

The Whole-school Approach to Reducing Harm From Alcohol and Drugs and Promoting Mental Health

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Introduction

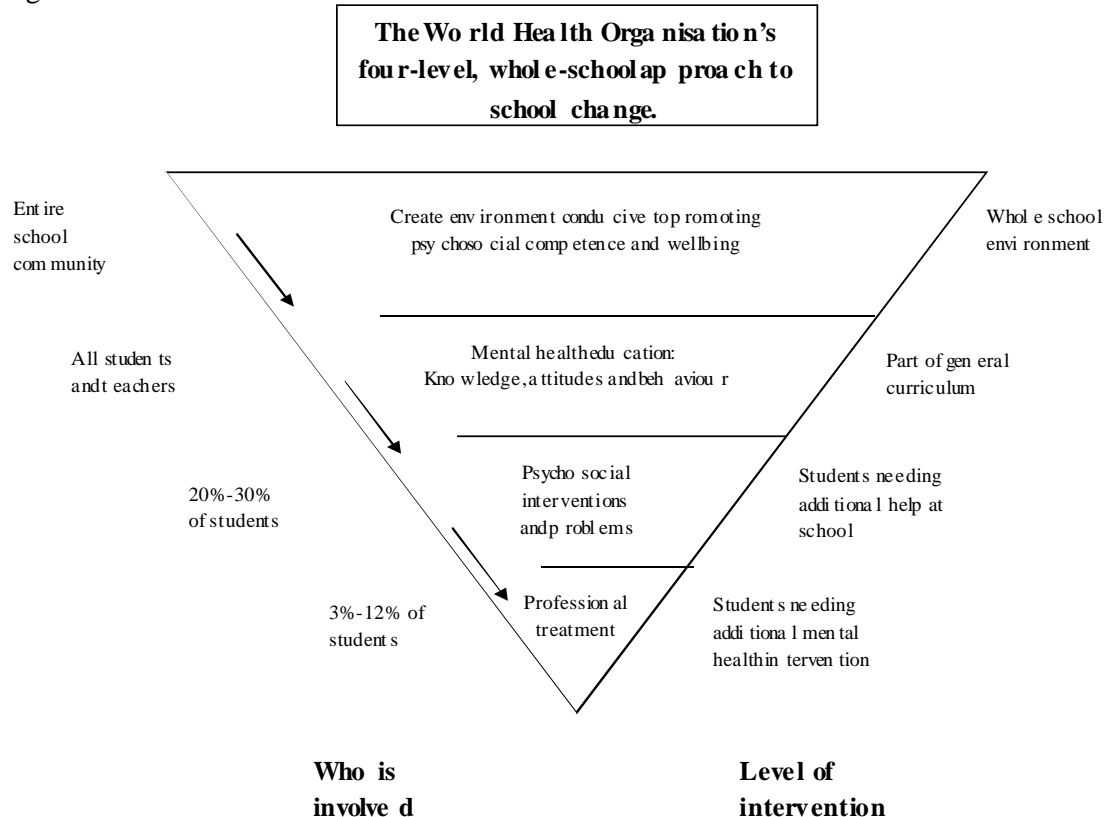
The World Health Organisation (WHO) has championed a global direction for schools to be health-promoting environments which consider young people in the contexts of school, home and community (World Health Organisation, 1995). This policy is supported by a number of studies and reviews that recommend that schools adopt a comprehensive whole school approach promoting a more integrated range of strategies to promote health and well being. These need to include school-wide environmental change, parental involvement and community-wide interventions (Roche, 2006, Flay, 2000, Weissberg, 2003, Nation, 2003, Elias, 1997, Tobler, 2000).

Policy and Framework Supporting a Whole School Approach

The World Health Organisation's school change model (Hendren et al., 1994) provides a way of conceptualising a *whole school approach*. Figure One shows an adaptation of the WHO model by Wyn and associates (2000). The four parts of the WHO model represent the multi-levels that comprise a *whole school approach*.

1. The widest part of the triangle emphasises the creation of a school environment that is conducive to learning.
2. The second layer of the triangle signals the need to educate for and about health and wellbeing for everyone. Education in this area is considered to be universal in its application, and is designed to reach all students. This includes the formal curriculum (e.g., health education) whereby young people experience learning opportunities which can help them gain understanding, knowledge and skills to support their own and others' health and wellbeing) as well as education opportunities for teachers and parents.
3. The third level of the triangle signals the need for targeted initiatives (i.e., selective and indicated) to support young people with high health and wellbeing needs. Selective initiatives are defined as those targeting young people who may be at risk, e.g., experiencing trauma and loss, alcohol and drug issues (theirs or others), family separation/divorce, parents with mental illness etc. Targeting these young people through selective programmes has been shown to be effective. Indicated programmes target young people showing early signs of mental health problems but have not yet presented at clinical levels. These initiatives may be in the form of peer support groups, peer mediation programmes, counselling and guidance, drug and alcohol programmes, grief support programmes and anger management programmes.
4. The tip of the triangle signals the need for more individually focused professional support, which may involve school-based counselling or referral when necessary to community agencies and adolescent health services (Wyn et al., 2000).

Figure 1:



(adapted by Wyn et al., 2000)

Internationally, a broad range of initiatives have been developed under the auspices of a whole school approach which ensures that the Health and Physical Education Curriculum is reinforced across the school by policies, procedures and practices which create a supportive school community environment. The Gatehouse Project implemented in secondary schools in metropolitan Melbourne, Australia is one such initiative (Patton et al., 2000, Bond et al., 2004). The project was designed as a primary prevention programme consisting of an institutional (i.e., settings) component and individual-focused components (i.e., universal classroom based learning) to promote emotional and behavioural wellbeing with the major aims being to “increase levels of emotional wellbeing and reduce rates of substance use, known to be related to wellbeing” (Bond et al., 2004, p.997). The Gatehouse study used a cluster randomised controlled design which involved 12 ‘intervention’ schools and 12 ‘control’ schools. Findings indicated that there was a reduction in young people’s health risk behaviours, particularly substance use. Possible explanations for this reduction were attributed to the intervention schools’ broader focus on young people’s connectedness, a more positive school climate, and the development of young people’s general cognitive skills in the individual-focused component of the intervention. With regard to young people’s reporting of symptoms of depression, the project had no apparent effect. The project team suggested that the intervention may not have been “sufficiently specific or sustained to produce an effect on these outcomes” (Bond et al., 2004, p.1002). Overall, these authors concluded that while whole school approaches show promise in relation to promoting young people’s wellbeing, achieving multi-levelled environmental and individual change is a complex process which requires sustained, long-term commitment by schools and communities.

New Zealand policy context

New Zealand policy documents also mirror international trends that emphasise the need for schools to deliver health education in the context of a socio-ecological model that embraces a range of individual and environmental strategies embedded within the principles of health promotion and positive youth development frameworks. These strategies are aimed at developing personal skills and strengths, creating safe physical and emotional school and community environments including supportive policies and practices. They also involve developing effective links with key agencies and the wider community (Ministry of Health, 2001, Ministry of Health, 1998, Learning Media Ltd, 2000, Learning Media Ltd, 1999). The Health and Physical Education Curriculum (Ministry of Education, 1999) reinforces this in recognising that health education programmes in schools need to be more than just a composite of information, values, skills and social competency training. There is considerable emphasis placed on strengthening links with the community both to address the consistency of the messages received from the media and other sources, and to provide support for school based strategies. The National Alcohol Strategy (Alcohol Advisory Council and Ministry of Health, 2001) also emphasised that there is more evidence for community based approaches and that strategies focusing on education alone are insufficient. The need for the cooperation and involvement of the whole school is emphasised.

More recently, the *Youth Development Strategy Aotearoa* was developed to “provide a policy platform for public sector agencies when developing policy advice and initiatives to those aged within the 12 to 24 years inclusive age group” (Ministry of Youth Affairs, 2002, p.7). The strategy has six key principles which state that youth development: (1) is shaped by the big picture; (2) is about young people being connected; (3) is based on a consistent strengths-based approach; (4) happens through quality relationships; (5) is triggered when young people fully participate; and (6) needs good information (Ministry of Youth Development, 2002).

Alcohol and drugs

Evidence from the literature indicates that initiatives to prevent or reduce harm from alcohol and drug that take an environmental community level approach can be effective in better outcomes (Tobler, 2000, Faggiano, 2005, Foxcroft et al., 2006). While a wider community focus is essential to this effectiveness, this can be complemented by an environmental approach to promoting wellbeing across the whole school community (Tobler, 2000), with health education programmes being a part of this comprehensive approach. This may include community input on school drug policy and practices, establishing linkages with the community and engaging participation of families (Cuijpers, 2002, Nation, 2003, Sanci, 2002, Wagner, 2004, Elias, 1997, World Health Organisation, 2002).

Mental health and suicide prevention

Nationally, in the last decade, two significant policy directions have been initiated at Government level to address young people’s healthy development. Firstly, the youth suicide prevention strategy *In Our Hands* (Te Puni Kokiri et al., 1998). Youth suicide has been identified in Aotearoa/new Zealand as a significant public health concern with suicide in this age group being the second leading cause of death and the fourth leading cause of hospitalisation among young people under the age of twenty-five years (New Zealand Health Information Service, 2001). *In Our Hands* was developed to provide a public health framework that recognised the need for a diverse and

multi-faceted approach to promoting and supporting young people's mental, emotional and social wellbeing. With respect to schools, this strategy included the following aspects:

- Promoting resilience
- Enhancing connectedness to school
- Fostering personal identity and self-worth
- Implementing mental health education programmes such as *Mental Health Matters*
- Providing supportive pastoral care and guidance systems in schools
- Providing avenues for help-seeking
- Providing programmes to enhance protective factors (e.g., promotion, prevention, early intervention)
- Developing clear processes for the identification, support and referral of young people at risk
- Supporting young people in distress
- Implementing school procedures for providing immediate crisis support, traumatic incident management and postvention support for those affected by suicide.

Conclusion

The literature suggests that both alcohol and drug and mental health school based health education programmes are more likely to be effective in creating behavioural and health outcomes when they are part of a whole school approach that seeks to enhance both education and health outcomes.