis between the ages of 10 and 12, and who have continued high usage;

b) studying the economic, social and cultural environments for selling drugs in school settings.

Table Of Contents

Executive summary 3

Recommendations 5

Table Of Contents 7

1. Introduction 8

1.1 Background to the report 8

1.2 Selection of Wairarapa and Kapiti regions 8

1.3 Cannabis and youth in New Zealand 9

2. Timelines and methodology 13

3. Community consultation 14

3.1 Wairarapa 14

3.2 Kapiti 17

3.3 Health co-ordinators survey responses 19

4. Results of the Survey 20

4.1 The demographics of the respondents 21

4.2 Respondents' reported use of cannabis 26

4.3 Reasons for choosing to use cannabis 30

4.4 Reasons for choosing not to use cannabis 32

4.5 Recent cannabis use 33

4.6 Age of first cannabis use 35

4.7 Obtaining cannabis 37

4.8 Requests for further information 40

4.9 Discussion of results 42

5. Findings and recommendations 45

5.1 Findings 45

5.2 Recommendations 47

6. References 49

7. Appendix A 51

1. Introduction

1.1 Background to the report

This report is from Regional Public Health, Hutt Valley Health, to the Health Funding Authority. It is intended as a needs assessment and survey with applicability to community feedback and policy development, especially in the Kapiti and Wairarapa regions, as well as offering for consideration research design and policy development issues relating to youth.

Following community Kapiti/Wairarapa stakeholders presentations and focus groups in August-December 1998 and student questionnaires being undertaken between February-April 1999, questionnaire and focus group documentation were collated and analysed by members of Regional Public Health, with subsequent analysis and editing from Drs Amanda Gilbert and Marten Hutt, Health Services Research Centre, Wellington.

This report has been produced for the Health Funding Authority to meet reporting requirements, but also in response to interest in its findings from the community focus groups, participating schools, politicians and media.

1.2 Selection of Wairarapa and Kapiti regions

Anecdotal evidence suggested the use of cannabis is widespread within the Wellington and Wairarapa regions. Because of the paucity of information about the extent to which cannabis is or is not a problem, Regional Public Health decided to undertake a needs assessment focusing on intermediate and secondary aged students, to assist with programme planning and development for this age group.

Kapiti was chosen because of its distance from Hutt Valley and for the need to improve networks with and provide support for this community. Wairarapa was chosen as an opportunity to develop alliances with the community and to find out what services are available and what support is required from Regional Public Health.

Generally, some schools spoke openly about the drug problem and were keen to participate in the student questionnaire, while others were concerned that the research could be picked up by the media and they could be portrayed very negatively, resulting in a loss of students to other areas.

In almost all cases organisations, agencies, schools and individuals have been positive about this project and Regional Public Health has appreciated their involvement and the information they have provided. Schools in the Wairarapa area were far more enthusiastic about their involvement than those in the Kapiti area. Regional Public Health has especially appreciated the support of the co-ordinators of the Masterton Healthy Communities and the Kapiti Safer Community Council, and the Wairarapa community focus group.

In both selected research areas adults and students spoken with indicated that sources of cannabis are widely known, it is freely available, easy to obtain and affordable, and there is general acceptance or tolerance of its use by most young people.

The fact that cannabis use is illegal or its cost appears to have little impact on young peoples' choice to experiment and use cannabis.

1.3 Cannabis and youth in New Zealand

> *While we continue to debate what, if any, legislative change to the marijuana laws is needed, one thing is clear - some young New Zealanders' use of marijuana is exacerbating their lack of opportunities; it impedes their chance of educational achievement; in some cases it becomes a habit that is hard to break; and in some cases it impacts negatively on mental health (Casswell 2000).*

Cannabis is the third most popular recreational drug in New Zealand, after alcohol and tobacco. It is the most widely used illegal drug. Drug use amongst young people within New Zealand is well established and occurs within a complex social context.

> *Exploration and risk taking is a normal part of adolescent behaviour as the transition is made into adulthood. It is a time of experimentation, exploration, curiosity and search for identity and part of that search involves some risk taking. (Howard 1996).*

In national policy terms, the Ministry of Health does not regard cannabis as a public health problem on the same level as tobacco and alcohol, but notes that 'evidence of high prevalence in certain population subgroups, together with the associated health effects of cannabis use, indicates that cannabis use is of public health significance' (Ministry of Health 1998a*).* Current targets are:

? to reduce the prevalence of current cannabis use (used in the last 12 months and not stopped using) to 8% or less among persons aged 15-45 years by the year 2005.

? to reduce the prevalence of frequent cannabis use (used 10 or more times in the last 30 days) to 1.5% or less among persons aged 15-45 years by the year 2005 (Ministry of Health 1998a).

The National Drug Policy (NDP) priority 4 is 'to reduce the prevalence of cannabis use and use of other illicit drugs'. 'Young people' are listed as a 'key group'. The consequent 'desired outcome' is to a 'reduction in the prevalence of cannabis use among people under 25'. Strategies include community programmes, health promotion, and links to existing Healthy Schools programmes (Ministry of Health 1998b). This is part of the harm minimisation focus of the NDP.

The Ministry of Health uses combined survey data to recommend a 'youth focus for cannabis programmes' (Ministry of Health 1998a). The primary New Zealand summary

of the public health issues that are associated with cannabis usage is the report Cannabis: The Public Health Issues, issued by the Ministry of Health in 1996. This report summarised the national and international literature on the impacts of cannabis on, to cite aspects relevant to youth, communications skills (p. 9), unsafe sexual practices (p. 9), adolescent conduct disorder (p. 15), and motor vehicle crashes (p. 25). Youth are listed as a 'high-risk group' (pp. 18-21).

The Wairarapa/Kapiti surveys are important in that 'There has been no research on the extent to which cannabis use occurs within the school setting nor any recent research on levels of cannabis use amongst school-aged individuals in New Zealand...' (Abel and Casswell 1998).

This report is a contribution to the few findings that do exist on usage patterns by New Zealand youth, some of which are summarised below:

NZ longitudinal studies.

Christchurch Health & Development Study: Study of a birth cohort of 1,265 children born in 1977. Fergusson et al 1993 examined patterns of cannabis use in a sample of 949 Christchurch children studied to the age of 15, and found that 9.9% of this group had used cannabis on one or more occasions. In a later study, cannabis use and dependence was investigated during the years 15-21, and revealed that, by 21, 69% of the cohort had used cannabis at least once. Over 9% of the cohort met DSM-IV dependence criteria. Cannabis use was higher among males and Maori. Key predictors were gender and measures of adolescent risk taking behaviours including cigarette smoking, adolescent conduct problems, afflictions with delinquent peers and novelty seeking (Fergusson and Horwood 2000).

The Dunedin Multidisciplinary Studies found that their cohort (the 40% of those aged to 18 who had used cannabis on at least one occasion), met the dependence criteria of DSM-IV by age 21 (Poulton et al 1997).

APHRU

A 1990 survey of 5,126 people aged 15-45 years found that:

? 43% had used cannabis at least once
? young males and Maori were higher users
? 23% of those who had used cannabis had tried it less than five times
? Only 3% were defined as frequent users (Black and Casswell 1993).

A comparison with a repeated 1998 survey found that the proportion aged 15-45 who had ever used cannabis had risen from 43% to 52% (Field and Casswell 1999).

Most recent Alcohol and Public Health Research Unit (APHRU) surveys suggest the age of first use of cannabis has dropped and younger people are smoking more when they do smoke (Casswell 2000).

APHRU surveys also indicate usage of alcohol, cannabis and tobacco are higher among Maori than non-Maori (Casswell 2000). This is supported by other surveys (Ministry of Health 1996, pp. 22-23). The most recent survey, of 1.593 Maori aged between 15 and 45 who took part in a 1998 national telephone survey found that 60% reported use of cannabis at some point in their lives. Only 4% were regarded as heavy users. Of the 60% who had used cannabis, 41% said they used it for the first time between the ages of 15 and 17 (Dacey and Barnes 2000).

A survey of 14,000 Canterbury students (Standard 3 - Form 7) found that 17.6% of the secondary school students reported using cannabis in the previous year (Pryde 1992).

Schools

With regard to the way schools handle this issue, a qualitative study of ten schools in Auckland carried out by APHRU looks at how these schools managed cannabis-related incidents and the related issues for boards of trustees and principals. Cannabis use in school was considered related to wider societal issues, and for some students, to more general behavioural problems. The report recommends more discerning use of indefinite suspension and resources for collaborative initiatives between schools and their local communities. (Abel and Casswell 1998).

Longitudinal research in Christchurch has found that use of cannabis before the age of sixteen is associated with early school leaving, although early cannabis users were more likely to come from socially disadvantaged backgrounds, bringing into sharp relief the use of disciplinary approaches (Fergusson and Horwood 1997). Truancy was also linked with cannabis use (Drug Advisory Committee et al 1995).

In health effects terms, among the impacts of cannabis use are subtle forms of cognitive impairment which may affect educational performance (Hall 1995; Smith 1995). There are a number of studies which concluded impacts on mental health status of youth (Ministry of Health 1996, pp. 19-20).

A needs assessment undertaken by FADE in low decile schools in five cannabis growing regions in New Zealand shows that schools in the five regions clearly recognise the drug related problems they face and an important need to up-skill teachers and improve resource provision. Many schools do not have definite drug policies and procedures in place recognising that the development of such policies is essential for the advancement of drug education programmes in schools. Staff involved in drug education tended to have no specialist qualifications in health education. However the needs assessment reports schools were making considerable use of the expertise of a range of outside agencies. (FADE 1998).

A 1997 qualitative study of the impact of suspensions on students (a third of whom were suspended for cannabis-related incidents) found the processes involved were negative and alienating experiences (Youth Law Project 1997).

The Ministry of Education has issued guidelines for drug education in schools. This provides guidelines for a harm minimisation approach in schools with the aim of 'effective drug education in a health-promoting school', to allow students 'to make informed and health-enhancing decisions about drug use and misuse'. The guidelines include policy development steps towards school drug policies, including effective consultation, interactions with the community, managing drug-related incidents and Maori perspectives in drug education procedures (Ministry of Education 2000).

2. Timelines and methodology

Due to the sensitive nature of cannabis use, a consultative approach was adopted to obtain the required information. Considerable time was spent in both the Wairarapa and Kapiti regions, meeting with and listening to young people, health professionals, community members and organisations, school staff, and local agencies. Discussions were held with Health Funding Authority (Central), New Zealand Drug Foundation, Foundation for Alcohol and Drug Education, and information was made available from the Ministries of Education and Health.

Stage 1 (August-December 1998)

Involved identification of communities, employment of a project officer to undertake the research, literature searching, development of information packages for schools, community groups and agencies, meeting with stakeholders to promote participation in the project, formation of focus groups in selected communities, design of student questionnaire, and survey questions for school health co-ordinators, submission of student questionnaire to ethics committee for approval, piloting of the student questionnaire and required changes made, formatting of the student questionnaire for computer scanning, collation of survey responses from school health co-ordinators, and preparation of a progress report at the completion of stage 1. Focus groups were conducted between Sept-December 1998.

Stage 2 (December 1998-April 1999)

Involved printing the questionnaire, negotiation of dates with schools and volunteers for undertaking the student questionnaire, actioning of the questionnaire and data entered. Administering the student questionnaires took place in the schools between February and April 1999.

Stage 3 (May 1999-November 1999)

Involved data entry of the questionnaires. The draft report with the results of the questionnaire were taken to both communities for discussion.

Stage 4 (December 1999-July 2000)

Included involvement of the Health Services Research Centre in re-analysing data and editing of documentation, with the aim of completing the report for the Health Funding Authority, and making the report available to schools and participating community organisations and agencies in a usable format.

Analysis of the questionnaire results are discussed in Section 4.

3. Community consultation

A community development approach was adopted for this project, recognising the sensitive and controversial nature of the subject. Meetings were arranged with local individuals and agencies, and groups of young people who were also asked to respond formally to a simple survey of three questions. Agencies and organisations providing treatment and/or education services were asked to respond to a questionnaire describing the services they provide. Results of both surveys are summarised below.

3.1 Wairarapa

Twenty-three individuals and agencies were invited to form a focus group to ensure the community was involved in the planning and development of the project. As well, agencies and/or organisations responded to a written survey of their capacities and views regarding cannabis use by youth in their catchments.

The Wairarapa community responded very enthusiastically to this approach with the Healthy Communities Group offering to umbrella the focus group. The group met on three occasions and their input was encouraged and valued. This group has decided that it is important to continue meeting as a focus group for alcohol and drug issues and co-ordination, and the Healthy Communities Co-ordinator offered to plan and facilitate further meetings.

Establishing contact and rapport with Wairarapa schools and agencies was enhanced by positive support for and from Choice Health's adolescent health nurse and smokefree and alcohol advisor, who were actively involved in all stages of the research project.

The focus groups/agency surveys revealed the following key issues:

Extent of usage and issues raised

The extent of cannabis usage by youth in the Wairarapa was expressed as being considerable, with comments such as that cannabis is "widely used and very easily obtained"; "majority of young women that use our service have smoked or are regular users"; "very widespread, but more pockets than evenly distributed".

Frustration was expressed about how to communicate with young people as to the health impacts of cannabis use. It was felt that cannabis should be a health issue, and that the focus needs to change from law enforcement. The health issues were not understood at all well. "[cannabis is] a health issue, not punitive. It's a public health problem".

The issue of intergenerational and early drug usage was noted: “Young people who are brought up in a cannabis household are at greatest risk”, “those who are getting it from their parents are starting as young as 10 and 11 years of age”.

Only one participant felt strongly that cannabis should be decriminalised, while others were concerned at the number of Maori in prison for growing and dealing cannabis: “Are young people who are caught with cannabis criminals?” Several commented on the fact that alcohol was just as great, or an even greater, problem than cannabis. Others commented on socio-economic issues such as the income generated by selling drugs, especially by those who were unemployed.

Agency and community responses

It was felt that cannabis is a community issue that requires a co-ordinated community solution. Young people should not be ‘treated’ in isolation from their social environment and the significant others in their lives. Education programmes need to start at the parenting programme level.

Young people are getting mixed or confusing messages on the use and impact of cannabis. Double standards exist and the reasons for use need to be understood and addressed. “We are competing with messages of it’s normal, it’s less harmful than smoking, it’s mellow etc”.

Agencies expressed concern at the current epidemic of at risk kids. They are seeing an increase in numbers abusing alcohol and drugs, particularly for under 17s (Wairarapa Addiction Services 1998).

Many respondents commented on the excellent treatment and education services provided for young people by Wairarapa Addiction Services. These comments were endorsed by several high schools. Positive feedback was received on a pilot programme undertaken in one of the colleges as the result of an education programme, and of the overwhelming response from the students to the self-referral service set up as a result. Four wrote positively of the DARE programme, one questioned its value long term and another was critical of its success. There was also a comment on the appropriateness of police delivering a drug programme.

It was argued that awareness and education programmes need to be developed and provided free of cost for community workers, health workers, youth workers and others who work with young people. Police are no longer allowed to provide drug education sessions for parents and teachers, their education role is limited to students only. “More support is required for mental health providers, youth workers and the police”; “Open forums are important...to make a difference real stories and real people need to deliver programmes”.

Schools

Almost all the respondents identified education as being the key in dealing with cannabis usage. There was expressed concern about the number and processes involved in the suspension and expulsion of students. Respondents would like to see agencies and schools working in a partnership to come up with alternative options that keep students in the school environment, and Wairarapa has the agencies in their community who have the expertise and the desire to work with schools on this issue: "School counsellors play an important role".

There was frequent comment that there needed to be more education in schools, with emphasis on both primary and secondary schools. Allied with this was expressed the wish for "information to be made available to parents about long term effects...parents need to know the signs of cannabis use, and where to go to for help".

It was felt education programmes needed to start in early teenage years or earlier: "education programmes need to start in intermediate schools".

3.2 Kapiti

With the support of the Safer Community Council Co-ordinator, an attempt was made to form a focus group in Kapiti involving secondary school counsellors/ health co-ordinators, agencies and organisations, but this did not eventuate. As the time frame did not allow a second attempt, additional meetings were held with 22 individuals, organisations and agencies to seek their input into the project.

Because of the uncertainty of the colleges' involvement in the student questionnaire, discussions were held with focus groups of young people. Many of those interviewed were users, some very heavy users, while others had either smoked experimentally or not at all. While the emphasis was on information regarding cannabis, of concern was the availability and use of LSD by young people.

The focus group/agency surveys revealed the following key issues:

Extent of usage and issues raised

The students stated that cannabis is freely available in Kapiti. All college students spoken to maintained they could obtain access to it if that was their choice. Senior students thought that 80% of the senior school would have tried it at some stage. Gold oil (type of hash oil) is very popular with Kapiti youth and often sells for a more attractive price: "High use in Kapiti area, lots of growing, good climate...student use getting younger...more people using it in their houses...families suffering and unaware of how to deal with the problem...so easy to get in the schools and in the community".

A large proportion of young people saw cannabis as a safer drug than alcohol, especially in relation to driving. Comments were made on how much easier it is to disguise. Boredom and lack of activities was seen to be a reason for excessive drug use by many young people. School holiday activities were put forward as one option for addressing this problem.

Agency and community responses

The focus groups of young people talked with were keen to debate issues and raise questions. It highlighted again the need for open forums where students can express their issues and ask questions and challenge in a safe environment.

In terms of agencies, it became apparent from talking to people that there was no formal networking occurring, although there were informal networks between some groups and individuals. There was evidence of competition between some services and between professionals and volunteer groups. As with Wairarapa, the DARE programme received contrasting comments; one spoke positively while another questioned its long term effects.

The majority of young people believed education was helpful, with a strong call for 'real life experience' speakers in the schools. It was agreed that young peoples' perception that the drug was harmless needs addressing urgently. A large proportion of respondents placed a greater emphasis on treatment services than on education. This could be due to the lack of specialist services specifically for adolescents in the Kapiti area. A variety of suggestions were made for increasing service relevance and effectiveness: "Support families to deal with family members who have a problem with drugs...offer a variety of treatment programmes including residential care...programmes on the effects of cannabis during school years...add drug free marae, workplaces, schools, colleges to advertising programmes...need for specialist alcohol and drug workers within mental health teams".

Schools

While it appears that most students respect the school rules, there are students who smoke cannabis in the school environment and dealing can occur in schools. Some students are dealing for other family members. It is widely known that students often go home at lunch break for the purpose of smoking the drug.

It was suggested that some teachers need to be educated on how to tell if a student is under the influence of drugs. It was felt that often this went unnoticed. Kapiti schools were sensitive to the cannabis issue, in a way not apparent in the Wairarapa: "schools apprehensive to programmes". This sensitivity will need to be addressed by Regional Public Health.

3.3 Health co-ordinators survey responses

A survey was undertaken of the health co-ordinators from ten secondary and two intermediate schools. Questionnaires were returned by nine schools, a response rate of 75%.

Eight of the schools had a drug education policy, with six having a policy for managing drug related incidents. Of these six, there was a variety of responses, ranging from referral to a counsellor to disciplinary proceedings depending on the severity of the case. Two schools cited indefinite suspensions for students found with drugs, while two said it would be a board of trustee decision. The co-ordinators were aware of the range of counselling options open to them, and all six said they would involve counsellors.

With regard to special programmes for students at risk, only two schools identified having such programmes alongside general programmes.

There was use of outside agencies to support drug programmes, and there were suggestions on how this might be increased. These included assistance with evaluation, managing a drug related incident, developing a drug teaching programme and knowledge updates on illegal drugs. Eight schools indicated that staff would benefit from attending workshops focusing on drug education and/or drug issues.

4. Results of the Survey

The questionnaire was developed with input from national researchers, young people, school staff and community agencies and discussed with the focus groups. Ethical approval for the survey was sought from and granted by the Wellington Ethics Committee. The questionnaire was then piloted with a group of seventh formers not returning to school in 1999 and with a group of students from an alternative learning centre. A copy of the questionnaire used in the survey is contained in Appendix A.

In total, 10 of the 12 intermediate and secondary schools in the Wairarapa and Kapiti regions took part in the survey. Parent and student consent was obtained for all those students who were to participate.

In order to ensure confidentiality for the participants and to maximise the reliability of responses, the questionnaires were delivered to each classroom in a sealed envelope with instructions attached to it. The questionnaires were handed out by the class teacher and completed immediately. These were placed directly into another envelope, which was sealed for collection.

In total 4,617 questionnaires containing usable responses[1] were returned; 2604 from the Wairarapa and 2013 from Kapiti. The anticipated sample size, based on the 1998 school rolls, was approximately 5450 students (3300 for the Wairarapa and 2150 for Kapiti). This gives an overall response rate of about 85%.

[1] Questionnaires returned uncompleted and some containing contradictory or obviously false responses were excluded from the sample.

4.1 The demographics of the respondents

Table 1 shows the ages of the questionnaire respondents from each of the two areas. The Wairarapa sample contains a large number of younger people, over a fifth (22%) of the sample was under 13 compared with only 2% of the Kapiti sample. This number is accounted for by the fact that the questionnaire was administered to students at intermediate as well as secondary schools in the Wairarapa region.

The relative numbers of students aged under 13 in the two regions means that the data is badly skewed and comparisons between each region would therefore be invalid. For this reason, this report will focus primarily on the responses made by students aged 13 years and over in both of the regions.

Finally, given that the age of respondents is the key independent variable in this survey, the two questionnaires for which age was not specified were also excluded at this point. This gives a revised total number of respondents of 3988 (2020 from the Wairarapa and 1968 from Kapiti).

Table 1: Ages of respondents to the questionnaire from the Wairarapa and Kapiti regions

Age	Wairarapa		Kapiti	
	N	%	N	%
10 or younger	0	0.0	0	0.0
11	264	10.1	0	0.0
12	318	12.2	45	2.2
13	513	19.7	470	23.3
14	512	19.7	399	19.8
15	423	16.2	456	22.7
16	292	11.2	368	18.3
17 or older	280	10.8	275	13.7
Missing	2	0.1	0	0.0
Total	**2604**	**100.0**	**2013**	**100.0**

Table 2 shows the revised distribution of ages of the respondents. Although the numbers are relatively similar, the Kapiti sample was slightly older with well over half the sample (56%) aged over 15. In comparison, just under half (49%) of the Wairarapa sample was aged over 15. Indeed, the distribution of ages between the two groups was found to be significantly different (chi-square = 25.26, df = 4, p<0.001). This difference suggests that considering the sample as a whole, by aggregating the two regions, would be inappropriate.

Table 2: Ages of respondents in the revised sample, excluding those aged under 13 years

Age	Wairarapa		Kapiti	
	N	%	N	%
13	513	25.4	470	23.9
14	512	25.3	399	20.3
15	423	20.9	456	23.2
16	292	14.5	368	18.7
17 or older	280	13.9	275	14.0
Total	**2020**	**100.0**	**1968**	**100.0**

The gender split for the two regions was found to be quite similar. The Kapiti sample contains almost equal numbers of male (50%) and female (49%) respondents and the Wairarapa sample comprises 53% male and 46% female respondents[2]. However, the differences between the two regions were not found to be significant (chi-square = 5.25, df = 2, p>0.05).

[2] 16 respondents (0.8%) in the Kapiti sample and 9 respondents (0.4%) in the Wairarapa sample did not specify their gender.

Table 3 gives a breakdown of the responses given by students to the ethnicity question in the survey. Respondents' ethnicity has been more difficult to measure and to classify.

A large number of respondents indicated that their ethnicity was 'other' than the choices listed in the questionnaire. These responses have, in many cases, been recoded according to guidelines given by Statistics New Zealand. Thus, another category 'Asian' has been included. Multiple responses, where students have ticked more than one option have been recoded according to the following conditions:

1. NZ European — Including single and combinations of European ethnic groups.

2. Maori — Respondents who indicated Maori as one of their ethnic groups.

3. Pacific Island — Respondents who indicated a Pacific Island ethnic group as one of their ethnic groups but who had not also ticked Maori.

4. Asian — Respondents who indicated an Asian ethnic group as one of their ethnic groups but who had not also ticked either Maori or Pacific Island ethnic groups.

5. Other — Remaining ethnic groups not included above.

This questionnaire included a further category 'Maori/European' which is not included in the Statistics New Zealand list. According to the protocol above, data from this category has been amalgamated with the Maori category.

Table 3: Respondents' ethnicity

	Wairarapa		Kapiti	
Ethnicity	**N**	**%**	**N**	**%**
Maori	144	7.1	97	4.9
Maori/European	274	13.6	274	13.9
Maori	418	20.7	371	18.9
Pacific Island	69	3.4	56	2.8
Pakeha/NZ European	1409	69.8	1415	71.9
Asian	37	1.8	32	1.6
Other (specified)	77	3.8	81	4.1
Missing	10	0.5	13	0.7
Total	**2020**	**100.0**	**1968**	**100.0**

Note: The category 'Asian' has been added retrospectively and is based on respondents' comments in the specified 'other' part of the question. Multiple answers have also been recoded according to guidelines provided by Statistics New Zealand. See main text for more details.

In both groups, the majority (around 70%) of respondents identified as Pakeha/NZ European. A fifth (21%) of Wairarapa respondents described themselves as either

Maori or Maori/European. Slightly fewer (19%) Kapiti respondents described themselves as Maori or Maori/European.

Otherwise, the two groups of respondents were relatively similar with respect to their indicated ethnicity. A chi-square test suggested that any difference between the samples was not a significant one (Chi-square = 10.7, df = 6, p>0.05).

Of those who indicated that their ethnicity was 'other' than the choices offered, a number were recoded as described above. The remaining responses are summarised in Table 4 below. In both regions the largest percentage (38% in Wairarapa and 52% in Kapiti) of this group of respondents identified themselves as either European or as being from a specific European country. Nearly 40% of Wairarapa respondents and 16% of Kapiti respondents gave insufficient information or did not specify their ethnicity.

Table 4: Summary of responses by students who indicated that their ethnic group was 'other' than those listed

	Wairarapa		Kapiti	
Ethnicity	**N**	**%**	**N**	**%**
North American	1	1.3	8	9.9
Australian	9	11.7	8	9.9
European	29	37.7	42	51.9
Indian	2	2.6	2	2.5
South African	6	7.8	5	6.2
South American	0	0.0	1	1.2
Multiple ethnic groups	0	0.0	2	2.5
Unspecified or non-specific	30	39.0	13	16.0
Total	**77**	**100.0**	**81**	**100.0**

Note: The category 'Asian' was added retrospectively to the main list of ethnic groups. This category accounted for between a quarter and a third of all 'Other' responses.

4.2 Respondents' reported use of cannabis

The key question in the survey relates to respondents' reported use of cannabis.

Table 5 provides a summary of the responses given by students aged 13 and over to this question.

Table 5: Respondents' reported use of cannabis

	Wairarapa		Kapiti	
Cannabis use	N	%	N	%
Have never used cannabis (marijuana, dope, weed, pot, dac)	1408	69.7	1255	63.8
Have used cannabis one or two times only	213	10.5	212	10.8
Have used cannabis (more than 2 times) but don't any more	178	8.8	243	12.3
Someone who uses cannabis now	221	10.9	258	13.1
Total	**2020**	**100.0**	**1968**	**100.0**

A large majority of both respondents from the Wairarapa and the Kapiti areas had never used cannabis. In the Wairarapa 70% of school students surveyed and in the Kapiti region just under two thirds (64%) indicated that they had never used it. Given the large number of students participating in the survey overall, the difference in cannabis use and non-use between the two regions is a significant one (chi-square = 20.8, df = 3, $p<0.001$).

From the table, therefore, about 30% of school students surveyed in the Wairarapa region have used cannabis at some time. Ten percent of students have used it no more than once or twice and nine percent report that they have used it but no longer do so. Eleven percent of those surveyed stated that they were current users.

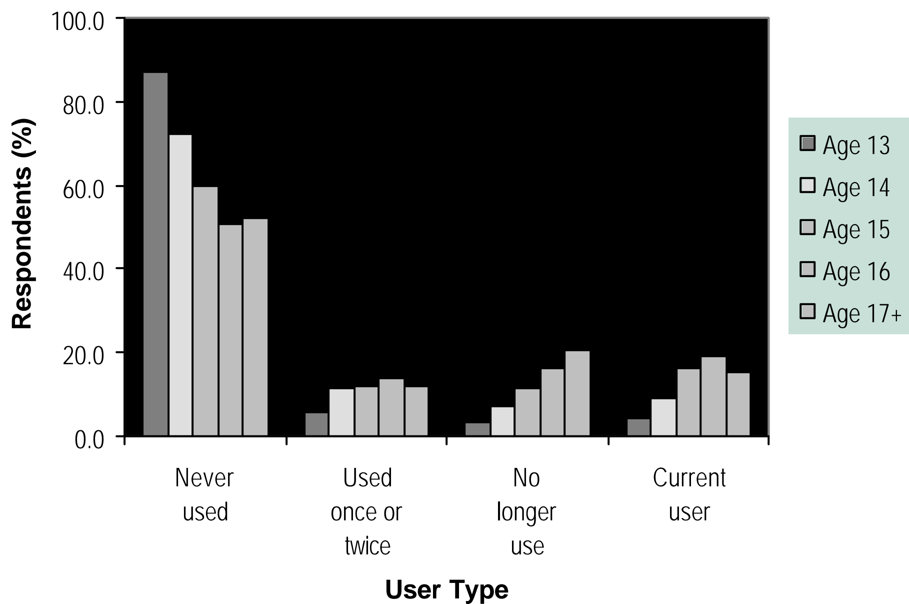
Similarly, in the Kapiti region about 11% of those surveyed report that they have tried cannabis only once or twice. A slightly greater number (12%) have used it before but do not do so any more. About 13% of school students in the Kapiti region indicate that they are current users of cannabis.

Respondents' reported usage of cannabis was also broken down by age, gender and ethnicity. In the following tables data from the two regions have been combined to show the overall pattern of cannabis use by respondents of different ages, genders and ethnicity's (see Diagrams 6, 7 and 8 respectively).

Diagram 6 shows that the percentage of respondents who have never tried cannabis decreases with age. In fact, nearly half (49%) of all 16 year olds surveyed had tried the drug at least once or twice. In comparison, at 13, only 13% had tried cannabis.

In general, the data show a gradual increase in the overall drug usage from age 13 to 17 years. However, it is interesting to note that the percentage of respondents claiming that they do not use cannabis any more increases steadily so that, at 17, over 20% report that they are no longer cannabis users.

Diagram 6: Respondents' use of cannabis across both regions shown by age



Patterns of cannabis use by gender are shown in Diagram 7 below. There was also very little difference between male and female respondents with respect to their use of cannabis. About 70% of female respondents and 64% of male respondents had never used the drug. Of the 479 respondents who indicated that they were current cannabis users, the majority (59%) were male and only 41% were female.

Diagram 7: Respondents' use of cannabis across both regions shown by gender

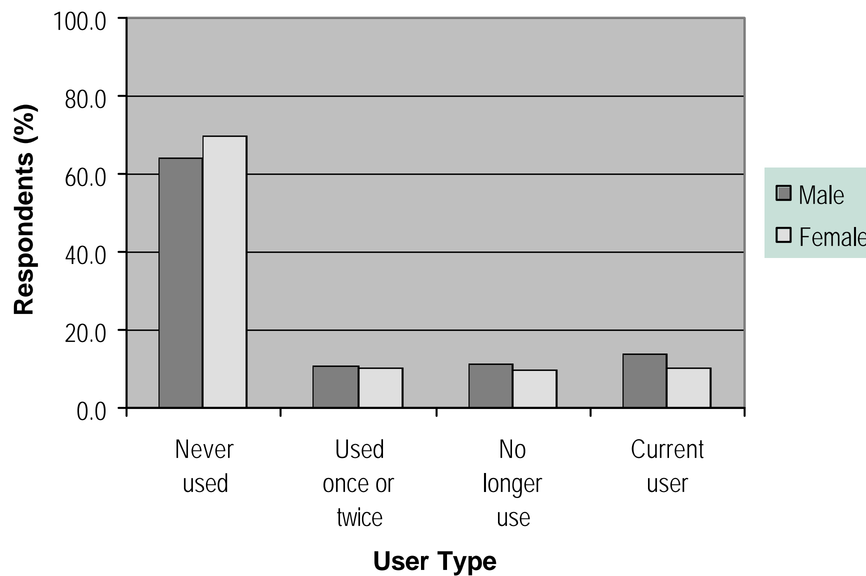
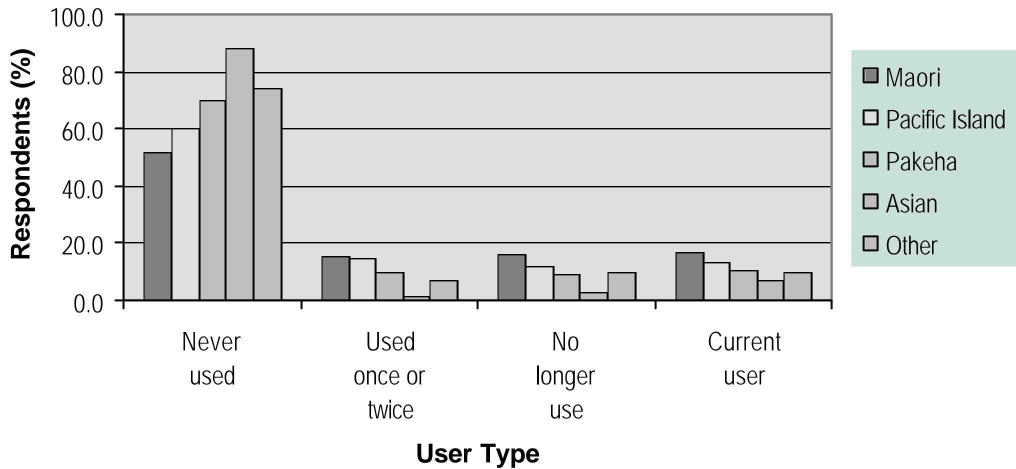


Diagram 8 shows that some interesting patterns did emerge from a comparison of ethnicity and cannabis use. In percentage terms cannabis use was lowest amongst those who identified as Asian with nearly 90% indicating that they had never used the drug and only 7% being regular users.

Diagram 8: Respondents' use of cannabis across both regions shown by ethnicity



About 70% of Pakeha or NZ European students had never used cannabis and 11% were regular users.

Cannabis use among Maori and Pacific Island respondents was greater overall. Across the age range studied (13 to 17 years), 48% of Maori respondents and 40% of Pacific Island had used cannabis at some time. Over 30% of Maori respondents had either used it once or twice or were no longer users but a further 17% were current users of the drug.

Of the original group of respondents (7% of the Wairarapa sample and 5% of the Kapiti sample) who had identified themselves as Maori in the questionnaire, over 19% in the Wairarapa and almost 18% in Kapiti were current users. About 26% of all Pacific Islanders had tried the drug or were no longer users and 14% reported that they were current cannabis users.

4.3 Reasons for choosing to use cannabis

Those respondents who had used cannabis at least once were asked to indicate the main reason for choosing to use it. In both regions respondents gave two main reasons, that it made them feel good (identified by about 29%) and that it made them feel spaced out or stoned (about 30%).

A number of respondents in both regions gave more than one answer to this question. Given that it was not possible to judge which of the reasons was the main one, all responses have been included in the analysis. Nearly 10% of all those with at least some experience of using cannabis gave no reason for having chosen to do so. Table 9 below gives a summary of responses made by all those who had used the drug at least once.

Table 9: Reasons for choosing to use cannabis given by those who had used the drug at some time

Reasons for choosing to use cannabis	Wairarapa		Kapiti	
	N	%	N	%
It makes me feel part of the group	35	5.7	59	8.3
It makes me feel good	175	28.6	211	29.6
I want to be "spaced out/stoned"	187	30.6	207	29.0
It helps me cope with family problems	40	6.5	36	5.0
It helps me cope with pressures at school	20	3.3	26	3.6
No one cares about me	11	1.8	12	1.7
I think it is a safer drug than alcohol	52	8.5	52	7.3
Other (specified)	77	12.6	134	18.8
Total responses	**597**		**737**	
Missing	80	13.1	36	5.0

Note: The total number of respondents was 612 in Wairarapa and 713 in Kapiti. Percentages add to more than 100% because some respondents specified more than one option.

A small number (about 6%) of respondents who had never used cannabis also gave an answer. It is most likely that these respondents were speculating about what their reasons might be for choosing to use cannabis. The main reasons they gave were that it would make them feel part of the group or that it would make them feel good.

In both regions, a relatively large percentage indicated that their reasons for choosing to use cannabis were other than the ones listed. Of these responses, the vast majority gave their reason as that they ‘just wanted to try it’ or they ‘just wanted to see what it was like’.

Aside from a few somewhat esoteric answers, however, the remainder of the 'other' comments did not provide any reasons substantially different from those listed in the original question.

4.4 Reasons for choosing not to use cannabis

Respondents who had never used cannabis were asked to indicate their main reason for choosing not to use it. Table 10, below, summarises their responses to the question. In both regions non-cannabis users indicated that their main reason for not using the drug was that they believed that it was bad for their health to use drugs. Nearly 60% of respondents in the Wairarapa and 47% in Kapiti gave this answer. In Kapiti, nearly a quarter (24%) of all respondents who had reported that they did not use cannabis gave no reason for this choice.

Table 10: Reasons for choosing NOT to use cannabis given by those who had never used the drug

	Wairarapa		Kapiti	
Reasons for choosing NOT to use cannabis	N	%	N	%
It's not cool	108	7.7	88	7.0
It is wrong to use drugs	246	17.5	157	12.5
It is bad for my health to use drugs	820	58.2	588	46.9
Other (specified)	176	12.5	178	14.2
Total responses	**1350**		**1011**	
Missing	156	11.1	302	24.1

Note: The total number of respondents was 1408 in Wairarapa and 1255 in Kapiti. Percentages add to more than 100% because some respondents specified more than one option.

A large number of those who reported that they had used cannabis (50% in the Wairarapa and 77% in Kapiti) also responded to this question. These respondents were principally those who had either used the drug only once or twice or who were no longer users. Their responses were very similar to those of the non-users of cannabis.

Of those who identified that there were other reasons for choosing not to use cannabis, the most cited reason was that they ‘just don’t want to’. However, many stated that they chose not to use cannabis for ‘all of the above’ reasons. Other reasons offered related to religion, sport, loss of memory associated with cannabis use and simply never having had the opportunity.

4.5 Recent cannabis use

From this point in the survey, until the final question, answers were requested only from respondents who had used cannabis once or twice, were no longer users or who were regular cannabis users. Thus, all analysis for these sections has been carried out excluding all respondents who reported that they had never used cannabis; sample sizes for the Wairarapa and Kapiti are 612 and 713 respectively.

Table 11 shows respondents' recent use of cannabis. In both regions recent use had been relatively low with 43% in the Wairarapa and 39% in Kapiti reporting that they had not used the drug at all in the preceding four weeks. About 32% of cannabis users in the Wairarapa and 37% in Kapiti had used the drug between one and four times but relatively small numbers had used the drug any more than that. Some respondents were heavy users. 9% of the Wairarapa sample and 7% of the Kapiti group reported having used cannabis twenty times or more in the preceding four weeks.

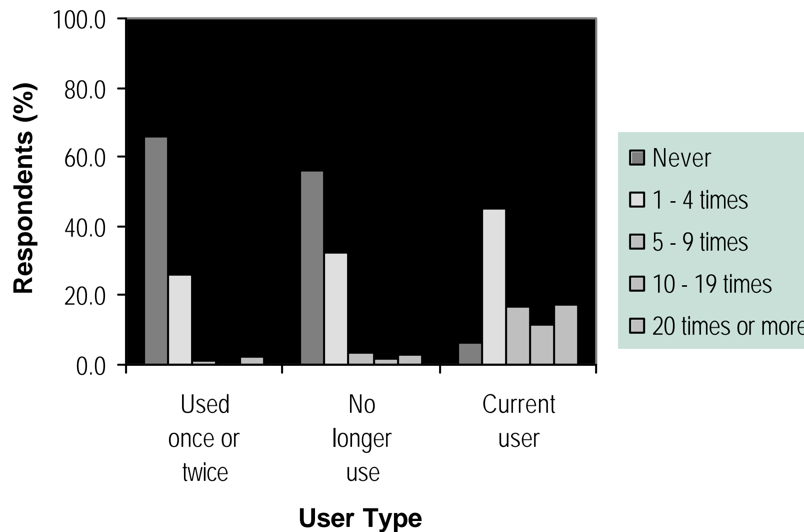
Table 11: Respondents' use of cannabis in the preceding four weeks

	Wairarapa		Kapiti	
Number of times used	N	%	N	%
Never	265	43.3	281	39.4
1 - 4 times	197	32.2	266	37.3
5 - 9 times	43	7.0	57	8.0
10 - 19 times	32	5.2	32	4.5
20 times or more	53	8.7	52	7.3
Missing	22	3.6	25	3.5
Total	**612**	**100.0**	**713**	**100.0**

Diagram 12 shows recent drug use of respondents from each of the different user types (used once or twice, no longer users, regular users). As expected, cannabis use by those who identified themselves as regular users was noticeably different.

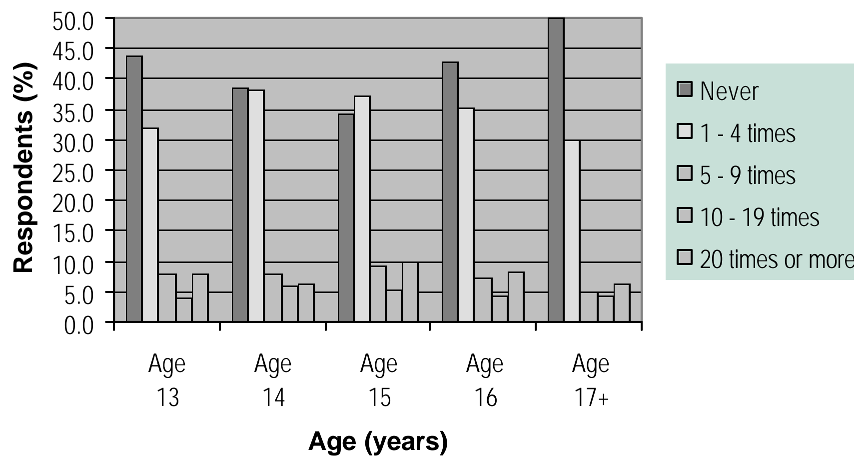
Interestingly, cannabis use among current users is relatively low with 45% having used the drug between one and four times in the preceding four weeks.

Diagram 12: Recent cannabis use by different types of users of the drug



In Diagram 13 the data are considered according to the ages of the respondents and the patterns of use are very similar. Among 13 year olds a high percentage had not used cannabis at all in the previous four weeks but even so, over 50% of 13 year olds who had used cannabis had done so in the last four weeks and a small percentage reported using it more than 20 times. A large percentage of 17 year olds had not used cannabis. In general, recent cannabis use by 17 year olds was lower than that of other ages.

Diagram 13: Recent cannabis use by respondents of different ages



4.6 Age of first cannabis use

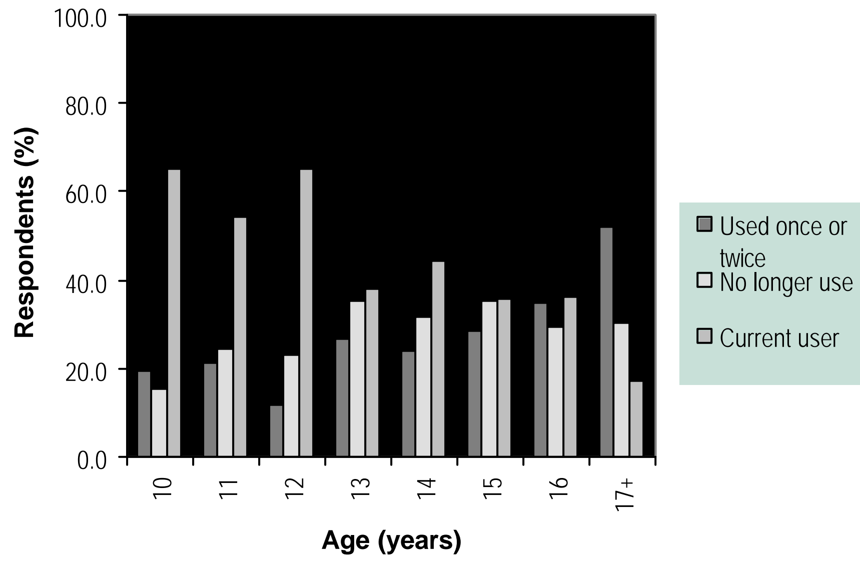
Respondents were asked to indicate at what age they had first used cannabis. Table 14 shows that first use was relatively low at ten and eleven years but then increases, reaching a peak at 13 and 14. About a third of cannabis users in the Wairarapa and 37% in Kapiti reported that they began using cannabis at either 13 or 14. However, about a quarter of each group did not specify their age of first use.

Table 14: Respondents' age of first use of cannabis

	Wairarapa		Kapiti	
Age of first cannabis use	**N**	**%**	**N**	**%**
10 years or younger	34	5.6	18	2.5
11	33	5.4	28	3.9
12	55	9.0	83	11.6
13	104	17.0	135	18.9
14	98	16.0	128	18.0
15	87	14.2	108	15.1
16	29	4.7	46	6.5
17 or older	17	2.8	6	0.8
Missing	155	25.3	161	22.6
Total	**612**	**100.0**	**713**	**100.0**

Diagram 15 shows respondents' first use of cannabis, compared with their current use of it. Most of those who had first tried the drug at ages between 10 and 12 were still current users. Those who had started later, at 13 years or older, were about equally likely to have either given up using cannabis or to have only used it a couple of times. Those respondents who began using cannabis at 17 years plus were more likely to have used it only once or twice.

Diagram 15: Types of cannabis use shown by age of first use of the drug



Respondents (%)
100.0
80.0
60.0
40.0
20.0
0.0
10
11
12
13
14
15
16
17+
Age (years)
Used once or twice
No longer use
Current user

4.7 Obtaining cannabis

Those respondents who had used cannabis were asked about whom they had obtained it from and how they had got it. Table 17 shows the people from whom respondents obtained cannabis and Table 19 shows how they reported having got it.

Table 17: Sources of cannabis acquisition

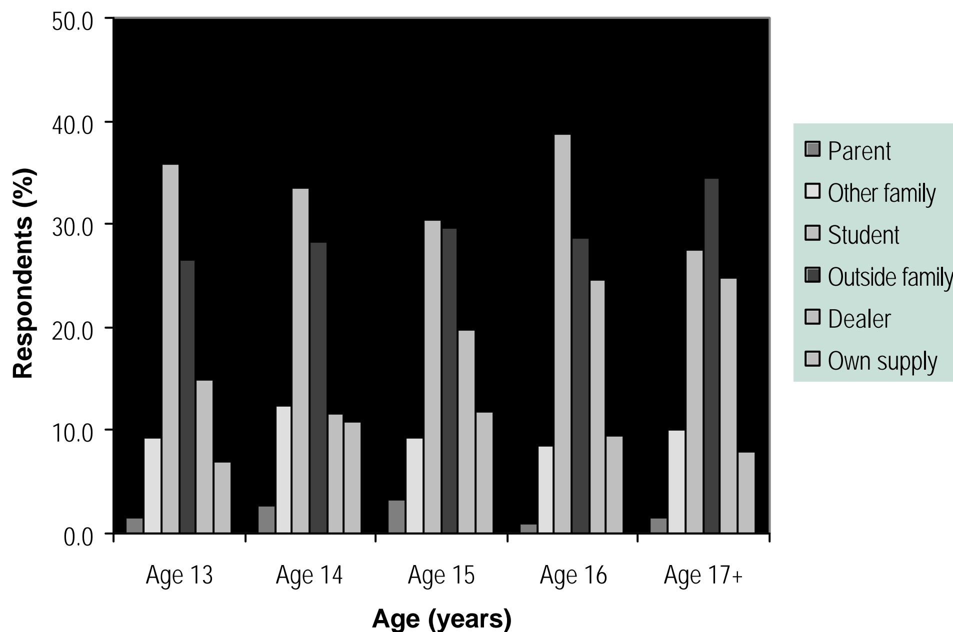
	Wairarapa		Kapiti	
Source of cannabis	N	%	N	%
I haven't used cannabis	11	1.8	5	0.7
A parent or caregiver	17	2.8	11	1.5
Other family members	67	10.9	64	9.0
A student from school	179	29.2	258	36.2
Someone outside the family (other than a student from school or dealer)	177	28.9	218	30.6
A dealer	125	20.4	139	19.5
My own supply	64	10.5	66	9.3
Other	6	1.0	0	0.0
Total	**646**		**761**	
Missing	51	8.3	28	3.9

Note: The total number of respondents was 612 in Wairarapa and 713 in Kapiti. Percentages add to more than 100% because some respondents specified more than one option.

In both Kapiti and the Wairarapa the most commonly mentioned suppliers of cannabis were other students (29% in the Wairarapa and 36% in Kapiti) or individuals from outside the school and the family (29% in the Wairarapa and 31% in Kapiti). In both areas about 20% of respondents obtained cannabis from a dealer and about 10% had their own supply.

When these data are broken down by age of respondent some patterns emerge. Diagram 18 shows the main sources of cannabis acquisition for respondents in both regions. Respondents aged 16 and under are most likely to have obtained their cannabis from another student or people outside the family (other than family members or dealers). At 17 years contacts outside the family are the most likely means of cannabis acquisition. This is a result of the changing demographics of those still attending school at that age. Dealers also seem to become more important sources as respondents get older.

Diagram 18: Sources of acquisition of cannabis for respondents shown by age



When asked about how they had usually obtained cannabis, most respondents indicated that they were given the drug. Well over half (54%) of respondents in the Wairarapa area and nearly two thirds (65%) in Kapiti answered in this way. About a quarter of each group indicated that they had bought it. In addition, a relatively high proportion (13% in the Wairarapa and 8% in Kapiti) reported that they grew it. Note that a number of respondents gave more than one answer to this question even though asked not to do so. It is not therefore possible to judge which of two responses was the most usual one.

Those who indicated that they had obtained cannabis by some other means generally gave reasons that might easily have been recoded into one of the existing options available. Most of these respondents stated that they shared the drug with friends or that friends bought it for them.

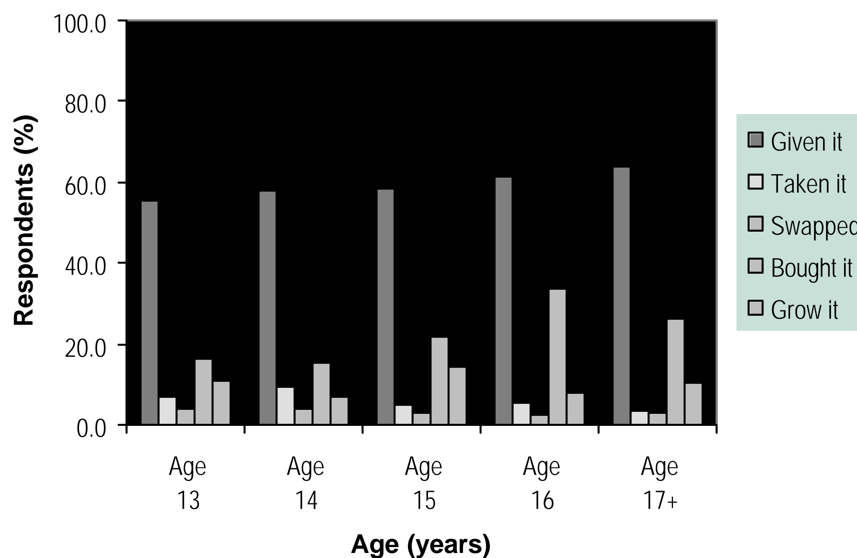
Table 19: How respondents obtained cannabis

	Wairarapa		Kapiti	
How cannabis was obtained	N	%	N	%
I haven't used cannabis	6	1.0	6	0.8
I have been given it	332	54.2	462	64.8
I have taken it without permission	32	5.2	43	6.0
I have swapped it for something other than money	22	3.6	20	2.8
I have bought it	155	25.3	161	22.6
I grow it	80	13.1	55	7.7
Other (specified)	39	6.4	28	3.9
Total	**666**		**775**	
Missing	37	6.0	25	3.5

Note: The total number of respondents was 612 in Wairarapa and 713 in Kapiti. Percentages add to more than 100% because some respondents specified more than one option.

Diagram 20 shows how respondents obtained cannabis compared to their age. The chart shows that the percentage of cannabis users who have been given cannabis increases slightly with age.

Diagram 20: How respondents obtained cannabis, shown by age



4.8 Requests for further information

The final question in the questionnaire asked what information respondents would want on cannabis, other drugs and the health effects of using them. All respondents, including those who had never used cannabis were invited to answer. Table 21 summarises all the responses.

Table 21: Further information required by respondents

Information required	Wairarapa		Kapiti	
	N	%	N	%
I would like information on the health effects of cannabis usage.	224	11.1	167	8.5
I would like information on the health effects of other illegal drugs.	168	8.3	185	9.4
I would like information on the people in the community who provide help and support for students with drug problems.	88	4.4	77	3.9
I do not require any information.	1585	78.5	1576	80.1
Total	**2065**		**2005**	
Missing	88	4.4	82	4.2

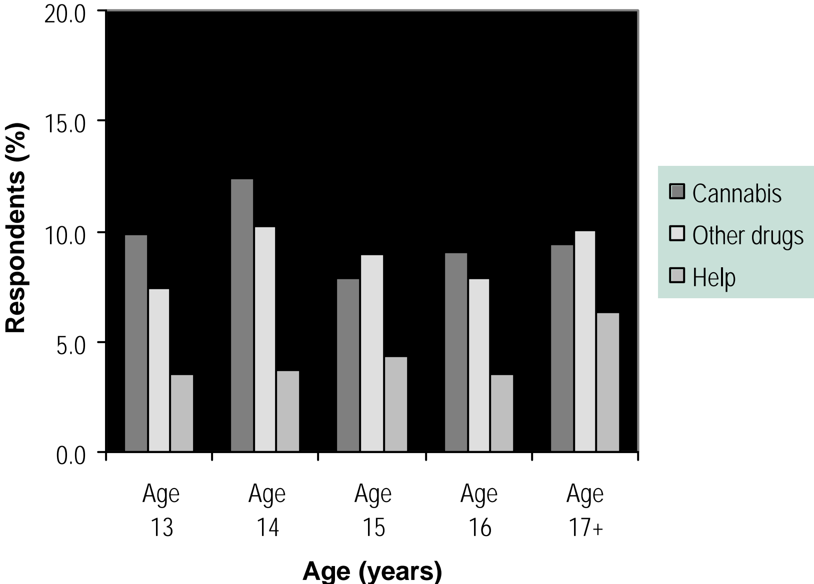
Note: The total number of respondents was 2020 in Wairarapa and 1968 in Kapiti. Percentages add to more than 100% because some respondents specified more than one option.

Although a relatively high proportion of respondents indicated that they did not require any further information about cannabis or other illegal drug usage, about 15% of all respondents felt that they did require some information.

About 400 respondents (about 10% of the surveyed sample) asked for information relating to the health effects of cannabis use and 350 asked for information about the health effects of other illegal drugs. 165 respondents indicated that they would like information about help and support for students with drug problems.

Diagram 22 shows interest in information about the health effects of both cannabis and other illegal drugs broken down by age of the respondents. This was greatest at age 14 and at age 17 plus. Interest in information about help and support for students with drug problems was highest in respondents aged 17 and over.

Diagram 22: Percentages of respondents, shown by age, requesting information about cannabis and other drugs



4.9 Discussion of results

The central finding of the survey is the prevalence of cannabis use among school students. In the Wairarapa, 11% percent of respondents to the questionnaire stated that they were current users of cannabis. In the Kapiti region 13% were current users of the drug. The slight difference between these two regions can probably be accounted for by the fact that the Kapiti group comprised, on average, more older students than the Wairarapa group (see Diagram 6).

The highest prevalence of cannabis use was among 16 year olds (19% reported being current users) and nearly 50% had at least tried it. These figures are quite alarming.

From this sample, one student in five of any class of 16 year olds could be experiencing the effects of having recently taken cannabis. These students are unlikely to be reaching their educational potential and, if their use of cannabis continues, will be unlikely to fulfil their future economic and social potential.

About 13% of 13 year olds had tried cannabis, and 5% claimed to be current cannabis users. This finding suggests that different approaches might be required in tackling cannabis use in schools.

At 13 or younger, where a relatively low percentage have tried cannabis, an education programme that focuses on preventing uptake of the drug, and its health effects would be of value.

Work with older school students, many of whom might have already tried cannabis, would do better by addressing the risks to health and well-being associated with use of the drug. This programme would include decision making skills which minimise the harm associated with drug taking and other social issues.

The concerns expressed from many sources that cannabis use is a particular problem for Maori were supported by the data. In comparison with overall cannabis usage, current cannabis use by Maori was about 19% in the Wairarapa and 18% in Kapiti.

These are particularly high percentages, especially given that they include data from respondents aged 13 years and up. This highlights the need to develop programmes that are specifically aimed at young Maori as the difference in prevalence suggests that the associated issues may also be different.

Respondents who had checked 'Pacific Island' on the questionnaire showed a prevalence of about 14% current cannabis use. This is slightly higher than the average for the whole sample (12%) but a difference of this size may simply be the result of random variations in the data.

Schools and community agencies developing programmes to address cannabis use by school students might also consider the reasons for use given by those who had used the drug. Primarily the reasons given related to the effect of the drug on the individual ('It makes me feel good' or 'I want to be spaced out/stoned'). The notion of being part of a group or taking cannabis as a result of peer pressure was relatively unimportant.

Furthermore, the fact that a high percentage of non-users of cannabis cited health risks as being their main reason for not using the drug, indicates that there is some receptiveness to a health focused approach.

The data on recent use of cannabis show that respondents aged between 14 and 16 had used cannabis more on average in the previous four weeks than either the younger or the older respondents. Indeed, by 17, half of those who had identified themselves as having tried cannabis stated that they had not used the drug at all in the four weeks preceding the survey. However, at age 13, although recent use of cannabis was proportionately lower, a relatively high number had used cannabis more than 20 times in the preceding four weeks.

High density of usage among younger respondents is an issue of some concern. In addition, the first use data show that, although many begin taking the drug at about 13, those who start younger (at ages 10 to 12) are more likely to be current users of the drug.

These students are the most at risk of having their entire secondary school experience, shaped by their use of cannabis, and their learning and educational attainment could be adversely affected as a result.

There is little information available about this 'core group' of cannabis users but the risks for them are such that further research into their motivations and issues associated with their usage could be considered to be very important.

The most common source of cannabis for both groups was from school friends or from friends outside the family. Overall, younger students were less likely to get cannabis from dealers, though, in the Wairarapa, about 22% of respondents aged 13 who used cannabis stated that they had got cannabis from a dealer. In comparison, in the Kapiti region, 9% of those aged 13 who had used cannabis had obtained the drug from a dealer. In Kapiti, 44% of 13 year olds who have used cannabis obtained it from other students; in the Wairarapa 27% obtained it in this way. At 16 years, dealers were used by about a quarter of respondents in both regions though the most popular source in either region was other students (35% in the Kapiti region and 41% in the Wairarapa).

Most of the respondents at all ages were given cannabis. This was probably in the context of social groups in which the drug might be shared among a number of young people. However, the proportion of respondents who buy cannabis increases with age and, by 16, over a third of those who had used cannabis had bought it.

The question of whether younger respondents are given cannabis as a way of persuading them to get into the habit of using it regularly and therefore buy it in the future was considered. The data as it stands does not support this. The proportion who are given the drug increases steadily with age. Again, more research would be required in order to learn more about the environments for selling cannabis and other drugs in schools.

Finally, although a high proportion of students says that they do not need more information there are a number that do. It might therefore be more appropriate to develop a good strategy for passing on the relevant information to the correct age group.

5. Findings and recommendations

5.1 Findings

The main findings from the student questionnaire were:

Usage

? 70% of respondents had not tried cannabis. Of the 30% of respondents in both areas who have tried cannabis about 11% in the Wairarapa and 13% in the Kapiti region reported that they considered themselves as "someone who uses cannabis now" (For this report these users are known as current users.)

? The percentage of respondents who have tried cannabis increases with age. Among 16 year old respondents overall, about 19% were current users and 50% had never used.

? Current cannabis use among Maori is higher than for any other ethnic group. 17% of those who identified as Maori or Maori/European and 18% of those who had originally identified as Maori were current users of cannabis. Pacific islanders current usage is 14%, slightly higher than the 12% average for the whole sample.

Reasons for use

? The main reasons given for choosing to take cannabis were that it made respondents 'feel good' or because they wanted to be 'spaced out / stoned'. Non-cannabis users identified the risk to health as being the major reason for not taking cannabis.

Recent use

? Among those who had tried cannabis, about 40% had not used it at all in the preceding four weeks - leaving 60% who had used the drug. Over a third had used it between one and four times and about 8% had used it 20 times or more.

? Density of use increased with age with about 10% of 15 year old cannabis users reporting very heavy usage in a four week period.

Age of first use

? Respondents had tended to try cannabis for the first time at age 13 or older. However, about 19% of all those who had tried cannabis had done so by the age of 12.

? Furthermore, of those who had tried the drug by the age of 12, about 60% reported being current users.

Obtaining cannabis

? The most common source of cannabis was from other students or from some other person outside either school or family. Dealers were used relatively little by younger respondents but, by 16, around a quarter of all cannabis was obtained from dealers.

? Overall, the majority of cannabis used by respondents had been given or shared, presumably in social situations. The percentages of respondents who bought cannabis increased with age so that, at age 16, about a third had bought it.

Information requirements

? The vast majority of respondents stated that they did not require any further information about cannabis usage, other illegal drugs or help and support for students with drug problems. However, about 15% of all respondents, including those who had never used the drug, did feel that they would like some more information.

5.2 Recommendations

It is recommended that:

? Cannabis education /information transfers are best targeted at younger students, from Year 7 on. Strategies need to be developed to address this age group.

? Cannabis education programmes supported by Regional Public Health need to be consistent with the "harm minimisation" policy framework as adopted by the National Drug Policy, and Ministry of Education Drug Education guidelines.

? Cannabis education programmes address the issues raised by the school co-ordinators survey, particularly in helping schools to develop workable drug policies, in accordance with the new curriculum guidelines.

? Drug education programmes have a health focus. This recommendation is for policy development and as a future research question. This health focus needs to be clearly differentiated from debates around decriminalisation.

? Programmes be developed that are specifically aimed at young Maori. Ideally, these would be 'by Maori - for Maori' in design, implementation and evaluation.

? The sensitivity of Kapiti schools to cannabis needs assessments be allayed, by Regional Public Health through education and consultation.

? Regional Public Health build on the positive Kapiti and Wairarapa stakeholder interest and commitment on this issue through formal networking support and advocacy, and in presenting back to all stakeholders the findings and recommendations of this report.

? The findings and recommendations of this report are raised by Regional Public Health with relevant politicians (central and local).

? Regional Public Health has a media strategy for presenting the findings and recommendations of this report.

? Future regional planning and lobbying efforts emphasise the lack of, in the Wairarapa and Kapiti regions, of specific drug-related agencies that have a youth orientation.

? Staff of Regional Public Health be encouraged to have built into their personal development programmes ongoing training in computer-based data analysis and in preparation, analysis and presentation of qualitative and quantitative data for report writing and particularly in questionnaire design and development.

? Further research be carried out on

a) focusing on the “core group” of cannabis users, i.e. those who first use cannabis between the ages of 10 and 12, and who have continued high usage;

b) to study the economic, social and cultural environments for selling drugs in school settings.

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7. Appendix A

CANNABIS STUDENT QUESTIONNAIRE

This questionnaire is anonymous and you will not be able to be identified from the information you give, however if there are any questions that you do not wish to answer that is your choice.

1. How old are you now?

? 10 years of age or younger

? 11 years of age

? 12 years of age

? 13 years of age

? 14 years of age

? 15 years of age

? 16 years of age

? 17 years of age or older

2. Are you a male or female?

? I am a male

? I am a female

3. Which of these groups best describes you?

? I am Maori

? I am Maori/European

? I am Pacific Island

? I am Pakeha/NZ European

? Other
Specify: ___________________

4. Which one of these sentences best describes you?

? I have never used cannabis (marijuana, dope, weed, pot, dac) **(If you tick this box, miss question number 5 and go to question number 6)**

? I have used cannabis 1 or 2 times only

? I have used cannabis (more than 2 times) but I don't anymore

? I am someone who uses cannabis now

5. If you choose to use cannabis what would be the MAIN reason? (tick one only and go to question number 7)

? It makes me feel part of the group

? It makes me feel good

? I want to be "spaced out/stoned"

? It helps me cope with family problems

? It helps me cope with pressures at school

? No one cares about me

? I think it is a safer drug than alcohol

? Other

Specify:____________________
_

6. If you choose not to use cannabis what would be the MAIN reason? (tick one only and go to question number 11)

? It's not cool

? It is wrong to use drugs

? It is bad for my health to use drug

? Other
Specify:____________________

7. In the last 4 weeks how many times (if any) have you used cannabis?

? never

? 1 - 4 times

? 5 - 9 times

? 10 - 19 times

? 20 times or more

8. If you use cannabis now, how old were you when you started using cannabis?

? 10 years of age or younger

? 11 years old

? 12 years old

? 13 years old

? 14 years old

? 15 years old

? 16 years old

? 17 years old or older

9. If you have ever used cannabis, who have you usually got it from? (please tick one only)

? I haven't used cannabis

? a parent or caregiver

? other family members

? a student from school

? someone outside the family (other than a student from school or dealer)

? a dealer

? my own supply

10. If you have ever used cannabis, how have you usually got the cannabis? (please tick one only)

? I haven't used cannabis

? I have been given it

? I have taken it without permission

? I have swapped it for something other than money

? I have bought it

? I grow it

? Other Specify:_____________________

11. Tick the boxes that apply to you.

? I would like information on the health effects of cannabis usage

? I would like information on the health effects of other illegal drugs

? I would like information on the people in the community who provide help and support for students with drug problems.

? I do not require any information