



a note from David Dossetor...



A Stitch in Time Saves... 84

Health Economics for Mental Health and Intellectual Disability: Evidence based medicine and the growth of health economics of preventative mental health intervention.

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Introduction

What has economics got to do with preventing mental health? In the current context where mental health is stigmatised and underfunded, I suspect that it will have greater impact than any advocacy or media event, and will do much more to bring agencies that deal with children together to transform the way we work to improve the prevention and treatment of their mental health. In the last part of the article I shall draw on what evidence there is for doing the same for children and adolescents with intellectual and other developmental disabilities. In short, health economics will provide the economic justification for up-scaling the national and international investment in mental health, as it will save and make money in the gross national product, at cheaper costs than other types of health intervention, let alone improve the quality of life and wellbeing in those at risk of mental disorder.

The development of mental health economics:

The first section of this paper is based on health economics research from the Personal Social Services Research Unit at the London School of Economics and Political

Science in the United Kingdom (UK), under the leadership of Martin Knapp (Knapp, McDaid and Parsonage, 2011). If the aim of mental health clinicians is the alleviation of symptoms, promotion of quality of life, support of family caregivers and improvement of broad life chances, this should also apply to those responsible for allocation of resources. However, resources are scarce relative to the demands and the needs of the population and choices need to be made, linked to the aim of the health system, to improve health and quality of life.

Economics brings a rational approach to managing scarce resources through cost-effectiveness analysis. In the mental health market economy, services are bought just like groceries but differences include: it is more difficult for the consumer to judge the quality of the service; consumers are unwilling to be seen buying services or as having mental health problems because of the stigma and prejudice (Knapp and McDaid). Further, the risks of consuming poor quality mental health services are greater than poor quality groceries. A mental health treatment can be expensive, often unaffordable, unless it is covered by a mental health insurance. Accordingly most middle to high income countries rely on prepayment systems such as taxation, or insurance which enables the benefits to be spread to poorer consumers.

Consumers may also over use a free service. Accordingly, first world countries have a mix of public funding through taxes, or social insurance complemented by out-of-pocket expenses and voluntary private insurance. Demand grows with increasing numbers in contact with the services and those unrecognised and untreated identified through epidemiology. Resource limitation leads to the consideration of efficiency and equity of service provision. Choices include: Are a greater number of sessions delivered by a psychologist more or less efficient than fewer sessions delivered by a psychiatrist who also relies on the efficacy of medication?

Equitable allocation means giving more service to those with greater need, and charging poorer consumers less. The premise "Does it work and is it worth it?" is the basis of cost-effectiveness analysis. Cost-utility makes it possible to compare the costs between various health conditions. For example the cost of conduct disordered children was 18 times higher

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than other children, most noticeably including criminal justice systems costs. However only 5% of the cost benefit of parenting groups for children with persistent antisocial behaviours came to the health service, the rest fell to schools especially special education, social care agencies, families and welfare systems. It becomes a complex task to measure the cost or benefit because of the problems of costing across different agencies. For example children with persisting antisocial behaviour cost £5,960 per year, but cost of effective treatment was a one off cost of £4,307.

The trade-off of cost/benefit of treatment is measured by quality-adjusted life years (QALYs); this metric of how many people need to be treated for a particular condition with a certain treatment to gain one QALY enables a comparison between treating different conditions. In the UK, one QALY has been costed at £30,000 (\$46,000). For example QALYs show that the cost of improving depression by computerised cognitive behaviour therapy was cheaper than professional sessions. Conversely the cost of treating depression is mainly borne by health services but the cost of non treatment is borne mainly by unemployment, disability and welfare agencies. Such an economic analysis in the UK, led to £180 million increase in cognitive behaviour therapy services (CBT) through the 'Improving Access to Psychological Therapies'. For depression, one QALY by computerised CBT cost £1,250 pounds, by psychotherapy cost £6,412 pounds and by pharmacotherapy £16,138 pounds. Conversely, in severe depression medication is more effective and a recent adolescent study showed medication and specialised case management skills from a psychiatrist were cheaper than standard CBT from a psychologist. These are important considerations. In 15 to 24 year olds, 45% of all disability adjusted life years (DALYs, ie untreated QALYs) are due to neuropsychiatric disorders both in rich and poor countries, with accidents, self-injury and violence close behind. The rise of health economics research gives a rationale for improving population wellbeing and in con-



sequence greater productivity and economic progress.

Knapp, McDaid and Parsonage (2011) have reviewed the literature for mental health promotion and mental illness prevention. They reviewed 15 topics based on availability of a significant body of research on these problems in the UK. The Odds Ratios (OR) of the benefit of these interventions only measure actual costs rather than the costs of QALYs, but an OR>1 has financial gain, for example an OR of 5 means for each £1 spent, other costs are reduced by £5! All examples are much cheaper than the average cost of a QALY in the general health system. Below is a selected number of topics applicable to mental health of children and young people.

1. Parenting interventions for the prevention of persistent conduct disorders (CD): CD occur in 4.9% of 5-10 year olds of which 50% persist. CD related crime costs £22.5 bn/ year and 1-2mn over the lifetime of a single prolific offender. Parenting programs to improve parenting style and relationships: improve 33% to no and 5% to moderate problems. Calculations listed over 25 years do not include benefits from improved employment, improved adult mental health outcomes and improved quality of life, and relationships. (OR 7.82)

2. Early detection of psychosis: Onset is in late adolescence-early adulthood. Early detection reduces the risk of transition to full psychosis and shortens duration of untreated psychosis. Intervention involves CBT, psychotropic medication and contact with psychiatrists, whereas routine treatment is provided by GP and counsellor. This increased costs in early intervention provision reduces subsequent health costs. (OR 10.27)

3. School-based interventions to reduce bullying: On average 39% of children are bullied in the previous 12 months. Adverse effects include psychological well-

being, educational attainment, plus long term effects of employability and an average reduced lifetime earnings of £50,000. High quality programs with peer mediators and classroom intervention leads to a 21-24% reduction in the proportion bullied with associated benefits. (OR 14.35)

4. Early intervention (EI) for psychosis: 6900 young people experience first episode psychosis in England with high costs to public services. EI reduces relapse and readmission and improves return to employment, education or training and their future quality of life. Assertive treatment involves a multidisciplinary team and an aim of encouraging a return to vocation pursuits. EI cost less than standard care £10,927 to £16,704. (OR 14.35)

5. School-based social and emotional learning (SEL) programmes to prevent conduct problems (CD) in childhood: 6% of 5-10 year olds have severe CD (SCP) and 19% mild (MCP), rising to 9% and 29% in adolescence. Total crime cost of CD in UK is 60bn/year. Potential savings per SCP is £15000 and £7500 per MCP. Other costs include fewer qualifications, early age parenthood, unemployment, divorce, substance abuse, and psychiatric disorder. School-based SEL helps to recognise/manage emotions, set/achieve positive goals, appreciate the other's perspectives, establish and maintain relationships, make responsible decisions and handle interpersonal situations constructively. International research shows that SEL significantly improved social/emotional skills, behaviour, and academic performance at a reduction of 9% of both SCPs and MCPs. (OR 83.73, £132cost/family)

These interventions show extraordinary cost effectiveness. The most dramatic outcome was the Odds Ratio for Social Emotional Learning where the total returns for every £1 spent was 83.73 to 1,

hence the title of this article 'a stitch in time saves... 84!'

Richard Williams, a Child Psychiatrist who was a guest at the RANZCP Child Faculty Scientific Meeting in 2012, has been advising the UK Government that with the economic recession there is greater necessity for investment in prevention as there will not be funding for adequate child and adolescent mental health services. In NSW there are significant intervention trials for some problems, including health visiting for post natal depression, parent training for conduct disorders (Triple P & 123Magic), early psychosis prevention and intervention (www.eppic.org.au), and preventing conduct disorder (CD) with social emotional learning ("getting on track in time").

The Impact of Schools on the Mental Health and Wellbeing of Children and Adolescents: The growing evidence.

NSW Department of Education and Communities recently commissioned "The psychological and emotional wellbeing needs of children and young people: models of effective practice in educational settings" (Urbis 2011). This extensive review of international literature found that over time students' wellbeing increased on a range of measures such as achieving developmental milestones, effective coping skills, positive attachments and positive social relationships. For example, the number of students who had experienced high psychological distress had reduced from 15.4% in 1996 to 13.3% in 2008. Yet students with both internalising and externalising mental health problems were also probably worse off. The report outlined an increase in the diagnosis of autism and other mental disorders, most common were ADHD (7%), social anxiety (4-9%), depression (4% in 13-17 year olds), suicidal ideation (20%) and CD (2% of 13-17 year olds). A high prevalence of bullying-including cyber bullying, an increase in numbers of young people drinking at concerning levels of alcohol and

increased rates of obesity were reported. Other factors of concern were poor physical health including diabetes, body dissatisfaction and disordered eating, changes to families and family structures including increased sole parenting, heightened emphasis on achievement and disengagement from school of those unlikely to succeed (16%), rapid social and cultural change with materialism with individualistic values leading to alienation and social fragmentation.

The National Safe Schools Framework helps Australian schools to develop effective student safety and wellbeing policies. This national framework comprises of: 1. leadership commitment to a safe school, 2. supportive and connected school culture, 3. professional learning, 4. positive behaviour management, 5. engagement with the student with a focus on wellbeing and student ownership, 6. early intervention and targeted student support and 7. partnerships with families and communities. This framework has been further articulated in the MindMatters and KidsMatters Initiatives. Universal programs for student wellbeing and mental health are widely adopted including Social and Emotional Learning Programs (SEL) such as FRIENDS (developed in Australia), the Olweus Bullying Prevention Program and various cognitive behavioural programs, including services from school counsellors and psychologists. SEL models to respond to psychological and emotional wellbeing needs are more likely to be effective if they are: 1. aimed at promoting mental health than preventing mental illness; 2. involve the whole school and school environment, 3. promote adaptive, cognitive and behaviour strategies, 4. involve parents and the community, 5. take account of age and gender, 6. are implemented over extended time periods and allow for booster sessions 7. have positive presence of staff and mentoring. SEL also improves academic achievement (by 11-17percentile points!), as well as stress

management, empathy, problem solving, and decision making skills (Durlak et al, 2011).

Selected programs are more effective than universal programs for students who are diagnosed or at risk for specific problems, even if universal programs promote protective factors and resilience. This may apply for students with depression, emotional disturbance, and violence. Timing and age of the students are important. Areas needing additional research include: where multiple ecological factors hinder delivery of programs, the development of social skills, when to refer to mental health services, disadvantaged groups including socio-economically disadvantaged communities, indigenous young people, same sex attracted young people, students from culturally and linguistically diverse backgrounds *and students with*

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disabilities.

In summary mental health promotion is more effective than mental health prevention as a universal intervention. Social and emotional learning is most effective in primary school aged children and positive psychology approaches for high schools (Headspace National Youth Mental Health Foundation, 2011).

Selective school interventions for those identified or at risk of mental health problems

NSW MH-Kids commissioned an ‘evidence check’ from the Sax Institute entitled: ‘School based intervention programs and

shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health problems: a rapid review’ (2012). This focused on prevention and early interventions for various mental health problems including: anxiety, depression, substance abuse, CD (including oppositional defiant disorder), ADHD and eating disorders. The report examines, target ages, the types of interventions and describing examples of shared care collaborative models between schools and mental health services. This gives the reader an introduction to recognised programs.

The report classified school based mental health programs into six sub types from 1. awareness raising such as mental health first aid, 2. stigma reducing and help seeking, 3. SEL, 4. specific disorder prevention programs for selected classes or groups such as MOODGYM, 5. whole school programs such as Beyond Blue, Sensibility and Mind Matters, and 6. more intensive strategies for those students most affected by mental health. However the review then focused on 4,5 and 6, thus providing a different slant from the Urbis review, searching both the black (peer reviewed literature especially randomised control trials) and grey literature (other unpublished reports such as PhDs and government and other agency’s reports). The optimal developmental age/stage for school based intervention or early intervention mental health program will depend on: age of onset of disorder (usually 2-3years before the average age of onset); risk factors and triggers associated with disorder, target groups more at risk, life transitions and stressors and availability of effective program for that age. A summary of specific disorders and programs are listed in table 1.

Health Auspiced Programs are where a mental health service has a relationship with schools, examples include: Headspace Australia, HeadStrong Jigsaw Ire-



Disorder	Affect	Recommended Programs
Anxiety	60% of 38 randomised control trials (RCTs) for anxiety prevention provided significant improvements and 74% of these were based on CBT.	FRIENDS (9-16years; Barrett et al, 2006); Stress Inoculation Training (15-17yrs; Hains & Szykowski, 1990); MoodGym (internet based, 13-17; Calear et al, 2009).
Depression	50% of 56 RCTs reported significant improvements of which 82% were based on CBT.	FRIENDS; Resourceful Adolescent Program (RAP) (13-14yrs; Shochet & Ham; 2004); Penn Resiliency Program (11-14yrs; Chaplin et al, 2006); Interpersonal Psychotherapy-Adolescent Skills Training (11-16; Young et al, 2006).
Substance Abuse	Successful universal alcohol interventions use a social influence approach eg resistance skills training with interactive sessions and improved environment. Effective drug prevention programs didn't focus on effects of drugs, or moral value driven approaches but exchange of ideas and developing new skills.	CLIMATE (used on-line resources) (13 yrs; Newton, Teesson et al, 2010); GateHouse (13 yrs; Patton, Bond et al, 2006); The School Health and Alcohol Harm Reduction Project (13 yrs; McBride, Farrington et al, 2004).
Externalising disorders	Multifaceted interventions eg with small group sessions and parenting programs eg Early Risers or Fasttrack or those that deliver single element based interventions. Eg Good Behaviour Game.	Good Behaviour Game (Grade 1; Barrish, Saunders & Wolfe, 1969); PeaceBuilders (Grade K-5; Embry et al, 1996); Responding in Peaceful and Positive Ways (Grade 6; Meyer et al, 2000).
Eating disorders	Body image dissatisfaction and attitudes to one's body have been improved with 'Everybody's different' stress reduction and self-esteem program (O'Dea & Abraham, 2000). Better outcomes involved programs that were interactive rather than passive, run by an expert rather than a staff member, that were multi-session programs, and incorporated dissonance induction or body acceptance content.	US Planet Health (females 10-14yrs; Gortmaker et al, 1999); Everybody's Different (11-14yrs; O'Dea, 1995); Media Smart (Grade 8; Wilksch & Wade, 2009).

Table 1: Summary of school-based intervention programs and shared care collaborative models targeting the prevention of or early intervention in child and adolescent mental health (Source: Sax Institute 2011).

land, Youth One Stop Shops NZ and NSW School-Link Australia. There is not a strong published evidence of effectiveness. NSW School-Link Program began in 1999 when 8 Area Health Services were funded for mental health promotion prevention and early intervention (PPEI), Professional Training and Pathways to Care. The training in 10 topics are now available on DVDs. Evaluation found that school counsellors were more confident in managing less severe mental health problems (MHPs) and better at referring more severe MHPs.

Promotion, Prevention and Early Intervention (PPEI) for children and adolescents with intellectual disability and Special Education.

In 2009 Justice Health and the Children's Hospital at Westmead were also funded. CHW School-Link aims were reported in the needs analysis 'Leading The Way' (Dossetor et al, 2009) and the activities in advocacy, education, building path-

ways to care are well reported in editions of this Newsletter.

We have reviewed the literature on PPEI in children and adolescents with intellectual disability, of which there are few. Feedback in 'Leading the Way' indicated that PPEI used in mainstream school settings are not suitable for those with intellectual disability.

The programs found to be effective in schools that cater for intellectual disability are listed: those with some scientific evidence in bold (1-6) which are reviewed in Dossetor, White and Watson (2011), those that have encouraging findings (7-12). Research is usually restricted to mild intellectual disability but often the interventions are felt suitable for moderate intellectual disability.

1. **Stop Think Do** (www.stophinkdo.com)
2. **The Paths Curriculum** (www.prevention.psu.edu/projects/PATHS.html)

3. **Social Decision Making** (www.footprint.com.au)
4. **The Alert Program** (www.alertprogram.com/)
5. **Stepping Stones Triple P** (www.triplep.net)
6. **Emotion Based Social Skills Training** (www.ebsst.com.au)
7. Signposts (www.signposts.net.au/)
8. Secret Agent Society (www.sst-institute.net/)
9. Mindfulness/Acceptance and Commitment Therapy (www.actmindfully.com.au/)
10. Cool Kids (www.emotionalhealthclinic.com.au)
11. Problem based Learning (PBL) (www.pbis.org/)
12. Kids Matter (www.kidsmatter.edu.au/)

The Canberra Roundtable on Mental Health for people with intellectual disability on 22/5/13 emphasised the need to establish

both universal and targeted PPEI in schools. NSW Every Student Every School policy presents an opportunity for Special Schools to work together to build a range of curricula for promoting and preventing the mental health of children and adolescents with intellectual disability. KidsMatter and Positive Behaviour for Learning or Positive Behavioural Interventions and Support frameworks have evidence of benefit in mainstream schools but have been positively reported in special schools. They both represent whole school frameworks in which specific content is needed.

Kids Matter has four dimensions of activity: a positive school community, social and emotional learning, parenting support and education, and early interventions for students. PBL breaks school needs into universal/whole school proactive primary prevention (80-90%), secondary prevention for targeted or high risk groups (5-10%) and tertiary prevention for high need individuals (1-2%). Key elements are collaboration, data driven, educative, clear expectations of behaviour, and rewarding desired behaviours.

There are recent reviews on early intervention in Autism (and/or intellectual disability), which helps develop a framework for PPEI. For example Roberts and Prior (2006) identified the characteristics of effective programs and include:

1. Autism specific, with focus on attention, compliance, imitation, language & social skills;

2. Addresses needs for high support teaching environment;
3. Strategies to promote generalisation of new skills;
4. Addresses need for predictability and routine;
5. Functional communication approaches;
6. Support transition to preschool, high school and into post school/employment;
7. Family are supported and engaged in partnership with professionals.

“Improving the emotional and behavioural well-being of young people with intellectual disability is likely to have the greatest impact on reducing the cost of care....”

No intervention suits all, as different children respond in different ways. Early, intensive, family-based treatment programs have substantial short and long term benefits so long as adapted to the individual and family. Different interventions show great variation in cost of provision and no studies have looked at cost benefit.

A Framework for PPEI in special schools that cater for intellectual disability.

When considering all of the existing research and frameworks of mental health

prevention and promotion programs, the key elements applicable for most children with intellectual disability include:

1. Specialised parent training programs which show powerful effects and improve family relationships and attachments, despite the evidence that problems are often biologically driven. These could be part of admission to a special school, building a relationship with each family and their disability support team.

2. Behavioural Approaches: are widely used and have the second best level of evidence of effect in intellectual disability, which includes Applied Behavioural Analysis and Contingency Approaches.

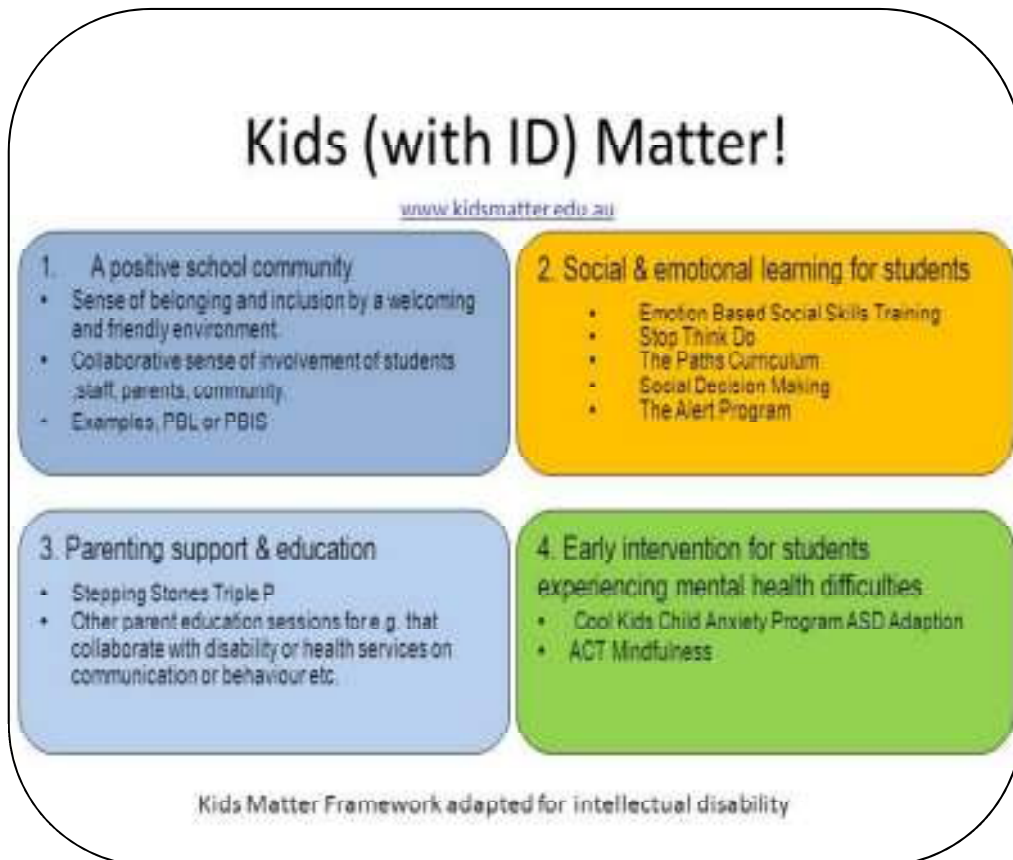
3. Development Promoting Programs that are matched according to developmental stage are the next type of intervention which is widely accepted, and gradually establishing a scientific based (eg TEACCH):

a. Augmented and Alternative Communication for those with profound/severe intellectual disability and problems of motor and language development: motor skill development and sensory exploration are pre-requisites of programs that enable independent communication through such as with electronic devices/switches to express choice. This progresses onto object communication, followed by picture communication (White, Chapt 15 in Dossetor, White and Whatson, 2011), but need to promote attention skills.

b. Specialised Social and Emotional Learning: Following the establishing some communication, next is programs that focus on the staged development of emotional recognition, followed by theory of mind and problem solving (such as EBSST) which are the components of specialised social and emotional learning. These are the skills that need scaffolding from supportive adults to facilitate internalisation of developmental competencies before social skills can be taught and children can develop relationships which in turn are the pre-requisite of mainstream SEL.

c. Specialised Social skills Training: Stop Think Do, The Paths Curriculum, Social Decision Making, The Alert Program are suitable SEL from an early stage, involving problem identification, identifying feelings and working out behaviours.

d. Targeted intervention: It is not clear whether targeted intervention such as Cool Kids and ACT/Mindfulness is also suitable as a universal intervention in special schools to improve anxiety and mood regulation or whether they are better reserved for high risk children (or suitable for both). There is a mental



health promotion resource which has reported success in the United Kingdom with small groups of young adults with learning disability and we are looking at piloting this program in 2014 in a school environment with adolescents.

4. Individualised Approaches for complex cases require specialised assessment and approaches to intervention, although this can be in a classroom setting. Examples that have face validity but lack scientific evidence include:

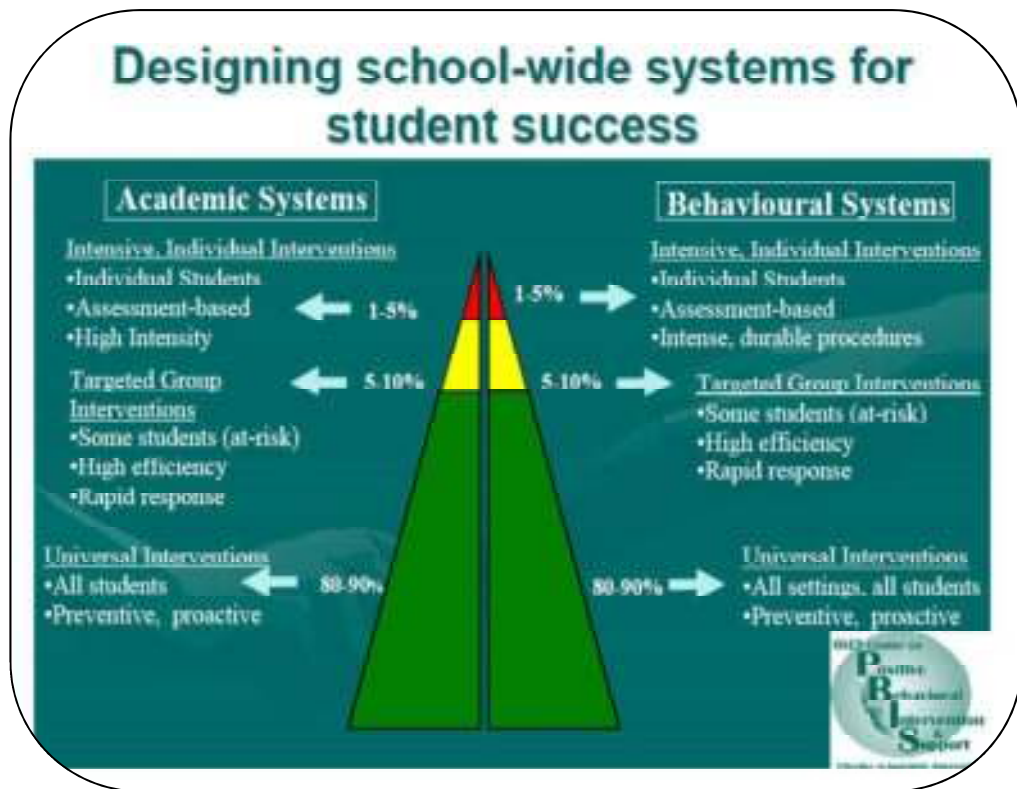
a. Complex Learning and Developmental Disabilities (CLDD): CLDD provides an individualised approach to understanding a child's problems with learning, taking a multidimensional approach using the Engagement Profile and Scale to help increase a learners' engagement leading to deep learning, modifying the learning process through dimensions of awareness, curiosity, investigation, discovery, anticipation, persistence and initiation, with a range of interventions. This model provides an interface between special education and neuropsychology, using educational approaches to understand and help (www.complexld.ssatrust.org.uk).

b. SPICE Model (Dosen, 2003): Social, Physical, Intelligence, Communication, Emotional are the dimensions of SPICE which are rated according to developmental age skills measured on each dimension. Jennie Curran (personal communication) has used this measure as an assessment tool to help design interventions for the mental needs of children and adolescents with intellectual disability and mental health problems, and are now using it in a special school-based project.

c. Multidisciplinary School-based Clinics: are being established in NSW in a number of Special Schools which are appreciated, but need evaluation. This can bring together the expertise of a specialist multidisciplinary team from disability, health and non-government organisations which can include: a paediatrician, an occupational therapist, a speech therapist, clinical psychologist and psychiatrist and family/cybernetics therapist. This diversity of professionals brings a range of skills which school staff can apply to both the presenting case and future cases including the management of high risk behaviour.

Conclusion

Health economics are likely to have a large effect in promoting and preventing mental health. In young people with intellectual disability, emotional and behavioural disturbance accounts for the greatest variance in the burden of care. Improving the emotional and behavioural well-being of



young people with intellectual disability is likely to have the greatest impact on reducing the cost of care. School-based PPEI is an important component to the lifespan approach to improving mental health in people with intellectual disability. Since there are large community costs in caring for people with intellectual disability it is pretty safe to predict that improved activity and skill in promotion and prevention of mental health is likely to be enormously cost effective, while also contributing to gain in quality of life and participation. This framework may be the basis on which special schools could test out interventions and add to the evidence on best educational practice and establish the health economic case for this special need population. CHW School-link would welcome further discussion or even a network of interested parties and partners on this topic.

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