LITERATURE REVIEW ON MEETING

THE PSYCHOLOGICAL AND EMOTIONAL WELLBEING NEEDS OF CHILDREN AND YOUNG PEOPLE: MODELS OF EFFECTIVE PRACTICE IN EDUCATIONAL SETTINGS

Final Report

August 2011

Prepared for the Department of Education and Communities
**URBIS STAFF RESPONSIBLE FOR THIS REPORT WERE:**

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Director</td>
<td>Alison Wallace</td>
</tr>
<tr>
<td>Associate Director</td>
<td>Lee Holloway</td>
</tr>
<tr>
<td>Senior Consultant</td>
<td>Ronald Woods</td>
</tr>
<tr>
<td>Consultant</td>
<td>Lucinda Malloy</td>
</tr>
<tr>
<td>Group Support</td>
<td>Jillian Rose</td>
</tr>
<tr>
<td>Job Code</td>
<td>SSP 14511</td>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>ACER</td>
<td>Australian Council of Educational Research</td>
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<tr>
<td>ACT DET</td>
<td>Department of Education and Training (Australian Capital Territory)</td>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>AEDI</td>
<td>Australian Early Development Index</td>
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<tr>
<td>AGCA</td>
<td>Australian Guidance and Counselling Association</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>ARACY</td>
<td>Australian Research Alliance for Children and Youth</td>
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<td>ATP</td>
<td>The Australian Temperament Project</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BPS</td>
<td>British Psychological Society</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
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<td>CBT</td>
<td>Cognitive Behaviour Therapy</td>
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<tr>
<td>COAG</td>
<td>Council of Australian Governments</td>
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<tr>
<td>CWI</td>
<td>Child and Youth Well-Being Index (USA)</td>
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<td>CWU</td>
<td>Child Wellbeing Unit (NSW Department of Education and Communities)</td>
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<td>SA DECS</td>
<td>Department of Education and Children’s Services (South Australia)</td>
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<tr>
<td>DEECD</td>
<td>Department of Education and Early Childhood Development (Victoria)</td>
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<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations</td>
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<td>DOHA</td>
<td>Australian Government Department of Health and Ageing</td>
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<td>EBP</td>
<td>Evidence-based Practice</td>
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<td>IEP</td>
<td>Individualised Education Plan</td>
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<td>IMHP</td>
<td>Intensive Mental Health Program (USA)</td>
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<td>IPT</td>
<td>Interpersonal Therapy</td>
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<td>LSAC</td>
<td>Longitudinal Study of Australia’s Children (Growing Up in Australia)</td>
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<td>LSAW</td>
<td>Longitudinal Survey of Australian Youth</td>
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<td>ACRONYM</td>
<td>DEFINITION</td>
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<tr>
<td>MCEETYA</td>
<td>Ministerial Council on Education, Employment, Training and Youth Affairs</td>
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<td>MCEECDYA</td>
<td>Ministerial Council on Education, Early Childhood Development and Youth Affairs</td>
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<td>NP</td>
<td>National Partnerships</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>NSW DEC</td>
<td>Department of Education and Communities (NSW)</td>
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<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<td>QLD DET</td>
<td>Department of Education (Queensland)</td>
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<td>PATHS</td>
<td>Promoting Alternative Thinking Strategies</td>
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<td>RAP</td>
<td>Resourceful Adolescent Program</td>
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<td>RCT</td>
<td>Randomised Controlled Trial</td>
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<td>SA DECS</td>
<td>Department of Education and Children’s Services (South Australia)</td>
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<td>SASS</td>
<td>Skills for Social and Academic Success</td>
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<td>SBMH</td>
<td>School-based Mental Health</td>
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<td>SDQ</td>
<td>Strengths and Difficulties Questionnaire</td>
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<td>SEAL</td>
<td>Social and Emotional Aspects of Learning program (UK)</td>
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<td>SEL</td>
<td>Social and Emotional Learning (USA)</td>
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<tr>
<td>SES</td>
<td>Socio-economic Status</td>
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<td>SEWB</td>
<td>Social and Emotional Wellbeing</td>
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<td>STARTTS</td>
<td>NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors</td>
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<tr>
<td>STEAM</td>
<td>Supporting Tempers, Emotions and Anger Management</td>
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<tr>
<td>TVET</td>
<td>TAFE-delivered Vocational Education and Training</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WA DoE</td>
<td>Department of Education (Western Australia)</td>
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<td>WHO</td>
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Executive summary

INTRODUCTION

Schools have become recognised as important locations for addressing student wellbeing, with advantages including their reach and familiarity to students and families, and the increased opportunities they afford for mental health promotion and prevention efforts.

In responding to the wellbeing of students, schools are faced with an array of models to promote wellbeing that have different aims and objectives, target groups and methods of implementation. Selecting a model that responds to the needs of individual students and the school community is important, but ensuring that the model is implemented effectively is critical to achieving desired outcomes.

In May 2011, Urbis was commissioned by the NSW Department of Education and Communities (NSW DEC) to undertake a review of national and international literature in order to:

- identify emerging trends concerning the psychological and emotional wellbeing needs of children and young people
- identify and analyse national and international models of effective practice currently being implemented, and published research that informs evidence-based practice in working with children and young people in educational settings, including strategies adopted by schools involved in National Partnerships.

This report sets out the findings of the literature review.

METHODOLOGY

This report was prepared between May and August 2011 and involved an extensive search and review of relevant published and grey literature from Australia, the United States of America (USA), the United Kingdom (UK), Canada, New Zealand and Norway. Focus was placed on the USA, the UK (including England and Wales and Scotland), Canada and New Zealand because they would provide the best available literature in English, and Norway was included as an example of a Nordic country which has innovations in many public policy areas, including education.

Urbis used a multi-pronged approach to identifying and collecting literature, and worked with Monash University to ensure all relevant material was identified and collected for this review. In total, we searched 29 electronic databases using a variety of keyword combinations developed in consultation with NSW DEC. These databases covered an extensive array of journals, including journals focusing on education, psychology and health more generally.

In addition, Urbis obtained ‘grey literature’, or literature which could not be identified through standard database searches, by undertaking targeted searches using key internet search engines and by searching key Australian and international websites (eg Commonwealth and State/Territory education and health departments, professional associations, and youth-focused research and interest groups). To ensure the most current and rigorous studies into the effectiveness of models of school-based practice were included in this review, our research focused on evaluation literature published in peer-refereed journals in the past five years (2006-2011). Where our search indicated that important studies had been conducted between 2001 and 2006, these studies were also included in the literature review.

On the basis of the literature search, it is evident that the two broad areas of focus of the literature review (trends in the psychological and emotional wellbeing of children and young people, and models of effective practices of working with children and young people in educational settings) are well-researched areas in the academic literature.

The literature is international in scope and only few of the studies focused on developments in Australia alone. More typically, and especially so in connection with studies examining the effectiveness of universal school-based programs, the researchers would describe or analyse studies that had been published in English-language journals, including research carried out in Australia, the USA, the UK,
Canada, New Zealand and also Norway. Research from the USA is particularly well-represented in the literature.

On the basis of the methodology described above, a total of 212 individual items of literature were included in the analysis for this study, of which 108 were research studies published in peer-reviewed journals.

TRENDS IN THE PSYCHOLOGICAL AND EMOTIONAL WELLBEING OF CHILDREN AND YOUNG PEOPLE

There is a wide range of understandings of child and adolescent wellbeing, and debate on the indicators that should be used to measure the psychological and emotional wellbeing of children and young people.

In order to measure child and youth wellbeing, use is made of positive and deficit indicators. The trend in recent years has been towards a focus on positive indicators in a conceptual approach that is explicitly strengths-based. Measures of wellbeing based on objective data, such as national statistics, are complemented by subjective measures, drawing on self-reports of children and young people themselves, as well as reports by adults such as teachers and parents.

At a general level, psychological and emotional wellbeing and mental health refers to the achievement of expected developmental milestones and the establishment of effective coping skills, secure attachments, and positive social relationships. Psychological and emotional distress manifests in internalising behaviours (such as anxiety and depression) and externalising behaviours (such as aggressive, violent or disruptive behaviour), and has an impact on the child’s successful learning at school.

The literature is inconclusive on whether there has been an increase in psychological and emotional distress and mental health problems in children and adolescents in recent years. Some studies point to significantly higher rates of mental health complaints and increases in behavioural and emotional problems, such as anxiety and depression.

However, other studies do not support the notion of a dramatic increase in behavioural and emotional problems in children and adolescents. Rather, they suggest that the majority of children are progressing well and that any differences in behaviour or temperament are modest, or they indicate that overall happiness scores among children and young people have increased over time.

Adding to the uncertainty, some studies talk about a reverse in mental health trends, for example that after a period of measured increases in mental health problems, there have recently been measured decreases in these problems.

Many studies point to differences in the prevalence of mental health problems affecting boys and girls, with more boys demonstrating externalising behaviours and more girls demonstrating internalising behaviours. However, what is ambiguous is whether there has been a change in the prevalence of internalising and externalising behaviours among boys and girls.

It has been suggested that rather than saying the psychological and emotional distress and mental health problems of children and young people are currently more prevalent than they were in previous decades, it could be argued that they are more extreme (at both the positive and negative ends of the continuum) now than they were before. This would explain why some studies have shown an increase in positive features such as self-esteem and happiness, as well as an increase in negative features such as mental health problems.

Inconsistent trends in psychological and emotional distress and mental health trends can be, at least partly, attributed to changes in the way mental health problems are measured, and the varying methodologies used by researchers.

Drawing on the debates in the literature, the following are put forward as trends in the psychological and emotional wellbeing issues of Australian children and young people:

- The majority of young people rate their health as ‘good’ or ‘excellent’ and there have been measured improvements in the physical health of children and young people overall, including declining mortality rates.
The majority of today's Australian children are progressing well in terms of their temperament style and behaviour problems, and NSW data point to significant decreases in the proportion of students who had experienced high psychological distress (in the last six months prior to measurement) between 1996 (15.4%) and 2008 (13.3%).

There have been consistent increases in the past decades in the numbers of students diagnosed with disabling conditions in NSW schools, and this is particularly true for autism and mental disorders.

The prevalence of bullying is high – a nationwide study has found that approximately one in four Australian students in Years 4-9 were bullied every few weeks or more. There is an ongoing concern amongst young people about bullying and the rise of cyberbullying as a new form of bullying.

There have been declines in the numbers of high school students in NSW who have ever consumed alcohol, but nationwide data show that considerable proportions of young people are drinking alcohol to levels that could lead to harm. In addition, there is a consistent trend for young people to rate alcohol to be an issue of concern to them.

Strong and consistent increases in the rates of combined overweight and obesity amongst Australian schoolchildren have been measured over the past 20 years, with a 1.8% increase over the preceding five years. In addition, studies find that young people are consistently worried about body image.

Children and young people express concern with regard to psychological-emotional wellbeing issues such as family conflict and coping with stress and depression.

While research findings on trends in the overall incidence of mental health problems and psychological and emotional distress are inconclusive, factors that are currently having an impact on the mental health and psychological and emotional wellbeing of young people are clearer. These include:

- developments in communications technology (which have led to the emergence of cyber-bullying)
- poor physical health which can impact on mental health
- body dissatisfaction and disordered eating
- changes to families and family structures, including a measured increase in sole parent families and an increased rate of marriage breakdown
- education and work pressures, including a heightened emphasis on achievement and disengagement from school for those identified as unlikely to succeed
- economic factors, with some experts suggesting there are counter-intuitive rises in mental health problems associated with improvements in economic conditions
- rapid social and cultural changes, with vigorous debate on the impact of the growth of materialistic and individualistic values on individual alienation and social fragmentation.

ADDRESSING STUDENT WELLBEING AND MENTAL HEALTH IN THE SCHOOL SETTING

In responding to the wellbeing needs of students, education systems and school communities in many parts of the world have adopted a health promotion focus in keeping with recommendations made by the World Health Organisation (WHO). Australia was one of the first countries to adopt the ‘health promoting schools’ approach. Within this approach, there are three overlapping tiers of intervention:

- Universal programs aim to develop students’ social, emotional and behavioural competencies. Focusing on primary prevention, they including classroom-based approaches, changes to the school environment as a whole and wellbeing programs beyond the school to include the family and community. According to the health promotion model, the greatest amount of time and resources should be spent on these whole-school approaches.
Selected interventions are for students who have been identified as being at risk for developing emotional or behavioural disorders. Use is made of individual and group approaches to help prevent the onset of behaviour or emotional problems.

Targeted interventions are for individual students who have been identified as having an emotional or behavioural problem or a mental health disorder. The focus is on individual treatment and the prevention of further difficulties for students identified as having problems.

Schools in Australia also operate within the National Safe Schools Framework, which provides a vision and a set of guiding principles for safe and supportive school communities that also promote student wellbeing and develop respectful relationships.

School-based mental health personnel need to be acutely aware of the diversity in the student body, and sensitive to the possible ways in which these differences may impact on students’ mental health and wellbeing, and therefore on academic achievement.

Key issues in working with Aboriginal and Torres Strait Islander students include gaining knowledge and awareness of the factors that may impact upon the educational outcomes of students (such as past negative experiences of school) and the effects of racism at the individual, institutional and professional levels. These understandings are also important when working with Culturally and Linguistically Diverse (CALD) students. In addition, school personnel need to be aware of other issues, such as the impacts of trauma on students with refugee backgrounds.

Students with disabilities are integrated to a large extent into mainstream schools usually with a range of additional supports provided to enable them to function well in the mainstream settings. It is important not to view the identity and wellbeing of such students primarily through the lens of their ‘condition’.

Gender and sexuality are also key areas to focus on in working with students. It is important to recognise the differences boys and girls have with regard to development and adjustment problems. Working with same-sex attracted youth requires understandings of the nature, incidence and prevention of school-based harassment and of sexual identity development.

The literature provides many examples of programs, especially universal programs, which have been adopted in school systems in Australia and around the world. These include, for example, the broad approach to addressing student wellbeing via universal, often curriculum-based, approaches known as social and emotional learning (SEL). They also include programs with specific titles such as FRIENDS (which was first developed in Australia) and the Olweus Bullying Prevention Program (which was developed in Norway), as well as cognitive-behavioural programs of varying kinds.

These programs often include a range of activities and methods which together constitute an ‘intervention’. Amongst others, interventions may include:

- awareness-raising
- knowledge dissemination
- skills training
- individual counselling
- working with small groups of students
- system-wide changes to impact on the ethos or climate of the school
- social, recreational and sporting or other physical activities
- harnessing the support that can be provided to individual students by their peers and family members and community services.
In addition to these programs, the school systems in the countries considered in this literature review provide students with support services that include school psychologists, school counsellors and social workers operating in the school setting itself. The service approaches of school counsellors include:

- direct services to students, including psychological and behavioural assessment and psychological treatment and counselling
- indirect services, including consultations with teachers and parents
- whole school services, including assisting schools with the planning, preparation, implementation and evaluation of psychological and educational strategies
- systems-level services, including assisting with crisis management policy and response and recovery strategies.

Many jurisdictions also have overarching policy frameworks focusing on child and youth wellbeing.

EVIDENCE FOR EFFECTIVENESS OF MODELS TO RESPOND TO PSYCHOLOGICAL AND EMOTIONAL WELLBEING NEEDS

The evaluative literature considered in this study indicates that emotional, behavioural and social problems of children and adolescents, including anxiety, depression, disruptive behaviour problems, and substance abuse, can be prevented or ameliorated through the use of school-based interventions.

Given the breadth of the issues that are covered by various interventions, it is difficult to provide succinct answers as to what works best or what programs and interventions can be considered evidence-based. However, based on the best available evidence, the following appear to have strong evidence for effectiveness:

- Programs are more likely to be effective if they
  - are aimed at promoting mental health rather than preventing mental illness
  - involve the whole school and include changes to the school’s environment
  - assist students to develop adaptive, cognitive and behaviour strategies
  - involve parents and the wider community
  - take into account the age and gender of the children
  - are implemented over a long period of time (continuously for more than one year)
  - allow for periodic follow-up of positive interventions (also described as ‘booster sessions’) in order to maintain positive outcomes and counter the evidence that effect sizes (statistical measure of the impacts of interventions on wellbeing outcomes) decrease over time.

- The continuing presence of appropriate adult staff and a mentoring or a stable relationship between students and school staff are important aspects of program delivery.

- Social and emotional learning programs are effective in enhancing students’ academic achievement and thus offer students a practical educational benefit. In addition, they have been shown to improve students’ stress management, empathy, problem solving and decision-making skills. They appear to be more effective if they follow established curriculum and implementation guidelines.

Less effective programs or interventions appear to be those that are fear-inducing and those focused on knowledge (delivering information) only.

Selected programs appear to be more effective than universal programs for students who have been identified as being at risk for, or diagnosed with, specific problems, although universal programs have a role in enhancing protective factors which help to build resilience. Other trends in the evidence include:
For students with depression, selected programs may be more efficacious due to the increased room for change amongst participants with elevated symptoms of depression, and intervention programs consisting of 8 to 12 sessions may be more successful at reducing symptoms than programs which are shorter or longer than this.

For students with emotional disturbance, targeted programs may have greater impacts than preventive interventions on social skills.

Selected programs targeting children and adolescents at risk for violence may be effective, but caution should be adopted in working with such students on a group basis.

The age (and therefore the developmental stage) of children is an important consideration for the adoption of wellbeing programs in schools. For example, studies show that programs focusing on emotion management are more effective for younger than older children, suggesting that it is important to deal with emotional problems in earlier grades. They also show that younger children are less likely than older children to engage in help-seeking behaviour. By contrast, greater success in achieving positive changes concerning drug and alcohol problems is achieved when focusing on the middle school years.

Implementation issues are particularly important for schools to consider, since a program producing results in a controlled research study may in theory look promising, but the positive results may or may not be transportable to the real-world school setting. The issues that education departments and school communities need to consider when implementing a mental health and wellbeing program in an educational setting can be summarised according to:

- the characteristics of the innovation (program, approach, intervention) and its 'fit' with the school
- the characteristics of the implementer, including whether it is better to make use of school personnel or specialists from outside the school, or a combination, and the knowledge, skills and preparation required for implementation of the program
- the timing and phasing of the program, including how it fits into the school’s program, the ideal length of an intervention and whether ‘booster sessions’ are included to consolidate learnings sometime after the initial presentation of the intervention.

EVALUATIONS OF SCHOOL COUNSELLING AND SCHOOL SOCIAL WORK

Compared to studies examining the effectiveness of universal preventive and promotive school-based programs, there are relatively fewer studies examining the effectiveness of school counselling that make use of randomised controlled research designs. Nevertheless, several studies were found in the course of the literature review which examined or evaluated school counselling/school psychology or school social work services.

Available studies consistently show high levels of satisfaction with the contributions of school counsellors/psychologists. School counselling is valued for:

- intervening in the continuum of practice levels, from individual students to classes and whole schools, as well as with families
- being an integral part of students’ support strategies
- good collaborations with the teaching staff.

A common theme in the descriptions of school counselling/psychology services in the various countries is that school counsellors/psychologists devote a large proportion of their time to carrying out assessments, and proportionally less time engaged in providing intervention and prevention activities. Notwithstanding this, they are involved in the development and implementation of school-wide programs, and in developing and maintaining linkages with services external to the school.

School social workers are recognised as being skilled in providing crisis management, group work interventions, individual counselling, family counselling and community (whole school and
neighbourhood) development interventions. Evaluations of school social work have found that it appears to be more effective in helping students with internalising disorders (e.g., anxiety, depression, self-esteem and identity problems) than those with externalising disorders (e.g., aggression, conduct disorder, hyperactivity).

School social work is especially effective in contributing to the academic performance of students through focusing on drop-out prevention, improving grades and attendance. This suggests that a key value of school social work lies in its alignment with the major function of schools, i.e., the educational success and achievement of their students.

AREAS REQUIRING ADDITIONAL RESEARCH
Researchers and authors have identified a range of areas in the literature where there is currently limited knowledge, and point to the need:

- to ensure that evaluations can be undertaken of the multiple environmental/ecological factors that can hinder or promote effective delivery of student wellbeing programs in the real-world settings of schools
- for theory-driven research that aids in the accurate assessment of various skills and identifies how different skills are related (in recognition of the fact that there is no standardised approach to measuring social and emotional skills)
- for research on how best to deploy and support existing resources within school settings that may provide the entry points for delivery of mental health services in support of the school’s primary educational mission
- for research that would identify empirically based interventions that target both academic/educational and mental health functioning in schools
- to address the dearth of studies conducted in relation to specific cohorts of young people, including those in socio-economically disadvantaged communities, Aboriginal young people, same-sex attracted young people, students with disabilities and students from CALD backgrounds.
- for studies that focus on the content and delivery style of especially universal prevention programs in order to investigate what makes them more or less effective.

In conclusion, irrespective of whether there has been a broader increase in psychological and emotional distress and mental health problems among children and young people, the literature suggests that schools need to consider the needs of their individual students and the broader school community when employing strategies and programs to promote wellbeing.

This literature review synthesises the models that are available to schools, identifies key characteristics of models that are effective, and highlights key implementation issues schools should address to ensure strategies and programs adopted achieve desired outcomes.
1 Introduction

This report presents the outcomes of a literature review conducted by Urbis for the New South Wales Department of Education and Communities (NSW DEC). The project involved carrying out a review of national and international literature in order to:

- identify emerging trends concerning the psychological and emotional wellbeing needs of children and young people
- identify and analyse national and international models of effective practice currently being implemented, and published research that informs evidence-based practice in working with children and young people in educational settings, including strategies adopted by schools involved in National Partnerships.

Sections 3 and 4 focus on emerging trends by exploring understandings of wellbeing of children and young people in the literature and understandings of psychological and emotional wellbeing and distress. Included in these sections are:

- conceptualisations of wellbeing in the literature
- issues for consideration in the conceptualising and measuring of the wellbeing of children and young people
- data on the wellbeing of Australia’s children and young people
- explorations in the literature of psychological and emotional wellbeing, mental health and psychosocial and emotional distress
- emerging trends concerning the psychological and emotional wellbeing needs of children and young people
- factors contributing to poor mental health outcomes for children and young people.

Sections 5 to 10 consider national and international models of school-based practice, and in doing so, they:

- consider how mental health and wellbeing are addressed in school settings and the levels of school-based intervention described in the literature
- describe approaches and programs adopted in Australian schools and schools in other developed countries, including the United States of America (USA), the United Kingdom (UK), Canada, New Zealand and Norway
- consider issues surrounding models for specific cohorts of young people
- describe and analyse evaluations of the effectiveness of models of practice that have been accessed through the literature search for this report
- draw together the findings from the studies to summarise which programs and approaches have strong evidence for achieving desired outcomes.
This literature review is located as a study within, and contributes towards, a comprehensive review of school counselling services in NSW. The review of the school counselling service comprises the following research processes [NSW Department of Education and Training (DET), 2011]:

1. Description of the current school counsellor workforce, including mapping the type of work in which school counsellors are involved.

2. Gathering the views of key stakeholder groups (including parents and students) on school counsellor supply and demand trends, service delivery models and trends in the range and nature of student needs.

3. Description and analysis of the current use and mix of student welfare services available to schools.

4. A literature review to identify emerging trends concerning the psychological and emotional wellbeing needs of children and young people, and to identity and analyse models of effective practice to respond to these needs (the focus of this report).

5. Provision of costed options for revised policies regarding the placement of sufficient school counsellors at high schools.

According to the study brief, the review of school counsellor services in NSW Government schools is based on specific recommendations flowing from recent parliamentary inquiries:

- Inquiry into Bullying of Children and Young People (2009)
- Inquiry into Children and Young People 9-14 Years in NSW: The Missing Years (2009)
- Inquiry into the provision of education for students with a disability or special needs (2010)
- The coronial report on the suicide of a student from Kadina High School.

These inquiries assume that school counselling has an important role within the public school system. The ‘Inquiry into Children and Young People 9-14 Years in NSW’ noted that in-school counselling was one of the key early responses to the difficulties encountered by middle years students, but also that several ‘submissions to the Inquiry raised issues such as accessibility, quality, training and level of demand for school counselling services’ (Parliament of NSW Committee on Children and Young People, 2009:53-54).

The methodology of the study is briefly described in section 2.
2 Methodology

2.1 OVERVIEW

Urbis used a multi-pronged approach to identifying and collecting literature, and worked with Monash University to ensure all relevant material was identified and collected for this review. In total, we searched 29 electronic databases using a variety of keyword combinations developed in consultation with NSW DEC. These databases, listed below, covered an extensive array of journals, including journals focusing on education, psychology and health more generally.

In addition, Urbis obtained ‘grey literature’, or literature which could not be identified through standard database searches, by undertaking targeted searches using key internet search engines and by searching key Australian and international websites.

The focus was on collecting evaluation literature, giving priority to those studies that have used rigorous evaluation methodologies and drawing on Australian literature, as well as a selection of key relevant overseas material focusing on the USA, the UK, Canada, New Zealand and Norway. Focus was placed on the USA, the UK (including England and Wales and Scotland), Canada and New Zealand because they would provide the best available literature in English, and Norway was included as an example of a Nordic country which has innovations in many public policy areas, including education.

To ensure the most current and rigorous studies into the effectiveness of models of school-based practice were included in this review, our research focused on evaluation literature published in peer-refereed journals in the past five years (2006-2011). Where our search indicated that important studies had been conducted between 2001 and 2006, then these studies were also included in the literature review.

On the basis of the literature search, it is evident that the two broad areas of focus of the literature review (trends in the psychological and emotional wellbeing of children and young people, and models of effective practice to address the wellbeing of children and young people in educational settings) are well-researched areas in the academic literature.

The literature is international in scope and only few of the studies focused on developments in Australia alone. More typically, and especially so in connection with studies examining the effectiveness of universal school-based programs, the researchers would describe or analyse studies that had been published in English-language journals, including research carried out in Australia, the USA, the UK, Canada, New Zealand and also Norway. Research from the USA is particularly well-represented in the literature.

2.2 ELECTRONIC DATABASE SEARCHES

As noted above, extensive searches of electronic databases were undertaken in collaboration with Monash University.

The electronic databases searched include:

- A+Education
- AEI-ATSIS - Australian Education Index – Aboriginal and Torres Strait Islander Subset
- APAIS-Health
- British Education Index
- British Library
- Campbell Collaboration
- Cochrane Library
- EBSCO host research databases
- Educational Research Abstracts Online
- Embase
- ERIC
- FAMILY: Australian Family & Society Abstracts Database
- Google Scholar
- Humanities & Social Sciences Collection
- IBSS: International Bibliography of the Social Sciences
- IDP Database of Research on International Education
- Medline
- New Zealand Educational Theses Database
- PAIS International
- ProQuest Dissertations & Theses
- Proquest Education
- PsycINFO
- Sage Journals Online
- Scopus
- Social Sciences Citation Index: SSCI
- Social Services Abstracts
- Sociological Abstracts
- Trove
- Web of Knowledge

2.3 ‘GREY LITERATURE’ SEARCH

In addition, Urbis sought to obtain ‘grey’ literature which could not be identified through standard database searches by:

- undertaking a targeted internet search using Google.com and other relevant search engines, particularly focusing on material that would not be published in other ways. Sources such as Amazon were also used to identify relevant books and book chapters

- undertaking a search of key Australian websites, including:
  - DEC and education departments in other States/Territories
  - Department of Health and Ageing, NSW Health and equivalent State/Territory bodies
  - Australian Institute of Health and Welfare
– Parliament of NSW and other State parliaments
– Professional associations (eg NSW Public Schools’ Principals Forum)
– Youth-focussed research and interest groups (eg Australian Research Alliance for Children and Youth, Foundation for Young Australians)

- liaising with DEC to obtain information on relevant grey literature
- calling key organisations, such as the Australian Research Alliance for Children and Young People, to ascertain whether they held any grey literature that was not available on their websites.

2.4 SEARCH TERMS
As agreed with NSW DEC, a variety of keyword combinations to identify relevant literature through database and internet searches were used. These keyword combinations are described below.

2.4.1 RELATING TO EMERGING TRENDS CONCERNING THE PSYCHOLOGICAL AND EMOTIONAL WELLBEING NEEDS OF CHILDREN AND YOUNG PEOPLE

- wellbeing + concept/framework/conceptual framework
- psychological/wellbeing/developmental/social/emotional + needs + children/ young/middle years/adolescent
  as above + emerging/trends
- children/young/middle years/adolescent + issues/concerns/anxieties
  as above + emerging/trends
- Specific topic terms (eg. mental health/depression/anxiety/bullying/cyber-bullying/self-esteem/eating disorders/ resilience/self-efficacy) + young/children/middle years/adolescent
  as above + emerging/trends

2.4.2 RELATING TO MODELS OF EFFECTIVE PRACTICE IN EDUCATIONAL SETTINGS

- psychological/emotional/wellbeing + educational settings/ schools
  as above substituting specific topics/issues (eg bullying) for psychological/wellbeing
- effective practice/best practice + psychological/emotional/wellbeing + educational settings/ schools
  as above substituting specific topics/issues (eg bullying) for psychological/wellbeing
- program/model + school counsellor/ school counselling/ school psychology/ school psychologists/ school social workers/ guidance officers/guidance counsellors/ student support services officers/ school welfare workers/ youth workers/educational psychologist
  as above + evaluation/review/outcome/effectiveness
- program/model + school counsellor/ school counselling/ school psychology/ school psychologists/ school social workers/ guidance officers/guidance counsellors/ student support services officers/ school welfare workers/ youth workers/educational psychologist + Aboriginal/non-English speaking
background/English as a second language/refugee/disability/homosexual/gay/lesbian/sexual orientation

as above + evaluation/review/outcome/effectiveness

- National Partnership + psychological/emotional/wellbeing + schools/educational settings

as above + evaluation/review/outcome/effectiveness
3 Understanding the wellbeing of children and young people

3.1 INTRODUCTION
This section draws on available literature to explore the concept of ‘wellbeing’ as it pertains to children and young people. It provides a description of theorists’ overall understanding of wellbeing and the domains and components or indicators which contribute to that understanding.

Issues for consideration in the conceptualisation and measurement of wellbeing, particularly as it pertains to the psychological and social-emotional wellbeing of children and young people are also discussed, including:

- development and wellbeing
- being and/or becoming
- dependency
- positive and deficit indicators
- objective and subjective measures
- methods to assess wellbeing.

To conclude this section, a brief description is provided of the wellbeing of Australia’s children and young people, drawing on objective and subjective measures.

3.2 CONCEPTUALISATIONS OF WELLBEING IN THE LITERATURE
There is no agreed definition of the term ‘wellbeing’ in the research literature. However, the term is used in three main ways as follows:

- As an overarching concept regarding the quality of people’s lives, wellbeing is described as a dynamic process, emerging from the way in which people interact with the world around them (Rees et al 2010a).
- Use of the concept has enabled a broader inquiry into all aspects of health. In policy terms it has been used to focus attention on how governments can promote good mental and emotional health, thus extending the context beyond the treatment of mental illness or disorder (Carlisle, Henderson & Hanlon 2009: 1556).
- It is used as a positive, ecological concept that encompasses developmental stages across the life course, integrating physical, cognitive, and social-emotional functions, and also having a subjective dimension in the sense of satisfaction associated with fulfilling one’s potential (Pollard & Davidson 2001: 8).

Drawing on a range of texts, Table 1 summarises several conceptualisations of wellbeing, including the identified domains and components that researchers recommend should be used to understand and measure the wellbeing of children and young people.
<table>
<thead>
<tr>
<th>RESEARCHER/THEORIST</th>
<th>GENERAL APPROACH TO CONCEPTUALISING WELLBEING</th>
<th>IDENTIFIED DOMAINS AND COMPONENTS OF WELLBEING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding based on a systematic review of child wellbeing literature (Pollard &amp; Lee 2003)</td>
<td>The analysis of literature suggests that there is no consistent, unified definition of wellbeing or agreement on how to measure it. Wellbeing is multidimensional and should not only be measured with deficit indicators.</td>
<td>Physical Positive indicators (including physical health, nutrition, personal body care, safety-related behaviour) Deficit indicators (including health compromising behaviours, physical manifestations of stress and/or illness) Psychological Positive indicators (including life satisfaction, resilience, self-worth) Deficit indicators (including depression, fearfulness, hyperactivity) Cognitive Positive indicators (including academic achievement, cognitive ability, school-related behaviours) Deficit indicators (including developmental delay, school behaviour problems) Social Positive indicators (including parent-child relations, relationship with peers, participation in cultural activities) Deficit indicators (including anti-social behaviour, poverty, troubled home relationships) Economic Including assessments of family resources, adequacy of parental income and economic hardship</td>
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<tr>
<td>Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) (Fraillon 2004)</td>
<td>Understanding based on the definition of a measurement construct for student wellbeing in Australian schools. The primary purpose was to develop recommendations regarding elements of wellbeing that may be susceptible to school intervention.</td>
<td>The intrapersonal dimension: a student's internalised sense of self and capacity to function in their school community, including: autonomy emotional regulation resilience self-efficacy self esteem spirituality curiosity engagement mastery orientation</td>
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<td>UNICEF child wellbeing framework (Statham &amp; Chase 2010: 7; UNICEF 2007; Bradshaw, Hoelscher &amp; Richardson 2006)</td>
<td>Researchers produced an index of child wellbeing based on OECD surveys and databases.</td>
<td>Health and safety The basis of achieving wellbeing, closely related to family resources and freedom from violence Subjective wellbeing The result of how children respond to the demands and resources in their environment including self-defined health personal wellbeing wellbeing at school Peers and family relationships Key is the quality of relationships within the family; relationships with peers gain importance as children get older</td>
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<tr>
<td>Report Card on the Wellbeing of Young Australians developed by the Australian Research Alliance</td>
<td>The framework for measuring wellbeing considers outcomes for children and young people and the conditions needed for</td>
<td>Material wellbeing Determines economic resources Health and safety Mental health is an important component of Education, training, employment Educational achievement Peer and family relationships Caring, quality family Behaviour and risks Behaviours may negatively Subjective wellbeing Assists in understanding how risk and Participation Participation in community and decision making activities Environment Environment contributes to wellbeing through health</td>
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<td>RESEARCHER/THEORIST</td>
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<td>IDENTIFIED DOMAINS AND COMPONENTS OF WELLBEING</td>
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<td>for Children and Youth (ARACY 2008); draws on the UNICEF index developed by Bradshaw et al (2006)</td>
<td>them to develop their full potential. Indicators are grouped into 8 domains, which together constitute 'wellbeing for young Australians' available to purchase services, housing and peer activities. Poverty impacts on children and young people indirectly through the strain it places on parents and the family's lifestyle</td>
<td>health and safety. Mental health disorders commonly manifest themselves in adolescence and participation are indicators of wellbeing and also predictive of outcomes later in life relationships have a significant and lasting impact on development and wellbeing. In the absence of peer relationships, children and young people may experience social exclusion impact on wellbeing as they contribute to poor health or social outcomes. Behaviours and the taking of risks may often be linked to peer relationships and the need to belong. protective factors actually play out for children and young people provides opportunities for children and young people to learn new skills, communicate and cooperate with their peers, build community networks and express their opinions and views and socio-economic impacts. Future livelihoods depend on future environmental conditions</td>
</tr>
<tr>
<td>Child and Youth Wellbeing Index (CWI), developed by the Foundation for Child Development and the Child and Youth Well-Being Index Project at Duke University, USA (Land 2010)</td>
<td>Designed to measure how USA children are faring over time, the CWI is based on a composite of 28 key indicators of child and youth wellbeing that are grouped into seven domains. Annual reports using the CWI have enabled measurement of trends in child and youth wellbeing in the USA from 1975 to the present</td>
<td><strong>Family economic wellbeing</strong> Including: poverty rate (families with children) secure parental employment rate median annual income (families with children) <strong>Safe/Risky behaviour</strong> Including: teenage (aged 10-17) birth rates rate of violent crime offenders (aged 12-17) rate of binge alcohol drinking (Grade 12) <strong>Social relationships</strong> rate of children in families headed by a single parent rate of children (aged 1-18) who have moved within the last year <strong>Emotional/spiritual wellbeing</strong> suicide rate (ages 10-19) rate of weekly religious attendance (Grade 12) per cent who report religion as being 'very important' (Grade 12) <strong>Community engagement</strong> Including: rate of youths not working and not in school (ages 16-19) rate of voting in Presidential Elections (ages 18-20) <strong>Educational attainment</strong> reading test scores (ages 9, 13 and 17) mathematics test scores (ages 9, 13 and 17) <strong>Health</strong> Including: mortality rate (ages 1-19) rate of children with very good or excellent health as reported by parents rate of overweight children (aged 6-19)</td>
</tr>
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<td>UK National Survey of Young People’s Wellbeing (Rees, Bradshaw, Goswami &amp; Keung 2010a)</td>
<td>Based on surveys carried out in 2005 and 2008 in the UK that aimed to develop a better understanding of the concept of wellbeing as it relates to young people, taking full account of the perspectives of young overall subjective wellbeing</td>
<td>A five item measure of overall wellbeing consists of the following statements: 'My life is going well' 'My life is just right' 'I wish I had a different kind of life' 'I have a good life' 'I have what I want in life' Young people are asked to indicate how much they agree or disagree with each statement. The mean rating of the five items is used as the index of overall wellbeing. <strong>Satisfaction with particular domains of wellbeing</strong> Measurements of wellbeing in particular domains can indicate aspects of young people’s lives that are more or less important for their wellbeing. The development of the list of domains was guided by consultation with young people, literature on wellbeing and statistical analysis. The list contains ten domains of wellbeing, namely: family friends</td>
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<tr>
<td>RESEARCHER/ THEORIST</td>
<td>GENERAL APPROACH TO CONCEPTUALISING WELLBEING</td>
<td>IDENTIFIED DOMAINS AND COMPONENTS OF WELLBEING</td>
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<td>people themselves. Self-report measures of wellbeing were used to identify the reasons for variations in wellbeing and to monitor changes in wellbeing over time.</td>
<td>with each statement on a five point scale from 'Strongly agree' to 'Strongly disagree', producing a total life satisfaction score in the range from 0 to 20</td>
<td>• health</td>
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<td>• appearance</td>
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<td>• time use</td>
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<td>• the future</td>
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<td>• home</td>
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<td>• money and possessions</td>
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<td>• school</td>
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<tr>
<td>• amount of choice</td>
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<tr>
<td>Warwick-Edinburgh Mental Well-being Scale developed in the UK on the basis of a scale developed in New Zealand in the 1980s (Tennant et al 2007)</td>
<td>The Scale focuses entirely on positive aspects of mental health and is intended to support mental health promotion initiatives. It was developed by an expert panel drawing on current academic literature, qualitative research through focus groups, and psychometric testing of an existing scale. It was validated on a student and representative population sample.</td>
<td>Individuals completing the scale are required to tick the box that best describes their experience of each statement over the past two weeks using a 5-point Likert scale (none of the time, rarely, some of the time, often, all of the time). The Likert scale represents a score for each item from 1 to 5 respectively, giving a minimum score of 14 and maximum score of 70. The questions are:</td>
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<td>I've been feeling optimistic about the future; I've been feeling useful; I've been feeling relaxed; I've been feeling interested in other people; I've had energy to spare; I've been dealing with problems well; I've been thinking clearly; I've been feeling good about myself; I've been feeling close to other people; I've been feeling confident; I've been able to make up my own mind about things; I've been feeling loved; I've been interested in new things; I've been feeling cheerful</td>
</tr>
</tbody>
</table>
As illustrated in Table 1, and debated by authors including Statham and Chase (2010), Bradshaw et al (2006), Pollard and Lee (2003) and Land (2010), there are many different ways in which childhood wellbeing has been conceptualised. For example:

- The frameworks describe a wide range of necessary domains, from as few as two to as many as ten.
- The domain of ‘health’ may be understood as physical health, including aspects such as fitness levels, diet, nutrition and risky behaviour, and it may or may not include psychological or emotional health, which may be treated as a separate domain.
- Subjective wellbeing is at times identified as a separate domain, seen as synonymous with ‘psychological wellbeing’, included within other domains, or not considered at all.
- Some frameworks consider spiritual wellbeing to be a domain of its own, or sometimes equated with psychological and/or emotional wellbeing.

In short, and of particular relevance to this study, there is little agreement on what should be incorporated into or understood by psychological, emotional, psychosocial and/or spiritual wellbeing. The different frameworks provide different understandings of these concepts and of their contribution to the overall understanding of wellbeing.

Drawing on the available literature, improvements in theorising and operationalising childhood wellbeing are likely to emerge from the strengthening of a shared understanding that childhood wellbeing:

- focuses on attributes and strengths, as well as on difficulties and deficiencies (see eg Lippman, Anderson-Moore & McIntosh 2011)
- is multidimensional (as illustrated in Table 1 above, and with acceptance that theorists may not always agree on the specific dimensions and their components)
- takes into account the context of children and young people’s lives and uses both objective and subjective measurements (as discussed for example by Pollard & Lee 2003)
- incorporates the views and perspectives of children and young people themselves, and is considered at different stages of development (Statham & Chase 2010: 15-16)
- considers the wellbeing of children in the present and does not focus exclusively on long-term outcomes (Statham & Chase 2010: 15-16).

3.3 ISSUES FOR CONSIDERATION IN CONCEPTUALISING THE WELLBEING OF CHILDREN AND YOUNG PEOPLE

Table 1 has provided understandings of child wellbeing based on recent literature, including the identified domains and components of wellbeing. The literature points to a number of issues that are important to consider when summarising understandings of child wellbeing, and these are briefly discussed below.

3.3.1 DEVELOPMENT AND WELLBEING

Since social and emotional wellbeing is seen as a key element in a child’s development, the terms social and emotional wellbeing and social and emotional development are sometimes used interchangeably. Thus the facilitators and barriers that may support and hinder a given child’s development may be regarded as indicators of that child’s wellbeing (Hamilton & Redmond 2010: 6).

As summarised by Ben-Arieh (2006), there are many developmental theories of child wellbeing. In focusing on their psychological, physical, social, moral and spiritual development, the ‘standards for development’ are based on a preferred adult outcome, implying the need to prepare children for their transition into later stages in life or to monitor the developmental process (Ben-Arieh 2006: 2).
3.3.2 BEING AND/OR BECOMING

Linked to the above point of wellbeing being closely tied to development, some theorists emphasise children’s ‘becoming’ (developing into adulthood), while others emphasise children’s ‘being’ (childhood as a stage itself and children being persons in their own right) (Hamilton & Redmond 2010: 17; Ben-Arieh 2006: 4; Fattore, Mason & Watson 2007).

A critique of viewing children as ‘becoming-adults’ is that it leads to the abstracting of children from the social and economic contexts in which they live, ignores the complexities of individual children’s lives and risks inappropriately simplistic policy responses, such as blaming parents for children’s lack of coping skills or poor self-esteem (Fattore et al 2007: 9).

Consequences of focusing on children as being persons in their own right include:

- Research into child wellbeing has shifted from a focus on children’s survival (with a focus on indicators of risk factors and deviance) towards a focus on the promotion of child development (Ben-Arieh 2006: 6-7).
- Whereas an emphasis on ‘becoming an adult’ implicitly assumes that the child is by definition incompetent and that judgements on his/her wellbeing are dependent on adult expert judgment, a focus on ‘being’ assumes that the children are competent and should be able to speak for themselves (Hamilton & Redmond 2010: 17).
- Linked to the above point, children have in recent decades been more involved in the measuring and monitoring of their own wellbeing (Ben-Arieh 2006: 8-9).

Ben-Arieh (2006:9) recommends that both perspectives (viewing children as persons today and children in their future adult status) are legitimate and necessary for public policy.

3.3.3 DEPENDENCY

The issue of age is important since it has an impact on children’s and young people’s dependency on others, principally the family (Hamilton & Redmond 2010: 18). Whereas for young children it may be difficult to separate the child’s wellbeing from that of his/her parent’s, the issue is less clear when considering the wellbeing of older children, for whom wellbeing is dynamic and sometimes fast-changing (Hamilton & Redmond 2010: 18).

3.4 MEASURING THE WELLBEING OF CHILDREN AND YOUNG PEOPLE

3.4.1 POSITIVE AND DEFICIT INDICATORS

A number of studies (cf Pollard & Lee 2003; Lippman et al 2011) discuss the issue of making use of positive and/or deficit indicators of child wellbeing. In previous decades, the most common measures of early childhood development pertained to deficiencies in achievements, problem behaviours, and negative circumstances. However, the absence of problems or failures does not necessarily indicate proper growth and success. This has led to an increasing shift toward focusing on positive indicators when describing and measuring wellbeing.

Lippman et al (2011) point to a new conceptual approach that is explicitly strengths-based, focused on cultivating children’s assets, positive relationships, beliefs, morals, behaviours, and capacities, and which aims to give children the resources they need to grow successfully across the life course. According to Ben-Arieh (2006: 8), the challenge has become to develop indicators that ‘hold societies accountable for more than the safe warehousing of children and youth’.

One of the difficulties in agreeing on positive indicators is that it may be easier to observe and quantify negative behaviours and outcomes, as opposed to gaining agreement on what defines positive development and how to measure it (Lippman et al 2011).
3.4.2 OBJECTIVE AND SUBJECTIVE MEASURES

In recent times there have been substantial international initiatives regarding the measurement of the wellbeing of children and young people (Rees, et al 2010a; Statham & Chase 2010). Despite the wide variation in methods employed, Pollard & Lee (2003: 66) found in a survey of the international child wellbeing literature that measures of wellbeing could be broadly distinguished according to whether they were:

- **objective**: eg reviews of individual child case histories, education assessments and national statistics, often used for cross-national comparisons

- **subjective**: using one or more of a wide variety of instruments and a range of respondents eg children and young people themselves, teachers and parents.

There has been increasing recognition that measures of wellbeing based on objective data (social indicators) need to be supplemented by subjective indicators focusing on personal happiness and satisfaction, but also that there are risks of swaying too far towards very individualised concepts of child wellbeing (Statham & Chase 2010: 15).

3.4.3 METHODS TO ASSESS WELLBEING

As is evident from the brief discussion above, wellbeing can be measured through the use of social indicators and/or through self-report measures. The lack of agreement on indicators that should be used for measuring the wellbeing of children and young people has resulted in the lack of a standard method to assess wellbeing. Based on a survey of literature, Pollard and Lee (2003: 66) identified a wide range of methods, including structured and non-structured interviews, standardised tests and single-item questions from national data sets.

Pollard and Lee (2003: 68-69) note that, despite the existence of a large number of instruments to assess child wellbeing, many of the instruments were not designed to measure wellbeing as a construct in itself. They focus rather on measuring a range of indicators of wellbeing. In a review these authors undertook of the child wellbeing literature, they found that some instruments only make use of measures of positive indicators (such as self-esteem and life satisfaction), or that they focus on deficit indicators (such as depression and anxiety). Only some studies use a combination of the two (Pollard & Lee 2003: 68).

3.5 HEALTH AND WELLBEING OF AUSTRALIA’S CHILDREN AND YOUNG PEOPLE

Drawing on the understandings of child wellbeing provided above, this section provides a brief description of the health and wellbeing of Australia’s children and young people, with a focus on both objective and subjective measures.

3.5.1 OBJECTIVE MEASURES

The Australian Institute of Health and Welfare (AIHW 2011) provides the latest available information on how Australia’s young people are faring according to national indicators of health and wellbeing. According to the AIHW, many young Australians are faring well; however, there is considerable scope for further gains, particularly among Aboriginal and Torres Strait Islander young people.

According to the AIHW (2011), positive indicators of the health and wellbeing of Australia’s young people include the following:

- There have been large declines in death rates (mostly due to declines in injury deaths), and declines in asthma hospitalisations, notifications for hepatitis (A, B and C) and improved survival for cancer, with survival for melanoma very high.

- Most young people are achieving national minimum standards for reading, writing and numeracy, are fully engaged in study or work, and have strong support networks.

- Most young people are able to get support from outside the household in times of crisis.
There have been favourable trends in the measurement of key risk and protective factors, such as declines in smoking and illicit substance use, and most Year 10 and Year 12 students using contraception.

In addition to declines in risk-taking behaviours (such as illicit substance use), there are indications of changes occurring in the consumption of alcohol by adolescents. Drawing on the *New South Wales School Students Health Behaviours Survey 2008* (NSW Health 2009: 96), the proportion of students who had ever had an alcoholic drink *decreased significantly* between 1987 and 2008 (from 90.2% to 77.2%). The decrease has been significant in students aged 12-15 years (88.5% to 72.3%) as well as students aged 16-17 years (96.0% to 89.6%).

According to the AIHW, issues requiring attention from policy makers include:

- rising rates of diabetes (41% increase in insulin-dependent diabetes since 2001) and sexually transmissible infections (largely chlamydia)
- high rates of mental disorders among youth aged 16-24 (26% in 2007)\(^1\)
- high rates of road transport accident deaths among males
- many young people are overweight or obese, and are not meeting physical activity or fruit and vegetable consumption guidelines
- despite overall declines in the numbers of young people using alcohol at all, considerable proportions or young people are drinking alcohol at risky or high-risk levels for short-term harm (30%) and long-term harm (12%)\(^2\), are using illicit substances (19%), and are victims of alcohol- or drug-related violence (38%)
- many young people are homeless.

(Appendix A provides additional Australian data on the wellbeing of children and young people, based on selected indicators of child development and wellbeing in Australia (drawing on national samples). Since data have been gathered on many of these indicators over numbers of years, it is also possible to describe trends in comparison with earlier measures, including whether the trend is ‘favourable’, ‘unfavourable’ or whether there is ‘no change or clear trend’. These trends are noted in Table 8 in Appendix A.)

**3.5.2 SUBJECTIVE MEASURES**

Drawing on data from the AIHW, also referred to in section 3.5.1 above, the majority of young people (93%) rated their health as ‘good’, ‘very good’ or ‘excellent’ in 2008\(^3\) (AIHW 2011: 15).

Drawing on data from the *New South Wales School Students Health Behaviours Survey 2008* (NSW Health 2009: 63)\(^4\), the proportion of students who experienced high psychological distress in the six months prior to measurement decreased between 1996 (15.4%) and 2008 (13.3%). The decrease has been more significant in students aged 16-17 years (17.3% to 14.0%). The understanding of psychological distress adopted by NSW Health in this survey is provided in the box below.

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1 The AIHW notes that data on the prevalence of mental health disorders among 12–15 year olds, and whether the proportion of deaths from suicide has changed over time, are currently unavailable (AIHW 2011: viii).

2 According to the New South Wales School Students Health Behaviours Survey 2008 (NSW Health 2009: 96), among students aged 12-17 years who had consumed alcohol in the seven days prior to measurement, 60.9% consumed one to five drinks, 18.6% consumed six to ten drinks, 8.2% consumed 11-15 drinks, 4.5% consumed 16-20 drinks, and 7.8% consumed 21 or more drinks.

3 This is higher than the Organisation for Economic Cooperation and Development (OECD) average of 87%, with Australia ranking 13\(^{\text{th}}\) out of 31 on this self-assessment scale (AIHW 2011: 16-17).

4 All students in Years 7-12 in 118 participating schools in NSW were included in the survey (NSW Health 2009: 7-8). The survey instrument was a self-administered questionnaire, which included questions on alcohol, demographics, height and weight (including perception of body mass), injury, nutrition, physical activity, psychological distress, sedentary behaviour, substance use, sun protection (including sunburn experience and solarium use), and tobacco.
UNDERSTANDING OF ‘PSYCHOLOGICAL DISTRESS’ BY NSW HEALTH (2009)

Psychological distress is understood as covering a range of feelings experienced by people who may have identifiable mental health problems such as anxiety or mood disorders, or who may be highly stressed for situational reasons. High psychological distress may be associated with poor performance at school, behavioural problems, and increased rates of alcohol, tobacco, and substance use.

Psychological distress in students is identified by three components, namely:

− feeling unhappy or sad or depressed during the last six months
− feeling nervous or stressed or under pressure during the last six months
− being in trouble due to behaviour during the last six months.

Source: NSW Health (2009: 62)

The National Survey of Young Australians provides data that is useful to illustrate the concerns of children and young people themselves. As part of this study, young people in every State and Territory were asked to rank the issues of personal concern to them. The data from 2007 to 2010 for the NSW respondents are provided in Table 2 and Figure 1:

TABLE 2 – MAJOR ISSUES OF PERSONAL CONCERN TO YOUNG PEOPLE IN NSW

<table>
<thead>
<tr>
<th>ISSUES OF PERSONAL CONCERN</th>
<th>PERCENTAGE OF SAMPLE IDENTIFYING THE ISSUE OF PERSONAL CONCERN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body image</td>
<td>31.4</td>
</tr>
<tr>
<td>Family conflict</td>
<td>28.9</td>
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<td>Coping with stress</td>
<td>27.4</td>
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<td>School or study problems</td>
<td>25.7</td>
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<td>Suicide</td>
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<td>Depression</td>
<td>18.6</td>
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</tbody>
</table>

Source: Mission Australia (2010: 47)

The survey is carried out by Mission Australia. In the ninth survey carried in 2010, 50,240 young people aged 11 to 24 participated, representing the largest number of respondents in the survey’s history. 7,577 completed the survey online, with the remainder being completed in hard copy. The survey was distributed to a range of organisations, including all secondary schools. The largest proportion of respondents was aged 15 to 19 (51.0%), followed by those aged 11 to 14 (46.8%) (Mission Australia 2010: 2).
In 2010, 98.5% of the respondents from NSW were aged between 11 and 19 years (Mission Australia 2010: 42).

As can be seen from Table 2 and Figure 1:

- The top three issues of concern to young people in NSW in 2010 were body image (31.4%), family conflict (28.9%) and coping with stress (27.4%). The fourth ranked issue was school or study problems (25.7%).

- In addition to these four major issues, there were a number of other issues that were of concern to at least one in five respondents, reflecting the diversity of issues of concern to young people. These were personal safety, bullying/emotional abuse and alcohol.

- On the whole, there is no clear trend in the level of concern young people in NSW express with regard to the listed issues. For example, concern over ‘school or study problems’ decreased from 26.2% in 2007 to 19.0% in 2008; decreased further to 17.9% in 2009; but increased to 25.7% in 2010. Concern over ‘coping with stress’ decreased from 28.4% in 2007 to 21.6% in 2008, and further decreased to 19.3% in 2009, but then increased to 27.4% in 2010.

- Exceptions to the above are concern over ‘alcohol’, which has shown a consistent increase from 2007 to 2010 (Mission Australia 2010: 47), consistent with measured increases in children aged 12-14 who have engaged in risky drinking on more than one occasion (see Appendix A); and concern over bullying/emotional abuse, which has remained relatively consistent over the four years of measurement.
- There are fluctuating levels of concern with regard to psychological and emotional wellbeing issues such as family conflict, depression and suicide.

3.6 SUMMARY

There is a wide range of understandings of child and adolescent wellbeing and debate on the indicators that should be used to measure the wellbeing of children and young people.

Conceptualisations generally include understandings that wellbeing refers to the ability to cope with stressors; the development of autonomy and trust; the development of the self-system (including self-esteem and identity); the development of empathy and sympathy; and the formation of positive social relationships.

There is debate on the domains of wellbeing and the components that should be included to measure these domains. For example, the domain of ‘health’ may be understood as physical health, including aspects such as fitness levels, diet, nutrition and risky behaviour, and it may or may not include psychological or emotional health, which may be treated as a separate domain. Subjective wellbeing is at times identified as a separate domain, seen as synonymous with ‘psychological wellbeing’, included within other domains, or not considered at all. Some frameworks consider spiritual wellbeing to be a domain of its own, or sometimes equated with psychological and/or emotional wellbeing.

In order to measure child and youth wellbeing, use is made of positive and deficit indicators. The trend in recent years has been towards a focus on positive indicators in a conceptual approach that is explicitly strengths-based. Measures of wellbeing based on objective data, such as national statistics, are complemented by subjective measures, drawing on self-reports of children and young people themselves, as well as reports by adults such as teachers and parents.

On a range of objective and subjective wellbeing measures, Australian children and young people are doing well, but there are areas of concern relating to issues such as obesity and body image, high rates of mental disorders among older adolescents, and ongoing concerns with substance use. In section 4, trends in the psychological-emotional wellbeing of children and young people are discussed in greater detail.
4 Trends in psychological and emotional wellbeing and distress

4.1 INTRODUCTION

A range of reviewed texts consider the issue of the social and psychological-emotional needs of school-aged children and possible trends in these. When discussing the needs of children and young people, commentators agree on the need for young people to develop skills, competencies and resilience in order to better deal with developmental challenges (Brechman-Tousaint & Kogler 2010; ARACY 2011).

A number of available texts (Brechman-Tousaint & Kogler 2010; ARACY 2011; Parliament of NSW 2009a; Trussell 2008) make use of the concepts ‘risk and protective factors’ and ‘resilience’ when discussing the social and emotional needs of children and young people. The concepts of resilience, risk/protective factors and developmental needs are briefly discussed in this section, in order to provide a conceptual background to the discussion that occurs in the remainder of this section.

4.1.1 RESILIENCE

The following understandings of resilience are summarised from the discussions of the concept in the available literature:

- Most definitions of resilience contain two elements, namely ‘exposure to adverse or traumatic circumstances’ and ‘successful adaptation following exposure’. As such, a central theme within the definition of resiliency ‘points to adversity being the stimuli that precedes the resiliency process’ (Trussell 2008: 150).

- Resilience is not an all-or-nothing characteristic. An individual may easily overcome one set of challenges, while other challenges prove to be more difficult for the same person. It is unlikely that a child or young person will demonstrate resilience across all situations (Brechman-Tousaint & Kogler 2010).

- Resilience is not a fixed attribute of an individual, and if circumstances change then resilience may also change. Consequently a child’s resilience may change over time, according to their developmental stage and subsequent experiences (Brechman-Tousaint & Kogler 2010).

Australian studies have shown that the development of resilience in young people can be linked to long-term success in life and the prevention of substance abuse, violence and suicide (ARACY 2011). Resilience is also critical for young people to manage or cope with the transitions they will face in their lives, including the onset of puberty (ARACY 2011; Parliament of NSW 2009a).

A central theme within the understanding of resilience is ‘the interplay between risk and protective factors’ (Trussell 2008: 151) and these are briefly discussed next.

4.1.2 RISK AND PROTECTIVE FACTORS

Whereas risk factors heighten the probability that children will experience poor outcomes, protective factors increase the likelihood of a positive outcome for young people and help to promote resilience. Both risk and protective factors can be broadly grouped into four domains, namely child, family, school and community factors (Parliament of NSW 2009a: 9).

Risk factors can be defined as stressors that increase the likelihood of the development of emotional, social or behavioural problems and thereby impede or threaten normal development (Trussell 2008: 149). A range of risk factors at the level of the individual child has been identified in the literature, including:

- biological risks that impact the central nervous system and impact development, such as genetic/inborn predispositions and prenatal, perinatal or postnatal damage
psychological risks - individual personality characteristics that are associated with poor future outcomes, such as difficulty forming nurturing and loving relationships, regulating emotions or benefiting from social support

family risks, including severe parental conflict and overcrowding within the home (especially the accumulative effects of adverse family factors)

risks pertaining to the school, such as normative beliefs about aggression, overcrowded classrooms and frequent changes in school staff

community risks - conditions and influences that turn neighbourhoods into hostile environments, such as the concentration of poverty within a given community, violence and crime, lack of support services, or social and cultural discrimination

stressful life event risks - unexpected circumstances that cause extraordinary levels of stress and hardship, including parental death or divorce and surviving a life threatening experience.


Protective factors are the environmental context variables that ‘buffer or mediate the negative impact of biological or psychosocial events over time’ (Trussell, 2008:150). Protective factors help to build resilience by:

- preventing the initial occurrence of a risk factor
- interrupting the processes through which risk factors operate
- acting as a buffer for risk factors, providing a cushion against negative effects
- promoting self-esteem and self-efficacy.

(Department of Health and Ageing 2010: 13)

Protective factors at the level of the individual child include:

- an even temperament that elicits positive responses from others
- an affectionate relationship with a significant adult
- an external support system which provides a sense of belonging and fosters confidence
- an overall disposition to set goals and actively participate in decisions regarding her/his life and future
- an average intelligence
- a history of effective parenting
- areas of talent or accomplishments
- socio-economic advantages.

(Trussell 2008: 151)

4.1.3 DEVELOPMENTAL NEEDS

In considering the health and wellbeing of children and adolescents, Benson (2007: 53) makes the point that attention needs to be paid to promoting developmental strengths as well as combating risks, environmental threats, and social dysfunctions that obstruct human development. He writes that ‘these two approaches ought to be complementary and in balance. Currently, it seems they are imbalanced, with the latter approach dominating public dialogue, public policy, and scientific inquiry’ (Benson 2007: 53).
The developmental needs of children in the ‘middle years’ (9-14) have been described as including:

- **physical development**, particularly in relation to the onset of puberty and the development of sexual identity
- **social and emotional development**, including opportunities for social and emotional skills development
- **peer relationships**, including managing/responding to peer pressure and peer expectations
- **self-esteem/body image**, including challenges in adapting to societal messages about body image
- **the transition to independence**, including beginning to think independently from parents.

(ARACY 2011: 12-15)

The Committee on Children and Young People (2009) has suggested that addressing the following developmental needs is integral to the development of resiliency and to the social and emotional wellbeing of children and young people:

- possessing a good level of self-esteem, based on a positive sense of self and positive recognition from others
- belonging and feeling connected and supported, which is dependent on healthy relationships
- the need for increasing independence in a safe environment, including at home, school, places of recreation, places of worship, the neighbourhood, and public places such as shopping centres and parks
- the ability to achieve, learn and feel competent
- being heard, participating, and being listened to, including being able to make choices in everyday situations, and influence everyday occurrences at home and at school.

(Parliament of NSW Committee on Children and Young People 2009: 17-32)

### 4.2 PSYCHOLOGICAL-EMOTIONAL WELLBEING AND MENTAL HEALTH

#### 4.2.1 MENTAL HEALTH

Several understandings and definitions of mental health appropriate to children and youth in school settings are discussed in the literature. For example, mental health in childhood and adolescence is defined by Friedrich, Mendez & Mihalas (2010: 122) as ‘the achievement of expected developmental milestones and the establishment of effective coping skills, secure attachments, and positive social relationships’.

Mentally healthy children and adolescents ‘enjoy a positive quality of life; are free of symptoms of psychopathology; and function well at home, in school, and in their communities’ (Friedrich et al 2010: 122).

A definition adopted in Australia is the following:

…mental health and wellbeing is about our feelings, thoughts, relationships and behaviour. For many people – and especially for a number of Aboriginal and Torres Strait Islander peoples – mental health includes a sense of spiritual, cultural and community wellbeing. In a school setting, the mental health and wellbeing of individuals and the whole school community are both important. Mental health and wellbeing is not static; it changes over time, just as physical health and wellbeing does.

(Department of Health and Ageing 2010: 7)
4.2.2 SOCIAL AND EMOTIONAL WELLBEING

This literature review focuses on the ‘psychological and emotional wellbeing of children and young people.’ The concept ‘psychological and emotional wellbeing’ does not generally appear as a construct in the available literature, although ‘psychological’ and ‘emotional’ wellbeing are often discussed as domains of wellbeing (see Table 1 and the discussion in section 3.2 of this document).

The term ‘social and emotional wellbeing’ or SEWB is, however, frequently referred to in the literature in debates on mental health, and is explained in this section. As Bernard Stephanou & Urbach (2007) note, the study of social and emotional wellbeing in childhood is less well delineated than the study of childhood mental health and the concept ‘social and emotional wellbeing’ is more associated with health, whereas ‘mental health’ is more associated with illness and disorders.

A change toward focusing on wellbeing is part of the move towards a strengths-based approach (as discussed in section 3.4.1). In keeping with this shift in perspective, the absence of childhood mental disorders may be an indicator of children’s positive social and emotional wellbeing, but social and emotional wellbeing additionally encompasses positive environmental influences that interact with the positive social and emotional characteristics of young people. The result of the interaction of contextual and individual factors results in different outcomes such as positive relationships and the achievement of potential (Bernard et al 2007).

Pollard and Davidson (2001) draw upon a wide range of existing literature, including psychometric measures of wellbeing, to describe social and emotional wellbeing as encompassing multiple elements, including:

- the ability to cope with stressors
- the development of autonomy and trust
- the development of the self-system, which includes identity, self-concept, and self-esteem
- the development of empathy and sympathy
- the formation of positive social relationships with parents, siblings, and peers.

As discussed in section 3 of this report in connection with the wellbeing concept as a whole, there is currently no single indicator or set of indicators that is universally accepted by researchers, commentators and academics as appropriate for measuring the social and emotional aspects of wellbeing. This ‘poses problems for policy makers and researchers working in this area and makes monitoring of progress problematic’ (Hamilton & Redmond 2010: 16).

Many existing measures are based around the presence of emotional, social or behavioural problems indicating a deficit in social and emotional wellbeing (Pollard & Lee 2003: 69). There is less agreement on what social and emotional wellbeing actually constitutes (ie how to define it in a positive sense) or on what the pre-requisites might be for attaining it (ARACY 2011: 28).

As a consequence, research has often involved observation of individual behaviours that are seen as socially problematic (such as disruptive behaviour at school), which has in turn been associated with observation of another set of problems, for example hyperactivity or low self-esteem (Hamilton & Redmond 2010: 6).

Measurement also needs to take account of the person’s or people’s views that are being measured. There are indications that there are marked differences between children’s, parents’ and teachers’ views of child wellbeing and about what constitutes children’s wellbeing (Morrow & Mayall 2009: 225).
A useful summary is provided by Australian researchers Bernard et al (2007), who identify child social and emotional wellbeing as comprising:

- person factors, including the cognitive (e.g., cognitive style, language abilities) and social-emotional (e.g., resilience, positive social orientation, positive work orientation) domains
- environmental factors, including factors related to the home (e.g., high expectations communicated for achievement and behaviour); school (e.g., positive teacher-student relationships); and community (e.g., places that can accommodate young people’s interests).

### 4.2.3 CHILDREN’S ‘SUBJECTIVE’ OR ‘PSYCHOLOGICAL’ WELLBEING

Children’s ‘subjective wellbeing’ is regarded by some researchers as synonymous with ‘psychological wellbeing’ (see discussion in section 3.4.2 of this document) and there has been a ‘gradual shift in the last few years away from being over reliant on objective measures of child wellbeing towards engaging children and young people in defining the parameters around what constitutes wellbeing’ (Statham & Chase 2010: 10).

For example, a pioneering study was carried out in Australia, in which researchers worked extensively with 126 children aged 8-15 years in both rural and urban locations to develop wellbeing indicators based on children and young people’s perspectives (Fattore et al 2007). The study concluded that there were three overriding concepts of wellbeing as defined by children, namely:

- a positive sense of self, including being valued by others and having own space to reflect
- security, including feeling secure in social relations
- having autonomy and agency and being able to act freely, exert choices and exert influence, but being able to do so within strong social relations

(Fattore et al 2007; Statham & Chase 2010: 10-11).

### 4.3 PSYCHOLOGICAL AND EMOTIONAL DISTRESS

While the previous section has considered wellbeing and mental health from a positive and well-functioning point of view, this section considers the challenges children and young people might face in achieving (positive) mental health and psychological-emotional wellbeing.

#### 4.3.1 PREVALENCE

International epidemiological data point to the prevalence of mental health problems in children and adolescents, with approximately one quarter of youth experiencing a mental disorder in the year preceding measurement, and about one third across their lifetimes (Merikangas 2009: 16). Based on international epidemiological data, the most common disorders in children and adolescents that are described as mental health problems are the following:

- anxiety disorders, including Generalised Anxiety Disorder and Social Anxiety Disorder, with girls tending to have more of all subtypes of anxiety disorders

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6 This understanding is based on a study carried out for the Australian Council of Educational Research (ACER) of the social and emotional wellbeing of over 10,000 students attending 81 schools across Australia, making use of data gathered from students and teachers (Bernard et al 2007).

7 The study was a collaborative project between the New South Wales Commission for Children and Young People and researchers at the Social Justice and Social Change Research Centre at the University of Western Sydney. The project was designed to inform the Commission in implementing its legislative mandate to develop a set of wellbeing indicators to monitor children’s wellbeing over time (Frattore et al 2007).

8 It is also important to recognise that most mental disorders of adulthood begin in childhood and adolescence (Merikangas et al 2009: 7).

9 Data from Norway, for example, indicate that between 15% and 20% of all young people have mental problems that impact their daily functioning, and that between 4% and 7% have problems that need treatment (Andersen & Nord 2010).
- behaviour disorders, including Attention Deficit and Hyperactivity Disorder (ADHD), Conduct Disorders and Oppositional Defiant Disorder, with prevalence higher in boys than girls for all types except oppositional defiant disorder
- mood disorders, including depressive disorder and bipolar disorders, often associated with other disorders such as anxiety and conduct disorders
- substance use disorders (alcohol and other drugs), with inconsistent indicators of gender differences (some studies showing equal prevalence rates, others showing that males have greater rates than females).

(Merikangas et al 2009: 9-13; Stopa, Barrett & Golingi 2010: 5; Graetz et al 2010: 13)

The general prevalence of emotional and behavioural disorders in Australian public schools is estimated to be 3% to 10% of the school-going population. A general educator can thus expect at least one student diagnosed with an emotional and behavioural disorder to be enrolled in their class (O’Neill & Stephenson, 2010:65). Drawing on data from the National Survey of Mental Health and Wellbeing conducted in Australia in 200710, Sawyer et al (2007: 188) found:
- The most common mental disorder amongst 13 to 17 years olds was ADHD, which had a prevalence of 7%, and was more common in males.
- The prevalence of Major Depressive Disorder was 4% among 13 to 17 year olds, with no significant differences between males and females.
- The prevalence of Conduct Disorders amongst 13 to 17 year olds was 2%, and was more common in males.

On a cautionary note, Adelman and Taylor (2006: 294-295) write that more and more children and young people who are manifesting emotional upset, misbehaviour, and learning problems are routinely assigned psychiatric labels which 'flies in the face of the reality that the problems of most youngsters are not rooted in internal pathology, and many troubling symptoms would not develop if environmental circumstances were appropriately different'.

These authors recommend placing mental illness in perspective with respect to psychosocial problems and broadly defining mental health to encompass the promotion of social and emotional development and learning (Adelman & Taylor 2006: 295).

4.3.2 MANIFESTATIONS OF PSYCHOLOGICAL AND EMOTIONAL DISTRESS

The manifestations of psychological and emotional distress in school-aged children are often described in the literature by making use of the concepts ‘internalising’ and ‘externalising’ problems or behaviours (cf Weist, Rubin, Moore, Adelsheim & Wrobel 2007; Cooper & Cefai 2009; Franklin, Kim & Tripodi 2009). These concepts are discussed next. In addition, it is recognised that psychological and emotional distress has an impact on the child’s success at school (cf Franklin et al 2009), and this significant issue is also discussed in this section.

INTERNALISING BEHAVIOURS

Children and young people exhibiting internalising behaviours are those with disorders such as depression, anxiety or suicide ideation (Weist et al 2007: 55). Internalising conditions are generally not as easily identified as those with externalising disorders (Weist et al 2007: 55), and Cooper and Cefai (2009: 94) note that published empirical sources focusing on disruptive and acting-out behaviour among school students far outweigh sources dealing with ‘acting in’ problems.

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10 The National Survey of Mental Health and Well-being included data from 1,490 adolescents aged 13-17 years (Sawyer et al 2007: 186).
As noted above, anxiety disorders are the most common of the mental disorders of children and adolescents. Social anxiety disorder is described as an example of an internalising behaviour in the box below.

**SOCIAL ANXIETY DISORDER AS AN EXAMPLE OF AN INTERNALISING BEHAVIOUR**

Social Anxiety Disorder, whose onset peaks in adolescence (with a prevalence rate from 4% to 9%), is associated with significant impairment, including few friends, loneliness, depressed mood, disturbances in school performance and difficulty with interpersonal relationships. Studies have found that this continues as an impairment into adulthood, leading to issues including increased risk for suicide attempts, alcohol use, inability to work, depression, and severe social restrictions.

Students with social anxiety are often overlooked, most likely due to their quiet, compliant manner, and it is common for adults to underestimate the adversity associated with the disorder. Few teachers and parents believe that social anxiety requires treatment, even when they recognise extreme shyness or nervousness, and may expect that young people will ‘grow out’ of their anxiety.


It is estimated that the prevalence of depressive disorders in adolescents can range from 1% to 8% in any given year, and it is one of the major causes of morbidity among adolescents (Calear & Christensen 2010: 429). Negative outcomes associated with depression, such as poor academic performance, physical ill-health and suicide attempts, are also experienced by children and adolescents with ‘subclinical levels of depression’ (Calear & Christensen 2010: 429).

Suicide ideation has been reported in up to 20% of all high school students. Suicide has been reported as the single leading cause of death among adolescent youth below the age of 15 in Australia, China, New Zealand, Ireland and Sweden (Cusimano & Sameem 2011: 43).

Anxiety and depression do not need to be at clinically diagnosable levels for them to be issues for children or young people. According to data from the National Survey of Young Australians (see Table 2 of this report), ‘coping with stress’ is an areas of concern for more than a quarter of young people in NSW.

**EXTERNALISING BEHAVIOURS**

Young people with externalising disorders are those who act out their troubles through aggressive, disruptive or violent behaviour (Weist et al 2007: 55).

Youth violence and related aggressive behaviours have become serious public health issues with physical, economic, social, and psychological impacts and consequences. Based on 2005 data, 35.9% of students in the USA had been in a physical fight in the previous year, with the prevalence rates across local surveys varying between 30.4% and 46.5% (Park-Higgerson, Perumean-Chaney, Bartolucci, Grimley & Singh 2008: 466).

Bullying behaviour is a subset of the larger construct of antisocial-aggressive behaviour and is described as an example of externalising behaviour in the box below.

**BULLYING AS AN EXAMPLE OF AN EXTERNALISING BEHAVIOUR**

Although there is no universally accepted definition of bullying, three critical features appear in most definitions, namely:

− repetition – repeated hurtful behaviour
− intent to harm – intention to cause physical, psychological and/or emotional harm

11 These data are derived from the 2005 Youth Risk Behavior Survey carried out in the USA (Park-Higgerson et al 2008).
BULLYING AS AN EXAMPLE OF AN EXTERNALISING BEHAVIOUR

- power imbalance between the perpetrator(s) and the victim(s) – through differences such as physical size and strength, age or status within a peer group.

(NSW Parliament Legislative Council General Purpose Standing Committee No.2 2009: 11)

Ken Rigby has defined bullying as ‘a desire to hurt + hurtful action + a power imbalance + (typically) repetition + an unjust use of power + evident enjoyment by the aggressor and a sense of being oppressed on the part of the victim’ (Rigby n.d.).

‘Covert bullying’ has been defined as

…any form of aggressive behaviour that is repeated, intended to cause harm and characterised by an imbalance of power, and is ‘hidden’, out of sight of, or unacknowledged by adults. Covert bullying includes behaviours linked to social aggression, relational aggression and indirect aggression as long as the behaviour remains either unwitnessed, or unaddressed, by an adult.

(Cross et al 2009: xxi)

It is difficult to know the full extent of bullying in schools. Bullying often happens away from teachers and adults, and victims of bullying often do not tell anyone about it because they feel ashamed and embarrassed, or are frightened that telling someone will make the bullying worse. It has been suggested that only a very small percentage of students ever tell anyone they are being bullied (Campbell, 2005).

Research evidence indicates that involvement in bullying is detrimental to children’s academic success and their physical and mental health. Effects on victims include:

- a higher incidence of anxious, fearful, insecure and depressed emotions
- diminished self-esteem and social withdrawal
- a greater than average engagement in school avoidance behaviours, including dropping out of the school system
- greater likelihood of bringing weapons to school and to exact revenge in acts of violence.

Effects on perpetrators include:

- a greater propensity for cognitive distortions and biases related to perceived threats in their environment
- greater vulnerability to depression and suicidal ideation than their non-involved peers
- the heightened risk for substance use and later criminal behaviour
- increasing unpopularity with peers as they get older.

(Merrell et al 2008; Park-Higgerson et al 2008: 466; Ryan & Smith 2009: 248)

IMPACT OF WELLBEING ON ACADEMIC ACHIEVEMENT AND TRANSITIONS TO EMPLOYMENT

In addition to the internalising and externalising manifestations of psychological-emotional distress discussed above, engagement in and success at school is an important marker of the wellbeing of students and, concomitantly, improved wellbeing has a positive effect on academic performance (cf Franklin et al 2009; Durlak et al 2011).
Both internalising and externalising disorders have an impact on success at school; for example, meta-studies have shown that the serious academic consequences of anxiety disorders include:

- There are higher levels of academic impairment and relatively low levels of achievement among anxious children compared with children in the general population.
- Teacher perceptions of academic difficulties among anxious students are on a par with those of children who have externalising difficulties.
- Anxious students report having difficulties in performing school-based tasks, including giving oral reports, concentration and completing homework tasks.
- Anxious students are more likely to drop out of schooling prematurely.

(Cooper & Cefai 2009: 94)

Research studies provide strong empirical evidence for the positive impact of student wellbeing on academic achievement:

- A review of more than 200 school-based research studies carried out in the USA on the impact of interventions to promote social and emotional skills in children and adolescents between the ages of five and 18 revealed an 11% improvement in achievement test scores following participation in such a program (Charvat 2008: 1). At the same time, studies in California have shown that students who experience high levels of stress or depression tend to do poorly in school. As the percentage who report that they feel sad or hopeless increases, reading, language, and mathematics test scores decrease (The California Endowment 2008).
- A longitudinal study carried out in the USA provided strong empirical evidence that interventions that strengthen students' social, emotional, and decision-making skills also positively impact their academic achievement, both in terms of higher standardised test scores and better grades (Fleming et al, cited in Charvat 2008: 2).
- There is a growing body of international research indicating that the inclusion of social and emotional learning into the school curriculum enhances students' connection to school, classroom behaviour and academic achievement, and studies have documented the connections between social and emotional variables and academic performance (Durlak et al 2011: 417). For example, students who are more self-aware and confident about their learning capacities try harder and persist in the face of challenges. Students who set high academic goals, have self-discipline, motivate themselves, manage their stress, and organise their approach to work have been found to spend more time on learning and achieve better grades. Students who use problem-solving skills to overcome obstacles and make responsible decisions about studying and completing homework do better academically (Durlak et al 2011: 417-418).

In discussing the impact of wellbeing on academic achievement, Hoagwood et al (2007: 88-89) point out that academic success can be measured quantitatively through, for example, grades and test scores, and qualitatively through indicators such as academic engagement and classroom behaviour. In the short term, it is the latter that are more likely to show positive changes as the result of wellbeing interventions.

**IMPACTS ON THE TRANSITION TO EMPLOYMENT**

Current research suggests that higher levels of education do not necessarily equate to higher levels of happiness or life satisfaction, even though education clearly impacts upon levels of income and employment prospects. Data analysed on the basis of the *Longitudinal Surveys of Australian Youth* (LSAY) (Dockery 2010: 11-16) suggest that:

- Students who have completed Year 12 plus a certificate I or II are the happiest.
- Students who failed to complete school and did not gain any post-school qualifications are by far the least happy.
People who pursue a university education are not initially relatively less happy people; rather they become relatively less happy upon gaining a university degree.

The LSAY program studies the progress of several groups of young Australians as they move from school into post-secondary education and work\(^\text{12}\) (Fitzpatrick, Lester, Mavromaras, Richardson & Sun 2011; Dockery 2010). According to data from the LSAY, young people who complete Year 12 or post-school qualifications will find employment more quickly than young people who leave school early (Fitzpatrick et al 2011: 7).\(^\text{13}\)

According to the *How Young People are Faring* study (Foundation for Young Australians 2010: 6)\(^\text{14}\), around 16% of teenagers are not fully engaged in study or work, and this trend towards marginalisation has been increasing in recent years amongst young males.

Dockery (2010: 11-16) undertook a review of the literature (including international empirical evidence) on the effects of education on wellbeing (including subjective wellbeing) and found that although education has a positive association on variables such as health and income, higher levels of education have a negative effect on happiness. Explanations for this are often linked to higher levels of expectation among the higher educated (Dockery 2010: 15).

This finding is consistent with Australian data, in particular with a 2002 study finding that the simple mean ratings of life satisfaction (on a scale from 0–10; with 10 representing the highest level of satisfaction) for Australians who had only completed Year 11 or below was 8.03, higher than the 7.79 measured for those with a university degree (Dockery 2010: 15).

According to the *Education Amendment (School Leaving Age) Regulation 2009* under the *Education Act 1990*, which came into effect in January 2010, students in NSW must stay at school until they complete Year 10. For those students that elect not to complete years 11 and 12, a participation phase then applies until the young person reaches the age of 17, which includes undertaking an apprenticeship or traineeship or being enrolled in a training course with a private training organisation (NSW Public School, n.d.). One consequence is that the minimum school-leaving age in NSW has been raised from 15 to 17 (NSW Public Schools, n.d.).\(^\text{15}\)

At the time of writing, no research has been found which investigates the impact of this change on the wellbeing of NSW students, probably due to the recent time since the change occurred.

4.4 TRENDS IN PSYCHOLOGICAL AND EMOTIONAL PROBLEMS

4.4.1 TRENDS

According to Sweeting, West, Young & Der (2010: 1819), substantial increases have been identified in a number of psychosocial disorders among young people in most western countries since the Second World War. However, the findings are not consistent, trends are complex and there are methodological problems (eg differences in the diagnostic criteria or data-gathering methods used) that call into question the trends.

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\(^\text{12}\) The first cohort of LSAY sampled students undertaking Year 9 level education in Australia in 1995 and interviewed them annually over a 12-year period to 2006. All respondents could potentially have been questioned in all 12 survey waves (Fitzpatrick et al, 2011:13).

\(^\text{13}\) According to the LSAY, Year 12 completion itself does not give the same advantage as completion of a post-school qualification when it comes to finding full-time permanent employment. The type of post-school qualification does not change the speed of finding any job; university and VET graduates have similar experiences. Better educated women attain employment faster than their less educated counterparts, although the difference is slightly less for men. A man with a degree obtains work five times faster than a man who did not complete Year 12, while a woman with a degree obtains work eight times faster than a woman having less than Year 12 (Fitzpatrick et al 2011).

\(^\text{14}\) The *How Young People are Faring* study assembles data from a range of sources, including the monthly Labour Force Survey and the annual Education and Work survey (both from the Australian Bureau of Statistics [ABS]), the LSAY (described above) and data from international sources in order to make cross-country comparisons (Foundation for Young Australians 2010: 2).

\(^\text{15}\) At the same time full-time paid employment for 25 hours or more a week is a recognised alternative after the completion of Year 10, provided the young person is aged at least 15. If the young person is working part-time then they will need to combine their work with approved education or training to satisfy the legal requirements of the Act (NSW Public Schools, n.d.).
Drawing on the available literature, it is evident that a number of researchers have attempted to understand whether measurements of child wellbeing show a trend towards an increase in positive indicators, an increase in negative indicators or homeostasis over time (cf. Collishaw, Maughn, Natarajan & Pickles 2010; Hamilton & Redmond 2010: 33-35; The Nuffield Foundation 2004).

Of particular interest in the measuring of trends is a study by Collishaw et al (2010) which compared two nationally representative cohorts of 16-17 year olds living in England in 1986 and 2006. The study found:

- Reports by both youth and parents of emotional problems affecting girls were more prevalent in 2006 than in 1986.
- Rates of parent-reported problems increased for boys over the 20-year period, but youth reports did not mirror this trend (ie while parents indicated that boys had more emotional problems, the young people themselves did not).
- Twice as many young people reported frequent feelings of depression or anxiety in 2006 as in 1986.
- There was no evidence that trends in emotional problems for boys and girls varied by socio-demographic group.

(Collishaw et al 2010: 888-890).

Findings from several other studies are briefly summarised in the box below.

**STUDIES INVESTIGATING TRENDS IN CHILD AND ADOLESCENT EMOTIONAL AND PSYCHOLOGICAL WELLBEING OVER TIME**

Based on Australian longitudinal studies, the majority of Australian children are currently progressing well in terms of their temperament style and behaviour problems. Specifically, measurements suggested that children of the 1980s and 2000s appeared similar in temperament style and behaviour and, where there were differences, they were modest in size (Smart & Sanson, 2008).

According to parent reports, children of the 2000s were doing as well as children of the 1980s, and were a little easier in temperament style, and less inclined to show acting out and hyperactive behaviour or anxiety. According to teacher reports, children of the 2000s were slightly more likely to display conduct problems and hyperactivity than children of the 1980s, although they tended to be less anxious.

In a study on the self-reported happiness and self-esteem of children and young people aged 11-15 in the United Kingdom (UK) over the period 1994 to 2007, Bradshaw and Keung (2011:13) found that overall happiness scores increased significantly over this time (especially for girls), and that happiness was significantly higher in 2008 than in all the previous years, except for 2007. The authors note that it is difficult to draw clear conclusions about the causes of this improvement, but there is some evidence that it can be linked to **improved relationships with friends** and **improved happiness with school**.

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17 Two ongoing longitudinal studies, the Australian Temperament Project (ATP) and the Longitudinal Study of Australian Children (LSAC), contain parallel data on children’s temperament and behaviour problems, enabling a comparison of children born 20 years apart (Smart & Sanson 2008). The ATP is following a cohort of children aged four to eight months at the first data collection (born in 1982–83), while the LSAC is following two cohorts, the first aged 0 to one years at first collection (born in 2003–04), and the second aged four to five years at first collection (born in 1999–2000).

18 Bradshaw and Keung (2011) made use of British Household Panel Survey data to explore trends in subjective wellbeing of young people aged 11–15 in the United Kingdom (UK) over the period 1994-2008. Two dimensions of subjective well-being were measured, namely ‘happiness’ and ‘self-esteem’.
STUDIES INVESTIGATING TRENDS IN CHILD AND ADOLESCENT EMOTIONAL AND PSYCHOLOGICAL WELLBEING OVER TIME

Based on data gathered in the UK in 1974, 1986 and 1999\(^9\), adolescent emotional problems (such as depression and anxiety) have increased for both girls and boys since the mid-1980s, and adolescent conduct problems increased in both boys and girls over the whole 25-year study period. Analysis suggests that this seems to be an increase in non-aggressive conduct problems such as lying, stealing and disobedience rather than aggressive problems such as fighting (The Nuffield Foundation, 2004).

According to NSW DEC data (NSW Government 2010), there has been a dramatic increase in the number of students identified with autism or mental health disorders in NSW Government schools. It is estimated that from 2005-2009, the incidence of mental health disorder and autism increased by 36% and 88% respectively.

Making use of the Child and Youth Wellbeing Index (CWI) used to measure child and youth wellbeing in the USA using a consistent set of indicators since 1975; (see Table 1 in section 3), Land (2010: 3-5) writes that between 2000 and 2008, the overall CWI increased by 5.45%, due especially to positive changes in the ‘safe/risky behaviour’\(^20\), the ‘social relationships’ and the ‘community engagement’ wellbeing domains. During the same period, the ‘emotional/spiritual’ wellbeing domain decreased by 2.16%, due especially to decreasing trends of youth attachments to religion.

Hagquist (2010) analysed trends in mental health complaints (internalising problems) by making use of data collected during 1985-2005 among students in Sweden in grades 5, 7, and 9\(^21\). The study shows that there were significantly higher rates of mental health complaints in 2005/2006 compared with 1985/1986 among older adolescents, in particular girls, whereas the rates were almost unchanged among younger boys and girls. Only amongst girls in grade 9 had there been a successively (linear) increase of mental health complaints across the years of investigations.

According to the AIHW (2011: viii-ix), the suicide rate for young people aged 15-24 years in Australia in 2007 was 10 per 100,000, but it is unknown whether the proportion of deaths due to suicide has changed over time. Epidemiological data from the USA documents that youth suicide tripled between 1960 and 1990 among 15-19 year olds, decreased during the 1990s, but increased by 8% from 2003 to 2004, the largest annual increase in 15 years (Cusimano & Sameem 2011: 43).

Drawing on data from Dutch and American studies into adolescent behaviour problems, The Nuffield Foundation (2004: 4) finds that the data do not support the notion of a dramatic increase in behavioural and emotional problems in children and adolescents. For example, in the USA study, scores between 1976 and 1989 showed that there were increasing problems and decreasing competencies, but these trends were reversed between 1989 and 1999.

The first empirical research into bullying in Australian schools was published in the 1990s and found that bullying was prevalent in Australian primary and secondary schools (Rigby 2002). Six years later, a large scale national survey of 38,000 schoolchildren aged between 7 and 17 found that approximately one in six children in Australian schools are bullied by their peers each week (Rigby 2002).

Further research into the prevalence of bullying in schools was recently carried out by the Child Health

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\(^9\) The Nuffield Foundation (2004) analysed data from national surveys undertaken in 1974, 1986 and 1999, looking at trends in the same kinds of problems in UK adolescents over the whole 25 year period. The focus of the study was 15-16 year olds at each time point.

\(^20\) Based on the CWI data, the rates of involvement of children and young people in the USA in all measured forms of ‘risky behaviors’ including teenage birth, smoking, drinking, illicit drug use and violent crime have declined by 27.93% between 2000 and 2008 (Land 2010: 8-9).

\(^21\) The number of participating students each year varied between 2,933 and 4,421. The attrition rates varied between 10% and 15% in the participating schools. The longitudinal study is limited in the sense that it does not gather data on externalising problems, and may thus have a bias toward mental health conditions experienced more often by young women (Hagquist 2010: 259).
Promotion Research Centre, on behalf of the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR)\textsuperscript{22}. The study, published in 2009, found that approximately one in four Australian students in Years 4-9 were bullied every few weeks or more. The most prevalent type of bullying was ‘hurtful teasing’ (Cross et al. 2009).

Strong and consistent increases in the rates of combined overweight and obesity amongst Australian schoolchildren have been measured over the past 20 years, with a 1.8% increase over the preceding five years (Gill et al., 2009: 146). In NSW, the prevalence of overweight and obesity combined among students aged 7-16 rose from 11% in 1985 to 20% in 1997 to 25% in 2004 (Booth, Dobbins, Okely, Denney-Wilson & Hardy 2007: 4; Booth et al 2006: 4).\textsuperscript{23} For boys, the rate of increase sped up between the latest two surveys. That is, being overweight is becoming more of a problem for boys and it is occurring more quickly than before. For girls, while there is variation in age groups, in general the rate of increase is slowing. That is, while the rate of overweight and obesity is still rising, it is rising more slowly than it did between 1985 and 1997.

4.4.2 DISCUSSING THE TRENDS

The international data summarised above suggest that it is difficult to draw firm conclusions as to whether there has been an increase in mental health problems among children and young people. Researchers from The Nuffield Foundation (2004: 6) suggest that there is evidence in some studies for measured increases in positive features such as ‘competence’, as well as increases in negative features such as ‘mental health problems’. This could mean that ‘some young people are doing much better, while others are doing much worse’ (The Nuffield Foundation 2004: 6).

In keeping with this uncertainty, Carlisle et al (2009: 1558) point to a debate on whether current understandings of emotional health are not ‘unrealistic’. These researchers argue that it is normal, not pathological, to feel dissatisfied, disillusioned or depressed at times, whereas such emotions are increasingly judged as ‘treatable’ disorders in an ‘increasingly medicalised society’.

Writing of the situation in Sweden, Hagquist (2010: 258) notes that unambiguous notions of increasing mental health problems among children and adolescents are conveyed by the media and ‘reflected in the public health debate’. He recommends that there be a more nuanced approach to the question, taking into account issues such as gender differences and the balance between focusing on internalising and externalising behaviours.

Hamilton and Redmond (2010: 33-34) draw attention to the ‘homeostasis thesis’ in the debate, namely that long term trends in national averages of social and emotional wellbeing scores are unlikely to vary greatly, and instead there is an overall picture of stability.

4.5 FACTORS CONTRIBUTING TO POORER MENTAL HEALTH OUTCOMES

Drawing on the concepts of ‘risk/protective factors’ discussed in section 4.1 above, changes in the measurement of mental health problems could be due to the emergence of new risk factors, to increases in the frequency of, or vulnerability to, existing risk factors, or to the disappearance or reduction of protective factors (Sweeting et al 2010: 1819-1820).

\textsuperscript{22} Students from 106 schools across Australia participated in the study, including 7,500 students from 22 NSW schools.

\textsuperscript{23} These data were gathered in NSW, based on comparing results from the 2004 NSW Schools Physical Activity and Fitness Survey (SPANS) with the 1997 SPANS and the 1985 Australian Health and Fitness Survey for students in Years 2-10 (age range 7-16 years) (Booth et al 2006: 4).
A number of the reviewed articles make reference to today's children and young people dealing with 'multiple stressors in a complex society' (Puskar, Sereika & Tusae-Mumford 2003: 71). As described in Table 2 above, 'coping with stress' was the third ranked issue of concern for young people in NSW, with 27.3% of respondents indicating it was a major personal concern, up from 18.7% in 2009 (a significant increase). Australian research (Smart & Sanson 2008) suggests that parents perceive the daily environment in which children live to be increasingly less safe, stable and predictable.

A range of factors that may contribute to poorer mental health for children and young people are briefly discussed next.

4.5.1 EMERGENCE OF NEW TECHNOLOGIES

A growing body of evidence (Hosie 2007; Johnson 2010; Couvillon & Illieva 2011) points to the importance of modern communications technology in the lives of children and young people24.

An emerging trend, representing the confluence of the older problem of bullying with new technology has been described as 'cyberbullying'. Traditional forms of bullying were public matters, generally consisting of physical actions, abusive comments or the spreading of rumours. If caught, bullies had to stand up to their victims and face anyone else who happened to be nearby. With cyberbullying, bullying has taken on a 'new dimension' because bullies can hide behind their computer screens, reach a much larger audience and not have to reveal their identities.

Drawing on a study carried out in Australia (Cross et al 2009: xxi), cyberbullying was 'defined by young people as cruel covert bullying used primarily by young people to harm others using technology such as: social networking sites, other chat-rooms, mobile phones, websites and web-cameras'.

Cyberbullying has been identified as including the following specific forms:

- **Flaming** - sending angry, rude and/or vulgar messages about a person to an online group or to that person via email or other text messaging.
- **Online harassment** - repeatedly sending offensive messages via email or other text messaging to a person.
- **Cyberstalking** - online harassment that includes threats of harm or intimidation.
- **Denigration (put-downs)** - sending harmful, untrue or cruel statements about a person to other people or posting such material online.
- **Masquerade** - pretending to be someone else and sending or posting material that makes that person look bad.
- **Outing** - sending or posting material about a person that contains sensitive, private, or embarrassing information, including forwarding private messages or images.
- **Exclusion** - cruelly excluding someone from an online group.

(Couvillon & Illieva 2011: 96; Beran & Li 2007: 17)

4.5.2 POOR PHYSICAL HEALTH IMPACTING ON MENTAL HEALTH

Mental health is related to other aspects of (physical) health and disability. As noted by Manning (2009: 47), many physical and mental health diagnoses have high rates of comorbidity. In terms of comorbidity, for example, children with asthma are at increased risk to also be suffering from depression, especially

24Drawing on ecological systems theory, child development is assumed to be the consequence of ongoing reciprocal interactions between the child and his/her microsystem (immediate home, school, and community environments) (Johnson 2010: 32). In recent times, the increasing presence of digital technologies in children’s immediate environments suggests the need for a proposed theoretical *techno-microsystem* which ‘situates the developing child in the context of Internet use in home, school, and community environments’ (Johnson 2010: 32). It is suggested that this would be an important area of research in the coming years with regards to its impacts on child development.
among girls. Diabetes and obesity are associated with each other. Children who suffer from both diabetes and obesity are at substantially greater risk for developing psychiatric disorders, including eating disorders, depression, and anxiety disorders, when compared to children who only have diabetes (Manning 2009: 47).

Drawing on Australian data (the National Survey of Mental Health and Wellbeing, also discussed above) Sawyer et al (2007: 189-190) find that rates of health-risk behaviours (including alcohol and drug use) are higher amongst adolescents with a mental disorder than amongst adolescents without a mental disorder.

According to Merikangas et al (2009: 15) many epidemiological studies have shown that children with physical illness are more likely to develop depression, and children with emotional disorders have an increased risk of developing physical disorders.

The available literature and statistical data, point to continuous improvement in the health of young Australians, but also anomalies:

- There has been declining morbidity from infectious diseases as a result of improved hygiene, nutrition and living and working conditions, and medical advances (Eckersley 2011: 629).
- There has been a rise in life expectancy, with death rates for young people aged 12-25 having halved in the past 20 years (Eckersley 2008: 9).
- There are consistent inequalities especially among young Indigenous Australians, young people in regional and remote areas and young people suffering socioeconomic disadvantage (Eckersley 2008: 7).
- There are adverse trends in non-fatal chronic health problems, including mental health problems (discussed above) and diseases linked to obesity, physical activity and nutrition (discussed in greater detail next).

4.5.3 BODY DISSATISFACTION AND DISORDERED EATING

‘Body dissatisfaction and disordered eating are on the rise among today’s young people’ (Shulman & Mulloy-Anderson 2009: 42), and the phenomenon represents a clear example of the link between mental and physical wellbeing or the lack of it.

There has been a marked increase in childhood and adolescent obesity, which has become identified as a public health concern (Zenzen & Kridli 2009). In Australia, problems with overweight and obesity now affect around one in every four schoolchildren. Being overweight or obese places young people at risk of a wide range of health problems including diabetes, heart disease, some cancers and mental illness (Eckersley 2011: 630).

As was made clear on the basis of data presented in Table 2 above, ‘body image’ has been the major concern of children and young people over the past few years and as such can be linked to their sense of subjective wellbeing.

The finding regarding young people’s concerns with body image is consistent with international research from other developed countries, which points to:

- an increase in ‘body dissatisfaction’ in school-aged young people in the USA, linked to societal messages and cultural norms that ‘proclaim thinness as the ideal body type’ (Shulman & Mulloy-Anderson 2009: 34)

- declines in patterns of physical activity amongst children and adolescents in the USA, which contribute to problems with obesity, and which have been linked to other health issues such as

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25 Zenzen and Kridli (2009: 243) write that, while a decline in physical activity may be one factor to explain the increase in obesity, other contributing factors may include poor dietary habits, limited health education, genetics, socioeconomics, and the breakdown of the family unit. These authors draw on the conclusion of the American Academy of Pediatrics in suggesting that ‘the increase in the incidence of childhood obesity is multifactorial, with both genetic and lifestyle factors contributing to its development’ (Zenzen & Kridli 2009: 243).
higher blood pressure, higher insulin and cholesterol concentrations and more abnormal lipid profiles (Zenzen & Kridli 2009: 243).

Drawing on WHO data, Gill et al (2009) write that problems associated with the common pattern of obesity progressing into adulthood has led to the earlier development of chronic diseases such as type 2 diabetes. More recent data have clearly indicated that many of the ill-health consequences of excessive weight are present in children and adolescents who are defined as overweight (Gill et al 2009).

The development of eating disorders such as anorexia and bulimia nervosa represents an extreme response to the problems discussed above and can have detrimental effects on psychological, social-emotional and academic development. Its prevalence among children and adolescents has been linked to ‘sociocultural risk factors’ (messages and cultural norms proclaiming thinness as the ideal body type), combined with individual risk factors such as perfectionism and low self-esteem (Shulman & Mulloy-Anderson 2009: 34).

4.5.4 FAMILY STRUCTURE AND FAMILY DYNAMICS

Family-related changes include greater diversity in family forms (eg the proportion of families with dependent children headed by a lone parent) compared to earlier times. Hayes (2008:61-62) describes some of the demographic changes affecting Australian families that have occurred over the past century:

- Trends in fertility have changed dramatically, declining from 3.12 (children per family) in 1921 to 2.11 in 1934, increasing to 3.55 in 1961, decreasing to 1.73 in 2001 and increasing to 1.81 in 2006. The overall trend in the 20th century has been one of decline.
- Age at first marriage rose from 21 years in the early 1970s for women to 28 years in 2005, and from 23 to 30 years for men during the same period.
- An increased rate of marriage breakdown is a contemporary reality, with the Australian Bureau of Statistics (ABS) estimating that 46% of marriages will end in divorce.
- 23% of Australian children have a natural parent living elsewhere and around three in ten children live in sole-parent, step- or blended families. In 1986, sole-parent families accounted for 15% of families with dependent children; by 2004, the figure was 20%. Hayes suggests that about half of all children who are disadvantaged live in single-parent families, predominantly headed by their mother.

(Hayes 2008: 61-62)

Reviews suggest that children from divorced families tend to have poorer psychological adjustment, self-concept and social competence than those of married parents, and boys are particularly at risk around the time that their father leaves the household (Hayes, 2008:62). On the other hand, the effect sizes are small and for some children and young people, parental separation or divorce may be positive (Sweeting et al, 2010:1820).

Studies in the United Kingdom (UK) have found that the diversification of family structures since the 1960s from the ‘nuclear family of breadwinner father, stay-at-home mother and biologically related children’ accounted for less than 2% of the variation in subjective wellbeing, whereas responses to the statement ‘my family gets along well together’ accounted for over 20% of the measured variation (Rees, Bradshaw, Goswami & Keung 2010; Sweeting et al 2010). This suggests that ‘arguments with parents’ and (especially for females) ‘worry about family relationships’ are at greater risk of contributing to young people’s psychological distress than changes to family structure (Sweeting et al 2010: 1827-1828).

This conclusion is supported by recent studies in Europe which have found that, rather than an association between poor child wellbeing and the prevalence of ‘broken’ families,

…what seems to be more important to children’s subjective wellbeing than family structure is the extent to which parent and children get along … [and that] … family conflict had the strongest association with child unhappiness.

(Statham & Chase 2010: 13)
4.5.5 EDUCATION AND WORK PRESSURES

Studies in the UK have found that school performance, school attendance, teacher interaction and school/leisure conflict are all dimensions of adolescent stress and all are significantly associated with psychological distress (Sweeting et al 2010: 1820). Comparisons of data gathered in the UK since 1987 show that there has been ‘increased disengagement from and, among females, increased concerns about school’ (Sweeting et al 2010: 1824).

A heightened emphasis on achievement in some schools may marginalise and demotivate students identified as unlikely to succeed. School disengagement has been associated with negative psychological and behavioural outcomes (Sweeting et al 2010: 1820).

Children, and especially adolescents, are also impacted upon by ongoing changes in global labour markets, by the dynamic relationship between education and employment, and through changes in ‘the significance of traditional markers of adult status and of traditional institutions in industrialised countries’ (Wyn 2007: 37).

4.5.6 ECONOMIC FACTORS

Economic factors include overall economic conditions within a country and levels of income inequality. Hayes (2008: 61) refers to the paradox that as the capacity for wealth generation of market-based economies has risen in recent years, so has ‘a growing perception of substantial threats to the health and wellbeing of today’s children’.

The Nuffield Foundation (2004: 5) points to the ‘counter-intuitive way’ in which rises in mental health problems seem to be associated with improvements in economic conditions and physical health.

4.5.7 RAPID SOCIAL AND CULTURAL CHANGES

Perhaps one of the reasons for the paradox described in the previous point has to do with the rapidity of social and cultural changes, and a number of researchers address this point. These changes include the impacts of electronic media and technology (including the projection of violence into people’s lives), dietary changes and environmental concerns relating to drought, floods and anthropogenic climate change (Eckersley 2008). As noted by the Australian educational researcher Johanna Wyn, ‘it has become increasingly necessary for young people to have the skills and capacities to manage uncertainty and complexity’ (Wyn 2007: 36).

A series of meta-analyses of studies of children and young people conducted at different times over the latter half of the 20th century (Sweeting et al 2010: 1821) have highlighted increases in self-reported anxiety and suggest a causal role for decreased social connectedness and increased environmental dangers. As noted by Sweeting et al (2010: 1821) on the basis of the analyses of data between 1987 and 2006,

> the bulk of the evidence … suggests that reduced social trust and religious commitment coupled with increased commercial involvement, focus on appearance, subcultural affiliation, the ‘going-out scene’ and electronic media might have contributed to increasing mental health problems.

A number of writers address the issue of the recent emergence of an ‘individualised’, ‘materialist’ and/or ‘consumerist’ way of life that may make it harder for children and young people to develop a strong sense of identity, purpose, belonging and security. For example, Carlisle et al (2009: 1557) describe wellbeing as ‘a collateral casualty of modernity’. Drawing on ‘the now vast empirical and theoretical literature on wellbeing’, these authors point to a debate in disciplines including neuroscience, psychiatry, political science and philosophy on the parallel growth of materialistic and individualistic values, and an ‘increased sense of individual alienation, social fragmentation and disengagement’ (Carlisle et al 2009: 1556).

26 Sweeting et al (2010: 1822) drew on the West of Scotland Twenty-07 longitudinal study of three age cohorts and the Peers and Levels of Stress study in 2006 in order to generate comparative data.

27 Carlisle et al (2009: 1556) carried out the research for this paper under funding by the Scottish Government’s National Programme for Improving Mental Health and Wellbeing. The lead author Sandra Carlisle is based at the Medical School of the University of Glasgow.
Amongst Australian researchers, Eckersley (2008; 2009; 2011) presents a consistent view of a declining optimism about national and global futures among young Australians. As an underlying trend, Eckersley points to the ‘loss of social support and personal control’ that contribute to adverse wellbeing outcomes for young people and these factors include:

- a heightened sense of risk, uncertainty and insecurity
- a lack of clear frames of reference
- a rise in personal expectations, coupled with a perception that the onus of success lies with the individual, despite the continuing importance of social disadvantage and privilege
- a surfeit or excess of freedom and choice, which is experienced as a threat or tyranny
- increased self-esteem, but of a narcissistic or contingent form that requires constant external validation and affirmation
- the confusion of autonomy with independence or separateness.

(Eckersley, 2009:9)

As summarised by Eckersley:

*The totality of the evidence suggests that fundamental social, cultural, economic and environmental changes in Australia and other Western societies are impacting adversely on young people’s health and wellbeing. These changes have made it harder for young people to feel accepted, loved and secure; to know who they are, where they belong, what they want from life, and what is expected of them: in short, to feel life is deeply meaningful and worthwhile.*

(Eckersley 2008: 24)

### 4.6 SUMMARY

Psychological-emotional wellbeing and mental health refer to the achievement of expected developmental milestones and the establishment of effective coping skills, secure attachments, and positive social relationships. Psychological and emotional distress manifests in internalising behaviours (anxiety and depression) and externalising behaviours (acting out troubles through aggressive, violent or disruptive behaviour). There is a strong evidence base that wellbeing has an impact on children's academic success at school.

In considering psychological-emotional wellbeing, the literature draws attention to the importance of resilience, and the interplay between risk and protective factors in the development and maintenance of resilience. A consistent focus on the developmental needs of children and adolescents can help to prevent focusing too much on threats and problems that children and young people may face (the deficits), and draw equal attention to the establishment of effective coping skills, secure attachments and positive social relationships (the strengths).

Research also points to the importance of acknowledging the impact of age and gender in explaining differences in wellbeing. Mental health problems tend to increase in the later adolescent years, and boys and girls show characteristically different patterns of wellbeing, including higher rates of internalising problems for girls and higher rates of externalising problems for boys.

Trends in the mental health and psychological-emotional wellbeing of children and adolescents are influenced by:

- developments in communications technology, which have meant that technology has become more and more important in the lives of children and young people and has, amongst others, led to the emergence of cyberbullying
- poor physical health which can impact on mental health
- body dissatisfaction and disordered eating
- changes to family structures and family dynamics, including a measured increase in sole parent families and an increased rate of marriage breakdown
- education and work pressures, including a heightened emphasis on achievement and disengagement from school for those identified as unlikely to succeed
- economic factors, with some experts suggesting there are counter-intuitive rises in mental health problems associated with improvements in economic conditions
- rapid social and cultural changes, with vigorous debate on the impact of the growth of materialistic and individualistic values on individual alienation and social fragmentation.

It is difficult to draw firm conclusions as to whether there has been an increase in psychological-emotional distress and mental health problems among children and adolescents over the past years. Many studies point to significantly higher rates of mental health complaints and increases in the behavioural and emotional problems in children and adolescents, including anxiety and depression.

Other studies point to nuances in the data, such as clear differences between boys and girls and reverses in trends. Many writers also point to changes in the measurement of mental health problems, and differences in measurement outcomes depending on whether the information is sought from parents, teachers or young people themselves.

Drawing on the debates in the literature, the following are put forward as trends in the psychological and emotional wellbeing issues of Australian children and young people:

- The majority of Australian young people rate their health as 'good' or 'excellent' (higher than the OECD average) and there have been measured improvements in the physical health of children and young people overall, including declining mortality rates.
- The majority of today’s Australian children are progressing well in terms of their temperament style and behaviour problems, and NSW data point to significant decreases in the proportion of students who had experienced high psychological distress (in the last six months prior to measurement) between 1996 and 2008 (from 15.4% to 13.3%).
- There have been consistent increases in the past decades in the numbers of students diagnosed with disabling conditions in NSW schools, and this is particularly true for autism and mental disorders.
- The prevalence of bullying is high – a nationwide study has found that approximately one in four Australian students in Years 4-9 were bullied every few weeks or more. There is an ongoing concern amongst young people about bullying and the rise of cyberbullying as a new form of bullying.
- There have been declines in the numbers of high school students in NSW who have ever consumed alcohol, but nationwide data show that considerable proportions of young people are drinking alcohol to levels that could lead to harm. In addition, there is a consistent trend for young people to rate alcohol to be an issue of concern to them.
- Strong and consistent increases in the rates of combined overweight and obesity amongst Australian schoolchildren have been measured over the past 20 years, with a 1.8% increase over the preceding five years. In addition, studies find that young people are consistently worried about body image.
- Children and young people express concern with regard to psychological-emotional wellbeing issues such as family conflict and coping with stress and depression.
- According to the AIHW (2011: viii) it is currently unknown whether the proportion of deaths of children and young people in Australia from suicide has changed over time.

In section 5, available literature is drawn upon to discuss the role of schools in addressing students' mental health and wellbeing.
5 The role of schools in addressing student wellbeing

5.1 INTRODUCTION

Schools play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and wellbeing of young Australians, and in ensuring the nation’s ongoing economic prosperity and social cohesion. Schools share this responsibility with students, parents, carers, families, the community, business and other education and training providers.

(MCEETYA 2008: 4)

This section briefly considers the role of schools in supporting the mental health and psychological and emotional wellbeing of children and young people. Issues that are considered are:

- the benefits of focusing on student wellbeing in the school setting
- the adoption of the health promoting schools approach, promulgated by the World Health Organisation (WHO)
- levels of school-based intervention, including universal prevention programs, selected programs and targeted or specialised interventions.

Before doing so, we draw on available data to identify young people’s self-identified sources of advice and support, and data which suggest that, despite the prevalence of mental health problems, there is a gap between needs and the accessing of services.

5.2 SELF-IDENTIFIED SOURCES OF ADVICE AND SUPPORT

The National Survey of Young Australians (refer section 3.5.2 and Table 2) provides data on young people’s self-identified sources of advice and support, summarised in Table 3 below.

TABLE 3 – SELF-IDENTIFIED SOURCES OF ADVICE AND SUPPORT FOR YOUNG PEOPLE IN NSW

<table>
<thead>
<tr>
<th>WHERE YOUNG PEOPLE TURN TO FOR ADVICE AND SUPPORT</th>
<th>PERCENTAGE OF SAMPLE IDENTIFYING THE SOURCE OF ADVICE AND SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends</td>
<td>86.0</td>
</tr>
<tr>
<td>Parents</td>
<td>74.9</td>
</tr>
<tr>
<td>Relative or family friend</td>
<td>61.5</td>
</tr>
<tr>
<td>Internet</td>
<td>25.9</td>
</tr>
<tr>
<td>Community agencies eg youth worker</td>
<td>11.7</td>
</tr>
<tr>
<td>Magazines</td>
<td>11.4</td>
</tr>
<tr>
<td>Teacher</td>
<td>10.1</td>
</tr>
<tr>
<td>School counsellor</td>
<td>8.5</td>
</tr>
<tr>
<td>Another person (eg doctor) in community</td>
<td>7.8</td>
</tr>
<tr>
<td>Telephone helpline</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Source: Mission Australia (2010: 50)

In 2010 16,129 surveys were returned from NSW, representing 32.2% of the total number of respondents who indicated which state/territory they came from.
In 2010, 98.5% of the respondents from NSW were aged between 11 and 19 years.

Drawing upon the data presented in Table 3, a number of trends can be described.

- The sources of advice and support for young people when they have a problem have remained relatively consistent over time. Friends, parents, and relatives/family friends were overwhelmingly the most important sources of advice for respondents in 2010, as they had been for each of the nine years of the survey. Friends were a major source of advice and support for 86% of respondents, and parents were an important source for almost three quarters (74.9%) of respondents. Three in five (61.5%) identified relatives or family friends as major sources of advice and support.

- One source of support which has been showing consistent growth is the internet. In 2010, a quarter of respondents (25.9%) identified the internet as an important source of advice and support, up from 10.8% in 2002.

- School counsellors were described as a source of support by 8.5% of respondents, down from 10% in 2009 and 11.3% in 2008. It is noteworthy that, compared to the national average, slightly fewer NSW respondents identified school counsellors as a source of advice and support. This difference has been consistent over the years of the study: while 8.5% of young people in NSW named school counsellors as sources of support in 2010, the corresponding national percentage was 9.1%; the difference was 10% versus 10.8% in 2009; the difference was 11.3% versus 11.5% in 2008; and in 2007 the difference was 10.2% versus 10.8% (Mission Australia 2010: 50).

The importance of informal sources of support, especially friends/peers, to children and young people as reflected in the data above is supported by studies carried out in Canada and the USA, namely that ‘most young people rely on their friends for help and…very few go to counsellors or other sources in the first instance’ (Dillon & Swinbourne 2007).

5.3 GAP BETWEEN MENTAL HEALTH NEEDS AND SERVICES

A consistent theme in the literature is that there is a significant gap between the mental health needs of children and adolescents and the services available to address those needs. Some examples from the literature include the following:

- A range of studies carried out within the USA have shown that, while between 12% and 27% of youth have behavioural problems, depression and anxiety, only one sixth to one third of these youth receive any mental health treatment (Weist et al 2007: 54; Manning 2009: 44). In another study, drawing on data from the Surgeon General’s Report on Mental Health, Trussell (2008: 149) notes that although one in ten children and adolescents in the USA will suffer from mental illnesses significant enough to impact social and educational functioning, only one in five actually receive mental health support, and that ‘the gap between services and the emotional needs of children and adolescents is a known problem’.

- In Australia approximately 14% of children and adolescents have mental health problems and only one in four receives professional help (De Jong & Griffiths 2008: 29).

- Drawing on data from the UK, Hilt-Panahan et al (2007: 32-33) write that the majority of children and adolescents affected by depression and depressive symptoms do not access intervention, influenced by individual barriers (eg fear of stigma and embarrassment), health provider barriers (eg knowledge of mental health problems) and systemic barriers (eg the availability of mental health providers).

5.4 ADDRESSING MENTAL HEALTH AND WELLBEING IN THE SCHOOL SETTING

Wellbeing is clearly within the ambit of education as integral to the processes of learning achievement, as well as being an outcome, both immediately and over time.

(South Australian Department of Education and Children’s Services [SA DECS] 2010: 6)
Drawing on the discussion of risk/protective factors and resilience discussed in section 4.1 of this document, effective schools can embody a range of protective factors, including the following:

- successful *instructional practices* that impact the greatest number of students
- a *curriculum* that allows for variations across the learning continuum so that individual differences can be addressed
- teachers that are able to apply *effective rules, supervision and follow-through*
- a well-managed *classroom and school ‘ecology’* that promotes a sense of community, safety and security
- *opportunities for social support*, enabling students to develop relationships with peers and adults.

(Trussell 2008: 151-153)

Bacon et al (2010: 49) point to a number of benefits to focusing on student wellbeing in the school setting:

- It is congruent with the broader aims of education to not only focus on the mastering of disciplines, but also on the development of social and emotional competencies that would enable students to flourish within and beyond school.
- An emphasis on academic skills alone could have the effect of marginalising other important competencies for working life, such as collaboration, empathy and emotional resilience.
- Dedicating time to improving the wellbeing of students can have a positive effect on academic achievement and positive behaviour in the classroom.

In support of the latter point, recent studies have made strong links between academic outcomes and the quality of relationships in schools, prosocial behaviour and resilience (SA DECS 2010: 5). Research consistently states that there is a relationship between addressing the social outcomes of children and subsequent positive academic outcomes.

Some of the advantages of school-based mental health programs and services include:

- Schools provide enhanced access to services for youth, since they serve as a single location through which the majority of youth can be reached.
- School programs reduce barriers to treatment such as cost and transportation.
- Schools offer services in a familiar setting and may thus contribute to reduced stigma for help seeking.
- Treatment implemented within schools allows for real-world interventions and provides opportunities for practising skills in realistic contexts and with diverse individuals (eg teachers, staff, and peers), thereby increasing the likelihood of generalisation to students’ natural environments.
- Schools provide increased opportunities for mental health promotion and problem prevention efforts.
- Parents frequently consult teachers about their children’s problems and having mental health programs in schools that include a focus on teachers may enhance the quality of advice they provide to parents


Rowling (2007: 23-24) takes an historical approach when describing the promotion of mental health programs within school settings as 'the latest in a wave of health and social issues that schools have increasingly been called upon to include in curriculum and policies'.

Some characteristics of school mental health programs include that, compared to other health programs (eg those dealing with topics such as sexual health and alcohol and other drugs), there is less emphasis
on dimensions of social control and a more positive perspective (with many ‘do’ rather than ‘don’t’ messages). In addition, there is a sizable existing mental health/mental illness workforce with well-developed research and practice standards that could be of benefit to schools (Rowling 2007: 24).

5.5 HEALTH PROMOTING SCHOOLS

In the past decade, there have been calls for schools to formally adopt a health promotion model to address student mental health and wellbeing (cf Askell-Williams et al 2009; Stewart-Brown 2006; Friedich et al 2010: 215). Rowling (2009) points to a strong evidence base in scholarly work, in systematic reviews and in policy documents to support a shift towards whole school approaches to mental health promotion (Rowling 2009: 357).

The WHO produced a set of guidelines for ‘health promoting schools’, covering six areas:

- school health policies
- the physical environment of the school
- the social environment of the school
- school/community relationships
- the development of personal health skills
- school health services.

(Stewart-Brown 2006: 7)

Australia was one of the first countries to implement the health promoting schools initiative (Stewart-Brown 2006: 8). Within this approach school mental health promotion has been defined as:

... a full continuum of mental health promotion programs and services in schools, including enhancing environments, broadly training and promoting social and emotional learning and life skills, preventing emotional and behavioral problems, identifying and intervening in these problems early on, and providing intervention for established problems.

(Weist & Murray 2007: 3)

Graetz et al (2010:14-15) note that there are challenges to adopting a population health model, including lack of system support, leadership and staff turnover, and access to professional development. The resources required to implement such a model are likely to include:

- a conceptual framework that provides a ‘big picture’ overview including the rationale, key benefits and clear achievable goals
- an implementation process that provides step-by-step guidelines to support the implementation and maintenance of initiatives
- key resources such as staff training and access to evidence-based programs.

(Graetz et al 2010: 15)

It is also important to recognise that young people’s health and wellbeing is not simply the responsibility of schools, but also requires partnerships between education, health and human services (Wyn 2007: 46).

In the development of schools as centres not only of learning but also of health (and particularly mental health) promotion, Rowling (2009) suggests that two areas are particularly relevant for consideration:
Distributed leadership – schools need many leaders at many levels in order for leadership to be effective, since it impacts on sound decision-making, effective human resource management, moral purpose, understanding of change processes, relationship building and knowledge building. A school with distributed leadership for mental health and wellbeing would *inter alia* be able to articulate strategies for creating a safe learning environment for all, conduct discussions on key aspects of pedagogy for health and wellbeing with staff, and create transition pathways for students experiencing difficulties in mental health.

Professional learning – if education and health sectors work collaboratively in the school setting as a working and learning environment, then the wellbeing of staff becomes a necessary part of the overall school intervention. The implementation of material on mental health could have positive impacts on staff and the school as a whole, including improvements in teaching efficacy.

(Rowling 2009: 362-365)

A key issue with respect to the development of school-based mental health services is the existence of separate program components and the failure to coordinate these components into a coherent whole, leading to the fragmentation of programs and their marginalisation within the school system as a whole (Adelman & Taylor 2006: 295; Walter et al. 2011: 186). In order to deal with these problems, there have been attempts to promote coordination through methods that include:

- the use of data to support decision-making
- screening universally to identify needs and monitor progress
- creating an environment that supports learning and prosocial behaviours
- teaching prosocial skills
- developing a continuum of evidence-based interventions and implementing the interventions with fidelity.

(Walter et al. 2011: 186)

A continuum of interventions ranges from programs aiming to promote healthy development and prevent problems (primary prevention), through to those aimed at addressing problems soon after onset, and on to treatments for severe and chronic problems (Adelman & Taylor 2006: 295). This continuum of interventions is discussed in greater detail next.

### 5.6 LEVELS OF SCHOOL-BASED INTERVENTION

The various mental health service strategies used by schools and the mental health system may be classified on the basis of when the intervention is implemented in relation to the onset of a condition (Kutash, Duchnowski & Lynn 2006: 4-5). This is in keeping with public health and health promotion conceptualisations, and has led to the description of three broad levels of intervention or three overlapping tiers. These collectively represent a continuum of interventions that increase in intensity to meet individual student needs (Miller, Eckert & Mazza 2009: 169).

This convention has been adopted by a large number of the reviewed articles in their discussion of school-based mental health programs (cf. Graetz et al. 2010; Miller et al. 2009; Kutash et al. 2006; Barrett et al. 2006: 403-405; Anderson & Doyle 2005) and the three levels are briefly described below.

#### 5.6.1 UNIVERSAL PREVENTION PROGRAMS

A majority of children are thought to never exhibit an emotional or behavioural problem that is of sufficient severity or persistence to impair their functioning or daily interactions. However, many programs and approaches are *aimed at all children in hopes of helping to prevent the onset of various emotional or behavioural challenges*. These universal prevention programs, as they are called, are provided to all children through school-wide implementation (Kutash et al. 2006: 4-5).
In commenting on these universal or whole-school approaches, Graetz et al (2010:14) note that many of them have been directed at enhancing the school environment with the aim of achieving a greater sense of belonging or ‘connectedness’ among students, since these are regarded as key ‘protective factors’ for mental health.

Another approach has been implementation of classroom-based skills programs intended to enhance students’ social and emotional skills. As such, they are interventions that are incorporated into the curriculum (Graetz et al 2010: 14).

Universal approaches also refer to elements of the so-called ‘hidden curriculum’, which aims to reinforce the desirable attitudes and counteract the undesirable attitudes to health that are taught in the explicit or formal curriculum (Stewart-Brown 2006: 7). Aspects of the hidden curriculum are described in the box below.

**The school’s hidden curriculum**

A school’s hidden curriculum includes:

- the ethos (culture) established by the atmosphere of the school and the values implicitly asserted by its mode of operation
- the school’s code of discipline and prevailing standards of behaviour
- attitudes adopted by staff towards students and the development of good relationships within the school
- the promotion of staff health and wellbeing
- the promotion of self-esteem among students.

Source: Stewart-Brown (2006: 7-8)

Multi-setting approaches expand prevention efforts beyond the school to also include the family, community, and peers (Shepard & Carlson 2003; Paternite 2005). This approach is based on an ‘ecological framework’ that emphasises the interactions and relationships among influential systems in the child’s life (school, family, community, peers).

The multi-setting model assumes that any given child outcome is determined by multiple factors interacting over time. An ecologically oriented prevention program, in contrast to a traditional or medical model, attempts to address the complex nature of children’s behaviour by developing interventions across and between systems (Shepard & Carlson 2003: 641-642).

Advantages of universal approaches include:

- Their implementation can help to reduce difficulties associated with screening for mental health problems (see further discussion on screening in section 8.5.9 of this report).
- They can reach a broad range of children and adolescents with varying levels of risk for mental health problems.
- They can reduce stigmatisation of mental illness and avoid the stigmatisation of target groups.
- They can enhance peer support.

(Sawyer et al 2010: 199; Barrett et al 2006: 403-404)

Limitations of universal programs include:

- Many programs are of limited duration and may not produce lasting changes.
Many programs have relatively small effect sizes (ie changes to the mental health and wellbeing variables that are intended to be impacted upon through the interventions).

There may be difficulty in ensuring that interventions are correctly delivered and that participants are fully engaged in all intervention components.

There is a challenge to correctly implementing interventions within the context of routine practice in schools across large geographical regions.

Many programs do not pay adequate attention to changing the school environments within which children and adolescents live their day-to-day lives despite claiming that they do.

(Sawyer et al 2010: 200)

5.6.2 SELECTED/SELECTIVE OR SECONDARY PREVENTION PROGRAMS

Some children and adolescents are at risk for the development of emotional or behavioural disorders due to personal, familial or environmental conditions. The second tier of intervention, referred to as the selected or secondary prevention level, is comprised of more intensive interventions for those students who do not adequately respond to universal interventions (Miller et al 2009: 170).

With respect to risk factors, Adelman and Taylor (2006: 296) note that the intervention focus is not only on individuals, but on conditions at home, in the neighbourhood and at school, since the primary causes for most emotional, behaviour, and learning problems are external factors related to the neighbourhood, family, school, and/or peers28.

Selective or secondary prevention programs, in addition to focusing on individual students, can combine students with similar risk factors for group interventions aimed at helping to prevent the onset of behaviour or emotional problems (Kutash et al 2006: 5). Selected programs may focus on remedial skills that are lacking in students at risk for disorders (Schaeffer et al 2005).

As noted by Elias (2003: 11), providing social-emotional assistance to children facing difficult events is a 'sound prevention strategy that also promotes better academic learning'. It is important for programs that involve selection of students to avoid stigmatisation and labelling (Anderson & Doyle 2005: 222).

5.6.3 SPECIALISED OR TARGETED INTERVENTIONS

Mental health treatments are usually employed once a child or adolescent has been identified as having a disorder or condition. These specialised individual interventions are grouped under the heading of, ‘indicated’ or ‘targeted’ interventions (Kutash et al 2006: 5; Anderson & Doyle 2005: 222). Targeted intervention is also a form of prevention - specifically tertiary prevention - which aims to prevent further difficulties or problems in those children or adolescents who have already been identified as having problems (Jordan et al 2009).

This third tier of wellbeing intervention is characterised by highly individualised and specialised programs for those students who do not adequately respond to universal and selected levels of prevention and intervention (Miller et al 2009: 170). It may include:

- the development of individual intervention plans (Stephens 2011)
- individual psychotherapy (Nicholson et al 2009)
- case management (Wyman et al 2010).

28 Risk factors may include extreme economic deprivation, community disorganisation, high levels of mobility, violence, drugs, poor quality or abusive caretaking, poor quality schools, negative encounters with peers, inappropriate peer models and immigrant status (Adelman & Taylor 2006: 296).
The advantages of targeted interventions are that they address specific risk factors and are individualised, while potential disadvantages include the need to screen students for participation and the associated potential for stigmatisation (Anderson & Doyle 2005: 222).

5.7 SUMMARY

A consistent theme in the literature is that there is a significant gap between the mental health needs of children and adolescents and the services available to meet those needs. Schools have become recognised as important locations for addressing the wellbeing needs of students, with advantages including the reach and familiarity of schools to students and family members, and the increased opportunities they provide for mental health promotion and prevention efforts in a real-world setting.

Mental health programs in schools focus on issues that include:

- the development of skills and enhancing of knowledge (often described as psychoeducation)
- improving peer relationships
- improving teacher-student relationships
- improving the ethos of the school and the development of school policies.

Many schools have adopted a health promotion focus, within which three overlapping tiers of intervention occur, namely:

- universal programs – focusing on primary prevention and including classroom-based approaches, effecting changes to the school environment as a whole, and expanding efforts beyond the school to also include the family and community
- selected interventions – more intensive interventions for students who are identified as being at risk for developing emotional or behavioural disorders
- targeted interventions – for individual students who have been identified as having an emotional or behavioural problem or a mental health disorder.

As summarised by Adelman and Taylor (2006: 295):

> A comprehensive framework for mental health intervention must address risk factors, protective buffers, and the promotion of full development related to youngsters, families, schools, and communities. Promotion of mental health encompasses efforts to enhance knowledge, skills, and attitudes in order to foster social and emotional development, a healthy lifestyle, and personal well-being.
6 Understanding and addressing the wellbeing needs of diverse groups of students

An important question in respect of school based mental health services is how to specifically tailor mental health services in order to adequately cater to a diverse student body (Friedrich et al 2010; Frisby & Reynolds 2005). What is considered mentally healthy may be similar for diverse groups of children, but what is needed to achieve this outcome may vary for different groups of children.

There has been growing evidence that supports the influence of group differences on children’s vulnerability to risk, presentation of symptomology, aetiology of disorders, access to care, response to interventions, and mental health outcomes (Friedrich et al 2010: 123). For example the needs of children in rural schools may be quite different from those of children in urban schools; and the needs of children with developmental disabilities may be different from the needs of those who are intellectually gifted.

This section briefly considers several aspects of diversity of importance in the Australian context, namely:

- Aboriginal and Torres Strait Islander students
- students from CALD backgrounds
- students with disabilities
- gender differences
- same-sex attracted youth.

6.1 ABORIGINAL AND TORRES STRAIT ISLANDER STUDENTS

Although there has been improvement in Indigenous education outcomes over the past decade, progress has been slow and significant disparities between the education outcomes of Indigenous and non-Indigenous students continue, and have been widely recognised (Doyle & Hill 2008: 27). A range of indicators are provided in the table below.

### TABLE 4 – OVERVIEW OF CURRENT STATE OF INDIGENOUS EDUCATIONAL OUTCOMES

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>INDICATORS</th>
</tr>
</thead>
</table>
| Attendance | - Indigenous students are likely to be absent from primary and secondary school two to three times more often than non-Indigenous students.  
- The gap in school attendance appears early in primary school and widens in the early years of secondary school. |
| Retention | - In 2006, the retention rate from Years 7/8 to Years 10 and 12 was 91% and 40% for Indigenous students compared to 99% and 76% for non-Indigenous students respectively.  
- Many of the Indigenous students who leave school early have poor literacy and numeracy skills and limited post-school options. |
| Student performance and achievement | - Indigenous students perform significantly below mainstream numeracy and literacy levels.  
- As Indigenous students progress through school, the proportion who achieve the national benchmark standard decreases (eg the proportion of Indigenous students who meet the national benchmark drops significantly between Year 3 and Year 7). |
| Post-secondary qualifications | - Indigenous students obtain fewer post-school qualifications than non-Indigenous students.  
- In 2003, the rate of VET module completions for Indigenous students was 65%, compared to 78% of the total VET student population.  
- Over 70% of Indigenous people aged 15 years and over have no non-school qualifications, compared to 49.5% of non-Indigenous people. |

Source: Doyle & Hill (2008: 28-32)
Factors that may impact on the education outcomes of Indigenous students are described in Table 5.

**TABLE 5 – FACTORS IMPACTING ON THE EDUCATIONAL OUTCOMES OF INDIGENOUS STUDENTS**

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>INDICATORS</th>
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</thead>
<tbody>
<tr>
<td>Social or community context&lt;sup&gt;29&lt;/sup&gt;</td>
<td>Low household income, which often means that families are not able to cover school fees and other school-based costs.</td>
</tr>
<tr>
<td>Home context</td>
<td>Low parental or family engagement with the education system</td>
</tr>
<tr>
<td>School context</td>
<td>Access to education, particularly in regional and remote communities</td>
</tr>
<tr>
<td>Student context</td>
<td>Past negative experiences of school, compounded by the experiences of parents and other family members</td>
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</tbody>
</table>

Source: Doyle & Hill (2008: 37-48)

Models and guidelines for the development of cultural competence in working with Aboriginal and Torres Strait Islanders have been developed by the Australian Psychological Association (Purdie et al 2010). The box below outlines the knowledge, values, skills and attributes that are potentially important when addressing the psychological and emotional wellbeing needs of Aboriginal and Torres Strait Islander students.

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<sup>29</sup> Drawing on data from the Australian National Survey of Mental Health and Wellbeing, Stopa et al (2010: 5) write that ‘socio-economic disadvantage is a well-known risk factor for childhood psychopathology; children from poor families are more likely to experience a range of emotional and behaviour problems’. 

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Elements of cultural competence in mental health practice with Aboriginal and Torres Strait Islanders

Knowledge

- Broad or generic understanding of the nature of ‘worldviews’ and ‘culture’, and the implications of culture for understanding human behaviour.
- An understanding of the specific cultural and historical patterns that have structured Indigenous lives in the past and the ways in which these patterns continue to be expressed in contemporary Australia.

Values

- Professionals being aware of their personal values and beliefs.
- The capacity and willingness to move away from using own cultural values as a benchmark for measuring and judging the behaviour of people from other cultural backgrounds.
- An awareness of the values, biases and beliefs built into the practitioner’s profession and an understanding of how these characteristics impact on people from different cultures.

Skills

The ability to:

- work collaboratively with a broad range of health services and providers
- incorporate the principles of culturally sensitive practice in mental health care
- engage in conflict resolution
- effectively debrief
- self-monitor.

Attributes

Developing an understanding of:

- the nature and dynamics of power as it operates in many levels from practitioner–client interactions to organisational and political systems
- the nature and impacts (on both Indigenous and non-Indigenous people) of unearned or ascribed privilege
- the nature and effects of racism at individual, institutional and ideological and discipline levels
- the history of relationships between Indigenous Australians and systems and professions
- the effects of this history on Indigenous perspectives about the professions and the extent to which each profession is constrained by the culturally constructed models and disciplinary knowledge and theories used by the profession.


The implications that may be drawn from the brief overview of the specific needs of Aboriginal and Torres Strait Islander students is that school personnel need to be aware of the factors impacting on Indigenous
educational outcomes and find ways to address those factors within the school through development and implementation of culturally competent knowledge, values, skills and attributes.

6.2 STUDENTS FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

*Educational institutions, like other host-country institutions, often unwittingly replicate minority-majority tensions and become places where exclusion and discrimination are experienced at different levels by immigrant and refugee children.*

(Rousseau & Guzder 2008: 533)

Australia is a multicultural society, with over half of the people migrating to Australia arriving from a non-English speaking country and who, together with their children, constitute 40% of the country’s population (Mitchelson 2011: 245). There is currently no reliable national or State level data describing the prevalence of mental health problems in CALD young people, but commentators suggest that the stresses involved with migration and acculturation can interact with recognised risk factors for mental health and lead to increased psychological distress (Mitchelson 2011: 245).

These problems may be particularly acute for children and young people with refugee backgrounds. Drawing on data from the *Good Starts* study conducted in Melbourne, Corres-Velez et al (2010: 16-19) find that over their first three years of settlement, refugee youths’ experiences of social inclusion or exclusion have a significant impact on their subjective wellbeing. The most important predictors are:

- subjective social status in the host community, or the degree to which they are subjected to an ‘us versus them’ mentality
- the degree to which they are subjected to discrimination and bullying.

According to Davidson et al (2008: 166), refugees settling in Australia have difficulty navigating the educational system. There is no current comprehensive national policy for the education of refugee children and adolescents and to date there has been relatively little empirical evaluation within school settings. Despite high numbers of refugee children coming to Australia with little to no formal schooling, there are no standardised interventions for these children when they enter local schools, and the experiences of children will be highly variable across teachers and schools.

The *Good Starts* study found that, while experiences in the English language schools were generally positive for the refugee children, the transition to mainstream high school was less positive. Many of these adolescents experienced a decrease in perceived achievement, a lack of support from teachers and a significant increase in experiences of discrimination (Gifford et al 2009: 15).

Most refugee children are entered into age-appropriate classrooms, regardless of their prior schooling experience, knowledge or educational performance (Davidson et al 2008: 166). This results in major obstacles for students, particularly for those entering at higher levels of the school system. Additional challenges arise when the physiological effects of trauma and interactions with peers affect refugee children’s school performance. Symptoms associated with experiences of trauma may include difficulty concentrating, memory disturbances, anxiety and depression. Emotional problems have been shown to be related to these children’s learning difficulties and academic achievement. (Davidson et al 2008: 166).

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30 Between 2003 and 2007, 16,290 young people aged 10–19 with refugee backgrounds settled in Australia (Gifford et al 2009).

31 The *Good Starts* study was a longitudinal study carried out between 2004 and 2008 (Gifford et al 2009). It investigated the experiences of settlement among a group of 120 recently-arrived young people with refugee backgrounds settling in Melbourne. Young people were recruited through three English language schools (median age 15 years and the young people had an average of 5.7 years of schooling prior to arrival). The study aimed to identify the psychosocial factors that promote successful transitions during the settlement process, and describe in depth the contexts, settings and social processes that promote health and wellbeing among young refugees over time (Gifford et al 2009).
A range of interventions that can contribute to healing and growth for children affected by trauma are described in the box below.

### Three ‘Pillars of Safety’ for Children affected by Trauma

#### Safety

The first imperative in working with traumatised children is creating a safe place for them. This includes carer attributes such as consistency, reliability, predictability, availability and honesty.

#### Connections

The qualities of the therapeutic relationship are more important than the specific therapeutic techniques that are used. Since traumatised children have learned to associate adults with negative emotions, the task is to help restructure these associations so that the children can develop positive emotional responses.

#### Emotion and impulse management

The most pervasive and far-reaching impact of complex trauma is the ‘dysregulation of emotions and impulses’. A primary focus of work with traumatised children needs to be on teaching and supporting them to learn new ways of effectively manage their emotions and impulses. The teaching of self-regulation skills includes using basic skills of active listening, consciously labelling troublesome emotions, teaching a range of emotional management skills and other approaches that promote the use of rational processing.

Source: Bath (2009: 5-7)

Describing the situation in Australian schools, Mitchelson notes that although a number of programs have been developed to target resilience in children and young people as a means of mental health promotion (several of these programs are described in sections 7 and 8 of this document), there are few that have been specifically designed for CALD children and young people. In order to address this gap, the BRITA Futures resilience-building program was designed in Queensland and has also been adopted in other States and Territories - it is described in section 7.5.7 below.

Recommendations for addressing refugee children’s diverse personal and educational needs within the school system include:

- using play and artistic expression to help migrant children to construct meaning and identity and to come to terms with trauma
- engaging bilingual classroom assistants
- promoting parent ties to the school
- recognising the unique contributions that immigrant and refugee children can provide within the classroom by facilitating cultural exchange and understanding
- addressing gaps in mainstream and youth services in meeting the sexual and reproductive health needs of immigrants and refugees.

(Rousseau & Guzder 2008: 543-546; Davidson et al 2008: 166; Gifford et al 2009: 110)

Schools can also support students by linking them with other support services in the community. In NSW, for example, the NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) provides a range of services including:

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32 This is based on work carried out in Darwin by Howard Bath and associates (Bath 2009).
- psychiatric assessment
- individual counselling
- youth programs
- community development programs.

(Aroche & Coello 1994)

Multicultural Mental Health Australia (MMHA) is another service that can be accessed by members of CALD communities. MMHA actively promotes the mental health and wellbeing of Australia’s diverse communities through ‘partnership with the Australian mental health sector, transcultural mental health and refugee services and networks, federal, state and territory governments as well as the community’ (Multicultural Mental Health Australia 2010: 3).

6.3 STUDENTS WITH DISABILITIES

The ABS 2003 Survey of Disability, Ageing and Carers found that around 8%, or 317,900, children aged 0–14 years had a disability; the prevalence of a disability increased from 5.3% in 1981 to 8.3% in 2003; boys were more likely than girls to report disability (10% and 7%, respectively); and the most prevalent disabilities among children were intellectual/learning disabilities, reported for an estimated 166,700 children (4.3%), and physical/diverse disabilities, reported for an estimated 162,800 children (4.2%) (AIHW 2009: 24-25).

In NSW, the term ‘students with a disability or additional learning needs’ is used to refer to those students who may require additional support at some time in their schooling due to a disabling condition (NSW Government 2010: 7). Students with disabilities are increasingly enrolled in mainstream classrooms in many countries, including Australia, under the policy of inclusion (O’Neill & Stephenson 2010: 65). The NSW Government supports education for students with a disability or additional learning needs directly through the NSW DEC, and more than 76% of students with a disability or additional learning needs in NSW are supported in Government schools33 (NSW Government 2010: 5).

As outlined in section 4.4.1, there has been a change in the profile of students receiving additional support in NSW Government schools over recent years and in particular, a sharp increase in the number of students identified with autism or mental health disorders as their primary disability. While the incidence of intellectual and physical disability has remained fairly constant between 2003 and 2008 and the incidence of sensory disability has fallen by 8%, the incidence of mental health disorder and autism has increased by 36% and 88% respectively over the same period (NSW Government 2010: 19-22).

There has also been a 76% increase in NSW Government expenditure on students with a disability or additional learning needs attending Government schools (from over $600 million in 2003/04 to more than $1.1 billion in 2009/10), representing a 10% average yearly increase over this period (NSW Government 2010: 25).

Reasons provided for these changes include:

- reduced numbers of children with some disabilities and increased survival rates of infants with other conditions due to changes in medical practices

33 In NSW Government schools in 2009:
- more than 16,000 students with a confirmed disability were supported in regular classes in regular schools
- more than 13,000 students with a confirmed disability or additional learning or behavioural needs were supported in 1,690 support classes in regular schools
- more than 4,000 students with a confirmed disability or additional learning or behavioural needs were supported in 620 support classes in special schools
- more than 50,000 students in mainstream classes experiencing difficulties in learning were supported by 1,387 specialist teachers across the state
- 1,225 Government school students with a disability were enrolled in TAFE-delivered Vocational Education and Training (TVET).

(NSW Government 2010: 14)
- increased awareness of certain conditions leading to increased diagnoses of different types of disability and mental health disorders
- increased incidence of mental health disorders and autism spectrum disorders across the community (also reflected in international data) and increased incidence of certain disabling conditions (such as foetal alcohol spectrum disorders) which lead to physical and/or cognitive impairment.

(NSW Government 2010: 22)

Students with disabilities (particularly intellectual disabilities) may have additional mental health problems. For example, Dossetor (2011) writes that 30-50% of children and adolescents with intellectual disability have significant mental health problems. Students diagnosed with emotional and behavioural disorders have been described as the most challenging students with disabilities in mainstream classrooms (O’Neill & Stephenson 2010: 65).

Llewellyn and Leonard (2009: 6) point to the importance of family to children and young people with disabilities, but note that a critical issue to be addressed is the examination of health and wellbeing from the perspective of young people with disabilities in their own right. This is contrary to a perspective which views the child or young person’s identity and wellbeing primarily through the lens of their ‘condition’, whereas issues such as access, environment and participation/inclusion are critically important to their wellbeing.

6.4 GENDER DIFFERENCES

Research indicates that gender plays a significant role in the prevalence rates of psychopathology from early childhood to adolescence (Friedrich et al 2010: 124).

During the preschool and elementary years, boys are overwhelmingly identified as exhibiting more significant adjustment problems than girls. These problems primarily relate to externalising behaviours, including conduct disorder, physical aggression, and attention deficit hyperactivity disorder (ADHD). Boys are three to ten times more likely than girls to experience psychopathology during this developmental period (Friedrich et al 2010: 124).

In adolescence, adjustment problems are more equally distributed across both genders although the types of problems that are most common differ by gender. Boys outnumber girls in manifesting physical aggression and violence (externalising problems); girls outnumber boys in manifesting internalising disorders such as eating disorders, anxiety, and depression. Adolescent females are more than twice as likely as males to become anxious and/or depressed and female students are also significantly more likely than male students to have considered, planned, and attempted suicide. In contrast, because they use more lethal means, adolescent boys are four times more likely than adolescent girls to complete suicide (Friedrich et al 2010: 124).

Gender differences also emerge with respect to students’ responses to mental health and wellbeing interventions. Studies find that girls are consistently more positive in their responses to these programs, and boys additionally have more negative self-perceptions and attitudes towards school as a whole (Hallam 2009: 329).

Other gender differences that have been measured in the course of studies examining the effectiveness of mental health and wellbeing programs are discussed in section 9 of this report.

6.5 SAME-SEX ATTRACTIONED YOUTH

Research points to a range of negative emotional consequences associated with being either an open or ‘in the closet’ same-sex attracted adolescent, including:

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34 Dossetor also notes that there are difficulties in diagnosing mental health problems in people with intellectual disability, which is one reason for the wide variability in estimates of comorbidity. For example, people with intellectual disability have difficulty articulating abstract or global concepts such as depressed mood, because of limited cognitive and verbal skills (Dossetor 2011: 3).
• social stigmatisation and isolation
• internalised homophobia
• depression
• substance abuse
• poor school performance
• violence and victimisation.

(Kayler et al 2008: 4)

There have been numbers of studies which have identified wellbeing issues facing same-sex attracted youth in schools, including:

• 7.5% of students in Grades 7-11 in a 2004 California study reported having been bullied because of their actual or perceived sexual orientation.

• A large UK survey with same-sex attracted youth in secondary and further education (N=1,145) found that 65% said they had been bullied within the public school system, with the figure rising to 75% among students attending faith-oriented schools.

• A range of studies have found that where there is little or no support from family members, there is an increased risk of emotional disturbance (eg low self-esteem), sexual health risk behaviours and suicide attempts (up to three or four times more often than their heterosexual counterparts).

• An Australian study found that there is a relationship between a negative school climate and truancy behaviour and academic outcomes for same-sex attracted youth.


In a study carried out in the UK, Rivers and Noret (2008) compared the wellbeing of 53 students who reported being solely or primarily attracted to members of the same sex with 53 matching peers who reported being attracted solely to members of the opposite sex. The researchers found greater evidence of loneliness and hostility towards others amongst the same-sex attracted youth compared to their peers, along with reports of occasional drinking alone. On the basis of this study, they suggest that ‘the management of reactive aggression or hostility toward others may be a key determinant of healthy gay, lesbian and bisexual development’ (Rivers & Noret 2008: 174).

The development of a sense of identity is perhaps the key developmental task of adolescence, and this task is ‘significantly more complicated for same-sex attracted youth because they must develop an ‘achieved’ identity within the context of social stigmatisation and, many times, without the support of family, peers and schools’ (Kayler et al 2008: 6). They must also ‘manage hidden identity status, resulting in elaborate efforts to pretend to be something other than what they are’ (Hohnke & O’Brien 2008: 70).

One model of sexual identity development, namely the Cass model, is described in the box below.

#### Cass model of sexual identity development

The Cass model of sexual identity development, which includes six stages, may take years through which to progress. The stages are as follows:

1. **Identity confusion**, including the clandestine search for information and denial.
2. **Identity comparison**, including incongruence between same-sex attraction and the predominant view of self as having an opposite-sex attraction.
3. **Identity tolerance**, including the need to seek out the company of other same-sex attracted individuals.

4. **Acceptance**, including exploring ‘coming out’ issues and the loneliness and alienation that may accompany this.

5. **Pride**, including clashes with institutionalised heterosexism in school settings.

6. **Synthesis**, which is usually rare for an adolescent to achieve, and is generally experienced in adulthood.

Source: Kayler et al (2008: 10-14)

School counsellors can play a pivotal role in the support and wellbeing of same-sex attracted youth within the school environment, including:

- being available as a source of support, while not assuming that a same-sex attracted student necessarily wants to discuss issues related to her/his sexual orientation

- providing formalised education programs

- carrying out research into the nature, incidence and prevention of school-based harassment

- consistent intervention and interruption of incidents of harassment

- influencing the overall school climate by promoting issues of social justice for all students

- developing an understanding of sexual identity development, including the ‘stages’ through which same-sex attracted individuals might move (such as in the model described above)

- establishing school-based support groups for ‘gay and lesbian students and their allies’.

(Hohnke & O’Brien 2008: 71-72; Kayler et al 2008: 14)

### 6.6 SUMMARY

School-based mental health personnel need to be acutely aware of the diversity in the student body, and sensitive to the possible ways in which these differences may impact on students’ mental health and wellbeing, and therefore on academic achievement.

Key issues in working with Aboriginal and Torres Strait Islander students include gaining knowledge and awareness of the factors that may impact upon the educational outcomes of students (such as past negative experiences of school) and the effects of racism at the individual, institutional and professional levels. These understandings are also important when working with CALD students. In addition, school staff need to be aware of issues such as the impacts of trauma on students with refugee backgrounds.

Students with disabilities are integrated to a large extent into mainstream schools usually with a range of additional supports provided to enable them to function well in the mainstream settings. It is important not to view the identity and wellbeing of such students primarily through the lens of their ‘condition’.

Gender and sexuality are also key areas to focus on in working with students. It is important to recognise the differences boys and girls have with regard to development and adjustment problems. Working with

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35 Australian researchers Hohnke and O’Brien (2008: 68) describe schools as often ‘intensely heterosexist institutions, where a presumption of heterosexuality dominates both the classroom and the playground…and compulsory heterosexuality is perpetuated and actively promoted through the school’s provision of the “hidden curriculum” (see discussion of the ‘hidden curriculum’ in section 5.6.1 of this report). Heterosexism is also perpetuated through implicit or explicit prejudice, discrimination or acts of violence against sexual minorities.

36 An Australian example of such a program is the *Out with Homophobia* workshop developed by Family Planning Queensland, which attempts to inform and train school staff in meeting the challenge of addressing homophobic bullying and harassment issues in their school environment (Hohnke & O’Brien 2008: 73).
same-sex attracted youth requires understandings of the nature, incidence and prevention of school-based harassment and of sexual identity development.

A crucial underlying step towards the development of effective specialised programs for identified groups of students is the training and professional development of the teaching and other school-based staff who are working with them in order to enhance their abilities to respond in specific ways to the wellbeing needs of these students.

In the sections which follow, school-based mental health programs are described, and research is drawn upon to evaluate their effectiveness. The focus (in the writing) is on interventions to promote some aspect of positive mental health and social and emotional wellbeing (following definitions of mental health and social and emotional wellbeing described in sections 3 and 4 of this document).
7    Models of working with children and young people in educational settings in Australia

7.1    INTRODUCTION
This section provides a description of school-based models to support the psychological-emotional development and mental health of students in NSW and the other Australian States and Territories. Following the conventions in the literature, interventions to prevent violence and aggression are generally included when discussing mental health programs because violence and aggression are mentally unhealthy, may be manifestations of a mental health problem, are conducive to disorder, and have a well-recognised effect on the mental health of others (Stewart-Brown 2006: 9). These include anti-bullying programs.

In addition, programs focusing on suicide prevention, programs focusing on body dissatisfaction (including body image, overweight and eating disorders), and programs focusing on substance use are briefly included since the research generally includes these as mental health topics.

The Australian Government's National Framework for Health Promoting Schools has provided a unifying policy framework for all States and Territories (Department of Health and Families 1999). In keeping with the 'health promoting schools' international initiative promulgated by the WHO (described in section 5.5 of this document), there is recognition that schools are a key setting for improving the health and wellbeing of students and the broader school community (Wyn 2007; Department of Health and Families 1999)37.

The National Safe Schools Framework provides a vision and a set of guiding principles for safe and supportive school communities that also promote student wellbeing and develop respectful relationships (MCEECDYA 2011: 2). The Framework acknowledges that student safety and wellbeing are enhanced when students:

- feel connected to their school
- have positive and respectful relationships with their peers and teachers
- feel confident about their social and emotional skills
- feel satisfied with their learning experiences at school.

(MCEECDYA 2011: 2)

The elements and key actions of the National Safe Schools Framework are described in the box below.

37 The vision of the Framework is that ‘all children in Australia will belong to school communities which are committed to promoting lifelong learning, health and well-being’ (Department of Health and Families 1999: 14). The framework has the following characteristics:

- a broad and inclusive view of health that acknowledges the importance of mental health promotion
- an emphasis on creating an environment that has the best possible impact on health
- an integrated whole-school approach that recognises that a range of interconnected factors can have an influence upon students’ health.

(Department of Health and Families 1999)
<table>
<thead>
<tr>
<th>Elements of the National Safe Schools Framework</th>
<th>Examples of key actions and practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership commitment to a safe school</strong></td>
<td>- The development and communication of a clear vision for a safe, supportive and respectful school, including actions that encourage staff to commit to the vision and to feel confident about their participation in its implementation</td>
</tr>
</tbody>
</table>
| **Supportive and connected school culture**   | - Teaching, staff modelling and promotion of explicit pro-social values and expectations for behaviour in accordance with these values  
- Parent and carer connectedness to the school  
- A focus on staff wellbeing and safety |
| **Professional learning**                      | - Ongoing professional learning about emerging changes in research and technology related to student safety and wellbeing  
- The inclusion of non-teaching and casual, specialist and visiting staff in relevant professional learning opportunities |
| **Positive behaviour management**             | - Careful selection of evidence-informed positive behaviour management approaches that align with the school community’s needs  
- Effective risk prevention plans for student behaviour management during off-campus and school-related out-of-hours activities |
| **Engagement, skills development and safe school curriculum** | - A strong focus on the enhancement of student engagement with learning  
- Teaching of skills and understandings to promote cybersafety and for countering harassment, aggression, violence and bullying |
| **A focus on student wellbeing and student ownership** | - Defined structures and strategies for enhancing student wellbeing  
- Provision of multiple opportunities for students to develop a sense of meaning and purpose  
- Adoption of strengths-based approaches to student learning and participation  
- Provision of a range of opportunities for student ownership and decision-making, student voice and peer teaching |
| **Early intervention and targeted student support** | - Effective processes for the early identification of students and families who need or could benefit from additional support  
- Ongoing and follow-up support to individual students and families in times of need |
| **Partnerships with families and community**  | - Working collaboratively with parents and carers by providing opportunities for education on issues relating to student safety and wellbeing  
- Working with community organisations to extend support to students and families as needed |

Source: MCEEDYA (2011: 4-7)
7.2 STUDENT SERVICES FOCUSING ON WELLBEING AND MENTAL HEALTH IN NSW SCHOOLS

7.2.1 BROAD RANGE OF APPROACHES FOCUSING ON WELLBEING

According to a 1996 Student Welfare Policy Manual for NSW Government schools, student welfare ‘encompasses everything the school community does to meet the personal, social and learning needs of students’ and includes ‘the total school curriculum and the way it is delivered’ (NSW Department of School Education 1996: 4).

At a more specific level, a range of student welfare services are available within and to schools, including the following:

- **Resources for children with disability** – Children with special learning needs and/or disability are able to access specialist resources through their schools. Students with confirmed disability may be enrolled in regular classes, support classes in regular schools or special schools. Students who experience difficulties in basic areas of learning are supported through the Learning Assistance Program in their local school. In addition, Learning Support Teams assist classroom teachers to address the educational needs of students with a disability, learning difficulty or behaviour disorder [NSW Department of Education and Communities (NSW DEC), n.d.].

- **Resources for children with behaviour problems** – Programs are available that focus on bullying, student mentoring and specialist support for students with disruptive behaviour. For example, with regard to student mentoring, there is recognition that the presence of a caring adult may be important in assisting students to overcome adversity and to achieve at school. Mentoring seeks to provide such a presence by establishing a trusting relationship between student and mentor that: focuses on the needs of the student; models and fosters caring and supportive relationships; and develops active community partnerships [NSW Department of Education and Training (NSW DET) 2005: 3].

Another example is the Positive Behaviour for Learning program, which has been introduced into schools in the Western Sydney region since 2005 (Mooney et al 2008)\(^\text{38}\). The program encourages schools to manage student behaviour by gathering observational data and evaluating specific outcomes on the basis of the data collected. It aims to equip schools to identify and teach behaviours that they have determined are appropriate for their students (Mooney et al 2008: 2-4).

- **The role of the school community in supporting student health** – School programs protect and promote student health and safety, and support individual students who need help with health issues (such as through providing first aid and temporary care). Government schools also cooperate with NSW Health on public health issues such as immunisation and responding to disease outbreaks (NSW DEC n.d.). The School-Link initiative, which represents collaboration between the health and education sectors in NSW, is described in greater detail in section 7.2.4 below.

- **Peer mediation** – Schools seek to empower students by teaching them the skills to resolve conflict in non-violent ways. Within the context of peer mediation, one or two students trained in mediation lead other students through a structured process to resolve a dispute. As an early intervention strategy, peer mediation can play a part in reducing violence, truancy and vandalism in schools (NSW DEC n.d.).

- **The role of the NSW Department of Education and Communities in child protection** – A Child Wellbeing Unit (CWU) has been established in the Department in order to promote the safety and wellbeing of children and young people in collaboration with other government departments (such as the NSW Police Force). The CWU is comprised of three teams, each with seven Assessment Officers which includes an Aboriginal Assessment Officer. There is also a Child Wellbeing Consultant (Senior Psychologist) employed within the Unit. Responsibilities include those related to the mandatory reporting of suspected child abuse and working with other agencies (such as Community Services) over time to enable better responses to children and families in need of assistance (NSW Government n.d.).

\(^{38}\) The Positive Behaviour for Learning program is based on the Positive Behaviour Interventions and Supports (PBIS) program developed in the USA (Mooney et al 2008).
• **Out of Home Care Program** – A range of services are provided to support the health and wellbeing of students who are in out of home care (e.g., foster care). The ‘Out of Home Care in Government Schools’ policy has been developed to clarify the roles of principals and other staff in supporting such students and NSW DEC works with other statutory organisations in relation to the provision of educational services for children and young people in out of home care (NSW DEC n.d.).

A range of whole-school primary prevention and early intervention programs may be adopted in schools, including *MindMatters* and *KidsMatter*. Several of these programs are described in section 7.5 below.

### 7.2.2 SPECIALISED SUPPORT FOR CHILDREN WITH A DISABILITY OR SPECIAL NEED

NSW provides a wide range of programs and initiatives to support children and young people with disability or special need, including a diagnosed mental health disorder, within the school system. These are briefly described next.

**CURRICULUM AND STAFFING**

The needs of many of students with disability and/or mental health disorders, especially those with relatively high support needs, are met using a staffing model where students are taught by either one, or a small number of consistent staff (NSW Government 2010). Special classes in regular or special schools provide this model.

In regular classes, students are provided with additional support through the Integration Funding Support program (NSW Government 2010). Funds through this program may be used in a range of ways to meet the learning outcomes identified for the student, such as for additional teacher time, teacher training, teacher release for programming, and school learning support officer time. In 2009, more than 16,000 students with a disability accessed this program.

**SCHOOL LEARNING SUPPORT TEAM**

School learning support teams are formed with the purpose of addressing the learning support needs of individual and groups of students through the coordination, development, implementation, monitoring and evaluation of educational programs (NSW Government 2010: 39). Membership of the learning support team is determined by each school according to local needs, although the team usually includes:

- a team facilitator (usually a member of the school executive)
- school counsellor
- teacher representatives
- specialist personnel (for example, specialist teachers in learning assistance, English as a Second language (ESL), Reading Recovery). Other personnel, including school learning support officers, and parents and carers participate as necessary. Participation will vary according to the needs of the school and function of the team at a particular time.

**SCHOOL LEARNING AND SUPPORT COORDINATORS**

Since the beginning of 2009, school learning support coordinators have been employed in 265 schools across the State to focus on students’ learning needs. These specialist teachers provide support for classroom teachers and students at the point of need (that is, as soon as any difficulty is noticed). The support takes account of the diverse learning history of students, the skills and support needed by the classroom teacher and the wider school community, and includes the promotion of a learning support network across a community of schools (NSW Government 2010: 41).

**SPECIALIST ITINERANT SUPPORT TEACHERS**

Specialist itinerant support teachers provide practical support to students with a disability and their teachers. These specialist teachers have expertise in areas such as autism, integration, transition, vision, hearing and behaviour.
LEARNING ASSISTANCE PROGRAM
Established in 2004, this program assists students enrolled in mainstream classes from Kindergarten to Year 12 who are having difficulty in literacy, numeracy or language, regardless of the cause (NSW Government 2010: 40).

BEST START KINDERGARTEN ASSESSMENT
The Best Start Kindergarten Assessment identifies the learning needs of every student during the first year of schooling and helps to identify students with additional support needs. The goal of the program is to reduce the need for more intensive programs in future years.

7.2.3 SUPPORT PROVIDED TO ABORIGINAL STUDENTS WITH A DISABILITY OR SPECIAL NEED
Specific support is provided to Aboriginal students with a disability or special need, as described in the box below.

Programs specifically designed for Aboriginal students with a disability or special need in NSW schools

- Aboriginal Education Officers provide assistance to Aboriginal students, parents and teachers. This includes working with teachers in the classroom to support Aboriginal students to engage with classroom activities, supporting parents to become involved in the school, and ensuring that appropriate learning supports and equipment are in place where necessary.

- The Aboriginal Early Language Development Program, which operates in 24 schools, aims to reduce the number of Aboriginal students in support classes for children with a disability. The K-4 program provides targeted support for Aboriginal children whose speech has been affected due to health related issues such as otitis media or conductive hearing loss.

- The Norta Norta Program funds schools to provide learning assistance for Aboriginal students in Years 4, 6, 8 and 10; tutorial assistance for senior Aboriginal students; independent Learning Hubs for Aboriginal students from K-12; and tutoring/mentoring/leadership programs for Aboriginal students in middle and senior years.

- The Schools in Partnership programs provide funds to help schools achieve learning outcome targets for Aboriginal students in literacy and numeracy results, school retention and school attendance.

- Personalised Learning Plans are developed in collaboration with students, parents/carers and include targets for learning against syllabus outcomes and agreed family support strategies. Additional services needed to support students with a disability or special needs are articulated in the Personalised Learning Plan and agreed to by all involved. Personalised Learning Plans for students with a disability need to include specific information related to transition, future pathways and cultural identity.

- Additional federal funding is available for teacher and Indigenous education assistant relief, involvement of local Aboriginal community members in school matters, and planning for improved educational outcomes for all Aboriginal students within funded schools.

Source: NSW Government (2010: 43-44)

7.2.4 JOINT EDUCATION AND HEALTH INITIATIVES
In addition to intervention carried out within schools, mental health intervention may also occur on the basis of collaboration between the education and health systems in a given jurisdiction. For example, the NSW School-Link Initiative, launched in 1999 by the NSW Government, aims to improve the mental
health of children, adolescents and young people in NSW (Maloney et al 2008). The Centre for Mental Health (NSW Health) in collaboration with the NSW Department of Education and Communities provides the School-Link Initiative with statewide coordination and leadership. 39

School-Link provides a framework and structure to support child and adolescent mental health services and schools in working collaboratively to promote mental health, and facilitate the early identification, management and support of students with mental health problems (Maloney et al 2008: 48).

Aiming to improve the mental health of children and young people in NSW, School-Link has three main areas of focus:

- Assisting in strengthening formal and informal links at local and area level between schools (and other educational institutions such as TAFE) and Area Health Service Mental Health services for children, adolescents and young people.

- A training program for mental health workers and school counsellors to enhance skills in the recognition, intervention planning, treatment, support and prevention of mental health problems in children and young people.

- Supporting the implementation of programs in schools for the prevention of or early intervention in mental health problems, such as the Resourceful Adolescents Program and MindMatters (both described in greater detail in section 7.5 of this document).

(Maloney et al 2008: 48; NSW Government 2010 Memorandum of Understanding)

A specific School-Link initiative has been developed by the Children’s Hospital at Westmead. Known as CHW School-Link, the initiative has been funded to support the mental health needs of children and adolescents with an intellectual disability. It focuses on:

- assisting in the pathways to care for students with mental health problems and disorders

- supporting the implementation of school-based mental health promotion, prevention programs and early intervention programs

- the training and education needs of school counsellors

- building local partnerships, raising awareness with various stakeholders and increasing education and support for relevant staff and clinicians.

(CHW School-Link 2011)

7.2.5 SCHOOL COUNSELLORS IN NSW SCHOOLS

School counsellors have been employed in NSW Government schools since 1935 (Donnelly 2006: 8). They have qualifications in both teaching and psychology, are school-based and have teaching hours and conditions [Australian Guidance Counselling Association (AGCA) 2008].

The major function of school counsellors is to provide a counselling and psychological assessment service to students with specific support needs, although all school students from pre-school to Year 12 are able to access the service (Parliament of NSW 2009: 28) 40. The school counselling service potentially has a role to play in each of the student welfare services briefly described above.

39 The School-Link initiative directly addresses two key recommendations of Mental Health of Young People in Australia: Child and Adolescent Component of the National Survey of Mental Health and Well-being (Sawyer et al 2000, cited in NSW Institute of Psychiatry n.d.), namely to ensure that school-based counsellors are properly trained in the assessment and management of young people’s mental health problems and that they are closely linked to specialised mental health services. The NSW School-Link Initiative is implemented across NSW by a number of School-Link Coordinators and other School-Link staff, located in the Area Health Services.

40 According to Donnelly (2006: 8), the 800 school counselors in NSW schools in 2005 provided services to 1,600 primary schools and 400 secondary schools and Schools for Special Purposes.
The work of school counsellors includes:

- counselling students who seek help for issues such as worrying about school work, conflict with friends or being in trouble at school
- responding to grief, loss, trauma and other child and adolescent issues
- assisting parents or carers who seek advice about their child’s school progress, educational options and behaviour, and supporting parents
- assessing students’ learning and behaviour through educational and psychiatric assessment, with the consent of parents/carers being required before any psychological testing is undertaken
- assisting schools to identify and address disabilities that affect students’ learning
- liaising with other services that are concerned with the wellbeing of students and providing a source of expertise for the school around particular issues and connections with local services
- managing and contributing to the school’s response to critical or serious incidents 41.

(NSW DET, n.d.; Parliament of NSW Committee on Children & Young People 2009; Donnelly 2006)

School counsellors also have particular training and skill development in the management of risk of harm incidents, including suicide 42 (Donnelly 2006).

According to 2009 figures, there are 790.8 full time equivalent school counsellor positions in the NSW Government school system (NSW DET 2009). These school counsellor positions are allocated to regions on the basis of need, taking into account issues such as the number of students with a disability who have significant support needs and indicators of socio-economic disadvantage.

Teams of school counsellors receive professional supervision/support from District Guidance Officers. All District Guidance Officers in a region receive professional supervision and support from a Principal Education Officer (AGCA 2008).

ISSUES THAT HAVE BEEN RAISED WITH RESPECT TO THE NSW SCHOOL COUNSELLING SERVICE

Submissions to the Inquiry into Bullying in NSW highlighted the importance of having access to counsellors at school, mentioning the need to provide more counsellors to ensure that counsellors are always available to students 43. Stakeholders to the Inquiry noted that the vast majority of counsellors spend their time on clinical assessment, leaving little time for crisis intervention and/or proactive counselling (NSW Parliament Legislative Council General Purpose Standing Committee No. 2 2009: 95).

Similarly in the recent Inquiry into the Status and Needs of Children Aged 9-14 years (Parliament of NSW Committee on Children and Young People 2009), it was also noted that school counsellors spend the

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41 In NSW a serious or critical incident in a Government school is described as an event which:
- causes disruption to the organisation
- affects individuals within the organisation
- impacts negatively on the effective operation of the workplace
- attracts negative media attention or a negative public profile for the NSW DEC.

42 The NSW Government’s whole-of-government approach to suicide prevention is contained in the NSW Suicide Prevention Strategy 2010-2015 (NSW Health 2010).

43 As noted in section 1 of this report, the Inquiry into Bullying of Children and Young people provided recommendations that supported the review of school counseling services, of which this study is a part.
bulk of their time doing assessments, with less available time to engage in provision of preventive and support services. Stakeholders to this Inquiry commented that counsellor interventions tended to be provided in response to crisis situations linked to children with behavioural issues, and that this (the perception that counselling was for students with poor behaviour) served as a discouragement to other students in accessing the counselling services (Parliament of NSW Committee on Children and Young People, 2009: 56).

In NSW, there is an average counsellor/student ratio of 1:1,050, and school counsellors typically also provide services to the feeder primary schools of the high schools in which they are based (Parliament of NSW, 2009:55). The NSW Commission for Children and Young People has recommended that the current counsellor/student ratio of 1:1,050 be improved to 1:500 (Parliament of NSW 2009: 55). The Inquiry into Bullying noted that the requirements for all school counsellors to have psychology degrees and teaching experience limited the number of potential counsellors available to schools (NSW Parliament Legislative Council General Purpose Standing Committee No. 2 2009).

### 7.3 STUDENT WELLBEING SERVICES IN THE OTHER STATES/TERRITORIES

#### 7.3.1 VICTORIA

Victoria has a range of programs that are designed to support the welfare and wellbeing of school-aged children and young people (Victorian Auditor-General’s Office 2010). These are:

- **Student Support Services Program** – This program aims to help vulnerable students by giving them access to student support services staff. The staff within the program comprises psychologists, guidance officers, speech pathologists, social workers and visiting teachers. The Victorian Department of Education and Early Childhood Development (DEECD) administers the program through nine regional offices.

- **Primary Welfare Officers Initiative** – This initiative aims to assist schools’ ability to support students at risk of disengagement who are not achieving their educational potential. Approximately one-third of schools teaching primary aged children receive funding from this program on a needs basis. Schools administer the program and select staff to meet their needs from professionals, including teaching staff, social workers, nurses, counsellors and psychologists.

- **Student Welfare Coordinators Initiative** – This initiative aims to help students handle issues such as truancy, bullying, drug use and depression. DEECD provides funding for all Government secondary schools to employ student welfare coordinators. Schools administer this initiative.

(Victorian Auditor-General’s Office 2010: 3)

In addition, the following programs are available to school students in Victoria:

- **School Focused Youth Service** - Established in response to the Victorian Government Suicide Prevention Taskforce. DEECD funds local government, community health and youth service organisations to manage the program, which support children and young people who are vulnerable and at risk of disengagement from school.

- **Primary School Nursing Program** - The program is offered to all children attending primary and English Language Centre schools in Victoria. The aim of the program is to provide all Victorian children the opportunity to have a health assessment, to link children, families and school communities to services available in the community, and to provide information and advice that promotes health and wellbeing.

- **Secondary School Nursing Program** - The program aims to improve the health and wellbeing of young people, reduce negative outcomes, and minimise risk-taking behaviour. DEECD funds the
employment of 100 nurses across 199 schools, which is administered through its nine regional offices.

(Victorian Auditor-General’s Office 2010: 3-4)

As can be seen from the brief description above, a feature of the system in Victoria is that there is a range of specifically funded programs and initiatives, and it is within the context of these programs and initiatives that personnel such as social workers and psychologists are employed.

7.3.2 SOUTH AUSTRALIA (SA)

OVERALL POLICY DIRECTION IN SA

South Australia has developed an overarching policy direction to guide its approach to child and youth (learner) wellbeing. The SA DECS Learner Wellbeing Framework for Birth to Year 12 has the following aims:

- promotion of a common understanding, consistent approaches and shared commitment to the development of learner wellbeing
- providing a strategic framework to connect initiatives, projects, policies and practices
- encouraging the participation of leaders, educators, learners, parents and other partners
- assisting sites to identify learners whose wellbeing may be at risk and allocating appropriate support
- promoting collaborative and cross-agency pathways of support to improve wellbeing.

(South Australian Department of Education and Children’s Services [SA DECS] 2007: 3)

The SA DECS Learner Wellbeing Framework is linked to the South Australian Curriculum Standards and Accountability Framework, and assists sites to develop a range of policies, programs and projects that equip learners to enhance their wellbeing, including:

- health promotion initiatives
- mentoring/buddying
- behaviour management
- individualised learning plans
- child protection
- drug strategies.

(SA DECS 2007: 12)

SPECIALIST MENTAL HEALTH/WELLBEING STAFF

The South Australian education system has a range of mental health professionals, namely:

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44 In keeping with many other frameworks that have been developed for child and youth wellbeing (see section 3 and Table 1 above), the South Australian framework identifies five dimensions to wellbeing, which are seen to collectively ‘provide learners with resilience and confidence in their ability to influence their world’ (SA DECS, 2007:5). The dimensions, and some of the aspects of these dimensions, are the following:

- cognitive – information processing, memory, curiosity, persistence, thinking, intelligence
- emotional – coping, self-development, trust and attachment
- physical – nutrition, physical safety, preventive health care
- social – parent-child relationships, sibling relationships, peer relationships
- spiritual – beliefs, values and ethics, altruism, a sense of connectedness to something larger than oneself.
- guidance officers who work predominantly in schools
- psychologists who work primarily in pre-schools
- school counsellors who are employed in many primary and all secondary schools; all are teachers, many of whom have no formal training or qualifications in counselling or psychology

(AGCA 2008)

In addition to the above mentioned mental health/wellbeing staff, South Australia engages Interagency Behaviour Support Coordinators who support schools by:

- providing advice on the implementation of the School Discipline Policy and the Suspension, Exclusion and Expulsion procedures
- working with government and non-government agencies to develop programs for students with significant behavioural problems
- ensuring schools are supported in exclusion procedures and that advice is provided in the alternative placement of students with significant behavioural difficulties
- extending the expertise of staff in working with students with significant behavioural difficulties through collaborative development of strategies, and provision of training and development in effective approaches to student behaviour management
- supporting sites in seeking direct support to assist with the management of students with significant behavioural difficulties either in the school or through out of school support programs.

(SA DECS nd.)

7.3.3 QUEENSLAND

A range of support personnel are employed within Queensland schools to assist students experiencing personal and school difficulties, including:

- guidance officers
- chaplains
- community education counsellors
- (regional) behaviour management support staff (330 across the State)

[Queensland Department of Education (QLD DoE) 2006b].

In Queensland, school-based counsellors are known as guidance officers. They are registered teachers with additional qualifications in guidance and counselling or psychology (AGCA, 2008).

The QLD DoE makes funds available for schools to engage (through community organisations) the services of a Youth Support Coordinator, chaplain, pastoral care coordinator, youth worker or other type of support worker to provide direct support to school children. For schools to be eligible for these types of services, they need to be supporting vulnerable students in low socio-economic areas and have in excess of 100 enrolled students (QLD DoE, 2006a).

Youth Support Coordinators play a role in helping at-risk students to re-engage with their schooling, to transition to further education, with training or employment, and with reaching their full potential. (QLD DoE, 2006c).

A new initiative in 2011 is the location of Regional Youth Support Coordinators in QLD DoE’s regional offices. In addition to continuing their front line work with school children, these personnel work with principals, teachers and community organisations to deliver targeted services (QLD DoE, 2006c).
As is the case with other States and Territories, a school chaplaincy service is available to Queensland schools that wish to engage these services. It is a volunteer program that requires the consultation and approval of the students’ parents and broader community prior to implementation.

7.3.4 WESTERN AUSTRALIA (WA)

In keeping with the Australian Government’s health promoting schools framework (see section 7.1), the WA Department of Education (WA DoE) has a number of initiatives focusing on the social, emotional, health and mental health of students that are embedded within the school curriculum and broader policies.

These include:

- **School psychologists** - In Western Australia, school psychologists are described as ‘using their knowledge of psychological, social and organisational learning theories and assessment processes to support schools in developing, implementing and monitoring interventions to achieve appropriate outcomes for a diverse range of students and school communities. In addition, school psychologists are regarded as ‘change agents at individual, group and systemic levels’ and make use of methods including research, consultancy, development, implementation and evaluation processes to enhance educational outcomes (WA DoE, 2001:11).

- **Pastoral care** - Pastoral care is the commitment of teaching staff to the wellbeing of each student and is achieved through the promotion of positive school environments that support the physical, social, intellectual and emotional development of every student. The approach is underpinned by a ‘positive school climate’ where:
  - teacher-student relationships are based on trust and mutual respect
  - each student’s physical, social, intellectual and emotional development is promoted
  - there are strong partnerships between the school, parents and community

  (WA DoE 2011a)

- **School chaplaincy program** – As in other states, this is a voluntary program that aims to assist schools and their communities to support the wellbeing of their students and provide greater pastoral care, general religious instruction, personal advice and comfort to students and staff45 (WA DoE 2011b).

- A range of whole-school primary prevention and early intervention programs may be adopted in WA schools, including the Aussie Optimism program, which was developed in the State. Several of these programs are described in section 7.5 below.

7.3.5 AUSTRALIAN CAPITAL TERRITORY (ACT)

Pastoral care in the ACT begins in preschool and is provided to the Territory’s school students continuously throughout their schooling years [ACT Department of Education (ACT DoE) 2010]. The Student Welfare ‘Pastoral Care Package’ strengthens the services directed at student wellbeing through student counselling, welfare services and support programs. The Pastoral Care Package includes the provision of a pastoral care coordinator in every high school. This coordinator manages the whole school student pastoral care programs that take a personalised approach to supporting student wellbeing (ACT DoE 2011).

Within the ACT, school-based pastoral care incorporates the following support personnel:

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45 WA DoE has allocated a significant amount of funding for schools that wish to engage the School Chaplaincy Program. Whilst YouthCARE is the current recognised service provider for schools and they have a formal agreement with the DoE, schools are not bound to use chaplaincy services through YouthCARE, they are free to engage a chaplain of any denomination (WA DoE 2011b).
• School counsellors - the ACT employs school counsellors who have qualifications in psychology and teaching. In 2008, in an Australia wide comparison of school counsellor services within public schools, the ACT was identified as having the highest ratio of counsellors to students across Australia (ACT DoE, 2011). At the same time, the Australian Guidance and Counselling Association (AGCA) notes that 'the ACT is having enormous difficulty attracting suitably qualified personnel to the school counselling service' (AGCA, 2008).

• Student management consultants – these personnel provide behaviour management support to students in the ACT, some having broader school network responsibilities, and others placed directly in schools. They also provide behaviour management support for preschools (ACT DoE 2011).

• national initiatives, such as those described in section 7.5 below.

7.3.6 NORTHERN TERRITORY (NT)
Specific initiatives focused on student mental health and wellbeing in the NT include:

• School psychologists (who are registered with the Psychologist’s Registration Board of the NT) and school counsellors (who are school-based and are not necessarily registered with the Psychologist’s Registration Board) are deployed in NT schools. The NT has difficulty in attracting and retaining suitably qualified staff as tertiary institutions there do not offer training at the required level (AGCA 2008).

• The Healthy School Age Kids is a joint initiative by the Department of Health and the Department of Education and Training (NT DET). It is a population health program for school-age children in remote areas of the NT that focuses on screening young people for health related problems or illnesses. One of the aims of the program is for health and education staff to work cooperatively to support children, families and communities through health promotion, education and the provision of health services. It is believed that such collaboration will improve the health, wellbeing and learning outcomes of school-aged children living in remote communities in the NT (NT DET 2009a).

• The Drug and Personal Safety Awareness Program is a curriculum resource designed to support School Based Police Officers to deliver drug education in conjunction with teachers. The program began running in 2009 (NT DET 2009b).

• Positive Learning Centres (currently located in urban schools in Darwin, Palmerston and Alice Springs) are available for students who have extreme challenging behaviours and would most likely benefit from intensive positive behaviour interventions. These Centres provide outreach and withdrawal support services and facilitate a case management model of alternative education provision using a team approach and broad network of resources within the community to produce effective outcomes. Students who are engaged with these Centres remain enrolled in their mainstream school, and their associated school, family and Positive Learning Centre support staff are all working together to achieve positive outcomes.

7.3.7 TASMANIA
The Tasmanian Department of Education (TAS DoE) says it has embraced an inclusive education policy whereby all students, regardless of their differences, are part of the school community and can feel that they belong. This means that a student’s social and emotional needs, as well as their intellectual needs, are responded to, recognising the relationship between their social and emotional wellbeing and their academic success (TAS DoE 2008a).

In keeping with this education policy, there are a number of initiatives that have a role in improving the health and wellbeing outcomes for Tasmanian youth and school children. These initiatives include:

• School psychologists - In Tasmania, school psychologists must have teacher qualifications in addition to being a State-registered psychologist (AGCA 2008). Senior school psychologists are line managers to school psychologists, and managers of school support are line managers of senior psychologists.
- Launching into Learning - This program currently operates in over 100 schools around the State. This is a program for younger students, which recognises parents as the child's first and most important teacher. The focus for parents and children is on language, literacy and numeracy as well as social skills development in the years prior to formal schooling to help children make a successful transition to school (TAS DoE 2008a:1-3).

- Inclusive education and Individual Education Plans, which aim to provide a framework that supports positive access and participation within the curriculum and in school and community life for students with additional needs (TAS DoE 2008b).

7.4 SUMMARY OF SCHOOL PSYCHOLOGY/SCHOOL COUNSELLOR ROLES IN AUSTRALIAN SCHOOLS

Currently all States and Territories have school counsellors/psychologists, but there is a great deal of interstate diversity, including:

- the use of different professional designation titles
- differences regarding work locations and conditions
- differences in their roles and responsibilities, and the nature of support services they provide
- variations in the ratio of professionals to students.

(Thielking 2006; AGCA 2008; Faulkner 2007b: 23; Oakland et al 2005: 1086)

The Australian Psychological Society (2009) has provided a framework for the description of school psychology/school counselling services in Australian schools, summarised in the box below.

<table>
<thead>
<tr>
<th>Focus area</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct service approach</td>
<td>- Psychological and behavioural assessment using standardised tests and observation</td>
</tr>
<tr>
<td></td>
<td>- Educational assessment to assist with special programming for students</td>
</tr>
<tr>
<td></td>
<td>- Psychological treatment and counselling for mental health problems, behaviour problems, developmental issues and the impact of problematic life events</td>
</tr>
</tbody>
</table>

In the early part of the 20th century, there were a number of developments in the educational system that served as precursors to the establishment of a role for psychology in Australian schools. These include:

- The beginning of the provision of psychology services to students with learning and intellectual disabilities in regular schools and the establishment of special schools for children with intellectual disabilities.
- The use of standardised intelligence test data as part of teachers’ professional skills.
- The appointment of a psychologist in the South Australian education department in 1924.
- The establishment of the Australian Council of Educational Research (ACER) in 1930, providing the impetus for psychometric testing in schools.
- Development of state-supported school psychology and guidance services during the 1950s.

(Oakland et al 2005: 1084-1085)
### Focus area | Services
--- | ---
Indirect service approach | Consultation with teachers to provide advice of mental health and other psychological issues affecting students
| Parent information sessions
| Consultation with parents about their child’s issues
| Consultation with relevant school staff to address individual student and class behaviour, learning styles and difficulties

Whole school service approach | Assisting schools with the planning, preparation, implementation and evaluation of psychological and educational strategies, including offering recommendations for external supports and programs that may assist the school

Systems service approach | Assisting with coordination of teachers, parent/carers and external agencies to address the psychological needs of a student, including assisting with crisis management policy and response and recovery strategies

Source: Australian Psychological Society (2009: 8-9)

Based on a comparative review of Australian public sector school psychology carried out in 2000 (Faulkner 2007b: 23-24), common professional responsibilities across the States and Territories were found to include:

- individual and group counselling of students
- psychoeducational student assessment using a wide variety of psychological assessment tools, and report writing
- provision of consultancy advice on effective behaviour management programs
- consultancy regarding psychological service to schools and communities
- liaison with other government or non-government welfare agencies or medical specialists
- parent counselling
- critical incident management and support in schools.

### 7.5 SCHOOL-BASED MENTAL ILL-HEALTH PREVENTION AND EARLY INTERVENTION PROGRAMS IN AUSTRALIA

This section describes key universal whole-school programs that have the aim of mental ill-health prevention and early intervention and that are being implemented in Australia. It should be recognised that, in an increasingly globalised world, it is difficult to draw a clear distinction between prevention and early intervention programs operating in Australia and those operating in international jurisdictions because there is much learning and sharing between countries.

According to Neilis and Christensen (2007), the majority of Australian prevention and early intervention programs are based on:

- cognitive behaviour therapy (CBT) or, more broadly, cognitive and behavioural approaches that focus on the development of problem-solving and social skills, cognitive restructuring, relaxation and assertiveness
- interpersonal therapy (IPT), which focuses on improving social networks, role transitions, taking perspective and conflict resolution
- psychoeducation.

7.5.1 KIDSMATTER PRIMARY

**KidsMatter Primary** is a national primary school mental health promotion, prevention and early intervention initiative that has been developed in collaboration with the Australian Government Department of Health and Ageing (DoHA), beyondblue: the national depression initiative, the Australian Psychological Society, and Principals Australia (Graetz et al 2010; Commonwealth of Australia 2009). The program aims to improve the mental health and wellbeing of primary school students, reduce mental health problems amongst students, and achieve greater support for students experiencing mental health problems. **KidsMatter** is based on a conceptual model that targets key risk and protective factors (see brief discussion of these in section 4.1) for child mental health in the areas of family context, child factors and school context (Slee et al 2009: 89).

To achieve these aims, **KidsMatter Primary** promotes collaborative involvement across the health and education sectors. Rather than presenting schools with a single defined program, it provides a **framework for mental health promotion, prevention and early intervention** that is specifically oriented to primary schools. The **KidsMatter** framework explicitly acknowledges the key influences of parents, families and school on children’s mental health, and is thus described as reflecting a ‘social-ecological approach’ (Graetz 2008: 15). The framework identifies four components, within which are target areas and objectives and indicative strategies and actions. These are summarised in the box below.

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>EXAMPLE TARGET AREAS</th>
<th>EXAMPLES OF STRATEGIES/ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive school community</td>
<td>Enhancing a sense of belonging and inclusion within the school community</td>
<td>Whole-school professional development</td>
</tr>
<tr>
<td></td>
<td>Promoting a welcoming and friendly school environment</td>
<td>School community events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parent and child activity sessions</td>
</tr>
<tr>
<td>Social and emotional learning (SEL)</td>
<td>Ensuring all students receive Social and Emotional Learning (SEL) curriculum</td>
<td>Whole-school professional development</td>
</tr>
<tr>
<td></td>
<td>Providing opportunities for students to practise and generalise SEL skills</td>
<td>Selection of appropriate SEL program using <strong>KidsMatter</strong> Programs Guide</td>
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<tr>
<td></td>
<td></td>
<td>Supporting SEL teaching through timetabling, planning and resourcing</td>
</tr>
</tbody>
</table>

Starting in September 2006, KidsMatter Primary was piloted in 101 Government, Catholic and Independent schools across Australia (Commonwealth of Australia 2009). As of June 2011, 296 participating primary schools had been added to the initial 101 pilot schools and additional funding aims to increase this to a further 1700 schools by June 2014 (Commonwealth of Australia 2009).
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>EXAMPLE TARGET AREAS</th>
<th>EXAMPLES OF STRATEGIES/ACTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting support and education</td>
<td>Ensuring school staff have skills, confidence and commitment to form collaborative working relationships with parents</td>
<td>Parents’ meeting room or resource centre</td>
</tr>
<tr>
<td></td>
<td>Provision of parenting information and education</td>
<td>KidsMatter Information Sheets</td>
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<td></td>
<td></td>
<td>Regular parent information sessions/workshops</td>
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<tr>
<td></td>
<td></td>
<td>Appointment of Community Officers to provide support and link parents with appropriate services and agencies</td>
</tr>
<tr>
<td>Early intervention for students experiencing mental health difficulties</td>
<td>Promotion of early intervention for mental health difficulties</td>
<td>Mental Health Day, including showcasing student views regarding what mental health is</td>
</tr>
<tr>
<td></td>
<td>De-stigmatising mental health difficulties</td>
<td>Making student support processes more explicit and accessible through, for example, policies</td>
</tr>
<tr>
<td></td>
<td>Identification and support for students experiencing mental health difficulties</td>
<td>Identifying and building relationships with local health and community agencies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health First Aid Training for staff</td>
</tr>
</tbody>
</table>


### 7.5.2 MINDMATTERS AND MINDMATTERS PLUS

*MindMatters* is a mental health promotion program which has been widely adopted in Australian schools (Wyn 2007: 46; Ainley et al 2006). It is strongly influenced by the WHO model for school mental health promotion discussed in section 5.5 of this report. It was developed in 1997 and 1998 as a resource concerned with a whole-school approach, curriculum materials and teacher professional development for mental health promotion in schools (Ainley et al 2006: 49).

The *MindMatters* Whole School and Whole Student Approaches to mental health and wellbeing

> address the ways in which the school’s ethos and environment, its curriculum and its partnerships and services can increase the resilience of students. It does this by nurturing protective factors and reducing risk factors in a range of contexts.

(DoHA 2010: 15)

*MindMatters* modules include:

- a whole student approach
- leadership
- teaching and learning for engagement
- student empowerment
- staff matters
- students experiencing high support needs in mental health
- communities do matter.  

(MindMatters 2011)

The three areas of focus in the whole school approach are:

- School ethos and environment: including allocating dedicated resources; clarifying and coordinating policies, structures and processes; and ensuring positive communication and relationships across the school.
- Curriculum (teaching and learning): which focuses on providing a Whole Student Approach; establishing and integrating curriculum content and teaching and learning for engagement.
- Internal and external partnerships and services: including facilitating community, family, parent and caregiver partnerships; managing school transitions; and developing internal and external referral pathways and partnerships.

(DoHA 2010: 58-87).

Implementation of MindMatters within the school setting also supports the application of the revised National Safe Schools Framework (described in section 7.1 above). Specifically, the nine elements of the Framework have been linked to the MindMatters Implementation Model for a whole of school approach to mental health and wellbeing. This enables a linking of the MindMatters modules (as briefly described above) with the elements of the National Safe Schools Framework. Thus, for example, the Framework element ‘a focus on student wellbeing and student ownership’ is linked to the MindMatters modules ‘students experiencing high support needs in mental health’; ‘a whole student approach’; and ‘student empowerment’ (MindMatters 2011).

As a development of the MindMatters initiative, MindMatters Plus aims to improve the capacity of secondary schools to cater for students who have high support needs in the area of mental health (De Jong & Griffiths 2008: 30). A key component of the initiative is the development of ‘school case management’, which has the aim of enhancing ‘the engagement of students with high support needs in meaningful learning’ (De Jong & Griffiths 2008: 32).

Motivations that have been put forward for adopting case management approach in schools include that case management:

- offers a coordinating mechanism which promotes a systemic approach to establishing an integrated action plan for students with support needs
- empowers the student and all stakeholders to participate collaboratively in problem-solving, ensuring accessibility of support and services, and ultimately developing an integrated action plan
- encourages clearer processes of accountability and appraising outcomes associated with an action plan
- contributes to the successful retention of students with support needs.

(De Jong 2006: 3)

Strategies adopted by case managers are the following:

- identification of the eligibility of the student for case management processes
- establishment of a professional relationship with the student
- identifying the student’s needs
- establishing an action plan on the basis of a collaborative and dynamic process
executing, coordinating and monitoring the action plan

developing a transition plan to move from the most intensive to least intensive case management

determining the effectiveness of the case management processes and the action plan.

(De Jong & Griffiths 2008: 35)

7.5.3 FRIENDS: PREVENTING AND TREATING ANXIETY IN CHILDREN AND YOUTH

FRIENDS is a universal school-based program to prevent childhood anxiety and depression through the application of cognitive-behavioural principles and the building of emotional resilience. It aims to reduce the incidence of serious psychological disorders, emotional distress and impairment in social functioning by teaching children and young people how to cope with, and manage, anxiety in the present and in later life (Barrett & May 2007: 4).

The broad conduct of the FRIENDS program is as follows:

- The school selects in which year level they want FRIENDS to be introduced (e.g., ages 10–12 or 15–16) and adds the program to its year curriculum.
- The school purchases program manuals for the teachers responsible for the year level selected and these teachers participate in a one-day group training session conducted by an accredited trainer.
- The school orders the number of workbooks required (one for each child) and collects the money from the parents, or arranges for parents to buy the books from the school’s usual textbook supplier (this is the only cost to the parents of the program).
- The program does not require specialist staff, but is run by teachers in normal class time, promoting concepts (such as self-esteem, problem-solving and building positive relationships with peers and teachers) which fit in with learning targets for students as established in state educational curricula.
- The school encourages parents to become involved with the program by attending optional parent sessions which can be run by a teacher using the program manual.

(Barrett & May 2007)

7.5.4 RESOURCEFUL ADOLESCENT PROGRAM (RAP)

The Resourceful Adolescent Program (RAP) is a universal depression prevention program that targets all teenagers in a particular grade as opposed to those at higher risk for depression. This approach was motivated by the assumption that it is easier to recruit and engage adolescents where students do not face the risk of stigmatisation by being singled out for intervention. The program has three components, namely RAP-A (for adolescents), RAP-P (for parents) and RAP-T (for teachers) (QUT Resourceful Adolescent Program n.d.).

RAP-A consists of 11 sessions of approximately 50 minutes duration. The program is run with groups of adolescents varying in size from eight to 16 students, usually as an integral part of the school curriculum (from grades 7 to 10). RAP-A attempts to integrate both cognitive-behavioural and interpersonal approaches to improve coping skills and build resilience (QUT Resourceful Adolescent Program n.d.).

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48 The acronym represents the different skills taught ie F = feeling worried; R = relax and feel good; I = inner helpful thoughts; E = explore plans; N = nice work, reward yourself; D = don’t forget to practise; and S = stay calm for life! (Barrett et al, 2006:406).

49 As described by the founder of the program, ‘FRIENDS is a community-oriented cognitive-behavioural intervention based on a firm theoretical model which addresses cognitive, physiological and behavioural processes that are seen to interact in the development, maintenance and experience of anxiety’ (Barrett & May 2007: 4).

50 RAP was developed at the School of Psychology and Counselling and the Queensland University of Technology to meet the need for a resilience-building program for teenagers which could be readily implemented in a school setting (Neil & Christensen 2007; QUT Resourceful Adolescent Program n.d.).
An Indigenous supplement has been designed to provide guidelines for the adaptation and implementation of the RAP for Indigenous adolescents. It describes a variety of adaptations that have been made to RAP-A to make it more suitable for Indigenous teenagers (QUT Resourceful Adolescent Program n.d.).

Since its development in 1996, RAP has become widely used throughout Australia with approximately 5,000 people representing over 2000 schools and health and community organisations trained to facilitate the program. RAP-A has also been successfully introduced in several other countries (QUT Resourceful Adolescent Program n.d.).

7.5.5 THE BEYONDBLUE SCHOOLS RESEARCH INITIATIVE – A UNIVERSAL PREVENTION PROGRAM FOR DEPRESSION

The beyondblue schools research initiative attempts to overcome some of the difficulties associated with universal programs (e.g. the challenge of correctly implementing interventions within the context of routine practice in schools across large geographical regions) by:

- basing the program on a conceptual model of adolescent depression which emphasises the dynamic interaction between risk and protective factors, adverse or stressful life experiences, and psychosocial adjustment

- the inclusion of multiple initiatives, each targeted at specific risk and protective factors related to individuals and their school environment, namely
  - utilising a comprehensive classroom curriculum program, with topics including improving problem-solving and social skills and improving resilient thinking styles
  - enhancements to the school environment (climate) as a whole through the Building Supportive Environments initiative, which aims to improve the quality of social interactions amongst all members of the school community
  - improvements in care pathways through the Building Pathways for Care and Education initiative, which aims to facilitate adolescents’ access to support and professional services at school and in the wider community
  - the conduct of Community Forums, which provide young people, their families and school personnel with information to assist them to identify problems, seek help for themselves, and help peers.

(Sawyer et al 2010: 200-202)

7.5.6 AUSSIE OPTIMISM PROGRAM

The Aussie Optimism Program is a mental health promotion strategy developed in WA that is designed to prevent internalising problems in children and adolescents aged 11-13 years who are preparing for the transition to high school (Roberts 2006: 2). It consists of twenty one-hour weekly sessions conducted in school time, and can be implemented in the last two years of primary school, or the first year of high school. The program is based on cognitive-behavioural intervention procedures and has two components:

- The Optimistic Thinking Skills Program targets cognitive risk and protective factors for internalising problems. This component teaches children to identify and challenge negative thoughts about the self, current life circumstances, and the future that contribute to depressive and anxiety symptoms. Children are taught to accurately identify, label and monitor their feelings.

- The Social Life Skills Program targets social risk and protective factors. It involves teaching children listening skills, assertiveness, negotiation, social problem-solving skills, decision-making and perspective taking. The children learn coping skills for dealing with a variety of controllable and uncontrollable life stresses, such as family conflict and making the transition to high school.

(Roberts 2006: 2)
In addition, school newsletter items and parent booklets are used to inform parents of the program content and to promote generalisation of skills in the home setting (Roberts 2006).

7.5.7 BRITA FUTURES

The BRiTA Futures Primary School and Adolescent programs were developed by the Queensland Transcultural Mantle Health Centre in 2003 to fill a gap in mental health promotion programs specifically designed to enhance protective factors and minimise risk factors in children from CALD backgrounds (Mitchelson 2011). The program is described in the box below.

The BRiTA Futures Primary School and Adolescent Programs

The program is founded upon a capacity building model of service delivery which links schools, community support and welfare organisations and public sector health organisations. It is delivered by facilitators already located within schools, such as teachers and school counsellors.

Both the Primary School and Adolescent programs utilise a whole-class approach and can be tailored to different group sizes, gender, ages, cultures and delivery timeframes. For example, while they are generally delivered in two-hour sessions over a period of eight or ten weeks, they can be delivered in a two to three day intensive camp format.

The modules address concepts of cultural and personal identity, including:

- self-talk and building self-esteem
- cross cultural communication
- understanding and managing emotions
- stages of conflict, triggers and resolution strategies
- building positive relationships and support networks.

The Adolescent program covers additional age-appropriate material, including challenging stereotypes, raising awareness of support services and setting goals and future directions.

Students receive a program manual in which each module is supported by interactive group activities, discussion questions and take-home activities. Both programs are evaluated using pre- and post-program questionnaires measuring levels of resilience and general mental wellbeing.

Source: Mitchelson (2011)

7.6 INITIATIVES IN TERMS OF THE SMARTER SCHOOLS NATIONAL PARTNERSHIPS

Innovative models of working with children and young people in Australian educational settings are likely to emerge in the context of Council of Australian Governments (COAG) National Partnership Agreements that have been made since 2008. These partnerships are based on the 2008 National Education Agreement. The objective of COAG’s National Education Agreement is that all Australian school students acquire the knowledge and skills to participate effectively in society and achieve employment in a globalised economy. Targets have been set to lift the Year 12 or equivalent attainment rate to 90% by 2020 and at least halve the gap for Indigenous students in year 12 or equivalent attainment rates by 2020 (COAG 2008a).

51 This includes children and young people who have migrated to Australia from a non-English speaking country, second and subsequent generations of Australians from a CALD background and those with a recent refugee background.
Innovations in terms of the Smarter Schools National Partnerships, based on the *National Education Agreement*, include:

- the identification and implementation of evidence-based interventions which achieve accelerated and sustained improvements in literacy and numeracy outcomes for students, particularly those falling behind, in terms of the *National Partnership Agreement on Literacy and Numeracy* (COAG 2008b)

- developing innovative approaches to support low socio-economic status (Low SES) school communities in terms of the *National Partnership Agreement on Low SES School Communities* (COAG 2008c)

- promotion of strategies that would increase education attainment and the engagement of young people with education, training and employment, in terms of the *National Partnership Agreement on Youth Attainment and Transitions* (COAG 2009).

NSW is participating fully in these Smarter Schools National Partnerships with, for example, 147 schools participating in programs focusing on improving literacy and numeracy (NSW Department of Education and Training 2009).

Evaluations of the National Partnership initiatives are likely to be generated in the coming years, but at the time of writing, no evaluative studies were able to be accessed.

### 7.7 SUMMARY

Departments of Education in the States and Territories operate within policy frameworks such as the *National Framework for Health Promoting Schools*, and the *National Safe Schools Framework*, which promotes the vision of all Australian schools as safe, supportive and respectful teaching and learning communities that promote student wellbeing.

In order to address the psychological-emotional and mental health needs of their students, the States and Territories have:

- their own jurisdictionally-specific policy frameworks that promote common understanding, consistent approaches and a shared commitment to the development of learner wellbeing, and provide a strategic framework to connect initiatives, projects, policies and practices

- universal prevention and mental health promotion programs, many (such as the FRIENDS program) of which have been developed in Australia and have been adopted in other countries as well, and others which have been developed in other countries and applied to the Australian school situation

- selected programs for students who have identified as being at risk for developing internalising or externalising mental health problems

- targeted programs for students who require specialist individual intervention

- specialist school-based counsellors or psychologists

- other personnel assisting students with their wellbeing needs, such as social workers, nurses and chaplains.

Common duties of school counsellors/psychologists in all the State/Territory jurisdictions include:

- psychoeducational student assessment using a wide variety of psychological assessment tools, and report writing

- individual and group counselling of students and parent counselling

- provision of consultancy advice on effective behaviour management programs and psychological services to schools and communities
• liaison with other government or non-government welfare agencies or medical specialists

• critical incident management and support in schools.

There is potential, in terms of the National Partnership initiatives described above, for programs to be developed in the Australian context that will be effective in addressing the specific wellbeing needs of particular groups of students, such as Aboriginal and Torres Strait Islander students and students from CALD backgrounds, including refugees.

In section 8 which follows, school-based initiatives that assist students with mental health and psychological-emotional wellbeing issues in international jurisdictions are described, and, as noted before, it is evident that there are many similarities between the Australian and international education systems and their mental health and wellbeing promotion approaches. This includes adoption of specific programs that have been developed in one country and taken on by other countries, and the functioning of school counsellors/psychologists in school settings.
8 Examples of programs from international jurisdictions

8.1 INTRODUCTION

This section provides a description of international school-based initiatives designed to assist students with mental health and psychological-emotional wellbeing issues. It focuses on:

- policy frameworks in the United Kingdom (UK) and the United States of America (USA)
- school counsellors, school psychologists and school social workers in various jurisdictions
- school-based mental health programs.

8.2 POLICY FRAMEWORKS IN THE UK AND USA

8.2.1 THE ‘EVERY CHILD MATTERS’ POLICY FRAMEWORK IN THE UK

In recent years, the ‘Every Child Matters’ policy framework has taken a whole of government approach in focusing on the provision of integrated services for young people aged 0-19 years. The aim of this policy framework is to provide every child and young person with ready access to the support needed to be healthy and safe, to enjoy and achieve, to make a positive contribution to society and to achieve economic wellbeing (Brechman-Tousaint & Kogler 2010: 15).

Outcomes of this policy approach have included:

- the promotion of multidisciplinary teams (based on the assumption that staff who work with children and young people should all have a common core of knowledge regarding child and family need)
- a nationally developed common assessment framework
- adherence to national standards for information sharing across agencies in the health, education, justice and social welfare departments.

(Brechman-Tousaint & Kogler 2010: 16-17)

Another consequence is that a growing number of primary and secondary schools are extending the range of activities and services that can be accessed from within school sites and extending the hours that the community can access these services and other school facilities. Since 2008, schools that provide integrated services have been funded as ‘Extended Schools’ that work with local authorities and either locate multi-agency/multi-disciplinary teams within the school site or build strong links to multi-disciplinary teams that are located nearby (Brechman-Tousaint & Kogler 2010: 19).

Extended Schools are required to provide a range of services that ensure children and young people with emotional, behavioural, health, mental health or other difficulties are identified early and well supported. Such children have access to speech and language therapy; family support services; child and adolescent mental health services; intensive behaviour support; counselling, and sexual health services (Brechman-Tousaint & Kogler 2010: 19-20).

8.2.2 MENTAL HEALTH SERVICES IN USA SCHOOLS

Developments in the USA have been well represented in the literature. Schaeffer et al (2005: 17) write that there has been a proliferation of school mental health programs across the USA. This has led to the expansion of the previously limited mental health services (primarily for students in special education52).

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52 Special education in the USA refers to education for students who do not benefit from ordinary educational methods (Jimerson & Oakland 2007: 417).
and a ‘move toward a full continuum of mental health promotion and intervention for youth in general and special education through school-community program partnerships’.

Schools in the USA are commonly regarded as the dominant de facto providers of mental health services for youth, providing an estimated 70–80% of psychosocial services to those children who receive services (Atkins et al 2010: 41). As noted by Teich et al 2007: 13), ‘schools are increasingly seen as a natural entry point for addressing children’s mental health needs’. Services incorporate key elements including:

- school–family–community agency partnerships
- commitment to a full continuum of interventions, including mental health education, mental health promotion, assessment, problem prevention, early intervention, and treatment
- services for all youth, including those in general and special education.

(Paternite 2005: 658-659)

A study carried out in the USA has enabled a description of the prevalence and distribution of mental health services throughout the public school system. Results from this study are summarised below.

- In the vast majority of schools (87%), all students were eligible to receive mental health services, while 10% of schools required students to have an Individualised Education Plan (IEP; indicating special education status) in order to qualify for services.
- Overall, schools reported that 19.7% of students had received some type of school-supported mental health service in the school year prior to the study.
- More than 80% of schools provided assessment for mental health problems, behavioral management consultation, crisis intervention and referrals to specialised programs, while two-thirds or more of schools provided individual counselling, case management and group counselling.
- Schools described curriculum-based programs, classroom guidance to enhance social and emotional functioning and interdisciplinary student assistance/service teams comprising mental health professionals, educators and nurses as the strategies they found most successful in improving student mental health.

(Teich et al 2007: 15-19)

In addition to the above services, the Children’s Mental Health Initiative provides funds for communities to develop and enhance systems of care to treat and support children and youth with serious emotional disturbance (Walrath et al 2009). In terms of this program, local community-based agencies work in coordination with local juvenile justice agencies, child protective service agencies, school districts (through school-based mental health service providers), and other community mental health services. Often service delivery is coordinated across agencies through the use of intensive case management, while in some communities various agencies may choose to co-locate and cross-train staff for service delivery in multiple contexts (Walrath et al 2009: 362).

For children with serious emotional disturbance, the Intensive Mental Health Program (IMHP) is available. Core elements of the program are described in the box below.

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53 According to Paternite (2005), mental health services in schools in the USA have historically been quite restricted, limited primarily to assessment, clinical consultation, and treatment services for students in or being referred to special education. However, in recent years there has been a progressive movement toward more comprehensive programs and services.

54 The study, School Mental Health Services in the United States, was conducted in 2002-03 and involved a nationally representative sample of the approximately 83,000 public elementary, middle and high schools in the USA (Teich et al 2007: 14-15).

55 The IMHP is the product of collaboration between university-based clinical child psychologists and the special education division of a public school system in the USA, and is designed for children with serious emotional disturbances (Vernberg 2004: 359-360).
### Core elements of the Intensive Mental Health Program (IMHP)

Core components of the IMHP include:

- a structured behavior management program utilised throughout the child’s waking hours
- an individually tailored array of evidence-based psychosocial and biomedical (pharmacological) interventions
- frequent consultation with parents, school personnel, and other caregivers
- empirically supported clinical assessment and continuous use of objective data to inform and guide treatment decisions
- service coordination with parents (or guardians) and all providers involved with the child.

Source: Vernberg et al (2004: 360)

Principles for best practice in school mental health in the USA were developed by Weist et al (2005)\(^{56}\) and are described in the box below.

### PRINCIPLES FOR BEST PRACTICE IN SCHOOL MENTAL HEALTH IN THE USA (WEIST ET AL 2005)

- All youth and families are able to access care, regardless of their ability to pay.
- Programs are implemented to address school and community needs and assets.
- Programs and services are user-friendly, empirically supported, and based on strengthening assets in young people and their environments.
- All stakeholders are involved in the program’s development, oversight, and continuous improvement.
- Quality assessment and improvement activities guide the program.
- A continuum of care is provided, including mental health promotion, early intervention and treatment.
- Staff hold to high ethical standards, are committed to children and adolescents, and display an energetic, flexible, and responsive style in delivering services.
- Staff are respectful of, and competently address, developmental, cultural, and personal differences among students, families, and staff.
- Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterises care.
- Mental health programs in the school are coordinated together and with related programs in other community settings.

Sources: Weist et al (2005)

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\(^{56}\) The authors developed these principles on the basis of: activities of a federally funded national center for school mental health; a review of the literature on principles for best practice in child and adolescent mental health and school health; consultation with national experts and family members; and testing of draft principles with a sample of 426 people involved in education, school health or mental health (Weist et al 2005).
8.3 SCHOOL PSYCHOLOGISTS AND SCHOOL COUNSELLORS IN VARIOUS JURISDICTIONS

8.3.1 USA

School psychologists in the USA have been identified by the National Association of School Psychologists as being the leading mental health experts in schools who are able to, amongst others:

- help schools develop cognitive and academic goals for all students, taking into account the need to adjust expectations for individual students
- help schools to design and implement prevention and intervention programs that promote wellness, social skills and life competencies
- provide leadership in creating educational environments that reduce alienation and foster the expression of appropriate behaviour
- develop programs that strengthen the connections among home, community and school.

(National Association of School Psychologists 2006: 19-20)

The services provided by school psychologists include:

- individual psychoeducational evaluations, frequently conducted on students referred for possible special education services, making use of standardised tests
- provision of direct services (tutoring, teaching and counselling) to promote the academic, social and emotional development of students
- working with parents, teachers, principals and other educators (indirect services)
- prevention services, focusing on issues such as drug and alcohol abuse, suicide, dropouts and school violence
- research and evaluation activities to assist professionals in education and psychology to develop a body of literature.

(Jimerson & Oakland 2007: 422-423)

According to Lear (2007: 413), school psychologists in the USA have reported spending an increasing percentage of their time on testing and student assessment, which comprised 79% of their work hours in the 1999–2000 school year.

The roles of school psychologists may overlap the duties of counsellors and social workers (discussed in greater detail below), and they often co-lead social skills groups and jointly serve on crisis support teams. Relative to counsellors, school psychologists are more likely to have training in behavioural analysis, mental health screening and diagnosis, research methods (and application of research to classroom practices), and specific disability areas (National Association of School Psychologists 2006).

School psychologists are typically funded through special education funds and their first responsibility is to the population of students at risk for failure and who have identified disabilities. In contrast, school counsellors typically work with the total school population regarding a variety of issues, including family and academic problems, career planning, course schedules and problem solving around course selection.

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57 School psychology developed in the USA from the early part of the 20th century, and it is a well-established sub-discipline within psychology, with an estimated 32,300 practitioners in 2005 (Jimerson & Oakland 2007: 418). There are diverse perspectives as to whether school psychology belongs in psychology or education, with school psychologists frequently identifying closely with their colleagues in education, while deriving much of their scholarship and work technology from psychology (Jimerson & Oakland 2007: 421).
and scheduling, social skills, crisis intervention and mental health counselling (National Association of School Psychologists 2006).

8.3.2 ENGLAND AND WALES

School psychologists in England and Wales are called ‘educational psychologists’ and mostly work for local education authorities, although there are a variety of models of service provision, summarised in Table 6 below. They generally visit a number of schools on a regular basis to consult with teachers and parents, and work directly with students. Some educational psychologists work privately or within independent schools. Educational psychologists also ‘collaborate with colleagues from the Health and Social Services departments, and other education employees’ (Squires & Farrell 2007: 87).

Educational psychologists are involved in assessment and intervention and helping schools develop policies and programs (such as how to manage students with behavioural problems). As many educational psychologists work for local education authorities, they are often called upon to advise or join working groups concerned with organisation and policy planning (Squires & Farrell 2007: 87).

To train to be an educational psychologist in England and Wales, candidates have since 2006 needed to complete a three-year postgraduate doctorate in educational psychology. To do this, candidates need to have a degree in psychology, be eligible for Graduate Basis of Registration with the British Psychology Society (BPS), and be able to demonstrate relevant experience of working with children and young people (Squires & Farrell 2007).

Based on research carried out into school counselling provision in the UK, the British Association for Counselling and Psychotherapy has generated a typology of school counselling (administrative) models currently operating in the country, summarised in Table 6 below.

TABLE 6 – ADMINISTRATIVE MODELS OF SCHOOL COUNSELLING PROVISION IN THE UK

<table>
<thead>
<tr>
<th>MODEL</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling as part of a multi-agency team</td>
<td>Professionals in these multi-agency teams could include counsellors, education welfare officers, youth workers and social workers. Teams are often employed in the context of specific funded initiatives, such as the Behaviour and Education Support Teams.</td>
</tr>
<tr>
<td>School-based healthcare staff</td>
<td>A school nurse or other healthcare professional, with or without appropriate counselling qualifications, provides counselling within the school.</td>
</tr>
<tr>
<td>Teaching staff</td>
<td>As part of a wider system of pastoral care provision within the school, counselling is provided by members of the teaching staff with or without appropriate counselling qualifications.</td>
</tr>
<tr>
<td>In-house peer support</td>
<td>Emotional support is provided by peers, often in the context of anti-bullying or other pastoral care programs operating within the schools.</td>
</tr>
<tr>
<td>Centralised local authority provision</td>
<td>A counselling service that is based within the local authority (municipality/local government) provides in-school counselling on a visiting sessional basis, or provides management and supervision of school-based counsellors who work as an integral part of each school’s staff team.</td>
</tr>
<tr>
<td>Singleton practitioner model</td>
<td>Counselling is provided by a counsellor who is employed directly by the individual school or a group of schools.</td>
</tr>
<tr>
<td>Provision by external agency</td>
<td>Under commercial contract to the school or local authority, a recognised agency provides counselling services, generally in-school, but also at the agency’s premises on request.</td>
</tr>
</tbody>
</table>

58 Squires and Farrell (2007) suggest that England is suffering from a shortage of educational psychologists, and that one explanation for this is that the profession may not be considered financially worthwhile. In 2004, the ratio of educational psychologists to students was approximately 1 to 2,757, although Squires and Farrell (2007) state these figures are less promising when those employed in management positions and those working part-time are eliminated. Some services are responding to this shortage by employing assistant educational psychologists who undertake more limited roles.
### Model Discussion

<table>
<thead>
<tr>
<th>Model</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster model</td>
<td>The counsellor is based within a secondary school and services the feeder primaries on a needs basis and to support transitions.</td>
</tr>
<tr>
<td>Management only model</td>
<td>Schools employ their own counsellor, but this is supported by a management service (based in the local authority or another agency) that advises and provides consultative support.</td>
</tr>
<tr>
<td>Vetted/pool model</td>
<td>The local authority creates a list of counsellors who meet a required professional standard, and schools recruit their own counsellor from the pool.</td>
</tr>
</tbody>
</table>

Source: British Association for counselling and Psychotherapy (2007: 10-11)

### 8.3.3 Scotland

According to the Standards in Scotland’s Schools etc Act 2000:

- School education needs to be directed to the development of the personality, talents and mental and physical abilities of the child or young person to their fullest potential.
- In providing school education, education authorities need to have due regard to the views of children or young persons in decisions that significantly affect them, taking account of their age and maturity.
- Education also needs to be based on principles of social inclusion, in which all children and young people, whatever their social or economic background, have the best possible start in life and go on to achieve their maximum potential.

(Committee on Standards in Scotland’s Schools etc Act 2002)

A comprehensive review of the provision of educational psychology services in Scotland was carried out in the early 2000s, with the following terms of reference and processes:

- establishing current staffing positions in terms of number, posts filled or vacant and staffing ratios
- examining characteristics of educational psychologists to identify future trends and problems relating to issues such as age profile and geographical imbalance
- seeking views of key stakeholders on issues impacting on supply and demand
- reviewing the services and considering those which would best deliver effective and efficient services to meet the needs of service users.

(Committee on Standards in Scotland’s Schools etc Act 2002: 14-15)

One consequence of the review was that the number of psychologists being trained was increased and funding was increased to provide additional personnel (British Psychology Society [BPS] 2011). While their role had in the past been focused on children and young people with special educational needs, it was enhanced to that of promoting equality of opportunity for all students.

In comparison to England and Wales, the roles and duties of educational psychologists in Scotland are therefore quite extensive (BPS 2011; Topping et al 2007: 341). The differences also lie in the mandatory nature of their duties, as set out in the Educational (Scotland) Act 1980. In terms of this legislation, educational psychologists are responsible for the care and management of children from birth to young adulthood (up to the age of 24) (BPS 2011; Topping et al 2007: 342), as well as the children’s parents and carers, and educational institutions. Educational psychologists are also responsible for educational management and broader work with other agencies including social work services (BPS, 2011).

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59 The majority of educational psychologists working in Scotland are employed by the Local Authority Educational Psychology Service or Psychological Service (BPS 2011). Some educational psychologists can also work wholly or partly in private practice.
There are a number of service delivery models for educational psychologists in Scotland, including:

- **The area model** – educational psychologists service a specified area or group of outfits and provide all needed services.

- **The sector model** – an individual or group of educational psychologists serve a particular sector such as primary schools and tertiary institutions.

- **Specialised area of support need (disability)** – educational psychologists are designated to particular areas of support need such as hearing or visual impairment.

- **The referral model** - whereby educational psychologists work as and where needed in line with presenting referrals.

The latter model is particularly helpful where geographical issues challenge the opportunity for school-based service

(Topping et al 2007: 343)

The core functions for Scotland’s educational psychologists are the following

- Assessment of the learning, behaviour, and social-emotional functioning of children and youth. There is an increasing tendency to use approaches such as dynamic testing (eg play-based, curriculum-based and direct observation), rather than traditional psychometric approaches (Topping et al 2007: 347).

- Interventions, including solution-focused brief therapy, person-centred approaches and video interactive guidance, which are applied on an individual or a systemic level (Topping et al 2007: 348).

- Providing training to children and other parties as needed regarding the learning, behaviour and development of children and young people (BPS, 2011).

- Consultancy services to users and educational institutions, they also afford advice and support to other staff in relation to the additional support needs of children and youth (BPS, 2011).

- Research to inform educational practice, policy and strategy, and evaluation (BPS, 2011).

8.3.4 CANADA

Psychologists working with school-age children in Canada were initially not employed in schools themselves: the development of school psychology as a firmly established role in the education systems of the Canadian provinces only gained momentum in the early 1980s (Saklofske et al 2007: 41). The designation and credentialing of school psychologists varies across the provinces, and there is much variability in the ratio of students to school psychologists in the provinces, influenced also by urban/rural factors (Saklofske et al 2007: 42).

The functions and responsibilities of school psychologists in Canada include:

- psychological and psycho-educational assessments to assess intellectual, educational, social, emotional, personality and/or neuropsychological development, making use of standardised instruments

- placement of students with special needs

- provision of therapy to students presenting with personal problems

- referrals and consultations to other community services

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*Within Scotland, terms such as ‘special needs’ and ‘special needs education’ have been replaced with ‘additional support needs’ under the Education (Additional Support for Learning) (Scotland) Act (2004) (Topping et al 2007: 342).*
Examples of Programs from International Jurisdictions

- Crisis intervention and crisis team management in response to issues such as school violence, catastrophic accidents and natural disasters
- Development of individualised educational programs and provision of other consultation services (e.g., in-service workshops on trauma) to teachers to support the needs of all students in school.

(Saklofske et al. 2001: 43-49)

According to Oakland et al. (2005: 1092) Canadian school psychologists tend to focus on educator and psychological assessment and the development and implementation of intervention programs. This provides less time for them to engage in the direct delivery of services, including preventive services and implementation of methods intended to promote students’ academic, social or emotional development.

8.3.5 NORWAY

In Norway, parents and authorised school personnel are able to refer any student problem to Educational Psychology Services, which are independently managed municipal services. Once referred, the student is assigned to one professional (Anthun & Manger 2007: 290). Educational psychologists engage in a range of professional activities, including:

- Testing and assessment (using instruments such as tests of intelligence and screening for psychological and social problems)
- Provision of counselling and treatment to individual students
- Consultation with other professionals (such as school personnel and professionals outside the school and parents)
- Systemic and developmental activities, such as programs to prevent bullying and create safer school environments.

(Anthun & Manger 2007: 289-291)

Educational psychologists are members of the Norwegian Psychological Association (in the Division of School Psychology) and anyone qualified as a psychologist may work as an educational psychologist (Anthun & Manger 2007: 287).

8.3.6 NEW ZEALAND

Psychologists working in New Zealand schools are called educational psychologists, and their primary role is to ‘use a wide range of assessment methods to chart complex problems in order to formulate intervention plans’ (Oakland et al. 2005: 1096). Most educational psychologists are employed by the Group Special Education section within the Ministry of Education, and therefore consult with educational institutions as external agents (Edwards et al. 2007: 265).

The services provided by educational psychologists broadly fall into the following three categories:

- Case referrals: educational psychologists receive referrals of students who present with severe needs. Assessment focuses on identifying the problem, followed by identification, implementation and evaluation of appropriate support systems.
- System level interventions and support: educational psychologists contribute to policy development within schools (e.g., crisis prevention and response), programs to prevent violence, school support and referral systems, and curriculum adaptation. They also lead traumatic incident teams that respond to crises that have a direct impact on students.

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61 A few educational psychologists are also employed directly by schools or groups of schools in conjunction with other special needs teaching staff such as learning and behaviour management staff (Edwards et al. 2007).
- Third party contracts: under various service contracts, educational psychologists provide input/advice to agencies that require input from a psychologist (for example, they conduct criterion assessments based on established criteria to determine if a young person is eligible for welfare payments where the young person is estranged from their family).

(Edwards et al 2007:271)

Edwards et al (2007: 272) argue that one of the main challenges for educational psychologists employed by Group Special Education is a heavy workload. In 2007, they estimated that there were approximately 150 psychologists, mostly educational but some clinical, working in educational settings. This equates to a psychologist to student ratio of 1:5,100 for children aged 5 to 18 years.

In addition to these challenges, some educational psychologists say that providing services under third party contracts (category three above), detracts from their core role of working with students, teachers and parents (Edwards et al 2007: 272).

8.4 SCHOOL SOCIAL WORK

School social workers help support student learning and well-being through direct service, service coordination, and advocacy. School social workers support the psychosocial and mental health needs of schools, students, and families so that they can best meet their academic mission of educating students. In the USA for example, school social workers have been carrying out this role in schools for the past 100 years (Franklin et al 2009: 667).

Social workers are recognised as being skilled in providing crisis management, group work interventions, individual counselling, family counselling and community (whole school and neighbourhood) development interventions (Pinka et al 2004). A systematic review of school social work practices (Franklin et al 2009) has found that school social workers focus on internalising (cognitive and emotional) problems and externalising problems (such as aggression and self-control issues), and also contribute to students’ academic and school-related outcomes. This includes focusing on issues such as drop-out prevention, grades and attendance.

Specific school social work interventions include:

- mediation programs designed to teach aggressive students to resolve conflicts non-violently
- solution-focused brief therapy
- peer mediation programs
- social skills training
- programs to increase students’ awareness of child abuse.

(Franklin et al 2009: 671-673)

The Social Workers in Schools (SWiS) program in New Zealand is briefly described in the box below as an example of social workers practising in schools.
The Social Workers in Schools (SWiS) program in New Zealand

The SWiS became fully operational in New Zealand in 2000. There are currently 128 social workers in around 320 primary and intermediate school clusters across New Zealand. One full-time social worker is typically employed to work across a cluster of four schools in urban areas or a three school cluster in rural areas. The four broad service areas of the social workers are:

- the provision of individual social work (casework) services for children and their families
- group work, focusing on prevention and intervention goals
- community networking, including coordinating services provided by other agencies
- the development of systems and resources to support children and families locally.

The goals of the SWiS program are to enhance the life chances of young people whose social and family circumstances place them at significant risk, to identify problems and issues early, and to provide easily accessible assistance and help to children and families.

Source: Brechman-Tousaint & Kogler (2010: 26-27)

The descriptions of school social work in the literature suggest that there are, in practice, not many differences between school social workers and school psychologists in respect of the work they do in order to enhance student wellbeing. The description of the SWiS program in New Zealand suggests that social workers in schools engage in direct practice with individuals, groups, families and communities in order to enhance student welfare, and are able to do more of this level of direct practice in lieu of the assessment functions carried out by school psychologists.

One clear difference is, therefore, that school social workers do not engage in the psychometric testing of students. Another possible difference, based on the research carried out by Franklin et al (2009), is that social workers focus more explicitly on the academic outcomes of students through focusing on issues such as drop-out prevention and school attendance.

8.5 SCHOOL-BASED MENTAL HEALTH PROGRAMS

This section provides examples of mental health and wellbeing programs that are currently available in schools in international jurisdictions, namely:

- social and emotional learning (SEL) programs
- cognitive-behavioural programs
- the Promoting Alternative Thinking Strategies (PATHS) curriculum
- the Mastermind curriculum for young adolescents
- Skills for Social and Academic Success (SASS), a program to address social anxiety and social phobia
- the Safe Schools/Healthy Students initiative
- the Intensive Mental Health Programs (IMHP) in the USA
- models of intervention which make use of the social supports provided by young people to each other, ie peer support models
- mental health screening
- Supporting Tempers, Emotions and Anger Management (STEAM)
- antibullying programs
- suicide prevention programs
- programs focusing on body image, obesity and eating disorders
- drug prevention programs.

As noted in section 7, many of these programs (especially those that focus on primary prevention) are international in nature, and may also be available in Australian schools.

8.5.1 SOCIAL AND EMOTIONAL LEARNING (SEL) OR SOCIAL AND EMOTIONAL ASPECTS OF LEARNING (SEAL)

The literature points to the development of social and emotional learning (SEL) in the USA and the Social and Emotional Aspects of Learning (SEAL) program in the UK as designed to develop children’s social, emotional and behavioural skills (see eg Collaborative for Academic, Social and Emotional Learning [CASEL] 2005; Hallam 2009; Durlak et al 2011). SEL is also part of the MindMatters whole-school initiative to addressing the mental health of Australian students described in section 7.5.2 of this report.

Social and emotional learning (SEL) is a broad term used to describe the process of developing fundamental social and emotional competencies in children (CASEL 2005: 5), which in turn would have a positive impact on academic performance (Durlak et al 2011: 406). Within this approach, integrated efforts to develop children’s social and emotional skills begin in primary school and continue throughout high school in order to develop five core social and emotional competencies:

- **Self-awareness**: including having a realistic assessment of one’s own abilities and a well-grounded sense of self-confidence.
- **Social awareness**: understanding what others are feeling, being able to take their perspective and appreciating and interacting positively with diverse groups.
- **Self-management**: dealing with emotions so they facilitate rather than interfere with tasks at hand, being conscientious, delaying gratification to pursue goals and persevering in the face of setbacks and frustrations.
- **Relationship skills**: including dealing with emotions in relationships effectively and resisting inappropriate social pressure.
- **Responsible decision-making**: based on an accurate consideration of all relevant factors and the likely consequences of alternative courses of action, respecting others, and taking responsibility for one’s decisions.

(Durlak et al 2011: 406; CASEL 2005: 5)

An underlying principle of the SEL approach is that the mastering of the competencies described above would result in students shifting from being

*predominantly controlled by external factors to acting increasingly in accord with internalized beliefs and values, caring and concern for others, making good decisions and taking responsibility for one’s choices and behaviors.*

(Durlak et al 2011: 406)

SEL skills are taught, modelled, practised and applied to diverse situations so that students use them as part of their daily repertoire of behaviours, also as a means of preventing specific problem behaviours such as substance use and interpersonal violence. SEL programming is also used to establish safe, caring learning environments involving peer and family initiatives and whole-school community building activities (Durlak et al 2011: 406-407).
Stoiber (2011: 47) discusses factors that may limit the adoption of SEL approaches in schools. The author notes that, at the onset of the 21st century, educators are functioning in an era when student academic performance via ‘high stakes assessments’ has become the priority. Current school improvements and educational reforms focus on academic instructional components, which generally ignore social and emotional learning as a fundamental educational target. In addition, school contexts may make it difficult to implement social-behavioral interventions ‘as intended’ because schools can be chaotic and/or lack the amount or type of resources to follow through on necessary procedures or steps of an SEL-type intervention.

8.5.2 COGNITIVE-BEHAVIOURAL PROGRAMS

A number of texts refer to the use of cognitive-behavioural approaches in schools (see eg Gillham et al 2007; Pugh 2010; Forman & Barakat 2011). Cognitive behavioural approaches seek to challenge maladaptive internal (mental) models of the physical and social environment and can involve:

- psychoeducation (training to reflect upon patterns of negative thought)
- somatic management (breathing and relaxation techniques)
- cognitive restructuring (finding alternative explanations)
- problem solving/finding new solutions
- testing and maintaining the new learning through exposure in real world settings.

(Pugh 2010: 393)

Cognitive-behavioural interventions are primarily delivered to individuals and groups, but can also be used with whole classes. An example of a group intervention is provided in the box below.

**Penn Resiliency Program**

The Penn Resiliency Program in the USA is a group intervention that teaches cognitive-behavioural and social problem-solving skills. It strive to teach students to think flexibly and accurately about the challenges and problems that they confront. Students learn about:

- the link between beliefs, feelings, and behaviours
- cognitive styles, including pessimistic explanatory styles
- cognitive restructuring skills, including how to challenge negative thinking by evaluating the accuracy of beliefs so that they can generate alternative interpretations.

Students also learn a variety of techniques for coping and problem-solving, including assertiveness, negotiation, decision-making, and relaxation. Students apply the cognitive and problem-solving techniques in their lives through group discussions and weekly homework assignments.

Source: Gillham et al (2007: 10)
8.5.3 PROMOTING ALTERNATIVE THINKING STRATEGIES (PATHS) CURRICULUM

The PATHS (Promoting Alternative Thinking Strategies) curriculum has been implemented in a number of countries and focuses on assisting students with the expression, understanding, and regulation of a broad repertoire of emotions. It specifically aims to develop social problem solving through the use of self-control and emotional awareness. Developed for first- to third-grade children, the PATHS curriculum is intended to be taught throughout the school year by regular classroom teachers (Bidgood et al 2010: 162; Riggs et al 2006).62

The PATHS curriculum places special attention on ‘neurocognitive models of development’, ie it is based on scientific understandings of brain development and functioning (Riggs et al 2006). In keeping with this focus, the curriculum aims to teach young people the skills that promote age-appropriate development of the higher-order neurological processes.

Strategies, described within the curriculum as ‘vertical control strategies’, include the promotion of self-control through mechanisms such as self-talk (eg stop, calm down, think). Other strategies, known as ‘horizontal communication strategies’, include assisting young people to verbally identify and label feelings and emotions in order to manage them, and encouraging them to talk about emotional experiences to strengthen horizontal integration (Riggs et al 2006). The curriculum also focuses on the processes of communication between the left and right hemispheres of the human brain.63

8.5.4 MASTERMIND: EMPOWER YOURSELF WITH MENTAL HEALTH

MasterMind is a relatively recent curriculum-based program that has been piloted in Seattle, Washington (Tacker & Dobie 2008). The program is not designed as an intervention for those with identified mental health problems, but aims to develop a ‘toolbox for mental health’ for young adolescents generally. It has the following goals:

- to create a safe environment where students can discuss mental health, including emotionally charged topics
- to increase student awareness about mental health issues
- to provide students with different learning styles, developmental levels, ethnic and socio-economic backgrounds and geographical settings with a range of educational materials that they can use to develop and maintain mental health.

(Tacker & Dobie 2008: 55)

The curriculum covers topics including self-esteem, media literacy, the effects of stress and ways to des-stress, and future goals. These topics were selected through a needs assessment process (including discussions with administrators, school counsellors, teachers and students) and on the basis of addressing national priorities for adolescent mental health. The curriculum and materials are flexible and can be modified on the basis of choice of topic, depth of exploration or length of sessions (Tacker & Dobie 2008: 5-56).

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62 PATHS is based on the Affective-Behavioural-Cognitive-Dynamic (ABCD) model of development, which places primary importance on the integration of cognition, language and behaviour in the promotion of social competence. A fundamental concept in the ABCD model is that, as young people mature, emotional development precedes most forms of cognitive development. The implication is that young children experience emotions and react to them long before they can put their experiences into words (Riggs et al 2006).

63 The left hemisphere is responsible for processing receptive and expressive language, while the right hemisphere specialises in processing both ‘comfortable’ and ‘uncomfortable’ receptive and expressive emotions. In order to verbally label emotional experiences and become consciously aware of them, information must be transmitted from the right hemisphere to the left via the corpus callosum (Riggs et al 2006).
8.5.5 SKILLS FOR SOCIAL AND ACADEMIC SUCCESS (SASS)

SASS is a school-based mental health program developed in New York in the 1990s to focus specifically on social anxiety disorder/social phobia in students (Masia-Warner et al 2005). The SASS program is described in the box below.

**SKILLS FOR SOCIAL AND ACADEMIC SUCCESS – A PROGRAM FOCUSING ON SOCIAL ANXIETY**

The SASS program comprises the following components, typically spanning three months and designed to be accommodated within the limits of school calendars, i.e. taking into account school holidays and examinations:

- 12 weekly group sessions for students (lasting approximately 40 minutes each) and consisting of one psychoeducational session, one session on realistic thinking, four social skills training sessions (initiating conversations, maintaining conversations and establishing friendships, listening and remembering, and assertiveness), five sessions on exposure, and one session on relapse prevention
- two booster sessions to address relapse, assess remaining obstacles and highlight additional ways to practise skills
- two brief individual meetings (lasting approximately 15 minutes) to identify individual treatment goals and identify treatment obstacles
- four weekend social events, which provide real-world exposure and the opportunities for generalisation of the skills.

In addition, parents attend two group meetings of approximately 45 minutes each, during which they receive psychoeducation regarding social anxiety and learn techniques to address their child’s anxiety. Teachers participate in two psychoeducational meetings (30 min) and conduct classroom sessions supervised by group leaders.


8.5.6 SAFE SCHOOLS/HEALTHY STUDENTS COORDINATED GRANT INITIATIVE

The purpose of the Safe Schools/Healthy Students coordinated grant initiative is to help school districts and communities in the USA develop and implement comprehensive community-wide strategies for creating safe and drug-free schools and for promoting healthy childhood development, so that students can grow and thrive without resorting to violence or other destructive behaviours (Felix et al 2007: 4). It has become the primary mechanism for the federal government in the USA to support the prevention of school violence, and funding is provided through the Departments of Health and Human Services, Education, and Justice (Massey et al 2007).

Examples of specific programs within the initiative include:

- On-Campus Intervention Program (OCIP): This is a three-day program that offers an alternative to out-of-school suspensions. In this program, a student remains in school but is separated from the rest of the student body for the duration of the period of a suspension (usually three days); a teacher is present to help students complete academic work and stay current with their studies; and a counsellor is present to provide individual and group intervention for behavioural and emotional problems that students may be experiencing.

- An anger management and conflict resolution program known as the Think First curriculum: This initiative aims to promote the emotional and social competencies of students and to reduce the incidence of aggressive and disruptive behaviours. It is provided in either a class-based environment or in a separate program.

(Massey et al 2007: 60-64)
8.5.7 INTENSIVE MENTAL HEALTH PROGRAMS (IMHP) IN THE USA

In the USA, an estimated 5% of children experience severe emotional and behavioural difficulties in any six-month period (Walrath et al 2009: 361). Although specific intervention strategies for such students are tailored individually for each child, the IMHP adheres to nine basic principles (Vernberg et al 2004: 360):

- Maintain placement in the child’s home and neighbourhood school so that relationships with family members, teachers, and peers are not severed and responsibility to care for and educate is not diminished.
- Emphasise an evidence-based approach to guide interventions so that treatment components are consistent with research on empirically supported psychosocial and pharmacological interventions.
- Focus on cognitive and behavioral skill development in an explicit effort to teach and promote appropriate behaviours and social and cognitive skills in real world settings.
- Attend to cross-setting linkages and events to promote understanding of the interrelationships among conditions at school, after-school settings, and home with fluctuations in children’s symptomatology and adaptive behaviour.
- Emphasise generalisation and maintenance of treatment outcomes by focusing on teaching and prompting the use of skills needed to function successfully in the school and at home.
- Collaborate with everyone involved with the child to gain consensus on goals and treatment strategies.
- View assessment and diagnosis as an ongoing process, with a focus on developing comprehensive case conceptualisations that serve as direct guides for treatment decisions.
- Maintain a developmental focus so that the child’s maturity and ability to reason are always considered in selecting and implementing specific treatment strategies.
- Cultivate an authoritative parenting style for adults involved with the child emphasizing clear, developmentally appropriate expectations coupled with warmth and positive attention.

Interventions carried out within the IMHP are thus a form of targeted (tertiary prevention) intervention.

8.5.8 PEER SUPPORT MODELS

As noted in section 4 (also see Table 3), young people are more likely to turn to friends for support with mental health issues. This has been one motivation for the increased attention and funding provided to peer support models, ie approaches to addressing mental health and emotional wellbeing issues in schools by strengthening and making use of the social support provided by young people to each other. Not only are peers in the school environment the most likely source of help for young people in crisis, there is also evidence that ‘having supportive friends is a strong protection against diminished mental health and other problems’ (Dillon & Swinbourne 2007).

Key aspects of all peer support schemes are that selected students are trained to be peer supporters; and that certain students will be users of the scheme, helped either directly by the peer supporter, or by the peer supporter arranging or encouraging other forms of help to be sought and/or given to them. Longer-term aims are to improve peer relationships generally and to reduce rates of unresolved conflicts and bullying among students in the school; and to have positive effects on the school climate or ethos (Houlston & Smith 2009).

Examples of peer support models are provided in the boxes below.
### HELPING FRIENDS

Helping Friends is a program that has been operating in north Queensland since 1990. The program was promoted to school-based youth health nurses and teaching staff, and it was these individuals who took up the program in 22 senior secondary schools. In the early years of program delivery, feedback from schools was sought and the program and its evaluation were refined to reflect the feedback. The program is supported by a facilitator’s manual, participant workbooks and a CD ROM containing presentations and templates for program documentation. The key aim of the program is to increase help-seeking behaviour amongst young adolescents.

Source: Dillon & Swinbourne (2007)

### SOURCES OF STRENGTH SUICIDE PREVENTION PROGRAM

‘Sources of Strength’ was developed in the USA but is now being implemented in a number of countries. It is built on a universal school-based suicide prevention approach designed to build protective influences across a full student population. The purpose is to modify the norms propagated through communication within peer groups to alter perceptions of what is typical behaviour and of the social consequences for positive coping behaviours. Peer leaders model and provide encouragement to their friends to:

- name and engage ‘trusted adults’ to increase communication between young people and adults
- reinforce and create an expectancy that friends would ask adults for help for suicidal friends, thereby reducing implicit suicide acceptability
- identify and use interpersonal and formal coping resources.

Changing these factors is designed to connect suicidal youths with capable adults and to reduce the likelihood that lower risk youths will enter into suicidal ideation or behaviour.

A small number of school personnel are trained to take on the roles of adult advisors who would guide the peer leaders to conduct safe suicide prevention messaging.


In the UK, forms of peer support include:

- befriending
- mediation/conflict resolution
- mentoring
- counselling-based approaches, more commonly used in secondary than in primary schools.

(Houlston & Smith 2009)

Writing of the use of peer counselling in the UK, Houlston and Smith (2009) note that peer counselling schemes can improve the self-esteem of peer supporters, and also impact positively on issues such as perceptions of bullying in a school. They also note that there may be problems with the acceptance and use of such programs by older students.
8.5.9 MENTAL HEALTH SCREENING

A number of the reviewed articles (see eg Weist et al 2007; Pinka et al 2004; Adelman & Taylor 2006) make reference to mental health screening as an important methodology for schools.

Through their daily interaction with students, school staff engage in a process of ‘natural screening’ that can be helpful in initiating supportive accommodations for certain students (Adelman & Taylor 2006).

In contrast, formal screening is accomplished through assessment procedures that often identify many students who do not really have significant problems and there is ‘a need to guard against tendencies to see normal variations in students’ development and behavior and other facets of human diversity as problems’ (Adelman & Taylor 2006: 296). Instead, screening data should primarily be used to sensitize professionals and provide a preliminary indication that something may be wrong (Adelman & Taylor 2006: 296).

A major motivation for mental health screening is that it provides an important means of identifying and reaching out to students who have internalising disorders that are generally not as easily identified in the school setting as externalising disorders (Weist et al 2007: 55). Formal screening programs are thus particularly recommended for the detection of mental health problems such as depression and suicide ideation. The development of school-based screening is part of the process in countries such as the USA of expanding their mental health and social services for all students as part of coordinated school health programs.

At the same time, criticisms have been levelled at it, including that screening may be perceived as ‘government intrusion’ or ‘a violation of the family’s right to privacy’, and contribute to misunderstandings linked to the stigma surrounding mental illness (Weist et al 2007: 55). Because of the frequency of false positive errors64, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment, which may also lead to stigmatisation of certain students (Adelman & Taylor 2006: 296). Research has found that student screening programs are rated as significantly less acceptable than other forms of school-based suicide prevention (eg in-service training) among high school principals, school psychologists, school superintendents, and students (Miller et al 2009: 184).

An example of a formal screening program is provided in the box below.

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ADDLING A SCREENING PROGRAM TO A SCHOOL-BASED MENTAL HEALTH TREATMENT PROGRAM

A mental health treatment program at a middle school in a low-income neighbourhood in New York City provides crisis management, group therapy sessions, individual counselling, and family counselling by social workers and by social work student interns (second year Master’s students). Students are referred to the treatment program mainly by teachers and assistant principals, and also by parents, classmates, or through self-referral. The primarily informal means of referral created concern that many students were not receiving the necessary help, particularly those students whose potential mental health needs did not lead to disruptive behaviour in the classroom. For this reason, a universal mental health screening program was implemented at the school. The goal of the screening program was to screen all sixth-, seventh-, and eighth-grade students for anxiety, depression, and substance use.

Once the screening program was in full operation, it involved a staff that included a full-time program director, a full-time case manager, part-time interviewers, and three psychiatrists, one of whom was based at the school. The on-site psychiatrist spent about 30% of her time in screening activities once the screening program was in full operation. The on-site psychiatrist also provided some treatment services. The other two psychiatrists visited the school regularly as consultants.


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64 Over-identification of problems through formal screening procedures has been described as the generation of ‘false positive errors’ that arise often because many factors found to be symptoms of problems are also common characteristics of young people, especially in adolescence (Adelman & Taylor 2006: 296). Errors should be detected by follow-up assessments.
8.5.10 SUPPORTING TEMPERS, EMOTIONS AND ANGER MANAGEMENT (STEAM)

The Supporting Tempers, Emotions, and Anger Management (STEAM) program developed in the USA is designed to help children manage their emotions. It combines generalised emotion management with anger management (Bidgood et al 2010: 165). It is designed to help children and adolescents by teaching them to identify what emotion they are experiencing and to employ the skills necessary to express their feelings in a positive and healthy manner.

The program aims to teach emotion management through an emphasis on:

- self-awareness
- triggers of emotions
- body signals
- skills to express emotions before the child has lost control.

Considerable emphasis is placed on teaching techniques to handle anger, as most students are referred based on their inability to manage this emotion (Bidgood et al 2010).

The STEAM program combines play activities with techniques such as group discussion. Activities include relaxation training, role-playing, journaling of the child’s feelings, completion of a log of anger-provoking situations, and exercises in self-esteem. The STEAM program consists of 12 sessions, 90 minutes in length, which occur on a weekly basis. (Bidgood et al 2010: 165).

8.5.11 ANTIBULLYING PROGRAMS

THE OLWEUS BULLYING PREVENTION PROGRAM

The Olweus Bullying Prevention Program was the first comprehensive whole-school antibullying program implemented on a large scale and systematically evaluated, with many other programs based on this model (Ryan & Smith 2009: 248-249). The program was developed in Norway but has been implemented widely around the world. According to Stephens (2011), the main goal of the Olweus Program is to make school a safe and positive learning environment in which:

- adults display warmth, positive interest and engagement
- there are clear boundaries concerning unacceptable behaviour
- there is consistent use of non-physical, non-hostile but negative sanctions when rules are broken
- adults at school (and ideally at home) act with authority and as positive role models.

In schools where any of the above features are absent and where bullying occurs, the Olweus Program describes itself as ‘an instrument for restructuring the opportunity and reward structure that supports bullying behaviour. The aim is to develop an environment with fewer openings for bullying and less or smaller ‘prizes’ for bullies’ (Stephens 2011: 385-386).

The Olweus Program is described in the box below.
THE OLWEUS BULLYING PREVENTION PROGRAM

The general prerequisite for the program is adult engagement, with teachers taking charge. Specific measures are:

### School-level measures

- Anonymous self-report questionnaire survey of students to measure the extent of bully–victim problems before and after program implementation and at regular intervals for as long as it remains in operation.
- School conference day on bullying with staff, parent representatives and student representatives to promote collective support for the program.
- Adult supervision during break times and adults intervening decisively when bullying is observed or suspected, including the reporting of bullying incidents. Vigilant supervision of students in ‘dead zones’ (eg changing rooms), where bullying is often out of adult sight, is essential.
- Setting up of staff discussion groups to promote a whole-school approach to dealing with bullying.
- Setting up of a counter-bullying co-coordinating group with overall responsibility for running the program.

### Classroom-level measures

- Class rules against bullying to foster democratic, whole-school participation regarding four main directives: ‘We will not bully others’; ‘We will try to help students who are bullied’; ‘We will make it a point to include students who are easily left out’; ‘If we know somebody is being bullied, we will tell the form teacher (or other teacher) and an adult at home’.
- Class meetings with students, led by the teacher, to raise awareness of issues surrounding bullying and how to deal with it.
- Meetings with students’ parents, which the teacher uses to foster a united front against bullying.

### Individual-level measures

- Serious talks with bullies and victims in order to put a stop to bullying and to signal the setting up of follow-up measures, among which is the assurance of protecting the victim. Bullies are advised that consequences/sanctions will follow if they continue bullying. These can involve: apologising to the victim; personally paying for any damage to the victim’s possessions; verbal reprimand; sitting outside the principal’s office during recess; ‘time-out’ in a dull location; school to contact the bully’s parents; and removal of privileges.
- Serious talks with parents of bullies and victims, the aim being to get the bully’s parents to tell their child to stop bullying and to encourage the victim’s parents to persuade their child to befriend a confident and kind student.
- Development of individual intervention plans which, in cases of resistant bullying, can require changing classes or schools of involved students.

Source: Stephens (2011)
THE ZERO ANTI-BULLYING PROGRAM

The Norwegian ‘Zero’ program is aimed at reducing bullying in school65, with the principle of zero-tolerance of bullying giving the name to the program (Roland et al 2010). The Zero Anti-bullying program understands bullying as not predominantly a reaction to frustrating peers or other frustrating contextual events. Rather, it is assumed that weak teacher control and teacher support might result in weak social cohesion within a class and provide a climate for bullying. The Zero Anti-bullying Program is described in the box below.

<table>
<thead>
<tr>
<th>The Zero Anti-bullying Program (Norway)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A major part of the program is aimed at classroom standards and activities. The main teacher discusses bullying in different ways with the students according to guidelines given in the program. All staff are responsible for responding to students’ comments on issues appearing in the curriculum or interactions related to this. In addition, all staff are responsible for responding to students’ ad hoc comments and reactions related to episodes of bullying. This direct work, focused on bullying, aims to improve empathy in pupils generally and building a norm system related to bullying. An important side effect is the consistent demonstration of adult attitudes.</td>
</tr>
<tr>
<td>All teachers are supposed to lead their classes in an authoritative way. The central dimensions in authoritative leadership profiled in Zero are personal support, academic support and control. The principle of authoritative adult leadership is also executed in all common areas such as corridors and schoolyards. During the breaks, on-duty teachers and other staff wear a yellow reflective vest with the Zero logo on it, which is aimed at making them visible and emphasizing their authority.</td>
</tr>
<tr>
<td>Schools are provided with a clear procedure for intervention when bullying is identified, and all staff are expected to follow this:</td>
</tr>
<tr>
<td>- The victim is contacted first, and normally two or three meetings are held. The victim is comforted and assured that he or she will be informed before each step is taken towards the bully or bullies.</td>
</tr>
<tr>
<td>- Contact with parents is made immediately, if they are not already involved.</td>
</tr>
<tr>
<td>- Contact with the pupil who is bullied and the parents is maintained during the intervention period and often afterwards.</td>
</tr>
<tr>
<td>- The bullies are addressed after one to three meetings with the victim. The main approach is a confrontation strategy to make the bullies aware that the school knows about the problem and does not accept it.</td>
</tr>
<tr>
<td>- The teacher has individual meetings with each of the bullies first and then with all of them together. The parents are contacted the same day.</td>
</tr>
<tr>
<td>- Subsequently, the teacher arranges follow-up meetings with the group of bullies at least once a week to ensure that the bullying has stopped.</td>
</tr>
</tbody>
</table>


65 The program was developed by the Centre for Behavioural Research at the University of Stavanger, Norway. This program was part of the Norwegian Manifesto Against Bullying that was launched in 2002 by the Government and important stakeholders (Roland et al 2010).
8.5.12 SUICIDE PREVENTION PROGRAMS

School-based programs focusing specifically on suicide prevention are less common in the literature, especially when they involve students themselves.

Universal suicide prevention programs appear to be the most widely used approach in the schools and typically focus on increasing awareness of suicide, providing information regarding risk factors and warning signs, dispelling myths about suicide and teaching appropriate responses to peers who may come into contact with someone who may be suicidal.

Selected suicide prevention programs focus on the sub-population of students who may be at higher risk for engaging in suicidal behaviour, such as those who have mental health problems. Targeted suicide prevention programs are aimed at young people who have already engaged in suicidal behaviour, and are based strongly on individualised, evidence-based interventions (Miller et al 2009: 170-171).

Two selected suicide prevention programs are described in the boxes below.

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**SIGNS OF SUICIDE PROGRAM**

The Signs of Suicide program, developed in the USA, combines curricula to raise awareness of suicide and related issues with a brief screening for depression and other risk factors associated with suicidal behaviour. In the didactic component of the program, students are taught that suicide is directly related to mental illness, typically depression, and that suicide is not a normal reaction to stress or emotional upset. Youth are taught to recognise the signs of suicide and depression in themselves and others, as well as specific action steps for responding to those signs. Action steps are described using the acronym ACT:

- **Acknowledge** – acknowledge the signs of suicide that others display and take those signs seriously
- **Care** – let the person know that he/she is cared for and that others want to help
- **Tell** – tell a responsible adult.


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**PERSONAL GROWTH CLASS I PROGRAM**

The Personal Growth Class I program focuses on at-risk youth (ie at risk for school dropout and suicidal behaviour) and includes an assessment interview. The program provides one semester of small-group activities related to social support, weekly monitoring of mood management activities, interpersonal communication, training in self-esteem enhancement, decision-making, and personal control training.


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8.5.13 PROGRAMS FOCUSING ON BODY IMAGE, OBESITY, EATING DISORDERS

These programs are not the focus of this study, but are briefly described here since, as indicated in section 4 of this report, the links between body dissatisfaction issues and mental health and wellbeing issues of children and young people are well established.

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66 Accurately predicting precisely which students will engage in suicidal behaviour has inherent limitations. Despite their potential utility, universal (eg class-wide or school-wide) student screening approaches to suicide prevention ‘present multiple logistical difficulties that will likely make their implementation a significant challenge to school personnel’ (Miller et al 2009: 184).
Typically, school-based prevention programs target a combination of:

- nutrition education
- physical activity
- a reduction in sedentary behaviours among children.

(Cook-Cottone et al 2009: 696)

The programs often aim to include family members in the above efforts. Programs range from increasing physical activity and teaching children about nutrition, to extensive, multifaceted interventions addressing activity, nutritional education, as well as school lunch food offerings (Cook-Cottone et al 2009).

8.5.14 DRUG PREVENTION PROGRAMS

Similar to the programs described above, drug prevention programs are not the focus of this study; nevertheless, substance abuse is recognised as a mental health issue (Marikangas et al 2009).

Based on a review of drug prevention programs in schools, Soole et al (2008) identify the following program types:

- Programs that focus on interpersonal development, such as self-esteem enhancement, improving coping and stress management skills, and improving personal decision-making through self-reflection.
- Resistance skills training, usually involving a strong knowledge dissemination component and emphasising the development of refusal and resistance skills.
- Generic skills training, including knowledge dissemination, as well as a focus on teaching generic life skills such as decision-making, problem-solving, communication and assertiveness.
- Counselling.
- Social influence programs, in which young people are educated about the influence of the media, peers and adults on drug use and misconceptions regarding drug use are corrected and replaced with more accurate information.
- Sporting and recreational activities programs.
- Theatre and drama-based drug education.
- Competency enhancement, emphasising the teaching of generic life skills and other relevant skills such as those pertaining to dating and relationships, and often including peer delivery.
- System-wide change, involving inclusion of family, community and/or media interventions, and policy level changes that affect the overall school climate.

(Soole et al 2008: 273-277)

8.6 SUMMARY

This section has provided descriptions of a range of school-based initiatives in international jurisdictions that assist students with mental health and psychological-emotional wellbeing issues. The material complements that which is described in section 7 of this report, namely descriptions of models in Australian jurisdictions.

Models of school-based delivery of counselling services can be found in jurisdictions that are comparable to NSW (such as England, Scotland and New Zealand). Depending on the historical developments in the various jurisdictions, school-based mental health staff may include ‘school counsellors’, ‘school...
psychologists’ and/or ‘school social workers’. Working with individual students, family members and other service providers, school counsellors carry out clinical assessments, and provide crisis intervention and pro-active/preventive counselling services.

A common theme in the descriptions of school counselling/psychology services in the various countries is that they devote a large proportion of their time to carrying out assessments, and proportionally less time engaged in providing intervention and prevention activities. At the same time, they are involved in the development and implementation of school-wide mental health and wellbeing programs.

It is evident from the literature that, in addition to commonalities with regard to school counselling/educational psychology, developed countries also have in common a range of whole-school approaches to student wellbeing. For example:

- the broad approach to addressing student wellbeing via universal, often curriculum–based approaches known as social and emotional learning (SEL) has been found in the education systems of many countries, including Australia
- programs with specific titles such as the Olweus Bullying Prevention Program (which was started in Norway) have been adopted in many countries
- cognitive-behavioural programs of varying kinds are found in school systems in many developed countries.

Based on the descriptions provided of several of these programs in section 7 and 8 of this report, it is evident that such programs often include a range of activities and methods which together constitute an ‘intervention’. Amongst others, interventions may include:

- awareness-raising
- knowledge dissemination
- skills training
- individual counselling
- working with small groups of students
- system-wide changes to impact on the ethos or climate of the school
- social, recreational and sporting or other physical activities
- harnessing the support that can be provided to individual students by their peers and family members and community services.

Evaluations of the effectiveness of school-based mental health and wellbeing programs that have been sourced in the literature review are discussed next.
9 Evaluations of the effectiveness of school-based mental health and wellbeing interventions

9.1 INTRODUCTION

The available literature points to a strong emphasis on developing evidence-based interventions that can affect the academic and behavioural outcomes and social-emotional wellbeing of children and adolescents in school settings. Merrell and Buchanan (2006: 167-168) point to

...an optimistic appraisal...for a future where practitioners and administrators select interventions based not only on their likely match to the needs of particular students, but also on the aggregated evidence regarding their effectiveness and the conditions under which they are most likely to be effective.

The result is that research findings indicate that emotional, behavioural and social problems of children and adolescents can be prevented or ameliorated through the use of school-based interventions, which have been used to prevent as well as to treat a variety of problems, including anxiety, depression, disruptive behaviour problems and substance abuse (Forman & Barakat 2011: 283).

This section provides an overview of current evaluative research in the field on the basis of the literature accessed for this study. It is important to note that while some of the programs included in this section, have been described in sections 7 and 8 of this report, many of the evaluation studies do not focus on specific programs but rather on a range of programs (for example under the rubric of ‘universal prevention programs’); or they do not provide sufficient detail on a specific program that is being evaluated; or they are systematic reviews or meta-analyses that consider the evaluation evidence for numbers of programs and studies.

For ease of reading and reference, the studies and data are presented in this section as follows:

- Studies focusing on school-based mental health prevention and early intervention programs. Most of these studies focus on universal programs, but some include selected and targeted interventions.

- Evaluations of specific programs (ie programs that have a recognised ‘name’ such as FRIENDS) or those that focus on specific methods (such as cognitive-behavioural interventions) or on specific wellbeing/mental health areas (such as depression).

- Systematic reviews or meta-studies focusing on suicide prevention, overweight and obesity and substance use. These programs are not the focus of this review but, as discussed in section 4, contribute to understandings of child wellbeing and have a direct or indirect impact on the psychological/emotional wellbeing and mental health of students.

- Evaluations of school counselling, school psychology and school social work.

The section is concluded by:

- providing a summary of systematic reviews and meta-studies that are drawn upon specifically to shed light on what interventions appear to work

- discussing some of the implementation and research issues raised in the available literature

- providing suggestions by researchers and authors for improvements and further research.

67 Meta-analysis is a range of systematic, quantitative methods used to synthesize research findings from multiple studies investigating similar outcome variables. The key to meta-analysis is the calculation of an ‘effect size’ measurement, which enables comparison among individual research findings from a number of studies using a common measurement (Soole et al 2008: 269). The ‘effect size’ is determined by the particular researcher(s) and is not standard across all meta-analyses.
There is a strong research focus on the issues dealt with in this literature review, and in the discussion that follows, priority is given to randomised controlled trials (RCTs) appearing in peer reviewed journals, as well as systematic reviews and meta-analyses of such trials. 68

9.2 SCHOOL-BASED PREVENTION AND EARLY INTERVENTION PROGRAMS

Many of the studies accessed in the literature review focus on school-based mental health prevention and early intervention programs as a whole, since, as described in section 5 above, the WHO health promotion framework has become a widely-used model in school systems in the developed world. This section considers the outcomes of these studies.

**EFFECTIVENESS OF SCHOOL-BASED PREVENTION AND EARLY INTERVENTION PROGRAMS FOCUSING ON MENTAL HEALTH AND WELLBEING OUTCOMES**

Neil and Christensen (2007) examined the nature and efficacy of Australian school-based prevention and early intervention programs for anxiety and depression. The researchers identified 24 studies69 pertaining to nine programs, six of which were universal, two were selected, and one was a targeted/treatment program. The study found:

- A large proportion of the programs reported positive outcomes either immediately or at follow-up trials, which ranged from four months to four years following the programs.

- Both the selected and universal approaches appear to produce short to mid-term small to moderate reductions in anxiety and depression in schools.

- The programs with the strongest evidence for effectiveness were the FRIENDS program and the Resourceful Adolescent Program (RAP) (see descriptions of FRIENDS and RAP in section 7 of this report). The FRIENDS program includes booster sessions at one and three months after the conclusion of the program, and accounted for four of the six successful 12-month follow-up trials. The authors note that 'the FRIENDS program is further supported by its successful implementation with migrant students and maintenance of treatment effects for up to 36 months’ (Neil & Christensen 2007: 307). Since most of the RAP trials were not randomised controlled trials (RCT), the researchers recommend that further research is needed to demonstrate the efficacy of this particular program.

Zoellner (2009: 17-21) analysed the evaluations or implementation reports of Australian whole-school programs focusing on mental health promotion. On the basis of this study, the researcher identified three commonly reported differences between the health and education professionals70, which may have an impact on the implementation of programs that are often developed by mental health professionals but implemented by teachers:

- Education could be characterised as having an ‘individualistic orientation’, with teachers having autonomy over curriculum materials, instructional strategies and assessment, while health promotion is characterised by notions of teamwork and group processes.

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68 Randomised controlled trials in school settings involve random assignment of students to intervention and control groups, matching of students in the intervention and comparison conditions, and pre-test and post-test measurements of the effects of the intervention on one or more outcomes as identified by the researchers (see Wilson & Lipsey 2007: 3).

69 The authors searched the Cochrane, PsychInfo and PubMed databases, and obtained additional materials from program websites, reference lists and authors. Only programs developed in Australia and overseas programs that had been trialed in Australia were included in the review. Programs were included that addressed symptoms of anxiety or depression in a school context or increased student resilience through the development of positive coping skills. Universal, selected and treatment programs were included (Neil & Christensen 2007).

70 Zoellner (2009: 17) notes that the (mental) health and education sectors have historically operated in isolation and are characterised by different methods or training for entry to the professions, funding sources, bureaucratic structures, and philosophical and knowledge heritages.
The education sector has a formal leadership structure that includes the role of principal, while there is a tendency for leadership in the health sector to be described in a managerial sense.

Change is an accepted way of ‘doing business’ in the school system, with a new cohort entering and finishing each year, students moving interstate each year and relatively high staff turnover, whereas evidence-based programs favour adherence to program fidelity and a steady-state environment.

(Zoellner 2009: 17-21)

Stewart-Brown (2006: 9-11) examined the international evidence on mental health promotion and the prevention of mental health problems in schools. The systematic review found:

- There was contradictory evidence regarding the relative effectiveness of universal and targeted approaches, with two reviews suggesting that universal, primary preventive approaches were more effective, and two reviews suggesting the opposite.
- Programs were more likely to be effective if they were aimed at promoting mental health rather than preventing mental illness.
- School-based programs are more effective when they: involve the whole school, and include changes to the school’s ‘psychosocial environment’; focus on personal skills development; involve parents and the wider community; and are implemented over a long period of time (continuously for more than one year).
- Programs focusing on developing self-esteem showed modest effects, while knowledge-based programs were not effective.

Drawing on a review of universal and early intervention mental health programs in the international literature, Browne et al (2004: 1372-1376) provide an overview of the effectiveness and efficiency of mental health services for school-aged children. The study finds, amongst others, that:

- Universal or early intervention programs are more effective than programs aimed at reducing existing negative behaviours.
- Younger children benefit more than older children.
- Programs to address a specific problem or problems have greater effect than broad, unfocussed interventions.
- Programming that has multiple, integrated elements involving more than a single domain (eg family or school) is more likely to have positive results than single focus, single domain interventions.
- Effect sizes decrease over time for knowledge and skills acquisition and behaviour reduction, suggesting the need for periodic follow-up and reinforcement of positive interventions.
- Easily accessible school-based services encourage continuing participation in mental health services.

The systematic review found that interventions ranged from programs offering only to develop classroom skills to comprehensive programs lasting several years with whole school and parental involvement. Interventions covered issues such as the resolution of conflicts, antisocial behaviour, prevention of depression and suicide and promotion of self-esteem and emotional literacy (Stewart-Brown 2006).

The authors define effectiveness measures as those based on comparing outcomes for children and youth receiving and not receiving services; and efficiency as the cost of providing services compared to the cost to society of not providing such services (Browne et al 2004: 1372).
EFFECTIVENESS OF SCHOOL-BASED PREVENTION AND EARLY INTERVENTION PROGRAMS FOCUSING ON MENTAL HEALTH AND WELLBEING OUTCOMES

programs, but there are risks in terms of possible breaches of confidentiality and stigmatisation.

Andersen and Nord (2010) carried out a study in Norway which provides a robust research approach. The researchers examined the effectiveness of a national preventive program in mental health targeted at students in Norwegian secondary schools. The researchers assessed the degree of achievement of the program’s stated goals of increasing student’s understanding and recognition of mental problems and illness, and at lowering their thresholds for help seeking.

The study found that, compared with effect sizes (i.e., statistical calculations of the impacts of interventions on student wellbeing/mental health outcomes) from similar studies (between 0.01 and 0.30 in Norway and between 0.26 and 0.57 in international surveys), the effect sizes of the Norwegian preventive mental health program lie in the higher end of the scale (Andersen & Nord 2010), suggesting that the country’s national preventive program was effective in meeting its aims.

Spence and Shortt (2007: 540) investigated the effectiveness and efficacy of universal school-based programs targeting depression in the English-language literature. On the basis of a comprehensive review of international studies, they find that the majority did not demonstrate positive effects upon depression immediately after the intervention. Outcomes were marginally stronger around 6 to 10 months after intervention, but where longer follow-up measurement was included, these effects were not maintained.

On the basis of their findings, the authors write that ‘it would be premature for policy makers and practitioners to assume that an investment in relatively brief, universal, school-based interventions is likely to produce significant long-term benefits in preventing depression among young people’ (Spence & Shortt 2007: 540). Nevertheless, the researchers find evidence for ‘small but significant, short-term benefits for targeted prevention for depression among children and adolescents (e.g., with students experiencing parental separation or divorce, bereavement, parental mental health problems or elevated depression symptoms), the majority of which involve cognitive-behavioural approaches.

On the basis of the study, the researchers suggest that efforts might be better focused on targeted rather than universal interventions for the prevention of depression in young people, but studies are needed that examine the relative costs and benefits of these two approaches before such conclusions can be drawn (Spence & Shortt 2007: 540).

Calear and Christensen (2009) conducted a systematic review to identify and describe school-based prevention and early intervention programs for depression and to evaluate their effectiveness in reducing depressive symptoms. The results of the review are mixed, with only half of the trials reporting a significant reduction in depressive symptoms at post-test or follow-up. Effect sizes ranged

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73 A sample of 880 students in a county where the program had been implemented was compared with a sample of 811 students in a county where the program had not yet been implemented. Data was collected through questionnaires prior to intervention and at one, six, 12 and 24 months after intervention (Andersen & Nord 2010).

74 In this study, the researchers made use of the Society for Prevention Research standards (Spence & Shortt 2007: 527), discussed in greater detail in section 9.8.1 of this report.

75 The researchers included studies that had been published between 1998 and 2008 with the following inclusion criteria:

- Study participants were children aged 5-12 years and adolescents aged 13-19 years.
- The primary aim was to reduce or prevent the symptoms of depression or to build resilience.
- The intervention was school-based.
- The study used randomised controlled trial methodology.

(Calear & Christensen 2010: 430)
Evaluations of the Effectiveness of School-Based Mental Health and Wellbeing Interventions

from 0.21 (small) to 1.40 (large). The universal programs that included all participants regardless of symptom level displayed the lowest level of efficacy and effectiveness. Targeted/indicated programs had a higher proportion of successful trials at post-test and follow-up than both selective and universal programs, supporting the use of targeted programs to produce immediate and long-lasting change in depressive symptoms (Calear & Christensen 2009: 435).

In a systematic review of school-based mental health interventions in the USA that target both mental health and educational outcomes of children at risk for antisocial behaviour, Hoagwood et al (2007: 87) found that effective initiatives (i.e., programs that had positive impacts on both the academic and mental health outcomes of the children) were complex and highly intensive programs involving:

- interventions at multiple levels (e.g., educational, behavioural problems, family support)
- interventions across multiple contexts (classroom, school-wide interventions, home)
- individual level behaviour management techniques
- extended periods of time (over at least one year).

(Hoagwood et al 2007: 87)

The reviewed studies found, however, that the effects of mental health interventions on academic outcomes are modest and often do not hold over time. While mental health interventions are designed to remove learning barriers, the likelihood of academic gains also depends on the presence of effective instructional techniques. From a research point of view, there are questions around how to measure academic success. The study suggests that academic engagement and classroom behaviour are likely to be more sensitive to change as a result of mental health interventions in the short-term, rather than the generally used indicators of academic progress, such as grades and scores (Hoagwood et al 2007: 88-89).

Slade (2002) examined the effects of school-based mental health programs on mental health service use by adolescents at school and in the community in the USA. The study found:

- Students who attend schools with mental health counselling services offered on-site are more likely to have received counselling at school than students attending schools where on-site services are not offered.
- The existence of school-based mental health programs does not affect the rate at which counselling is received outside of school.
- Students from low SES and minority status backgrounds use non-school-based services less frequently and school-based services more frequently than students from higher socio-economic backgrounds.

(Slade 2002: 159)

In a study focusing on the student wellbeing/mental health role of teachers in schools in the USA, Han and Weiss (2005: 672-673) surveyed the existing literature to determine what evidence exists for the effectiveness of teacher-administered classroom-based programs addressing mental health and wellbeing promotion in schools. On the basis of the study, the researchers identify four ‘essential ingredients’ that characterise potentially sustainable teacher-implemented classroom mental health programs, namely:

- **Acceptability to schools and teachers:** teachers must view the program as acceptable, and the program’s structure and content need to motivate and inspire teachers to want to implement the program.

- **Effectiveness in changing children’s behavioural and emotional functioning:** best achieved by selecting programs that have been demonstrated to be effective via empirical evaluation, and
implementing the program as intended (which requires teachers to be trained in applying the principles of the program).

- **Feasibility to implement the program on an ongoing basis with minimal (but sufficient) resources**: programs should require minimal additional resources for ongoing implementation after the initial training phase, and the program needs to be suitable for integration within the school’s operations and infrastructure.

- **Flexibility and adaptability**: teachers must understand the program well enough so that they are able to modify it to suit their students’ needs without sacrificing the core principles and central intervention techniques.

### 9.3 EFFECTIVENESS OF SPECIFIC PROGRAMS

The literature provides many examples of studies focusing of evaluating programs, such as those described in sections 7 and 8 of this report. Here we provide examples of these evaluations.

#### 9.3.1 EVALUATION OF MINDMATTERS

Ainley et al (2006) studied the dissemination and use of *MindMatters* and associated policies in schools across Australia (see description of the *MindMatters* initiative in section 7.5.2 of this report). The national survey found, amongst others:

- *MindMatters* was used in some way in two thirds of secondary schools and was a key resource in one fifth of all the schools surveyed.

- Awareness of *MindMatters* was high, with fewer than 5% of schools not being aware of the program at all.

- *MindMatters* had a significant impact on school ethos and culture, and the view that mental health and wellbeing was an integral part of the school ethos and culture was greater in schools that used MindMatters as a key resource than in other schools

- Schools that used *MindMatters* as a key resource reported that it influenced the development of policies and programs, and that it resulted in greater effectiveness of antibullying programs and programs that foster student resilience.

(Ainley et al 2006: 48-50)

On the basis of the evaluation, the researchers write that their findings ‘highlighted the importance of the linkages to the mainstream curriculum and to the school organisation for successful general programs concerned with student well-being’ and that wider implementation of the initiative was likely to depend on ‘moving schools that are currently using it as an ancillary resource to using it more widely as a key resource’ (Ainley et al 2006: ix).

#### 9.3.2 EVALUATION OF KIDSMATTER

Following the trialling of *KidsMatter* (described in section 7.5.1 of this document) in 100 schools across Australia in 2007-08, the program was evaluated (Slee et al 2009). The findings of the evaluation indicated, on average, an improvement in student wellbeing and a decrease in mental health difficulties. The impact appeared greater for students who had been assessed as having mental health problems at the level of ‘borderline’ or ‘abnormal’ before the program started.

Dix et al (2011) examined the relationship between the quality of implementation of the *KidsMatter* school-wide health and wellbeing initiative in Australian schools on student academic performance. The

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76 These were measured by making use of the Strengths and Difficulties Questionnaire scores, decreases on the Mental Health Difficulties scale, and increases on the Mental Health Strengths scale (Slee et al 2009: 76-86).

77 96 schools from various States, locations and education sectors were included in the study. During the two years of the KidsMatter trial, questionnaires on a variety of aspects of school and student functioning were administered to the students’
study found that schools that implemented *KidsMatter* well also had improved learning outcomes for students, equivalent to six months more schooling by Year 7, over and above any influence of socio-economic background (Dix et al 2011: 6).\textsuperscript{78}

On the basis of the study, the authors conclude that ‘schools that were committed long-term to the effective school-wide implementation of the *KidsMatter* mental health initiative\textsuperscript{79} may well have better positioned themselves to support both students’ mental health and academic outcomes’ (Dix et al 2011: 6).

### 9.3.3 EVALUATION OF THE SCHOOL-LINK INITIATIVE IN NSW

The School-Link initiative in NSW (see section 7.2.4) was evaluated in 2004-05 (Maloney et al 2008). Changes reported by schools involved with School-Link include:

- changes in knowledge and ability to manage mental health issues (82% of schools reported raised awareness about mental health issues and 74% reported an increase in knowledge about mental health)
- skills and confidence in delivering mental health programs (64% reported increased confidence and 54% reported improved skills)
- structural changes (58% reported school policy that supports mental health programs and 34% reported that mental health programs were embedded in the curriculum).

On the basis of this evaluation, the authors conclude:

*School-Link has established a strong partnership between health and education at all levels, raised the awareness of child and adolescent mental health issues, and made some gains in the area of prevention and early intervention. The next challenge is to maintain and build on the momentum and the foundations that have been established.*

(Maloney et al 2008: 53)

### 9.3.4 RESEARCH ON THE IMPACT OF SOCIAL AND EMOTIONAL LEARNING (SEL) PROGRAMS

SEL programs have been described in section 8.5.1 of this report. The available literature suggests that they are one of the most prevalent forms of mental health/student wellbeing interventions adopted in schools in many jurisdictions.

Payton et al (2008) considered the findings from three large-scale reviews on the impact of SEL programs on students\textsuperscript{80}. On the basis of the study, the researchers found:

- In post-intervention measurements, students in SEL programs demonstrated improvements in multiple areas of their personal, social and academic lives with positive effects on: social-emotional skills; attitudes towards self, school and others; social behaviours; conduct problems; and emotional distress. However, there were fewer statistically significant improvements in follow-up measurements.

\textsuperscript{78} Data was gathered from the views of those experiencing the *KidsMatter* intervention (parents and teachers) as well as those providing dedicated support for the implementation (Dix et al 2011: 3).

\textsuperscript{79} Implementation was investigated in this study by means of an ‘Implementation Index’ focusing on three elements:

- fidelity of implementation
- extent of the ‘dosage’ of the intervention that was delivered
- the quality of the delivery process.

(Dix et al 2011)

\textsuperscript{80} The review was based on 317 studies published by December 2007 that involved 324,303 participants between the ages of 5 and 13. The studies all included a control group and reported information for calculating effect sizes (Payton et al 2008: 4-5).
- SEL yielded an average gain on achievement test scores of 11 to 17 percentile points, thus offering students a practical educational benefit.

- SEL interventions were effective for students with and without presenting problems, for schools in urban, suburban and rural areas, and for racially and ethnically diverse student bodies.

- SEL interventions had no significant effect on drug use.

(Payton et al 2008: 6)

Durlak et al (2011) carried out a large-scale meta-analysis of SEL programs. The researchers explored the effects of interventions across multiple outcomes for students between the ages of 5 and 18 who did not have any identified adjustment or learning problems81 (Durlak et al 2011: 407).

The meta-analysis found that, compared to controls, participants in SEL programs demonstrated significantly improved social and emotional skills, attitudes, behaviour and academic performance, reflecting an average 11-percentile point gain in achievement. The largest gain amongst participants was in social-emotional skill performance, including ‘emotions recognition’, stress management, empathy, problem solving and decision-making skills (Durlak et al 2011: 412-417).

The study also found that classroom teachers and other school staff effectively conducted SEL programs, suggesting that interventions ‘can be incorporated into routine educational practice and do not require outside personnel for their effective delivery’ (Durlak et al 2011: 417).

Similar to the Durlak et al (2011) study, Hallam (2009) examined the effectiveness of the SEAL program in the UK, including assessing the impact of the program on the participating children and assessing the perceptions of school staff following implementation of the program. Findings from the study included:

- School staff were generally positive about the impact of the program, with 82% of teachers agreeing that it increased students’ ability to control emotions such as anger. The program also increased staff understanding of the social and emotional aspects of learning and helped them to better understand their students.

- In terms of the children, there were clear gender differences in response to almost all of the measures, with girls consistently more positive in their responses and boys having more negative self-perceptions and attitudes towards school.

- It may not have been the introduction of the SEAL materials per se which enhanced the perception of children’s behaviour and wellbeing, but simply the focus in the school on improving behaviour. It was therefore difficult to separate effects of the program from effects of the more general ethos and culture of the school.

- The program tended to consolidate the negative identity of a minority of disaffected students (ie students identified as being at risk) and there was a trend toward provision of additional support to effect changes in these students. This includes working with small groups of students alongside the conduct of the main program.

(Hallam 2009: 328-329)

9.3.5 IMPLEMENTATION OF COGNITIVE-BEHAVIOURAL PROGRAMS

As is the case with SEL interventions, cognitive-behavioural programs are frequently discussed in the literature as key approaches to responding to student wellbeing in school settings.

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81 The sample consisted of 213 studies involving 270,034 students, with 75% of the papers published within the past two decades; 47% of the studies employed randomised designs, 15% of the studies collected follow-up data at least six months after the intervention ended, and the majority of programs were delivered by teachers (53%) or non-school personnel (21%) (Durlak et al 2011: 411-412).
Gillham et al (2007: 9) write that several cognitive-behavioural interventions are used in schools to prevent depressive symptoms in young people. However, there is a lack of studies which demonstrate the effectiveness of these programs when they are delivered by school-based personnel and ‘when these programs do work, it is usually unclear whether the cognitive-behavioral therapy skills or other nonspecific factors (eg time spent in a structured after-school activity, attention from an adult, support from peers) is responsible’ (Gillham et al 2007: 9).

In order to address this research gap, these authors undertook an evaluation of one form of cognitive-behavioural intervention, the Penn Resiliency Program (described in section 8.5.2 of this document) in three schools in a suburban metropolitan area in the United States. The study found that the effects of the program were ‘inconsistent’ in that there was a measured reduction in depressive symptoms in two of the schools over a 2.5-year period, but not in the third (Gillham et al 2007: 17).

The authors were unable to identify the source of the differential effects amongst the schools but suggest that ‘subtle differences among the schools in program endorsements, students’ needs, or general school climate may have enhanced...effectiveness in two schools and/or hindered its effectiveness in the third’ (Gillham et al 2007: 17).

The implementation of the program was carefully measured in this study, described in the box below.

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**Measuring implementation integrity**

An integrity coding system was designed to measure program leaders’ adherence to the intervention protocol.

Intervention sessions were audio-recorded.

Following the intervention phase, four lessons from each group were selected for intervention adherence coding. These lessons were chosen because they contained key content and included early, middle, and later sessions. Group leaders were not informed which lessons would be rated.

Two research assistants rated each lesson on the presentation of 11–14 concepts, skills, or activities. For each content item, raters used a 7-point scale ranging from 1 (no coverage) to 4 (satisfactory coverage) to 7 (excellent coverage).

Source: Gillham (2007: 11-12)

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Results from this study point to the need to focus on evaluating interventions in real world settings that would lead to the development of dissemination procedures that enable schools to include evidence-based programs as part of their educational mission (Gillham 2007: 18).

Forman & Barakat (2011) investigated the research literature that focuses on the successful translation of research findings on cognitive-behavioural interventions to the daily practice of schools. They found that the following factors have a significant positive effect on the implementation process:

- aspects of the organisational structure, including the use of regular school staff members as program implementers
- standardised program materials that were clear, explicit and easily understood and used by the implementer
- the fit of the intervention with school goals, policies and other school programs
- high-quality initial training in the content and process of delivering the intervention to students and ongoing technical assistance or consultation after the initial training
- direct support for the intervention by the principal.

(Forman & Barakat 2011: 292-293)
9.3.6 EVALUATION OF PROGRAMS FOCUSING ON DEPRESSION

PROBLEM SOLVING FOR LIFE PROGRAM

Spence et al (2005) carried out an investigation to determine whether the effects of participation in a depression prevention program carried through over time. Conducted in Queensland, the study involved 1,500 Grade 8 students attending 16 high schools that were matched in pairs according to demographic features and randomly assigned to either an active intervention or a monitoring-control condition. The effects of the program were examined separately for those with elevated depression scores measured by means of the Beck Depression Inventory (the high symptom group) and for those whose initial depression scores fell below a cut-off point (the low symptom group) (Spence et al 2005: 160-161).

In a study carried out shortly after the program was conducted, the researchers identified benefits following participation in the preventive intervention in comparison with the control group. This was true for students in both the high symptom group and the low symptom group. However, these benefits were no longer evident by one-year follow up (Spence et al 2005). The results of the study conducted in the four year follow up period revealed no significant differences between students who completed the preventive intervention compared with those who did not. In particular, of those students who were identified as showing elevated symptoms of depression (but not criteria for a depressive disorder) at baseline, around 25% reported experiencing a diagnosable depressive disorder over the following four-year period, irrespective of whether they had participated in the preventive intervention.

On the basis of this study, Spence et al (2005: 166) write that ‘this finding suggests that the high-symptom group were indeed at risk and also demonstrates the stability of such problems [symptoms of depression] over prolonged periods’.

TEACHING KIDS TO COPE

Puskar et al (2003) made use of a randomised, controlled, clinical trial design to evaluate the short and long term effectiveness of a group-administered, cognitive-behavioural intervention on rural adolescents. The study used a randomised, controlled clinical trial design to evaluate the short and long-term effectiveness of the ‘Teaching Kids to Cope’ intervention on depressive symptomatology and coping strategies in a sample (N=89) of rural adolescents in the USA (Puskar et al 2003: 72).

The study found that adolescents in school settings who are experiencing depressive symptoms ‘can benefit from short-term intervention that focuses on coping skills’ and that positive outcomes are maintained during the year follow-up (Puskar et al 2003: 78). On the basis of the study, the authors identified common themes of ‘adolescent coping’ that could be addressed in a group intervention (carried out over ten sessions) focusing on depressive symptomatology. These are described in the box below.

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82 The Problem Solving for Life Program is a whole class initiative delivered weekly in 45 minute - 1 hour sessions by classroom teachers as part of the school curriculum. The focus is on ‘cognitive restructuring’ and life problem skills training (Spence 2005; Spence & Shortt 2007: 531).

83 A total of 751 students (47.5% male and 52.5% female) took part in the universal prevention program and 749 students (49.4% male and 50.6% female) in the monitoring-control condition.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Discussion</th>
<th>Effective cognitive-behavioural intervention strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issues of daily living</td>
<td>A perception of not having sufficient personal resources, energy and time to meet the complex demands of the adolescent experience is a consistent theme. Difficulty in establishing a balance among multiple demands (family, peers, work and school) is often identified as the source of the issue.</td>
<td>Cognitive-behavioural techniques include:</td>
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<td></td>
<td></td>
<td>- thought reframing</td>
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<td></td>
<td></td>
<td>- problem solving</td>
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<td></td>
<td></td>
<td>- relaxation exercises</td>
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<td></td>
<td></td>
<td>- social support</td>
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<tr>
<td>Identity issues</td>
<td>Students struggle to identify the 'self' in terms of their relationships with family and peers, sexuality, risk taking behaviours (such as drug and alcohol use) and career choices.</td>
<td>- providing scripted exercises that are role-played</td>
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<tr>
<td></td>
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<td>- active problem-solving and sharing of experiences through discussion, drawing and poetry</td>
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<tr>
<td></td>
<td></td>
<td>- discussion of identity issues around family, peers, school, career choice, sexuality and drug and alcohol use</td>
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<tr>
<td>Regulation of emotions</td>
<td>Experiences of emotional reactivity and depressive symptoms are often discussed only by around session seven or eight of the program. Issues are discussed in relation to a specific event or more often as ongoing thought patterns.</td>
<td>Strategies to decrease the intensity of emotional reactivity and depressive thoughts include:</td>
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<td></td>
<td></td>
<td>- thought reframing</td>
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<td></td>
<td></td>
<td>- distracting activities</td>
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<td></td>
<td></td>
<td>- talking to peers or family</td>
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<td></td>
<td></td>
<td>- relaxation</td>
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<tr>
<td></td>
<td></td>
<td>- problem-solving activities</td>
</tr>
<tr>
<td>Confidentiality struggles</td>
<td>Adolescents are ambivalent about sharing personal thoughts due to fears of peer gossip and family intrusiveness.</td>
<td>Use of a behavioural activity focusing on 'trust', and recognising that confidentiality issues are likely to emerge whenever more personal comments are made during the sessions</td>
</tr>
</tbody>
</table>

Source: Puskar et al (2003: 77-78)
SCHOOL-BASED INTERNET PROGRAM FOR REDUCING DEPRESSIVE SYMPTOMS

O’Kearney et al (2009) investigated the impact of a school based internet program for reducing depressive symptoms in adolescent girls. The study found that the program (MoodGYM) produced a significantly faster rate of decline in self-reported depressive symptoms than the usual curriculum, and that the benefit was most evident for those girls with initial levels of depression above the cut-off for a clinically relevant level of symptoms. At the same time, the low rates of completion of the program highlight the problems in ensuring adherence to internet programs for depression (O’Kearney et al 2009: 70).

9.3.7 EVALUATION OF THE FRIENDS/FRIENDS FOR LIFE PROGRAM

It was noted in section 9.2 above in connection with the synthesis study of Neil and Christensen (2007) that the FRIENDS program has strong evidence in support of its effectiveness in addressing depression and anxiety in school settings in Australia. The effectiveness of the FRIENDS program as a universal preventive mental health program has been confirmed by other studies in the UK (Maxwell et al 2008: 278). In this section, studies examining the longer term effects of FRIENDS are briefly described.

Barrett et al (2006) aimed to evaluate the longer term prevention effects of the FRIENDS program across two grades, with long-term follow-up data from 12-month, to 24-month, to 36-month follow-up. Results demonstrated that there were significantly fewer students measured at the 36-month follow up with high risk anxiety indicators when compared to the control groups. The authors note, however, that the findings are different for girls and boys and that for girls, who reported the highest scores of anxiety at pre-intervention and who reported the largest reductions in anxiety up to 12-month follow-up, it seems that prevention effects are only durable up to 24-month follow-up (Barrett et al 2006: 410).

Stopa et al (2010) examined the effectiveness of the FRIENDS for Life program (see description of program in section 7.5.3) in a socioeconomically disadvantaged population in Queensland. The study involved 963 children attending Grade 5, 6 and 7 in public schools in south-east Queensland, which enabled comparisons based on age (Stopa et al 2010: 8-9).

Making use of pre-intervention, post-intervention and 12 month follow-up assessment, the study found that participants reported fewer anxiety and depression symptoms post-intervention and no significant difference in scores between post-intervention and 12-month follow-up. This suggests that ‘these improvements remained robust over time’ (Stopa et al 2010: 15).

By comparison, and contrary to prediction, the use of cognitive-behavioural problem-solving significantly decreased 12 months post-intervention and there was no significant change in the use of assistance-seeking over time (Stopa et al 2010: 16). This suggests that, participants were less likely, or no more likely to use these positive coping skills following the intervention. The authors compared this finding with those from another study which investigated changes in coping strategies for children in Grade 6 (late primary school) and Grade 9 (early high school) (Lock & Barrett 2003, cited in Stopa et al 2010: 16), and find support for the view that while younger children (in primary school) are less likely to avoid anxiety-provoking situations post-intervention, they are also less likely to use positive coping strategies post-intervention than older children (in high school).

On the basis of this study, the researchers conclude that long-term reduction in the symptoms of anxiety and depression is possible when intervening with children from disadvantaged communities at the universal level.

9.3.8 EVALUATION OF THE STEAM GROUP WORK PROGRAM

Bidgood et al (2010) evaluated the effectiveness of the STEAM group work program conducted by social workers in helping both elementary age children and adolescents to better manage their emotions (the program is described in section 8.5.10 of this report). This study is particularly useful as it examines the impact of developmental phase (age of the children) on the effectiveness of a mental health program. The intervention was carried out in Canada.

84 The authors point out that the study was significantly limited due to not being able to have a waiting-list control and that the results of the study are based solely on children’s subjective self-reporting of symptoms (Stopa et al 2010: 18).
Results from the study showed that the STEAM program, as rated by teachers, parents, and the children themselves, was effective in producing changes in emotional management skills (Bidgood et al 2010).

However, this research demonstrated that these effects varied by age group, with the youngest children showing the most improvement. Specifically, as measured by the self-reports of the students included in the groups, and teacher and parent ratings, children in Grades 1 through 3 rated themselves as improving significantly following the program, while children in Grades 7 and 8 demonstrated no improvement following the STEAM program.

On the basis of this study, the authors conclude:

The potential for improvement demonstrated by the children in Grades 1 through 3 appears to be dampened even by the time children reach Grades 4 through 6. Interventions should occur as soon as possible before patterns of poor emotional management become ingrained. Overall, these results appear to suggest that it grows increasingly difficult to produce improvements in emotional management skills as children age.

(Bidgood et al 2010: 168)

9.3.9 EVALUATION OF AN INTENSIVE MENTAL HEALTH PROGRAM (IMHP) IN THE USA

As described in section 8.5.7 of this report, the IMHP involves a comprehensive, multifaceted therapeutic intervention, including both psychosocial and pharmacological interventions, and involves tailoring an array of intervention strategies to individual children experiencing severe emotional and behavioural difficulties. On the basis of a trial investigating the effectiveness of the IMHP (Vernberg et al 2004), 84% of the children showed clinically significant improvement in overall functioning as measured by the Child and Adolescent Functional Assessment Scale.

The researchers note that the serious level of dysfunction required for admission to the IMHP, the length of treatment (an average of 12 months), and the lack of comparable alternative treatment options pose challenges to conducting a randomised controlled study of the IMHP. It is likely that the integrated package is necessary, attending to the multiple needs of these complex combinations of symptoms and impaired role performance (Vernberg et al 2004).

9.3.10 EVALUATION OF THE SKILLS FOR SOCIAL AND ACADEMIC SUCCESS (SASS) PROGRAM

Masia-Warner et al (2005) examined the efficacy of the SASS program, which is a targeted school-based intervention for social anxiety disorder (described in section 8.5.5 of this report).

The study found that adolescents in the intervention group demonstrated significantly greater reduction in social anxiety and avoidance, as well as significantly improved overall functioning, than those in the control group. 67% of treated subjects, compared to 6% of wait-list participants, no longer met criteria for social phobia following participation in the program; thus the results were ‘clinically significant’ as well as being statistically significant.

On the basis of the study, the authors suggest that an empirically-based, school intervention consisting of social skills training, exposure, and realistic thinking is feasible and, as shown through the study, resulted in significant improvement in the functioning of teenagers with social anxiety disorder. At the same time, the researchers caution that the school setting posed a number of challenges, including the program’s schedule being affected by school trips, exams, vacations and, at times, teacher reluctance to

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85 This includes measurements of child functioning at home and school, behaviour toward others, regulation of moods and emotions, self-harm, and problems in thinking, all of which improved significantly (Vernberg et al 2004).
86 The study made use of a randomized wait-list control trial of 35 adolescents. Independent evaluators evaluated participants at pre-intervention, post-intervention and nine months later (Masia-Warner et al 2005).
87 The authors note that positive results demonstrate that the SASS intervention is superior to no intervention, but do not provide information about relative efficacy, namely whether effects are due to specific treatment ingredients or general therapeutic factors (Masia-Warner et al 2005: 720).
release students from class; students’ reluctance to participate (including fear of classmates being aware of their participation in a group of this nature) and ‘burdensome recruitment and assessment processes’ (Masia-Warner et al 2005: 719).

The authors suggest that future studies should examine whether it is better to provide a program of this nature in the school setting or in a clinical setting.

9.4 EFFECTIVENESS OF PROGRAMS FOCUSING ON EXTERNALISING BEHAVIOURS

Inman et al (2011: 210) draw close links between programs that focus on mental and emotional health and those that focus on violence and aggression prevention, noting that mental disorders lead to higher rates of suicide, violence, juvenile incarcerations and unintentional injuries. Drawing on a review of evidence-based studies, they suggest that programs such as PATHS (see section 8.5.4), which have a primary focus on violence prevention, also have a role in promoting social and emotional competence and ‘prosocial behaviours’.

The available literature points to a large number of studies, systematic reviews and meta-analyses of school-based programs that focus on externalising behaviours (including aggression, violence and bullying) amongst children and young people (see eg Park-Higgerson et al 2008; Merrell & Isava 2008; Wilson & Lipsey 2007; Hahn et al 2007). In consideration of the vast literature on the topic, only a selection of meta-analyses or systematic reviews is briefly discussed in this section.

### EFFECTIVENESS OF PROGRAMS FOCUSING ON AGGRESSION, VIOLENCE AND ANTI-BULLYING

Wilson and Lipsey (2007) synthesised the literature on the effectiveness of school-based prevention programs for reducing aggressive and disruptive behaviour, including fighting, bullying, name-calling, intimidation and acting out. The meta-analysis found that there was a range of effective programs available to schools, with the most successful characterised by:

- Universal programs delivered to all the students in a classroom or school, with many of the studies focusing on schools with low SES or in high-crime neighbourhoods, suggesting that the children in these universal programs may be considered ‘at risk’ by virtue of their socioeconomic background or neighbourhood context.

- Targeted programs for children, who are typically identified by teachers as having social problems or because of conduct problems, and who participate in programs outside of their regular classrooms.

- Cognitively-oriented approaches, although many of the programs also used behavioural, social skills or counselling treatment modes of intervention.

(Wilson & Lipsey 2007: 11)

The authors point out, however, that only 32 of the 249 studies in the meta-analysis examined routine practice programs that are implemented in a school on an ongoing basis and evaluated by a researcher with no direct role in developing or implementing the program. They note that this shows ‘how little evidence exists about the actual effectiveness, in everyday real-world practice, of the kinds of school-based programs for aggressive/disruptive behavior represented in this review’ (Wilson & Lipsey 2007: 13).
On the basis of a systematic review of programs to prevent violent and aggressive behaviour in schools (drawing on international literature), Hahn et al (2007) conclude that there is strong evidence that universal school-based programs decrease rates of violence among children and youth, with a median effect of a 15% reduction in violent behaviour among students who participated in such a program (Hahn et al 2007: S121). These authors point to a number of trends in the characteristics of school-based programs that were included in the review:

- A focus on disruptive and antisocial behaviour is common in elementary school and in middle school, shifting to general violence and specific forms of violence (such as dating violence) in higher grades.

- The intervention approach shifts from approaches which modify behaviour by changing the cognitive and affective mechanisms linked with such behaviour, to approaches that make greater use of social skills training (emphasising the development of behavioural skills rather than changes in cognition, consequential thinking or affective processes).

- In the higher grades, there may be a decreased focus on the teacher as the primary program implementer and an increase in the use of other personnel such as student peers or members of the team conducting the research study.

- No clear association emerged with respect to whether more program exposure was associated with larger effects.

- Longer follow-up was associated with smaller effect size, suggesting that the effectiveness of school programs decreases slightly as time since the conclusion of the program increases.

(Merrell et al 2008: 38)

Merrell et al (2008) conducted a meta-analytic study of the English-language school bullying intervention research conducted from 1980 to 2004. They found tentative evidence for the effectiveness of school bullying programs which include the following:

- enhancing students’ social competence, self-esteem and peer acceptance

- enhancing teachers knowledge of effective practices, feelings of efficacy regarding intervention skills and actual behaviour in responding to incidences of bullying at school

- reducing participation by students in both bully and victim roles.

The authors caution that their conclusions are ‘tentative’ because the majority of effects measured across the studies were too weak to be considered meaningful or clinically important. They also note that studies on the effects of bullying interventions focus primarily on indirect measures of the behaviour, such as student and teacher self-reports. Of greater concern is that a minority of intervention outcomes were associated with significant negative effects, particularly interventions that ‘group together deviant peers for treatment’ (Merrell et al 2008: 38-39).
Couvillon and Ilieva (2011) reviewed the international literature regarding school-wide prevention programs and strategies on cyberbullying. Although their recommendations are not based on a systematic review or meta-analysis, they point to trends within the relatively young research in the field, including:

- Cyberbullying prevention is best seen as a proactive school-wide approach, rather than an event-driven, after-the-fact action that needs to remediate damage and be narrowly defined by a specific incident.
- The banning of electronic devices does not solve the problem because students will have access to them outside of school.
- The teaching and modelling of ‘digital citizenship’ is encouraged, and especially emphasis of the point that appropriate social behaviour is even more important when communication occurs in anonymity.
- Consequences from and effects of cyberbullying should be clearly communicated as no one is immune to becoming a target.

(Couvillon & Ilieva 2011: 99-100)

Ryan and Smith (2009) identified 31 peer-reviewed evaluations of antibullying programs published in English between 1997 and 2007 in order to assess the rigour of evaluations. They found that evaluations conducted to date do not meet the criteria for efficacy or effectiveness trials. Hence the outcomes of bullying prevention studies cannot be accepted as conclusive.

In summary, while there has been a great deal of research focus on aggression/violence programs in schools, and particularly antibullying programs, the evidence base is not strong in terms of assisting schools to select programs that have the best chance of succeeding.

9.5 STUDIES OF SCHOOL-BASED PROGRAMS FOCUSING ON ISSUES RELATED TO PSYCHOLOGICAL-EMOTIONAL WELLBEING

In the following sections, brief reference is made to studies examining the effectiveness of school-based programs focusing on:

- suicide prevention
- overweight and obesity
- substance use.

These issues are not the focus of this review but, as discussed in section 4, they contribute to understandings of child wellbeing and have a direct or indirect impact on the psychological/emotional wellbeing and mental health of students.

9.5.1 SUICIDE PREVENTION

The literature search carried out for this study suggests that, in comparison with other areas of school based intervention for mental health and wellbeing issues, on which (as discussed earlier) there is a vast
evaluation literature, suicide prevention is a wellbeing area that requires more research. Meta-studies that have been accessed are briefly described below.

Wyman et al (2010) studied the impact of suicide prevention programs in USA high schools. The authors note that school-based suicide prevention programs focus primarily on reducing individual-level risk factors by:

- increasing the identification of students at potential risk of suicide
- referring high risk students for treatment.

The most common modes of intervention, and their effectiveness based on evaluation research, are described in the box below.

<table>
<thead>
<tr>
<th>Modes of intervention in suicide prevention programs</th>
<th>Effectiveness of the modes of intervention based on evaluation studies</th>
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</thead>
<tbody>
<tr>
<td>Screening for mood and suicide ideation</td>
<td>Students identified as being ‘at risk’ are likely to utilise available treatment as long as case management is included as part of the intervention</td>
</tr>
<tr>
<td>Training of teachers to increase their ability to identify and refer at risk students</td>
<td>No measured increase in communication between teachers and students about suicide</td>
</tr>
<tr>
<td>Curriculum content combined with screening</td>
<td>There is a short-term decrease in self-reported suicide attempts, but no increase in students’ use of services</td>
</tr>
<tr>
<td>Using peer dynamics to enhance students’ protective influences</td>
<td>Implementation of a program such as ‘Sources of Strength’ (see section 8.5.8 of this report) increases the rate of peer referral to adults; increases the perception amongst students that adults are supportive of suicidal youth; and enhances the acceptability of help-seeking behaviour. 88</td>
</tr>
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Cusimano and Sameem (2011) undertook a systematic review of all studies that had been published since the 1960s that evaluated the effectiveness of school-based suicide prevention programs for adolescents. 89 Only eight studies met the researchers’ strict inclusion criteria for the systematic review. Six of these studies were based in the USA, one in Israel and one in Belgium.

The researchers found that the programs adopted a wide range of learning formats, including the use of video discussion lessons, curriculum taught by regular health teachers in the schools, responding to scenarios of suicidal ideation, and teaching youth to recognise the signs of suicide in themselves and their peers (Cusimano & Sameem 2011: 45-46).

Overall, statistically significant improvements were noted in relation to knowledge, attitudes and help-seeking behaviour, and a decrease in self-reported ideation was reported in two studies. None of the studies reported on suicide rates. The study found no evidence that increased knowledge led to deleterious effects such as increased suicidal ideation or feelings of hopelessness. On completing a

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88 The study was limited in that it relied of self-report data and did not measure changes in the long term (Wyman et al 2010: 1658-1659).

89 Studies were included that focused on middle and high school-based suicide prevention curriculum programs including male and female participants aged 13-19 years. They were required to be randomised controlled studies with follow-up examinations, or interrupted time series analysis with a concurrent comparison group (Cusimano & Sameem 2011).
suicide prevention course, students were found to associate suicide with mental illness, rather than ascribing symptoms to sadness (Cusimano & Sameem 2011: 46-48).

The findings of this review suggest that, following participation in a program, students may be more attentive to the seriousness of peer suicidal ideation. Nevertheless, the authors note that there is a lack of studies focusing on suicidal ideation, which is far more common than either suicide attempts or successful suicide (Cusimano & Sameem 2011: 45-48).

On the basis of their findings, the authors conclude:

...school-based suicide prevention programmes can improve knowledge, attitudes and help-seeking behaviours among youth, and may foster environments more attentive to peer suicidal ideation...[but]...there is considerable work still required in this field. (Cusimano & Sameem 2011: 49)

9.5.2 EATING DISORDERS, OVERWEIGHT, OBESITY

A number of recent meta-analyses were accessed in the review of literature that focus on eating disorder, overweight or obesity prevention and/or treatment programs in school settings (Cook-Cottone et al 2009; Zenzen & Kridli 2009; Shulman & Mulloy-Anderson 2009). These are briefly described below.

Drawing on public health literature, Zenzen & Kridli (2009: 243) describe the following as necessary in school-based obesity prevention programs:

- a focus on diet and nutrition, including classroom-based nutritional education sessions
- physical education programs, including fitness interventions and specifically tailored physical activity programs
- healthy lifestyle education, including the use of video sessions and computer-tailored models
- parental involvement, without which results are usually of short duration.

On the basis of a review of studies of programs focusing on obesity (N=16), these researchers find that:

- Interventions proved to be beneficial in one or more areas (eg diet, physical activity, knowledge about healthy lifestyles), but few were multifactorial, addressing all four of the above initiatives.
- None of the studies achieved an outcome of significantly lowering BMI\(^{90}\) compared to control groups.
- Many of the interventions were carried out for six months or less.

(Zenzen & Kridli 2009: 255)

Stewart-Brown (2006) identified systematic reviews of studies of interventions to promote healthy eating and physical activity in schools and found that:

- Greater benefits were observed in girls and older students.
- Programs that were effective adopted whole school approaches and provided healthy food in school canteens.
- Peer led interventions were effective for young women, especially in terms of healthy eating.

(Stewart-Brown 2006: 12)

\(^{90}\) Body Mass Index (BMI) refers to the ratio of weight in kilograms to the square of height in meters. BMI between the 85th and 95th percentile for age and gender is considered at risk of overweight, and BMI at or above the 95th percentile is considered overweight or obese (Zenzen & Kridli 2009: 242).
On the basis of these findings, Stewart-Brown suggests that effective programs are those that involve changes to the environment of the school and the involvement of parents, and that where teachers were involved, training was important.

Shulman and Mulloy-Anderson (2009) reviewed school-based mental health programs and their effects on eating disorders and, despite the paucity of evidence, point to the following:

- The key to effectiveness is empowering individuals to recognise and counter damaging society and peer messages while simultaneously developing self-esteem and body acceptance.

- Effective programs aim to create changes in both individuals and their surrounding environments, such as the development of school cultures that promote healthy eating behaviours and discourage weight-teasing.

- School mental health providers need to provide training for school personnel on how to identify and refer at-risk students for prevention and/or treatment interventions.

Shulman and Mulloy-Anderson (2009: 42) also note the growth in recent efforts to integrate obesity prevention with eating disorder prevention efforts. One program of this nature, which has been evaluated, revealed a reduction in disordered weight control behaviours such as purging and diet pill use.

9.5.3 SUBSTANCE USE AND ABUSE

Substance misuse is considered to be an aspect of mental ill-health, and the promotion of life and social skills and of wellbeing is an aspect of substance abuse prevention (see Kimber & Sandall 2009: 1403).

In a review of studies focusing on substance use prevention in schools, Stewart-Brown (2006: 11-12) concludes (also in keeping with findings from previous reviews) that programs on preventing substance use are amongst the least effective of school health promotion programs. The review found that some programs were mildly effective at delaying the onset of drug use and reducing the quantity of drugs consumed, but most of these programs were ineffective. Meta-studies that showed a small effect at one-year follow-up showed an even smaller effect in studies with a two-year follow-up.

Soole et al (2008) examined the effectiveness of school-based drug prevention programs in preventing illicit drug use, and also examined whether effective program characteristics differed from those identified in reviews of prevention of licit substance use (such as alcohol and tobacco). The study found that interactive programs focusing on social influence and how best to respond to social influence, appear to be the most effective school-based drug prevention. It also found that more intensive programs appear to increase program effectiveness; and that universal programs may be slightly more effective. These findings were common for programs focused on the prevention of licit and illicit substance use. (Soole et al 2008: 280).

Kimber and Sandall (2009) conducted a long-term (over five years) follow-up study of the effects of social and emotional learning programs on all forms of substance use in schools in Sweden. The study found that there were positive effects of the programs on non/light users of drugs and alcohol and occasional smokers, but they note that there has been an historical research difficulty in demonstrating the effectiveness of adolescent drug and alcohol problems, with one of the issues being difficulty in agreeing on when ‘use’ becomes ‘misuse’ (Kimber & Sandall 2009: 1410-1411).

91 The program Planet Health was originally intended to decrease obesity in students by promoting positive behavioral and cognitive choices and skills, but, through its emphasis on increasing intake of daily fruits and vegetables and eating in moderation, it was found to have the unanticipated result to also prevent eating disorders (Shulman & Mulloy-Anderson 2009: 42).

92 The study included literature on drug prevention intervention involving a school-based intervention component, and thus also allowed for programs containing, family-based, community-based, media-based or other multifaceted components. Included studies were required to have a pretest-posttest, comparison/control group design. Articles published in English after 1990 were included, and 58 studies were found to meet the inclusion criteria (Soole et al 2008: 263-264).

93 On the basis of the research, students were classified as nonuser, light users, moderate users or heavy users of drugs (hard and soft), volatile substances (for sniffing), alcohol and tobacco (Kimber & Sandall 2009: 1405-1406).
9.6 EVALUATIONS OF SCHOOL COUNSELLING/SCHOOL PSYCHOLOGY AND SCHOOL SOCIAL WORK

The studies based on available literature that provide evaluations of school counselling, school psychology and school social work services are described in this section.

**EVALUATIONS OF SCHOOL COUNSELLING/SCHOOL PSYCHOLOGY AND SOCIAL WORK**

Slade (2002: 159-164) studied the effects of school-based mental health programs on students’ visits to school-based counsellors and to non-school-based mental health providers, using USA data from the National Longitudinal Study of Adolescent Health. Analysis showed that:

- Students were substantially more likely to see a counsellor where mental health services were available on site.
- Students with a learning disability, depressive symptoms and behaviour problems were significantly more likely than others to make use of school-based counselling services.
- Relative to other schools, schools offering on-site mental health counselling do not increase or reduce their students’ use of counselling services outside of school. This suggests that, in a given year, the school-based and community-based counselling services essentially operate as two parallel systems.
- Students from minority race/ethnic backgrounds and low socio-economic status backgrounds use school-based services more frequently and non-school-based services less frequently.

In an overview of international research that had been carried out into the collaboration between school counsellors and teachers, Tatar and Bekerman (2009) find evidence that collaboration between school counsellors and teachers has achieved:

- the promotion of social emotional learning programs in classrooms
- the implementation of play therapy with behaviourally-at-risk students
- the improvement of students’ use of standard English, and the improvement of teacher-student relationships in the language learning process
- the reduction of reading problems among students who have low self-esteem and poor reading performance
- the provision of assistance to parents of kindergarten children so they can be actively involved in their children’s educational development, especially in the development of appropriate reading skills
- the restructuring of junior-high schools aimed at transforming the educational experiences of marginalised students
- the facilitation of friendships of students with moderate-to-profound disabilities.

On the basis of this evidence, the authors conclude that ‘the implementation of school changes and the development of common frameworks for the solving of issues that arise…are more effectively obtained by the collaborative efforts made by school counsellors and teachers’ (Tatar & Bekerman 2009: 190).

Donnelly (2006) used qualitative methods to examine the experience of school counsellors working in NSW, the ACT and Queensland in managing critical incidents in their own or other schools. On the basis of the study, the researcher found that school counsellors’ roles could be analysed in three broad areas:
EVALUATIONS OF SCHOOL COUNSELLING/SCHOOL PSYCHOLOGY AND SOCIAL WORK

- Pre-crisis preparation – including writing the school’s crisis management plan and developing mechanisms for training the school’s crisis management team
- Intervening during crisis management – including providing support to students, staff and families, and establishing networks with external resources and services
- Follow-up after the crisis has passed – including evaluation of the crisis management structures and processes, monitoring progress of people needing ongoing support and maintaining contact with outside services.

A key issue that emerged on the basis of the research was the support needed for school counsellors themselves, including their need to deal with stress and ‘vicarious trauma’ (secondary traumatic stress disorder in those who treat the traumatised). The leadership in the school, and access to training, ongoing professional development and clinical supervision were found to be key resources in helping school counsellors deal with these.

In an Australian study, Thielking (2006) investigated a range of professional issues associated with the provision of school-based psychological services for Victorian school psychologists94. The study found that school psychologists dealt with a diversity of student problems, including students with attention deficit disorder, parental emotional abuse, parental or family drug taking issues, domestic violence, delayed developmental disorders, learning difficulties, truancy, anger management and criminal behaviour. The study also found that Government school psychologists participated in significantly less supervision than those in non-Government schools (Thielking 2006: 142-147).

Although there were differences in attitude between psychologists, principals and teachers regarding the activities and responsibilities of school psychologists (such as on the topic of handling discipline) there was also much agreement on the psychologists’ roles within the schools. These roles include:

- conduct research on issues relevant to the school
- be up to date on relevant research
- conduct IQ and psychological assessments
- provide counselling to students
- organise group programs for students
- organise workshops for teachers on issues concerning students’ welfare
- inform primary student’s parents of their child’s participation in counselling.

(Thielking 2006: 158-159)

On the basis of these findings, the researcher writes that ‘it is a matter of interest that these areas of agreement relate to a model of service delivery that involves a combination of both individual and systemic activities, and might suggest that school psychologists, principals and teachers all support such a model’ (Thielking 2006: 159).

94 The study sample consisted of 81 school psychologists, 21 principals and 86 teachers.
Boyle & MacKay (2007) surveyed the involvement of educational psychologists in student support in mainstream schools in the UK, and compared their findings with similar surveys conducted in the UK from the 1970s. The study found significantly higher levels of satisfaction with the contributions of educational psychologists compared with earlier surveys, with over 70% of head teachers valuing their input.

The researchers note that the highest levels of user satisfaction by schools are ‘associated with service delivery which marries work at the level of individuals, class, school and family’, in addition to the traditional role of individual assessment (Boyle & MacKay 2007: 27). The researchers also write that there was particular support for ‘the extent to which the educational psychologist is regarded as an integral part of the schools’ pupil support strategy’.

On commission from the Welsh Assembly Government, the British Association for Counselling and Psychotherapy evaluated counselling in schools across the UK in order to assess whether current counselling models used in the UK are sufficiently robust and flexible enough to apply more widely throughout Wales (British Association for Counselling and Psychotherapy 2007). The study developed quality indicators for best practice and good service delivery and made recommendations that include:

− School counselling services should have sustainable funding.
− Meetings between counsellor and client ought to take place in a dedicated, comfortable, soundproof room which can be accessed discreetly by young people. Consideration must be taken however, to ensure counsellor safety when they are working with young people.
− School counselling should be seen as non-stigmatising by the school community and a normal part of its student support services.
− The service should be monitored and evaluated by individuals or an agency (in or out of the school) with experience in this specialised area of work.
− Since unlimited confidentiality is not possible with this client group (due to demands of legislation), counselling services must regularly communicate their policy on breaking confidentiality to protect individuals.
− All schools and young people have individual needs and priorities, and counselling services need to be able to respond as far as possible to these.
− Counsellors should be members of a professional body and as such have an established ethical framework and complaints procedure.
− There existed some confusion about the term ‘counselling’, with school staff and students often being unclear and confused about the definition of the term and the difference between formal professional counselling and other types of support. Information should be made available to all schools about what counselling actually is and what it is not.

In addition, the study identified models of school counselling service delivery (summarised in Table 6 in section 8.3.2 of this document) and identified a range of advantages and disadvantages that are shared across several models. Without putting forward a single recommended model, the researchers used these components to develop the above mentioned quality indicators for best practice and good service delivery.

Nicholson et al (2009) point to meta-analyses that conclude that psychotherapy is a viable treatment option producing positive outcomes in individuals with a variety of mental disorders. They investigated
this claim in respect of psychotherapy and counselling offered in schools and found that while services can be beneficial to many students, there are a range of possible negative effects for some students on a range of issues:

− Although psychotherapy can be used as an effective intervention for some students with anxiety and/or depression, possible negative effects may occur when counselling children in groups. Attention needs to be given to the selection of group participants, leadership style of counsellor and group members, as well as personality factors, all of which may contribute to the overall positive or negative outcomes of group counselling.

− Meta-analyses are split in their evaluation of the effectiveness of school-based psychotherapy for children with disruptive behaviour disorders, but studies have shown that exacerbations in the incidence of problem behaviour could arise when children are counselled in groups.

− Findings with regard to the effectiveness of grief counselling are mixed, with evidence for deleterious effects for some individuals as a result of grief counselling.

− Substance use counselling has been identified as creating ‘iatrogenic effects’ such as increased alcohol, cigarette, marijuana and multiple drug use following involvement in drug prevention interventions.

− Although social skills training programs may be beneficial for some students in schools, aggressive and antisocial youth appear to be vulnerable to possible deleterious effects, such as an increase in the belief that aggression would lead to positive effects for the aggressor.

(Nicholson et al 2009: 232-236)

Sanetti et al (2011: 73) investigated the ‘treatment integrity’ of interventions within the school psychology literature from 1995 to 2008 in order to determine the profession’s development of evidence-based practice (EBP). The authors describe the following dimensions as important to treatment integrity:

− adherence – degree to which an intervention was implemented as intended

− quality of implementation

− exposure – the duration and/or frequency of the intervention

− program differentiation – the difference between the intervention and another intervention or ‘practice as usual’.

The study found that half of the researchers provided quantitative treatment integrity data, the majority of which were ‘adherence data’ (ie focusing on the degree to which an intervention was implemented as intended) rather than data relating to the quality of implementation, exposure or program differentiation.

The study also found a majority of published studies do not define what a school psychology intervention is or what it looks like, and thus it can be difficult to empirically link a measured outcome to the intervention. Reasons for this may include:

− School psychology researchers may identify with a range of theories and ideas to develop an approach that does not necessarily translate into a clearly defined set of steps or stages.

− Most school-based interventions are implemented across numerous settings, for multiple

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95 A total of 2,023 articles were reviewed, and studies were included whose design allowed for conclusions regarding a causal relationship between implementation of an independent variable (ie an intervention) and change in a dependent variable (ie student outcome). On this basis, a total of 223 studies met the inclusionary criteria (Sanetti et al 2011: 75).
students and may not be readily observable.

(Sanetti et al 2011: 81)

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<th>EVALUATIONS OF SCHOOL COUNSELLING/SCHOOL PSYCHOLOGY AND SOCIAL WORK</th>
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| Based on research carried out on educational psychology in schools in England, the most frequently reported benefit of educational psychology practice was the good working relationships that the educational psychologist had established with children, parents and other service organisations involved in the life of the child (Farrell et al 2006). The research found that most respondent groups (including other school staff) valued the contact that they had with educational psychologists, but would have welcomed more. The study found that educational psychologists were too heavily involved in statutory assessments, which prevented them from expanding their work into other areas where psychological skills and knowledge would be beneficial (Farrell et al 2006).

Jordan et al (2009) conducted a survey of school psychologists throughout Canada and found:
- The most common services were those that were provided for children with learning disabilities and behaviour problems.
- School psychologists spent most of their time doing intellectual, behavioural and/or emotional assessments.
- In terms of intervention, most time was spent in tertiary prevention (ie preventing further difficulties or problems in those already having problems), and the least amount of time was spent on prevention for all students.

The data support findings from other surveys conducted in Canada that school psychologists would prefer to spend less time doing assessment and have an increase in time providing other services such as consultation and intervention (Saklofske et al 2007). Jordan et al (2009: 247) write that ‘these wider and more comprehensive roles are not always supported or feasible because school psychologists are still highly valued for their very important role in psycho-educational assessment’.

In a systematic review, Franklin et al (2009) examined the effectiveness of school social work practices on internalising behaviours, externalising behaviours and academic and school-related outcomes. Results of the study include96:
- The best outcomes appeared to come from school social work interventions that used targeted mental health and educational interventions to change the behaviours of students.
- In terms of externalising problems, overall random effects weighted mean effect size estimate of .23 indicating that student participants in the school social work intervention group scored .23 standard deviations above those in the control group (this is considered a small effect size).
- In terms of internalising problems, an overall random effects weighted mean effect size estimate of .40 indicating that student participants in the school social work intervention group scored .40 standard deviations above those in the control group (this is considered a medium effect size).
- The individual studies examined under the academic and school-related outcome category showed that medium to large effect sizes were found for most of the studies that tried to increase student knowledge and improve grade point averages through social work practice.

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96 Studies were included in this systematic review if they were published from 1980 to 2007, and if they involved primary, experimental and quasi-experimental research designs that examined the effectiveness of a social work intervention or program service conducted in a school setting in the USA (Franklin et al 2009: 669).
On the basis of their analysis, the authors conclude that school social work practices appear to be more effective with internalising disorders (e.g., anxiety, depression, self-concept) than externalising disorders (e.g., aggression, conduct disorder, hyperactivity); and that the impact of social work practice on improving academic performance of students is important in terms of aligning with the major function of schools, i.e., academic achievement (Franklin et al. 2009: 674-675).
### 9.7 SUMMARY OF EFFECTIVENESS STUDIES: WHAT APPEARS TO WORK

Drawing on the systematic reviews and meta-analyses accessed in the literature, Table 7 below provides an overview of the effectiveness of interventions. The focus of this section is on identifying what appears to work.

<table>
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<tr>
<th>FOCUS OF STUDY</th>
<th>SCOPE OF STUDY</th>
<th>FINDINGS REGARDING EFFECTIVENESS</th>
<th>LIMITATIONS</th>
<th>DISCUSSION: WHAT APPEARS TO WORK</th>
<th>REFERENCE</th>
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<tr>
<td>Synthesis of meta-analyses: review of evidence-based evaluations of universal and early intervention programs for school-age children (N=23)</td>
<td>Published and unpublished English-language scientific literature that focused on evaluations of universal early intervention and mental health promotion initiatives. Reviews had to address a focused question, have effective and appropriate selection methods for relevant articles, appraise study validity and provide consistent, complete and precise results.</td>
<td>Universal or early intervention programs develop protective factors, generally by increasing competence or skills, and are more effective than programs to reduce existing negative behaviours. Program effectiveness varies by age, gender and ethnicity of children. Programs to address a specific problem or problems and which are sensitive to cultural or gender-based differences have greater effect than broad unfocused interventions. Programming that has multiple, integrated elements involving more than a single domain (school, family, community) is more likely to have positive results than single focus, single domain interventions. Effect sizes decrease over time for knowledge and skills acquisition and behaviour reduction.</td>
<td>Although the various studies noted some inconsistent methodology, and deficiencies in study design, intervention strategies and reporting, the number of common findings from many differing samples and interventions lends credence to their reliability.</td>
<td>Universal early intervention programs appear to be effective at developing protective factors in respect of a specific problem or problems. Program effectiveness varies by age, gender and ethnicity of children (eg younger children benefit more than older children; gender-focused programs are advisable; programs for Indigenous children have more positive results when they use traditional knowledge and modes, are based on community initiatives and involve both family and community). Programming that has multiple integrated elements involving more than a single domain is more likely to have positive results than single focus, single domain interventions. Positive outcomes associated with skill acquisition are enhanced by interventions using interactive learning based on solid theoretical bases. Since effect sizes decrease over time,</td>
<td>Browne et al (2004)</td>
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<td>FOCUS OF STUDY</td>
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<td>Meta-analysis of school-based universal interventions focusing on enhancing students’ social and emotional learning (SEL) (N=213)</td>
<td>Studies written and published or unpublished in English by 31 December 2007 Targeting students between age 5 and 18 who did not have any identified adjustment or learning problems Including a control group</td>
<td>Compared to controls, SEL participants demonstrated significantly improved social and emotional skills, attitudes, positive social behaviour and academic performance Programs delivered by teachers in classrooms were more effective than those delivered by non-school personnel, and student academic performance improved only when school personnel conducted the intervention Successful programs made use of recommended practices to develop students’ skills.</td>
<td>Only a limited number of studies (15% of those included in the survey) met the criteria of collecting follow-up data at least six months after the intervention ended</td>
<td>SEL programs enhance social-emotional skills performance, such as emotions recognition and stress management. SEL programs appear to be more effective if they follow established curriculum and implementation guidelines that include: - sequencing - using a connected and coordinated set of activities - using active forms of learning - having at least one component dedicated to developing personal or social skills - targeting specific SEL skills rather than skills or positive development in general.</td>
<td>Durlak et al (2011)</td>
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<td>FOCUS OF STUDY</td>
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<td>If follow-up data were collected, they were to be at least six months following the end of the intervention</td>
<td>Studies needed to use randomised controlled trial methodology, to be peer reviewed, and to involve participants that were aged 5-19 years</td>
<td>Of the 42 studies identified, 55% were universal trials that included all students, 7% were universal trials that excluded students exhibiting clinical levels of depression, 24% were 'indicated trials' (defined as a secondary prevention or targeting at risk young people) and 14% were selective trials (defined as a tertiary prevention or targeting young people that already had an identified problem).</td>
<td>Trial quality was on the whole poor</td>
<td>SEL programs are also effective in enhancing students’ academic achievement (Payton et al 2008).</td>
<td>Clear &amp; Christensen (2009)</td>
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Systematic review of school-based prevention and early intervention programs for depression (N=42)

The studies needed to have the aim of reducing or preventing the symptoms of depression, or building resilience. Indicated trials appeared to be more efficacious than selective and universal programs, with a higher proportion of successful trials at post-test and follow-up and more consistent outcomes at both post-test and follow-up. Trials that were shorter than eight sessions or longer than 12 sessions were less successful at reducing symptoms. The results of this study agree with previous research, which suggests that indicated programs, or programs targeting at risk young people, may be more efficacious due to the increased room for change amongst participants with elevated symptoms of depression. An intervention program consisting of 8 to 12 sessions may be more successful at reducing symptoms than programs of shorter or longer duration.
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<td>Meta-analysis of school-based prevention and intervention programs for children and adolescents at risk for, and with, emotional disturbance (N=29)</td>
<td>Programs were selected that focused on children at risk for, and those that had been identified as having, emotional disturbance (exhibiting characteristics such as an inability to learn, inability to build or maintain satisfactory interpersonal relationships, general pervasive mood of unhappiness or depression that adversely affect school performance.</td>
<td>Intervention programs yielded a mean effect size of 1.35, while prevention programs yielded a mean effect size of 0.54. Programs implemented in the schools are generally effective in alleviating the early onset of emotional and behavioural symptoms and reducing persistent symptoms.</td>
<td>Many of the studies made use of single-subject research designs. Studies did not adequately control for the impact of child characteristics (such as age, gender and level of symptom severity), teacher characteristics (such as teaching experience) and/or parent involvement. Studies did not adequately assess emotional and behavioural functioning in the home.</td>
<td>Prevention and intervention programs were moderately effective at reducing internalising and externalising behaviour problems in school. Prevention and intervention programs were found to be somewhat effective in improving children’s active engagement in school. Treatment/ intervention programs produced greater effects on social skills than prevention efforts. The study was not able to determine which aspects of the interventions were most effective, only that the programs had an effect on emotional disturbance.</td>
<td>Reddy et al (2009)</td>
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<td>Meta-analysis of school-based violence prevention programs, based</td>
<td>Studies of school-based interventions that were designed to reduce. The results in testing of the hypotheses were: programs that use theory-based interventions showed a smaller effect size than those that were not theory-based.</td>
<td>Most of the studies reported small effect sizes. Interventions using a single approach (using the curriculum only in the class) had a mild positive effect on reducing aggressive and violent behaviour.</td>
<td>Park-Higgerson et al (2008)</td>
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FOCUS OF STUDY | SCOPE OF STUDY | FINDINGS REGARDING EFFECTIVENESS | LIMITATIONS | DISCUSSION: WHAT APPEARS TO WORK | REFERENCE
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one five hypotheses (N=26) | externalising, aggressive and violent behaviour and that utilised randomised controlled trial (RCT) design with students randomly assigned to either an intervention or a control group. | (hypothesis not supported)  
- selective programs targeting at-risk groups at school showed a larger effect size than universal programs (hypothesis supported)  
- single-approach programs (using the curriculum only in class) produced positive effects, whereas multiple-approach programs did not provide evidence of a benefit (hypothesis not supported)  
- programs targeting higher grades showed a larger effect size than programs targeting lower grades (hypothesis not supported)  
- programs conducted by specialists (personnel from outside the school) had a larger effect than those conducted by school teachers (hypothesis supported) | Many of the studies had sample sizes that were less than 100  
Many studies were not included in the analysis because they did not report the details of their studies and measurable outcomes, including means and standard deviations | compared to multiple-approach programs.  
More successful programs use non-theory-based interventions, focus on at-risk and older children, and employ intervention specialists rather than school personnel.  
Including perspectives about the underlying processes that contribute to the development of violent behaviour and how these processes and paths can be altered (i.e., the inclusion of theory) does not seem to improve effectiveness. | 

Systematic review of research to measure the effectiveness of anti-bullying and victimisation programs (N=59) | Studies (published from 1983 to 2007) in all countries in which bullying had been addressed in school settings  
Randomisation; a pre-test measure of bullying; or comparable control condition.  
Minimum of 200 students in their | School-based anti-bullying programs are often effective with, on average, bullying decreasing by 20% - 23% and victimisation by 17% – 20%. Particular program elements were associated with a decrease in bullying and victimisation, including:  
- parent training/meetings  
- disciplinary methods, including improved playground supervision, classroom rules and classroom management  
- the duration of the program for children and teachers  
- the intensity of the program for children and teachers. | The studies raised many questions that need to be addressed in future research, including:  
- Why are there different effects of program elements and design features on bullying and victimisation?  
- Why do results vary | The most important program elements that were associated with a decrease in bullying were parent training, improved playground supervision, disciplinary methods, school conferences, information for parents, classroom rules, classroom management, and videos. Programs inspired by the work of Dan Olweus (see description of program in section 8 of this report) worked best (Ttofi 2008: 72).  
In agreement with this finding, Inman et al (2011: 211) write that the Olweus Bullying Prevention Program has evidence for effectively addressing the issue of | Farrington & Ttofi 2009; Ttofi et al 2008
samples. One program element, namely working in groups with peers, was significantly associated with an increase in victimisation.

Why do results vary by research design?
Why do programs work better with older children?

Summary of meta-studies focusing on issues related to mental health and wellbeing (body image, suicide, substance use)

Meta-analysis of studies focusing on overweight and obesity prevention in schools (N=40)

Studies published between 1997 and 2008. Interventions needed to be implemented within the school setting (preschool through 12th grade), either during school hours or after school. Treatment programs were excluded and programs focusing on eating disorder prevention were excluded.

Although obesity prevention programs may yield outcomes such as increased student knowledge, BMI reduction remains elusive. The effects of programs to elementary and high school students were stronger than those to students in middle school.

Universal programs targeting all students were more effective than selected programs. Interventions of short duration (0-12 weeks) had weaker effects than extended interventions.

Programs that did not include engagement in physical activity as part of the intervention produced better effects than those that did.

Only a small proportion of studies addressed the psychological and emotional reasons for overconsumption. Most studies did not control for socio-economic status, which may be an important intervening variable.

Obesity prevention programs seem to work better:
- for students in elementary school and senior high school
- when delivered to mixed-sex groups
- when using universal programs
- when of longer duration
- when they involve collaboration of intervention specialists with teachers.

A failure to address more of the psychological aspects of eating, and particularly 'emotional' and 'binge' eating, may be associated with generally weak effects.

In terms of promoting healthy eating, effective programs are those that adopt whole-school approaches, including

Cook-Cottone et al 2009
<table>
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<th>Focus of Study</th>
<th>Scope of Study</th>
<th>Findings Regarding Effectiveness</th>
<th>Limitations</th>
<th>Discussion: What Appears to Work</th>
<th>Reference</th>
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<td>Comprehensive review of school-based suicide prevention programs (N=13)</td>
<td>Studies for inclusion were required to contain information pertaining to the implementation and outcomes of a program designed to address suicidal behaviours among children and youth. Studies published between 1967 and 2008 were included.</td>
<td>The majority of universal prevention program studies typically focused on curriculum programs presented to students, ie programs embedded within the context of health education classes making use of an extended or abbreviated psychoeducational curriculum for students. There were far fewer selected prevention programs (only three were identified) and there were no studies of treatment programs. Of the 13 studies reviewed, only five showed promising evidence for statistically significant outcomes, and only two demonstrated strong evidence in this area.</td>
<td>Very few studies provided promising evidence of educational or clinical significance, or identifiable components linked to statistically significant primary outcomes, or program implementation integrity. No studies provided evidence supporting the replication of program effects.</td>
<td>There is some evidence that prevention programs that include providing information to students regarding suicide awareness and intervention, teaching them coping and problem-solving skills, and teaching and reinforcing strengths and protective factors while addressing risk taking behaviours may lead to improvements in students’ problem-solving skills and self-efficacy, as well as reductions in self-reported suicide vulnerability.</td>
<td>Miller et al 2009</td>
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<td>Meta-analysis and narrative review of drug prevention programs focusing on illicit drugs, and compared with studies focusing on</td>
<td>Studies were included that included any drug prevention involving, in part, a school-based intervention</td>
<td>Improved effectiveness was observed for programs adopting a more interactive approach, ie those programs that provide contact and communication opportunities for the exchange of ideas among participants. Programs involving a greater number of sessions impact positively on both licit and Base rates of illicit drug use are often low at the time that programs are implemented. Few studies are able to report on actual self-reported drug use,</td>
<td>The study found that successful intervention programs typically involve high levels of interactivity, time-intensity and universal approaches. Greater success is achieved when focusing on the middle school years.</td>
<td>Soole et al (2008);</td>
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<td>licit drugs and alcohol (N=58)</td>
<td>component. The focus was on illicit drug use. Studies were required to have a pre-test post-test, comparison/control group design.</td>
<td>illicit drug use. Multifaceted programs and booster sessions have been shown to have a positive effect on programs dealing with licit substances, but not with illicit substances, where, in a number of instances, they actually appeared to have an unintended negative impact on program effectiveness.</td>
<td>since these are illegal behaviours.</td>
<td>It is important to note the assessment of Stewart-Brown (2006:11-12), based on a review of findings from several reviews focusing on substance use prevention in schools, that such programs are amongst the least effective of school health promotion programs.</td>
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9.8 RESEARCH AND IMPLEMENTATION ISSUES

Drawing on the available literature, this section briefly considers issues that may need to be considered when researching school-based interventions focusing on the psychological and emotional wellbeing needs of children and young people and, in particular, the implementation of research findings to school settings.

9.8.1 DEMONSTRATING THE EFFICACY AND EFFECTIVENESS OF AN INTERVENTION

A number of the texts reviewed refer to the importance of determining both the efficacy and the effectiveness of an intervention program (see eg Anderson & Doyle 2005: 223; Merrell & Buchanan 2006: 168; Hallfors et al 2006: 2254; Spence & Shortt 2007). These authors point out the differences between the two, here briefly summarised.

- **The efficacy of an intervention** is established on the basis of its implementation in well-controlled settings, enabling procedures such as randomised assignment to experimental and control groups and tight control over sources of extraneous variance. Efficacy trials test whether an intervention does more good than harm when delivered under optimal conditions. Program implementers are usually highly trained professionals who ensure that targeted participants receive a ‘maximal dose’ of the intervention. Many best practice guidelines require the criterion of efficacy as a condition for an intervention being described as ‘evidence-based’.

- **The effectiveness of an intervention** is established through its implementation in an applied setting. Applied or ‘real world’ settings tend not to have the tight control of conditions that are possible in studies of efficacy. In school-based trials, regular school personnel are recruited as implementers, and implementation is often allowed to vary naturally so that measuring the amount and quality of intervention delivered is an essential component in analysis of the impact of the intervention.


A program producing positive results in a controlled research study may in theory look promising (described as having ‘strong internal validity’), but the positive results may or may not generalise to other settings, populations and contexts, and particularly may not be replicable in a normal school environment (described as having ‘weak external validity’) (Anderson & Doyle 2005: 223; Merrell & Buchanan 2006: 168).

Researchers are generally in favour of interventions being tested by means of both efficacy and effectiveness studies. According to the Society for Prevention Research standards, which assist policy makers and practitioners to determine which interventions are efficacious, effective and appropriate for dissemination (Spence & Shortt 2007: 527), an intervention can only be regarded as meeting criteria for effectiveness in terms of positive effects under real-world conditions if it also meets the criteria for efficacy, i.e. that it demonstrates beneficial effects under optimal, controlled conditions of delivery.

These conditions include using a psychometrically sound measure of the targeted behavioral outcome, in comparison to at least one control condition; using random assignment to conditions or other rigorous comparison procedure; a clearly defined sample; and legitimate statistical analytic methods (Spence & Shortt 2007: 527). As noted by Durlak et al (2011: 407), ‘interventions are unlikely to have much practical utility or gain widespread acceptance unless they are effective under real-world conditions’.

9.8.2 IMPLEMENTATION ISSUES

A number of researchers and authors discuss the issue of implementation quality or treatment integrity/fidelity (see eg Greenberg et al 2005; Forman & Barakat 2011; Zoellner 2009; Sanetti et al 2011). Meta-analyses have found that many studies are described too broadly to be replicated and few include quantitative measurements of treatment fidelity (Greenberg et al 2005: 16; Sanetti et al 2011: 73-74).

Literature on implementation suggests that implementation success in an organisational context can be related to:
• characteristics of the innovation (the new program or practice), including whether the program is better than what the school is currently doing

• characteristics of the implementer, including especially the knowledge and skills required for implementation of the program

• characteristics of the organisation, including time, financial and technology requirements.

(Forman & Barakat 2011: 283-285)

Writing of the situation in the USA, Schaeffer et al (2005: 18) write that the expenses involved in using evidence-based interventions can be impediments to their implementation since protocols can be very expensive to purchase, especially those that require additional training or ongoing developer support. At the same time, mental health programs operate on a limited budget and often do not include funds for training, quality assurance, or ensuring evidence-based practice.

The difficulties in providing treatment services on school premises include:

• environmental characteristics eg poor office spaces, crowded classrooms

• frequent changes in personnel

• distinctions in the knowledge bases and cultures of education and mental health staff

• difficulties in fully engaging families.

(Weist et al 2007: 55)

Zoellner (2009) writes that, while Australian schools are suitable sites for the implementation of whole-school mental health and wellbeing programs, there needs to be recognition that they are settings that may not easily conform to health-related models of evidence and ways of working97. He recommends:

• development of more complex and shared views (between the health and education sectors) on the nature of the evidence that would support the effectiveness and efficiency of any particular program

• looking for different indicators for mental health and wellbeing in recognition of the scale and prevalence of change in schools

• new ways of thinking about how to recognise the scale and prevalence of change in schools and finding a method to control for that change in the development of evidence.

(Zoellner 2009: 23)

The accurate implementation of an approach, intervention or programs is often aided by means of manuals, training, technical assistance and monitoring. According to Schaeffer et al (2005: 16), these are important issues for schools to consider in adopting an intervention. For example, a number of evidence-based intervention protocols stipulate that potential users contact the developer directly for on-site training, ongoing technical assistance, and monitoring of the fidelity of the intervention. Evidence-based interventions that make these requirements are among the most expensive and complicated to implement in real-world settings (Schaeffer et al 2005: 16). In addition, the availability and usability of the manuals that describe evidence-based interventions vary tremendously, depending in part on the extent to which the intervention has been tested and refined.

In a model generated by Han & Weiss (2005) on the basis of a review of implementation of mental health and wellbeing programs in schools, the sustainability of an intervention is seen to proceed through three phases. This model is described in the box below.

97 As discussed in section 9.1 above, Zoellner (2009: 17) notes that the mental health and education sectors have historically operated in isolation and are characterised by different methods or training for entry to the professions, funding sources, bureaucratic structures, and philosophical and knowledge heritages.
A model for the implementation of mental health and wellbeing programs in schools

- Pre-implementation phase - the time period prior to implementation when teachers and administrators at a particular school are introduced to the program, and implementation plans for the specific school are developed.
- Supported implementation phase - the time period during which teachers are trained in the program and receive ongoing in-classroom consultation on program implementation.
- Sustainability phase - additional or external support for implementation, such as training and consultation, have been withdrawn and the school continues to operate the program with its internal resources.

In each phase, there are factors that may facilitate or impede the ultimate sustainability of the program.

Source: Han & Weiss (2005: 675)

9.8.3 THE VARIED NATURE OF SCHOOLS FROM A RESEARCH POINT OF VIEW

Although schools may be an appropriate context for the provision of mental health services, using evaluations conducted in highly controlled environments as an indication of what will work in schools can be problematic. The positive intervention effects demonstrated by research-based treatments may not be replicated when ‘transported into the real-world settings of schools’ (Fisher et al 2004: 243).

An important consideration for school-based mental health programs is determination of the ‘transportability’ of evidence-based programs in school settings, including how to adapt these treatments to facilitate their use in school settings without impacting their efficacy (Masia-Warner et al 2005: 709). One clear limitation pertaining to schools as applied settings for effectiveness studies arises because schools differ widely from each other, based on factors such as cultural and linguistic diversity, the prevailing school philosophy, the quality of the professional personnel and community standards and values (Merrell & Buchanan 2006: 168).

Atkins et al (2010: 40-41) point to limited progress in establishing consensus about effective and efficient school mental health programs that can be sustained ‘within the varied ecologies of schools’, and scant evidence for the effectiveness of current school-based service models or reason to think that these services are providing advantages over clinic-based services.

9.8.4 DIFFICULTIES IN MEASURING STUDENT WELLBEING

Difficulties in, and disagreements over, the measurement of child and adolescent wellbeing have been discussed in sections 3 and 4 of this report. These difficulties may also hinder the adequate evaluation of the effectiveness of school-based interventions aiming to impact positively on student wellbeing. As noted by the Victorian Auditor General (2010: 12), student wellbeing is hard to measure, because it is ‘both difficult to define precisely and because it is multi-faceted. As such, it is difficult to directly attribute the impacts of specific programs and services to more general improvements in student wellbeing’.

Also when considering universal prevention programs, Schaeffer et al (2005: 16) write that in contrast to treatment approaches, evidence-based preventive interventions for youth tend to focus on broader skills rather than on alleviating specific symptoms. It may be difficult to accurately measure changes in skill levels, and to link these changes to the impact of a specific school-based program.

9.8.5 LIMITATIONS TO STUDYING THE EFFECTIVENESS OF UNIVERSAL INTERVENTIONS

In an article focusing on adolescent depression, Sawyer et al (2010: 200) point to some of the difficulties encountered when studying the effectiveness of universal interventions applied to whole-school populations. These include:

- Most interventions are of insufficient duration to produce lasting changes.
Sample sizes have typically been insufficient to provide adequate power to detect the relatively small effect sizes which would be expected in universal prevention trials, particularly with a low prevalence disorder such as depression.

Little attention has been paid to changing, and hence measuring changes to, the school environments within which adolescents live their day-to-day lives.

Ensuring that interventions are correctly delivered and that participants are fully engaged in all intervention components is difficult in universal interventions.

(Sawyer et al 2010: 200)

Preventive interventions are often administered in school classrooms by classroom teachers (with support from mental health professionals) rather than mental health providers. Because teachers are so highly involved in these approaches, implementation of universal and selected interventions requires the support and ‘buy-in’ from the school administration, a consideration not usually present in the treatment world, where providers tend to function relatively autonomously (Schaeffer et al 2005: 16-17).

### 9.9 ASSISTING SCHOOLS TO SELECT SUITABLE INTERVENTIONS

On the basis of a study focusing on the selection of interventions for school-based practice, Merrell and Buchanan (2006) put forward a framework that can assist schools in choosing suitable evidence-based interventions. The framework contains five dimensions:

- **Reach** – what proportion of the target population participated in the intervention.
- **Efficacy** – the impact of the intervention on specified outcome criteria when it is implemented as intended.
- **Adoption** – the target settings or organisations that may adopt a given intervention program.
- **Implementation** – consistency and quality of delivery of the intervention, particularly when the intervention is implemented in the real-world setting of the school.
- **Maintenance** – how well the intervention effects are maintained over time.

(Merrell & Buchanan 2006: 174)

### 9.10 STRATEGIES FOR FOSTERING THE ADOPTION OF EVIDENCE-BASED INTERVENTIONS IN SCHOOLS

Schaeffer et al (2005: 20) describe three strategies for encouraging implementation of evidence-based interventions in schools:

- All stakeholders should be involved in the process, including program staff (clinicians and administrators), school staff (teachers and principals), parents, and youth. All should be able to participate in the identification and implementation of evidence-based programs suitable for the school.
- Efforts involving these multiple stakeholders should be enacted at all stages of the change process, including identifying the problem areas to be addressed, selecting intervention approaches, motivating and educating for change, enacting the practice into routines, and participating in quality assurance activities.
- The intensity of effort must be maintained, under the assumption that successful implementation will be associated with the number of stakeholders and implementation components that are enlisted and that continue to be involved as the program is implemented.
9.11 AREAS REQUIRING FURTHER RESEARCH OR IMPROVEMENTS TO THE QUALITY OF CURRENT RESEARCH

The literature points to the following areas requiring further research or improvements to the quality of research currently available:

- Ensuring that the implementation of an intervention is well monitored so that its effectiveness can be assessed. This includes ensuring that evaluation can be undertaken of the multiple environmental/ecological factors that can hinder or promote effective delivery of new programs in the real-world setting of the school (Durlak 2011: 419-420; Greenberg et al 2005).

- The need to measure changes in skills levels, especially where the intervention aims to enhance social and emotional skills. Because there is no standardised approach to measuring social and emotional skills, there is a need for theory-driven research that aids in the accurate assessment of various skills and identifies how different skills are related (Durlak 2011: 419).

- Research on how best to deploy and support resources already within school settings that may provide the entry points for delivery of mental health services to children and young people in support of the school’s academic mission (Atkins 2010; Hoagwood et al 2007: 89).

- Research that would identify empirically based interventions that target both academic/educational and mental health functioning in schools (Hoagwood et al 2007: 67).

- Research on service models that integrate promotion, prevention and interventions, including consideration of the mental health needs of the entire school population (Atkins 2010).

- Studies that analyse the impact of school district policies on educational and mental health promotion, including examining the fiscal barriers to integrating mental health supports and identifying strategies for eliminating economic disincentives to integrative services (Atkins 2010).

- Longitudinal studies that assess measures of knowledge, attitude and behaviour outcomes in groups of young people at high risk of suicide (Cusimano & Sameem 2011: 49).

- Addressing the dearth of studies conducted in socio-economically disadvantaged communities (Stopa et al 2009: 18).

- Studies that focus on the content and delivery style of especially universal prevention programs in order to investigate what makes them more or less effective (Calear & Christensen 2009: 435).

9.12 SUMMARY

This section has considered current evaluations of the effectiveness of school-based programs addressing psychological-emotional wellbeing and mental health issues of students.

In terms of the effectiveness of programs focusing on the prevention of mental ill-health or the promotion of wellbeing at a general level, the following appear to have strong evidence:

- Programs are more likely to be effective if they
  - are aimed at promoting mental health rather than preventing mental illness
  - involve the whole school and include changes to the school’s environment
  - assist students to develop adaptive, cognitive and behaviour strategies
  - involve parents and the wider community
  - take into account the age and gender of the children
  - are implemented over a long period of time (continuously for more than one year)
allow for periodic follow-up of positive interventions (also described as ‘booster sessions’) in order to maintain positive outcomes and counter the evidence that effect sizes on hoped-for outcomes decrease over time.

- The continuing presence of appropriate adult staff, and the availability of mentoring or a stable relationship with a successful adult are important aspects of program delivery.
- Social and emotional learning programs appear to be more effective if they follow established curriculum and implementation guidelines.

For specific issues such as anxiety and depression selected programs appear to be more effective than universal programs, although universal programs have a role in enhancing protective factors. Other trends in the evidence include:

- For students with depression, selected programs may be more efficacious due to the increased room for change amongst participants with elevated symptoms of depression, and intervention programs consisting of 8 to 12 sessions may be more successful at reducing symptoms than programs which are shorter or longer than this.
- For students with emotional disturbance, treatment/intervention programs produce greater effects on social skills than prevention efforts.
- Selected programs targeting children and adolescents at risk for violence may be effective, but caution should be adopted in working with such students on a group basis.
- For obesity prevention, universal programs targeting all students are more effective than selected programs and interventions of short duration (0-12 weeks) had weaker effects than extended interventions.
- For drug prevention programs, successful intervention typically involves high levels of interactivity, time-intensity and universal approaches, and greater success is achieved when focusing on the middle school years rather than on younger or older students.

Social and emotional learning (SEL) programs are effective in enhancing student’s academic achievement and thus offer students a practical educational benefit. In addition, they improve students’ stress management, empathy, problem solving and decision-making skills.

The evidence on peer mentoring programs is mixed, and it appears less reliable for skill maintenance.

Less effective programs appear to be those that are fear-inducing and those focused on knowledge (delivering information) only.

According to research studies, psychotherapy and counselling services can be beneficial for many students and often contribute to positive effects in the lives of children receiving the support. Studies consistently show high levels of satisfaction with the contributions of school psychologists.

A common theme in the descriptions of school counselling/psychology services in the various countries is that school psychologists/counsellors devote a large proportion of their time to carrying out assessments, and proportionally less time engaged in providing intervention and prevention activities. Notwithstanding this, they are involved in the development and implementation of universal mental health and wellbeing programs.

All children will not respond to therapeutic intervention in the same way and counsellors need to remain cautious of the potentially harmful outcomes (iatrogenic effects) of psychotherapy and counselling in schools. For example, group interventions may be deleterious for students with disruptive behaviour.

School social work practices appear to have more of an impact on internalising disorders (eg anxiety, depression, and self-concept) than externalising disorders (eg aggression, conduct disorder, hyperactivity). The demonstrated impact of social work practice on improving the academic performance of students is important in terms of its alignment with the major function of schools, ie educational achievement.
10 Conclusion

The literature review has identified emerging trends concerning the psychological and emotional wellbeing needs of children and young people. It has also identified and analysed national and international models of effective practice currently being implemented in educational settings. The study forms part of a review of school counselling services in NSW Government schools being carried out in 2011.

10.1 EMERGING TRENDS

There is a wide range of understandings of child and adolescent wellbeing and debate on the indicators that should be used to measure the psychological and emotional wellbeing of children and young people. Conceptualisations generally include understandings that wellbeing refers to the ability to cope with stressors, the development of autonomy and trust, the development of the self-system (self-esteem, identity), the development of empathy and sympathy, and the formation of positive social relationships.

Psychological and emotional distress manifests in internalising behaviours (anxiety and depression) and externalising behaviours (acting out troubles through aggressive, violent or disruptive behaviour) and has an impact on the child’s success at school. There is currently no single indicator or set of indicators that is universally accepted by researchers, commentators and academics as appropriate for measuring the psychological and emotional aspects of wellbeing.

Trends in the mental health and psychological-emotional wellbeing of children and adolescents are influenced by:

- developments in communications technology which have led to the emergence of cyberbullying
- poor physical health, which can impact on mental health
- changes to families and family structures, including a measured increase in sole parent families and an increased rate of marriage breakdown
- education and work pressures, including a heightened emphasis on achievement and disengagement from school for those identified as unlikely to succeed
- economic factors, with some experts suggesting counter-intuitive rises in mental health problems associated with improvements in economic conditions
- rapid social and cultural changes, with vigorous debate on the impact of the growth of materialistic and individualistic values on individual alienation and social fragmentation.

It is difficult to draw firm conclusions as to whether there has been an increase in psychological-emotional distress and mental health problems among children and adolescents over the past years. Many studies point to significantly higher rates of mental health complaints and increases in the behavioural and emotional problems in children and adolescents.

However, other studies do not support the notion of a dramatic increase in behavioural and emotional problems in children and adolescents. Rather, they suggest that the majority of children are progressing well and that any differences in behaviour or temperament are modest, or they indicate that overall happiness scores among children and young people have increased over time.

Some studies suggest that inconsistent trends in psychological and emotional distress and mental health can be, at least partly, attributed to changes in the way mental health problems are measured and varying methodologies used by researchers.

Drawing on the debates in the literature, the following are put forward as trends in the psychological and emotional wellbeing of Australian children and young people:
• The majority of young people rate their health as ‘good’ or ‘excellent’ (higher than the OECD average) and there have been measured improvements in the physical health of children and young people overall, including declining mortality rates.

• The majority of today’s Australian children are progressing well in terms of their temperament style and behaviour problems, and NSW data point to significant decreases in the proportion of students who had experienced high psychological distress (in the last six months prior to measurement) between 1996 and 2008 (from 15.4% to 13.3%).

• There have been consistent increases in the past decades in the numbers of students diagnosed with disabling conditions in NSW schools, and this is particularly true for autism and mental disorders.

• The prevalence of bullying is high – a nationwide study has found that approximately one in four Australian students in Years 4-9 were bullied every few weeks or more. There is an ongoing concern amongst young people about bullying and the rise of cyberbullying as a new form of bullying.

• There have been declines in the numbers of high school students in NSW who have ever consumed alcohol, but nationwide data show that considerable proportions of young people are drinking alcohol to levels that could lead to harm. In addition, there is a consistent trend for young people to rate ‘concern with alcohol’ to be an issue of concern to them.

• Strong and consistent increases in the rates of combined overweight and obesity amongst Australian schoolchildren have been measured over the past 20 years, with a 1.8% increase over the preceding five years. In addition, studies find that young people are consistently worried about body image.

• Children and young people express concern with regard to psychological-emotional wellbeing issues such as family conflict and coping with stress and depression.

According to the AIHW (2011: viii) it is currently unknown whether the proportion of deaths of children and young people in Australia from suicide has changed over time.

10.2 MODELS OF EFFECTIVE PRACTICE

A consistent theme in the literature is that there is a significant gap between the mental health needs of children and adolescents and the services available to meet those needs. Schools have become recognised as important locations for addressing the wellbeing needs of students, with advantages including their reach, familiarity and increased opportunities for mental health promotion and prevention efforts.

Mental health programs in schools focus on issues that include:

• the development of skills and enhancing of knowledge (often described as psychoeducation)

• improving peer relationships and teacher-student relationships

• improving the ethos of the school and the development of school policies.

Many schools have adopted a health promotion focus, within which three overlapping tiers of intervention can occur, namely:

• universal programs, often focusing on prevention and including classroom-based approaches, effecting changes to the school environment as a whole and expanding efforts beyond the school to also include the family and community

• selected interventions for students at risk for developing emotional or behavioural disorders, and often making use of group approaches

• targeted interventions for individual students who have been identified as having an emotional or behavioural problem or a mental health disorder.
The literature provides many examples of especially universal programs that have been adopted in school systems in countries such as Australia, the UK, the USA, Canada, New Zealand and Norway. In addition, the school systems in these countries provide student support services that include school psychologists, school counsellors and social workers operating in the school setting itself. Many jurisdictions also have overarching policy frameworks focusing on child and youth wellbeing. There is evidence in the literature that the USA has taken significant steps with regard to establishing mental health practices in schools, and many of the universal school-based approaches that are described in the literature have their origin in the USA and have spread internationally from there.

10.2.1 EVALUATION OF THE EFFECTIVENESS OF PROGRAMS

There is a rich evaluation literature on the effectiveness of school-based programs focusing on psychological and emotional needs of students, including meta-studies. Considering the breadth of the issues that are covered by such programs (focusing variously on one or more internalising behaviours, externalising behaviours and enhancing academic success or a combination of these) it is difficult to provide succinct answers as to what works best or which programs and interventions can be regarded as evidence-based.

Despite these limitations, studies suggest that the following factors contribute to the effectiveness of programs focusing on the promotion of wellbeing and prevention of mental ill-health in school settings:

- Programs are more likely to be effective if they
  - are aimed at promoting mental health rather than preventing mental illness
  - involve the whole school and include changes to the school’s environment
  - assist students to develop adaptive, cognitive and behaviour strategies
  - involve parents and the wider community
  - take into account the age and gender of the children.
  - are implemented over a long period of time (continuously for more than one year)
  - allow for periodic follow-up of positive interventions (also described as ‘booster sessions’) in order to maintain positive outcomes and counter the evidence that effect sizes on hoped-for outcomes decrease over time.

- The continuing presence of appropriate adult staff and mentoring or a stable relationship with a successful adult are important aspects of program delivery.

- Social and emotional learning programs have positive effects on social-emotional skills such as stress management and emotions recognition, and they appear to be more effective if they follow established curriculum and implementation guidelines.

- For specific issues, such as anxiety and depression, selected programs appear to be more effective than universal programs, although universal programs have a role in enhancing protective factors.

The age (and therefore the developmental stage) of children is an important consideration for wellbeing programs and studies show that younger children are less likely than older children to engage in help-seeking behaviour. Nevertheless, the importance of the age of the participating students differs according to the nature of the intervention. For example, studies show that programs focusing on emotion management are more effective for younger than older children, suggesting that dealing with emotional problems in earlier grades produces better outcomes. For issues such as obesity prevention, it may be older students who respond more favourably to programs, but it is also important to introduce such programs early on, preferably in elementary school.

Age is an important consideration for interventions focusing on anti-violence and reducing aggression. For younger students, it may be more important to focus on disruptive and anti-social behaviour by attempting to impact on the cognitive and affective mechanisms associated with such behaviour. In the later school years, attention should shift to specific forms of violence, such as dating violence, and greater use should be made of social skills training.
When working with adolescents, it is important to recognise the difficulties many of them face in balancing multiple demands from family, peers, school and also work.

Although the available literature points to the specific needs of the diverse groups of students, there was a dearth of studies that evaluated the effectiveness of programs specifically addressing the mental health and wellbeing needs of, for example, students from CALD backgrounds or same-sex attracted youth. Even with regard to gender-informed mental health programming, and in spite of much evidence for differences between boys and girls on many wellbeing issues, there continues to be a paucity of literature, both applied and experimental. In reviewing the intervention literature, we found very few empirically validated gender-informed or gender-specific programs currently available for implementation in schools... an increase in research on gender-specific universal, secondary, and tertiary school-based programming is clearly needed.

(Friedrich et al 2010: 132)

In similar vein, Stopa et al (2009: 18) point to 'the dearth of studies conducted in socio-economically disadvantaged communities'. This is an area that further research, as pointed out by Friedrich et al (2010: 123):

Gaining a better understanding of how differences among groups of children affect mental health outcomes has been recognized as a critical component of meeting the mental health needs of youth.

Nevertheless, school-based personnel need to improve their understandings of the diversity in the student body, as well as being familiar with services outside of the school that can be accessed in working with diverse groups of students.

There is a wide range of interventions and approaches that schools can choose from, many of which have evidence for their efficacy and effectiveness in school settings. At the same time, several issues need to be considered in adopting a school-based mental health initiative. These include:

- Getting the mix right in terms of universal, selected and targeted interventions adopted within a particular school, taking into account the specific nature and needs of the student body and the wellbeing issue or issues that are receiving attention.
- Determining whether a single approach or multiple approaches (including working with families) is more efficacious for the particular wellbeing issue that is focused upon.
- Considering key factors, such as policy, leadership and professional development, that may impact on student behaviour.
- Considering nuances within the student body, in terms of issues such as gender and age. Research is clear, for example, that emotion management is more effective for younger than older children, and that girls and boys exhibit widely different trends in terms of mental health and wellbeing indicators.
- Consideration of the possible deleterious effects of intervention, with the strong finding that the behaviours of aggressive and antisocial youth may be worsened by participation in especially group programs.

Implementation issues are particularly important, since a program producing results in a controlled research study may in theory look promising, but the positive results may or may not be transportable to the real world school setting, especially considering the varied nature of schools and that schools are primarily educational settings. Implementation issues include:

- the characteristics of the innovation (program, approach, intervention) and its ‘fit’ with the school
- the characteristics of the implementer, including whether it is better to make use of school personnel or specialists from outside the school, or a combination, and the knowledge, skills and preparation required for implementation of the program
• the timing and phasing of the program, including how it fits into the school’s program, the ideal length of an intervention and whether ‘booster sessions’ are included to consolidate learnings sometime after the initial presentation of the intervention.

10.2.2 EVALUATIONS OF SCHOOL COUNSELLING/SCHOOL PSYCHOLOGY AND SCHOOL SOCIAL WORK

In NSW, as in other States and Territories, school psychologists provide:

• direct services, such as psychological and behavioural assessment using standardised tests and observation

• indirect services, such as consultations with teachers and parents

• whole-school services, including the planning, preparation, implementation and evaluation of psychological and educational strategies

• assistance with systems service issues such as crisis management policies and response and recovery strategies.

Available studies consistently show high levels of satisfaction with the contributions of school counsellors/psychologists. School counselling is valued for:

• intervening in the continuum of practice levels, from individual students to classes and whole schools, as well as with families

• being an integral part of students’ support strategies

• good collaborations with the teaching staff.

A common theme in the descriptions of school counselling/psychology services in the various countries is that they devote a large proportion of their time to carrying out assessments, and proportionally less time engaged in providing intervention and prevention activities. Notwithstanding this, they are involved in the development and implementation of school-wide programs, and in developing and maintaining linkages with services external to the school.

School social workers are recognised as being skilled in providing crisis management, group work interventions, individual counselling, family counselling and community (whole school and neighbourhood) development interventions. Evaluations of school social work have found that it appears to be more effective in helping students with internalising disorders (eg anxiety, depression, and self-concept) than those with externalising disorders (eg aggression, conduct disorder, hyperactivity).

School social work is especially effective in contributing to the academic performance of students through focusing on drop-out prevention, improving grades and attendance. This suggests that a key value of school social work lies in its alignment with the major function of schools, namely the educational success and achievement of their students.

10.2.3 AREAS FOR FURTHER RESEARCH

The literature points to the following areas requiring further research or improvements to the quality of research currently available:

• Ensuring that the implementation of interventions is well monitored so that the effectiveness of these interventions in the real-world setting of schools can be rigorously assessed.

• Studies that focus on the content and delivery style of especially universal prevention programs in order to investigate what makes them more or less effective.

• Research that aids in the accurate assessment of psychological-emotional wellbeing skills and identifies how different skills are related.
- Research on how best to deploy and support resources already within school settings that may provide the entry points for delivery of mental health services to children and young people in support of the school’s academic mission.

- Research that would identify empirically based interventions that target both academic/educational and mental health functioning in schools and the impact of the one on the other.

- Research into service models that integrate prevention, promotion, and treatment interventions, including consideration of the mental health needs of the entire school population.

- Studies that analyse the impact of school district policies on educational and mental health promotion, including examining the fiscal barriers to integrating mental health supports and identifying strategies for eliminating economic disincentives to integrative services (Atkins 2010).

- Addressing the dearth of studies conducted in relation to the wellbeing of specific cohorts of young people, including those in socio-economically disadvantaged communities, Aboriginal and Torres Strait Islander children and young people from CALD backgrounds. This should include evaluations of the effectiveness of interventions to address the wellbeing needs of diverse cohorts of students in educational settings.
11 References


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Appendix A  Indicators of child development and wellbeing
### A.1.1 INDICATORS OF CHILD DEVELOPMENT AND WELLBEING (AIHW)

Table 8 – Selected indicators of child development and wellbeing in Australia based on national samples

<table>
<thead>
<tr>
<th>WELLBEING ISSUE</th>
<th>STATISTICAL INDICATOR</th>
<th>VALUE</th>
<th>YEAR/S OF MEASUREMENT</th>
<th>TREND IN COMPARISON WITH EARLIER MEASURES (WHERE AVAILABLE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>What factors can affect children adversely</td>
<td>Birth rate of women who are 15-19 year old</td>
<td>17 per 1,000 women</td>
<td>2006</td>
<td>favourable</td>
</tr>
<tr>
<td></td>
<td>Women who consumed alcohol during pregnancy</td>
<td>60%</td>
<td>2007</td>
<td>favourable</td>
</tr>
<tr>
<td></td>
<td>Live born infants of low birth weight</td>
<td>6%</td>
<td>2006</td>
<td>no change or clear trend</td>
</tr>
<tr>
<td></td>
<td>Children aged 2-12 years whose body mass index (BMI) score is above the international cut-off points for ‘overweight’ and ‘obese’ for their age and sex</td>
<td>22%</td>
<td>2007</td>
<td>unfavourable</td>
</tr>
<tr>
<td></td>
<td>Children aged 12-14 years who are current smokers</td>
<td>5%</td>
<td>2005</td>
<td>favourable</td>
</tr>
<tr>
<td></td>
<td>Children aged 12-14 years who have engaged in risky drinking on any one occasion</td>
<td>2.6%</td>
<td>2005</td>
<td>unfavourable</td>
</tr>
<tr>
<td>How healthy are Australia’s children</td>
<td>New cases of insulin-dependent diabetes in children aged 0-14 years</td>
<td>23 per 100,000 children</td>
<td>2006</td>
<td>unfavourable</td>
</tr>
<tr>
<td></td>
<td>Children aged 0-14 years with severe or profound core activity limitations</td>
<td>4.3%</td>
<td>2003</td>
<td>unfavourable</td>
</tr>
<tr>
<td>How well are Australia’s children learning and developing</td>
<td>Attendance rate of children in Year 5</td>
<td>85-95%</td>
<td>2007</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td></td>
<td>Children in year 5 who achieved at or above the national minimum standards in reading</td>
<td>91%</td>
<td>2008</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td></td>
<td>Children in year 5 who achieved at or above the national minimum standards in numeracy</td>
<td>93%</td>
<td>2008</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td>What kind of families and communities do Australia’s children live in</td>
<td>Children aged 0-14 years in out-of-home care</td>
<td>7 per 1,000</td>
<td>2008</td>
<td>unfavourable</td>
</tr>
<tr>
<td></td>
<td>Parents rating their health as ‘fair’ or ‘poor’</td>
<td>13%</td>
<td>2006</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td></td>
<td>Children living with parents with mental health problems</td>
<td>21%</td>
<td>2006</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td></td>
<td>Households with children aged 0-14 years where the neighbourhood is perceived as safe</td>
<td>86%</td>
<td>2006</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td>WELLBEING ISSUE</td>
<td>STATISTICAL INDICATOR</td>
<td>VALUE</td>
<td>YEAR/S OF MEASUREMENT</td>
<td>TREND IN COMPARISON WITH EARLIER MEASURES (WHERE AVAILABLE)</td>
</tr>
<tr>
<td>-----------------</td>
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<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Households with children aged 0-14 years where respondent was able to get support in time of crisis from persons living outside household</td>
<td>94%</td>
<td>2006</td>
<td>no change or clear trend</td>
<td></td>
</tr>
<tr>
<td>How safe and secure are Australia's children</td>
<td>Hospitalisation rate for children aged 0-14 years due to injury</td>
<td>1,462 per 100,000</td>
<td>2006-07</td>
<td>favourable</td>
</tr>
<tr>
<td></td>
<td>Hospitalisation rate for children aged 0-14 years due to assault</td>
<td>20 per 100,000</td>
<td>2006-07</td>
<td>favourable</td>
</tr>
<tr>
<td></td>
<td>Hospitalisation rate for children aged 10-14 years due to intentional self-harm</td>
<td>41 per 100,000</td>
<td>2006-07</td>
<td>unfavourable</td>
</tr>
<tr>
<td></td>
<td>Children aged 0-12 years who were the subject of care and protection orders</td>
<td>7 per 1,000</td>
<td>2008</td>
<td>unfavourable</td>
</tr>
<tr>
<td></td>
<td>Accompanying children aged 0-14 years attending agencies funded under the Supported Accommodation Assistance Program ie experiencing homelessness</td>
<td>16 per 100,000</td>
<td>2006-07</td>
<td>data presented for the first time</td>
</tr>
<tr>
<td></td>
<td>Children aged 10-14 years who were under juvenile justice supervision</td>
<td>1.7 per 1,000</td>
<td>2006-07</td>
<td>data presented for the first time</td>
</tr>
</tbody>
</table>

Source: AIHW (2009: x-xi)