# STUDENT AND STAFF WELLBEING AND MENTAL HEALTH

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# ABOUT THIS DOCUMENT

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| Title: | Students and staff wellbeing and mental health – Report commissioned by Independent Schools Australia |
| Purpose: | This research describes wellbeing issues amongst school students to inform and make recommendations that would help protect the mental wellbeing of students and school staff. |
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# 1. EXECUTIVE SUMMARY

Student wellbeing is at the heart of positive learning outcomes and the development of a responsible and engaged citizenry.

The *Australian Student Wellbeing Framework*[1] describes Australian schools as 'learning communities that promote students' wellbeing, safety and positive relationships so that students can reach their full potential'.

While most children and young people in Australia report good mental wellbeing, the research shows this is a slim majority.

The research shows that rates of psychological distress are rising. More than 2 in 5 children and young people in Australia reported feeling stressed most or all the time, suggesting many are struggling. One in five report high levels of psychological distress, and 14 per cent meet criteria for a psychiatric disorder, indicating they are unwell. Of particular concern is the increasing prevalence of psychological distress in younger age groups.

Student wellbeing is integral to ensuring students are ready and able to learn. Poor wellbeing affects school attendance, learning, and academic outcomes, threatening core education goals. For example, by early secondary school, students with a mental disorder lag academically by almost three years compared to their well peers.

In theory, schools are an ideal setting for children and adolescents to seek and receive the help they need. The reality is different and most students turn elsewhere for support. Unwell young people are often anxious and embarrassed about getting help, and often believe they can deal with their mental health themselves.

To understand how schools can meet their full potential in supporting students, it is necessary to understand the evidence for successful intervention programs in school settings and how this can be achieved in Australian schools.

Wellbeing is not evenly distributed across Australia and inequities arise from students' backgrounds and circumstances. Different situations and school communities require different responses.

There is strong evidence for the effectiveness of school interventions for students' mental health. Mental health interventions may be universal focused on whole of school/group prevention; targeted programs for those at risk of poor mental health; or one-to-one interventions for those experiencing poor mental health.

Universal intervention frameworks can provide the base for more targeted responses to be delivered without shame or stigma. Universal programs provide the capacity to screen students to determine who requires more tailored supports, by identifying features of mental health problems, poor wellbeing or known risk factors.

For Australian schools to be effective at these three levels, there are barriers to overcome. One necessary element for success, is to support the wellbeing of teachers, which is intertwined with the wellbeing of students. Teaching is a stressful profession at the best of times. With the added complexities associated with the pandemic, it is even more so.

Schools also experience challenges in identifying, implementing, managing and evaluating mental health programs.

They face a crowded space of competing programs offered by external providers, with little guidance as to which approaches have solid evidence of efficacy.

Under pressure of an already crowded curriculum, staff have limited capacity to dedicate time and skills to mental health interventions.

There are also gaps in the programs and services that are available which need to be better understood and addressed. For instance, interventions need to be age-appropriate and yet few exist for younger children.

As well, clinical support needs to be readily available. This is often not the case, especially for schools in regional and remote Australia, with long waiting periods, if indeed specialist support is available at all.

Finally, meaningful evaluation built on accurate measurement is essential, to identify needs, targets for improvement and to track progress. There are few school or school system evaluation systems in place

Schools can overcome these barriers if they have access to the right resources for their school's particular needs and the capacity to invest and sustain their commitment. The following recommendations would enable schools to optimise their effectiveness;

1. Establish a coherent policy and practice framework for monitoring and developing student and staff wellbeing
2. Improve resourcing and training for student and staff wellbeing and inclusivity
3. Prioritise a culture of trust and wellbeing
4. Partner with the full diversity of families in the community.

# 2. INTRODUCTION

A core goal of education in Australia is achieving the wellbeing that enables economic and civic participation. Indeed, according to the Australian Department of Education, Skills and Employment. schools are the nexus for this goal to be realised as "learning communities [that] promote students' wellbeing, safety and positive relationships so that students can reach their full potential," (Australian Student Wellbeing Framework).[1]

Students also see the value of relationships for their wellbeing, along with a strong sense of social and emotional needs being met, having the support and autonomy they need, and doing what they can to look after themselves[1].

This report provides an overview of the current state of wellbeing among Australia's children and adolescents and shows that, although a majority report adequate social and emotional wellbeing and good mental health, for a growing number of Australia's children and youth, wellbeing is declining and psychological distress increasing, along with suicide rates. Reduced wellbeing and increased distress take a toll - not just on the young person's capacity to engage productively in their education, but on society as a whole.

Although Australia holds itself as the land of the 'fair go', wellbeing is inequitably distributed. From the time of entering school, children from disadvantaged homes show more vulnerabilities in the building blocks of wellbeing – emotional maturity, social competence, communication skills.

Mental disorders are more common amongst students from low-income homes, outer regional areas, amongst Aboriginal and Torres Strait Islander people, amongst LGBTQI2+ young people, and those exposed to adverse childhood experiences.

Because children almost universally attend school, the school setting is key for young people to interact with trained professional. It can be a place where action is possible to support students' wellbeing and mental health.

Pressure is mounting with calls for schools to take a stronger position in ensuring the social-emotional wellbeing and mental health of all students[2], on top of the existing responsibilities for literacy, numeracy and academic achievement overall.

But schools need help to reach that potential. This report examines barriers schools face in achieving optimal outcomes. Evidence indicates that working in schools can be a high-pressure profession, with relatively high rates of mental health problems and stress amongst teaching and other staff. The wellbeing of staff and students is intimately intertwined. Unlike student wellbeing, no *School* Staff *Wellbeing Framework* exists in Australia.

So how can school staff wellbeing be bolstered to enable them to meet the wellbeing needs of students? This report considers areas where school practices can make a real difference. It presents evidence for approaches that have potential to improve the wellbeing of Australia's school communities.

This report also addresses several key barriers that schools face in working toward student and staff wellbeing and recommends solutions.

# 3. THE STATE OF STUDENT WELLBEING

Achieving and maintaining a positive sense of self and belonging are among the most important challenges of childhood and adolescence. While Australian and international data suggest that many young people can achieve a positive state of wellbeing, this is currently not a reality for many.

Schools have good cause to be concerned about student wellbeing and mental health. Poor wellbeing – as indexed by psychological distress and mental disorders – limits the capacity of students to get the most out of their schooling Students with a mental disorder have progressively higher rates of school absenteeism over their schooling. Student wellbeing is integral to ensuring students are ready and able to learn.

Traditionally, ensuring the mental health and wellbeing of students has been largely left to the mental health care system. The Australian mental health care system is focused on intervention by specialists, often once the problem has progressed to crisis, and much less so on prevention and early intervention[2].

Moreover, little mental health care exists for children under 12 years of age beyond a "fragmented assortment of programs, service offerings, inconsistent sources of resources (that are not necessarily evidence-based), siloed professionals in private practice, alongside inequity in access due to a family's geographical and financial circumstances," (p. 15)[2].

Given that a half of mental disorders have an onset prior to the age of 14, this is not good enough to meet the needs of children and adolescents.

> *"Half of mental illnesses have onset prior to the age of 14"*

As recognised in key recent Australian reports, [2,4], schools have an essential role to play in preventing mental illness and supporting wellbeing. But currently they are not able to meet their potential.

## THE NATURE OF 'WELLBEING'

The *National Children's Mental Health and Wellbeing Strategy* (2021) considers wellbeing as a continuum, from being *well*, where children are in a state of positive mental health, to *coping*, where children are experiencing challenges to their mental health but have the resources to manage those challenges, to *struggling*, where children are experiencing challenges too great for their coping capacities and require additional support, to *unwell*, where they are experiencing signs of mental illness and need support to manage and recover. Wellbeing is about "the quality of a person's life [and] more than the absence of physical or psychological illness"[5].

In this spirit, Western Australia (WA) has taken a broader view of wellbeing, focusing on three domains: learning and participating; healthy and connecting to their culture and

community; and feeling safe and supported in meeting their needs[6].

Agreement is emerging that 'wellbeing' reflects the absence of mental illness, capacities to cope successfully with life's challenges without experiencing undue psychological distress, and a positive sense of self and of one's life as safe and purposeful, thereby enabling healthy choices to be made and fulfilling relationships to be achieved.

While definitions of wellbeing vary, there is broad agreement that (along with families and health services) education settings have a key role to play in supporting wellbeing[2].

Internationally, definitions of student wellbeing have emphasised the importance of the school setting for wellbeing, for example defining it as "a positive sense of self and belonging and the skills to make positive and healthy choices to support learning and achievement, provided in a safe and accepting environment for all students" (p.5)[7].

These attempts to define wellbeing provide clarity that wellbeing is a core target for successful and healthy child development and is worth promoting.

It is imperative to ensure wellbeing is not taken only as the simple absence of mental illness or low scores on measures of difficulties (e.g., the Strengths and Difficulties Questionnaire). In the research literature on wellbeing, there is discussion of the need to consider wellbeing as a distinct dimension from mental illness – someone may have a psychological disorder but be well; someone else may have no discernible disorder but be very unwell nevertheless[8].

It is also important to consider cultural variations in what constitutes wellbeing and what contributes to wellbeing may differ. In Australia, this is perhaps most salient in the assessment of wellbeing for Aboriginal and Torres Strait Islander children, where the health of one's community, country and culture are all explicitly considered as the relational scope of individual wellbeing[9]. But cultural conceptions of wellbeing may differ for other cultural and ethnic groups in Australia. The move to measure wellbeing must seek to ensure the full strengths of all cultures reflective of contemporary Australia, are allowed to be seen.

## WELLBEING OF YOUNG PEOPLE IN AUSTRALIA

For students, wellbeing has important ramifications for academic outcomes. Associations exist between child mental health and achievement at school entry, and are sustained through to Year 3[10]. These early inequities appear to become amplified over the school years.

For example, students with a mental disorder have progressively higher rates of school absenteeism over their schooling – from 11.8 days per year in Years 1-6 (compared to 8.3 days for students without such a disorder), 23.1 days for Years 7 through 10 (compared to 10.6 days), and 25.8 days (compared to 12.0 days) for those in senior Years[3] (see Figure 1).

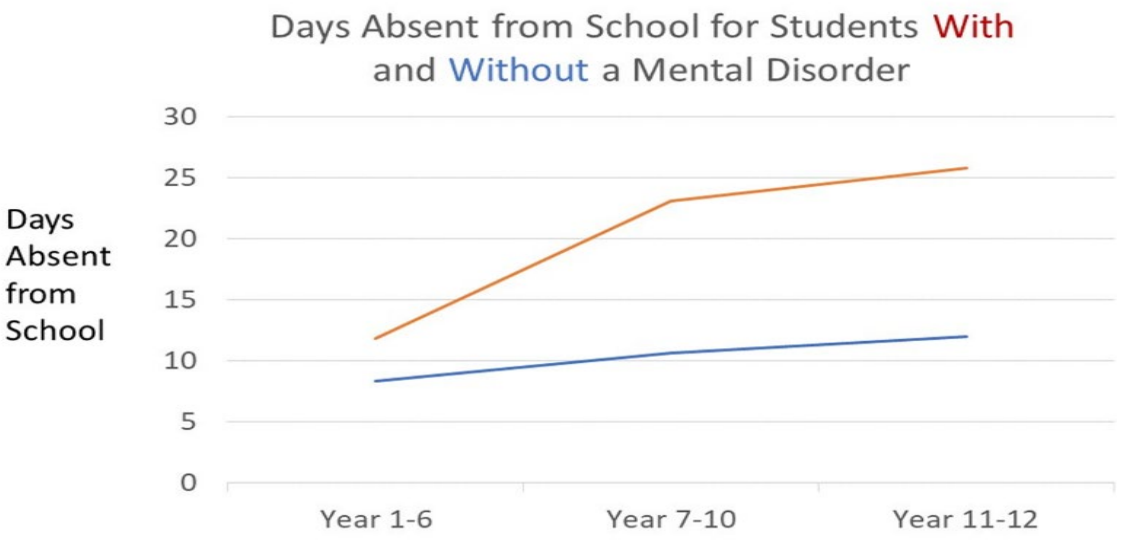


FIGURE 1 - DAYS ABSENT FROM SCHOOLS IS LINKED TO MENTAL HEALTH

Children with a mental disorder have been shown to lag academically behind their peers by 7 to 11 months from as early as Year 3; a gap growing by 1.5 to 2.8 years by the early secondary school years[11]. Thus, poor mental health threatens not only the social-emotional wellbeing of students, but their academic progress as well. Action is clearly required to better support the wellbeing of all students and reduce this gap.

## Research reveals disturbing trends

Recent reports from Mission Australia[12] shed light on the state of wellbeing amongst young Australians (aged 15 to 18 years). The majority (58.6 per cent) of the participants reported they felt happy/very happy with their life as a whole; more than a half indicated feeling positive or very positive about the future (55.5 per cent). These markers of wellbeing indicate that most Australian young people are experiencing wellbeing, but only by a slim margin.

(See Appendix A for an overview of key relevant Australian studies)

An estimated 2 out of 5 young Australians are not reporting they feel happy about their life, with over 10 per cent (10.7 per cent) indicating they were sad or very sad with their lives, and 13.9 per cent (~ 1 in 7) indicating they felt negative or very negative about the future. Moreover, 42.6 per cent indicated they felt stressed either most of the time or all of the time[12].

Over a half of the young women surveyed in 2020 indicated they were either stressed all of the time (15.4 per cent) or most of the time (38.5 per cent). By comparison, just over a quarter of male respondents were stressed all the time (5.9 per cent) or most of the time (20.9 per cent)[12].

These estimates are consistent with the *State of Mind 2021* report from *Smiling Mind*, which

found that 28 per cent of 18-25 year-olds were experiencing psychological distress[13]. Another study, which included a representative sample of Australian children and youth, is the 2014 *Young Minds Matter* study [14]. This study found that 1 in 5 (20 per cent) had either high or very high levels of psychological distress (13 per cent and 6.6 per cent, respectively).

The *Young Minds Matter* study conducted assessments for several common psychiatric disorders and found that an estimated 245,000 (around 14 per cent) of young Australians experienced a mental disorder in the 12 months before the survey; of those, 23 per cent had a severe disorder. *Sidebar 1* highlights some mental health findings from the *Young Minds Matter* study, including rates of deliberate self-harm and attempted suicide.

Of great concern are data from various sources indicating that the wellbeing of young Australians may be declining. Mission Australia data indicate that life satisfaction has dropped for young Australians since 2012 and rates of psychological distress have risen [15] . Increasingly large numbers of girls report psychological distress – from 2.4 per cent in 2012 to 34.1 per cent in 2020 [15]. Since 2012, the proportion of young people who indicate they are happy with their life has dropped 12 percentage points – from 71 per cent to 59 per cent[15].

This was particularly pronounced for girls, with an increase from 22.4 per cent in 2012 to 33.5 per cent in 2019 and 34.1 per cent in 2020 reporting psychological distress [15] (see Figure 2).

The increase for males is less stark – from 12.6 per cent in 2012 to 16.8 per cent in 2019 and 15.3 per cent in 2020. For non-binary (e.g., "queer", "trans") young people, rates are higher – ranging from 39.2 per cent (2019) to 55.7 per cent (2020).

Sidebar 1. Rates of Psychological Disorders, Self-Harm and Suicide Attempts Amongst Australian Young People,

From the Young Minds Matter Study 9

- Anxiety and attention-deficit/hyperactivity disorder (ADHD) were the most common disorders (7.0% and 6.3%, respectively). Anxiety was the most common disorder among girls (7.7%) and ADHD the most common disorder among boys (9.8%)
- Based on self-reported data in the Young Minds Matter survey, in 2013–14, among young people aged 12–17: around 1 in 10 (11% or an estimated 186,000) reported ever having deliberately injured themselves. Around 7.5% reported that they preferred not to say, indicating that the proportion may be higher.
- 5.9% of young people (or 100,000) had self-harmed 4 or more times over their lifetime
- 8.0% of young people (or 137,000) had self-harmed in the past 12 months, with the proportion more than 3 times as high for females (12%) as males (4.0%), and nearly twice as high for those aged 16–17 (12%) as for those aged 12–15 (6.2%).
- Approximately 128,000 or 7.5% had seriously considered attempting suicide in the previous 12 months. The proportion was more than twice as high for females as for males (11% and 4.5% respectively).

Other sources help to confirm this trend in mounting psychological distress. A report from the Australian Bureau of Statistics (ABS) found that between the years 2014–15 and 2017–18, the proportion of young people (aged 15 to 24 years) reporting they have any long-term mental or behavioural condition increased from 19 per cent to 26 per cent[16]. The *DETECT Study*, conducted by *Telethon Kids Institute* during in May-June 2020, found that 40 per cent of primary and secondary students in Western Australia scored above the threshold for elevated difficulties and distress, compared

with an Australian baseline of 14 per cent in 2014[17].

Between 1998 and 2013–14, the *Young Minds Matter*[1] surveys showed that among young people aged 12–17, rates of major depressive disorder increased from 2.9 per cent to 5.0 per cent. Since 2014, there is evidence the proportion of young people with psychological distress in Australia has increased.

In 2012, the *Mission Australia Youth Survey* reported 18.6 per cent of respondents as psychologically distressed, increasing to 27.0 per cent in 2019 and 26.6 per cent in 2020[15].

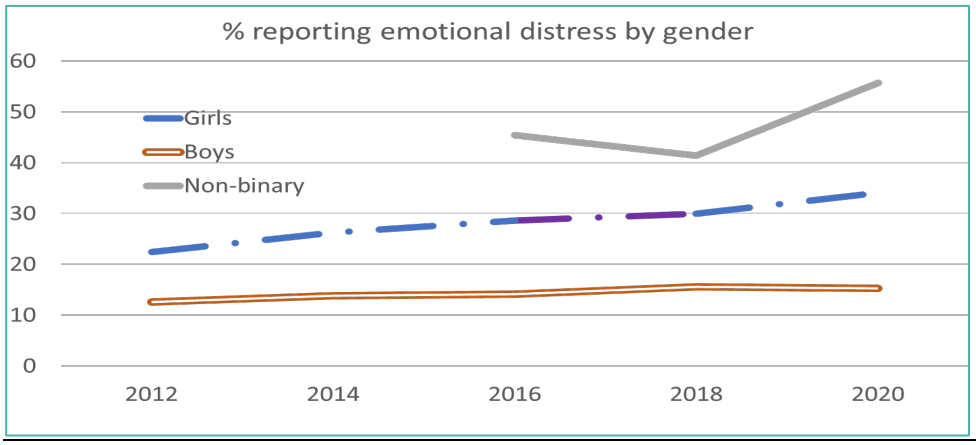


FIGURE 2 . RATES OF EMOTIONAL DISTRESS ARE MOUNTING IN AUSTRALIA.

Other Australian data provide support for this concerning trend, with 48.3 per cent of 12-18-year-old Australians scoring above the threshold for psychological distress during July-August 2020[18].

Moreover, at a school-level, the DETECT study found the proportion of students experiencing difficulties and emotional distress impinging on their quality of life ranged from 20 per cent to a high of 65 per cent, indicating high

[1] The Young Minds Matter study, completed in 2014, remains the best source of data for child and adolescent mental health due to its nationally representative sample and depth of inquiry. At the time of writing, no follow-up study is planned to provide hard data on changes in mental disorders in the intervening years.

clustering of distress within school communities (Telethon Kids Institute, unpublished). It is unclear whether anxieties and stress around the COVID-19 pandemic *caused* these high levels of distress.

The rates of distress do suggest a lack of resilience or overall wellbeing of children and young people. It may be the disruptions to schooling, coupled with the global uncertainty about the pandemic, were sufficient to account for such a magnitude of emotional distress. Or it may be that these rates were not caused by the pandemic and were a natural progression of the increase in rates of distress noted by other sources.

As Australia does not systematically track the mental health and wellbeing of its children and young people, it is impossible to be certain.

## Inequities in wellbeing

Wellbeing is not equitably distributed in the Australian population, as observed in the Young Minds Matter study[14]. Rates amongst those residing in outer regional areas were 1.6 times greater than those in major cities, with21 per cent of those children in outer regional areas experiencing mental illness compared to 13 per cent,. (See also later section: The need for one-to-one interventions). Rates were 2.3 times higher among young people living in areas of lowest socioeconomic status compared to those living in areas of highest socioeconomic status (23 per cent and 9.9 per cent, respectively).

These findings are echoed in the Mission Australia report. Young people from economically disadvantaged homes (where neither parent was working) reported psychological distress at higher rates (38.1 per cent) than those with at least one parent in paid work (25.6 per cent). Aboriginal and Torres Strait Islander youth have also reported increasing psychological distress, from 28.4 per cent in 2012 to 34.0 per cent in 2020. Young people with disabilities (including physical, cognitive and psychological disorders) have reported increases in distress from 32.1 per cent in 2012 to 43.0 per cent in 2020[15].

The Mission Australia study also examined risk factors for emotional distress. The proportion of young people reporting a disability who experienced psychological distress increased from 32.1 per cent in 2012 to 43.0 per cent in 2020. Similarly, 34.0 per cent of Aboriginal and Torres Strait Islander young people reported emotional distress compared with 26.8 per cent amongst non-Indigenous youth.

Young people who identify as non-binary report greater distress than cisgendered young people. Cisgender girls reported more distress than cisgender boys. Other reviews of research have found that same-sex attracted young people are at elevated risk of mental health problems[19].

In supporting student wellbeing, it is essential to consider equity: some students will have greater vulnerability and greater needs that require more intensive support. To ignore this is to risk leaving behind those who most need the help. “Improving the overall outcomes of a school by increasing the gains of the most privileged might elevate average outcomes but at the risk of a growing gap between those who have and have not. [20]

## Impact of adverse child experiences

Whether before or after school entry, some students will be exposed to one or more stressful events, predisposing them to trauma and poor wellbeing. A study of Aboriginal and Torres Strait children (less than 14 years of age) found that 51 per cent experienced at least one adverse experience (death of family

member or close friend, parental separation or divorce, abuse or witnessing of violence, family member incarceration)[21]. Exposure to adverse childhood experiences (ACE) has been shown in research to be associated with mental illness. ACE include exposure to (a) household substance abuse problems, (b) family mental illness, (c) domestic violence, (d) neighbourhood violence, (e) parental divorce, (f) parental death, (g) parental incarceration, and (h) race or ethnicity-based discrimination. While experiencing any one of these might impede student wellbeing, the accumulation of multiple exposures is particularly linked to mental illness.

A study from Telethon Kids Institute found students with any school-age ACE were 1.87 times more likely to have been suspended from school once, and 2.92 times more likely to have been suspended multiple times, compared to children without any ACE exposure [22]. Exposure to ACE is more likely in some populations, including Aboriginal and Torres Strait Islander peoples, students from other cultural and linguistically diverse backgrounds, and gender diverse young people, who may be exposed to discrimination from others.

American adolescents exposed to four or more ACE were 10 times more likely to report a depressive disorder, more than 7 times more likely to report a behavioural or conduct problem, 4 times more likely to report ADHD, 5 times more likely to report an anxiety disorder and 15.7 times more likely to have a substance use disorder.

Elevated rates of conduct problems are particularly likely to pose challenges for these students, both for their peer relationships and relationships with teachers and staff, and to impact upon their behaviour and performance at school. Ensuring the wellbeing of these students is a key challenge for schools.

## Schools may contribute to poor wellbeing

Unfortunately, for many students, school is a contributor to poor wellbeing. School or study problems are a source of concern for over a half of distressed young people. Factors include academic pressure, time spent online and insufficient sleep, plus adverse school experiences, such as bullying.

### Academic pressure

Young Australians rate their education as their biggest personal concern in the previous year (34.2 per cent)[7]. For young people experiencing psychological distress, school or study problems were an issue of concern for over half (53.6 per cent), and school and study satisfaction was the fourth highest ranked life concern (after friendships, family, and mental health) for young women experiencing distress [15]. The Western Australian *Speaking Out Survey*[23] found over 90 per cent of Year 9-12 girls reported school or study problems as source of stress – the highest rate by a margin of 30 per cent. Boys reported school or study problems as their top concern by a wide margin compared to the second ranked concern (of family conflict): 77.7 per cent compared to 31.1 per cent.

Of course, schools are supposed to challenge students' capacities, to bring them to new understandings, and thereby to enable them to learn what we, as a society, have deemed essential. Some stress is to be expected. There is no avoiding the fact that there will be tough times at school. But these statistics suggest that for too many students, the pressures of school are proving to be too much.

For some students, the challenge of academic success may elicit a self-critical perfectionism, which has been shown to predict increases in depressive behaviours over the school year[24], as well as panic disorder and anxiety

disorder features in middle-school-aged students[25]. Other studies with children and adolescents show perfectionism to be associated with eating problems, concerns about physical appearance and stress[26].

For many students from high socio-economic backgrounds, extrinsic pressure from professional parents to achieve high scores may drive perfectionist tendencies[27]. American research on affluent youth found perfectionism was associated with personal distress and delinquency, in particular substance abuse[28,29]. From the teachers' perspective, the Australian regulatory environment (e.g., NAPLAN testing) puts a pressure on students that can impede learning. The cost of doing well in school may be very steep for some students.

### Bullying

Schools can also inadvertently be the forum for serious risk factors to student wellbeing, such as bullying. Internationally, over one in three young people have experienced bullying at some point in their lives[30]. Among distressed young people, 27.1 per cent indicate they were very concerned about bullying[15]. Whether bullying happens in school or online, it affects schooling.

Students involved in bullying feel less safe and less connected to school[31]. In Western Australia, 15.1 per cent of students (Years 4-12) report having missed school due to fear of bullying, with 1 in 5 girls in Year 7 to 12 having missed school in the past year due to bullying fears[23]. Bullying victimisation predicts increased distress over time [32] and increases risk of depression[33] and other serious mental illness including psychosis[34].

These relationships may help explain why bullying victimisation is also significantly associated with reduced school attendance and poor achievement outcomes[35]. What happens at school is unquestionably on the minds of many young Australians, especially those experiencing serious threats to their wellbeing.

## Online and sleep behaviour

Other key indicators of young people's psychological distress are outside the school domain but hold important consequences for school performance. Of concern is the proportion of young people spending significant time using digital communication devices and its possible impact on sleep and physical activity.

In Western Australia, 93 per cent of students in Years 10-12 access the internet daily on a smartphone or computer. Even in Years 4 to 6, 43 per cent of students are online every day of the week, and fewer than 15 per cent are 'hardly ever' or 'never' online[23].

Young people with psychological distress were more likely to spend nine or more hours online per day (31.4 per cent) in contrast to those without psychological distress (19.9 per cent)[15].

Time online may cut deeply into a young person's sleep, given one in ten get less sleep than they need due to gaming or being on their phones/devices. More than 40 per cent of distressed young people get less than six hours sleep per night.

Sleep-competing behaviours, like being online, appear to impact on sleep quality and daytime functioning for Australian young people, and only half of the students interviewed got the recommended amount of sleep on school nights [36]. About one-in-ten young people indicated they miss out on sleep due to gaming or being online [23].

Over one quarter (28.5 per cent) of Western Australian students in Year 7 to 12 go to bed later than 11pm on school nights, and almost

13 per cent of Year 10 to 12 students go to bed after midnight.

A Melbourne study suggests that sleep problems appear to be a common issue for children experiencing emotional or behavioural disorders[37]. Young people who reported feeling distressed were more than twice as likely to get six or fewer hours of sleep per night (41.4 per cent) than those without distress (16.0 per cent)[15].

Sleep quality is also associated with academic achievement[38] and internet usage appears to be a mechanism in that relationship[39].

These are disturbing statistics related to the prevalence of potential factors associated with student wellbeing and psychological distress as well as academic outcomes.

# WELLBEING OF STAFF

To support the wellbeing of students, teachers and other school staff must also be coping well. In an ideal world, teachers, education assistants, administrators and school leaders would all be effective trusted resources and supports for every student, creating a safe and accepting school climate.

But staff wellbeing may itself be a challenge to schools. Some school staff may be too stressed themselves to provide the needed support to students.

Teachers face a range of stressors in their work, from heavy teaching loads, perceived lack of support from colleagues and administration, and challenging student behaviours[40]. Staff wellbeing, unmentioned in the Australian Student Wellbeing Framework, is a serious problem to the profession.

## State of wellbeing among teachers and other school staff

Teaching is a high stress occupation. The impact of work stress on wellbeing is well documented. Internationally, research indicates teachers are at risk of 'burnout', characterised by emotional exhaustion, by depersonalisation (putting space between oneself and the students to reduce the stress) and by disconnection from the intrinsic rewards of one's work[41]. This experience can result in either reduced job performance or a decision to leave the profession behind [41,42]. Rates of early career teachers leaving the profession are especially high[43]. Emotional exhaustion drives a high attrition rate amongst teachers

The emotional exhaustion that may cause some Australian teachers' to leave their position is a function of the stress arising from high workloads, the challenges of managing student behaviour problems, and issues arising in trying to balance work and life at home[44].

*Safe Work Australia* reported that more than 7 out of 10 workers' compensation claims for mental health conditions involved work related stressors[45]. Safe Work Australia reported that, amongst female claimants, teachers were the number one occupation group to receive mental-health-related workers' compensation[45].

A small study of Queensland teachers (across sectors and levels) found indices of elevated rates of depression, anxiety and alcohol dependence disorders, relative to the Australian population [46].

The addition of a global pandemic and the raft of changes to how schools were expected to operate, created yet another layer of stress.

A Telethon Kids Institute DETECT study collected data for 1170 Western Australian

school staff members, including 615 teachers, 335 administrators, and 146 classroom-based support staff, found that over 6.5 per cent of these staff members scored in the depressive risk range[47]. This study was conducted during the early return to work after the COVID-19 pandemic in 2020 and it is unclear whether the pandemic accounts for these rates.

To put the rates in context, the most recent nationally representative estimates of depressive disorder in adults is a prevalence of 6.2 per cent, inclusive undoubtedly of many people not in the workforce at all. Hence, it is reasonable to consider the 6.5 per cent estimate amongst school staff to be high for a working population. Moreover, 82 per cent of teachers surveyed indicated the pandemic has increased their workload somewhat (37 per cent) or a lot (45 per cent). Clearly, the stresses of working in schools can impact staff wellbeing.

## Connection between teacher wellbeing and student wellbeing

Beyond its impact on teachers themselves, poor teacher wellbeing is associated with poor student wellbeing and heightened student psychological distress[48], in part though the likely deterioration of the quality of relationships between teachers and students. Moreover, teacher burnout has been shown to be associated with reduced student academic achievement[49] and student behavioural outcomes[50].

Students can tell when teachers are experiencing burnout or demoralisation, as demonstrated by correlations between teacher-reported burnout and student-reports of their teacher's social-emotional competence[51].

One Canadian study found teacher burnout was correlated with student cortisol levels, hinting that teacher stress may spill over to affect student physical stress responses [52]. Given that emotionally exhausted teachers in the United States give more student office discipline referrals and more in-school suspensions[53], there may be a good reason for the heightened cortisol amongst students.

These findings on teacher stress and burnout indicate the relationship between student and teacher wellbeing are deeply intertwined. Thus, supporting educator wellbeing to prevent or overcome demoralisation and burnout is essential to safeguard the mental health and wellbeing of staff and the wellbeing, behaviour, and achievement of students.

Achieving a positive school climate, with quality relationships between students, teachers, administrators, and parents is the ideal.

# 4. THE GREATER POTENTIAL OF SCHOOLS

Schools provide a setting with immense potential for promotion of wellbeing, social and emotional competencies, and positive mental health. Schools are a near-universal setting for children and young people. School settings are not stigmatising, and provide the opportunity for trained professionals to observe children in a range of contexts and facing a diverse set of challenges[2].

However, there are signs that the requisite trust for safe and supportive relationships is absent. Many schools are yet to reach their potential in protecting wellbeing of their students.

## WHERE YOUNG PEOPLE TURN FOR SUPPORT

Schools are staffed by trained professionals, including school psychologists, counsellors, school nurses, pastoral care specialists, and educators focused on supporting students. Although most school staff are not trained in mental health, they do understand human development and often have years of experience helping students both formally and informally with their problems.

But these trained adults at school are not where students turn to for help (see Figure 3). Young people experiencing psychological distress first seek help from their friend/s, then from parent/s or guardians. In third place is the internet, exploring ways to find help online – a potentially risky proposition, given the challenge of finding good, reliable advice online.

For young people experiencing distress, just over one in four students indicated they would talk to a teacher (27.4 per cent) or school counsellor (27.3 per cent). These were ranked eight and nineth for sources of help. By comparison, 39.5 per cent of students without psychological distress would speak to a teacher and 31.4 per cent to a school counsellor[15], ranking seventh and eighth.

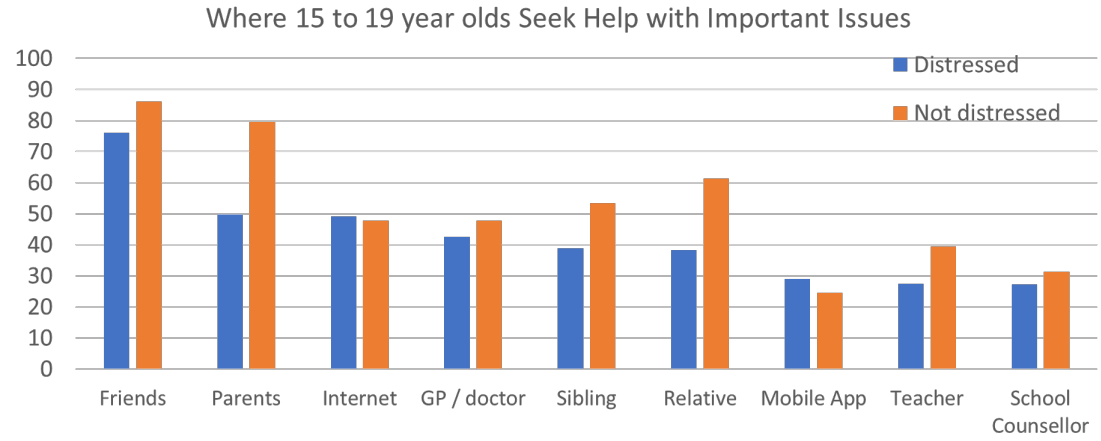


FIGURE 3 - YOUNG AUSTRALIANS ARE NOT TURNING TO THEIR TEACHERS OR SCHOOL COUNSELLORS FOR HELP

### Why young people do not seek help

*Mission Australia* [15] found for young people experiencing distress, the top three barriers to seeking help were feeling scared/anxious to get help (67.8 per cent); feeling embarrassed (66.8 per cent); and feeling they can deal with it by themselves (63.8 per cent) - with more than a half of young people experiencing distress not knowing what kind of help they needed (58.9 per cent). Notably, more than a quarter of respondents reported not having family or friends who could support them (26.9 per cent).

In theory, schools and the adults who work there could be critical to offering a safe and supportive environment for young people to seek help, especially for those with no family or friends they can trust to give reliable advice. Yet, results from the Speaking Out Survey in Western Australia indicate that almost one in three students in Years 7 to 12 do not believe their teachers care, believe in them or listen to them[23,54].

## WELLBEING SUPPORT IN A SCHOOL SETTING

Schools have the potential to provide the missing prevention focus, to promote wellbeing and protect students *and* staff from risks to wellbeing. Evidence of the impact of mental health promotion in schools indicates that teaching students about mental health can support positive outcomes ranging from life satisfaction to academic achievement.

### Levels of intervention

No single approach will keep all children well. Schools must be mindful of students who are experiencing early signs of struggling, or unwell students and staff. Interventions that are selective (i.e., delivered to those experiencing a risk factor for poor wellbeing) or indicated (i.e., delivered to those already showing early signs of distress or poor wellbeing) are needed. But these approaches risk being counterproductive if they stigmatise the very students they aim to help.

A review of the literature provides three core areas of evidence that can be understood against the 'Iceberg model of prevention and intervention'. (See Figure 4.)

The most severely affected individuals will require indicated intervention strategies, but more individuals will benefit from selective and universal prevention and intervention strategies that promote the wellbeing of all children from the earliest possible age, and enabling early intervention as needed[2].

In addition to prevention efforts, schools need to have effective targeted responses. Tiered intervention for wellbeing and mental health, providing different degrees of intervention intensity relative to student need, can provide value for mental health outcomes.

As indicated by the pyramid of prevention, theories of prevention and intervention often distinguish interventions that address whole populations (universal) or reflect 'the pointy end' of health problems. Students showing signs of mental disorders or psychological distress require tailored intervention strategies delivered by trained health or school counselling professionals, whether in the school or at an external agency. Waiting for students to reach the apex of psychological need is neither an ethical nor an effective strategy.

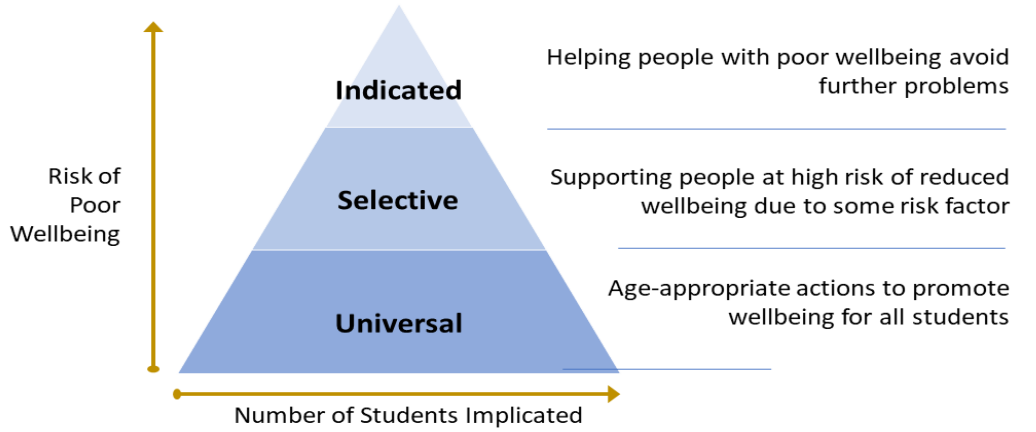


FIGURE 4 THE ICEBERG MODEL OF PREVENTION AND INTERVENTION

## Universal interventions

School actions that promote wellbeing, prevent mental illness and protect students from school-based risks can be referred to as *universal* in their focus, providing practice and policy direction to benefit the entire student population and often the broader whole school community, including staff, families, and the broader community.

Universal interventions provide a valuable framework and infrastructure for determining who might benefit from more tailored selective and indicated interventions. By working with the school community to provide and normalise a set of shared understandings and common perspectives for thinking about mental health and wellbeing, these whole-school approaches can lay the ground for more bespoke responses.

For example, the primary recommendation of the Mission Australia report[15] was to "implement standardised mental health screening in schools to build a universal system for identifying and responding to young people's mental health issues" (p.12). (See Spotlight 1: the Cool Kids program for an example of such an approach). Such screening is feasible within the framework of a universal school approach.

*"Students experiencing emotional/behavioural difficulties are more likely to receive punitive school disciplinary action than adequate therapy support"*

Spotlight 1

The Cool Kids Indicated Intervention

Difficulties with anxiety reflect one of the most prevalent forms of psychological problems, and these 'internalising problems' can contribute to the risk of other challenges like being bullied.

The Cool Kids family of programs, developed and tested by Ron Rapee in NSW and colleagues is based on cognitive-behavioural therapy principles, and has been shown to be effective in reducing anxiety across a range of child and adolescent groups, including socioeconomically disadvantaged youth (147) and young people with autism spectrum disorder (148).

Cool Kids can be used as a treatment for diagnosed anxiety or as an indicated program, for example for students who score high on a screening report of anxiety symptoms. Studies from Australia and Denmark show that it reduces anxiety problems and is effective up to 12 months following intervention[149].

Determining *which students might benefit* from selective intervention requires consideration of the nature and magnitude of the risk factors involved such as school behaviour and school attendance.

### Student Conduct Problems

Some behaviours map clearly onto the common understanding of mental illness, such as depression and anxiety, and these problems are treated as mental health difficulties (e.g., using the Cool Kids intervention, see Spotlight 1).

Currently, student conduct problems are often treated only as cause for 'discipline', not as potential mental health red flags. Many mental health problems and much neurodiversity can present as disruptive behaviours and difficulties relating to others and managing emotions and behaviours. Such problems may reflect undiagnosed or subthreshold psychological or neurological disorders including but not limited to attention-deficit hyperactivity disorder (ADHD), conduct disorder or oppositional defiant disorder or other emotional disturbances

Classroom behaviour problems may also reflect neurodiversity or undiagnosed disabilities such as autism-spectrum disorder [55] or foetal alcohol disorder [56]. For these students, and other students with likely mental health disorders, indicated and individualised treatment is required.

Evidence suggests, however, that students experiencing these difficulties are more likely to receive punitive school disciplinary action than adequate therapy support [57,58]. Emotional/behavioural conditions are the strongest predictors of school exclusion and repeated exclusion[57], but students with unrecognised mental health problems [58,59] or who are neurodivergent (e.g., ADHD, Autism, learning disability) are also more likely to be excluded from school [60].

The responses targeted to these students need to work with the core problems. Such tailored intervention may prevent school exclusion and/or early drop-out that limit the life opportunities of some young people.

This highlights the need for whole-school shared understandings of mental disorders and their effect on classroom behaviour and on policy and practices to prevent and respond constructively to disruptive behaviours.

### Selective interventions

Actions focused on students who are at elevated risk due to their background or

behaviours, are referred to in public health as "selective"

Given the depth of understanding about risk and protective factors for psychological disorders and wellbeing, it is possible to be more proactive to implement selective interventions by targeting vulnerable sub-groups based on some known general consideration (e.g., a shared risk factor). Selective interventions that target young people or subgroups who have an elevated risk of developing poor mental health have been found to be effective overall in promoting good outcomes[61]. This suggests selective interventions can target students who are not showing symptoms of mental disorders to good effect.

Selective interventions by their nature single out students at risk, putting them in danger of stigmatisation. In targeting any intervention that focuses on high-risk students, it is imperative to avoid stigmatisation emerging from the school setting. Fear of embarrassment and stigmatisation are key barriers to mental health help seeking [62].

Currently, many students are embarrassed about mental health and do not seek help from available school psychologists and counsellors [15]. Given peer and parent perceptions are drivers of student comfort with mental health services [63], the universal approach may be imperative in setting the stage for non-stigmatising selective interventions. Establishing innovative selective interventions may be valuable too, especially those accessed through electronic devices[64].

### Indicated interventions

Working to support students already showing problems with poor wellbeing is referred to in public health as "indicated".

Indicated interventions are targeted toward students actively experiencing behavioural or emotional problems. Such intervention may be one-on-one in nature or limited to a small-group therapeutic setting. Often indicated interventions are implemented once some signs of problems have emerged, on the basis that these problems can be prevented from becoming aggravated. These interventions are most likely to be led by the school psychologist or other trained mental health professional and may involve collaboration with outside agencies.

### Risks of being only reactive

As documented in the Productivity Commission report on Mental Health, school services support for wellbeing tends to be reactive – emerging from acute mental health needs.

While robust data on current school practice in Australia is rare, the *Young Minds Matter* report provides a glimpse. This study found that of those students (aged 4-17) with a diagnosed mental illness, 50.4 per cent used a school-based service of some type. For students with a sub-threshold mental illness (in the range of concern but not meeting full diagnostic criteria), only 40 per cent used any service.

These services appear be activated more for certain types of difficulties than for others: for students with a major depressive disorder, over 3 in 5 access some school service (61.9 per cent). Students with conduct disorder also appear to get 'picked up' by the school, with 53.8 per cent getting some sort of help. But for anxiety disorders, only 44.1 per cent receive school help, and only 37.0 per cent of those with attention-deficit/hyperactivity disorder receive some form of school service[65].

It is not clear from the *Young Minds Matter* data who gets what type of school support. The *Young Minds Matter* study has, to date,

only reported on what services are used by students with *any* of the diagnosed mental disorders [65]. The most common school service for those with a psychological disorder was individual counselling (28.4 per cent) with a "special class" or "special school" indicated by 13.1 per cent of parents; group counselling indicated by 9.2 per cent; school nurse by 5.6 per cent and "other school services" indicated by 17.1 per cent of parents [65].

But it is unclear whether the type of service students receive at school depends on the type of mental disorder they experience: for example, are students with depression more likely to receive individual counselling, while students with conduct disorder likely to be assigned to a special class or special school?

It is also unknown how effective those school responses might have been, as the *Young Minds Matter* study was cross-sectional in nature and no follow-up is planned for the participants.

## Social Emotional Learning (SEL)

School-based interventions that focus on Social Emotional Learning (SEL) have been shown to deliver improved wellbeing, reduced conduct and emotional problems [66–68].

SEL is the acquisition of capacities to understand and manage one's emotions and thoughts, to understand and empathise with other people, to initiate and sustain respectful and rewarding relationships and to make responsible choices across the settings in our lives[69]. SEL enables children and young people to meet their social goals through positive behavioural choices, building social and emotional competencies to enable them to recognise and control their emotions, building positive relationships, showing consideration for others, making thoughtful and morally engaged choices, and coping successfully when the going gets tough. (See Appendix B.).

### Evidence for wellbeing promotion (interventions)

Evidence indicates that wellbeing promotion can work. A meta-analysis of 276 intervention studies aiming to promote good mental health [61] found overall significant improvement on ten different mental health and wellbeing outcomes, ranging from quality of life to academic performance (see sidebar 2).

One strategy that was particularly important for mental health literacy and cognitive skills was psychoeducation: Direct teaching about mental illness and wellbeing.

**Sidebar 2. Promoting mental health & wellbeing**

Mental health promotion interventions are on average effective in improving:

- Mental health literacy
- Emotional problems
- Self-perceptions and values
- Quality of life
- Cognitive skills
- Social skills

A meta-analysis from 2011 examined the use of whole-school SEL interventions finding SEL delivers significant improvement in the skills, attitudes and behaviours that support wellbeing, and reductions in problems with disruptive behaviours and emotional distress[66]. Moreover, SEL interventions are associated with an 11-percentile gain in achievement [66]

A more recent meta-analysis has shown whole-school SEL interventions are effective in improving social and emotional adjustment, behavioural adjustment and in reducing

internalising symptoms (e.g., anxiety and depressive features) in students [67]. Universal SEL interventions may also provide value for students with more intense needs, including possible exposure to traumatising events (see Spotlight 2).

A study of Australian schools teachers specialising in behaviour and engagement examined how best practices for engaging with students who exhibited complex, extreme challenging behaviours in the context of past trauma[72].Their analysis highlighted interrelated dimensions of personal safety, connection and relationship, the need for upskilling and growth, the need for adequate time to make a difference, the need to manage the expectations and pressures for the student to meet standard expectations, and staff capacity for self-reflection. Although making the time to get to know the student does not fit well into the daily demands of schools, for some students in need, there is no shortcut.

It is important to note the answer for students experiencing mental health challenges is not simply referring students on to an external provider: 40-60 per cent of families who begin community mental health services end prematurely[73]. One possible answer is co-locating mental health services within schools[74], thereby reducing significant barriers to getting help. Co-location and integration of mental health and wellbeing services into broader – and less stigmatising – settings improves the acceptability of those services[75].

### Whole-school approaches

For universal mental health and wellbeing interventions, whole-school intervention approaches bring together students, staff members, families, and the broader community. (See Sidebar 3).

#### Spotlight 2. Trauma-Informed School Practices for Aboriginal and Torres Strait Islander students

The ongoing reality is that Australia's First Nations continue to experience high rates of exposure to adverse childhood experiences and trauma. The legacy of displacement from traditional lands, the Stolen Generations, paternalistic policies and practices, institutionalisation, along with the current reality of increased incarceration, racism, and loss of culture mean that intergenerational and personal trauma are potent risks in the lives of young people. These experiences increase the risk of a poor wellbeing and mental health problems (see 2.2.). What can schools do to help?

Culturally safe trauma-informed practice in education is invaluable in supporting the wellbeing of Australia's Indigenous students. Schools can be a place for culturally safe support and positive relationships that can build the resilience and augment existing strengths to achieve positive outcomes. Multiple trauma-informed models of care exist. One formulation used by Australian researchers focused on

(a) self-regulation of the body, including appropriate identification of emotions and behaviour in response to those emotions

(b) relationships that encourage attachment and whole-school relationships

(c.) stamina to foster emotional intelligence and resilience

(d) engagement of students in the learning process

(e.) identification of personal strengths and values of students

The conceptual overlap of this approach with social-emotional learning models points to the potential synergy of these approach when combined within the school setting. [70,71]

Whole-school SEL, which provides comprehensive policy and practice reform to engage students, parents, staff, and the broader community in creating a positive school climate, provides greater impact than stand-alone classroom curricula. SEL interventions that include community or family components as important agents in promoting wellbeing have been shown to be more effective overall[67]. Although SEL-based interventions are promising for schools, it is important to note that no individual intervention is guaranteed to work.

Evidence shows the most effective bullying prevention programs target all the members of the school community including parents/guardians[76,77]. This is not surprising, as parents play a crucial role in the establishment and ongoing development of children's capacities for emotional self-regulations, social skills, and capacities to maintain positive peer relationships (see Cross & Barnes[78]). School-based efforts to build parent confidence and capacity to support their children's social behaviours have been shown to be effective [79].

A 2021 report on whole-school approaches to student wellbeing provides an orientation[80]:

> Whole-school approaches are coordinated school-led initiatives that provide a range of activities (multi-component), generally including classroom activities and other whole-of-school actions like policies and processes, activities that aim to involve the broader school community – families of students and others in the local community who could support student wellbeing. (p.4.)

The whole-school focus helps ensure a positive school culture can emerge to enhance school connectedness. Activities aim to ensure school-level policies both reflect the prioritisation of wellbeing and become living documents reflected in the practices of the school.

Whole-school strategies include processes to evaluate and improve upon existing school policies and practices in relation to social-emotional learning and related wellbeing strategies, and to build the collective school capacity to implement and maintain the new policies and practices [81].

### Sidebar 3. What Makes an Intervention a "Whole-School" Intervention?

Whole-school interventions aim to make wellbeing part of the school culture and be more than a standalone program. They can do this by:

- Building the capacity of all the staff including teachers and school leadership
- Fostering a supportive school ethos and culture by promoting a vision of school connectedness and safety for all students, staff, and families
- Writing proactive policies and establishing effective practices that are informed by the evidence of what works
- Teaching staff, students, and families the key understandings and competencies needed to help ensure wellbeing and mental health
- Ensuring safe physical (and cyber) environments for students to reduce risks like bullying and provide safe spaces students and staff to express their identities
- Forging meaningful partnerships with all families across the cultural and socioeconomic diversity of the broader community based on mutual respect and understanding.

The implementation of whole-school wellbeing promotion and mental illness prevention can support schools achieve the vision of the Australian Student Wellbeing Framework "that Australian schools are learning communities that promote students' wellbeing, safety and positive relationships so that students can reach their full potential" (p.2)[82].

The Framework emphasises active leadership, authentic student involvement, cultivation of a supportive setting for positive behaviour, partnerships with families and the broader community, and a school community that is inclusive and respectful: all important elements to look for in proven whole-school social-emotional-learning and wellbeing promotion interventions. But this prevention framework will not catch all students before problems can arise.

## SOCIAL INFLUENCES AND RELATIONSHIPS

A positive school climate is one where the school community feels safe, where the relationships between individuals at the school are positive and marked by trust and respect, and people feel cared for[83,84]. A positive school climate is associated with good academic, behavioural, wellbeing and mental health outcomes for students [84]. For example, student reports of feeling connected to the school is a key predictor of student wellbeing. A study of 15 South Australian Independent Catholic schools found that school connectedness accounted for 56 per cent of the variance in Year 11 students' self-report of wellbeing[85].

Australian students recognise the role of their relationships with teachers, friends, and family for their own individual wellbeing [1]. The qualities of these relationships influence whether students feel connected to the school and perceive a positive school climate. A positive school environment and the relationships therein are critically important for student wellbeing.

Connectedness to one's peers is an important protective factor for student wellbeing, and an outcome that whole-school SEL interventions can successfully address. Along with their friends, many students turn to their parents when they need help. But peers and parents may harbour misunderstandings or inaccurate beliefs about how to support wellbeing and mental health.

Improving the mental health literacy of parents and peers can help support young people who are struggling or unwell. School-based interventions can help parents and peers understand how to support students when they are unwell.

To work effectively with parents in an equitable way, however, schools need to engage with all parents, including those from disadvantaged backgrounds and families of students with dysregulated behaviour problems. These are risk factors for relationships between teachers and students, which can be marked by conflict and a lack of trust [86], and which are linked to poor student and teacher wellbeing.

Finally, the relationship between teachers and school leaders is an important target for improving student and staff wellbeing, for example to reduce teacher burn-out and staff turnover. Leadership that empowers and motivates teachers by building a shared vision and common values and by prioritising staff wellbeing is the most likely to contribute to better outcomes for the whole-school community.

Student's sense of school connectedness and a positive school climate arise from the web of

relationships that can promote or hinder their wellbeing and development. This web was described by Bronfenbrenner in his social-ecological model of human development (Bronfenbrenner, 1979; see Figure 5).

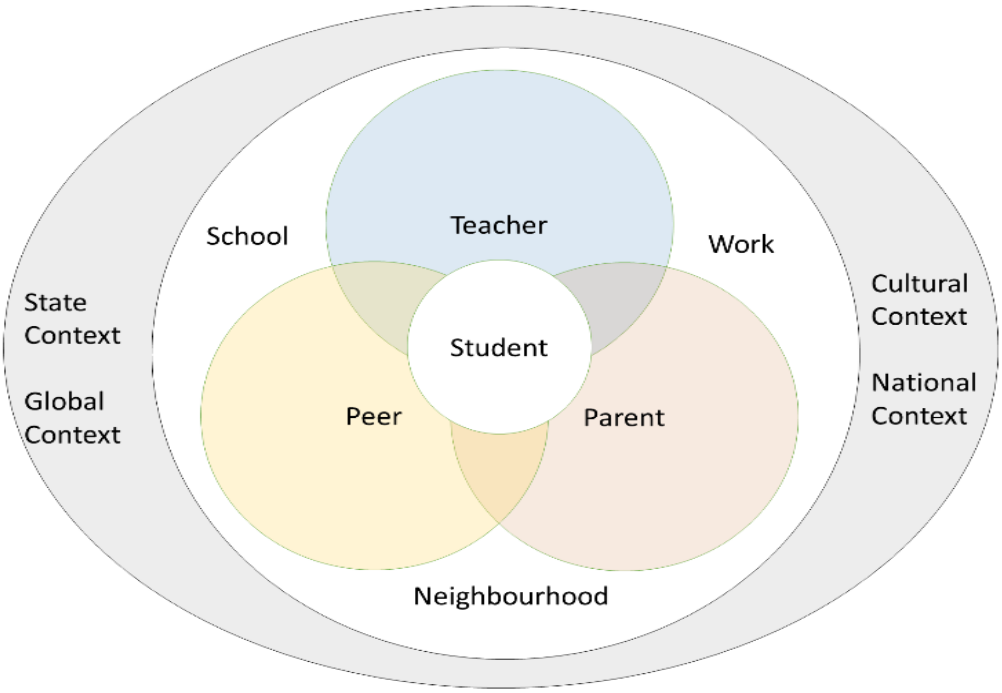


FIGURE 5 STUDENTS ARE SURROUNDED BY AN ECOLOGY OF DYNAMIC INTERACTING SOCIAL INFLUENCES ON THEIR DEVELOPMENT

This seminal model describes various people in the child's life who have a direct relationship on the child (microsystems), such as a parent, a teacher, or a peer. This model also focuses attention on the overlap and interaction of those key social relationships (mesosystems). For example, the relationship of the parent and the teacher can have its own effects - if a parent does not get along with a particular teacher, that may undermine their influence.

The model also highlights the forces outside the child's direct experience, but which indirectly affects them through the microsystems (exosystems), such as when a teacher feels unsupported by the administration, or when neighbourhood risks influence parents to limit their child's autonomy.

Finally, the whole cultural, regulatory, and political context has further indirect influence via shaping how schools are staffed, how parents are supported, and how neighbourhoods are developed (the macrosystem). This model lets the web of relationships be considered more precisely. Of course, everyone is at the centre of their own web, including teachers and administrators, when considering their own wellbeing.

## Peer Relationships

Schools have a valuable role to play in promoting positive relationships between students, where peers can proactively and effectively support one another to promote wellbeing. Peer connectedness is an important factor in student wellbeing[88]. For distressed and non-distressed youth alike, friends are the most common port of call when help is needed (see Figure 3).

Whole-school SEL interventions have shown their efficacy in improving peer connectedness for students[89], for example in reducing student loneliness[79]. SEL approaches have robust evidence indicating improvements in social skills and attitudes toward oneself and others, and in improving social behaviours overall[66]. Such interventions work for secondary students, by enhancing their interpersonal domain outcomes[68]. Other intervention strategies may help wellbeing broadly as well. By reducing the rates of victimisation, bullying prevention programs have been found to also reduce loneliness and improve mental health outcomes such as depression and anxiety[90].

Mental health literacy helps create effective peer support. Knowing about wellbeing and mental health is a key part of ensuring students can effectively help one another. For example, a small NSW trial of a mental health literacy program delivered to adolescents boys in the context of a community football club found significant increases in the boys' knowledge of mental illness, intent to help a friend who might need it, and positive attitudes toward helping overall [91]. Mental Health First Aid training for students has shown some promise, but also some risks: an Australian trial with Year 10-12 students found increased recognition of some disorders and in the quality of support given, but also found a decline in students' willingness to tell others about their own mental health difficulties[92].

Knowing about a problem is not always enough to ensure the students get helping responses from their friends or peers when they are struggling. Attitudes and intentions to help, rather than to mock, avoid or stigmatise, are also needed. While school-delivered, education-focused mental health literacy may help overall [93]. Education-only approaches may not shift the stigma and improve attitudes, and contact with a person who has experienced mental illness may be important to promoting attitude change and de-stigmatisation[94].

Schools' approaches to supporting positive peer relationships can go further than mental health first aid. A predisposition to help can also be inculcated more broadly. One approach may be to focus on kindness in general. Engaging in prosocial behaviour and altruistic 'acts of kindness' has been shown to be associated with one's own wellbeing[95,96]. A randomised controlled trial assigned adolescents to a condition where they performed kind acts for others or kind acts to themselves[97]; those assigned to help others reported less stress and more positive emotions than the other group.

## Parent/Child relationships

Though the parent-child relationship may feel very external to the school's context, schools have a valuable role to play in supporting students via the family setting. Even in secondary school, most students report turning to their parents when they need help with their problems (see Figure 3, above). But many parents have little understanding of mental illness[98–100]. Those understandings they do hold may be inaccurate[101], which has the potential to do more harm than good for young people. Even when parents can

recognise symptoms of mental illness, they struggle to know whether help is needed[100]. Parents get their knowledge from a range of sources, but not, according to current research, from schools[100].

Mental health literacy training for parents, delivered to Australian parents of adolescents athletes through their sports clubs, has shown some evidence of improvements in parental confidence to support their children, and increased willingness to seek help for themselves[102]. Whole-school interventions to address bullying have been shown to improve parents' willingness to discuss issues like bullying[103]. Schools can use whole-school intervention frameworks to improve parent understanding of how to support their child's wellbeing and mental health. To do so equitably, however, would require having a strong relationship established between the school and the families that make up the school community.

## School/Family relationships

Key to whole-school approaches are explicit efforts to engage and partner with families and the broader community[80]. Establishing strong partnerships with families and the local community context helps ensure the promotion of wellbeing becomes a priority for the broadest possible coalition of people in students' lives. The relationship between teachers and the family is critical for student wellbeing, and likely staff wellbeing as well. In the early school years, it is common for parents to be in close contact with the school; declining with each passing school year[104]. Evidence indicates that students benefit from parents who maintain an active role in their child's schooling[105]. For example, for students with reading difficulties, teachers' perceptions of their relationship with the parent are related to children's school engagement, and thereby their achievement [106]. Parent involvement in the early years of school is related to closer teacher-child relationships and lower levels of conflict in between teacher and student[107] (see below).

This involvement is especially important for low-income students, who are more likely to experience conflict with teachers[107]. Principals and Parent and Community Committee presidents from schools in low-income communities perceive a lack of parent interest and lack of confidence as key barriers to parent engagement[108]. Some teachers hold negative perceptions about low-income families' willingness to be involved with the school[109] and may focus on the problems (i.e., deficit thinking), rather than identifying strengths to work with. Past school experiences may mean that many low-income parents/carers are reluctant to be involved with the school[110]. Families of students with dysregulated behaviour problems, for example due to attention deficit/hyperactivity disorder, also may have barriers establishing positive relationships with teachers[111]. Households facing disadvantage due to financial poverty, cultural and linguistic diversity, or with children with diagnosed or undiagnosed mental health disorders that express as conduct problems, may require particularly careful proactive school initiative to ensure healthy relationships.

## Student/Teacher relationships

For student wellbeing, the relationship between the teacher and student has been the subject of much research revealing robust associations between the quality of the teacher-child relationship and student school engagement and academic achievement[112]. Positive facets of the relationships – like a sense of warmth or closeness with the student, from the teacher's perspective – are associated with greater school liking and less

school avoidance. Negative aspects of the relationship – for example, a sense of conflict with a student – is associated with lower levels of student engagement and increased risk of aggression[86] and peer victimisation[113]. Of course, the students who experience the greatest challenges with emotional and behavioural problems, and thereby the greatest threats to wellbeing, are those with whom teachers have the most conflict and the least close relationships[114]; the highest academic achievers, by contrast, experience the least conflictual, least dependent and closest relationships with teachers.

These relationships become very important for psychologically distressed students. Although students spend a large proportion of their waking time in the school setting interacting with school staff and teachers, they tend not to confide in those adults when they are experiencing difficulties, as shown by almost 3 in 4 young people choosing not to speak to teachers or school counsellors when in crisis[15].

Teacher wellbeing is a significant facet of the teacher-student relationship as well (see section above). The wellbeing of teachers is significantly associated with student wellbeing, and the quality of the student-teacher relationship is an important mechanism in accounting for the association[48]. Teachers who feel more confident about their work are more likely to establish close relationships with students and experience less conflict with them[115]. The stress of feeling overwhelmed and exhausted at work likely impedes teachers' capacities to establish positive relationships[116], highlighting the need to focus on staff wellbeing.

As well, staff reports of work stress are lower for those who experience supportive relationships with their colleagues and a positive school climate [117]. Fortunately, there is evidence that stress reduction interventions may benefit not only school staff but the students whom they teach [118]. Helping teachers improve their wellbeing appears to help the broader school community.

## Teacher/School leadership relationships

The relationships at school also include those between the school leadership and the teaching staff. Staff departures at schools have been shown to be a function of perceived inadequate support from the school administration[119]. For schools considered hard to staff (with high staff turnover rates, due e.g., to high rates of emotional or behavioural problems), the need for leadership that promotes staff wellbeing is paramount. The emotional, instructional and environmental support provided by school administrators enables teachers to hold a sense of personal and professional growth that informs decisions to remain in high-stress roles[120]. Moreover, in those challenging settings, principals believe they are providing greater support than the teachers perceive, but teachers disagree[120]. This makes leadership practices like recognition for good work, opportunities for salary increases and for professional development and adequate staffing and planning time especially important for regular and casual staff alike[121,122].

A meta-analysis indicates the actions taken by school leadership are important for teacher outcomes and for the overall organisation[123]. This study found little difference between traditional educational models of leadership (i.e., instructional, distributed, transformational), as they all were associated with modest effects on school

outcomes[123]. Instead, the study found the practices that are implemented by the leadership may matter most. The most potent practices involved empowering and motivating teachers and building shared vision and values. These results highlight the value for school leadership of focusing on the people who make up the school by addressing teachers' needs.

The leadership of the school is also responsible for introducing the initiatives that may benefit staff wellbeing overall. Whole-school approaches, as the term would suggest, involve all the teachers and staff at the school, not just the few who put up their hands to lead change. Establishing effective whole-school action may entail extra labour for the workforce. This means school staff need to see the relevance and potential pay-off for their efforts[124]. But it also means staff wellbeing must be at the forefront of such efforts. Bolstering the overall school climate is a key goal to ensuring staff and school leader welfare. This includes not only the relationships discussed in the previous section, but also the overall administrative climate – reflecting the policies and practices that not only affect the work of the other school staff but also the quality of relationships between administration and staff[43].

# 5. BARRIERS FOR SCHOOLS

The fact that school-based wellbeing interventions *can* be effective should not be confused with the idea that they *will be* effective. A review of such interventions for adolescent students found that only 4 of 15 studies that used the gold-standard randomised-controlled-trial design found significant positive effects on student wellbeing[125]. Being 'evidence-based' is not the same as having evidence to demonstrate that a program delivers what it promises.

There is currently a great deal of variation in how schools choose to address welling and mental health promotion, and in schools' social and emotional culture[2]. For example, a study of 17 government schools in the ACT found significant variance in school staff perceptions of the school culture; those perceptions were predictive of students' academic achievement[126].

A study of NSW schools' efforts to implement whole-school activities (i.e., the *KidsMatter* Primary initiative) found only 20 per cent of schools had fully implemented whole-school activities in place. Just over half (53 per cent) were 'making progress', with positive school cultures seen as being in place, but SEL and family engagement still being introduced. Finally, 26.9 per cent of schools were seen to be 'struggling' to introduce the whole-school components needed for effective promotion, and protection of student wellbeing[127]. The extent to which an intervention is implemented determines the change that can happen[128,129].

Schools also diverge in how wellbeing and mental health are discussed in the school, how easy it is to get access to wellbeing support (e.g., school psychologist staffing decisions), teachers' awareness of and training in approaches to support wellbeing, and the degree to which the school climate is one of respect, trust and mutual support[2].

## (UN)SUITABLITY OF SCHOOL INTERVENTION PROGRAMS

The recommendations of the 2014 National Review of Mental Health and Programmes and Services called for stronger school-based mental health and wellbeing approaches. This has led to action through the *Be You* initiative and the *National Workforce Centre for Child Mental Health*. These initiatives have sought to raise the awareness and capacity of educators and other services to recognise mental illness and be able to respond effectively to it.

But in the wake of those recommendations, several challenges have been noted, including the reality of competing priorities in schools, inadequate training for educators, little meaningful assessment of outcomes of the initiatives, and a 'crowded space' of competing programs with hundreds of external providers offering wellbeing services and/or professional development, policy recommendations and frameworks, many of which are not evaluated or lack the robust use of evidence[4].

### Competing and unaccredited programs

School staff face a crowded space of competing programs offered by external providers, with little guidance as to which approaches have solid evidence of efficacy. Without accreditation standards for such

programs, schools are in the dark. The national *Be You* initiative provides some guidance by providing links to Australian wellbeing relevant programs, but few of these show adequate evidence to be confident they can be easily implemented and effective once in place.

The recent Productivity Commission report on Mental Health has flagged the challenges of sorting through the "very large number of programs that can be delivered internally or outsourced" and that "schools find it difficult to navigate this crowded space" (p.196; Productivity Commission, 2020), and called for accreditation of school wellbeing programs based on the quality of evidence. In this context, judicious selection and use of such possibilities is recommended, to ensure there is adequate evidence to warrant the effort and expenditure required to implement these resources effectively.

In the wake of this crowded space, the *Be You* initiative serves as gatekeeper and clearinghouse of wellbeing-relevant interventions for schools to implement. The searchable database lists domains of interventions including "mentally healthy communities", "family partnerships", "learning resilience", "early support" and "responding together" – Categories that do not clearly intersect with the needs of schools.

*Be You* currently lists 52 programs in Australia, for primary and secondary schools. But as of October 2021, only two interventions have achieved the four-star ratings for evidence and implementation. These two interventions are: the *Animal Fun* program[2] to promote motor skills and social skills of children in early learning and early primary school settings, and *Friendly Schools*[3], a whole-school, social-emotional-learning and bullying-prevention intervention for primary and secondary schools.

## Evaluation tools

Selecting and implementing the approach a school needs is not simple. Schools need guidance and support to identify their own needs, to map the gap in what they are already doing, and to choose an approach that provides them what they need. But this is a time- and resource-consuming set of demands for most schools, and a major barrier to action.

Meaningful action requires accurate measurement to identify needs and targets for improvement and to track progress. Currently, student wellbeing lacks a common metric across Australian jurisdictions. Cultural appropriateness of wellbeing assessment is also not resolved, especially for Aboriginal and Torres Strait Islander students. Moreover, the tasks of instrument selection, data collection, collation, analysis likely overtax the capacities of school administration teams.

## Resourcing

Schools face challenges in the resourcing of wellbeing interventions, especially schools in regional and remote Australia. School psychologists are trained to provide the universal and targeted intervention supports required but are routinely unable to work proactively given their workload is dominated by psychometric testing and responses to crises. This is a particular problem in regional

[2] https://animalfun.com.au/

[3] https://www.telethonkids.org.au/our-research/brain-and-behaviour/development-and-education/health-promotion-and-education/friendly-schools/

and remote Australia, where need is greater and services fewer.

Telehealth is a part of the solution, but cannot be the whole solution, especially for younger students for whom telehealth may be inappropriate, especially considering ongoing poor connectivity and lack of access to technology in these regions. The digital divide must not accelerate inequity in mental health and wellbeing.

## AGE-APPROPRIATE INTERVENTIONS

Interventions need to be age-appropriate both in terms of their optics and their content. Interventions that are effective with one age group cannot be superficially 'aged-up' with older students, due to shifts in the developmental drivers of wellbeing and mental health as children age.

As any teacher might say, the content and approach used for maths education instruction with an early primary student would not work with a senior secondary student. But it is not always as clear what is 'age appropriate' in terms of mental health and wellbeing. What capacities for self-management might be expected of an 8-year-old compared to a 12-year-old? What are the challenges to social self-awareness for a 6-year-old compared to a 16-year-old?

It seems clear that developmentally tailored strategies are needed to address the different drivers and threats to wellbeing that exist over the ages. Similarly, engaging students in the intervention strategies requires meeting them where they are.

The risks of failing to be age-appropriate is more serious than one might imagine. A meta-analysis of bullying intervention studies provides an illustrative lesson[130]. For the meta-analysis, the authors selected school-based bullying intervention trials that had collected data for multiple age-groups. The authors found up to Year 6, these bullying interventions had a positive effect in reducing bullying. In continuing years the efficacy dropped, such that by Year 9, interventions were *counter-productive* on average – *increasing bullying in schools*. The authors proposed these bullying prevention programs were likely designed with middle-school (or younger) students in mind, with materials superficially "aged-up" for older students, who may not have bought in to the aesthetic or content. Instead, they propose interventions need to consider who they are targeting, and the developmental challenges of that age-group.

The need for age-appropriate interventions is especially salient for pre-adolescent children, for whom external mental health services are limited. In Australia, *headspace* is a primary beneficiary of new mental health funding, but only works with youth aged 12 and over (up to 25 years of age). The *headspace* website[4] notes more than 75 per cent of mental health issues develop before the age of 25. But unmentioned is that over half of mental illness has an onset by the age 14[131].

*headspace* is an essential external resource providing support for adolescents and young adults; they assist schools in doing so, for example by providing free mental health education across Australia and in partnering with the Department of Education in Victoria to reinforce the work of Student Support Service Officers in schools. But younger children are left in the cold.

[4] https://headspace.org.au/about-us/who-we-are/

In Australia, the *Student Wellbeing Hub* aims to provide age-appropriate wellbeing resources for schools. The *Hub*, home to the *Australian Student Wellbeing Framework*, is an initiative of *Education Services Australia*, for the Australian Government Department of Education. It provides free professional learning, webinars, and a school wellbeing check. It provides hundreds of links to resources, across a wide range of topics, including sexual-health promotion, Internet addiction, eating disorders, discrimination, and social emotional learning. But this glut of information may be adding to the sense of wellbeing as a "crowded space", discussed above. Clearer unbiased, trustworthy guidance on navigating the wealth of possibilities to implement age-appropriate strategies is needed.

## EVALUATION OF OUTCOMES

*"Accurate measurement is the foundation of understanding needs, identifying targets for improvement, and monitoring progress over time,"* (p.73,134].

For schools to invest their time and resources in student and staff wellbeing initiatives, it is important to ensure the investment is worthwhile.

The Australian Productivity Commission Report on Mental Health noted a key challenge faced by schools in supporting mental health and wellbeing is the limited tracking of outcomes, and where outcomes are tracked, "data [are] not always used effectively"[4] (p.196). The Report has further emphasised the need for student wellbeing to be integrated into the National School Reform Agreement, such that specific targets and measures are introduced for student wellbeing, in line with other school outcomes.

Although some states have achieved high levels of consistent data (e.g., the South Australian *Wellbeing and Engagement Collection* for 90+ per cent of government schools), other jurisdictions have much more sporadic participation rates, with both schools and students opting not to take part. In New South Wales, for example, student participation rates vary from 41 per cent to 91 per cent, raising concerns about the accuracy and generalisability of the data to the full student population[5].

Currently, getting a sense of student wellbeing across Australia would be a case of comparing apples and oranges, without a common evidence-based metric for assessment of wellbeing across jurisdictions or relevant benchmarks that would facilitate comparisons across States and Territories. The National School Reform Agreement recommended by the Productivity Commission Inquiry (2020) have called for a national minimum dataset collected from government and non-government schools, regularly collected, and communicated.

> "Promoting wellbeing and good mental health is not a distraction from academic achievement, but a prerequisite"

Until national indicators of student and staff social and emotional wellbeing can be established, schools have a more urgent need to identify and benchmark student and staff strengths and needs and track the progress of student and staff wellbeing, especially in the context of implementing a wellbeing initiative. Not unlike the assessment of student academic progress, the assessment and evaluation of student wellbeing is critical to understanding,

monitoring, and targeting students' needs and the effectiveness of wellbeing policies and practices. Although wellbeing is a subjective phenomenon, robust free-of-charge wellbeing and quality of life measurement instruments do exist that could be deployed for children and adolescents.

Schools can select measures, benchmark student data, and conduct follow-up data collections at various stages following implementation of new wellbeing initiatives. However, the process of implementing and interpreting measures of social and emotional wellbeing and mental health can pose several challenges to school leadership.

The selected measures must have well established psychometric properties to ensure accurate and consistent results. Second, the selected measures must be relevant for all the students or staff in the school. Readability is one facet of this is a measure designed for older adolescents may not translate for use with younger students.

Cultural appropriateness is another – measures that hold strong psychometric properties for dominant culture students may not accurately portray the strengths or challenges faced by students from other cultures.

Also, measures must be respected for what they are designed for, and not over-interpreted. Some measures, such as the Australian Early Development Census, used Australia wide, are designed for community-level analysis, not for detecting individual-level mental health or wellbeing challenges.

Finally, measures need to be adequately summarised, collated, and reported, which may tax the time and capacities of school staff. Preparing databases for statistical tests and running those tests to determine whether any observed changes in scores over time are statistically significantly different from the baseline measure may require statistical skills not present in the school administrative team.

These challenges suggest the process of measuring the impact of student and staff wellbeing initiatives may require system-level support and/or professional development.

## FITTING WELLBEING INTO A CROWDED CURRICULUM

Many educators recognise the value of activities to support student wellbeing and mental health. Fewer would say they have lots of time – either in preparation or in class – to make those activities come to life.

The introduction of NAPLAN in 2008 has focused teachers onto literacy and numeracy, with some teachers reporting they feel pressure to "teach to the test". This has created a "zero-sum-game" sense that addressing wellbeing would come at the expense of literacy and numeracy. But given wellbeing underpins a capacity to take on new challenges, and that SEL interventions result in increased academic achievement for students, these pressures may be impeding the academic growth of Australia's students. In other words, promoting wellbeing and good mental health is not a distraction from academic achievement, but a prerequisite to it.

A study of Australian teachers in relation to this challenge found that teachers viewed it like "juggling with both hands tied" (p.2663)[133]. This reflects a tension between meeting core academic curriculum and the need for students to achieve and meet their social and emotional wellbeing needs.

The fact that Australia has seen *declines in performance on reading and mathematics since the introduction of NAPLAN*, according to data from the Programme for International student Assessment (PISA)[134], does not make those pressures less salient. Indeed, these declines tend to be laid at the feet of the teachers, who get blamed for being "ineffective". But given the link between poor wellbeing and academic achievement, it is possible the declines in academic performance might be a function of decreased wellbeing. It might further be possible the increased pressure created by NAPLAN has contributed to the decline in wellbeing, given the emphasis this process puts on Australia's students.

And so, currently teachers and their school leaders feel pulled as in a "tug-of-war"[133] with student achievement priorities pulling one way and student wellbeing priorities pulling another, as if there was no association between the two..

Teachers see the pressure that assessment places on their students and report the pressure on themselves to "teach to the test" due to systemic pressure; teachers also see their own power to buffer students from that pressure and to help them cope with stressors like NAPLAN and the pressure to implement the Australian Curriculum[27]. Some teachers – particularly primary school teachers, female teachers, more experienced teachers, and staff at non-government schools – are concerned that a strong academic performance focus in the school may undermine student resilience.[133] But if student wellbeing serves to empower students to take on challenges, adopt a more productive growth mindset, and avoid the problems that can pull them deeper into ill mental health, then wellbeing can be seen as a prerequisite to achievement, not as a competing priority.

There is some evidence the actions discussed above may help with this problem. Awareness and understanding of school wellbeing initiatives have been shown to increase the likelihood of teachers believing it was possible for schools to be both 'caring' and 'high performing' at the same time[133]. This holds promise that universal wellbeing interventions may literally give hope to school staff that they can both care for and teach their students as a part of their job. But when wellbeing interventions are seen to be brought in haphazardly, with inadequate professional development, or unsustained implementation, or tokenistic efforts that are not valued by the school leadership, that hope can fade[133].

Some teachers rightly see the teacher-student relationship is at the heart of any effort to promote wellbeing. But with good implementation and proper training, interventions can improve both wellbeing and achievement. If teachers can see that the initiative is not wasting their time or that of their students, and if the intervention can address the real challenges compromising wellbeing, buy-in will result.

## THE NEED FOR ONE-TO-ONE INTERVENTIONS

Most available external interventions primarily provide universal and selective strategies for schools to promote wellbeing. However, there are few indicated interventions for students experiencing severe wellbeing challenges.

Whilst many schools have some funding for school psychologists, few have adequate time to work one-on-one in the school setting[135]. Although school psychologists

are extensively trained and are able to deliver individualised support to students (and to school staff members), the role tends instead to be focused on educational and psychological testing and assessment[4]. Given the potential for relationship building in the school setting, it is an unfortunate reality that school psychologists are not staffed adequately to provide care to more students and staff in the school.

The National Children's Mental Health and Wellbeing Strategy[2] has called for 'well-equipped educators' who are:

> …. able to develop effective working relationships with external health providers […] including paediatricians, psychologists, allied health professionals including speech pathologists and occupational therapists, community health centres, and mental health services. (p.79).

The Strategy makes no mention the existence of 'internal' school psychologists or other school-based mental or allied health services. A well-resourced team of school mental health staff holds promise in helping address the problem of struggling and unwell students who are not able to access the local health care they need. Currently, however, funding for school mental health precludes an integrated care approach within the school. So, when indicated interventions efforts implemented by the school are not enough to meet students' needs, schools have little choice but to seek external providers.

## Lack of services in regional and remote areas

Reliance on outside services may suffice in urban centres. Unfortunately, Australia faces serious supply and demand problems, despite new funding, particularly for children, young people, and their families in regional and remote areas of Australia. As described in the National Children's Mental Health and Wellbeing Strategy[2]:

> [T]here is a dearth of mental health professionals for children in rural and remote areas. The provision of training and education for child mental health professionals is largely only available in metropolitan areas. Supports for rural mental health professionals (training, workforce, and pastoral) are lacking, adding to the burden experienced by professionals who are located remotely. Market failure in rural and remote areas also results in private practitioners being drawn into larger metropolitan areas, diminishing supply of desperately need child mental health professionals in more remote communities (p.66).

The lack of services in rural and regional Australia is a serious problem, especially in the context of the elevated need in those areas. Students who live in outer regional areas are 1.6 times more likely to have a mental disorder than children from metropolitan areas[14]. Children who grow up in rural and remote areas face increased risk of poverty, parental unemployment, sole-parent households, social isolation, and less access to early childhood education and care[136]. Children growing up in remote regions are twice as likely be the subject of a 'substantiation' investigation into child abuse[4]. Data from the teacher-reported Australian Early Development Census indicate that children living in very remote areas were three times as likely to be developmentally vulnerable on two or more developmental domains[136].

This inequity in risk factors for poor wellbeing is in no way addressed by increased services provided to regional and remote areas. For rural and remote

communities, there are many barriers to access. As most paediatricians and specialist health care is located in major towns and cities, it is common for families to face round-trip travel of over 200km to get care, assuming this is feasible at all for the family (e.g. if they own their own transportation)[136].

To further illustrate the problem: In the state of Victoria, the metropolitan Melbourne area has 17 psychiatrists per 100,000 people. In regional Victoria, there is 1 psychiatrist per 100,000 people. Increasing and retaining the workforce in regional and remote areas of Australia is an ongoing problem for mental health services, and it is unclear whether the current incentives can mitigate the problem[2]. As illustrated by Figure 5, this pattern is common across mental health professions.

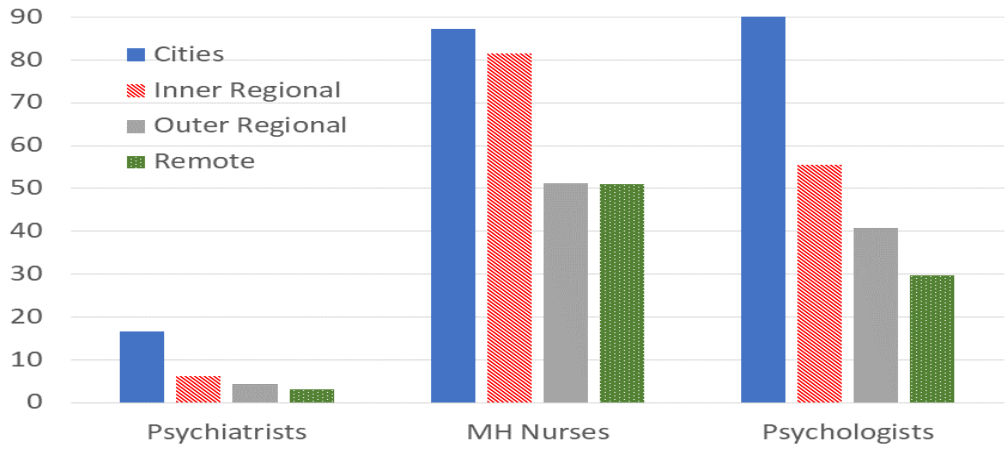


FIGURE 6 RATES OF FTE PSYCHIATRISTS, MENTAL HEALTH NURSES, AND PSYCHOLOGISTS PER 100,000 (2014)[136]

## The role of telehealth

In response these concerns, and catalysed by the COVID-19 pandemic, telehealth approaches to mental health care have become a more prominent part of the perceived solution[137]. Medicare-subsidised telehealth provides a way for regional and remote-based professionals and families to access care they would otherwise struggle to obtain due to the distances and supply problems noted above. In combination with the capacity of GPs to provide mental health plans, this holds promise for Australian children and adolescents, ideally for both crisis response and ongoing management. New initiatives include regional suicide prevention networks, and a culturally safe 24/7 telephone crisis line for Aboriginal and Torres Strait Islander peoples. It is unclear yet how these will affect the issues of supply and demand for schools concerned about student wellbeing.

Telehealth features prominently in the *headspace* model and other services aimed at adolescents and youth. The *Kids Helpline* provides telephone and online counselling for Australians as young as 5 years of age. An analysis of contacts to *Kids Helpline* found that only about 11 per cent of contacts are from children (5 to 12 years). In contrast, adolescents (13 to 17 years) make up 36 per

cent of telephone contacts and 63 per cent of webchat contacts[138] and young adults (18 to 25 years) make up 43 per cent of Kids Helpline total contacts. But for younger children, telehealth is unlikely to be able to replace face-to-face therapeutic responses, which often require whole family engagement. In some cases, parents can facilitate this process[139], with recent data from Wales indicating video conferencing is feasible for remote (i.e. by Welsh, not Australian, standards) locations[140] and to treat trauma-exposed youth[141].

But telehealth cannot replace face-to-face therapy for all purposes[137]. Indeed, for some Australian communities, telehealth remains a challenge if not an impossibility due to poor mobile and internet connectivity in remote regions and lack of technology [136]. Given that practitioners prefer videoconferencing for healthcare purposes [142], this digital divide between regional and metro areas risks sustaining or even amplifying inequities in mental health provision in remote and regional areas. It is also essential to ensure that telehealth solutions do not displace those few providers already working in regional and remote areas[142].

Some providers have recognised the needs of students and schools in rural and remote areas. For example, Reach Out has an 'action pack' for schools with staff training, lessons, and resources. But it is limited to students in Years 9 to 12. As these are the students who can access current telehealth options from headspace and other providers, it leaves younger students relatively disadvantaged. More solutions are needed for young student wellbeing and mental health support in schools located in remote and regional areas of Australia.

# 6. RECOMMENDATIONS FOR SCHOOLS

For schools to be effective in protecting the wellbeing of students and staff, they need to have the capacity and the skills to implement these recommendations.

## 1. Schools need policies and practices that support student and staff wellbeing

1a. Assign, train and resource dedicated school team members (plural) to identify needs and gaps in school services and programs;

1b. Review all policies and practices to ensure they promote wellbeing and reduce risks (e.g., bullying), promote sleep hygiene and online behaviour, reduce stigma and shame around mental illness;

1c. Implement proven and appropriate whole-school programs to prevent mental illness, protect vulnerable students, and promote social-emotional wellbeing;

1d. Develop or acquire tools for tracking wellbeing and reporting.

## 2. Improve resourcing and training for student and staff wellbeing and inclusivity

2a. Provide professional development for all staff in social-emotional learning, mental health literacy, and bullying prevention. Appropriate professional development for primary and secondary school staff includes;

- trauma-informed education practices and inclusive action - safe responses to at-risk students
- Aboriginal and Torres Strait Islander cultural competency
- LGBTQIA2+ concerns, pronouns, and policies (e.g., around toilets) both primary and secondary schools;

2b. Allocate adequate time to staff to implement strategies to meet the need for universal and targeted intervention approaches;

2c. Increase access to allied and mental health and/or wellbeing staff; with clear direction (as outlined by a National Guiding Framework).

## 3. Prioritise a culture of trust and wellbeing;

3a. Promote relationships across the whole-school community, including the relationships of teachers and students, and the partnership of school and families by providing meaningful opportunities for these groups to engage with each other;

3b. Ensure staff have sufficient training and time to deal effectively with teacher-student conflict and respond to student behaviour problems in ways that recognise a potential indicator of deeper problems and not just cause for punishment;

3c. Ensure respectful intra-staff relationships and school leadership-staff relationships.

## 4. Partner with the full diversity of families in the school community.

4a. Seek support for meaningful, respectful engagement and partner with families where student wellbeing is an issue, including disadvantaged families, culturally diverse and/or Aboriginal and Torres Strait Islander families;

4b. Work with 'parent committees' and school boards to ensure initiatives for full input and outreach to disengaged families and to prevent a 'clique' of parents becoming the dominant voice.

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# APPENDICES

# APPENDIX A: KEY STUDIES ON AUSTRALIAN CHILDREN AND YOUNG PEOPLE'S WELLBEING

| Study | Years | Ages | Sample Details | Sampling Approach | Key Outcomes Measured | Key Ref |
|---|---|---|---|---|---|---|
| ABS National Health Survey | 2014-2018 | 15 years & older | ~21,000 people from 16,000+ households. | National household data collection | Long-term mental or behavioural condition | [16] |
| DETECT Schools study | 2020 | 8-18 | 24,003 students; 1,202 school staff; 3,463 parents of K-12 students | Western Australia (W.A.); schools selected by Department of Education; opt-out parent consent | Wellbeing; emotional distress; Impact of pandemic; | [143] |
| Mission Australia Youth Survey 2020 | 2020 | 15-19 | 25,800, including 1,129 (4.4%) Aboriginal & Torres Strait Islander respondents & 19.9% LOTE | National; Online through Schools w active parent consent | Happiness & optimism; Stress; Values; Personal Issues; Help seeking; Future plans for study & training; Experiences of unfair treatment | [12] |
| Mission Australia Youth Mental Health Report: 2012-2020 | 2020 | 15-19 | 25,800, including 1,129 (4.4%) Aboriginal & Torres Strait Islander respondents & 19.9% LOTE | National; Online through Schools w active parent consent | Psychological distress | [15] |
| Speaking Out Survey 2020 | 2019 | 9-18 | 4,912 Western Australians including 957 (19.5%) Aboriginal students; 18% LOTE participants | W.A.; Random representative sample via schools with opt-out parental consent | Health, sleep, life satisfaction, resilience, depression, sources of stress, | [23] |
| State of Mind (Smiling Mind) | 2020 | 18-25 | Unknown – only percentage breakdowns reported | Unknown | Self-reported stress, psychological distress; anxiety, depression, or other mental health condition | [13] |
| Young Minds Matter (2nd Australian Child & Adolescent Survey of Mental Health & Wellbeing | 2014 | 4-17 (with self-report for 11-17) | 6,310 households and 2,967 young people self-reporting | National; Random in-person household recruitment | DISC-IV mental disorders – anxiety, depression, ADHD, conduct. Parent-rated problems (Strengths & Difficulties Questionnaire; SDQ), school attendance, family/ demographic context, parent mental health; Self-reported DISC major depressive disorder; SDQ scales; psychological distress; self-harm & suicide; bullying; service use; health risk behaviours | [14,65,144] |

# APPENDIX B: SOCIAL EMOTIONAL LEARNING

Based on the work of the U.S. based CASEL group[5], SEL can be broken down to five interrelated components: Self-awareness, Self-management, Social awareness, Relationship skills, and Responsible decision making.

*Self-awareness*: The ability to accurately recognize one's emotions and thoughts and their influence on behaviour. This includes accurately assessing one's strengths and limitations and possessing a well-grounded sense of confidence and optimism.

*Self-management*: The ability to regulate one's emotions, thoughts, and behaviours effectively in different situations. This includes managing stress, controlling impulses, motivating oneself, and setting and working toward achieving personal and academic goals.

*Social awareness*: The ability to take the perspective of and empathise with others from diverse backgrounds and cultures, to understand social and ethical norms for behaviour, and to recognise family, school, and community resources and supports.

*Relationship skills*: The ability to establish and maintain healthy and rewarding relationships with diverse individuals and groups. This includes communicating clearly, listening actively, cooperating, resisting inappropriate social pressure, negotiating conflict constructively, and seeking and offering help when needed.

*Responsible decision-making*: The ability to make constructive and respectful choices about personal behaviour and social interactions based on consideration of ethical standards, safety concerns, social norms, the realistic evaluation of consequences of various actions, and the well-being of self and others.

[5] https://casel.org/