Educational Psychologists and therapeutic intervention: enabling effective practice

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Mental health in the UK

• Economic reasons for addressing mental health in adults – Layard (LSE, 2009)
• 20% of children and young people are purported to have a mental health problem of some description (Meltzer et al, 2000)
• CAMHS – take referrals, but not enough to meet demand (Stallard et al, 2007)
• Schools have an important role (Tier 1 & host of initiatives designed to be preventative)
• 2500 EPs in the UK¹

What do we mean by therapeutic intervention?
Definition of therapy

For the purposes of the research, the following definitions were provided.


- Therapeutic work may involve the direct intervention of a psychologist with an individual child or a group of children. Equally it is applicable to the wider role of supporting others who work with children on a daily basis (MacKay and Greig, 2007).
Rationale for study

• Increasing interest/focus on the role of EP as therapeutic provider (MacKay, 2007)

• Government focus on social and emotional wellbeing (SEAL, TaMHS)

• Sought to extend and develop the findings of two pieces of small-scale research undertaken by trainee educational psychologists (Corban, 2009; Templeton, 2010)
Part 1
The Research Questions

• What therapeutic interventions do EPs use?
• How do they use them in practice?
• What are the barriers and enablers to EPs engaging in therapeutic practice?
Part 1 - Methodology

- Online questionnaire distributed to all UK Educational Psychology Services and via professional forum and bulletin
- Questions derived from literature and the findings of previous small scale doctoral research projects
- Open and closed questions
- 455 responses received to online (75%) and paper (25%) versions of the questionnaire
- www.epsandtherapy.co.uk
Do you use therapeutic interventions as part of your current professional practice?

Number of EPs using therapeutic interventions as part of their current practice

- Yes: 92%
- No: 8%
How have you used therapeutic intervention?

Percentage of EPs using therapeutic intervention in different contexts

- Individual direct therapeutic intervention: 80%
- As part of assessment: 70%
- Consultation: 60%
- Working through others: 50%
- Group work: 40%
- Systemic work (eg training): 30%
- Other: 10%
What therapeutic intervention(s) have you used during the last two years?

Therapies used by EPs in the last two years

<table>
<thead>
<tr>
<th>Therapy used</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution Focused Brief Therapy (SFBT)</td>
<td></td>
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<tr>
<td>Cognitive Behavioural Therapy (CBT)</td>
<td></td>
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<tr>
<td>Personal Construct Psychology (PCP)</td>
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<tr>
<td>Motivational Interviewing (MI)</td>
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<tr>
<td>Narrative Therapy (NT)</td>
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<tr>
<td>Therapeutic stories</td>
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<tr>
<td>Art &amp; play therapy</td>
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<tr>
<td>Neurolinguistic Programming (NLP)</td>
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<tr>
<td>Video Interactive Guidance (VIG)</td>
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<tr>
<td>Eye Movement Desensitisation &amp;...</td>
<td></td>
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<tr>
<td>Human Givens (HG) Therapy</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>
Key facilitators

1. Access to training (e.g. “The amount of work done in this area by individual EPs varies considerably, depending on the training they have received”)

2. Service culture offers flexibility in the model of working

3. Personal interest in therapeutic intervention

4. Schools valuing therapeutic intervention and their relationship with the EP
Key barriers

1. Limitations of service time allocation model/service capacity (e.g. “The service does not operate a time allocation model, and so EPs have the flexibility to target more intensive support where needed”)

2. Other priorities identified via stakeholders

3. Lack of training

4. Lack of practice
Part 2
The Research Question

• What features enable and ensure effective provision of therapeutic interventions by EPs?
Part 2 - Methodology

• Four services selected on the basis of responses to survey (Part 1)

• Inclusionary criteria: capability to enable effective therapeutic practice; support from the PEP; time available

• Data collection:
  o Documentary analysis (e.g. inspection of service training and publicity materials, anonymised report examples)
  o Interview with the PEP
  o Interviews/focus groups with EPs involved in the delivery of therapeutic interventions
  o Interviews/focus groups with multi-agency role partners, service commissioners and stakeholders
Service profiles

Service A

- Small metropolitan service
- Very experienced team (minimum 10 years as an EP)
- Time not allocated to schools, instead there is a helpline manned by PEP, SEPs, SPEPs
- Work allocated through a weekly panel
- Good links with other therapeutic providers
- Specialisms: therapeutic play, critical incident response, parenting
Service B

- Medium sized metropolitan service, high levels of deprivation
- Strong roots in therapeutic provision (historic links with CAMHS and art therapy)
- Time allocation model
- High priority given to CPD
- Strong links with other therapeutic providers (CAMHS, voluntary agencies)
- Specialisms: Family Therapy, Human Givens Therapy, CBT
Service C

- Large urban/rural service
- No allocation system – work negotiated via phone contact
- No referrals – children become known to EPS via consultation
- Majority of EPs do therapeutic work as part of their day to day casework
- Low staff turnover. Good relationships between EPs and schools
- Specialisms: critical incident response, CBT, STORM (suicide prevention and assessment), SFBT
Service D

- Small urban/rural service covering large and diverse geographical area
- Critical incident response the impetus for development of therapeutic services
- Direct consideration of therapeutic work within service development plan
- Therapeutic practice covers different areas of EP practice (assessment, consultation, intervention, research, training)
- Some constraints of time allocation model
- Specialisms: EMDR, CBT/Friends, Penn Resiliency Program, therapeutic stories, Video Interactive Guidance
Themes from the qualitative data

1. What are therapeutic interventions?
   • Approaches/practice
   • Definition of therapeutic intervention

2. Role of the Educational Psychologist
   • Changing context of EP role
   • Multiagency working
   • Personal interest
   • Role of EP in relation to therapeutic intervention

3. Service context
   • Access to therapeutic interventions
   • Contracting/organising therapeutic work
   • Leadership
   • Opportunities to practise
   • Specialist work with vulnerable groups
   • Supervision
   • Time/resources
   • Training
Contracting/organising therapeutic work

- Appropriate accommodation for therapeutic provision at EPS
- Centralised referral systems
- ‘Marketing’ therapeutic services
- Work at group/whole school level. Working through other practitioners
Leadership

• Commitment to address therapeutic provision at service development level
• Commitment to training and development
• Strong strategic role
• Support for delivery of therapeutic interventions
• Therapeutic expertise amongst leadership team
Specialist work with vulnerable groups

• Anxiety disorders
• ASD/ families of children with ASD
• Bereavement
• Critical incident response
• Emotionally-based school refusal
• Looked after children (including work around fostering and adoption)
• Trauma
Supervision - possibilities
(see also Squires, 2010; Squires and Dunsmuir, 2011)

• Buying in supervision
• Group supervision
• Pairing of neighbouring EPSs to provide peer support
• Peer supervision, particularly where colleagues have accessed similar CPD
• Setting up networks and support groups for EPs
• Specialist supervision from multiagency partners (e.g. CAMHS)
• Virtual supervision (e.g. email contact or Skype with a specialist practitioner)
Time/resources

• Links to TaMHS and other initiatives
• No time allocation for service delivery/limitations on time for therapeutic input
• Ring-fenced time for delivery of therapeutic interventions
• Traded work
• Working through others
Factor analysis of facilitators and barriers

• Looked at facilitators and barriers using factor analysis (Principal Components Analysis)
• Items above .4 (in red) are considered to load strongly with a factor
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<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
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</thead>
<tbody>
<tr>
<td><strong>Facilitators - schools valuing relationship with EP</strong></td>
<td>0.741</td>
<td>-0.110</td>
<td>-0.134</td>
</tr>
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<td><strong>Facilitators - schools valuing therapeutic intervention</strong></td>
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<td>0.002</td>
<td>-0.122</td>
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<tr>
<td><strong>Barriers - other priorities identified via stakeholders</strong></td>
<td>0.644</td>
<td>0.083</td>
<td>0.097</td>
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<tr>
<td><strong>Barriers - stakeholders do not identify EPs as providers of therapy</strong></td>
<td>0.624</td>
<td>-0.003</td>
<td>0.032</td>
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<tr>
<td><strong>Barriers - historical context for EP work</strong></td>
<td>0.544</td>
<td>-0.164</td>
<td>0.141</td>
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<td><strong>Barriers - not best use of EP time</strong></td>
<td>0.401</td>
<td>-0.328</td>
<td>0.259</td>
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<td><strong>Barriers - lack of training</strong></td>
<td>-0.050</td>
<td>-0.873</td>
<td>-0.033</td>
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<tr>
<td><strong>Barriers - lack of practice</strong></td>
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<td>-0.778</td>
<td>-0.028</td>
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<tr>
<td><strong>Facilitators - access to training</strong></td>
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<td>-0.536</td>
<td>0.033</td>
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<tr>
<td><strong>Barriers - access to supervision</strong></td>
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<td><strong>Facilitators - personal interest in therapeutic intervention</strong></td>
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<td>-0.403</td>
<td>-0.044</td>
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<tr>
<td><strong>Facilitators – supervision</strong></td>
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<td><strong>Facilitators - management support</strong></td>
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<td>-0.074</td>
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<td><strong>Facilitators - peer support</strong></td>
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<td>0.568</td>
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<td><strong>Barriers - service capacity</strong></td>
<td>0.162</td>
<td>0.196</td>
<td>0.522</td>
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<td><strong>Barriers - limitations of service time allocation model</strong></td>
<td>0.199</td>
<td>0.196</td>
<td>2.459</td>
</tr>
</tbody>
</table>
Three components

1. Role of the EP
2. Training and practice
3. Support and service context

The emergent components were then triangulated with the qualitative data
Role of the EP

- Stakeholders did not always identify EPs as providers of therapy
- Health-based professionals, particularly those working for CAMHS did not readily identify EPs in this role
- The statutory duties placed on the EP may significantly impinge on the potential for EPs to work therapeutically
- Given the prevalence of children and young people with mental health needs, schools and families do value therapeutic input and there is demand for it
Role of the EP

Service A:
There are some services that are geared more towards [provision of therapeutic interventions] and I think ‘mmm’, because this [model of service delivery] started out to fill the gaps and avoid too much overlap. So for example if you’ve got a clinical psychologist involved, and a specialist behaviour teacher and an autism teacher, we sometimes question, ‘What role do we have here?’ As a collective they can cover things, but we rely on them to tell us what they can’t fulfil and what they may need from us.
Role of the EP

Service B:

In families where there’s a child who’s got a diagnosis of ASD. I’ve had quite a few of those cases where it’s been the parents really struggling to come to terms: either feeling that there will be a diagnosis and supporting them to actually get to CAMHS; or if they already have a diagnosis, how are they going to cope in the future and thinking about schooling? So there are some cross-overs. You sometimes have to say, “Well, I’m here with my EP hat on at the moment and now I’m going to do the family therapy thing”.
Training and practice

• Many EPs have significant additional counselling or therapeutic skills in a whole range of therapeutic approaches
• Some EPs are additionally accredited by professional bodies such as the British Association for Counselling and Psychotherapy (BACP)
• A number of EPs reported that the training received was inadequate, particularly in helping them develop the higher order skills involved in therapy
• It was not always easy to find opportunities to practise or consolidate skills developed through training
• Supervisory structures were not always in place to enable EPs to effectively deliver therapeutic interventions
• Interest in therapeutic interventions led to significant personal attempts to prioritise the delivery of therapy as part of their casework
Training and practice

Service C:

Now the funding is nowhere near equivalent because a doctorate is quite expensive and the CBT training has been relatively cheap; but in terms of time allocation, they’ve the same access to additional time for studies and supervision. Last year, one of our delivery lines was ‘therapeutic interventions’ and people that were doing the CBT accreditation had an allocation of time. It could be clearly identified as the time available for CBT interventions and that was when other members of team started to say, “Well I think I’ve got this child that may benefit. Can you pick them up and do some intervention?”
Training and practice

Service D:

• What we ended up saying as a team, not that everyone wanted to go down [the therapeutic] road, is that what we were looking for was for everyone to identify one particular therapeutic approach that they were at least working on.
Support and service context

- Management and peer support were seen as integral to the delivery of therapeutic interventions.
- In many cases, service capacity and/or the service time allocation model limited opportunities for therapeutic intervention.
- Availability of time a significant issue.
- Indications that EPs might signpost schools to other therapeutic providers, rather than delivering the therapeutic interventions themselves.
- Problems: time to undertake ongoing work; a lack of flexibility to enable intensive support where required; competing priorities (e.g. statutory work); limited number of school visits; schools’ willingness to pay for ongoing work via a traded services model; only a small number of EPs available to deliver therapeutic interventions.
Support and service context

Service D:

In terms of intensive work, we would have an intervention meeting. There would be actions for lots of people and I would take on a commission - because we don’t talk about referring children, but we do talk about commissioning a piece of work. So I’ve got a girl who has got memory loss at secondary and so I’m seeing her on a very regular basis...

I would say we probably aren’t committing ourselves to more than up to six sessions. So we’re not pretending that we can be doing long-term detailed therapeutic work.
Support and service context

Service C:

• I think a big difference for me has come about since we restructured the service and identified some specialist senior posts. We took the decision when we had some vacancies, rather than reconfiguring around team leaders and management posts, to create specialist senior posts. You can see the huge benefit of having a specialist senior for emotional health and wellbeing and I think that gives a really strong message both within the team and outside the team. We use this leadership role very much to support keeping the team emotionally healthy. I think that has a very high priority.
Discussion

• Reflect on how what you have heard in the presentation contrasts with your own experiences

• Educational Psychologists and therapeutic intervention: follow up questionnaire
Publications to date


• Planning paper on enabling effective practice: Educational Psychology in Practice?
Discussion

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