
Final Report

August 2019

Dr Alison Baker
Dr Linda Chiodo
Associate Professor Julie White
ODYSSEY HOUSE: BUILDING RESILIENCE IN SCHOOLS: AN EVALUATION REPORT

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Acknowledgements

We respectfully acknowledge the traditional owners of country throughout Victoria and pay respect to the ongoing living cultures of First People. We acknowledge the elders, and their families and forbears who have been the traditional custodians of Victorian land for many centuries. We acknowledge that the land on which we work is the place of age-old ceremonies of celebration, initiation and renewal and that the First Nation people’s continuous living culture has played a significant and unique role in the life of this region.

We would like to thank the participants who took part in this research and provided us with insights. We would also like to acknowledge and thank Odyssey House for their assistance throughout this evaluation.
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¹ School names have been replaced with a pseudonym.
Executive Summary

…it doesn’t have to get disastrous before you engage with people. It can actually be embedded as awareness around thinking around decision-making and so on. So [the clinician] being part of our community was a huge help in engaging students, because they know her. And the access to accurate, up-to-date information, detox availability, all that kind of stuff is very, very useful…(Teacher, South Community School)

As we’ve been involved with the school we’ve actually noticed the change within the school itself in that they’ve been able to set up, they’ve been able to put things in place and particularly put in some of the suggestions that we’ve made along the way in place which has diminished the impact of the issue for the school. (Drug and Alcohol Clinician, Odyssey House: Building Resilience in Schools)

Substance use including the abuse of alcohol and drugs has been identified as a significant contributor to the poor health and psychosocial wellbeing of young people and adults both within Australia (Champion, Newton, Barrett, & Teesson, 2013; Toumbourou, Rowland, Ghayour-Minaie, Sherker, Patton, & Williams, 2018) and internationally (Turhan, Onrust, ten Klooster, & Pieterse, 2017). The purpose of this study was to document Odyssey House’s Building Resilience in Schools program and to evaluate the ways in which the program assists young people to negotiate the challenges of substance use and mental health concerns. This program involves embedding and integrating a drug and alcohol counsellor into the school environment to increase young people’s access to specialised mental health information and services as well as to better support and develop the wellbeing capacities of Victorian secondary schools. The program initially functioned within alternative education spaces, however during the evaluation period was introduced into mainstream Victorian secondary colleges.

This study was guided by three main aims:

• document the initiative with the purpose of developing a detailed understanding of the structure and elements of the program;

• examine the extent to which the Building Resilience in Schools program contributes to preventing and reducing substance use and mental health related harms in young people; and

• how the program develops the welfare capacities of Victorian secondary schools in relation to students engaging with drugs and/or alcohol.

The report investigates a set of interrelated findings about the impacts of the program on the wellbeing of participating students and broader school community (e.g. school staff and teachers). Conclusions and
recommendations, resulting from the findings, focus on the significance of place-based services for young people.

The findings were generated from detailed analysis of data collected by Odyssey House school-based clinicians working with young people and the broader school communities. As part of this research we also conducted interviews with school-based clinicians and focus group interviews with teachers from participating schools that reflect the multiple ways in which young people were supported in the program, while also pointing to key capacities the teachers and staff developed.

Four key outcomes of this study are summarised below.

Young people require specialised, sustained and accessible wellbeing services in schools.

Both within flexible learning options and mainstream schools there are cohorts of young people negotiating complex mental health concerns (including impacts of trauma) and substance misuse, which require accessible and sustained support. Despite such identified needs, for many of the young people who participated in the Building Resilience in Schools program, this was their first experience of drug and alcohol counselling. Thus, signifying the importance of Odyssey House clinicians being embedded within the school setting. In addition to this place-based service provision, the flexibility in frequency and type of support assists clinicians to better meet the needs of young people. Findings indicate that both young people in community and mainstream schools require regular support. The most common support provided by school-based clinicians was direct counselling and assessment.

Program participation leads to positive wellbeing outcomes for students.

The majority of students who participated in the Building Resilience in Schools program experienced positive outcomes including reduced substance use. Other indicators of wellbeing that were positively impacted, post intervention, included mental health, emotional regulation and school engagement. From the findings it was evident that the school-based program is proactive in moving young people towards setting and achieving goals around substance use reduction. Also, the dissemination of harm minimisation knowledge and practice regarding the use of drugs and alcohol was an important outcome.

School-based services and interventions are optimal for positive outcomes.

The Building Resilience in Schools program embeds a drug and alcohol counsellor into the school context. In this study it became evident that this characteristic, which allows for the development of positive youth-adult relationships, was fundamental to the program’s success and acts as an exemplar for other wellbeing initiatives aimed at young people. The placement of clinicians in the school setting allowed for high levels of trust and rapport to be developed with students and teachers alike. This trust and rapport was characterised as vital for the complex support offered to young people. Furthermore, developing connections with the broader student cohort increases opportunities for early intervention efforts.

The Building Resilience in Schools program contributes to the welfare capacity of schools.

2 The terms ‘community’, ‘alternative’ and ‘flexible’ refer to small-scale educational options that specifically focus on young people struggling to remain connected with mainstream or local schools.
This school-based intervention supports the wellbeing and welfare capacity of schools in numerous ways. This program makes a significant contribution to connecting schools with specialised services, knowledge and contacts. These specialised clinicians strengthen pre-existing and multidisciplinary wellbeing teams by increasing their knowledge and recognition of young people with co-occurring issues (drug/alcohol use and poor mental health). By providing tailored professional development around trauma, mental health and substance use, school-based clinicians can strengthen teacher and wellbeing staff responses to young people with complex issues. Through this capacity building, the Building Resilience in Schools program makes a significant contribution to ensuring that schools and classrooms are safe spaces for young people negotiating mental illness and substance use.
1 Introduction

This report provides an overview of how the Building Resilience in Schools program operates to build resilience in young people in relation to substance use and mental health.

The overall purpose of this study was to:

1. document the initiative with the purpose of developing a detailed understanding of the structure and elements of the program;
2. examine the extent to which the program contributes to preventing and reducing substance use and mental health related harms in young people; and
3. how the program develops the welfare capacities of Victorian secondary schools in relation to students engaging with drugs and/or alcohol.

More broadly, the intention was to contribute practically to the local knowledge about interventions to improve health and wellbeing in schools. The outcomes of this study have the capacity to contribute to improvements of the service, and be an example for other schools exploring place-based drug and alcohol initiatives.

1.1 Current Context

In recent times the Victorian Government has renewed its commitment to improve the educational outcomes of the State’s young people and better equip schools and educational settings with the tools and resources to improve student engagement and wellbeing. One way this is evidenced is that after a successful pilot period, the Department of Education and Training (DET) allocated significant funds ($44 million) to the roll out of the Navigator program (2019-2021) across Victorian catchment areas. The Navigator program is characterised as a “partnership between the community sector, DET and education providers to enable a service that actively seeks out disengaged young people and provides individualised support that is targeted to supporting their re-engagement back into education” (www.education.vic.gov.au). Through these partnerships the objective is to deliver holistic care and support to young people to minimise the impact of any barriers to learning and enhance psychosocial outcomes linked to educational participation and achievement. Together with case management and outreach services, the Navigator framework emphasises a “place based responses to disengagement”. This is achieved by bridging the gap between schools and local services and promoting collective and collaborative problem solving and service provision to better meet the needs of students. This multifaceted model has positively contributed to students’ educational readiness, improved wellbeing – including improved confidence and self-regulation. Importantly increased school engagement and re-
engagement by young people has also been observed as a result of the Navigator program (www.education.vic.gov.au).

Thus, this commitment by the DET indicates a recognition that not only Victorian young people require increased support to achieve learning goals, rather that the school setting is a fundamental context in which such support can be delivered. Making schools inclusive places where young people with complex needs are encouraged to participate rather than excluded increases positive outcomes for young people and the community both in the short and long-term.

As detailed in the following report Odyssey House has been present within FLOs and community school settings prior to the Navigator program. However, with their move into mainstream schools, this policy context provides the broader setting in which Odyssey House’s Building Resilience in Schools program operates as well as an avenue for Odyssey House to continue to contribute improving the educational and wellbeing outcomes of young people experiencing complex mental health and drug and alcohol concerns. Inline with the Government’s priorities the Building Resilience in Schools program works to provide place-based services in combination with outreach support – specifically for young people experiencing mental health and drug and alcohol concerns as well as co-occurring psychosocial challenges. Importantly, the Building Resilience in Schools program also shares the Government’s objective to not only address individual student needs, rather to contribute to strengthening the welfare capacity of schools.
2 Odyssey House: Building Resilience in Schools Program

Odyssey House is one of the first [organisations] that …has got all that really well-established expertise and experience. (Teacher Participant)

Odyssey House Victoria has long been established as an important provider of drug and alcohol related services and treatment. As well as maintaining a commitment to their geneses in the provision of residential drug and alcohol treatment services, Odyssey House also offers a range of community-based services and treatment options. Their programs and services work to meet the needs of both adults and young people experiencing drug and alcohol problems as well as other co-occurring psychosocial challenges (e.g. mental health concerns, family disengagement, school/employment issues). The organisation’s core principles and approach to such treatment can be characterised as holistic, non-judgemental and with a focus on prevention.

These fundamental principles continue to be evident in Odyssey House’s Building Resilience in Schools program. The objective of this program is to build resilience in vulnerable young people who are experiencing or considered to be ‘at risk’ of experiencing problematic substance use and mental health issues. Odyssey House has built strong connections within the education sector, particularly within alternative education spaces. The key characteristic of this innovative program is the integration of an experienced drug and alcohol clinician into the school environment with the aim of providing a range of holistic and school-based support services that include:

- Alcohol and Other Drug screening and counselling (inclusive of the support, referral and facilitation to other treatment and detox services where necessary)
- Mental health screening, support and referral
- Drug and alcohol education
- Secondary consultation and professional development for teaching and school welfare staff
- Family/caregiver support and referral
In addition to providing these supports and services, the Odyssey House school-based program allows for flexibility in service provision to ensure the program and the school-based drug and alcohol counsellors are available to meet the specific needs of the various school communities in which they work. Therefore, where applicable, the *Building Resilience in Schools* program also provides the following services and supports:

- 10 week drug and mental health resilience building program (primarily for VCAL students in Years 11-12)
- Wrap-around pro-social activities including peer leadership and connection camps
- Skill building and activity days
- Multimedia/animation design program
- Brokerage fund to support students considered most at risk

Table 2.1: Mapping Program Aims, Activities and Outcomes

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<tr>
<th>Program Component</th>
<th>Aim</th>
<th>Activity</th>
<th>Outcomes</th>
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| 1. Drug and alcohol counselling and education | To reduce young people’s substance use or decrease their risk of participating in problematic and risky substance use. | • Individual and group counseling and assessment.  
• The dissemination of harm minimisation information at both the individual and classroom-based level.  
• Provide outreach support to young people.  
• Assist and facilitate detox services when necessary. | Risk behavior and harm reduction.  
Access to additional support services (referral).  
Maintained or improved engagement in education. |
| 2. Psychosocial wellbeing support | To recognise the co-occurring nature of mental health concerns and substance use for young people. To support young people in their development of | • Individual counseling and wellbeing support.  
• Providing tailored wrap around support to improve young people’s psychosocial conditions.  
• Provide necessary referrals to specialised mental health services when necessary. | Improved mental health outcomes.  
Access to additional support services (referral).  
Maintained or improved engagement in education. |
<table>
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<th><strong>3. Supporting School Communities</strong></th>
<th>To work towards making educational settings accessible and inclusive spaces for young people, including those experiencing mental health and substance use concerns.</th>
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<td></td>
<td>• Participate in necessary care and case management meeting with other multi-disciplinary and/or multi-agency teams.</td>
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<td>• Provide outreach support and information to families.</td>
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<td>• Building trusting relationships with both school staff and students.</td>
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<td>• Become part of the school community – e.g. attend school events, have a presence in classrooms.</td>
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<td></td>
<td>• Facilitate school camps, activity and skill building days.</td>
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<td><strong>4. Strengthening Wellbeing Capacity of Schools</strong></td>
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<td>• Provide teachers and wellbeing staff with both formal and informal (secondary consults) professional development.</td>
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<td></td>
<td>• Form part of the school’s existing multi-disciplinary wellbeing team, providing expert knowledge and contacts.</td>
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<td></td>
<td>• Inform the school climate to increase opportunities for early intervention and prevention of substance misuse among students.</td>
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<td>• Advocate for student’s needs and wellbeing with teachers.</td>
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In general, the Building Resilience in Schools program has a number of elements found to be necessary for successful wellbeing programs and school-based drug and alcohol interventions. Underpinned by principles of harm minimisation, the program offers remedial responses to student substance use, and provides the opportunity for adoption as a whole school approach, making it accessible for students exhibiting differing risk levels (Evans-Whipp, Plenty, Catalano, Herrenkohl, & Toumbourou, 2015; Midford et al., 2014; O’Toole, 2017).

**Program Expansion**

The origins of the program were within flexible learning options (FLOs), but in the latter half of 2017, the expansion of the Building Resilience in Schools program into mainstream Victorian secondary schools began. FLOs are schools that provide education and development to a cohort of young people who are managing a number of co-occurring complex psychosocial challenges, including potential substance use issues (Arpawong et al., 2015). Education spaces presented a unique opportunity for Odyssey House to provide assistance to young people considered to be experiencing (or at-risk of) significant concerns regarding drug and alcohol use or exposure to substance abuse (e.g. family substance use).

However, it is not only young people in flexible learning settings that experience risky substance abuse. Students in mainstream high schools also face these risks. The increasing rate of substance use (particularly cannabis use) and the co-occurring poor mental health of contemporary youth among Australian communities has been highlighted across several recent studies (Guerin & White, 2018, VicHealth, 2017; Yap, Reavley, & Jorm, 2011). This research points to the need to consider how programs embedded in alternative education settings can be adapted to mainstream secondary schools, contexts were specialised knowledge and services offered by the Building Resilience in Schools program and clinicians has not typically been provided in the past.

In addition, the program’s sole focus is not only intervention once problematic substance use has been identified. It also includes a preventative component in which drug and alcohol education is used (including harm minimisation) to raise awareness across the school community. School-based programs that take a holistic approach to harm minimisation with young people have recently gained momentum (Midford et al., 2014; O’Toole, 2017). Such programs bring together preventative educational responses for students at the lower end of the risk spectrum, while ensuring those who have a higher risk and more complex set of circumstances are supported through specialised wrap around care.
3 Literature Overview

The following section will provide an overview of previous research regarding the patterns of substance use of young people. Research and appropriate grey literature will be drawn on to outline the prevalence of drug and alcohol use among Australian youth. The negative impacts of substance use on the psychosocial wellbeing of young people will also be considered. Further to this the comorbidity of substance use and poor mental health will be highlighted. Consideration is also given to the barriers to the accessibility of youth focussed drug and alcohol specific, as well as, mental health services. Finally, the role of school-based drug and alcohol intervention programs and the provision of services within educational settings is discussed.

Substance use including the abuse of alcohol and drugs has been identified as a significant contributor to the poor health and psychosocial wellbeing of young people and adults alike (Champion et al., 2013; Toumbourou et al., 2018; Turhan et al., 2017). Nevertheless, alcohol consumption is commonly perceived as an integral part of social and cultural life and drinking to intoxication is normalised among particular groups (Hernandez, Leontini, & Harley, 2013; Stafford & Keric, 2017; VicHealth, 2014).

Despite this perceived tolerance of alcohol use, more recently concerns have been raised regarding the public health costs associated with risky alcohol consumption (NHMRC, 2009; Reavley, Jorm, McCann, & Lubman, 2011). In 2011 alcohol consumption was accountable for “5.1% of the total burden of disease and injury” and found to have contributed to 6,570 deaths (AIHW, 2017, p. 2). More broadly, accompanying these concerns regarding alcohol consumption, apprehensions regarding drug use becoming a ‘normalised’ part of youth culture for some groups has gained attention (Champion et al. 2013; Duff, 2003; Lynskey, Coffey, Degenhardt, Carlin, & Patton, 2003; Yap et al., 2011). Specifically, the increased acceptance of cannabis use by young people has been reported (Evans-Whipp et al., 2015).

Current rates of substance use (including alcohol and drugs) among Australian high school students vary. Evidence points to young people delaying alcohol consumption; however reductions in risky alcohol use have not been as clearly observed (Midford et al., 2014). A recent national survey of approximately 20,000 secondary school students across Australia highlights the hazardous engagement young people have with alcohol and other substances (Guerin & White, 2018). Further, even with this delayed use of alcohol during secondary school years, there is a growing body of evidence to suggest that once young people transition into adulthood and more so from high school to university their propensity for excessive alcohol consumption is significantly elevated (Davey, Davey, & Obst, 2002; Reavley et al., 2011; Rickwood, George, Parker, & Mikhailovich, 2011; Tembo, Burns, & Kalembo, 2017). Namely, young adults between the ages of 18 and 24 years, have been
found most likely to drink alcohol at levels which place them at considerable risk (AIHW, 2017).

With regards to the substance use patterns of Australian secondary students, a recent national survey reported that 76% of 17 year olds and 17% of 12 year olds had drunk alcohol in the past year. Approximately 65% of all participants disclosed at least one experience of risky drinking (5 or more drinks in one occasion) (Guerin & White, 2018). Concerning illicit drugs, The Australian Secondary School Students’ Alcohol and Drug Survey (ASSAD) reported that cannabis was most commonly used and this cannabis use had significantly increased amongst Australian high students in recent times (Guerin & White, 2018). This increase was noted for all periods – lifetime use, use within the past month, use within the past week. With regards to regular cannabis consumption, it was reported that:

Among the 15% of students who had used cannabis in the past year, 30% of males and 37% of females has used cannabis once or twice, while 38% of males and 29% of females had used it on 10 or more occasions (regular use). Regular use was more common among older than younger students (10% of 12 year olds; 37% of 17 year olds), and among male than female students from age 13. (Guerin & White, 2018, p. 29)

Notably the rates of students reporting cannabis use outweighed the numbers who disclosed using tobacco. This was the first occurrence of such a result, further postulating the potentially increasing commonality of cannabis use among young people in Australian secondary schools (Guerin & White, 2018). Consumption of other illicit drugs (for example, hallucinogens, ecstasy and inhalants) were relatively low, however the ASSAD survey found the usage had increased for 16 and 17 year olds (Guerin & White, 2018).

In general it is mandated that there is no quantity of alcohol, which can be safely consumed by minors (NHMRC, 2009). Comparable warnings around drug use in young people have also been made. These concerns relate to both the use of cannabis (Evans-Whipp et al., 2015) and more recently synthetic and/or psychoactive substances (Champion, Newton, Stapinski, & Teesson, 2016). Regular or problematic substance use has been shown to have immediate as well as long-term consequences for young people (i.e. continuing into adulthood) (Champion et al., 2013; Degenhardt, Coffey, Carlin, Swift, Moore, & Patton, 2010; Evans-Whipp et al., 2015; Lynskey et al., 2003; Yap et al., 2011). In a longitudinal study of the impacts of regular cannabis use on young people in Melbourne, Victoria, Lynskey et al. (2003) determined that this regular cannabis use in mid-adolescences was a hindrance to educational attainment, elevating the likelihood of early school disengagement or withdrawal. Risky consumption of drugs and alcohol has also been found to increase a young person’s vulnerability to antisocial behaviour, harm and injury, violence, sexual assault, drinking driving and suicide among other social ills (NHMRC, 2009; Quek et al., 2012). Evidence also continues to strengthen around the association between early substance abuse in adolescences (particularly cannabis use) and the increased risk of mental health concerns, including psychosis and substance use disorders in adulthood (Degenhardt et al., 2010; Yap et al., 2011).
In addition to this connection between substance abuse in adolescences and long-term mental health concerns, the comorbidity between drug and alcohol use and poor mental health in young people has been identified (Guerin & White, 2018, VicHealth, 2017; Yap et al., 2011). That is, substance use has been shown to be greater for young people who have a reported mental health condition (Guerin & White, 2018, Lawrence et al. 2015). Furthermore, young people with psychological and emotional concerns often use alcohol and drugs to cope with their mental health condition. In contemporary times, the dialogue around the mental health and psychosocial wellbeing of young people has elevated. Australian young people identify mental health has a primary concern for themselves and their communities (Mission Australia, 2018). This is not unanticipated as mental health is characterised as the main health challenge for Australian youth between 12-25 years of age (Headspace, 2011).

With the prevalence of mental health concerns, the demand for youth focused service provision including drug and alcohol services has also increased (Lawrence et al., 2015; YacVic, 2015). However, in light of this demand, shortfalls in youth focused services persist (Lawrence et al., 2015; YacVic, 2015). Consequently, these shortfalls and gaps decrease young peoples’ access to timely and appropriate services.

Therefore, there have been calls to further consider the ways in which such mental health and wellbeing services (including drug and alcohol services) are delivered and made available to young people (YacVic, 2015). Namely, services need to be flexible, youth specific and allow for positive relationships to be built between young people and workers. Primary barriers to young people seeking mental health support have been found to be, not wanting to speak to a stranger and the stigma of seeking mental health assistance (Lawrence et al., 2015). That is, it has been asserted that:

Young people are more likely to work well with services they know and trust, and which offer ‘soft entry’ or ‘drop in’ options and holistic support. Forcing them into unfamiliar services, making them navigate extra layers of ‘gate keeping’ and assessment, or denying them support unless they can meet very specific criteria, would result in many young people not accessing help. (YacVic, 2015, p. 25)

Further to this, the increased integration of mental health as well as drug and alcohol services into youth focused sectors including education has been recommended (YacVic, 2015). The intention of these recommendations is to improve accessibility of services and importantly positive wellbeing outcomes for young people.

In an effort to improve accessibility for young people, schools have been identified as key context for the delivery of mental health services as well as those services pertaining to substance misuse (Fazel, Patel, Thomas, & Tol, 2014; Lawrence et al., 2015; O’Toole, 2017). Young people spend significant amounts of time within educational spaces, therefore are more easily reached in this context (Fazel et al., 2014; O’Toole, 2017). Importantly, this school-based approach (e.g. service provision and educational interventions and programs)
allows not only for students considered ‘at risk’ to be supported, rather strengthens prevention among a broader range of young people (O’Toole, 2017).

3.1 School-Based Drug and Alcohol Prevention and Intervention

This increased integration of mental health and more specifically drug and alcohol services into secondary schools is in line with the Victorian Government’s holistic approach to student wellbeing. The Victorian Government has prioritised building young people’s resilience including making the school setting a place in which young people “develop confidence, social skills and healthy life habits” (www.education.vic.gov.au). Hence, schools and educational settings have a responsibility to be safe spaces for young people where their intellectual, physical, psychological and social development and wellbeing can be supported and fostered (Centre for Education Statistics and Evaluation, 2015). It has been acknowledged that, “schools can have a direct impact on students’ health – both their physical and mental health”, including their susceptibility to partake in harmful substance use (Banfield, McGorm, & Sargent, 2015; Centre for Education Statistics and Evaluation, 2015, p. 5).

In general schools and educational institutions vary with regards to their responses to student wellbeing and risky behaviour such as substance use (Evans-Whipp et al., 2015). School-based substance use policies can be characterised as remedial (for example, supportive and educative) or punitive (for example, out of school suspensions) particularly with regards to student violations (Evans-Whipp et al., 2015). Support for remedial approaches, which include counselling and appropriate referrals has been generated, due to findings indicating that schools that practice this approach have reduced cannabis use among students (Evans-Whipp et al., 2015). Concerning drug prevention policies, Evans-Whipp et al. (2015) state that unlike schools in Washington State (USA), which predominantly adopted an abstinence approach to substance use, Victorian schools are more orientated towards harm minimisation philosophies. This positioning towards harm minimisation ideologies within Australian secondary schools has been further confirmed (Midford et al., 2014). Midford et al. (2014) explains:

> school drug education programs based on harm minimization principles should provide practical knowledge and skills to enable young people to make safer decisions in regard to drug use...a harm minimization approach is arguably more relevant to students as it permits an overt focus on the types of drug use decisions young people make. (p. 73)

Coinciding with this growing recognition of the importance of the school environment in addressing substance use and improving student wellbeing, a diverse range of school-based intervention, prevention and health promotion initiatives have been observed (Champion et al., 2013; Newton et al., 2016; Will & Sabo, 2010). These diverse programs have been trialled in various educational settings both within Australia (Champion et al., 2016; Midford et al., 2014) and in other Western contexts (Maslowsky et al., 2017). There are a number of
challenges inherent in employing effective drug and alcohol intervention programs across school contexts (Champion et al., 2012; Hopson & Steiker, 2008). Identified barriers to achieving positive outcomes (for example, improving student wellbeing and reduced substance use) include the diversity within and between school settings, such as differences in student needs and demographics (Champion et al., 2012; Hopson & Steiker, 2008). An additional barrier is the inadequate resource allocation (financial, teacher time) to effectively facilitate programs. Thus, it is apparent that school-based intervention programs seldom achieve long-term positive outcomes for young people engaging in alcohol misuse (Champion et al., 2012). That is, from a brief review of a subset of programs (see Appendix A) it is evident that while some programs achieve short-term goals – for instance reduce substance abuse or attitude change towards drugs and alcohol – these anticipated changes are not as apparent long-term. Furthermore, these programs often are designed to be brief interventions either delivered by teaching staff or external facilitators, rather than specific mental health or drug and alcohol services embedded within the school environment. It is asserted that this service model (embedded services) provides more opportunity for young people to engage in necessary services.

In summary, improving wellbeing outcomes for young people including the reduction in early on-set substance use is not solely the concern of young people, their families and schools. Rather, the enhanced mental health and psychosocial wellbeing of youth has significant implications for their ability to participate in the community and contribute to Australia’s growth and social capital (Centre for Education Statistics and Evaluation, 2015). Attempts to improve mental health and reduce substance use including “risky alcohol consumptions among young people can lead to lower levels of public violence, drink driving and injury – thereby benefiting the Victorian community, our health system and the economy” (VicHealth, 2017, p. 7). Furthermore, due to the increased prevalence of mental health concerns and substance use in Australian youth it is imperative that effective and accessible services are available. The school setting has been identified as a key context for the delivery of such services and prevention efforts.

The following sections of the report will further detail the evaluation objectives and the methodology utilised to examine the impact of Odyssey House’s school-based Building Resilience in Schools program. Study findings and final recommendations will subsequently be discussed.
4 Methodology

4.1 Case Study

This study adopted a mixed methods framework that combines both qualitative and quantitative research methods and is a common approach for evaluation research of this nature (Patton, 2015; Yardley & Bishop, 2013). A case study methodology is appropriate for the study of real-life events, programs or settings and their contexts (Merriam, 2009). Defining the ‘case’ is essential in this approach in order to focus on developing a comprehensive and in-depth investigation of the complex issue (Mills et al., 2017). Case study approaches often involve the collection of multiple forms of data and evidence to document, explore and analyse elements of the case and how it impacts individuals and groups within the immediate context (Mills et al., 2017; Flyvbjerg, 2011).

In this study the case is defined as the Building Resilience in Schools program and the schools contexts in which the program is embedded within. In documenting the aims, structure and activities of the program, we sought to establish how this model is embedded and adapted across different school contexts. We also sought to investigate the impact on the program for the young people involved in terms of their substance use and overall wellbeing. Finally, the study sought insights from school staff to explore how the program can develop capacity to support students with complex issues relating to substance use and mental health. With this focus, our case study approach can be understood as both descriptive (Willig, 2013; Merriam, 2009), in that it sought to be detailed and comprehensive in its exploration of the program and its activities, but also evaluative by analysing how the program’s elements impact young people and the school community.

Whilst more broadly, it is also intended that this research contribute practically to local knowledge about interventions to improve health and wellbeing in schools – specifically, the effectiveness of embedded drug and alcohol treatment and support services. This research is also expected to contribute to improvements in the services provided by Odyssey House. It may also serve as an exemplar for other schools investigating how to respond to particular issues confronting their students.

The program school settings

This study involved the participation of five Odyssey House clinicians who were placed within one or more settings in which the Building Resilience in Schools program was delivered. For the purposes of this study, data was collected pertaining to young people across five Victorian secondary schools – three of these setting are classified as FLOs and two are mainstream secondary colleges. Table 4.1 provides a brief description of these educational settings.
Table 4.1: Community and mainstream school profiles

<table>
<thead>
<tr>
<th>North Community School</th>
<th>South Community School</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Community School is a small community school operating across two Melbourne-based campuses. The main campus is situated in the inner Melbourne suburbs. They are co-educational secondary school (Years 7-10) and offer VCE, VET and VCAL options to senior students. They have fewer than 100 enrolled students across all year levels. North Community School is an alternative education space which works to meet the diverse needs and strengths of their students. They also provide a number of wellbeing and wrap round services to cater to their student group.</td>
<td>South Community School is a co-educational alternative education setting servicing the Melbourne’s south suburbs. Together with providing secondary education including VCE and VCAL units, the school works to cater to the wellbeing of students who have found traditional schooling unsuitable. The school maintains small enrolment numbers, allowing the development of a strong school community and effectively meeting the complex wellbeing and educational needs of their students.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Views Secondary School</th>
<th>Park Secondary School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Views Secondary School is a long-standing government school located in the Melbourne’s north-western suburbs. They cater to a school population of over 1400 students from years 7-12. Curriculum affords senior students both VCE and VCAL pathways as well as programs for students who demonstrate advanced learning. They provide their students with a large number of co-curricular activities and modernised facilities and buildings. A multi-disciplinary wellbeing team supports students.</td>
<td>Park Secondary School is located in one of Melbourne’s western growth corridors. Park Secondary School is characterised as a mid-size government secondary college providing education to local young people from Years 7-12. The school is structured into Junior, Middle and Senior schools within a single campus. It offers both VCE and VCAL units, whilst also offering pathways for students demonstrating excellence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>West Community School</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Community School is alternative education space, which works to provide a safe and flexible environment for young people to learn. Student’s who attend West Community School have experienced exclusion from mainstream schools and are negotiating a number of complex behavioural and psychosocial challenges. West Community School is a auspice of another local secondary school in Melbourne’s outer western suburbs.</td>
</tr>
</tbody>
</table>

4.2 Data Collection

Primarily, use was made of data routinely collected by Odyssey House school-based clinicians as part of their role in the school (for example, screening tools, case notes). In addition, the research team conducted semi-structured interviews with Odyssey House clinicians to improve understanding to their role and ways in which the program has been facilitated in various education settings. Similarly, given that the program is embedded into
the school setting, the research team also conducted focus group interviews with teachers to gain insight into the ways they are supported by Odyssey House clinicians and to identify how the program operates within the school community. See Table 4.2 for a more detailed outline of the various data collection methods and sources.

Table 4.2: Data Collection Methods

<table>
<thead>
<tr>
<th>Data Collection Method</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>Individual semi-structured interviews with Odyssey House drug and alcohol clinicians conducted by research team. <strong>Purpose:</strong> to gain insight into their role, the program and how they support students, teachers/wellbeing staff and parents.</td>
</tr>
<tr>
<td>Focus groups interviews</td>
<td>Two focus group interviews with teaching and wellbeing staff (e.g. school psychologist) from two community school settings. <strong>Purpose:</strong> gain information regarding the ways in which the Building Resilience in Schools program as or has not contributed to the welfare capacity of staff and the school more broadly – with specific focus on addressing challenges students are negotiating with regards to drugs and alcohol use.</td>
</tr>
<tr>
<td>Intake assessment/ screening tools</td>
<td>An assessment conducted during initial sessions by clinician. Inclusive of mental health screenings as well as alcohol and other drug screenings.</td>
</tr>
<tr>
<td>Treatment plans</td>
<td>Individual treatment plan conducted with each client by clinician. <strong>Purpose:</strong> sets out client goals and actions to work towards these goals.</td>
</tr>
<tr>
<td>Clinician case notes</td>
<td>Maintained by each Odyssey House clinician. <strong>Purpose:</strong> to document client (young person) progress, including number of sessions attended, treatment goals achieved, summary of treatment experience, referral and linkages to other services made. Also documents the support provided to parents and school staff (e.g. principals, teachers, wellbeing staff).</td>
</tr>
<tr>
<td>Pre/post student surveys</td>
<td>Completed by the young person (with assistance of the clinician if required). <strong>Purpose:</strong> gauge the young person’s sense of belonging and relationships with school, friends and family. Also measures the young person’s relationship with education and pro-social activities, and asks key questions about the service.</td>
</tr>
<tr>
<td>Daily contact records</td>
<td>Completed by clinician. <strong>Purpose:</strong> to maintain daily records regarding their activities including - number of support contacts (i.e. education advice, follow up, group sessions, health advice, other advice, general support), case conferencing, secondary consultations, assessments, counselling sessions, outreach activities, referrals made.</td>
</tr>
<tr>
<td>Camp feedback</td>
<td>Student feedback forms regarding Odyssey House led camps.</td>
</tr>
</tbody>
</table>

**Note:** Due to student disengagement and the introduction of additional school settings in later stages of the evaluation, the above data was not collected for all young people who participated in the school-based service.

The study’s findings are based on data collected for 44 students across the five educational settings who in various extents participated in the Building Resilience in School and accessed the services of school-based drug and alcohol clinicians. It is important to note that the data collected for each participant was not necessarily consistent due to the varied nature of student needs and participation in the program. Thus these anomalies have been accounted...
for and will be highlighted throughout the findings as necessary. Also key participants in the evaluation research were four Odyssey House clinicians interviewed by the research team; and six teachers from two of the community school settings who shared their insights and experiences in researcher led focus groups.

4.3 Participant Profile

Young people involved in this study included 44 students across the five educational settings who worked directly with Odyssey House school-based clinicians as part of the Building Resilience in Schools program. Of these 44 students, 25 were male, 18 were female, and 1 participant was non-gender conforming. Although clinicians worked with young people across age groups, the majority of students who engaged with the Building Resilience in Schools program were in Years 10 (40.9%), 9 (14.3%) and 7 (14.3%). Refer to Figure 1 for more details. The prevalence of Year 10 students is consistent with previous research that identifies young people in mid-adolescence to more likely to participate in substance misuse – such as, risky drinking and illicit drug use (Guerin & White, 2018).

Figure 4.1: Program Participation Numbers (Year Levels)
As expected for this age group, young people commonly lived with their parents (75%), whilst a quarter (25%) of the participant group currently live with other relatives or friends. The majority of young people and families were reported to reside in privately owned accommodation, while a quarter lived in public or private rental properties (25%). Only one young person identified as living in transitional or crisis accommodation. It is important to note that 20 percent of this participant group has had the Department of Human Services involved in their care, indicating that almost a quarter of the participants may have had experiences of stress or trauma requiring state intervention.
5 Study Findings

The primary aim of this study was to (a) articulate the key characteristics of the *Building Resilience in Schools* program and (b) the ways in which school-based clinicians worked within the parameters of the program to address the co-occurring mental health and substance abuse issues being negotiated by young people in Australian secondary school settings. The findings have been generated through analysis of both quantitative and qualitative data. This data is inclusive of program intake and assessment documents, individual case notes and clinician data logs. Interviews and focus groups conducted with clinicians and teaching groups respectively further supplements this data.

The following section highlights a number of key study findings. Firstly the mental health status and psychosocial circumstances of the young people accessing the program was examined, followed by the key program outcomes, including an examination of wellbeing indicators for young people following participation in the program. Key program outcomes centre on the multifaceted methods of engagement and service provision school-based clinicians adopt within the *Building Resilience in Schools* program. The current findings highlight the ways in which such methods of engagement work to create more inclusive educational environments for young people experiencing mental health and drug and alcohol concerns. Table 5.1 outlines the primary findings that will be discussed in this section.

Table 5.1: Summary of Study Findings

<table>
<thead>
<tr>
<th>Mapping mental health concerns and psychosocial challenges among young people in the program.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Trauma, mental health and wellbeing.</td>
</tr>
<tr>
<td>• Prevalence of aggression and risk taking behaviour in young people.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Young people require flexible (tailored) and sustained supports.</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Participation in the <em>Building Resilience in Schools</em> program leads to positive outcomes for young people.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>The importance of relationships, trust and place-based service in delivering holistic care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Building relationships and trust with young people.</td>
</tr>
<tr>
<td>• Developing a collaborative working culture for holistic care.</td>
</tr>
</tbody>
</table>

| Capacity building for an inclusive school environment. |
5.1 Mapping mental health concerns and psychosocial challenges among young people in the program

Another…boy – never met dad, mum died two years ago…smoking pot and drinking…living with an older [sibling who is]…now his carer…this kid, had nothing…we managed to get some funding to get him some clothes…his thing was smoking cannabis, based mostly around the trauma of…having had his mum die

...he hasn’t smoked pot at all now, still dealing with the trauma…one of the things with him was improving…his physical health, so we’ve had him to the doctors…got him into boxing and he’s dropped a few kilos, but is still going home and the only thing at home is frozen pizza

...we’re going to look at getting the family involved in some stuff to say “hey, what’s your budget and we can look at this, this is going to benefit him, it’s going to benefit his mental health, which in turn will hopefully mean that he doesn’t go back to smoking pot”.

He also was able to reengage back into mainstream schooling – that was one of his goals – and he said to do that he needed to talk to someone about his drug use and talk to someone about his health… (Drug and Alcohol Clinician)

It has been well documented in the research literature that young people often turn to drug and alcohol use to assist with managing mental health and psychosocial challenges (Arpawong et al., 2015; Yap et al., 2011). The quote above illustrates how complex trauma can result in young people engaging in substance misuse and indicates the benefits of a holistic school-based approach to drug and alcohol assistance for students. To effectively understand the power of the program it is important to develop an appreciation of the wellbeing needs of young people who are engaging with drug and alcohol clinicians embedded within their school environments.

The following section will outline the findings regarding the mental health status of young people at the time of intake into the program. Findings will centre on their broader indicators of wellbeing as well as any behavioural issues or high-risk behaviours evident in the participating student cohort.

Trauma, mental health and wellbeing

This study found that 29.3% of young people involved in the program were found to have experienced trauma (for example, experienced/witness death in family, family substance concerns, sexual assault, neglect and abuse) as well as having previously experienced suicidal thoughts and/or attempts (30%). Thus, we assert that many young people enter the Building Resilience in Schools program with instability in their wellbeing and negotiating previous and current psychosocial challenges and circumstances. Current findings
concerning the complexity of the circumstances young people are negotiated was further strengthened by the following teacher reflections concerning the cohorts they are engaging with:

…the main one would be unstable home lives. That’s major so that will impact on their attendance…who’s at home, who’s supporting them to get up in the morning. Also their peers, their social life and then leading into their drug and alcohol use so a lot of them are out partying with their mates…it’s what’s going on at home….some of them are in out-of-home care so that’s really unstable for them. If I’m looking at a young person the main barriers for them maybe benefitting are all those other things that are going on in their lives. There’s just too much happening in home life and mental health and family issues, relationship issues, a lot of them in dysfunctional boyfriend, girlfriend things going on…(Drug and Alcohol Clinician, South Community School).

I think common ones are relationship issues with the family, that’s a big one. Teen drug use, like within social groups and pressure from friends to use, that’s another theme. Mental health is the biggest one by far. Young people experiencing really significant anxiety and starting quite young…and we know the relationship between mental health and family breakdown in drug and alcohol…if we can get in and teach and support those young people to build healthy relationships with adults for one. But also, to learn how to manage their problematic emotions, and work through some of their issues, and build those skills and build that resilience, then they’re less likely to use substances down the track. …(Drug and Alcohol Clinician, Views Community School)

Therefore, it is evident that the young people who engage with school-based clinicians enter the program with a number of barriers to not only improved wellbeing but also overall program participation. Importantly, current findings point to need for school-based programs to be multifaceted rather than targeting young peoples’ drug and alcohol use in isolation.

Due to the co-occurring nature of poor mental health and substance use in young people, it was anticipated that students engaged with the Building Resilience in Schools program would have poor indicators of psychological and emotional wellbeing. With regards to the mental health status of the participating cohort, the majority of young people (56.1%) had mental health concerns. When specified these mental health concerns mostly related to depression and anxiety. On a similar measure of overall wellbeing, 41.5% of the participant group rated their mental health as requiring attention and improvement. This is significant as drug and alcohol use has been found to be more prevalent in young people who experience poor mental health or have received a mental health diagnosis (Guerin & White, 2018). The prevalence of mental health issues within this participating cohort further strengthens the calls
for increased school-based wellbeing interventions. Interventions are required to not only address problematic substance use. Rather dual-diagnosis services, which have the capacity to address root causes linked to substance abuse such as family breakdown and poor mental health are necessary (VicHealth, 2017).

Similarly, findings indicate that for participating young people emotional regulation was also nominated as in need of attention and improvement for close to half of the participant group (45%). In general other areas of psychosocial wellbeing including physical health and general appearance were rated as average or good for this group of young people. See Figure 5.1 for details of psychosocial wellbeing for young people involved in the program.

Figure 5.1: Student Psychosocial Wellbeing Indicators

Prevalence of aggression and risk taking behaviours in young people

Despite the reported low mental health and need to address emotional regulation of participants, on average it is argued that this group of young people were not identified as having a high level of behavioural issues such as anger, aggression and violence (see Table 5.2). This is likely because the majority of the participating young people attend from mainstream school populations where behavioural codes of conduct are more strongly enforced.

Table 5.2: Prevalence of Anger, Aggression and Violence

\[ N=41 \]

*Note: Behavioural issues were measured on a scale from 1 (not at all) to 5 (definitely)*
However, 22% of young people engaged with school-based drug and alcohol clinicians nominated anger as ‘often an issue’. Similarly, aggression was noted as a behavioural concern ‘sometimes’ or ‘often’ for 17.1% and 12.2% of participants respectively. Violence was considered an issue ‘sometimes’ for 19.5% of the cohort and ‘definitely’ for 7.3% of young people in this group. Interestingly, previous research points to the notion that behaviour concerns such as anger or aggression in young people are not necessarily a consequence of substance use, rather like substance misuse itself is part of the maladaptive coping strategies employed in relation to stressful life events or experiences of trauma (Arpawong et al., 2015; Yap et al., 2011). Figure 5.2 further outlines the prevalence of these behavioural concerns across the participating cohort.

**Figure 5.2: Prevalence of Anger, Aggression and Violence**

Further to this, the study found that just under a quarter of the cohort (24.4%) were identified as participating in high-risk behaviours. Of this group of young people, binge drinking (33.3%) and other substance use (16.7%) were most frequently nominated as the high-risk behaviours they engaged in. This demonstrates the high level and diversity of challenges addressed by Odyssey House’s school-based clinicians.

In summary, the current analysis indicates that the students engaged directly with Odyssey House school-based drug and alcohol clinicians present with not only drug and alcohol concerns, but face a complex combination of issues; such as co-occurring mental health concerns (including suicidal ideation and previous attempts) and limitations in emotional
regulation. Behavioural issues (anger, aggression and violence) were evident among a minority of young people engaged in the program, but still warrant attention. Whilst definitive analyses establishing links between particular experiences (such as trauma and certain behavioural issues) were not able to be conducted due to a relatively small sample, we can identify that many participants in this program had overlapping and co-occurring issues. As identified in previous research, particular experiences of trauma, difficult life circumstances (such as family breakdown) can lead to poor mental health outcomes, difficulty regulating emotions, hostility or aggression and engaging in high risk behaviours such as problematic substance use (Arpawong et al., 2015; Yap et al., 2011). Therefore we assert that this profile of young people indicated that within mainstream and FLO educational environments there are young people who require access to clinicians who can work comprehensively with them to better meet their complex needs. Furthermore, substance misuse, poor mental health and psychosocial indicators of disadvantage negatively impacts on young people’s connection and capacity to access such necessary wellbeing services. This heightens the need and rationale for school-based service provision as provided by the Building Resilience in Schools program.

5.2 Young people require flexible (tailored) and sustained supports

A primary finding of the study was that young people require wellbeing and drug and alcohol intervention programs that provide sustained support within the school environment. Due to young people demonstrating various levels of risk and need both within and well as between school settings, programs and services require a level of flexibility to meet these diverse needs. It has been found that key characteristic of the Building Resilience in Schools program is the range of different strategies employed by school-based clinicians in their work with young people. The following section will document the range of approaches and engagement strategies the Building Resilience in Schools program affords as well as examine the contact frequency between clinicians and young people. Furthermore, young people particular those negotiating substance abuse and complex psychosocial challenges do not follow a linear trajectory when engaging in treatment services. We argue in this study that the Building Resilience in Schools program is well positioned to provide the necessarily level of support for this cohort of young people.

Young people directly participating in the Building Resilience in Schools program commonly presented with complex psychosocial challenges, including participation in binge drinking and risky substance use. However, it was found that the majority of this participating student cohort had not previously engaged with drug and alcohol counselling (92.5%) prior to their involvement in the Building Resilience in Schools program. This corroborates previous research, which highlights the reduced accessibility of mental health services (including youth-focused drug and alcohol services) for young people external to the school context (Lawrence et al., 2015; O’Toole, 2017; YacVic, 2015). Only 7.5% of students involved in the
program had previous experience with drug and alcohol counselling. Therefore a finding of this study is that given the noted challenges and barriers young people encounter when engaging with wellbeing services (including drug and alcohol counselling), many of these young people would have not accessed necessary supports had Odyssey House clinicians not been placed in their schools (Lawrence et al., 2015; O’Toole, 2017; YacVic, 2015). Young people are not routinely referred to specialised services until their substance use becomes more problematic, or their wellbeing needs develop to be overt. Consequently, school based programs provide opportunities for early intervention in substance abuse (or in some cases prevention) via the dissemination of education and harm minimisation practices to reduce student risk, together with more direct counselling and support (Midford et al., 2014).

Further establishing this finding, the benefits of this increased accessibility of support offered by Odyssey House’s place-based program were recognised by school teachers and school-based clinicians alike. Teachers from South Community School commented on the barriers their student cohort experience when accessing services external to school:

Teacher 2: To get to another external service is really hard for some kids. And it’s not just because they don’t have the resources to get there. It might be like, “well I don’t know who that person is. I don’t know what to say to them”. So to be able to accompany someone to their first meeting with [the school-based clinician]…that is really valuable.

Teacher 1: For our kids…the barriers around seeking help are enormous…I don’t know that any of our students have engaged in AOD workers outside of our internally placed ones…No-one’s organised their own detox. It’s always through [the school-based clinician]…And just the travel barriers…the barriers are huge.

Odyssey House’s specialised clinicians were also cognisant of the improved accessibility their school-based service provides students:

Some kids don’t want to walk into a psychologist, or a counsellor’s office, or even the youth centre because there’s stigmas attached to that…for the guys that are based in the mainstream schools…they’re there and they’ve got their office space and kids can come out of class and see them and I think it’s really good because no one sees them going in. I think you need to be there. You can’t just come in and sign in and sign out; it just doesn’t work. (Clinician, West Community School)

They wouldn’t come and see me otherwise…it’s scary for them…I honestly don’t think that they would - they wouldn’t engage with it as well if we weren’t in the school, I wouldn’t see as many as I’m seeing for sure….(Clinician, Views Secondary School)

Although the benefits of place-based services will be further examined in detail in other key findings of the study, what is ascertained here is the effectiveness of the Building Resilience in Schools program in breaking down initially barriers to young people accessing vital and effective services to support their holistic wellbeing.
This finding regarding the accessibility of and need for the *Building Resilience in Schools* program in secondary school settings is further strengthened by the reported frequency and engagement of students within the program. Frequency in contact and service provision by school-based clinicians varied among the participant cohort. A moderate contact level occurred with majority of young people (43.18%), followed by frequent contact (29.55%) and high contact service provision (27.27%).

Table 5.3 provides further information regarding the frequency of contact between students and school-based clinicians.

Table 5.3: Frequency of Service Provision

<table>
<thead>
<tr>
<th>Contact Frequency</th>
<th>Overall Percentage</th>
<th>Within group frequency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>43.18%</td>
<td>4 contacts (21.05%)</td>
</tr>
<tr>
<td>Frequent</td>
<td>29.55%</td>
<td>12 contacts (23.08%)</td>
</tr>
<tr>
<td>High</td>
<td>27.27%</td>
<td>23 contacts (25.00%)</td>
</tr>
</tbody>
</table>

*Within group frequency provides the average number of service contacts within each of the contact frequency levels.

These rates of participation and contact frequency of students highlight the recurrent level of support that school-based clinicians provide certain subsets of students or the extent of support that can be offered to address the wellbeing needs of students. That is, when considered in combination, findings indicate that close to 60% of students required frequent or high levels of clinician contact. We argue in this study that with the identified barriers young people in general experience - as well as the specific barriers identified for the participant group - this high level of service engagement would not have occurred with an external service provider. Further to this, it can be shown that young people in both FLOs and mainstream secondary schools require regular wellbeing and drug and alcohol support.

The educational contexts of this study were diverse and cater differently to student populations who present with different needs. In general, FLOs and mainstream secondary schools provide differing levels of support to young people. This influenced the way in which school-based clinicians worked with young people in the *Building Resilience in Schools* program. This also impacted on the contact levels between individual students and clinicians. Table 5.4 outlines the average number of service contacts between school-based clinicians and students within each secondary school.

Table 5.4: Service Contacts by School

<table>
<thead>
<tr>
<th>School</th>
<th>Average service contacts (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Community School</td>
<td>6.50</td>
</tr>
<tr>
<td>South Community School</td>
<td>11.00</td>
</tr>
<tr>
<td>Views Secondary School</td>
<td>19.74</td>
</tr>
</tbody>
</table>

4 Moderate contact was defined between 1-10 clinician contacts, frequent contact between 11-20 clinician contacts and high contact more than 20 clinician contacts. High contact topped out at 140 contacts – however this is considered to be an outlier in the dataset.
The highest level of direct service provision (an average of 36.67 service contacts per student) was recorded in West Community School, which provides education to a complex cohort of young people who have been excluded from mainstream education. Also worth noting is frequency of contacts also recorded in mainstream educational settings. The clinician embedded in Views Secondary School on average completes 19.74 service contacts with young people directly participating in the Building Resilience in Schools program which has been classified here as moderate. This level of frequency highlights the need of these specialised services to be embedded into mainstream schooling contexts as well as FLOs where they have traditionally been offered. With the increasing prevalence of mental health issues in young people as well as concern regarding substance misuse (Guerin & White, 2018, Lawrence et al. 2015), the need to address these challenges among students attending mainstream schools becomes more apparent.

Further consideration of information related to service contacts highlights the fundamental ways in which Odyssey House school-based clinicians work with young people and service the school community – including teachers, other wellbeing and support staff (e.g. psychologists, school nurses) and families. These service contacts primarily comprise of phone and electronic communications, counselling support and assessment, outreach, family support, drug and alcohol education and secondary consultations. Table 5.5 outlines the frequency of such service provision within the Building Resilience in Schools program. It is important to note that although commonly the case not all young people would have required a combination of such support types. However, it is argued in this study that this range of support types and the flexibility inherent in the program has the potential to result in positive wellbeing outcomes for young people presenting across the continuum of risk.

Table 5.5: Frequency of Support Type

<table>
<thead>
<tr>
<th>Support Type</th>
<th>Number of students provided</th>
<th>Total</th>
<th>Average per young person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling/Assessment</td>
<td>39</td>
<td>300</td>
<td>7.69</td>
</tr>
<tr>
<td>Phone/electronic communication</td>
<td>28</td>
<td>219</td>
<td>7.82</td>
</tr>
<tr>
<td>Outreach</td>
<td>15</td>
<td>77</td>
<td>5.13</td>
</tr>
<tr>
<td>Secondary consultations/Case conferences</td>
<td>19</td>
<td>65</td>
<td>3.42</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>38</td>
<td>3.67</td>
</tr>
<tr>
<td>School visit</td>
<td>11</td>
<td>65</td>
<td>5.91</td>
</tr>
<tr>
<td>DOA education</td>
<td>8</td>
<td>23</td>
<td>2.88</td>
</tr>
<tr>
<td>Family support</td>
<td>7</td>
<td>16</td>
<td>2.29</td>
</tr>
<tr>
<td>Group</td>
<td>3</td>
<td>21</td>
<td>7.00</td>
</tr>
</tbody>
</table>
The most frequent service type provided by Odyssey House school-based clinicians was direct counselling support and assessment for individual students. We assert that the provision and accessibility of this service type is one of the primary benefits of this school-based framework and service model. This counselling and assessment support was followed by frequent phone and/or electronic communication (e.g. emails) with students as well as outreach services. These patterns in service type and frequency point to the intensive service provision and support specialised school-based clinician can provide vulnerable young people.

In addition to the flexible and tailored approaches to treatment and support young people are permitted, it was found in the study that the continued and sustained support provided by the Building Resilience in Schools program was also fundamental to assisting young people to achieve positive outcomes. Young people who are negotiating substance misuse or at risk of such misuse often experience a number of co-occurring psychosocial challenges. Consequently, working with vulnerable young people is not straightforward and the positive outcomes or their progress with regards to reduced substance use (and improved mental health) do not often follow a linear trajectory. Thus, as evidenced by the following clinician reflections, without the Building Resilience in Schools program providing this sustained school-based engagement; young people with complex needs would not have experienced these positive steps forward (including periods of decreased substance use):

…with young people it could be two steps forward, three steps...That’s why the engagement is important...if they do have those three steps back, having the rapport and the trust, so they can actually let you know that. A lot of them don’t want to disappoint you, or they’re embarrassed, or they don’t want to let you down, because they've been doing so well. Then I sort of say, “look if you do relapse, or if you do do something bad or whatever, come and have a conversation about it, because I don’t judge you. Let’s just learn from that together”. (Clinician, Views Secondary School)

One of the biggest downfalls of the sector...is funding restrictions...it’s like “alright we have six weeks with this person to achieve this, this and this” and it doesn’t work. It’s never worked...sometimes it takes six months of just going in and saying “g-day, how are you” and they’re not even a signed up client yet...then for them to go see you in the street or somewhere they’re a little bit more away from the crowds they say “hey this is going on for me, can I have a chat?”... (Clinician, West Community School)

…a student I worked with for probably about two years on and off...We worked regularly on strategies and methods and things he could do to help reduce his drug intake...He would definitely reduce his cannabis intake...he definitely went up and down, relapsed and stuff but he definitely reduced his intake and stayed really motivated...when we met he didn’t drink alcohol and then he started binge drinking for a while. I think that was really good that I was working with him through that because that could have potentially been another massive issue. Him
being motivated and me talking through the safety and strategies and effects of that, he managed to pull himself back from the binge drinking.
(Clinician, South Community School)

To conclude this section, it has been found that the Building Resilience in Schools program affords school-based drug and alcohol clinicians the flexibility to appropriately tailor their service frequency and type to meet the diverse needs of contemporary young people. The need for consistent and sustained support is evident in both FLOs and mainstream secondary schools. Furthermore, what these results indicate is that students are actively engaging in the program in all school settings. Young people have been found to disengage from services, which they find uncomfortable or present them with extensive barriers (YacVic, 2015). Thus, establishing these regular engagement levels can itself be considered a successful program outcome. The next primary finding will further examine program effects with a focus on the positive outcomes young people gain from their participation in the Building Resilience in Schools program.

5.3 Participation in the Building Resilience in Schools program leads to positive outcomes for young people

Both of her parents were using ice and she was removed from her parents…father’s in prison, mother’s still using. There were supervised child protection visits, but she doesn’t want to see her mum

…she started developing a really bad habit of [self-harming] when she was stressed, and that was bringing her a lot of anxiety

…since she started to come and see me, and we’ve identified that her [self-harming] is linked to emotional and relational stress, and identified healthy coping mechanisms and alternatives

…I saw her this week and she hasn’t [self-harmed] in 25 days, and she’s just so stoked.

That’s been a really good outcome, you can just see, she’s gone from being really withdrawn and really quiet, giving me one-word answers at the start. To telling me stories, and really opening up and starting to trust again…

(Clinician, Views Secondary School)

The study found that participation in the Building Resilience in Schools program resulted in positive outcomes for young people. Program participation resulted in enhanced wellbeing, reduced substance use and improved management of psychosocial hardships. Drug and alcohol use is more common among young people with a mental health condition as well as
experience of additional psychosocial challenges (Arpawong et al., 2015; Guerin & White, 2018, VicHealth, 2017; Yap et al., 2011). Therefore, addressing young people’s overall mental health and psychosocial needs forms an important part of any successful substance use intervention. Odyssey House school-based clinicians both at program intake and when students exited the Building Resilience in Schools program measured indicators of student wellbeing. The following section will further highlight the shifts and patterns in young people’s wellbeing upon exiting Odyssey House’s school-based program.

With this orientation toward holistic wellbeing and an understanding of the association between drug and alcohol use and student wellbeing, clinicians assess students’ overall mental health, physical health, general appearance, school engagement, communication skills, emotional regulation and social relationships. Analysis of these measures before and after young people’s engagement with the program indicates that students presented with statistically significant differences in a number of these wellbeing measures. Following participating in the program, students demonstrated signs of significantly improved mental health, physical health, school engagement, communication skills, emotional regulation and social relationships. Figure 5.3 further signals these shifts in wellbeing post intervention.

Figure 5.3: Pre and Post Measures of Wellbeing

The largest effect size of these measures of wellbeing was for physical health, mental health and emotional regulation. Therefore, in this study we argue that for these measures of wellbeing the difference in pre and post scores can be most strongly attributed to young people’s participation in the Building Resilience in Schools program. Although these positive results do not directly indicate or correlate with reduced substance use, we argue that improved wellbeing particularly physical and mental health as well as young people’s ability to emotionally regulate would be connected to or an expected outcome of reduced substance
abuse. Furthermore, as the program and school-based clinicians also work with students to address psychosocial challenges co-occurring with their risky substance use or poor mental health, these broader indicators reflect the positive role the *Building Resilience in Schools* program is having in the health and wellbeing of Victorian school students.

In addition to these broader improvements in health and wellbeing, the current study found that from the data collected at program exit points reduced substance use by participating students was recorded. From the data collected from 31 of the 44 participants, the majority (54.8%) achieved two reduced substance uses indicators, while 38.7% achieved one outlined goal. Therefore, we assert in the current study that young people’s engagement with the program promotes reduction in their substance use. Similarly, the achievement of psychological and wellbeing objectives were collected for 21 of the 44 student participants; of these young people majority (52.4%) achieved two of their goals for this domain. These findings highlight the orientation the program has towards goal setting with young people and the progress it encourages, particular around the reduction of problematic substance use.

With the flexibility of the program, indicators of improvement and intervention goals varied with individual treatment plans. This is necessary to effectively meet the diverse circumstances and issues each young person entering the program is negotiating. As reported by school-based clinicians, for young people who did demonstrate reduced harmful substance use, this was evidenced by increased harm minimisation knowledge as well as via clients’ self-reports (see Table 5.6). This finding also points to the educative potential for the program as well as young people’s retention of the knowledge they gain via their participation in the program.

Table 5.6: Indicators of reduced substance use

<table>
<thead>
<tr>
<th>Evidence of reduced risky substance use</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased harm minimisation knowledge</td>
<td>19.2%</td>
</tr>
<tr>
<td>Verbal self-reports</td>
<td>15.4%</td>
</tr>
<tr>
<td>Reduced cannabis use</td>
<td>3.8%</td>
</tr>
<tr>
<td>Moderation of alcohol intake</td>
<td>7.7%</td>
</tr>
<tr>
<td>Reduced receptiveness to peer pressure</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

*Note: Data record for 26 out of 44 participants*

Further to these indicators of reduced substance abuse, school-based clinicians recorded benefits of the *Building Resilience in Schools* program for participating students. Table 5.7 outlines the most frequent benefits record for young people who engaged with the school-based service.

Table 5.7: Benefits of Program Participation

<table>
<thead>
<tr>
<th>Program benefits</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased knowledge and practice of harm minimisation</td>
<td>36.4%</td>
</tr>
<tr>
<td>Development of healthy coping strategies</td>
<td>24.2%</td>
</tr>
</tbody>
</table>
Reduced AOD use 18.2%
Periods of AOD abstinence 9.1%
Development of emotional regulation skills 6.1%
Connecting young person to detox 6.1%

*Note: Data record for 33 out of 44 participants*

The most commonly nominated benefit was increased knowledge and practice of harm minimisation. Previous research supports the significance of increased harm minimisation knowledge for young people to assist them in making safer decisions around substance use (Midford et al, 2014). These identified outcomes and gains for students can be attributed to participation in the *Building Resilience in Schools* program. This program has immediate impacts for young people and their wellbeing and a potentially positive long-term impact on psychosocial wellbeing (e.g. improving educational outcomes). The improved outcomes (including reduced substance use) of educative or supportive approaches to student substance use within schools versus punitive measures such as school exclusion have been well established (Evans-Whipp et al., 2015). However, limitations of evaluation research do not permit for these long-term impacts for young people as well as for the broader school and community to be captured.

In summary, analysis of the above data finds that participation in the *Building Resilience in Schools* program results in positive outcomes for participating young people. The study argues that Odyssey House’s school-based program promotes improved mental health, emotional regulation and school engagement – which together align with the general intentions and priorities of Australian education settings (Centre for Education Statistics and Evaluation, 2015). Importantly, it has been found that the program works with young people to achieve desired goals around reduced substance misuse. The findings of this study point to young people making very positive progress towards achievement of these goals. We argue that without the opportunity to participate in the *Building Resilience in Schools* program and receive tailored support from school-based clinician, it is unlikely that this positive progress would have been achieved.

### 5.4 The importance of relationships, trust and place-based service in delivering holistic care

This study has highlighted some elements of the *Building Resilience in Schools* program that are essential to its success, both for young people and the broader school community. In this section we identify how building relationships and trust with students is central to the program. Similarly, our analysis also surfaced the importance of building a collaborative relationship between the OH clinicians and the teaching and well-being staff so that holistic care and support could be provided to students.

**Building relationships and trust with young people**
Previous research has shown that young people do not often seek help or support for the issues they face because they are not comfortable speaking to a stranger (in a service) about sensitive aspects of their personal lives. As evidenced in this section, the *Building Resilience in Schools* program moves beyond simply basing a clinician in the school as part of a place-based specialised service. The process of embedding a specialist clinician into the fabric of the school community and increasing the likelihood of successful outcomes for young people of different risk levels requires careful relationship building with students in order to develop trust.

All of the clinicians interviewed identified the importance of building a relationship with students before they initiated conversations or discussions about their substance use or treatment. One clinician articulates his process of building rapport with students by participating in everyday activities on campus:

I … base a lot of my work on relationship-building initially, and getting that trust … going and then see where they want to go…I make it a rule that within the first week of [students] arriving … to go and introduce myself. And a lot of that’s based around being out in the yard, kicking a footy, or cooking a BBQ with them for lunch…

… what gives me the right to talk to you [a student] about improving your life if there’s no trust or no relationship? Within professional boundaries obviously, so being present gives me an insight into observing and hearing conversations (Clinician, Park Secondary School)

Across school settings (both FLOS and mainstream secondary schools) clinicians articulated how important relationship building and being present and involved is the best way to connect with young people.

I’ll sit in on classes. I help kids do some of their work …just seems to be the way that these kids benefit more…(Clinician, West Community School)

I think having something in the school is massive. Everyone is comfortable. Everyone knows who you are. I think that’s a really amazing, important part. Then also having that flexibility to do things like camps and run sessions. We did the animation program. Being able to do those kinds of things I think is amazing, building those ongoing relationships with the students and teachers…. Being in the schools is –Not just popping in or you’re here kind of thing. (Clinician, North Community School).

These clinician’s reflections draw attention to the ways they can begin building connections with students, but also the ongoing and consistent presence that the *Building Resilience in Schools* program model provides. Being embedded over a long period of time allows both students and teachers to ‘feel comfortable’ with the clinician and their role. Furthermore, it allows the clinician to complement the educational components of schooling with activities that promote wellbeing (i.e., arts-based projects and camps).
Teachers from participating schools also identified the importance of visibility and trust in increasing help seeking behaviours in young people. Of particular interest is this teacher’s reflection on the trust developed between teachers and clinicians and being able to confidently refer young people into the program.

I think visibility is everything. You have to be present. You have to be around. So, people who are going to be more cautious can suss you out from a distance...we completely trust that we can hand you over to Odyssey and it’ll be great. I’ll be really beneficial and you’ll gain something from it.

...two boys in particular - who have come and sought out help themselves and asked if they could be in contact with [the clinician]. So, it was really nice to see that the seed had been planted in that really positive relationship...that young person to feel that...they felt like it wasn’t the time to seek treatment then. But a few months had past and there was a realisation...they felt it was time and they could still come back and they felt they had that relationship to seek them out. (Teacher 2, North Community School)

The first part of this FLO teacher’s reflection points to the importance of the relationship between clinicians and school staff. This teacher pointed out that young people can ‘pick up’ on the doubts they may have referring them to a particular service. She noted that with OH and the school-based clinician students recognised that teachers trusted them and were enthusiastic about their expertise and what they offer. This hints at a broader set of dynamics that are essential to the success of the Building Resilience in Schools program as an embedded service, namely the collaboration between the clinician and school staff.

**Developing a collaborative working culture for holistic care**

The relationship and collaboration between the OH clinician and school staff was found to be central to the success of the program. A number of important processes were identified through our analysis, particularly ensuring that school staff actively involve clinicians in school culture, coordinated support for students and

Teachers in FLOs in this study have been working with OH clinicians embedded in their contexts in various ways for approximately 10 years. These teachers’ insights into ‘what works’ when it comes to integrating the program into school contexts was valuable as they had a longer period of time to reflect upon. Teachers from these settings noted that it was essential for teachers and school leadership to be proactive in the steps they take to integrate the program culture and staff into the school. They emphasised creating a space for the relationship to develop and understanding that it took time to build these relationships and see positive outcomes. This proactive stance on collaboration and trust building, one teacher identifies, is essential to a preventative approach to reducing drug and alcohol use.

Schools need to be super active about giving a place and a space for the relationship building and all that proactive cultural stuff that has been critical here...Be aware that some of the benefits take a little while to rise
to the surface, because prevention and decision-making are quite subtle. Invest in it and make sure that you’re really active in building positive relationships with the workers. Give them a job. Give them a space to get them involved so that every kid in the school knows who they are, even if they’re not talking to them yet….

It needs to be really proactive. It’s always worked best when the relationship building is happening when things are good as well as in positive situations where kids get to shine and show their strengths. Waiting to react is never going to work…other schools need to make sure that the Odyssey culture is included into classrooms, into school celebrations. Really working with the groups even when there’s nothing to talk about. So you know, they’re going to find clients before the problem has happened almost. So it’s a very proactive role before the shit hits the fan, basically…(Teacher, South Community School)

With the Building Resilience in Schools program only recently being embedded into mainstream secondary schools there were some clear insights into the ways in which clinicians and school staff (i.e., teachers, wellbeing staff and other) have been forming collaborations and coordinating their roles to provide support for students.

Clinicians believed that their role within the school was important to expanding the range and type of support available to young people. They understood their role to be one of support within wellbeing teams and to offer specialist knowledge and care in relation to drug and alcohol issues.

The advantage is that we go to the school, that we can actually support the school and offer this wellbeing stuff, and whatever secondary consult (direct support to wellbeing staff and teachers), especially about alcohol and drug related issues. The advantage is that we can offer a specialised AOD service, whereas the staff aren’t necessarily experts in that area.

(Clinician, Views Secondary)

The clinicians embedded in the mainstream secondary schools also identified the ways they had been working collaboratively with wellbeing teams and others in the school community to coordinate care for students with complex issues. The clinician below describes how she worked to coordinate care for a student who was seeing a number of specialists. Such collaboration and identification of roles was seen as vitally important to the young person’s improvements in mental health and substance use.

I’ve been seeing [a student] weekly and offering her counselling, about drug and alcohol, but about mental health issues. Then I found out, there’s a speech pathologist involved, there were also other people doing assessments and everything.

So, I’ve coordinated-- I’ve contacted all of them--and I’ve said look, I’ve heard that all these people are involved, can we just sit down and have a meeting about what our roles are, who’s involved. Also, can we bring this
client in to this, because she doesn’t understand what’s happening with her.

I think she’s benefited, because we’ve had several meetings, and she’s attended, to try and understand how she’s going to be supported going into Year 12. Also, I just find who’s taking responsibility for that. I saw her today, and she’s learning to manage her anxiety based on the stuff that we’ve learnt. She’s openly talking about her substance use, and monitoring what’s happening and how that’s linked to her emotions. I think that’s been a really good, really really good one (Clinician, Views Secondary).

All of the clinicians shared examples of how they worked with wellbeing staff to support students and a number also identified how they collaborated to ensure educators were aware of what was taking place. This type of advocacy work that clinicians were engaged in was something more specific to the mainstream school contexts and was important in maintaining the young person’s connection to learning and success in the classroom.

I do a fair bit of secondary consult with the other wellbeing staff, because they might see one of my clients when I’m not there …if a young person gives me consent about what a teacher could do, or how the coordinators could support them, I feed that back to them, and speak to the coordinators about how we can do it together. That’s probably been the main thing about that, because sometimes young people aren’t comfortable to talk to them. (Clinician, Views Secondary School)

Finally, across the school contexts one issue that was raised was in relation to the roles that clinicians, wellbeing staff and others take up when working together. One clinician identified this as something, which needed to be constantly revisited as the program was being implemented in the mainstream school context. However, this issue was not solely experienced in these traditional school settings, rather a psychologist based in the FLO school also identified how she worked with the OH clinician to navigate their overlapping roles, different approaches to issues of mental health and the ways they could collaborate to provide students with tailored support.

For me there was a division…the work that she was doing is also wellbeing related. But it was drug and alcohol specific. So, while there was an acknowledgement that when you have drug and alcohol issues, they don’t exist in a vacuum….students were free to focus on….the alcohol and drug use itself, if that’s what they preferred to do rather than acknowledge the background factors. But when we did have that staff member here, that she was available to do both of those things. And that provided access to the residential detox service…one thing I really appreciated was that I never felt like she and I were competing for the same things…just felt very easy a lot of the time. It felt very collaborative. If there were students that she was working with that I wasn’t, she would touch base with me and [teacher] via email to say this is the chats that I’ve had or the contact. (School psychologist, South Community School)
Similarly, one of the clinicians also identified how the navigation of roles was challenging even between the educator and the specialist:

One challenge that I find is with the teaching staff and trying to get them to the point of accepting that they’re experts in education, we’re experts in welfare and drug and alcohol. They need to work within their expertise and allow us to work within ours. (Clinician, Park Secondary School)

These reflections point to ways in which collaboration within a multidisciplinary team can be challenging and in need of constant attention. Across these accounts some important processes were identified by clinicians, wellbeing team members and teachers that are essential to success for an embedded model like the Building Resilience in Schools program. One of these processes related to the nature of the relationship between collaborators, which needed to be open, enthusiastic and student-focused. Other essential elements of overcoming challenges were clear communication about each specialist’s role and capacities so that each person involved was comfortable with what they could offer. Finally, communication and transparency with information sharing was also seen by a number of interviewees to be part of a positive working culture that led to the best outcomes for young people.

5.5 Capacity building for an inclusive school environment

One of the keys aims of the Building Resilience in Schools program is to strengthen the capacity of schools in relation to issues of student welfare, particularly substance use and co-occurring issues of mental health. Research literature has found school-based substance use programs as being beneficial because they increase student connections, reduce risk-taking behaviours and drug use among young people (Chapman et al., 2013; Foxcroft & Tsertsqvadze, 2012; Inman et al., 2011). In our study we found that the embedded and comprehensive nature of the Building Resilience in Schools program did enhance collaborative and coordinated responses to support students, but it also allowed for important capacity building with school staff that improved safety and social inclusion.

Slee (2011) broadly defines inclusive schools as those that ensure engagement, access and safety is provided for all students regardless of ability, circumstance or background. Such conceptualisations consider that schools are not just places of learning and education, but that they are places of development that encompasses the entire person (emotional, social and intellectual capacities).

The current study has highlighted that importance of this program in some of these gains at both the individual and interpersonal levels. This section brings together some of the important activities and support that form part of the Building Resilience in Schools program.
and the work of the clinician to identify how specific capacity building activities lead to outcomes that improve the school environment for all students. See Table 5.8 for further evidence of these capacity building activities.
Table 5.8: Evidence for Capacity Building Activities of the *Building Resilience in Schools* program

<table>
<thead>
<tr>
<th>Capacity building activity</th>
<th>Type</th>
<th>Examples of evidence or reflection on activity</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Professional Development Sessions (one-on-one and group with school staff) | Drug and alcohol Education (harm minimisation) | (1) We tend to forget about is that young people are talking about substance use but they’re doing that with other young people. They’re already getting a skewed view of the issue. So to have someone to come in and talk about the facts with no judgement or whatever, but have that open conversation at least they may be getting a slightly different view that might be able to kick off some changes. (Clinician, Park Secondary School)  
(2) [The clinician] ran some PD for staff on early intervention…on how to manage and deal with students who may be drug-affected who come into the classroom. How to support them and keep them safe, as well as keep everyone else around them safe….It can be tricky because we can have really disengaged students, so when they are here, we want to keep them here and we want to support them, but if they are drug-affected, how do we manage them and support them as best as we can?….I definitely think that from them [clinician] coming in and the work they've done….I'm a lot more mindful of the way I may approach a situation with a student with their mental health or alcohol and drug issues... it's a whole collective of things moving forward in trying to support the individual. (Teacher, North Community School)  
(3) I mean, actually getting tools that we refer to. I just saw today a diagram on my desk talking about the cycle of addiction with the peaks and the troughs and what problems are excused. Some really powerful education for staff, I think, that we'll refer to ongoing…the philosophy of no judgement. And compassion, I think, for kids who are making decisions around drugs and alcohol. It’s not anything to be ashamed of. It’s actually part of a wellbeing conversation. As opposed to naughtiness… I think that’s really helpful by having AOD conversations happening ongoing amongst the staff. (Teacher, North Community School)  
(4) Educating the teachers around potential reasons for substance use - it’s not always just recreation – because obviously I think most of the time it’s based on some traumatic event and dealing with it that way (Clinician, West Community School)  
(5) One [session] with all the teachers talking about sort of substance use relates to trauma and the feedback on that was really good from the teachers. Some                                                                 | Increased safety of student, peers and staff  
Increased retention of disengaged students  
Increased staff understanding in supporting students with trauma and mental health issues  
Awareness of the facts about alcohol and drug use among young people |
| Informal and tailored support for co-ordinators and teachers     | Knowledge transfer                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |


of the younger teachers are going ‘we’ve never heard about that’ (Clinician, West Community School)

| Secondary consults with wellbeing staff | Knowledge transfer and specialist coordinated care | (1) The advantage is that we go to the school, that we can actually support the school and offer this wellbeing support, and secondary consult, especially about substance use. The advantages are that, we can offer a specialised alcohol and drug service, whereas the wellbeing staff aren’t necessarily experts in that area. (Clinician, Views Secondary College) | Harm reduction
Increased student safety in schools
Better mental health outcomes for students
Increased capacity among welfare staff to support students with self-harm or suicidal tendencies |
| (2) I’ve done heaps of safety plans, because there’s just lots of talk about self-harming and suicide in that school. The feedback that I got from the staff, is that they’re really happy with it [secondary consult]. For those staff [wellbeing], it’s helpful because they’re not specifically trained in that, they’re more general wellbeing (Clinician, Views Secondary College). |

| Offering alternative activities for young people | Drug and alcohol education Creative skill development Developing student-teacher relationships | (1) the camps that I have done, 100% they are amazing. That’s obviously something that they’ve been doing in the program for years. It is 3-4 days away with some drug education, Again, it’s that being substance-free and having a good time, keeping them busy and just showing them that they can go with the first three or four days without smoking cannabis. (Clinician, North Community School) | Enhanced understanding and relationships between clinician, school staff and students
Increased knowledge and support for teachers about community and project-based learning
School environment is more inclusive and enjoyable which leads to increased retention |
<p>| (2) Then also having that flexibility to do things like camps and run sessions. We did the animation program. Being able to do those kinds of things I think is amazing, building those ongoing relationships with the students and teachers…. (Clinician, South Community School) |
| (3) Camp is probably example of that. I think again feedback from the teachers that come on the camp. They also found the experience amazing and having that time with the students to build more of a relationship and in a different environment. I know the teachers loved the camp and how Odyssey ran both camps and other activities. (Clinician, North Community School) |
| (4) We’ve ran a couple of camps in the time, and that’s been really successful. Because it's getting them out of the school environment and away from all the stress and day-to-day stuff here, and around home. So, getting them away out of where they normally feel comfortable, and just really getting down to the real gritty stuff of why they may be using or what's holding them back from cleaning up their act. So, camps have been really successful in that sense, I think. Educational too. (Teacher, South Community School) |</p>
<table>
<thead>
<tr>
<th>Bridging activities between school and community</th>
<th>Student outreach</th>
<th>Family outreach</th>
<th>Enhanced educational engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student outreach</td>
<td>(1) Another advantage is that I can see students outside of the school as well, so I can do outreach and still continue to see them on school holidays, if they need it (Clinician, North Community School).</td>
<td>(2) I said to them you can come and see me at the school or because I have an office at the [youth and community centre] I can see them there. I've given certain clients my contact number there and said, I've booked some people in to see over the holidays and check in (Clinician, Views Secondary).</td>
<td>Stronger relationships and connections between schools and families</td>
</tr>
<tr>
<td>Family outreach</td>
<td>(3) I've spoken to parents on the phone, and one parent has been involved in care team meetings. I have also presented to groups of parents to map out where people might be at and how they're presenting [with substance use issues] to give them an idea of maybe how to interact with their child to shift them maybe a bit further along in the cycle of change stuff (Clinician, Park Secondary School)</td>
<td>(4) Having this clinician in our community was a huge help in engaging students, because they know her. And the access to accurate, up-to-date information, detox availability, all those links are very, very useful. (Teacher, North Community School)</td>
<td>Improved students’ safety through decreasing risk and harm related behaviours</td>
</tr>
<tr>
<td></td>
<td>(5) It’s the clinician’s networks in general, with Headspace, if we thought a student could really use an assessment by psychiatrist, for instance, he has got the connection with Headspace clinicians, and was able to get that happening. Yeah, so all those brilliant connections we can just use across the board. (Teacher, South Community School)</td>
<td></td>
<td>Increased links and support for schools to service agencies in the community</td>
</tr>
</tbody>
</table>

(5) Fishing was amazing…I had a discussion with two of the boys around mindfulness they were like “this is so boring” and I said “we've spoken about mindfulness, take this as an opportunity to practice that sort of stuff”. Just a complete change just in that hour after that and the way they approached it; so that was really good. We did things like go karting and rock climbing and with the rock climbing they were a bit ratty on that day, but just talking about supporting each other and trying to build some resilience around overcoming boundaries and taking what is perceived as a risk, but in a controlled setting…And yes it’s scary and yes you’re going to feel like you’re going to fall, but you’re safe…it was cool seeing sort of some of those kids talk with other students that they don’t really socialise with or talk with and be supported through some of the challenges through that…it was for the kids to see teachers in a different light. (Clinician, West Community School)
There were a couple of parents that I had met, where I hadn’t met the students...because the students disengaged...using substances and the parents were trying to get them to re-engage with the school...other parents that I had met because there was conflict in the home around drinking alcohol and substance use and it got to the point where the young person locked out and so who you’ll advocate - and having to set some boundaries and all of that sort of stuff with those parents and that young person...(Clinician, Park Secondary School)

one family I referred off to one of the other programs that we were involved with; which is with the program which works with families and the young person...It’s mainly as needs arise. There’s been one parent where the younger person is not turning up at school but also the young person not coming home either. And their parents are putting out missing person alerts after two, three days, not seeing the young person. And there’s some significant health issues for the parents as well. And so, trying to put together a care team that covers to help support the parents and the young person. Again, it’s really difficult with the young person, when they’re not wanting to engage at home or at school... bringing people together not pulling people apart. Bringing people back into school not kicking them out of school. Bringing them back into the home not kicking them out of the home. (Clinician, Park Secondary School)
6 Conclusion and Key Recommendations

1. Young people require specialised, sustained and accessible wellbeing services in schools.

Both within FLOs and mainstream schools there are cohorts of young people negotiating complex mental health concerns (including impacts of trauma) and substance misuse, which require accessible and sustained support. Despite such identified needs, for many of the young people who participated in the Building Resilience in Schools program, this was their first experience of drug and alcohol counselling. Thus, signifying the importance of Odyssey House clinicians being embedded within the school setting. In addition to this place-based service provision, the flexibility in frequency and type of support assists clinicians to better meet the needs of young people. Findings indicate that both young people in community and mainstream schools require regular support. The most common support provided by school-based clinicians was direct counselling and assessment.

Key Recommendation:

- An increased focus and holistic approach on issues of mental health.

Our research shows that dual focus on mental health and substance abuse prevention and treatment is currently effective in supporting students with complex needs. Across school contexts, mental health is becoming a considerable concern for students who are considered ‘high risk’ but also for those who are ‘low risk’ with regards to substance use. We recommend that the Building Resilience in Schools program continue to develop and expand their mental health support across student and staff. In addition, strengthening schools’ partnerships with mental health providers outside the school context.

2. Program participation leads to positive wellbeing outcomes for students.

The majority of students who participated in the Building Resilience in Schools program experienced positive outcomes including reduced substance use. Other indicators of wellbeing that were positively impacted, post intervention, included mental health, emotional regulation and school engagement. From the findings it was evident that the school-based program is proactive in moving young people towards setting and achieving goals around substance use reduction. Also, the dissemination of harm
minimisation knowledge and practice regarding the use of drugs and alcohol was an important outcome.

**Key Recommendation:**

- Continue to provide individualised treatment plans and goal oriented supports for young people at the high end of the risk spectrum.

Our research shows that this program’s approach to improving outcomes for young people with complex needs who are considered high risk is highly successful. OH’s embedded approach in schools reduces barriers to seeking treatment and assistance for young people and should continue to be the cornerstone of their program delivery.

3. **School-based services and interventions are optimal for positive outcomes.**

The *Building Resilience in Schools* program embeds the drug and alcohol counsellor into the school context. In this study it became evident that this characteristic, which allows for the development of positive youth-adult relationships, was fundamental to the program’s success and acts as an exemplar for other wellbeing initiatives aimed at young people. The placement of clinicians in the school setting allowed for high levels of trust and rapport to be developed with students and teachers alike. This trust and rapport were characterised as vital for the complex support offered to young people. Furthermore, developing connections with the broader student cohort increases opportunities for early intervention efforts.

**Key Recommendation:**

- Increase preventative education programs and initiatives in high school settings.

In this study we identified that relationship building and the development of trust between clinicians and the school community was essential to the success of the program. We recommend that OH continue to expand and develop these connections and relationships in high school settings with students who are not considered high risk. In order to increase chances for early intervention we believe that increasing visibility through preventative education programs and activities with the broader student body will ensure young people seek support and help.
4. The Building Resilience in Schools program contributes to the welfare capacity of schools.

This school-based intervention supports the wellbeing and welfare capacity of schools in numerous ways. This program makes a significant contribution to connecting specialised services, knowledge and contacts with schools. These specialised clinicians strengthen pre-existing and multidisciplinary teams by increasing their knowledge and recognition of young people with co-occurring issues (drug/alcohol use and poor mental health). By providing tailored professional development around trauma, mental health and substance use, school-based clinicians can strengthen teacher and wellbeing staff responses to young people with complex issues. Through this capacity building, the Building Resilience in Schools program makes a significant contribution to ensuring that schools and classrooms are safe spaces for young people negotiating mental illness and potential substance use.

Key Recommendations:

- **Expanding tailored professional development for school staff.**
  Our findings show that current professional development activities for teachers and other school staff are useful for coordinating care, maintaining student engagement and increasing knowledge about student welfare issues. We note that each school context was incredibly different in terms of student needs, further developing a range of formalised professional development packages will be required to adapt the program to new school contexts.

- **Creating a shared vision and culture of wellbeing and inclusion in schools.**
  The research highlights that over time a clear vision and culture of wellbeing and inclusion was developed in FLO settings. We recognise that it takes time to build the relationships and trust to achieve a shared vision and culture across Building Resilience in Schools program staff, teachers and other school staff. However, as the program expands into large scale high schools we believe a direct and deliberate approach should be taken to facilitate this culture of wellbeing and inclusion. Targeted activities that enhance role boundaries and understandings (between clinicians and school staff), communication and the development of processes around coordinating care.
References


### Appendix A: Program Snapshot: School-Based Drug and Alcohol Interventions

<table>
<thead>
<tr>
<th>Program</th>
<th>Target Group</th>
<th>Intervention</th>
<th>Theoretical Underpinnings</th>
<th>Control</th>
<th>Post-intervention outcomes</th>
<th>Reference</th>
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<tbody>
<tr>
<td>Drug Education in Victorian Schools (DEVS)</td>
<td>Year 8 and 9 Victorian secondary school students</td>
<td>o 18 teacher led lessons delivered over two school years.</td>
<td>o Harm minimisation</td>
<td>Standard school-based drug education.</td>
<td>o Drug and alcohol knowledge and recall of drug education increased. o Reduced rates of alcohol consumption and harm – including among identified risky drinkers. o Improved communication with parents regarding substance abuse (primarily alcohol). o Alcohol related attitudes and drinking rates did not differ between intervention and control groups.</td>
<td>Midford et al. (2014)</td>
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<td>School Climates: Ecstasy and Emerging Drugs module (Internet based)</td>
<td>Year 10 students at participating Sydney secondary schools.</td>
<td>o Weekly online modules containing 20 minute cartoon storylines to communicate and share information concerning harmful drug (and alcohol) use. o Various online and teacher delivered activities (optional), such as discussions and worksheets.</td>
<td>o Harm minimisation</td>
<td>Health education as per standard curriculum.</td>
<td>o Use of NPS and ecstasy was low at the baseline. o 12-month follow up, control group were 10 times and 3 times more likely to use (or have intentions to use) NPS and synthetic cannabis respectively than the intervention group. o Intervention group: improved knowledge regarding substances. o 12-month follow up no intervention effect found regarding drug use.</td>
<td>Champion et al. (2016)</td>
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<td>Program</td>
<td>Grade/Setting</td>
<td>Description</td>
<td>Note</td>
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<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>Grade 8 and 9 students in South-eastern Wisconsin</td>
<td>Whole school based program. Students complete a short screening tool for substance use. Screening followed by a conversation with a health educator (centring on risk levels, perceived harms and benefits of their drug use). Purpose: to strengthen abstinence, decrease substance consumption. Necessary referrals for specialised treatment. Complete invention is presented within a 15-minute period.</td>
<td>Maslowsky et al. 2017</td>
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<td>Keepin’ It REAL (adapted program)</td>
<td>Alternative high school settings</td>
<td>Four resistance-based strategies are taught (refuse, explain, avoid, leave). Six weekly sessions for six weeks. Students at each school adapt the program lessons to better reflect their language, substance use, daily activities and life experiences.</td>
<td>Hopson &amp; Steiker (2008)</td>
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<td>Refuse, Remove, Reasons</td>
<td>Students (mean age = 15 years)</td>
<td>Brief 5-lesson universal classroom-based prevention program. Social learning theory</td>
<td>Morgo-Wilson et al. (2017)</td>
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<td><strong>RRR</strong></td>
<td>Enrolled in health classes across 12 private schools currently serviced by a substance abuse prevention agency (n = 678).</td>
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<td></td>
<td>o Centres on social resistance skills training and normative education.</td>
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<td></td>
<td>o Program delivered by external facilitators.</td>
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<td></td>
<td>o Lessons included a 5-10 minute video of narratives of real young people and age appropriate information.</td>
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<td>o Subsequent focussed questions and activities.</td>
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<td></td>
<td>o Four homework tasks (e.g. web videos, self reflection activities) are included.</td>
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<td>o Parental resources also included in program.</td>
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</table>

| **Clusters on Social Resistance Skills Training and Normative Education.** |
| --- | --- |
|  | (n=674). |
|  | o Increase in days getting drunk for participant group. |
|  | o Participant group reported increase awareness of risks and consequences of drug use and a reduced acceptance of drugs. |

| **CLIMATE Alcohol Course** |
| --- | --- |
| Year 8 Students (Australian High Schools) | Six computer-based lessons followed by structured activities (e.g. role-playing, small group discussions, decision-making activities, skill rehearsal). |
|  | Harm minimisation |
|  | Social Influence approach |
|  | Control group received standard education. |

| **Harm Minimisation Social Influence Approach** |
| --- | --- |
|  | 12-month follow up - improved alcohol related knowledge for participating students; decreased identification of the social benefits of alcohol. |
|  | Decreased alcohol use for female participants - including the frequency of excessive drinking, and the number of alcohol related harms experienced. |
|  | Male participants - no significantly different behavioural outcomes record between participant and control groups. |

| McBride et al. (2004) |
| --- | --- |

| **The School Health and Alcohol Reduction Project (SHAHRP)** |
| --- | --- |
| State secondary schools in Perth, WA (Metropolitan areas) | Program delivered in two phases over a two-years. |
|  | First phase: delivered to students in their first year of secondary school (8-10 skilled-based sessions). |
|  | Harm minimisation |
|  | Standard alcohol education classes (during) |

| **Harm Minimisation Standard Alcohol Education Classes** |
| --- | --- |
|  | Decrease in self-reported alcohol related harm. |
|  | Participants demonstrated more knowledge and safer attitudes regarding alcohol during intervention and at follow up. |

| Vogl et al. (2009) |
- Second phase: 12 activities presented over 5-7 weeks (e.g. skill rehearsal; scenario discussion)

- Difference significantly decreased at 32 months post program.

- Participants were significantly more likely to refrain from alcohol or be 'supervised drinkers' than students in the control group.

- Phase 1 and 2 – participant group consumed 31.4% and 31.7% less alcohol than control group. Between-group differences decreased 17 months post intervention.