

## **Title Page**

### **Changing thoughts, changing practice: examining the delivery of a group CBT-based intervention in a school setting**

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## **Abstract**

Promoting mental health and wellbeing for children and young people in the UK has attracted increasing prominence in recent years and has been a focus for government strategy within health and education. Training and practice in educational psychology has increasingly focused on developing skills and expertise to provide therapeutic support within school contexts, at an early stage of need. One approach, Cognitive Behaviour Therapy (CBT), has been heralded as an effective, evidence-based intervention for anxiety (NICE, 2013). This research examines the factors influencing the outcomes of a group CBT-based intervention, run by an Educational Psychologist (EP), in a school setting. The findings suggest that influential variables included pupil identification, measures of change applied and the role of school staff. It is concluded that EPs can play a key role in increasing access to psychological therapies, alongside considering due caution in relation to the application of traditional clinical approaches in school contexts.

Keywords: Cognitive Behaviour Therapy, anxiety, group CBT, adolescence, psychology

## **Legislative background**

Promoting mental health and wellbeing for children and young people (CYP) in schools has been central to government initiatives in the United Kingdom (UK) for more than a decade. Indeed, the most recent Special Educational Needs and Disability (SEND) Code of Practice (2014) has replaced 'behaviour' with 'mental health' as an additional need. The previous Labour government's *Every Child Matters* agenda embraced a conceptualisation of the requirements necessary to promote positive outcomes for CYP (DfES, 2003). Concurrent with this directive were two successive United Nations Children's Fund (UNICEF) reports (2007, 2013) that investigated the well being of CYP, and put the UK at the bottom of 21 developed countries for overall child well being in 2007; the more recent 2013 report indicates some improvements and the UK is now ranked 16<sup>th</sup> out of 29 developed nations.

More recent government initiatives have continued to focus on strategy to promote children's mental health and wellbeing. From the Department of Health (DH) these include the *No Health without Mental Health* initiative (2011) with the associated 2012 implementation framework and, more recently, *Closing the Gap: priorities for essential change in mental health* (2014). Both reports highlighted the paucity of current provision for meeting the needs of CYP, and the individual and social implications of unmet needs. These initiatives have developed policy to promote and enhance timely access to services. In September 2013, the National Institute for Health and Care Excellence (NICE) issued a briefing, *Social and Emotional Well Being for Children and Young People*, which is intended to help Local Authorities (LAs) and their local partners meet objectives outlined in the public health outcomes framework for England (2013-2016).

Within the Department for Education (DfE), the focus on mental health in recent years has included a number of initiatives that intend to work proactively and preventatively to address children's mental health needs through early intervention. These initiatives have included: *Social and Emotional Aspects of Learning (SEAL)* (DCSF, 2005) which sought to provide

“...a comprehensive whole school approach to promoting the social and emotional skills that underpin effective learning and positive behaviour” (p.1). This was followed by the *Targeted Mental Health in Schools* (TaMHS) programme (DCSF, 2008), which aimed to “transform” the delivery of mental health support to the 5-13 population through school-based interventions. The most recent government advice to schools, *Mental Health and Behaviour in Schools* (2014), aims to “...help schools promote mental health in their pupils and identify and address those with less severe problems at an earlier stage and build their resilience” (p.4).

Evidence of the need for development of these cross departmental initiatives is drawn from the most recent official survey of mental health conducted by the Office of National Statistics (ONS) on behalf of the DH and Scottish Executive in 2004. This report conducted by Green, McGinnity, Meltzer, Ford and Goodman (2005) notes that 10% of 5-16 year olds in the UK have a diagnosable mental health condition and that 12% of 11-16 year olds in the UK had been diagnosed with a mental illness, with conduct and emotional disorders reported as the most frequent. The DH report *No Health without Mental Health* (2011) estimates that 40% of CYP with mental health needs are not receiving any specialist care, and suggests that similar numbers of CYP experience less serious psychological difficulties, for which they could also benefit from support. Furthermore, the report states that half of lifelong mental health illnesses are present by the age of 14 and 75% by the age of 18. This is of great concern particularly considering a report by the World Health Organisation (WHO), which suggests that mental health needs in adolescents are less likely to be recognised and are therefore under treated when compared with adult mental health needs (Stengard & Appelqvist-Schmidlechner, 2010). In addition, this report suggests that only 6% of costs relating to mental health issues in European countries actually fall on the health services. The costs relate to expenditure across agencies that include: education, social services and youth justice. In the UK, the DH (2011b) estimates the wider economic cost of mental health needs across all government departments to be £105.2 billion annually. There exists a strong evidence base of unmet mental health needs in the child and adolescent population, which has significant implications for the health and well being of individuals, but also clear social and financial implications if these remain unmet.

### **Mental health needs in CYP**

The 2004 review of the mental health of CYP in the UK by Green et al. (2005) suggests that 4% of 5-16 year olds have an emotional disorder; that is, anxiety or depression. Of these, 54% were likely to be girls. In the older age group (11-16 years) McLean, Asnaani, Litz and Hofmann (2011) report that, in a recent large scale study of gender differences in DSM-IV anxiety disorders, females were found to have consistently higher prevalence rates for each of the anxiety disorders, apart from social anxiety. Anxiety difficulties have been found to have significantly detrimental effects on academic performance and interpersonal experiences and it has been argued that the presence of an anxiety disorder can place a young person at a greater risk for other disorders. Sauter, Heyne and Westenberg (2009) highlight the fact that “Anxious adolescents in particular may ‘slip through the cracks’ as they often do not present an immediate problem to school staff, parents...unlike adolescents displaying externalising

problems” (p.312). Weiner, Suveg & Kendall (2006) and DCSF (2008) also emphasise the fact that anxiety difficulties can often go unnoticed, due to their internalising characteristics, with externalising behaviours being more salient in the school environment due to the disruptive impact they can have.

### **Cognitive Behaviour Therapy**

Cognitive Behaviour Therapy (CBT) focuses on the nature of human experience, with an emphasis on the interaction of cognition, emotion and behaviour. It is based on an understanding of how an individual processes information from the environment and the impact of this on behaviour (Graham, 2005; Squires, 2006). CBT has been widely used with adults for a range of difficulties (for example, anxiety, depression, other mood disorders and eating disorders); furthermore, there is a growing body of evidence to support its use with CYP (Ruth & Fonagy, 2005). Its growing evidence base, and relative cost effectiveness (in comparison to other therapeutic interventions), has resulted in its increased recommendation in government and clinical literature (for example: the LSE Depression Report, 2006; Fonagy and Murphy, 2012; and NICE, 2013). Research in this field has traditionally drawn on evidence from randomised controlled trials (RCTs) conducted in clinical settings, with more recent developments aiming to increase the evidence base for the application of CBT-based interventions in non-clinical settings, for example, schools, and in both individual and group formats; for example, Squires (2001, 2006), Burton (2006), Christner, Forrest, Morley and Weinstein (2007), Rait, Mosen and Squires (2010).

### **Context for current study**

The move towards integrated children’s services has been promoted and well documented in recent government literature; for example, DfES (2003), DCSF (2008), DH (2008), DCSF (2010) and DfE (2013), with a greater emphasis on all support services: education, social care, health and justice system, working in partnership to deliver best outcomes for CYP. With this in mind, it is necessary to be conscious of the impact of delivering mental health services within such systems. Traditionally, CBT as a therapeutic intervention has been delivered in centres which are dedicated to the provision of mental health services, such as hospitals or clinics. Considering the prevalence of CYP with psychological conditions who are not currently receiving support (estimated to be up to 40%), the DfES (2003), DCSF (2008, 2010) and DfE (2014) all emphasise the important role schools have to play in both identifying and supporting CYP who are experiencing mental health needs. CYP spend a significant part of their lives in school and therefore the possibility of bringing support to them, rather than placing the emphasis on them finding it, would certainly appear beneficial. This would seem particularly so for those who are most vulnerable and may be unable, or unwilling, to access external support.

The *CAMHS Review* (DH, 2008) and *Mental Health and Behaviour in Schools* (DfE, 2014) both highlight the potential role for EPs to deliver therapeutic interventions, training, and to work with families, promoting more systemic mental health practice. Farrell, Woods, Rooney, Squire and O’Connor (2006), in their review of the functions and contributions of

EPs in the UK, also highlight the potential for EP service delivery to expand in this area. Clark (2011) highlights the current drive to increase the number of trained CBT therapists to meet the demand for mental health services; for example, the *Increasing Access to Psychological Therapies* (IAPT, 2008) programme. Stallard (2007) acknowledges that health services alone could not respond to the level of demand for CBT that would come from schools. Therefore EPs, with their psychological training, understanding of child development and knowledge of school systems, are extremely well placed to provide CBT interventions in school, as well as to evaluate the effectiveness of CBT delivered in such 'real world' settings. This would help to establish further the appropriateness of this approach to increasing access to therapeutic interventions for CYP (Hill, 2013). It is important to highlight however that this response is dependent on the promotion of a workforce to meet the need. This has obvious implications for future initial training programmes as well as EP delivery and service structures within LAs.

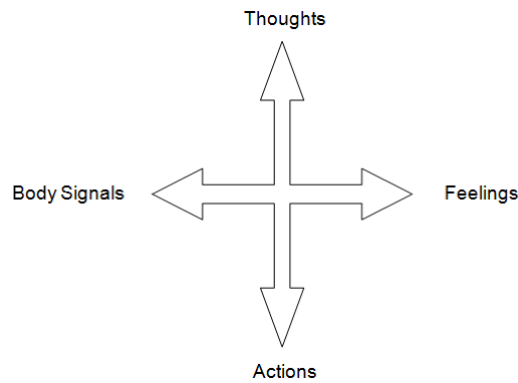
This study aimed to consider the factors impacting on the success and outcomes of a CBT-based group intervention. This was carried out in a LA Educational Psychology Service (EPS) which had previously delivered such interventions through the *Targeted Mental Health in Schools* (TaMHS) programme. EPs in this service are also commissioned by CAMHS to deliver individual CBT as part of the LA's Tier 2 CAMHS offer. CBT was therefore identified as a key service priority, with a particular focus on group interventions due to increasing requests for this type of support from local schools.

Schools in this LA are typically high achieving, with the secondary schools in particular often requesting support for student anxiety around transitions and exams. This increasing demand led to the focus for this research on identifying local factors contributing to successful group CBT-based intervention outcomes, with a wider focus on contributing to the growing evidence base in this area.

### **Pupil identification and procedure**

Pupils were initially identified through consultation between the researcher EP and school staff (SENCOs, Heads of Year and Teaching Assistants (TAs)). Nineteen girls aged 11-14 years were identified as likely to benefit from accessing an intervention to reduce their anxiety. Pupils were assigned to groups by school staff, in order to control for potential negative dynamics and also to address priority concerns; that is, staff required the pupils they held the greatest concerns about to participate in the initial phase of intervention. Four groups were formed – two experimental and two comparison groups. Pre-intervention measures were undertaken with all young people involved in the study (time 1), before the experimental groups participated in the six week intervention. The intervention sessions took place weekly, with all groups led by the researcher, and a TA co-facilitating in one school. The comparison group were not contacted during this time. After the intervention, post-measures were obtained from all participants (time 2) and, following this, the comparison groups then received the intervention. Further measures were taken from the comparison group participants after their intervention (time 3).

The intervention was bespoke, designed by the EP, but three central resources were used to inform the programme: *Cool Connections with Cognitive Behaviour Therapy* (Seiler, 2008), *Anxiety: Cognitive Behaviour Therapy with Children and Young People* (Stallard, 2009) and a CBT group intervention designed by Squires (2001). The CBT framework was presented as a ‘hot cross bun’ visual representation (for an example of this, see: Padesky & Greenberger, 1995). These resources were consistent with those used in the current EPS to ensure fidelity with the context.



The study used four quantitative measures: the *Spence Children’s Anxiety Scale* (SCAS) (Spence, 1998), the *Children’s Automatic Thoughts Scale* (CATS) (Schniering & Rapee, 2002), the *Strengths and Difficulties Questionnaire* (SDQ) (Goodman, 1997) and the *School Anxiety Scale-Teacher Report* (SAS-TR) (Lyneham et al., 2008). Post-intervention, semi-structured interviews were conducted with school staff and pupils and a focus group was held with parents from one school. A questionnaire containing both open and closed questions was administered to all participants at times 2 and 3 in order to gather a greater depth of data about the outcomes and potential influences. The researcher also kept a diary of observations and reflections.

The focus of this study was twofold: (i) to determine whether a group CBT intervention for anxious adolescents would be successful, delivered in a school context; and (ii) to consider the facilitators and barriers to the success of such a school-based intervention.

## Results

### *Quantitative data*

Because of the small sample size ( $n=19$ ), it was acknowledged that it was unlikely for there to be any statistically significant differences observed in the data between time 1 and time 2. However, the quantitative data gathered nevertheless provided an important context for the study and characterised the participants. A repeated measures analysis of variance (ANOVA) demonstrated no significant differences between times one and two; these results are shown in the table below:

	F	Sig.
SCAS		

Total score	0.012	0.914
Panic attack and agoraphobia	0.109	0.743
Physical injury fears	0.447	0.508
Separation anxiety	0.230	0.881
Social phobia	0.713	0.404
Obsessive compulsive	0.043	0.836
Generalised anxiety disorder	0.081	0.777
<i>SDQ</i>		
Overall stress	0.142	0.708
Emotional distress	0.145	0.705
Behavioural difficulties	0.015	0.905
Hyperactivity & attentional difficulties	0.566	0.457
Getting along with other children	2.096	0.157
Kind & helpful behaviour	0.001	0.974
Impact of difficulties	0.017	0.897
<i>CATS</i>		
Total score	0.018	0.894
Physical threat	0.578	0.452
Social threat	0.124	0.727
Personal failure	0.004	0.951
Hostile intent	0.362	0.551

*Table 1: ANOVA results*

An analysis of the pre-intervention data highlighted that the groups were not wholly homogenous at the outset, as demonstrated in Table 2 below. Between group differences were expected, as schools required those identified as most needy to participate in the first group. It is acknowledged that such data would make it difficult for any group generalisation to be made. It can also be seen from the standard deviations that there were a wide range of scores, which show that the mean scores are not necessarily appropriate for use.

	<i>Experimental Group (n=10)</i>		<i>Comparison Group (n=9)</i>	
<i>Measure</i>	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>

SCAS	41.6	24.0	29.6	17.6
CATS	58.4	36.8	32.3	25.6
SDQ	17.6	5.8	15.8	6.0
SAS-TR	22.1	6.9	23.1	7.0

Table 2: Differences between groups pre-intervention

Examining the data in more detail however, did provide some observations of interest. For example, for the SCAS measure, participants are considered to have clinically significant anxiety scores if they obtain a score greater than 59 (Spence, 1998). As highlighted in Figure 1 below, only three pupils in the experimental group and one from the comparison group obtained scores higher than this. This is not problematic in itself as the intervention was intended to target pupils displaying mild/early signs of anxiety, or considered ‘at risk’; however, almost half of the sample (nine pupils) had a score of 31 or below. SCAS standardisation indicates a mean score of 34 for girls aged 8-11 years and 27 for girls aged 12-15 years. This suggests that nearly half of the current sample had anxiety scores considered typical for their age group.

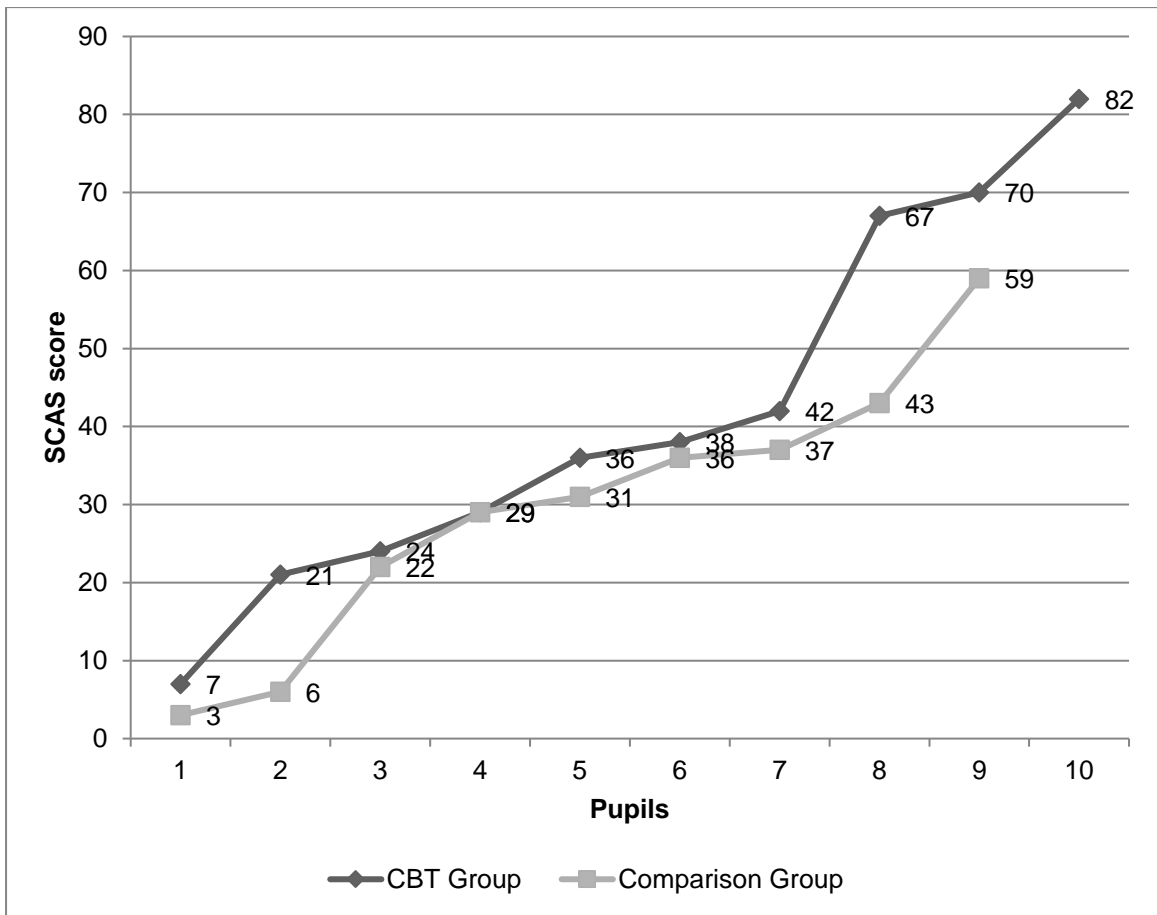
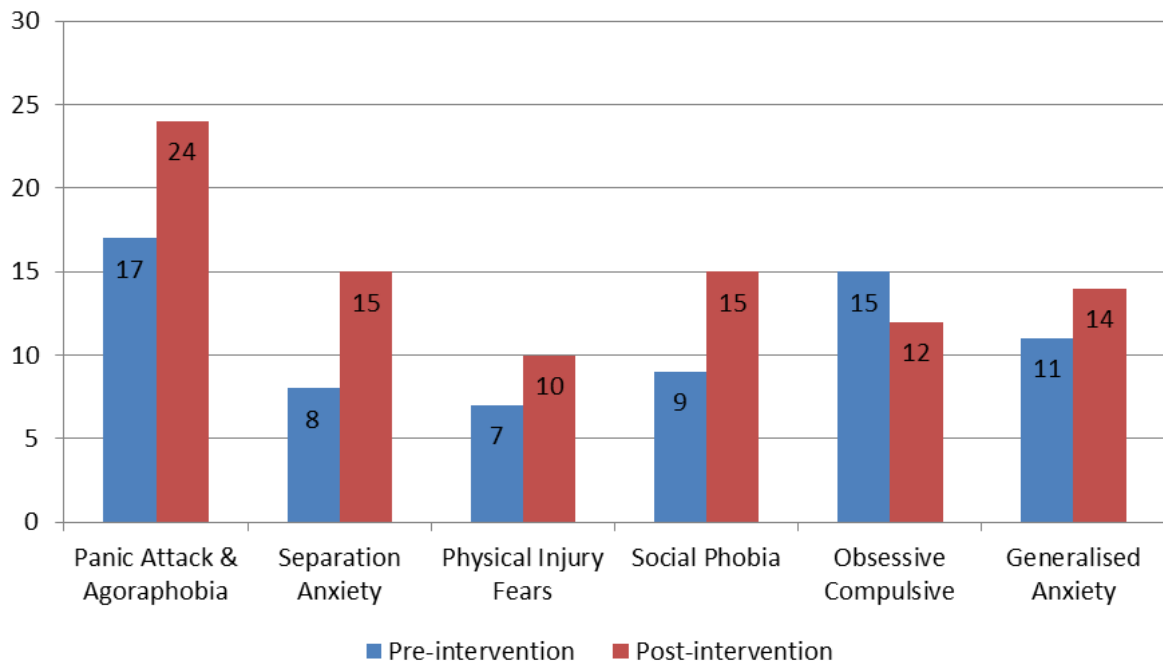


Figure 1: SCAS scores pre-intervention: comparison between groups



Examining the data further, it was worthwhile to extract individual scores as the small sample size and wide range of scores and outliers increased chances of the mean hiding data of interest about individual participants. One participant (Pupil X) is presented as a case, due to her extreme scores. This pupil obtained a clinically significant anxiety score pre-intervention on the *SCAS* (67), with a large increase in her scores on post-intervention *SCAS* measures (90) – this was the case across all the subscales of the *SCAS* (see Figure 2 below). In contrast to this, the *SAS-TR* showed that school staff perceived her anxious behaviour to have decreased (see Figure 3 below) with both their rating scales and *SAS-TR* scores.



*Figure 3: Pupil X's individual scores from SCAS measures*

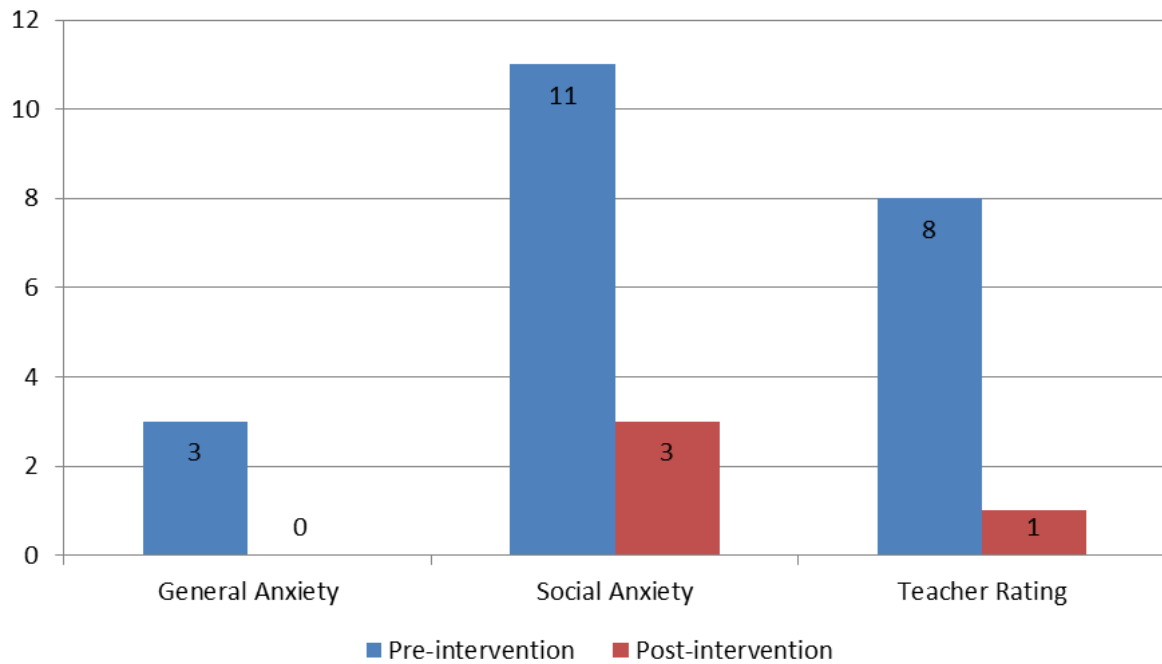


Figure 4: Pupil X's anxiety scores, as rated by staff on the SAS-TR

In contrast to her questionnaire scores, the qualitative information gathered showed that Pupil X reported improvements in her own feelings of anxiety and personal ability to manage them. She described the intervention as a helpful and positive experience and her mother also reported positive changes for her daughter. It is possible that participating in the intervention may have increased Pupil X's emotional vocabulary and awareness of her anxiety conceptualisations and manifestations, which led to greater identification in her post-measures. An increased familiarity with the researcher could also have impacted on how comfortable she felt revealing her thoughts and feelings. It is considered that it would have been interesting to obtain measures from a coping scale as it is hypothesised that the intervention may not necessarily have an impact on experiences of anxiety but on the participant's ability to cope with and manage them. These findings highlight a discrepancy between quantitative and qualitative measures in relation to outcomes.

Considering this further, Figure 4 below shows some discrepancies between the two measures obtained from staff relating to individual pupil anxiety. On a scale of 1-10 (1=no anxiety present; 10=very anxious most of the time), school staff rated the experimental group's anxiety at an average of 7.1 and the comparison group's at 5.7, at time 1. This was not unexpected, as pupils had been allocated to groups in order of priority of need. However, an examination then of the SAS-TR scores reveal that staff scored pupils from both groups relatively similarly. This may suggest a mismatch between the anxiety behaviours observed by staff (gathered more objectively through the SAS-TR statements) and their personal perceptions of individual pupil anxiety (a more subjective measure) provided on the teacher rating scale. This highlights that judgements made about the emotional needs of others can be susceptible to subjectivity and are often dependent upon beliefs, values, priorities and experiences of the person making such a judgement. Therefore, it is important to ensure that

information is gathered in a reliable and valid way for identification of needs and provision of support.

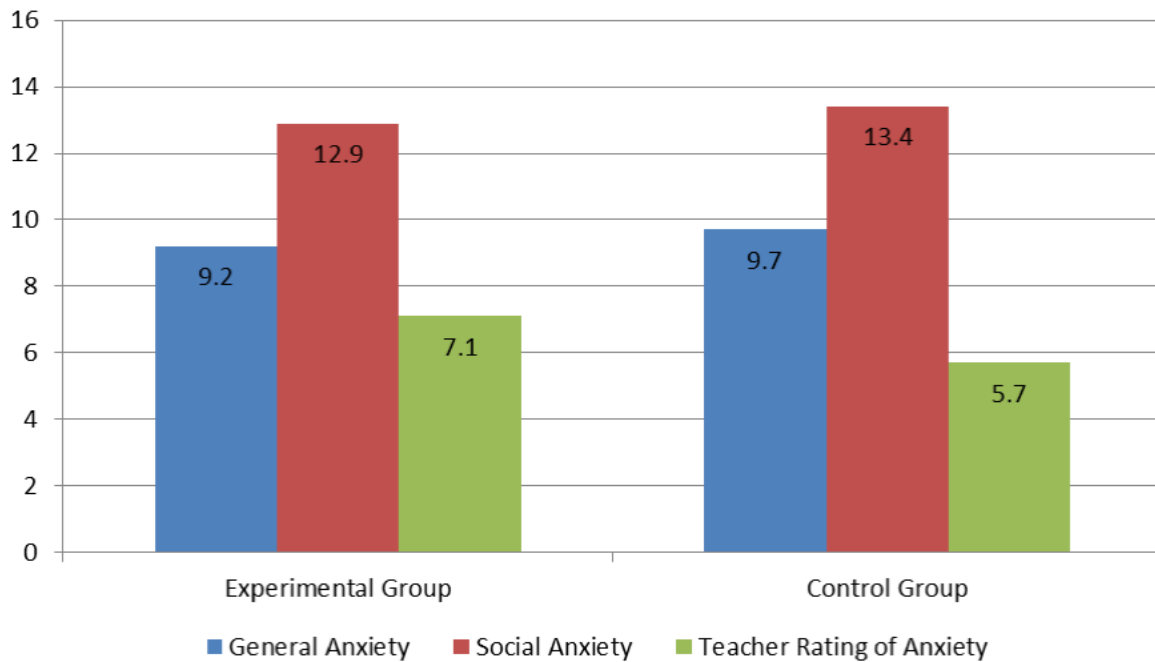


Figure 5: SAS-TR scores pre-intervention

### Qualitative data

Thematic analysis was used to explore themes emerging from the data gathered from interviews with pupils and school staff and a focus group held with parents. Four major themes were identified.

#### Theme one: Commissioning the group

##### Commissioning the Group

- Pupil Identification
- Managing Expectations
- Practical Measures

Concerns were raised by school staff about how to identify pupils who were having difficulties managing their anxieties. As secondary schools are particularly complex organisations, the key person involved in the identification process varied. As one member of staff said:

*“The person whose role it is in school to identify the students has to be very clear and there has to be a complete match between what you’re looking for, given what you’re planning to do, and what we’re trying to identify, for it to work well.” (SENCo)*

In line with typical EP practice, participants were chosen based on adult perceptions of experiences of anxiety, which the pupils may or may not have been in agreement with. As one member of staff identified:

*“Anxiety means different things to different people and people use the wrong words for something, they call it anxiety and it isn’t.” (SENCo)*

*Theme two: Measuring change*

#### Measures of Change

- Informal Measures
- Formal Measures
- Involvement of Parents
- Involvement of Pupils

In the current study, some change was identified qualitatively but not quantitatively. The need to provide quantitative data was highlighted by a member of staff:

*“I’m going to look at data in half-term and I’ll look at things like attendance and things like are they visiting the nurse as often as they did when they first arrived. And also we can look at academic achievement as well, so the whole area of tracking and data that we can look at to see if the CBT has had an impact on individual students.” (SENCo)*

However, it was observed that school staff seemed to rely more on their personal qualitative observations, which were more process than outcome focused; for example:

*“I’m such a person that will actually stand outside the unit at break and lunch time and just observe students and see how they’re interacting socially...so that is not a hard and fast data but I think that gives you a feeling of how they feel about themselves, their self-esteem, their confidence.” (SENCo)*

Qualitative observations also appeared to place a greater emphasis on the absence of an undesirable behaviour, rather than the observation of a desired one. For example:

*“No news is good news with students like that. If they don’t come forward in any shape or form to any member of staff as being a concern you can usually assume they’re fine.” (Head of Year)*

Further contrast between quantitative and qualitative outcomes were also highlighted by examining Pupil X’s responses in relation to her quantitative scores. She reported increased coping skills; for example:

*“This group helped me to realise really good things like about your thoughts and stop worrying about things that you don’t really need to worry about.” (Pupil X)*

Similarly, her mother reported:

*“I think her confidence has come on leaps and bounds to the point where she’s not, somebody might say something to her and she’s not stewing on it, she tries to deal with it.” (Parent of X)*

Such positive changes were also identified by other students and parents:

*“I used to think lots of bad stuff about myself, now I think a bit more positive thoughts.” (Pupil Y)*

*“I can talk to different people, like, kind of, like than I could at the start. But I wanted to be friends with them but I didn’t have the courage to, like, go and talk to them.” (Pupil Z)*

*“I don’t get that awful feeling when she comes out of school and she rings me and I say how was your day and my stomach is just in my mouth and I think please just say yes and it was always no, and now it’s yah, had a good day thanks.” (Parent of Y)*

*Theme three: Managing the therapeutic process in schools*

#### Managing the Therapeutic Process in School

- Ethical Delivery
- Orientation to the CBT Process
- Group Dynamics

As a traditionally clinic-based intervention, the application of a CBT approach in a school setting raised some practical concerns; for example, timetabling the group and securing an appropriate room within the school. This supported ensuring confidentiality and boundaries of privacy (for example, other staff and pupils entering the room during the group).

*“I think we’ve got an ideal room for you and I think any school that undertakes intervention groups has to have...(this)...it was private, you were able to put the blinds down...a small environment which made it more nurturing.” (SENCo)*

This issue of who actually delivers the intervention was raised in terms of privacy and confidentiality. One member of staff commented it was helpful for it to be:

*“...someone who’s not part of the establishment, someone who they know comes in and goes out, in their heads they know you don’t go into the staff room and talk about them or talk about their issues. So I think that means a lot to the students.” (Head of Year)*

However having an intervention run by an external service provider did also raise concerns about providing ongoing or follow-up support for the students. One member of staff commented that she would be able to informally continue to support some pupils but that she was worried about others:

*“The worry is that I don’t see...(named three students)...so where’s the reminder of it and going to remember...why you are using that strategy again?” (TA)*

Another concern was that the students already had existing relationships and roles within peer groups, which impacted on their engagement.

*“Because of the fact that they know each other so well...if they fell out that day there was an issue that had to be resolved on that day...so it’d be like they’d come to the CBT and then we’d get all the issues of the day that had exploded in break...so that was a hindrance.” (TA)*

*Theme four: Pupil engagement*

#### Pupil Engagement

- Cognitive and Developmental Levels
- Pervasiveness of Anxiety
- Motivation to Change

Concerns were raised in relation to the motivation of pupils to participate in an intervention which had been suggested by an adult (school staff and/or parent), rather than self-selected.

*“I just think it’s very hard to explain why you’re offering them, this is about something you want...” (Head of Year)*

while another said:

*“...with certain individuals in the group, we want them to change more than they want to change and that’s a bit of an issue I think.” (TA)*

It was apparent throughout the process that some students did find it difficult to engage with the CBT process in terms of understanding and applying the principles to themselves and applying and generalising them beyond example presented in sessions. One member of staff commented:

*“I think it was quite hard for them to get their heads around why they were in the group.” (TA)*

## **Discussion**

### ***Pupil identification***

With motivation to change and engagement in the process as key components for CBT, it can be seen that the process of pupil identification at the outset is a particularly pertinent issue. Pupils of concerns were identified as anxious by school staff; however, the quantitative scores obtained suggest that anxiety may not necessarily have been the key need for them. This highlights the need for the process of pupil identification to be carefully commissioned, with a strong role for EPs in raising awareness of key signs and symptoms of mental health needs. This highlights a gap for further initial support or training to be offered to school staff which could lead to more appropriate identification, not only for EP support but for CAMHS support at different levels. Indeed, Graham (2005) argues that CYP may not necessarily

recognise if they are exhibiting atypical responses to emotional difficulty and that school staff can be well placed to support pupils in understanding their behaviour and accessing support. Indeed, at the end of this intervention, school staff did identify that, in the future, they would like more support with this process, due to their own concerns about the ‘match’ of the intervention to the pupil in some cases.

The process of pupil identification should also consider the appropriateness of the intervention, ensuring the intervention ‘fits’ the young person and not ‘fitting’ the young person to an available intervention. One member of staff queried whether the cognitive component of the CBT was too “advanced” for some, reflecting on their academic attainment. However, it was reflected by the researcher that the group activities certainly would have offered novel and challenging ways of thinking, but this would have been one of the desired effects of the intervention and further support may have been needed to enable pupils to practise and embed these skills further as well as support for staff to feel confident in their expectation of student participation and engagement.

Additionally, it was observed that some pupils in this study appeared to be experiencing anxieties perpetuated by exposure to contexts and situations which could be argued to be justifiable, appropriate and adaptive responses. As a central aspect of CBT is to challenge distorted cognitions, concerns were raised about whether CBT was the most appropriate intervention for these pupils, which would have an impact on their engagement with the process.

### ***Measuring change***

In the current climate of demonstrating value, worth and accountability, the need for service providers to use adequate measures to deliver valid and reliable data is pertinent. Quantitative measures are traditionally highly valued due to their ease of administration and ease of use of numerical data. They can also facilitate enhanced objectivity and are able to demonstrate their validity and reliability. However, it is argued that, used alone, they may not be an adequate means of capturing the full response to a short-term intervention as their focus is more on outcomes than processes. The central question here related to how, or why, it did or did not work (measured more qualitatively), which can lead to a deeper understanding and learning experience than simply: did it work? Furthermore, it is argued that quantitative measures simply cannot capture the essence of human experience, with the vast array of individual feelings, perceptions, attitudes, experiences and different contexts that are the legitimate interest of psychologists evaluating interventions. In the current study, this was highlighted in the details of one pupil’s scores and outcome measures, which showed the value of looking beyond her questionnaire scores. Qualitative approaches may be better able to facilitate the evidence of this wider impact; however, it is also important to appreciate that these are typically more in-depth and time consuming and therefore may not be practical for everyday use. Further use of measures which draw on both methods; for example, use of *Targeted Monitoring and Evaluation (TME)*.

### ***Role of school staff***

Within this theme, the therapeutic relationship was also raised - this is considered to be a key component of CBT success. The ability for this to develop adequately within both a time-limited and group situation was an issue; it is presumed that the inclusion of a member of school staff can help build this relationship and provide the opportunity for continued support and reinforcement of skills learned within CBT frameworks. In this instance, the pre-existing relationships between students and school staff were observed to, at times, have a negative impact on student engagement with the process. At times, it seemed that there was a 'lapse' into the traditional classroom support relationship, with an observation of reciprocal expectation for the TA to problem-solve on behalf of the pupil and provide answers for them, compromising this component of CBT practice somewhat. This also relates to the concerns described previously relating to student ability to engage in the cognitive components. It was hypothesised that this view may have been somewhat influenced by beliefs about general cognitive ability from in class experience as well as an over reliance on the TA from some of the students which may have been driven by their typical expectations from the role. What is highlighted here is the need to ensure that adequate time is given to provide training and support for these members of staff, to fully understand the interventions and how to participate within them. The role of the EP in helping schools prepare to engage in therapeutic work through training, consultation or on-going supervision for staff members is key to effective implementation.

### **Conclusion and implications for EP practice**

Considering the large proportion of their lives that CYP spend in school, there is vast potential for schools to play a key role in the identification and support of psychological wellbeing and mental health. EPs are well placed to facilitate this development, with their skill set rooted in the application of psychology in educational settings. This study provides key issues for EPs to consider in relation to the provision of group CBT-based interventions in school settings. It has implications for practice particularly in relation not only to the planning and delivery such interventions but also the provision of an adequate level of support for school staff before, during and after such an intervention. This study highlighted particular needs for support in relation to the identification of pupils to match the intervention on offer. It can be seen that, for EPs delivering such interventions, the need to spend time in this planning stage is vital to the quality and outcomes. It is also important to provide adequate time for staff to develop their understanding of the key aspects of therapeutic support, nurturing this relationship with pupils and valuing the difference this offers. Such considerations obviously have implications for how schools use EP time. Farrell et al. (2006) state that a reduction in the amount of statutory duties placed on EPs has resulted in the opportunity to develop a greater range of practice, such as therapeutic interventions. Hill (2013) argues that recent child population studies and research evidence has highlighted the most vulnerable children in our society, and that recent legislative changes have provided EPs with a clear mandate to engage in therapeutic work with them.

With this in mind, it is important to reflect upon the recent national economic challenges which have led to an increased number of 'traded' services and a greater need for EPs to demonstrate impact, accountability and value. This study has highlighted potential



inadequacies in the use of quantitative measures alone and emphasises the need for EPs to carefully consider how they are measuring impact to ensure that the value is captured and evidenced. Within the current climate of increased commissioning and purchasing of services, it is important to also be able to evidence if there is a need for additional elements (such as training and supervision for school staff) alongside the delivery of such interventions, as this would have significant cost implications. It is acknowledged that EPs are external agents, and also an expensive commodity and that school staff would be well placed to provide universal and secondary support for students on a more regular basis, with access to training and ongoing consultation to support this process.

This research has identified a strong role for EPs in the development of a well-informed and competent front-line service delivery of CBT-based interventions for CYP to support their psychological and emotional wellbeing. The shortfall in the delivery of therapeutic interventions can be assisted through direct delivery by EPs, as well as by increasing the knowledge, understanding and skills of school staff in terms of assessment, support and identification of appropriate interventions. It is acknowledged that EPs have a unique understanding of the complexity of the school system and a high level expertise in applying psychology for CYP. Therefore, EPs have much to offer in terms of extending therapeutic delivery to CYP in schools and other settings to help the government achieve the aim to provide better access to psychological therapies for CYP, to promote their mental health and wellbeing and to help them achieve optimal outcomes. At the same time it will be important to continue to consider and exercise caution and ensure that the application of traditionally clinic-based interventions to school settings retain their quality, validity and fidelity. It will be important to continue to retain a stance of critical reflection and further studies into the application of high quality therapeutic interventions would add value to this evidence base.

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