Ten Years Later: Current Practices and Preferred Roles of School Psychologists in Nova Scotia

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ABSTRACT

This study surveyed school psychologists in Nova Scotia to determine whether they incorporate the core competencies in their practice at school and to update and extend the study conducted by Corkum et al. (2007) to learn about their current and preferred roles. Results indicated that school psychologists do not have the opportunity to fully engage in each core competency and that they spend the majority of their time conducting psychoeducational assessments. School psychologists continue to prefer reducing the amount of time spent on psychoeducational assessments. They highlighted the drawback of this, as it compromises their ability to engage in all core competencies. To allow school psychologists to have a comprehensive role, their workload needs to be reduced by reducing the school psychologist to student ratio to ensure that students receive quality service. Furthermore, the perception of the role of the school psychologist needs to be inclusive of all the services they could provide rather than solely focusing on and valuing psychoeducational assessments.

CHAPTER ONE

LITERATURE REVIEW

Mental Health Disorders

Approximately 15% of Canadian children and youth have a mental health disorder such as Attention-Deficit Hyperactivity Disorder (ADHD), depression or anxiety (Arboleda-Flórez, 2005), with 50%-70% of these disorders emerging before the age of 18 (Canadian Mental Health Association, 2017). It is expected that by 2020, there will be a 50% increase in mental health disorders in children and adolescents (Leitch, 2007).

Implications of mental health disorders in childhood and adolescence. Mental health disorders affect various areas of children and adolescents' lives and even those who exhibit symptoms but do not meet diagnostic criteria for mental health disorders can experience adverse effects (Wille, Bettge, Wittchen, Ravens-Sieberer, & the BELLA study group, 2008). Mental health difficulties affect students' learning, behaviour, and ability to pay attention (Wille et al., 2008). Fröjd and colleagues (2008) examined the effect of depression on students' academic performance and found that students who presented with symptoms of depression had lower grade point averages (GPA) and perceived their academic workload to be greater when compared with students without symptoms of depression. Additionally, students with more severe symptoms of depression reported having difficulty attending to classroom instruction and with social relationships (Fröjd et al., 2008). DeShazo Barry, Lyman, and Klinger (2002) compared the academic achievement of students with and without Attention-Deficit Hyperactivity Disorder (ADHD) and found that students with ADHD performed significantly lower and were more likely to be in special education classes than those without ADHD and were more likely to have a comorbid diagnosis of a learning disability (DeShazo Barry, Lyman,

& Klinger, 2002). Students with ADHD were less persistent when completing academic tasks and reported higher levels of frustration when the tasks were unsuccessfully completed than students without ADHD (Hoza, Pelham, Waschbusch, Kipp, & Owens, 2001). Mychailyszyn, Méndez, and Kendall (2010) compared parent and teacher ratings of students with and without anxiety on academic performance. Students with anxiety were found to perform lower academically, were not as happy, and were perceived to be less hardworking and ready to learn when compared to students without anxiety (Mychailyszyn, Méndez, & Kendall, 2010). These findings indicate that mental health disorders can have negative effects on students' academic achievement.

Mental health disorders can also negatively affect children and adolescents' social relationships. For example, children with ADHD have been found to have fewer friends, to be more likely to receive negative remarks from peers, and to be less likely to get along with peers (Bagwell, Molina, Pelham, & Hoza, 2001). Prinstein, Borelli, Cheah, Simon, and Aikins (2005) found negative implications on social functioning for adolescents with depression such that adolescents with more symptoms of depression were less likely to remain friends with the same individual for an extended period of time and also reported experiencing more criticism, dominance, and conflict in the friendship. According to Fröjd and colleagues (2008), students who presented with symptoms of depression found it more challenging to participate effectively in teams and to get along with classmates and teachers.

Mental health disorders not only affect children and adolescents academically and socially, but they also affect family functioning. Cussen, Sciberras, Ukoumunne, and Efron (2012) found that parents whose children had ADHD reported greater stress, had limited time for themselves, and were less likely to engage in family activities compared to families whose

children did not have ADHD. Ma, Roberts, Winefield, and Furber (2017) reviewed the literature and found that families that had a child with a mental health disorders experienced more conflict than families that did not have a child with mental health disorder. They also found that families with a child experiencing a mental health disorder did not spend as much time together and that siblings were less compliant with parental requests, thereby straining this relationship (Ma, Roberts, Winefield, & Furber, 2017). Sibling relationships have also been found to be affected by mental health disorders, in that when one sibling has a mental health disorder, siblings generally do not engage in activities together and have more conflict compared to siblings without a mental health disorder (Ma et al., 2017). Siblings of children and adolescents with mental health disorders have been found to be more likely to engage in problem behaviours (Barnett & Hunter, 2012), to report lower wellbeing as well as lower family satisfaction (Barnett & Hunter, 2012), and were more likely to experience a mental health disorder themselves (Barnett & Hunter, 2012; Dia & Harrington, 2006). Taken together, these findings indicate that mental health disorders can have many negative implications for children and adolescents' development and functioning across multiple domains.

Long-term outcomes of mental health difficulties. Experiencing mental health disorders in adolescence can influence one's functioning in young adulthood. Lewinsohn and colleagues (2003) found that people who experienced depression during adolescence experienced lower life satisfaction, had fewer social relationships, and had compromised relationships with family in young adulthood. Similarly, Fergusson and Woodward (2002) found that people who experienced depression during adolescence were less likely to enroll in university and to succeed academically. Experiencing depression during adolescence was also associated with substance use and abuse, suicide, an increased risk of experiencing comorbid anxiety, recurrent depression,

and anxiety (Fergusson & Woodward, 2002). Similar findings have been reported with respect to anxiety. Specifically, Woodward and Fergusson (2001) reported that people who experienced anxiety during adolescence are at an increased risk of experiencing other anxiety disorders, depression, substance use, suicide, and were less likely to enroll in post-secondary education in young adulthood compared to people who had not experienced anxiety in adolescence. Holmes and Silvestri (2016) found that mental health disorders negatively affect college students. Students who self-reported a diagnosis of a mental illness reported difficulties with respect to maintaining their attention, memory, and relationships with peers compared to participants without mental health disorders (Holmes & Silvestri, 2016). On the other hand, students without a mental health disorder have been found to complete higher levels of education in young adulthood (O'Connor, Sanson, Toumbourou, Norrish, & Olsson, 2017).

Mental health difficulties continue to affect the individual beyond childhood, adolescence, and young adulthood. Kessler and colleagues (2005) noted that adults experiencing mental health disorders generally reported the onset was during childhood or adolescence, indicating that mental health disorders persist into adulthood. Mental health disorders in adulthood are associated with an increased risk of premature death (Joukamaa et al. 2001); increased risk of job loss and subsequent unemployment (Olesen, Butterworth, Leach, Kelaher, & Pirkis, 2013); and lower life satisfaction (Fergusson et al., 2015). Individuals not experiencing a mental health disorder missed fewer work days and were more resilient than those experiencing a mental health disorder (Keyes, 2005). Given the negative outcomes of mental health disorders, access to services is essential to enhance quality of life and to reduce and/or eliminate the negative outcomes of mental health disorders.

Importance of early detection and prevention. Most mental health disorders occur prior to age 18 (Canadian Mental Health Association, 2017) and it is a time where significant neurological changes occur (Paus, Keshavan, & Giedd, 2008; Miguel-Hidalgo, 2013). Some of those changes involve white matter and grey matter in the cortex (Paus et al., 2008; Marsh, Gerber, & Peterson, 2008; Giedd et al., 2009), the synapses (Paus et al., 2008; Miguel-Hidalgo, 2013), and subcortical areas (Miguel-Hidalgo, 2013). Although neurological changes occur during the pre- and post-natal period, adolescents are more susceptible to mental health disorders when neurological changes occur during this developmental period (Miguel-Hidalgo, 2013). Negative circumstances and genetic factors can compromise brain development, increasing the risk of mental health disorders (Miguel-Hidalgo, 2013) as well as cognitive disorders (Paus et al., 2008), which significantly affect one's functioning and can persist beyond childhood and adolescence.

Given the significant negative effect of mental health disorders during childhood and adolescence, it is necessary to provide preventive services to children and adolescents (van den Heuvel, Barozzino, Milligan, Ford-Jones, & Freemen, 2016). Durlak, Weissberg, Dymnicki, Taylor, and Schellinger (2011) reviewed the literature on the effect of universal school based interventions on students' social and emotional learning and found that students in the treatment group demonstrated a significant increase in positive behaviour with peers, a decrease in problem behaviour with peers, and higher academic achievement. Although there was a reduction in the positive effects of the intervention six months post-intervention, the positive effects remained significant (Durlak et al., 2011). Bernstein, Layne, Egan, and Tennison (2005) conducted a school-based intervention program and compared three groups of seven to 11-year-old children with mild to moderate symptoms of anxiety who were placed in either a Cognitive-Behavioural

therapy (CBT) group, a CBT group with a parent involved, and a control (Bernstein et al., 2005). They found that students who were in the treatment groups had a significant reduction in anxiety symptoms. Bernstein, Bernat, Victor, and Layne (2008) followed-up with the sample three, six and 12 months post-intervention and found that students who were in the treatment group maintained the reduction in severity of anxiety symptoms. The CBT group with a parent involved resulted in greater gains when compared to the control group; however, there was no significant difference between the student's CBT group and the student's CBT group with a parent involved (Bernstein et al., 2008). Young, Mufson, and Davies (2006) held a school-based interpersonal psychotherapy group intervention for adolescents with presenting symptoms of depression. They also included another group of adolescents with symptoms of depression who received school-based counselling from a counsellor or a social worker to compare the effect of the interpersonal psychotherapy with counselling that is generally available at the school (Young et al., 2006). Although students in both groups improved, the improvement of students in the interpersonal psychotherapy group was significantly greater, as they reported fewer symptoms of depression (Young et al., 2006). The significant difference between both groups of students remained three and six months after both groups stopped receiving counselling and the interpersonal psychotherapy intervention (Young et al., 2006).

Percentage of children accessing services. Despite the benefits of interventions and the high prevalence of mental health disorders among children and teens in Canada, only one in four children access mental health treatment (Canadian Mental Health Association, 2017); however, this treatment may not be effective or evidence-based (Davidson et al., 2010). Because only a small number of children access mental health services, it is important to explore and understand the barriers as well as the facilitators that influence help-seeking behaviours to increase the

number of children and adolescents who access mental health services. Since children and adolescents are usually unable to access services independently, it is important to consider the barriers that parents face as well as the barriers that youth face when accessing mental health services to reduce them while implementing the factors that facilitate help-seeking to increase the number of children accessing services.

Role of parents in seeking and accessing mental health services for children. One key factor related to young people accessing services is the parents' recognition of their child's difficulties (Boulter & Rickwood, 2013; Sayal, 2006; Oh & Bayer, 2015; Sayal et al., 2010), as parents are often first to notice emerging symptoms of mental health disorders in their children and seek help (Boulter & Rickwood, 2013). Oh and Bayer (2015) investigated the process by which parents seek help using an Australian sample. They found that most parents reported they would seek help if they thought their child had mental health problems, with only 15% of parents indicating they would not be likely to seek help (Oh & Bayer, 2015). Furthermore, one-third of parents who were more likely to seek help for their children's mental health problems were more likely to correctly recognize their children's difficulties compared to only 15% of parents who were unlikely to seek-help for their children's difficulties (Oh & Bayer, 2015). Over half of parents accessed help for their children when they recognized that their children engaged in more challenging behaviour than average children; however, when parents did not recognize that their children needed help, only 16% of parents accessed help (Oh & Bayer, 2015). It is believed that those parents likely accessed help due to the school's involvement by making referrals (Oh & Bayer, 2015). Parents continue to be involved until their children reach adolescence and become financially independent (Rickwood, Deane, & Wilson, 2007). Once their children reach

adolescence, they allow their children to have a more proactive role in seeking help (Sayal et al., 2010).

Help-seeking facilitators for parents. When parents were asked about the factors that facilitated help-seeking for their children, they identified factors related to the quality of service provided to them (Boulter & Rickwood, 2013; Sayal et al., 2010). For example, parents identified building positive relationships with their child as a factor that would increase the likelihood of future help-seeking (Boulter & Rickwood, 2013; Sayal et al., 2010). Parents further noted that they were more likely to seek help in the future when service providers were nonjudgmental and validated their child's difficulty (Boulter & Rickwood, 2013). To increase the likelihood of parents seeking help for their children, it has been recommended that service providers avoid rushing parents, as parents frequently report that it is more helpful to receive a clear explanation of their child's diagnosis rather than simply receiving a label (Boulter & Rickwood, 2013). Furthermore, parents valued being a part of their child's treatment plan (Boulter & Rickwood, 2013). Although service providers play a crucial role in increasing the likelihood of parents' future help-seeking, this was not the only factor identified by parents. Parents further noted that their inability to continue dealing with their child's mental health difficulties and recognizing that their child's behaviour was different from other children also encouraged them to seek help (Boulter & Rickwood, 2013).

Barriers to help-seeking for parents. Parents have identified factors that interfere with and decrease the likelihood of accessing mental health services for their children in the future (Canadian Mental Health Association, 2017; Boulter & Rickwood, 2013; Jorm, Wright, & Morgan, 2007; Sayal et al., 2010). It is important to attend to these factors to enhance parents' experience and increase the likelihood of future help-seeking for their children. Cultural

differences can make it difficult for parents to openly discuss their child's difficulties with a professional, as it is very uncommon in some cultures to discuss their child's difficulties with anyone (Sayal et al., 2010). Parents fear being blamed for their child's illness and/or worry about the treatment their child receives (Canadian Mental Health Association, 2017). Parents have reported feeling embarrassed, that their concern was not taken seriously, and worried their child may be apprehended if they seek help for mental health difficulties (Sayal et al., 2010). They reported having to be persistent to access mental health services for their children by contacting many services to ensure their children receive the right service (Boulter & Rickwood, 2013). Parents also had to wait for long periods of time before they received any help (Boulter & Rickwood, 2013) and found the appointments with a general practitioners (GP) to be short (Sayal et al., 2010). They were reluctant to seek more help after the long wait-times and after being sent to many places, leaving them uncertain about where to go next (Sayal et al., 2010). Some parents noted that there were financial barriers to receiving support from counsellors and mental health specialists (Jorm et al., 2007). They also identified being worried about receiving the right help and about their child receiving a diagnosis quickly without being heard; however, a diagnosis was viewed positively by some parents to facilitate receiving supports at school (Sayal et al., 2010).

Help-seeking facilitators for adolescents. As children progress through adolescence, their peers have a greater influence on help-seeking behaviour (Rickwood et al., 2007). Researchers have found that during this developmental period, the help-seeking process is often initiated by a peer (Rickwood et al., 2007; Wilson & Deane, 2001), teacher or a caregiver (Wilson & Deane, 2001). Adolescents have identified factors that encouraged them to seek help in the future. They noted that previous positive experiences when seeking help encouraged future

help-seeking (Rickwood, Deane, Wilson & Ciarrochi, 2005; Wilson & Deane, 2001), that they were more likely to seek help from someone with whom they have a relationship and can trust (Wilson & Deane, 2001), and they found it helpful when they were aware of what to expect when going for help (Rickwood et al., 2005). They generally found it useful to receive help; however, they noted that they do not think all problems require seeking help (Wilson & Deane, 2001). In addition, they were more likely to seek help if they thought that their problem would be taken seriously and validated (Wilson & Deane, 2001).

Barriers to help-seeking for adolescents. Students identified negative beliefs and attitudes associated with mental health disorders and their treatment to be a barrier to accessing mental health support (Bowers, Manion, Papadopoulos, & Gauvreau, 2013; Rickwood et al., 2007; Rickwood et al., 2005). This was the main barrier for students who experience mental health difficulties and the main perceived barrier for students who do not experience mental health difficulties (Bowers et al., 2013). Adolescents were less likely to seek help in the future if they had a previous negative experience when help-seeking. (Rickwood et al., 2005; Rickwood et al., 2007). Negative experiences included feeling that they did not receive help as well as feeling that their problems were not taken seriously (Rickwood et al., 2005). Students identified feeling embarrassed and/or concerned about others' impression of them (Jorm et al., 2007; Rickwood et al., 2005). They also reported that they are more likely to seek help from family members (Jorm et al., 2007; Rickwood et al., 2005) and friends (Rickwood et al., 2005) rather than seeking professional help, as they are uncomfortable sharing personal information with an individual that they do not know (Rickwood et al., 2005). Students lacked the knowledge of where to find help at school and often the ability to recognize that they need help (Bowers et al., 2013). Another serious barrier is that students are often concerned about school counsellors

maintaining confidentiality in the school setting (Rickwood et al., 2005); however, further research has shown that parents and students generally find the school to be a more comfortable site in which to seek support due to the familiarity of the setting (Doll, Nastasi, Cornell, & Song, 2017). Findings such as these suggest that offering mental health services at school could enhance the connection between the school and the student's family, as there would be more communication and coordination (Vernberg, Roberts, & Nyre, 2008), which could potentially lead to better treatment response and outcomes for the child and family.

School-Based Mental Health Services

Schools are an ideal place for students to receive mental health support due to the amount of time young people spend there (Kern et al., 2017). Teachers and other school staff are often the primary individuals who notice presenting symptoms or changes in symptoms in students (Whitley, Smith, & Vaillancourt, 2012). It has been suggested that offering mental health services at school is more convenient than outside settings (Doll et al., 2017), as parents do not have to take time off work (Guo, Wade, Pan, & Keller, 2010), it eliminates the barrier of transportation (Guo et al., 2010), and increases accessibility of services (Guo et al., 2010; Doll et al., 2017). Offering mental health services at schools increases the likelihood students will seek help when services are offered (Slade, 2002) and makes services accessible to more students (Weare & Nind, 2011), as they are accessible to those who experience symptoms of mental health difficulties without meeting diagnostic criteria (Kern et al., 2017). In addition, community-based mental health services and hospitals lack the resources to meet the high demand of mental health needs, resulting in longer wait-lists (Reid & Brown, 2008). Reid and Brown (2008) further noted that there is a higher demand for mental health services in community-based mental health services and hospitals due to an increase in children and youth

requiring help. Therefore, offering mental health services at school is convenient for both students and their parents, ensures that students identified with a mental health disorder or symptoms receive support, and may potentially alleviate the high demand placed on community-based services and hospitals.

Characteristics of effective mental health programs in schools. Researchers have reviewed the literature (O'Mara & Lind, 2013; Rones & Hoagwood, 2000; Weare & Nind, 2011) and implemented programs (Nielsen, Meilstrup, Nelausen, Koushede, & Holstein, 2015) to identify and assess characteristics of effective school-based mental health programs for children and youth. Characteristics include providing long-term school-wide interventions focusing on mental health promotion (i.e., skill building) rather than on mental health disorders (O'Mara & Lind, 2013; Nielsen et al., 2005). It is also important to maintain consistency when implementing the interventions (Rones & Hoagwood, 2000; Nielsen et al., 2005), to include various methods of conveying the lesson (Rones & Hoagwood, 2000), and to use content that is developmentally appropriate for the age-group (Rones & Hoagwood, 2000; Nielsen et al., 2005). Incorporating the skills taught during the intervention as part of the curriculum in the classroom (Rones & Hoagwood, 2000; Weare & Nind, 2011) and in different settings (O'Mara & Lind, 2013) are also important in an effective school-based intervention. Finally, it has been suggested that involving school staff, students, and parents is important when implementing school-based mental health interventions (O'Mara & Lind, 2013; Rones & Hoagwood, 2000; Weare & Nind, 2011; Nielsen et al., 2005). Although school psychologists would be the ideal choice to implement school-based mental health services because they are "the most highly trained mental health experts in schools" (Sheridan & Gutkin, 2000, p. 488), teachers are often responsible for implementing interventions in the classroom (Reinke, Stormont, Herman, Puri, & Goel, 2011; Nielsen et al.,

2015). This is a shortcoming because although teachers would like to support students, they often lack the necessary skills and training to manage students' mental health needs (Reinke et al., 2011).

Training of School Psychologists

School psychology training focuses on learning, behaviour, evidence-based practice, evaluating programs, assessment and intervention (Canadian Psychological Association, 2007; Canadian Psychological Association, 2011; National Association of School Psychology, 2000). The National Association of School Psychologists (2000) further notes in the *Standards for Training and Field Placement Programs in School Psychology* document that school psychology training programs are to focus on assessment, intervention, consultation, interpersonal relationships, development, psychopathology, research, statistics, the guidelines of ethical practice, and receive supervision. This is similar to the expectations outlined by the Canadian Psychological Association (2011) in the *Accreditation Standards and Procedures for Doctoral Programmes and Internships in Professional Psychology* document for graduate programs in Canada. Graduate programs are to also focus on research by emphasizing critical-thinking skills, evidence-based practice to assist in program evaluation, and emphasize the importance of incorporating evidence-based practices (CPA, 2011). School Psychology training programs are to allow students to transfer and apply theoretical knowledge to practical experience during practica and internship by conducting assessments and interventions as well as engaging in consultation (CPA, 2011).

Competencies of School Psychologists

The practice of psychology is guided by core competencies set by the Canadian Psychological Association. The core competencies are areas of specialization in which

psychologists have extensive training, knowledge, and skills (NASP, 2000; The Psychological Association of Manitoba, n.d.). Core competencies include assessment and evaluation, intervention and consultation, ethics and standards, research, interpersonal relationships, and supervision (The Psychological Association of Manitoba, n.d.). School psychologists conduct assessments and diagnose mental health and cognitive difficulties (CPA, 2014) and provide interventions/services to support students in multiple domains, such as: emotional, social, behavioural, and academic functioning (NASP, 2010). School psychologists are expected to stay up-to-date with current research findings to ensure they incorporate evidence-based findings into their practice (CPA, 2007) and are to ensure that their practice is guided by the Canadian Code of Ethics, which outlines guidelines of ethical practice for psychologists (CPA, 2000). Because school psychologists interact with many individuals on daily basis, including but not limited to students, parents, school personnel, and third party individuals, they are expected to build rapport with people while maintaining professional boundaries (Psychological Association of Manitoba, n.d.). School psychologists are also expected to supervise practicum students and interns entering the field as well as psychologists on the candidate register (CPA, n.d.).

Service Delivery

The role of the school psychologist is to promote and address students' mental health and educational needs (Jordan, Hindes, & Saklofske, 2009; NASP, 2010; CPA, 2007). School psychologists are in a position to provide comprehensive care that varies from preventative services to treatment services to address school age students' mental health as well as other needs to support students and their families (Nastasi, 2000). Services provided by school psychologists include directly working with a student for assessment and/or interventions (CPA, 2007). Assessments help to understand a student's learning profile, emotional difficulties, and

behavioural challenges (NASP, 2010; CPA, 2007). The process involves gathering information from multiple sources (e.g., classroom teacher, guardians, administrators, observations, file review) about the student, gathering relevant data from the student, and providing evidence-based recommendations for school personnel and guardians (CPA, 2007; NASP, 2010).

School psychologists offer interventions at an individual level, a group level, and/or to a classroom for a range of emotional, social, and behavioural difficulties (CPA, 2007; NASP, 2010). School psychologists work one-on-one with students whose difficulties persist after accessing other supports at the school (CPA, 2007). School psychologists' involvement at the group level can include a group of students who share a common challenge, where strategies can be offered to help the students deal with/overcome their challenges (CPA, 2007). School psychologists can provide prevention services to classrooms or the entire school by using a curriculum in the early years to aid in preventing the exacerbation of symptoms (CPA, 2007).

Services also involve consultation with school personnel on an administrative level to identify students who need support or with teachers to provide strategies that would assist in dealing with students with challenging behaviour or learning difficulties (CPA, 2007). School psychologists collaborate with guardians and school personnel to ensure services are implemented appropriately for students (NASP, 2010). They also collaborate with teachers to assist in program planning that best fits the student's profile (CPA, 2007). School psychologists deliver professional development sessions for school personnel and/or guardians; provide relevant evidence-based practice information to staff; providing strategies to create a supportive and flourishing environment at school (CPA, 2007). School psychologists can also advocate for outside services on behalf of students and families, if needed. (CPA, 2007).

Accessibility of school psychologists in the schools. School psychologists in Nova Scotia service between four and seven schools each, with the school psychologist to student ratio ranging from 1:1220 – 1:2160 across school boards (King, McGonnell, & Noyes, 2016). NASP (2010) recommends that the ratio of school psychologist to students not surpass one school psychologist for every 1000 students (King et al., 2016). To ensure school psychologists are able to provide comprehensive services, the ratio is recommended to be 1:500 – 1:700 students (King et al., 2016; NASP, 2010); however, if a psychologist is working with more demanding cases then the ratio should be reduced (NASP, 2010). Although some school boards in Nova Scotia follow the recommended school psychologist to student ratio, many school boards surpass it (King et al., 2016), thereby reducing the availability of the school psychologist in each school. This is contrary to teachers' preference regarding school psychologists' involvement. Reader (2014) found that teachers would like school psychologists to be more accessible in the schools and to provide more mental health services to students. These findings echo those of a previous study (Watkins, Crosby, & Pearson, 2001) in which teachers noted that they value the services offered by school psychologists but would like a wider range of services to be available at their schools while maintaining the number assessments conducted. Although school psychologists are trained in mental health (NASP, 2000) and can implement interventions in the school (NASP, 2010), teachers are often tasked with implementing universal school-based interventions (Reinke et al., 2011) because school psychologists typically have a very demanding workload and often report that they are overloaded with numerous roles (Suldo, Friedrich, & Michalowski, 2010). Reinke et al. (2011) suggest that school psychologists collaborate with teachers to help in identifying effective and evidence-based programs to implement in the classroom. Similarly, based on the review by Weare and Nind (2011), it has been recommended that interventions be

carried out by school personnel who have been clinically trained during the early process of implementing the intervention then transfer the lead to teachers to maintain the routine of the intervention in the school.

Teachers acknowledge that school psychologists have a limited time at each school and suggested the number of psychologists be increased to allow psychologists to offer a wider range of services (Watkins et al., 2001). The role of school psychologists clearly needs to become more comprehensive to better address students' mental health needs in the school. In an effort to understand the role and responsibilities of school psychologists in Nova Scotia, Corkum, French, and Dorey (2007) surveyed school psychologists about their practices and preferred roles; psychologists indicated their preference to increase the amount of time spent on counselling, preventative services, and consultation in addition to conducting comprehensive psychoeducational assessments. These findings indicated that school psychologists would like a more comprehensive role when practicing in the educational system to incorporate all the areas of competency in which they were trained. However, although school psychologists would like to expand their scope of practice in the schools and although they have training in a broad range of practice areas in addition to their training in assessment, they must often balance their competencies with the job requirements set out for them by the Nova Scotia Department of Education and Early Childhood Development.

School Psychology Guidelines from the Nova Scotia Department of Education and Early Childhood Development

According to the School Psychology Guidelines published by the Nova Scotia Department of Education and Early Childhood Development (2009), the roles and responsibilities of school psychologists include prevention, consultation, assessment,

intervention, professional development, and research. However, the guidelines highlight that the role of the school psychologist is to meet students' educational needs, potentially limiting the range of services school psychologists can offer to school-aged children and their families. The guidelines indicate that school psychologists should provide educational sessions about "school-related issues, such as behaviour management and parenting skills" (Nova Scotia Department of Education and Early Childhood Development, 2009, p. iv), without mentioning that school psychologists can offer a wider range of services (e.g., intervention) related to broader mental health issues. Furthermore, the guidelines mention that school psychologists may consult with mental health professionals, suggesting that school psychologists are viewed differently than psychologists working in other settings, despite the fact that they receive training in the areas of mental health and child psychopathology.

Since the school psychology guidelines by the Nova Scotia Department of Education and Early Childhood Development were released after the Corkum, French, and Dorey (2007) study, it is important to determine whether the service delivery model and the scope of practice for school psychologists have changed at all in the intervening years. This is necessary because changes and improvements need to be made to the amount of time school psychologists are spending in the various job aspects to offer students more comprehensive mental health services in schools.

CHAPTER TWO

TEN YEARS LATER: CURRENT PRACTICES AND PREFERRED ROLES OF SCHOOL PSYCHOLOGISTS IN NOVA SCOTIA

Psychological services are provided in many contexts and are not limited to schools, hospitals, universities, private practice, businesses, courts or social welfare agencies (Canadian Psychological Association, n.d.). As a result, psychologists can work in many different areas. Being a psychologist does not mean that one only engages in clinical work; some psychologists provide clinical services, whereas others focus on research and training in university settings, meaning that the job of a psychologist can vary widely depending on the context. One area of psychological practice that can result in varied job responsibilities is school psychology. School psychologists have core areas of competency in which they obtain extensive knowledge and demonstrate strong skills (NASP, 2000; The Psychological Association of Manitoba, n.d.). Those areas include assessment and evaluation, intervention and consultation, ethics and standards, research, interpersonal relationships and supervision (NASP, 2000; CPA, 2007). Psychologists working in schools are trained in assessment and diagnosis of mental health and cognitive difficulties (CPA, 2014) and typically provide services for a range of difficulties to ensure students' academic, social, emotional and behavioural success (NASP, 2010). School psychologists conduct interviews with guardians and teachers/school personnel and directly observe the student (Saklofske et al., 2007). They administer and interpret standardized tests, make appropriate diagnoses, and make recommendations for and/or provide evidence-based interventions to student (CPA, 2014; NASP, 2010; Saklofske et al., 2007). According to the School Psychology Guidelines Committee of the Nova Scotia Department of Education and Early Childhood Development (2009), school psychologists in Nova Scotia can develop

appropriate individualized program or education plans that adapt the curriculum for students with difficulties to allow them to thrive in the environment. School psychologists frequently consult and collaborate with parents, teachers, and other school personnel for the wellbeing of the student (NASP, 2010; CPA, 2007) by involving guardians and school personnel in the formation of recommendations for students as well as the implementation of the recommendations (CPA, 2007). They can also hold information sessions for school staff and/or guardians (School Psychology Guidelines Committee, 2009; CPA, 2007). Ysseldyke et al. (2006) outlined in the NASP *School Psychology: A Blueprint for Training and Practice III* that school psychologists are aware and are considerate of diversity by simplifying the language used with those who do not speak English well and respecting individuals from all socio-economic statuses (Ysseldyke et al., 2006). The Canadian Psychological Association (2000) also outlines guidelines for ethical practice, which school psychologists incorporate in their practice. School psychologists are trained to use evidence-based practices and to stay up-to-date with current findings (CPA, 2007). Because school psychologists interact with many individuals on daily basis, they typically have strong communication skills, are good listeners, and are empathetic during challenging circumstances (Ysseldyke et al., 2006). School psychologists also supervise students and/or psychological associates when entering the field (CPA, n.d.).

The field of school psychology has expanded over the last few decades in Nova Scotia. Specifically, there were 19 practicing school psychologists in 1983 (Thompson, 1983), 54 practicing school psychologists in 2002 (Corkum, French, & Dorey, 2007), and there are 128 psychologists currently registered with the Nova Scotia Board of Examiners (NSBEP) who declare competency in school psychology (King, McGonnell, & Noyes, 2016). School psychologists generally provide service to between four to seven schools, meaning that they

currently provide services to a large number of students. This has been a longstanding expectation of school psychologists in Nova Scotia. For example, in a 2001 paper outlining the practice of school psychology in the province of Nova Scotia, Hann noted that the majority of school psychologists provided services to 3000 or 4000 students, which was well above the ratio of one psychologist for every 1500 students suggested by the National Association of School Psychologists at the time.

NASP currently recommends that the school psychologist to student ratio be one school psychologist for every 500 – 700 students, without exceeding 1000 students, to ensure the provision of comprehensive and quality psychological services to students who require them (NASP, 2010; King et al., 2016). Furthermore, if a school psychologist is working with students with severe difficulties or mental health disorders, then it is recommended that the ratio of psychologists to students be reduced (NASP, 2010). Cimino (2007) found that school psychologists offer fewer mental health services to students as the ratio of psychologist to student increases, suggesting that quality of service is likely compromised when a psychologist provides services to more students. Reducing the psychologist-to-student ratio allows school psychologists to comply with their ethical responsibility to provide quality service to students (CPA, 2014).

The field of psychology in Canada is moving towards the doctoral degree as the minimum requirement for entry into the practice of psychology. In 2006, NSBEP stated their intention to move towards doctoral registration in the future (King, McGonnell, & Noyes, 2016). Then in 2011, NSBEP voted to begin the legislative process to amend the Psychologists Act to require a doctoral degree as the minimum standard to practice as a psychologist in Nova Scotia (King et al., 2016). The move towards doctoral registration will allow psychologists to become

registered across jurisdictions using a standardized process, as there is currently variability in the registration requirements across jurisdictions (CPA, 2011). This will allow the mobility of psychologists and will ensure that psychologists receive similar comprehensive training prior to registration (CPA, 2011). The move towards doctoral registration extends the training period prior to registration, which may allow a change in the perception of the role of school psychologist. However, it is important to not underestimate the training of school psychologists trained at the master's level, as they still need to meet the same registration set by NSBEP as clinical psychologists (King et al., 2016).

Surveying School Psychologists

Surveying school psychologists is a useful way to obtain information about the practice of school psychologists in the field and their preferred roles. This can assist in learning more about scope of practice across regions and also to note any changes or growth in the field. Indeed, previous studies have reported that school psychologists would like to expand their scope of practice (e.g., Corkum et al., 2007) and that the nature of the job can vary between regions (see the 2016 special issue of the Canadian Journal of School Psychology on school psychology in Canada). Researchers have surveyed school psychologists to learn about how they manage their work time. For example, Thompson (1983) surveyed school psychologists in Eastern Canada and found that they spent 27% of their time on assessments, 24% on consultation, 16% on intervention with children, 10% on report writing, and less than 10% on each of administrative work, travel time, classroom observations, and in-service.

More recently, Corkum et al. (2007) surveyed school psychologists in Nova Scotia to learn about their actual and preferred areas of practice. They found that school psychologists spent 50% of their time conducting psychoeducational assessments, followed by consultation

with school personnel, conducting behavioural assessments, and providing individual counselling (Corkum et al., 2007). Psychologists reported that they typically spend less than 25% of their time providing in-service sessions, engaging in consultation with mental health professionals, prevention, supervision, group counselling, and research (Corkum et al., 2007). With respect to preferred roles, psychologists indicated that psychoeducational assessment was their preferred role, but they would prefer to spend about 25% of their time, as opposed to 50%, in this role (Corkum et al., 2007). Further, respondents noted that they would like to spend more time engaging in activities such as consulting with school personnel, group counselling, individual counselling, conducting research, and spending significantly more time in prevention services (Corkum et al., 2007). However, they were satisfied with the amount of time spent on behavioural assessment, in-service, supervision, and consultation with mental health professionals (Corkum et al., 2007).

Despite the comprehensive training school psychologists receive, their practice and training vary. The school psychologist role has been primarily viewed as the “tester” rather than having a wide scope of practice that can include but is not limited to intervention, counselling, consultation, and assessment (Corkum et al., 2007). Although school psychologists noted that they would like to expand their scope of practice (Corkum et al. 2007), the current School Psychology Guidelines issued by the Nova Scotia Department of Education and Early Childhood Development indicate that school psychologists should focus on meeting students’ educational needs (School Psychology Guidelines Committee, 2009; King et al., 2016). Shifting the perception of the role of school psychologists away from the “tester” would be beneficial, as they receive comprehensive training in each of the core competency areas and could provide an expanded range of psychological services to schools. However, school psychologists’ role in the

school is somewhat limited by its focus on meeting educational outcomes. School psychologists are an underused resource at a time when there is a high demand for mental health services in schools; increasing their scope of practice and range of services could decrease the burden on both the education and health care systems (van den Heuvel, Barozzino, Milligan, Ford-Jones, & Freeman, 2016).

The Current Study

The purpose of this study is to extend the study conducted by Corkum et al. (2007) to examine the scope of school psychologists' practice in Nova Scotia and to determine the extent to which they practice across each of the core competency areas. Additionally, school psychologists were also asked to report on their current and preferred roles. Extending the study conducted by Corkum et al (2007) will provide useful information about changes in school psychology practice in Nova Scotia over the last 10 years. Given that mental health services are in demand and that there is currently a high ratio of students to school psychologists in Nova Scotia (King et al., 2016), it is important to gather updated data about psychologists' current and preferred roles to obtain concrete information about the field to potentially advocate for the provision of an expanded range of mental health services. This is necessary to maximize the services offered that benefit students. In addition, since the study conducted by Corkum et al. (2007) was published, the Student Services Division of the NS Department of Education and Early Childhood Development has released new guidelines for school psychologists indicating that focus of psychological services in schools is to be on meeting students' educational needs; therefore, it is important to gather current information about school psychology practice to determine whether school psychologists believe their roles to be limited.

Method

Participants

Eleven psychologists practicing in Nova Scotia with training in school psychology participated in this study. To be included in this study, participants were required to be primarily employed in a school setting. Two participants did not meet the inclusion criteria and were excluded from the data analysis. All participants who identified their gender on the survey were females, with an average age of 31.

Measures

A survey based on the survey used by Corkum et al. (2007) was developed (with permission from the first author) for the purposes of this study. This 65-question survey was designed to obtain information about school psychologists' practice in the core areas of competency, as well as their current practices and preferred roles. The survey used in this study consisted of three sections (see Appendix A).

Section 1 gathered demographic information such as age, highest degree obtained in psychology, current employment status, and the area of psychology in which participants were trained.

Section 2 gathered information about school psychologists' current practice across the six core competencies (i.e., assessment and evaluation; intervention and consultation; ethics and standards; research; interpersonal relationships; and supervision) by responding to multiple choice questions and by using a Likert scale.

Section 3 of the survey asked psychologists to approximate the percentage of time they spend on specific activities in each academic year and to indicate their preferred percentage of time they would like to devote to each area of practice. At the end of each topic and section of

the survey, participants were given the chance to indicate further information they would like to provide through an open-ended question.

Procedure

Ethics clearance was received from Mount Saint Vincent's University Research Ethics Board prior to beginning the study. Members of the Child and Adolescent Psychology Interest Group (CAP-I) received an e-mail (see Appendix B) containing information about the purpose of the study and the link to the survey on LimeSurvey. Participants were required to click on the link to be directed to the survey. Once participants were directed to the survey, they were presented with the consent form (see Appendix C) on which they indicated consent by clicking a 'consent' button prior to beginning the survey. The survey took approximately 20 minutes to complete. Participants were also given the chance to enter their contact information to be entered in a draw to win one of three gift cards to a local book store.

Results

Data Analysis

Data were extracted from LimeSurvey and entered into SPSS. Descriptive statistics were computed for the demographic data, time spent in each competency area, and to determine the actual and preferred percentage of time school psychologists engage in each area of practice.

Participants' Demographic Information

All participants ($N = 9$) were trained in school psychology. Most participants ($N = 8$) were trained at the Masters level, with one participant indicating a Bachelor's degree as their highest level of education. Seventy-eight percent of participants ($N = 7$) were registered with NSBEP. As for the type of registration, 29% ($N = 2$) were registered psychologists and 71% ($N = 5$) were on the Candidate Register. Sixty-Seven percent of participants ($N = 6$) practiced in both

urban and rural settings, whereas 11% (*N* = 1) practiced only in an urban setting and 22% (*N* = 2) practiced only in a rural setting. Participants were employed in the Halifax Regional School Board, Chignecto-Central Regional School Board, Cape Breton-Victoria Regional School Board, and Anglophone South School District in New Brunswick. Forty-four percent of participants (*N* = 4) indicated that they worked at private practice in addition to their work in the schools, one participant reported that she worked in a community mental health centre, and one participant was a behaviour specialist. No participants worked in other settings (e.g., hospital).

This sample of school psychologists had been practicing for an average of 4.6 years (range = 1-17 years). They typically serviced between four and eight schools (*M* = 6.13, *SD* = 1.46) with 1000 – 3100 students enrolled (*M* = 2100, *SD* = 609.45). School psychologists typically provided services to 35-90 students (*M* = 62.56, *SD* = 19.84) in an academic year.

School Psychologists' Practice in Core Competencies

Assessment and evaluation. All participants reported that they conduct psychoeducational and behaviour assessments. Number of assessments conducted per year was highly variable, with participants reporting a range of 2-70 assessments per academic year (*M* = 42.22, *SD* = 19.60). There are many components to psychoeducational and behaviour assessments, such as - but not limited to - classroom observations, cumulative file review, interviews, consultation, and feedback meetings. Participants reported that they incorporate all components when conducting an assessment but to a varying degree (see Table 1 and Table 2). Academic difficulties were rated as the most common difficulty resulting in a referral for assessment by 77.8% (*N* = 7) of participants, followed by behaviour difficulties (55.6%, *N* = 5), attention difficulties (55.6%, *N* = 5), mood and anxiety (77.8%, *N* = 7), and selective mutism (77.8%, *N* = 7). With respect to providing diagnoses resulting from assessment, learning

disabilities were rated as the most common by 88.9% of participants (*N* = 8) and ADHD by 11.6% (*N* = 1). One participant indicated that she sees "ADHD, anxiety, ODD, CD in schools but [does not] diagnose."

With respect to the types of cognitive measures used as part of a psychoeducational assessment, the majority of participants (88%, *N* = 8) reported using the Wechsler Intelligence Scale for Children – Fourth or Fifth Edition (WISC-IV or WISC-V). Several participants (55.6%, *N* = 5) reported that they also use the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV) and the Comprehensive Test of Phonological Processing – Second Edition (CTOPP2), whereas 22.2% (*N* = 2) reported that they use the Woodcock Johnson Test of Cognitive Ability – Fourth Edition to assess cognitive functioning.

With respect to academic functioning measures, the majority of participants (88.9%, *N* = 8) reported using the Wechsler Individual Achievement Test – Third Edition (WIAT-III), whereas 11.1% (*N* = 1) reported using the Test of Written Language (TOWL) and the Woodcock Johnson IV Test of Achievement.

As for memory measures, most participants (77.7%, *N* = 7) reported using the Wide Range Assessment of Memory and Learning (WRAML), whereas 11.1 % (*N* = 1) of participants reported using the Children's Memory Scale (CMS). Participants were provided space to identify other measures they may use, one participant identified using the Test of Memory and Learning (TOMAL) as a measure for memory.

With respect to fine-motor ability/visual motor integration measures, all participants (100%, *N* = 9) reported using the Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI), whereas 11.1% (*N* = 1) use the Test of Visual-Motor Skills (TVMS 3) and the Bender Gestalt Test.

With respect to checklists or rating scales typically used to assess behaviour, all participants (100%, $N = 9$) use the Behaviour Rating Inventory of Executive Function (BRIEF) and the Behaviour Assessment System for Children (BASC). Several participants (88.9%, $N = 8$) reported using the Adaptive Behaviour Assessment System (ABAS), whereas 66.7% ($N = 6$) reported using the Conners Comprehensive Behaviour Rating Scales (CBRS), and 11.1% reported using the Child Behaviour Checklist (CBCL), Youth Self-Report (YSR), and the Teacher Report Form (TRF). In the space provided for participants to identify other measures they typically use, the Conners 3 was identified.

Intervention and consultation. Sixty-six percent ($N = 6$) of participants reported that they provide academic interventions and individual counselling, 88.9% ($N = 8$) provide group counselling, and all participants ($N = 9$) reported that they provide behaviour interventions. With respect to the focus of intervention, 66% of participants ($N = 6$) indicated that they provide interventions for academic skills, social skills, and self-regulation difficulties; 77.8% ($N = 7$) reported that they provide interventions for socioemotional difficulties and mental health difficulties, and 88.9% ($N = 8$) indicated that they provide interventions for behaviour difficulties. Participants reported that they provide interventions to between 6 – 45 students in an academic year ($M = 24.50$, $SD = 13.28$), with 2 – 25 students ($M = 11.68$, $SD = 9.19$) receiving individual interventions and 4 – 20 students ($M = 10.00$, $SD = 5.26$) receiving group interventions.

When making recommendations, all participants ($N = 9$) indicated that they consult with teachers/school personnel, 66.7% ($N = 6$) reported that they research strategies and resources, and 55.6% ($N = 5$) reported that they consider the parent's input. In the space provided to include additional considerations when writing recommendations, participants identified "consultation

with other psychologists” and “based on experience and knowledge of classroom and academic expectations”.

Ethics and standards. Seventy-seven percent (*N* = 7) of participants reported having experienced an ethical dilemma, 11.1 % (*N* = 1) did not experience an ethical dilemma, and 11.1% (*N* = 1) were not sure if they had experienced an ethical dilemma. Twenty-two (*N* = 2) percent identified that the ethical dilemma was related to maintaining confidentiality and conflict between employment demands and the code of ethics, whereas 33.3% (*N* = 3) identified that it was related to conflict between work policy and the code of ethics. In the space provided for participants to identify or elaborate on the ethical dilemma, one participant included consent and another participant indicated that “one of the most common ethical dilemmas/issues that arise in the workplace is the challenge of abiding by policy and following directives from supervisors that are not bound by the CPA code of ethics, nor are they necessarily informed or knowledgeable about such requirements. At times, this makes for some challenging conversations or situations”.

When asked how participants managed the ethical dilemma, 66.7% (*N* = 6) sought supervision from the NSBEP supervisor and sought supervision from workplace supervisor or senior colleagues; 55.6% (*N* = 5) consulted with peers; and 44.4% (*N* = 4) used the ethical decision making model to guide the decision.

Sixty-six percent of participants (*N* = 6) identified that one of the most common areas of conflict between the CPA code of ethics and the school board policy is that there are differences in the scope of practice outlined in the school board policy and by NSBEP. In addition, 33.3% of participants (*N* = 3) indicated that maintaining confidentiality was another common area of conflict between the CPA code of ethics and the school board policy.

Research. One participant reported conducting independent research. To stay up to date, all participants (100%, $N = 9$) reported that they attend workshops/professional development sessions, 66.7% ($N = 6$) reported that they set aside time to read published research and engage in formal/informal consultation, 88.9% ($N = 8$) reported that they attend conferences, and 77.8% ($N = 7$) indicated that they engage in informal discussion with colleagues.

Fifty-five percent of participants ($N = 5$) indicated that they present/incorporate current findings into their practice. Only five participants identified the most commonly discussed topics. Those participants indicated that mood, eating disorders, substance use, sleep, resiliency in students, and managing problem behaviour are most commonly discussed topics. Eighty percent of respondents ($N = 4$) indicated anxiety; 60% ($N = 3$) indicated ADHD and specific learning disorder/learning disability; 40% ($N = 2$) indicated trauma; and 20% ($N = 1$) indicated intellectual disability.

Interpersonal relationships. Participants were asked about challenges in building and maintaining rapport with parents/caregivers. Eighty-eight percent ($N = 8$) identified getting in touch with parents/caregivers as a common challenge. Several participants (55.6%, $N = 5$) identified that scheduling time to meet with parents/caregivers, parents/caregivers had difficulty understanding/responding to their child's needs, as well as misconceptions about psychology and/or psychologists were challenging in building rapport. Some participants (33.3%, $N = 3$) identified that parents/caregivers were reluctant to consent to a specialist referral to consult about the child's difficulties as another barrier to building and maintaining rapport with parents/caregivers.

Eighty-eight percent ($N = 8$) reported that they have had the opportunity to work with diverse students; however, all participants indicated race and socio-economic status as areas of

diversity they have encountered. Furthermore, 88.9% ($N = 8$) indicated ethnicity, 66.7% ($N = 6$) indicated gender, 44.4% ($N = 4$) indicated sexual orientation, 33.3% ($N = 3$) indicated physical abilities, and 22.2% ($N = 2$) indicated religious beliefs as types of diversity they have encountered. Participants identified challenges when working with diverse groups of students. For example, finding standardized assessment measures to use with Syrian refugees or First Nations students, meeting the high demand of students from low socioeconomic status, being aware of typical behaviours in different cultures, and "keeping an open mind to those who share very different beliefs or lead much different lives".

Participants often involve other professionals when conducting an assessment or intervention. Participants indicated that they were most likely to involve teachers, followed by principal or vice-principal, speech language pathologist, social worker, other psychologists, occupational therapists, physicians, and educational assistants. In the space provided for participants to indicate other professionals they may involve in their practice, one participant included the EAL support worker. Participants identified challenges encountered when working with other professionals in the school setting that included finding time to meet and consult, professionals being present at different times in the schools due to space issues, "lack of understanding of mental health", "[l]ack of respect for the profession", "educating others about the contributions a school psychologist can offer to help students thrive in school", and having different "opinions on the same topic/student or situation".

Supervision. One participant received formal training in supervision, which included workshops, coursework, and training during internship. Eighty-eight percent of participants ($N = 8$) did not receive formal training in supervision.

No participants had supervised practicum students in the last five years. Only one participant had supervised an internship student in the last five years and a candidate register psychologist in the last five years.

Many participants did not respond to the questions related to supervision; however, the two participants who responded to the question related to the benefits of supervising an intern and/or candidate register psychologist identified that it allows the psychologist to stay up-to-date with current trends in research and teaching (i.e., by hearing about what the student recently learned in his or her training program), allows the psychologist to give back to the profession, and that it is rewarding to see growth in student and/or candidate register psychologist. Fifty percent of respondents (*N* = 1) identified that it allows the psychologist to reflect on his or her own practice practices.

Thirty-three percent (*N* = 3) responded to a question regarding the barriers to supervising an intern. All respondents (100%) identified the time commitment (e.g., long supervision period); 66.7% (*N* = 2) identified the workload during the day (e.g., organizing a busy schedule around student needs), workload after school hours (e.g., checking student work and providing feedback), and being unsure about the student's competency; 33.3% (*N* = 1) identified taking responsibility for student's work (e.g., signing off on reports) as barriers to supervising an intern. None of the respondents identified being uncomfortable with a student shadowing them as a barrier to supervising an intern.

Thirty-three percent (*N* = 3) responded to a question regarding the barriers to supervising a candidate register psychologist. All respondents (100%) identified extra workload of providing supervision and time commitment to be barriers to supervising a candidate register psychologist,

with 33.3% (N = 1) identifying perceived responsibility for the candidate's clinical practice as a barrier.

Current Practices and Preferred Roles

The participant in the behaviour specialist role was excluded from this analysis, as it does not reflect the typical school psychologist role in the schools.

Current practices. Participants spend the majority of their time conducting psychoeducational assessments (See Table 3), followed by behaviour assessment, and feedback meetings, which are activities that are also part of the core competency assessment and evaluation. The next largest amount of time spent on an activity is for consultation with school personnel followed by consultation with parents/caregivers, which are activities part of the intervention and consultation core competency. Participants currently spend limited time on research as well as supervision.

Preferred roles. Participants would prefer to spend the largest, but a reduced, portion of their time on psychoeducational assessments as well as reduce the time spent on feedback meetings. On the other hand, participants reported that they would prefer to increase the time spent on individual and group interventions such as counselling, consultation with school personnel, consultation with other school psychologists, engaging in consultation to prevent problem behaviours, and pre-referral case consults. Participants also indicated that they would prefer to spend more time on research, attending professional development sessions, and supervising students.

Discussion

This study surveyed school psychologists in Nova Scotia to examine their scope of practice with respect to the core competencies put forth by the Canadian Psychological

Association and to determine their actual and preferred roles in schools. Results indicated that school psychologists in Nova Scotia do not spend an equal proportion of time practicing across the core competencies. Similar to the findings of Corkum and colleagues (2007), the majority of school psychologists' time is spent conducting psychoeducational assessments. School psychologists continue to prefer this as their primary role, but indicate a preference for decreasing the percentage of time spent in this area of practice. School psychologists would like to slightly increase the percentage of time spent on behaviour assessments but indicated that the number of behaviour assessments completed makes it difficult to provide follow-up and monitor students' progress. This suggests that the high number of assessments conducted each year may be compromising psychologists' ability to offer comprehensive assessments. For example, one participant indicated that to provide comprehensive and quality services and interventions, the number of psychoeducational assessments needs to be reduced, as the current demand for psychoeducational assessments makes it difficult to offer diverse services.

School psychologists indicated that they prefer to spend more time on interventions and consultation such as providing counselling at an individual and at a group level as well as consultation with school personnel, other psychologists, other school psychologists, and other disciplines; however, "[d]ue to the high number of referrals for assessment, caseload demands, and the number of schools psychologists are required to service, it is often challenging to provide comprehensive, consistent, and efficient interventions directly to students". This indicates that emphasis on psychoeducational assessments compromises other services that could be offered by school psychologists at the schools.

The absence of a comprehensive role and being overloaded with work limits school psychologists' ability to supervise interns and candidate register psychologists. School

psychologists spent a limited time on supervision 10 years ago when Corkum and colleagues (2007) conducted their study and this continues to be the case. In this study, school psychologists identified the workload and the time commitment as barriers to supervision. Corkum et al. (2007) also found that school psychologists spent a small portion of their time providing information sessions (in-servicing) and on research. The practice of school psychology continues to be limited in these areas, with some school psychologists indicating that they are not given the opportunity to provide information sessions for school staff and parents/caregivers, an indication that school psychologists do not engage in all of the roles outlined by the Department of Education and Early Childhood Development for school psychology practice in Nova Scotia. School psychologists indicated that they would prefer to increase the time spent delivering professional development sessions, attending professional development sessions, and on research in general. Given that school psychologists are expected to stay up to date to provide the most relevant interventions, it is important to provide them with the opportunity to attend professional development sessions and share their knowledge and current findings with school personnel and parents/caregivers.

School psychologists indicated experiencing ethical dilemmas in their practice, as the employment demands and work policy conflict with the guidelines of ethical practice outlined by the Canadian Code of Ethics (2000). For example, despite the training in assessment and diagnoses of mental health and cognitive difficulties school psychologists receive (CPA, 2014), participants indicated that they do not provide many diagnoses, with one participant stating that school psychologists are “strongly discouraged (nearly prohibited) from diagnosing ADHD, despite NSBEP’s backing that school [psychologists] are more than qualified to do so”. Another school psychologist indicated that the “school board wants things done fast, NSBEP wants things

done right". This is problematic because, according to the CPA code of ethics (2000), it is psychologists' ethical responsibility to provide quality services to students. Although not stated directly by participants under ethics and standards, school psychologists indicated that the quality of services they provide is compromised because they have a high number of caseload and assessments. Most school psychologists in this sample exceed the recommended school psychologist to student ratio of one school psychologist for every 1000 students recommended by NASP (2010) and this is also the case with many school boards across Nova Scotia as indicated by King and colleagues (2016).

Implications for School Psychology Practice

The results of this study suggest that school psychologists are overloaded with high caseloads, which prevents them from engaging in a comprehensive role as set by the Canadian Psychological Association (2014). School psychologists indicated their preference for a more comprehensive role and for having a wider scope of practice. The absence of a comprehensive role limits school psychologists' ability to supervise interns and candidate register psychologists as they identified the workload to be a barrier to supervision. School psychologists have an ethical responsibility to provide quality services to students; however, when school psychologists are overloaded with a high caseload, they indicated that it limits their ability to provide comprehensive services to students, limiting the mental health support students receive. Furthermore, teachers have previously noted that they would like school psychologists to be more present at school and to offer comprehensive services (Watkins, Crosby, & Pearson, 2001). In addition, there is a high demand for mental health services and long waitlists to access mental health services outside the schools (Reid & Brown, 2008); therefore, it is essential that the

service delivery model of school psychologists be revised to meet students' mental health needs in the schools.

Recommendations for school psychology in Nova Scotia.

School psychologists would benefit from advocating for the profession and informing school personnel and administrators about the different services they offer to help in changing the perception of the role of school psychologists. This can also inform school personnel and administrators of the valuable services that school psychologists can offer in addition to assessments. Furthermore, psychological associations such as Association of Psychologists of Nova Scotia (APNS) can support school psychologists (Hann, 2001) by advocating for a comprehensive role in the schools. Training programs can focus their training on the assessment measures school psychologists use in practice and ensure that prospective school psychologists are prepared to provide interventions for the most common difficulties (Corkum et al., 2007) as well as the topics most commonly discussed in addition to their training in the core competencies.

Limitations

The survey was sent to members of the Child and Adolescent Psychology Interest Group (CAP-I), which may have limited the number of school psychologists who received the survey. In the future, the survey could be sent to all school psychologists practicing in Nova Scotia through the Association of Psychologists of Nova Scotia (APNS) or through the Clinical Service Directors at all school boards across the province. Furthermore, the sample size of this study was small. The sample also did not include participants from all school boards across Nova Scotia; therefore, the results may not be generalizable to the practice of school psychology in Nova Scotia.

Future Research Directions

Future research can include more participants in their sample so that the results are more representative of the practice of school psychologists. In addition, future research can extend this study by comparing the practice of school psychology across Canada to compile the most comprehensive service delivery model that is inclusive of the core competencies and that allows school psychologists to deliver quality services to students. In the future, this study could also be extended and replicated after doctoral registration becomes the minimum requirement to learn about changes in the field.

Conclusion

School psychologists continue to lack a comprehensive role that allows them to fully engage in all areas of competency in their practice in school or engage in all the roles outlined by the Department of Education and Early Childhood Development for school psychology practice in Nova Scotia and are restricted to practice as allowed by NSBEP. School psychologists spend a large portion of their time on the core competency assessment and evaluation compared to the percentage of time spent on intervention and consultation. They also spend a minimal percentage of time on research as well as supervision. School psychologists prefer to change their current service delivery model to a more balanced and comprehensive role that allows them to offer diverse services to students. The Canadian Psychological Association (2014) underscores using all the services school psychologists can offer and highlights that psychoeducational assessments are an important but not the only aspect of the job. To obtain a balanced and comprehensive role, the school psychologist to student ratio needs to be reduced and the demands placed on school psychologists need to change by altering the perception of the role of school psychologists from primarily being a “tester” to a professional who is trained and capable of providing many

services that address students’ mental health, academic, social, emotional, and behavioural areas of functioning. Perhaps a change in the perception of the role of school psychologists can be initiated as doctoral-level training becomes the minimum requirement to enter the field without undermining the qualifications of school psychologist trained at the master’s level (King et al., 2016).

Table 1

Percentage of Participants including Psychoeducational Assessment Components

Activity	Participant's frequency of inclusion				
	Always (100%)	Usually (75-99%)	Sometimes (25-75%)	Rarely (1-24%)	Never (0%)
Classroom observations		55.6 (5)	22.2 (2)	22.2 (2)	
Cumulative record review	100 (9)				
Parent interview	66.7 (6)	22.2 (2)	11.1 (1)		
Teacher interview	55.6 (5)	44.4 (4)			
Student interview	66.7 (6)	22.2 (2)	11.1 (1)		
Individual standardized testing	100 (9)				
Consultation with school personnel	66.7 (6)	22.2 (2)	11.1 (1)		
Feedback meeting with school team	100 (9)				
Feedback meeting with parents/guardians	66.7 (6)	33.3 (3)			
Feedback meeting with student		44.4 (4)	44.4 (4)	11.1 (1)	
Follow-up		11.1 (1)	55.6 (5)	33.3 (3)	

Table 2

Percentage of Participants Including Behaviour Assessment Components

	Participant's frequency of inclusion				
Activity	Always (100%)	Usually (75-99%)	Sometimes (25-75%)	Rarely (1-24%)	Never (0%)
Formal observations (using a structured form)	11.1 (1)	22.2 (2)	33.3 (3)	33.3 (3)	
Informal Observations	66.7 (6)	33.3 (3)			
Observation in multiple settings	55.6 (5)	33.3 (3)	11.1 (1)		
Cumulative record review	77.8 (7)	11.1 (1)	11.1 (1)		
Parent interview	33.3 (3)	44.4 (4)	22.2 (2)		
Teacher interview	66.7 (6)	22.2 (2)		11.1 (1)	
Student interview	22.2 (2)	44.4 (4)	22.2 (2)	11.1 (1)	
Consultation with school personnel	77.8 (7)	22.2 (2)			
Feedback meeting with School team	77.8 (7)	11.1 (1)	11.1 (1)		
Feedback meeting with parents	33.3 (3)	55.6 (5)	11.1 (1)		
Feedback meeting with student	11.1 (1)	11.1 (1)	44.4 (4)	33.3 (3)	
Follow-up	33.3 (3)	33.3 (3)	33.3 (3)		

Table 3

Average and Standard Deviation of the Percentage of Time of School Psychologists' Current Practices and Preferred Roles

Category/ Activity	Approximate Percentage of Time Spend Annually	Preferred Percentage of Time Spent Annually
Psycho-educational Assessment	54.29 (28.05)	36.67 (31.09)
Behavioral Assessment	8.83 (6.94)	9.00 (4.18)
Threat Assessment	.00 (.00)	5.00 (1.38)
Intervention/Counselling (Individual)	5.44 (8.51)	7.92 (4.59)
Intervention/Counselling (Group)	4.00 (4.21)	10.83 (7.36)
Consultation with parents/caregivers	6.57 (4.54)	6.42 (5.20)
Consultation with school personnel	7.63 (7.42)	9.33 (8.41)
Consultation with other school psychologists	4.63 (2.83)	8.50 (6.59)
Consultation with other psychologists	.79 (.91)	3.38 (1.97)
Consultation with other disciplines (SLP, OT, PT, other)	2.86 (2.04)	5.70 (5.47)
Involved in multi-systems meetings	5.58 (6.25)	4.79 (2.79)
Engaging in consultation to prevent problem behaviours	4.33 (3.56)	7.25 (5.33)
Feedback meeting	8.08 (8.83)	7.25 (8.85)
Pre-referral case consults	3.50 (3.38)	5.50 (4.48)
Research	2.00 (2.74)	3.50 (4.18)
Providing professional development sessions	.36 (.75)	1.83 (2.48)
Attending professional development sessions	2.58 (2.06)	5.00 (2.76)
Program Planning for students	3.00 (2.00)	5.20 (3.19)
Student Supervision	.00 (.00)	.20 (.45)
Travel time	2.80 (2.17)	1.70 (2.11)

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Appendix A

Survey for Psychologists in Nova Scotia

The purpose of this survey is to learn about the amount of time school psychologists spend in each of the core competencies when practicing.

Demographic Information

Please indicate your age: ________

Do you identify as:

___Male

___Female

___Other

___Prefer not to say

Highest degree obtained in psychology:

___MA

___MSc

___PhD

___PsyD

___Other: ___________

In what area of psychology did your training focus?

____School psychology

____Clinical psychology

____Counselling psychology ____

____Clinical Neuropsychology

____Other (please specify):_______

In which type of community do you practice?

___ Urban

___ Rural

___ Both

Where do you currently work? (Check all that apply.)

___ Private Practice

___ School Board

___ Hospital

___ Community mental health centre

___Other (Please specify): ____________________________

If you work in a school board, for which school board do you currently work?

___ Annapolis Valley Regional

___ Cape Breton-Victoria Regional

___ Chignecto-Central Regional

___ Conseil Scolaire Acadien Provincial

___ Halifax Regional

___ Tri-County Regional School Board

___ South Shore Regional School Board

___ Strait Regional School Board

___ Prefer not to say

___ Other _______________

Are you currently registered with the Nova Scotia Board of Examiners in Psychology?

____Yes

____No

If yes, please specify current registration:

___ Registered Psychologist

___ Psychologist (Candidate Register)

___ Other (please specify): ____________

How many years have you been registered with the Nova Scotia Board of Examiners in Psychology (including the time on the candidate register)? ____________

How many years have you been working as a school psychologist? __________

To how many schools do you provide services? __________

Approximately how many students in total are enrolled in the schools in your circuit?

____

Approximately how many students do you provide services to in an academic year? __________

Approximately how many psychoeducational assessments do you conduct in an academic year?

____

Please consider your practice in the schools when responding to the following items (i.e., please do not provide information about the work you do in other settings, such as private practice).

Competency 1: Assessment and Evaluation

Do you conduct psycho-educational assessments?

____ Yes

____ No

If you conduct psychoeducational assessments, please respond to the following.

What components do you include when conducting a psycho-educational assessment and how often do you include them?

Activity	Frequency of Inclusion				
	Always (100%)	Usually (75-99%)	Sometimes (25-75%)	Rarely (1-24%)	Never (0%)
Classroom observations					
Cumulative record review					
Parent interview					
Teacher interview					
Student interview					
Individual standardized testing					
Consultation with school personnel					
Feedback meeting with school team					
Feedback meeting with parents/guardians					
Feedback meeting with student					
Follow-up					
Other: ___________					

Would you like to add any comments about your responses to the items above?

Do you conduct behaviour assessments (e.g., functional behavior assessments) for behaviour problems?

_____Yes

_____No

If you conduct behaviour assessments, please respond to the following.

What components do you include when conducting a behavioural assessment and how often do you include them?

Activity	Frequency of Inclusion				
	Always (100%)	Usually (75-99%)	Sometimes (25-75%)	Rarely (1-24%)	Never (0%)
Formal observations (using a structured form)					
Informal Observations					
Observation in multiple settings					
Cumulative record review					
Parent interview					
Teacher interview					
Student interview					
Consultation with school personnel					
Feedback meeting with School team					
Feedback meeting with parents					
Feedback meeting with student					
Follow-up					

Other: ___________					

Would you like to include any comments about your responses to the items above?

What are the most common difficulties that result in children being referred to you? (Please rank from most to least common, with 1 being most common.)

____Academic difficulties

____Behavioural difficulties

____ Selective Mutism

____Attention difficulties

____Other: __________

What are the most common diagnoses you provide? (Please rank from most to least common, with 1 indicating most common).

____ Learning Disability

____Attention Deficit Hyperactivity Disorder

____Intellectual Disability

____Oppositional Defiant Disorder

____Conduct Disorder

____ Anxiety Disorders

____ Other: __________

What measure(s) do you typically use to assess cognitive/intellectual functioning? (Check all that apply)

____WISC-V or WISC-IV

____W AIS-IV

____WPPSI-IV

____Standford-Binet-V

____ Comprehensive Test of Phonological Processing (CTOPP)-2

____Woodcock Johnson Test of Cognitive Abilities-IV

____Other: __________

____I do not assess cognitive/intellectual functioning

What measure(s) do you typically use to assess academic functioning? (Check all that apply)

______ Wechsler Individual Achievement Test (WIAT-III)

______ Wide Range Achievement Test (WRAT)

______ Test of Written Language (TOWL)

______Woodcock Johnson IV Test of Achievement

______ Other: ___________

______ I do not assess academic functioning

What measure(s) do you typically use to assess memory? (Check all that apply)

______Children's Memory Scale (CMS)

______Wide Range Assessment of Memory and Learning (WRAML)

______Wechsler Memory Scale (WMS)

______Other: _________

______ I do not assess memory

What measure(s) do you typically use to assess fine-motor ability/visual motor integration? (Check all that apply)

_____Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI)

_____Test of Visual-Motor Skills (TVMS-3)

_____ Bender Gestalt Test

_____ Other: _________

_____ I do not assess motor ability

What checklist or rating scales do you typically use to assess behaviour? (Check all that apply)

______Conners Comprehensive Behaviour Rating Scales (CBRS)

______ Adaptive Behaviour Assessment System (ABAS)

______Behaviour Rating Inventory of Executive Function (BRIEF)

______Behaviour Assessment System for Children (BASC)

______Child Behaviour Checklist (CBCL)

______ Youth Self-Report (YSR)

______ Teacher Report Form (TRF)

______ Other: ___________

_______I do not use rating scales

Would you like to include any comments about your responses to the items above?

Competency 2: Intervention and Consultation

What intervention services do you provide to students? (check all that apply)

______ Academic interventions

_______Group counselling

_______Individual counselling

_______Behaviour interventions

_______Other: _________

_______I do not provide intervention

What is your process when writing recommendations? (Check all that apply)

_____Considering parent's input

_____Consulting with teachers/school personnel

_____Researching strategies/resources

_____Other (please specify): ________

For what types of difficulties do you provide intervention? (check all that apply)

_______ Academic difficulties

_______ Socioemotional difficulties

_______ Behaviour difficulties

_______ Social skills difficulties

_______ Self-regulation difficulties

_______ Mental health difficulties (e.g., anxiety, depression, trauma)

_______ Other: __________

_______ Do not provide

Approximately how many students do you provide interventions to in an academic year?
____

Approximately how many students do you provide individual intervention to in an academic year? _______________

Approximately how many students do you provide group intervention to in an academic year?
____

Would you like to include any comments about your responses to the items above?

Competency 3: Ethics and Standards

Have you ever experienced (an) ethical dilemma(s) in your work as a school psychologist?

____Yes

____No

____Not Sure

If yes, did this dilemma relate to (check all that apply)

____Maintaining Confidentiality

____Conflict between work policy and the code of ethics

____Conflict between employment demands and the code of ethics

____Other (please specify if you feel comfortable doing so): ___________

If you responded yes to the above question, how did you manage the dilemma? (check all that apply)

_____Sought supervision from NSBEP supervisor

_____Sought supervision from workplace supervisor or senior colleagues

_____Sought consultation with peers

_____Used the ethical decision making model to guide the decision

_____Other: ___________

In your experience, where are the most common areas of conflict between the CPA code and school board policy? (Check all that apply)

_____Maintaining confidentiality

_____Differences in scope of practice outlined in school board policy and by NSBEP

_____Other: ________

Would you like to include any comments about your responses to the items above?

Competency 4: Research:

Are you currently conducting independent research?

___Yes

___No

Are you currently assisting a researcher conduct research (i.e., data collection in school)?

___Yes

___No

What do you do to keep up with research in the field? (Check all that apply)

_____Set aside time to read published research

_____Attend conferences

_____Attend a journal club

_____Engage in informal discussion with colleagues

_____Formal/informal consultation

_____Attend workshops/Professional Development sessions

_____ Other: __________

Do you present/incorporate current findings in psychology research in talks/presentations to school personnel and/or parents? (e.g., by facilitating workshops or information sessions or consulting about research findings)

____Yes

____No

If yes, what topics do you most commonly discuss? (Check all that apply)

____Anxiety

____Attention deficit/Hyperactivity Disorder

____Specific Learning Disorder/Learning Disability

____Intellectual Disabilities

____Mood

____Eating Disorders

____Substance use

____Sleep

____Trauma

____Resiliency in students

____Managing problem behaviour

____Other: _________

Would you like to include any comments about your responses to the items above?

Competency 5: Interpersonal Relationships

What are some challenges in building and maintaining rapport with parents/caregivers?

______Scheduling time to meet with parents/caregivers

______Getting in touch with parents/caregivers

______Parents/caregivers have difficulty understanding/responding to their child's needs

______Parents/caregivers reluctant to consent to a specialist referral to consult about the child's difficulties

______Misconceptions about psychology and/or psychologists

______Other: _____________

Do you have the opportunity to work with diverse groups of students?

_____Yes

_____No

What types of diversity have you seen in your practice? (Check all that apply)

______Race

______Ethnicity

______Gender

______Sexual Orientation

______Socio-economic status

______Physical Abilities

______Religious beliefs

In your experience, what challenges have you encountered when working with diverse groups of students? ________

Which other professionals are you most likely to involve in assessment and/or intervention? (please rank from most to least common).

___ Principal or Vice-principal

___Social worker

___Guidance counsellor

___Speech language pathologist

___Teachers

___Educational assistants

___Physicians

___Other psychologists

___Occupational therapist

___Other: _________

In your experience, what challenges have you encountered when working with other professionals in the school setting? ______________

Would you like to include any comments about your responses to the items above?

Supervision:

How many practicum students have you supervised in the last five years? _______________

How many internship students have you supervised in the last five years? ________

How many candidate register psychologists have you supervised in the last 5 years? __________

Have you received formal training in supervision?

_____Yes
_____No

_____Other: ________

If yes, what type of training have you received?

________Workshops

________Coursework

________Training during internship

________Other: ___________

In your experience, what are some benefits to supervising an intern student and/or a candidate register psychologist?

______Allows the psychologist to stay up-to-date with current trends in research and teaching (i.e., by hearing about what the student recently learned in his or her training program)

______Allows the psychologist to reflect on his or her own practice practices

______Allows the psychologist to give back to the profession.

______It is rewarding to see growth in student and/or candidate register psychologist

______Other: ________

In your experience, what are some barriers to supervising an intern?

______Workload during the workday (e.g., organizing a busy schedule around student needs)

______Workload after school hours (e.g., checking student work and providing feedback)

______Uncomfortable with student shadowing you

______Time commitment (e.g., long supervision period)

______Being unsure about a student's competency

______Taking responsibility for the student's work (e.g., signing off on reports)

______Other: ________

In your experience, what are some barriers to supervising a candidate register psychologist?

______Extra workload of providing supervision

______Time commitment

______Scheduling difficulty

______Perceived responsibility for the candidate's clinical practice

______Other: _______

Would you like to include any comments about your responses to the items above?

CURRENT PRACTICES

Please indicate the approximate percentage of time you spend in the following areas of practice on an annual basis. Then please indicate the percentage of time you would PREFER to practice in the following areas.

Category/ Activity	Approximate Percentage of Time Spend Annually	Preferred Percentage of Time Spent Annually
Psycho-educational Assessment	________	________
Behavioral Assessment	________	________
Threat Assessment	________	________
Intervention/Counselling (Individual)	________	________
Intervention/Counselling (Group)	________	________
Consultation with parents/caregivers	________	________
Consultation with school personnel	________	________
Consultation with other school psychologists	________	________
Consultation with other psychologists	________	________
Consultation with other disciplines (SLP, OT, PT, other)	________	________
Involved in multi-systems meetings	________	________
Engaging in consultation to prevent problem behaviours	________	________
Feedback meeting	________	________
Pre-referral case consults	________	________
Research	________	________
Providing professional development sessions	________	________
Attending professional development sessions	________	________
Program Planning for students	________	________
Student Supervision	________	________
Travel time	________	________
Other (Please Specify):	________	________

Would you like to include any comments about your responses to the items above?

Appendix B

Email to participants

Hello,

My name is Mirna Khalil. I am a graduate student in the School Psychology program at Mount Saint Vincent University. I am conducting a research study to fulfill my thesis requirement as part of the program under the supervision of Dr. Sara King.

The purpose of the study is to survey school psychologists in Nova Scotia about current and preferred roles. Gathering this data will update and broaden our understanding of the current scope of practice of psychologists working in schools and could provide important information to aid in the development of a doctoral program in school psychology.

The link below contains the survey, which will take approximately 20 minutes to complete. The survey consists of multiple choice questions, with the chance to elaborate on some of the questions (optional) and a few short-answer questions.

Prior to starting the survey, you will have the chance to enter your contact information for a draw to win 1 of 3 $50 Chapters gift cards to thank you for participating in the study.

Your participation is completely voluntary and your responses are anonymous. If at any point you wish to withdraw from the survey, you can exit the survey without submitting your responses. Once your responses are submitted, we cannot remove your data, as your responses are anonymous.

If you have any questions or concerns, please contact the principal investigator or the research supervisor.

The link to the survey was inserted here.

Sincerely,

Mirna Khalil, BA (Honours)
Graduate Student in School Psychology
Mount Saint Vincent University
Mirna.Khalil@msvu.ca

Sara King, PhD, R.Psych
Associate Professor
Faculty of Education
Mount Saint Vincent University
Sara.King@msvu.ca

Appendix C

Consent Form for Participants

Title: Ten years later: Current practices and preferred roles of school psychologists in Nova Scotia

Principal Investigator:
Mirna Khalil, BA (Honours)
Graduate Student in School Psychology
Mount Saint Vincent University
Email: mirna.khalil@msvu.ca

Research Supervisor:
Sara King, PhD, R.Psych
Associate Professor
Mount Saint Vincent University
Email: sara.king@msvu.ca
Phone: 902-457-6552

Introduction

You have been invited to take part in a research study. This form gives you information about the study. Before you decide if you want to take part, it is important that you understand the purpose of this study. Taking part in this study is voluntary (your choice). Informed consent starts with the initial contact about the study and continues until the end of the study. If you have any questions or concerns that this form does not answer, the principal investigator and research supervisor will be happy to give you further information. You do not have to take part in this study and you may withdraw from this study at any time.

The ethical components of this research study have been reviewed by the University Research Ethics Board and found to be in compliance with Mount Saint Vincent University's Research Ethics Policy.

Purpose of the study

This study is being conducted at Mount Saint Vincent University. The purpose of this study is to survey school psychologists about their current and preferred roles. Similar information was collected as part of a study conducted by Corkum, French & Dorey (2007); however, it is important to update our current knowledge of the field, as well as identify any changes in the practice of school psychology in Nova Scotia and identify areas of concern for school psychologists. Information gathered in this survey may also be useful as part of the development of a doctoral program in school psychology.

Study Design

If you wish to participate in the study, you will be asked to complete an online survey, which will take approximately 20 minutes to complete. The survey is hosted on a secure server through Mount Saint Vincent University. The survey will ask you about your background information, such as but not limited to your previous education, the number of years you have been practicing as a school psychologist, and the number of students to whom you provide services. The survey also includes questions related to each core competency area (i.e., assessment and evaluation, intervention and consultation, ethics and standards, research, interpersonal relationships, and supervision) as it relates to your practice as a school psychologist. The survey will include multiple choice questions with a few short-answer questions. The last section of the survey will ask you to estimate how much time you currently spend on different categories/activities related to the job and how much you prefer to spend on them. All participants will complete the same questions in the same order.

All responses are anonymous and you will not be identifiable to the researchers in any way. Although we will ask you for your contact information, this will not be linked to your survey responses.

Potential Harm

We do not foresee any risks or harm for you in taking part in this study. If any issues do arise as a result of your participation in our study, you are encouraged to contact the principal investigator, Mirna Khalil at mirna.khalil@msvu.ca or the research supervisor, Dr. Sara King, at (902) 457-6552 or sara.king@msvu.ca.

Potential Benefit

There are no direct benefits to taking part in this study. However, you will be helping the researchers learn more about the current scope of practice of school psychologists in Nova Scotia. What we learn through this study may help to identify possible areas for improvement with respect to delivery of school psychological services. Additionally, your responses may inform development of a doctoral program in school psychology.

Alternatives to Study

Participation in this study is completely voluntary (your choice). You do not have to take part in this study.

Withdrawal from Study

You may decide to withdraw from this study at any time. There are no risks involved with withdrawing from this study at any point. Your position will not be affected by this study. If the study is changed in any way that could affect your decision to continue, you will be told about the changes and you may be asked to agree to a new consent form. Should you decide to withdraw from the study, all data collected up to that point will be discarded and not used in the study. However, once the online survey is complete, it will not be possible to remove your data. If you decide that you no longer wish to participate, you should exit the survey before clicking "submit".

Costs and Reimbursements

The study will be at no cost to you. If you choose, your name will be entered into a prize draw to win one of three $50 Chapters gift cards as a thank you for participating in the study.

Confidentiality

Your confidentiality (privacy) will be protected throughout the study and after the study is complete. You will not be named in any reports or publications based on this research. Only an ID number will be used on the questionnaire you complete. No member of your affiliated school or school board will be aware whether or not you decide to participate in the study. Your responses will be password protected and encrypted to ensure privacy. Only researchers immediately involved in the research will have access to the information you give us. All studies conducted at Mount Saint Vincent University are subject to a potential audit by the Mount Saint Vincent University Research Ethics Board. Should an audit be conducted, your privacy will continue to be protected to the maximum extent of the law. If the results of the study are published in a scientific journal, the publication will not contain any identifiable information.

Please note that, if any issues do arise as a result of your participation in our study, you are encouraged to contact Dr. Sara King at (902) 457-6552 or sara.king@msvu.ca.

Research Rights

By clicking on the box below, you show that you have understood to your satisfaction the information regarding participation in the research project, and agree to participate in the study. In no way does this waive your legal rights nor release the investigator(s) or involved institution from their legal and professional responsibilities. You are free to withdraw from the study at any time without consequence.

If you have questions about research in general or this particular research study, at any time during or after your participation, you may contact Mirna Khalil (Mirna.Khalil@msvu.ca) or Dr. Sara King (902-457-6552 or sara.king@msvu.ca).

If you have questions about how this study is being conducted and wish to speak with someone who is not directly involved in the study, you may contact the Chair of the University Research Ethics Board (UREB) c/o MSVU Research and International Office, at 457-6350 or via e-mail at research@msvu.ca.

Prize Draw Information

If you would like to be entered in the draw to win 1 of 3 $50 Chapters gift cards, please complete the Contact Information portion of the survey.

Your contact information for the draw will not be connected in any way to the data you provide in the questionnaire, nor to the consent form you sign, and you will not be identified in the study using contact information from the draw. Your contact information for the draw will be kept in a password-protected and encrypted file and will be destroyed after the draw is complete.

Consent

I have read this information and consent form and have had the chance to ask questions which have been answered to my satisfaction before signing my name. I understand the nature of the study and I understand the potential risks. I understand that I have the right to withdraw from the study at any time without affecting my teaching position in any way. I understand that I am able to save and print this Consent Form for future reference. I freely agree to participate in this research study and indicate my consent by clicking the box below.