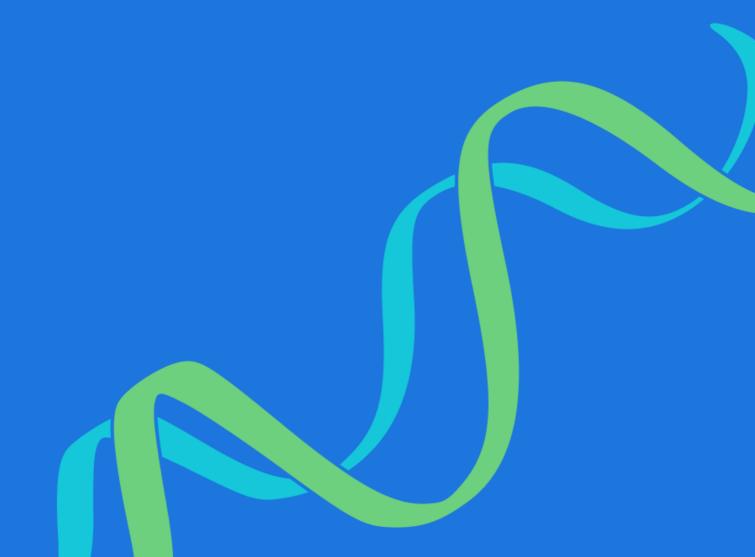Position statement

Psychologists in schools

April 2022 | Australian Psychological Society

Introduction

Each year, an estimated one in five Australian children starts school showing signs of psychosocial stress[1]. In a 12-month period, one in seven, or around 670,000 of Australia's 4 million school-aged children, can be expected to experience one or more mental, behavioural or neurodevelopmental disorders[1,2]. There are also those children, often referred to as the 'missing middle', who experience psychosocial distress but fall outside of diagnostic thresholds[3,4].

There is ample evidence about the negative impacts these alarming levels of psychosocial stress, mental ill-health and behavioural or neurodevelopmental disorders can have on young people. After asthma, anxiety, depression and conduct disorder are the leading causes of disease burden for Australian children aged 5–14 years[5,6]. For young people aged 15–24, suicide and self-inflicted injuries are the top cause of disease burden, followed by anxiety and depression[6,7]. Beyond disease burden considerations, school-aged children with mental health struggles experience impairments in other areas of development, such as psychosocial functioning (e.g., poor emotional regulation and social relationships)[8,9]. Children with mental health struggles are also more likely to experience academic struggles such as poor school engagement and learning challenges[10]. For example, average NAPLAN test scores are lower for students with mental disorders than those without mental disorders[11].

Alarmingly, the effects of the COVID-19 pandemic, from school shutdowns, social isolation and loneliness, and economic strain for families and communities, have further impacted the mental health and wellbeing of Australian school-aged children. Parents reported a decline in their children's mental health as the pandemic progressed[12]. Other research has found that up to three-quarters of adolescents reported worsening mental health due to COVID-19, with another study finding a four-fold increase in youth psychological distress[13,14]. Children experiencing the most significant deterioration in mental health during the pandemic are from many of the same cohorts already at increased risk of experiencing mental health struggles before the pandemic. These cohorts include children from diverse cultural backgrounds, including Aboriginal and Torres Strait Islander children, children with a disability or chronic illness, LGBTQI+ young people, and children whose parents experience high levels of psychological distress or mental ill-health[13,15–22]. Experts in this field are forecasting longer-term mental health and wellbeing issues associated with the pandemic, especially for vulnerable children and young people[23,24].

Advanced research designs have demonstrated that mental, behavioural and neurodevelopmental disorders in children and young people can provoke a damaging developmental cascade[25]. For many children, symptoms of mental ill-health can undermine school engagement, learning and relationships, which in turn impacts social adjustment and academic achievement. The spiralling negative effects of poor social and educational attainment further exacerbate mental distress[e.g.,26,27]. The cascade does not stop there.

The evidence is clear that psychological distress in childhood often continues into adulthood. A recent systematic review of over 40 studies demonstrated that the experience of mental, behavioural or neurodevelopmental disorders during childhood or adolescence, and from as early as five years of age, increases the risk of adult mental illness[28]. Estimates are that about half of adult mental health disorders begin before 14 years of age[29]. Half of those children and adolescents who 'outgrow' their diagnosis as they enter adulthood are more likely than those without a history of mental ill-health to experience significant functional difficulties with work, health, relationships and crime.[8]

There are also strong links between youth and adult mental ill-health and the accumulation of risk associated with modifiable adverse childhood experiences (ACEs), including child maltreatment, household drug use and violence, and family change and adversity such as parental separation, illness or poverty[30]. Exposure to ACEs is widespread. One in seven Australian children are exposed to 3+ risk factors, with one in five children aged 8–9 years exposed to ⩾5 risk factors[31].

There is a critical shortage of appropriate mental health services for children and young people in Australia. Many children and families cannot access much needed mental health support to manage psychosocial stress and mental, behavioural or neurodevelopmental disorders. Demand has long outstripped supply. Pre-pandemic data indicates that less than half of children aged 4-17 years of age who experience mental ill-health have access to mental health support services when needed, particularly those living in rural and remote Australia, where rates of mental illness are higher[32,33].

Recent estimates are that Australia has only 35% of the required psychology workforce[34]. Surges in help-seeking for mental health issues during the pandemic, especially in the lock-down periods, have seen wait lists for psychologists extend up to 6-12 months[35,36]. One in three psychologists has closed their books, compared to one in 100 before the pandemic[35].
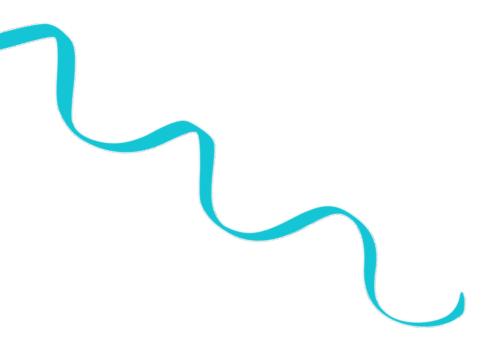
Improving outcomes

The Productivity Commission has estimated the cost of mental ill-health to our economy is $600 million a day, or $220 billion every year[37]. There is clear evidence that it costs significantly less to build mental health and resilience and intervene early, when school-aged children experience mental health, behavioural or neurodevelopmental struggles, than it does to treat mental illness in adolescence and adulthood.

For example, a return-on-investment study in the United Kingdom showed that for each case of mental ill-health prevented by school-based social and emotional learning programs, there are cost savings of almost $300,000 for severe problems and $150,000 for mild problems[38]. The Australian National Mental Health Commission demonstrated that school-based depression prevention programs result in fewer depression cases and can save over $37 million[39]. Overall, investing early in children's mental health and wellbeing results in a return-on-investment between $1 and $10.50 for each dollar spent[37].

Investing in the mental health of Australian children and young people is also an investment in global social impact. The United Nations Sustainable Development Goals Target 3.4 aims to reduce by one-third the premature mortality from non-communicable diseases through mental health promotion, the prevention and treatment of mental ill-health and reducing the suicide mortality rate[40].

In addition, education is a recognised social determinant of wellbeing, along with health and welfare. The AIHW report *Australia's health 2020 data insights* also points to educational attainment as a key social determinant related to death by suicide[41]. Clearly, protecting our children's educational experience has both social and economic benefits.

The APS position

The evidence is clear that lifelong mental health and wellbeing begins in childhood. Children and young people with good mental health are more likely to be resilient in the face of challenges and realise their potential, live fulfilling lives and become productive members of society[42]. Poor mental health significantly impacts the ability of children and young people to thrive in school, at home and in life[28]. The increasing rates of mental ill-health in our young people and the challenges associated with accessing timely and high-quality mental health support risks the health, wellbeing and futures of Australia's young people.

The Australian Psychological Society (APS) calls for investment in the mental health and wellbeing of Australian school-aged children by embedding within all schools a comprehensive, evidence-based approach to universal mental health promotion and prevention and early intervention for mental ill-health that is led by a highly trained and skilled psychology workforce.

1. Embed a highly trained and skilled psychology workforce in schools

As highlighted in the *National Children's Mental Health and Wellbeing Strategy*, children and families have, to date, received mental health care from a wide range of disciplines and people with various training backgrounds, which has led to variable care quality[43]. The APS concurs with the National Mental Health Commission that this is unacceptable. School-based mental health services can only meet their full potential when led, coordinated and supported by a dedicated and highly skilled psychology workforce[44]

Psychologists are an AHPRA-registered and evidence-based profession who have advanced skills in promoting mental health and wellbeing and preventing, identifying and treating mental ill-health[45]. As described in the *APS framework for effective delivery of school psychology services: A practice Guide for psychologists and school leaders*[46], school psychologists are leading mental health experts in schools. School psychologists have the training and skills to coordinate and deliver evidence-based, whole school, multi-tiered school-based mental health and wellbeing approaches. School psychologists also have specific skills in assessment and interventions for mental health, developmental, learning and behavioural issues. They can help children and young people achieve social and emotional wellbeing and academic success. School psychologists are perfectly positioned to be the bridge linking young people and their families to mental health support outside of schools, including primary health care, specialist community mental health treatment services and social services[47,48]. School psychologists know this services landscape well and can effectively refer and partner with these services if required for more intensive assessment or treatment.

School psychologists also partner with school staff and leaders as trainers, coaches, consultants and advisors as they implement mental health initiatives. Working in this way will further extend the reach of the psychology workforce in schools by supporting educators to support the mental health and wellbeing of their students. In the longer term, this specialist support provided to educators can extend the skills and capacity of the Australian education system to better support and improve the mental health and wellbeing of school-aged children.

Although ratios vary across Australian educational jurisdictions, estimates are that there is only about one school psychologist to every 1500 students[49]. This poor workforce ratio prevents many school psychologists from working to their full scope of practice as described. With high numbers of students to serve, school psychologists' work must often focus on the more complex cases.

There is much less opportunity to work on mental health promotion, prevention and early intervention work that can benefit all school students. As highlighted in the Productivity Commission's 2020 *Mental Health Inquiry Report*[37], a more favourable ratio of at least one full-time psychologist to every 500 students will enable best-practice comprehensive school-based mental health support services throughout all Australian public, private and independent primary and secondary schools. Ensuring that all children and young people are supported to be mentally healthy and well, not only those with complex mental health, learning or developmental support needs, is imperative and must include providing mental health support to young people in the typically underserved areas of regional, rural and remote Australia.

The number of fully trained psychologists available to work in schools could be scaled up within a short time frame of 2-3 years – but only with the right investment in postgraduate university training, sponsored placements (particularly in rural and remote areas) and quality professional supervision. For this to occur, there is an immediate need for investment to significantly increase the number of university psychology training places and psychology teaching and supervision staff. This includes funding for dedicated school psychology streams within these programs with sufficient resourcing to support the supervised school-based internship components. Dedicated university places and scholarships to greatly improve Aboriginal and Torres Strait Islander representation in school psychology roles are a priority. These investments in training psychologists will deliver immediate benefits for students' mental health and wellbeing by providing schools with access to a psychology intern workforce, particularly in rural and remote schools.

2. Resource schools to provide comprehensive, evidence-based approaches to mental health and wellbeing support

The Productivity Commission's 2020 *Mental Health Inquiry Report* and the National Mental Health Commission's first *National Children's Mental Health and Wellbeing Strategy,* released in 2021, both prioritise educational settings, in partnership with family, community and the broader service system, as critical for supporting the mental health and wellbeing of children and young people[37,43]. Schools offer an opportunity for almost universal support for childhood mental health, with most Australian young people attending schools for their education[5]. Review studies have consistently demonstrated the effectiveness of high quality school-based mental health services for decreasing mental health problems[50,51,52,53].

While acknowledging the work that schools already do to support the mental health and wellbeing of young people, the APS concurs with the Productivity Commission and the National Mental Health Commission that there is much more to be done to build on this work. Educators value mental health and wellbeing initiatives but face a confusing and disjointed proliferation of poorly evaluated programs and services, along with a multitude of uncoordinated interventions[54]. Yet, the evidence is clear. Improved mental health, psychosocial and educational outcomes are associated with whole school approaches sustained over time with internally coordinated tiers of health promotion, targeted prevention, and early intervention support and connected to the external support system[50,51,53,55].

More work is needed to support schools to address policies, procedures and behaviours that create stress and unhappiness for some students, stigmatise mental illness or decrease access to school mental health support services[56]. Educators need more support to develop their skills and confidence for: earlier identification of students who are experiencing mental health struggles, improving the mental health literacy of their students, discussing mental health concerns with parents and connecting children and families to additional supports and services when needed[57–60].

Crucially, educators need to be supported to manage the tensions and complexities associated with their teaching and pastoral care roles and maintain their own health and wellbeing, made especially challenging in recent times amid frequent changes to schooling throughout the pandemic[54,61–63].

Investing in a highly trained and skilled school psychology workforce and providing funding for the integration of coordinated, multi-tiered, whole school mental health and wellbeing programs is necessary to improve children's mental health and wellbeing and educational outcomes.

3. Develop a comprehensive national plan for the school psychology workforce.

Qualifications, conditions and role expectations for school psychologists are determined at the state level and vary across public, private and independent schools. There is a need for national consistency.

A sustainable school psychology workforce also requires acknowledgement of the complexity of the role and high levels of training, qualifications and skills that psychologists bring. Fair working conditions with clear workload models and access to appropriate career advancement and recognition, in addition to ongoing professional supervision and development, are all essential for a sustainable school psychology workforce. A national workforce plan for school psychologists is needed now.

What is needed

- Schools need access to multi-tiered, evidence-based, whole school mental health and wellbeing programs and a dedicated and highly skilled national psychology workforce to lead, coordinate and support school-based mental health and wellbeing programming and evaluation.

- Funding is required to achieve a minimum ratio of one full-time equivalent school psychologist for every 500 students. With just over 4 million students in Australian schools, at least 8,000 school psychologists are needed now.

- There is a critical need to grow the number of qualified psychologists through increased funding for postgraduate training, placements and supervision. Funding to increase the number of psychologists in schools will only work if we have enough trained psychologists.

- Dedicated training places and scholarships are urgently needed in rural and remote areas and to increase Aboriginal and Torres Strait Islander representation in school psychologist roles.

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